Royal Papworth Hospital
NHS Foundation Trust

Agenda item 04.ii

Report to:	**Trust Board**	**Date: 03 July 2025**
Report from:	**Executive Directors**	
Principal Objective/ Strategy and Title	**GOVERNANCE** **Papworth Integrated Performance Report (PIPR)**	
Board Assurance Framework Entries	**BAF – multiple as included in the report**	
Regulatory Requirement	**Regulator licensing and Regulator requirements**	
Equality Considerations	**Equality has been considered but none believed to apply**	
Key Risks	**Non-compliance resulting in financial penalties**	
For:	**Information**	

2025/26 Performance highlights:

This report represents the May 2025 data. Overall, the Trust's performance rating is **AMBER** for the month. There is one domain rated Green (Caring); there are three domains rated Amber (Safe, Finance and People Management & Culture) and two domains rated as Red (Effective, and Responsive).

Recommendation

The Trust Board is requested to **note** the contents of the report.

Royal Papworth Hospital
NHS Foundation Trust

Papworth Integrated Performance Report (PIPR)

May 2025

Compassion
Excellence
Collaboration

Content

Context:

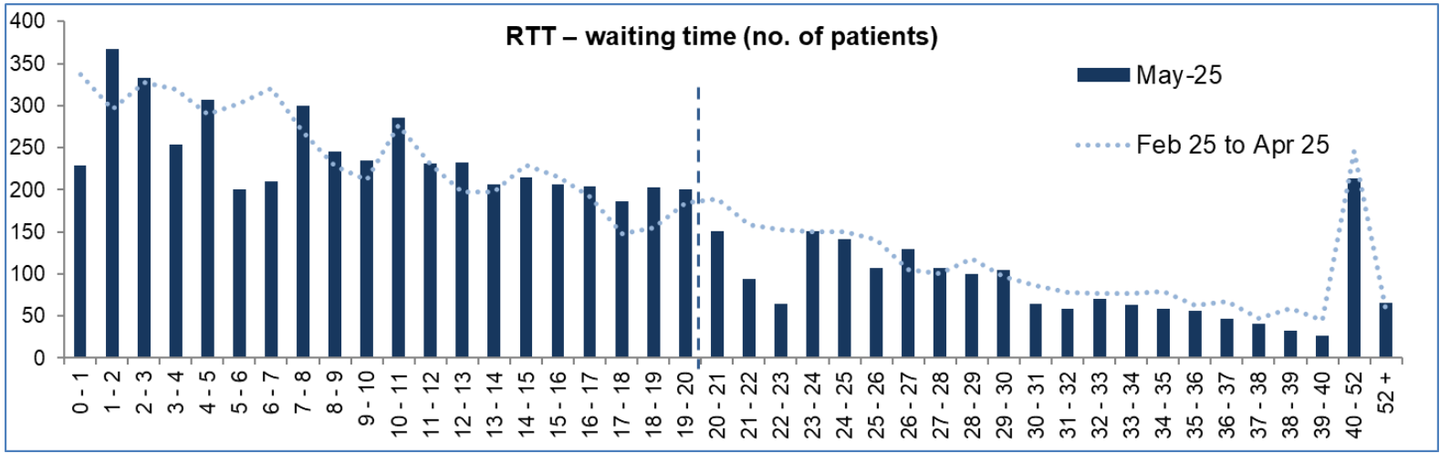
Royal Papworth Hospital
NHS Foundation Trust

Context - The activity table and RTT waiting time curve below sets out the context for the operational performance of the Trust and should be used to support constructive challenge from the committee:

All Inpatient Spells (NHS only)	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Trend
Cardiac Surgery	137	130	147	138	143	146	
Cardiology	638	733	650	679	718	746	
ECMO	4	4	2	8	0	4	
ITU (COVID)	0	0	0	0	0	0	
PTE operations	13	8	9	11	11	9	
RSSC	564	622	536	526	632	654	
Thoracic Medicine	459	549	510	501	497	508	
Thoracic surgery (exc PTE)	96	79	87	82	56	61	
Transplant/VAD	44	40	49	45	45	48	
Total Admitted Episodes	**1,955**	**2,165**	**1,990**	**1,990**	**2,102**	**2,176**	
Baseline (2019/20 adjusted for working days annual average)	*1,830*	*1,830*	*1,830*	*1,830*	*1,830*	*1,830*	
%Baseline	*107%*	*118%*	*109%*	*109%*	*115%*	*119%*	

Outpatient Attendances (NHS only)	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Trend
Cardiac Surgery	518	559	600	573	526	574	
Cardiology	3,505	3,897	3,634	3,842	3,945	3,960	
RSSC	1,848	2,258	2,091	2,166	2,095	2,248	
Thoracic Medicine	2,245	2,480	2,285	2,162	2,306	2,458	
Thoracic surgery (exc PTE)	135	171	125	132	100	110	
Transplant/VAD	280	269	254	281	330	306	
Total Outpatients	**8,531**	**9,634**	**8,989**	**9,156**	**9,302**	**9,656**	
Baseline (2019/20 adjusted for working days annual average)	*7,418*	*7,418*	*7,418*	*7,418*	*7,418*	*7,418*	
%Baseline	*115%*	*130%*	*121%*	*123%*	*125%*	*130%*	

Note 1 - Activity per SUS billing currency, includes patient counts for ECMO and PCP (not bedday)
Note 2 - NHS activity only
Note 3 - Note - Elective, Non Elective and Outpatient activity data may include adjustments to prior months. This will be where any activity submitted to SUS in the latest month completed in prior months. This may be due to delays in finalising the clinical information required for the actiivty to be coded and submitted to SUS.



Reading guide

Royal Papworth Hospital
NHS Foundation Trust

The Papworth Integrated Performance Report (PIPR) is designed to provide the Board with a balanced summary of the Trust's performance within all key areas of operation on a monthly basis. To achieve this, the Trust has identified the Board level Key Performance Indicators ("KPIs") within each category, which are considered to drive the overall performance of the Trust, which are contained within this report with performance assessed over time. The report highlights key areas of improvement or concern, enabling the Board to identify those areas that require the most consideration. As such, this report is not designed to replace the need for more detailed reporting on key areas of performance, and therefore detailed reporting will be provided to the Board to accompany the PIPR where requested by the Board or Executive Management, or where there is a significant performance challenge or concern.

- **'At a glance' section** – this includes a 'balanced scorecard' showing performance against those KPIs considered the most important measures of the Trust's performance as agreed by the Board.
- **Performance Summaries** – these provides a more detailed summary of key areas of performance improvement or concern for each of the categories included within the balanced score card (Safe; Caring; Effective; Responsive; People, Management and Culture and Finance). **The Safe, Caring, Effective and Responsive Performance Summaries now Statistical process control (SPC) which is an analytical technique that plots data over time. It helps us understand variation and in so doing guides us to take the most appropriate action. SPC is a good technique to use when implementing change as it enables you to understand whether changes you are making are resulting in improvement — a key component of the Model for Improvement widely used within the NHS.**

Key

KPI 'RAG' Ratings

The 'RAG' ratings for each of the individual KPIs included within this report are defined as follows:

Assessment rating	Description
Green	Performance meets or exceeds the set target with little risk of missing the target in future periods
Amber	Current performance is 1) Within 1% of the set target (above or below target) unless explicitly stated otherwise or 2) Performance trend analysis indicates that the Trust is at risk of missing the target in future periods
Red	The Trust is missing the target by more than 1% unless explicitly stated otherwise

Overall Scoring within a Category

Each category within the Balanced scorecard is given an overall RAG rating based on the rating of the KPIs within the category that appear on the balance scorecard (page 4).

- **Red (10 points) =** 2 or more red KPIs within the category
- **Amber (5 points) =** 1 red KPI rating within the category
- **Green (1) =** No reds and 1 amber or less within the category

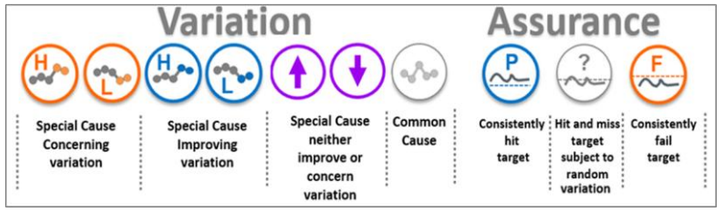
Overall Report Scoring

- **Red =** 4 or more red KPI categories
- **Amber =** Up to 3 red categories
- **Green =** No reds and 3 or less amber

Trend graphs

Within the balanced scorecard, each KPI has a trend graph which summarises performance against target from April 2021 (where data is available)

Statistical process control (SPC) key to icons used:



Data Quality Indicator

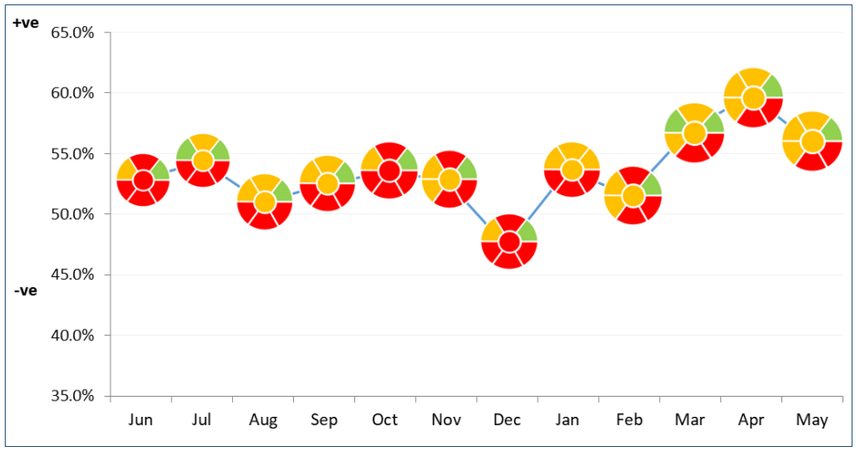
The data quality ratings for each of the KPIs included within the 'at a glance' section of this report are defined as follows. It should be noted that the assessment for each of the reported KPI's is based on the views and judgement of the business owner for that KPI, and has not been subject to formal risk assessment, testing or validation.

Rating	Description
5	High level of confidence in the *quality of reported data. Data captured electronically in a reliable and auditable system and reported with limited manual manipulation with a full audit trail retained. Sufficient monitoring mechanisms in place to* provide management insight over accuracy of reported data, supported by recent internal or external audits.
4	High level of confidence in the quality or reported data, but limited formal mechanisms to provide assurance of completeness and accuracy of reported information.
3	Moderate level of confidence in the quality of reported data, for example due to challenges within the processes to input or extract data such as considerable need for manual manipulation of information. These could effect the assurance of the reported figures but no significant known issues exist.
2	Lower level of confidence in the quality of reported data due to known or suspected issues, including the results of assurance activity including internal and external audits. These issues are likely to impact the completeness and accuracy of the reported data and therefore performance should be triangulated with other sources before being used to make decisions.
1	Low level of confidence in the reported data due to known issues within the input, processing or reporting of that data. The issues are likely to have resulted in significant misstatement of the reported performance and therefore should not be used to make decisions.

Trust performance summary

Royal Papworth Hospital
NHS Foundation Trust

Overall Trust rating - AMBER



FAVOURABLE PERFORMANCE

SAFE: 1) Safe staffing fill rates - Registered Nurse fill rates for day (90%) and night shifts (91%) are above target for May. Safer staffing fill rates for Health Care Support Workers (HCSWs) are at target of 85% for day shifts in May, incremental decrease noted from 86% in April. HCSW fill rates are above target at 88% for night shifts in May. RPH's active recruitment campaign for HCSWs have contributed to fill rate improvement meeting target of 85% and above. Overall CHPPD (Care Hours Per Patient Day) is 12.4 for May compared to 12.5 reported for April. 2) Increasing safer staffing fill rates continue to support increases in SS/CN time from October 2023 to present; there has been a slight decrease in SS time to 80% in May compared to 82% in April.

CARING: FFT (Friends and Family Test): In summary – Inpatients: Positive Experience rate was 99.2% in May 2025 for our recommendation score. Participation Rate for surveys increased to 44.1%. Outpatients: Positive experience rate was 97.4% in May 2025 and above our 95% target. Participation rate was 12.3%.

EFFECTIVE: Elective Inpatient activity - Elective activity continues in an upward trajectory with an upward RTT recovery. IHU patients continue to be prioritised to support flow within the system, additional capacity was made available as required. Overall activity very slightly below target, but April and May have both seen 2 bank holidays which has reduced capacity.

RESPONSIVE: RTT - While the RTT fails to meet the national target, month on month improvements are being noted through the elective recovery delivery group. Initiatives are under continuous review to ensure positive impacts are made, as well as new initiatives being developed and monitored through the elective recovery delivery group and Access Board. With the introduction of PSI lists from M01 and focused validation, the overall number of patients waiting has started to decrease. Enhanced governance is being implemented to ensure scheduling is being optimised 6 weeks in advance, as well oversight of long waiters.

PEOPLE, MANAGEMENT & CULTURE: Turnover was over our KPI at 10%. Of the 25 leavers (20.5wte) non-medical leavers, 8 were retirements/flexi retirements. 2) Our total Trust vacancy rate increased to 6.5% but remained below our KPI. The reason for the increase is that budgeted establishments were increased by 26.2 WTE with the implementation of the 25/26 workforce plan.

FINANCE: At month 2, the YTD finance position is a deficit of £0.05m, this represents a £0.05m favourable variance to plan. The favourable variance is driven by the budget phasing of planned spend on elective recovery initiatives compared to actual spend on these initiatives and the phasing of contingency reserves which are offsetting adverse business-as-usual pay variances and CIP under-delivery in the Divisions at month 2.

ADVERSE PERFORMANCE

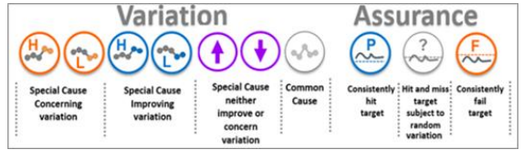
CARING: Responding to Complaints on time: 4 of 6 (66.67%) complaints responded to in the month were within agreed timescales. There were 2 late responses due to the delayed/completeness in investigation process (1 STA, 1 Cardiology). Of the 4 on time all required extensions as per Policy and Complainants were kept informed and agreed to the required extensions.

EFFECTIVE: ERU Bed Occupancy - Bed occupancy in M02 was 56.7%. This decrease is partly due to unfilled cardiac theatre slots which totalled 8 in May. Thoracic activity was done in lieu of this, but these patients do not go to CCA. The leadership team are reviewing the ratio of ERU and ICU beds, to ensure the current ratio is correct, this work is ongoing and will be reviewed in M02 once there is sufficient data to analyse. A deep dive into activity through ERU has been requested at BU as the admission rate has been dropping steadily over the last 3 months.

PEOPLE, MANAGEMENT & CULTURE: Total sickness absence fell slightly to 4%. The Workforce Directorate continues to support managers through training and the application of absence management protocols. A proposal for an absence management support programme for areas with high absence rates is being developed.

FINANCE: Pay expenditure is £0.5m adverse to plan. The YTD position reflects the impact of the 2025/26 pay award, which is offset within the income position. Furthermore, this includes unspent budget for elective recovery initiatives which is masking adverse variances in BAU Divisional positions. The Divisional adverse variances reflect ongoing temporary staff use in excess of establishments in a number of areas, alongside YTD non-recurrent arrears payments for several medical staff. Agency spend is reducing, both in terms of spend and usage, with the enhanced controls put in place in January 2025 taking effect and the YTD spend was the lowest in c17 months with Divisional agency trajectories are on track overall. Work continues with Divisional teams to understand bank usage in areas that are at substantive establishment and develop action plans to recover adverse pay variances.

At a glance – Balanced scorecard



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		Month reported on	Data Quality ***	Plan	Current month score	YTD Actual	Trend / SPC Variation & Assurance
Safe	Never Events	May-25	5	0	0	0	
	Number of Patient Safety Incident Investigations (PSII) commissioners in month	May-25	5	0	0	0	
	Learning Responses - Moderate Harm and above as % of total patient safety incidents	May-25	5	3%	0.9%	1.6%	
	Number of Trust acquired PU (Catergory 2 and above)	May-25	4	35 pa	0	1	
	Falls per 1000 bed days	May-25	5	4	2.2	0.0	
	VTE - Number of patients assessed on admission	May-25	5	95%	93%	93%	
	Sepsis - % patients screened and treated (Quarterly) *	May-25	3	90%	-	-	
	Trust CHPPD	May-25	5	9.6	12.4	12.5	
	Safer staffing: fill rate – Registered Nurses day	May-25	5	85%	90.0%	90.5%	
	Safer staffing: fill rate – Registered Nurses night	May-25	5	85%	91.0%	92.0%	
	Safer staffing: fill rate – HCSWs day	May-25	5	85%	85.0%	85.5%	
	Safer staffing: fill rate – HCSWs night	May-25	5	85%	88.0%	87.5%	
	% supervisory ward sister/charge nurse time	May-25	New	90%	80.00%	81.0%	
	Cardiac surgery mortality (Crude)	May-25	3	3%	2.3%	2.3%	
	MRSA bacteremia	May-25	3	0	0	0	
	Monitoring C.Diff (toxin positive)	May-25	5	7	1	1	
Caring	FFT score- Inpatients	May-25	4	95%	99.20%	99.20%	
	FFT score - Outpatients	May-25	4	95%	97.40%	97.90%	
	Mixed sex accommodation breaches	May-25	5	0	0	0	
	Number of written complaints per 1000 WTE (Rolling 3 mnth average)	May-25	4	12.6	8.1	8.1	
	% of complaints responded to within agreed timescales	May-25	4	100%	66.67%	66.67%	
	Duty of candour compliance undertaken within10wd (quarterly)	May-25	New	100%	100.0%	100.0%	
People Management & Culture	Voluntary Turnover %	May-25	4	9.0%	10.0%	8.8%	
	Vacancy rate as % of budget	May-25	4	7.5%	6.5%		
	% of staff with a current IPR	May-25	4	90%	78.04%		
	% Medical Appraisals*	May-25	3	90%	75.78%		
	Mandatory training %	May-25	4	90%	86.97%	87.14%	
	% sickness absence	May-25	5	4.00%	4.00%	4.11%	

		Month reported on	Data Quality ***	Plan	Current month score	YTD Actual	Trend / SPC Variation & Assurance
Effective	Bed Occupancy (inc HDU but exc CCA and sleep lab)	May-25	4	85% (Green 80%-90%)	74.80%	74.30%	
	ICU bed occupancy	May-25	4	85% (Green 80%-90%)	79.80%	79.00%	
	Enhanced Recovery Unit bed occupancy %	May-25	4	85% (Green 80%-90%)	56.70%	66.20%	
	Elective inpatient and day cases (NHS only)****	May-25	4	1679	1,767	3,454	
	Outpatient First Attends (NHS only)****	May-25	4	2180	2,579	4,874	
	Outpatient FUPs (NHS only)****	May-25	4	6903	7,077	14,084	
	% of outpatient FU appointments as PIFU (Patient Initiated Follow up)	May-25	4	5%	12.1%	11.9%	
	Reduction in Follow up appointment by 25% compared to 19/20 activity	May-25	4	-25%	-4.7%	-3.5%	
	% Day cases	May-25	4	85%	76.8%	76.3%	
	Theatre Utilisation (uncapped)	May-25	3	85%	88%	87%	
	Cath Lab Utilisation (including 15 min Turn Around Times) ***	May-25	3	85%	85%	84%	
Responsive	% diagnostics waiting less than 6 weeks	May-25	1	99%	91.6%	92.4%	
	18 weeks RTT (combined)	May-25	4	92%	65.4%		
	31 days cancer waits*	May-25	5	96%	95%	98%	
	62 day cancer wait for 1st Treatment from urgent referral*	May-25	3	85%	50%	25%	
	104 days cancer wait breaches*	May-25	5	0	4	9	
	Number of patients waiting over 65 weeks for treatment *	May-25	New	0	18		
	Theatre cancellations in month	May-25	3	15	20	24	
	% of IHU surgery performed < 7 days of medically fit for surgery	May-25	4	95%	33%	32%	
	Acute Coronary Syndrome 3 day transfer %	May-25	4	90%	73%	73%	
	Number of patients on waiting list	May-25	4	7255	6796		
	52 week RTT breaches	May-25	5	0	65	121	
Finance	Year to date surplus/(deficit) adjusted £000s	May-25	4	£(91)k	£(58)k		
	Cash Position at month end £000s	May-25	5	£75,889k	£75,114k		
	Capital Expenditure YTD (BAU from System CDEL) - £000s	May-25	4	£232k	£39k		
	CIP – actual achievement YTD - £000s	May-25	4	£1293k	£438k		
	Agency expenditure target £'k	May-25	5	£440k	£179k		
	Bank expenditure target £'k	May-25	5	£390k	£417k		

* Latest month of 62 day and 31 cancer wait metric is still being validated ***Data Quality scores re-assessed M03 and M08 **** Plan based on 25/26 demand recovery plan.

Safe: Performance Summary

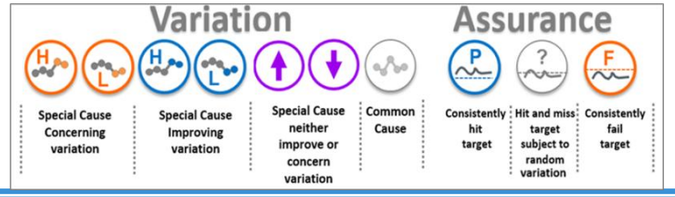
Accountable Executive: *Chief Nurse* ***Report Author:*** *Deputy Chief Nurse / Deputy Director of Quality and Risk*

Royal Papworth Hospital
NHS Foundation Trust

	Metric	Latest Performance		Previous	In month vs target	Action and Assurance		
		Trust target	Most recent position	Position		Variation	Assurance	Escalation trigger
Dashboard KPIs	Never Events	0	0	0				Review
	Number of Patient Safety Incident Invetigations (PSII) to commissioners in month	0	0	0				Review
	Learning Responses - Moderate Harm and above as % of total patient safety incidents	3.00%	0.89%	2.21%				
	Number of Trust acquired PU (Catergory 2 and above)	35 pa	0	1				Review
	Falls per 1000 bed days	4.00	2.21	1.58				Review
	VTE - Number of patients assessed on admission	95.0%	93.3%	94.3%				Review
	Sepsis - % patients screened and treated (Quarterly) *	90%	-	-				Review
	Trust CHPPD	9.6	12.4	12.5				Monitor
	Safer staffing: fill rate – Registered Nurses day	85%	90%	91%				Review
	Safer staffing: fill rate – Registered Nurses night	85%	91%	93%				Review
	Safer staffing: fill rate – HCSWs day	85%	85%	86%				Action Plan
	Safer staffing: fill rate – HCSWs night	85%	88%	87%				Review
	% supervisory ward sister/charge nurse time	90%	80%	82%				Action Plan
	Cardiac surgery mortality (Crude)	3.0%	2.3%	2.2%				Monitor
	MRSA bacteremia	0	0	0				Review
	Monitoring C.Diff (toxin positive)	7 pa	1	0				Review
Additional KPIs	E coli bacteraemia	Monitor	1	0				Monitor
	Klebsiella bacteraemia	Monitor	1	1				Monitor
	Pseudomonas bacteraemia	Monitor	1	0				Monitor
	Other bacteraemia	Monitor	1	0				Monitor
	% of medication errors causing harm (Low Harm and above)	Monitor	22.0%	10.5%				Monitor
	All patient incidents per 1000 bed days (inc.Near Miss incidents)	Monitor	40.2	35.7				Monitor
	SSI CABG & Valve infections (inpatient/readmissions %)	2.7%	-	-				Review
	SSI CABG & Valve infections patient numbers (inpatient/readmisisons)	Monitor	-	-				Monitor
	WHO Safety checklist % - Surgery	Monitor	91.7%	88.8%				Monitor
	WHO Safety checklist % - Cath Labs	Monitor	96.3%	0.0%				Monitor

Safe: Patient Safety/Harm Free Care

Accountable Executive: *Chief Nurse*
Report Author: *Deputy Chief Nurse / Deputy Director of Quality and Risk*



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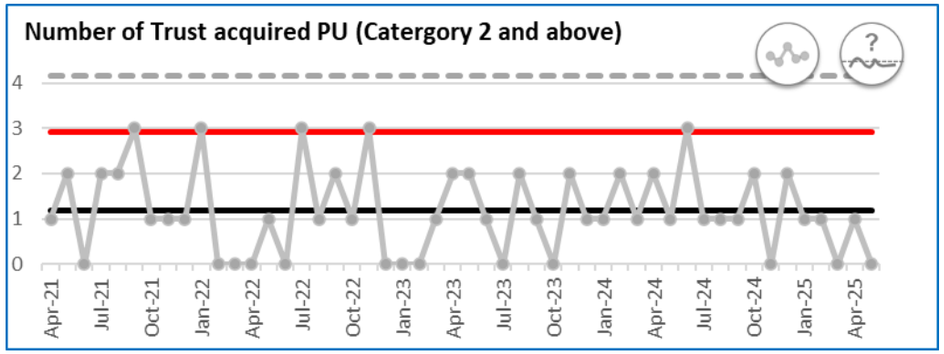
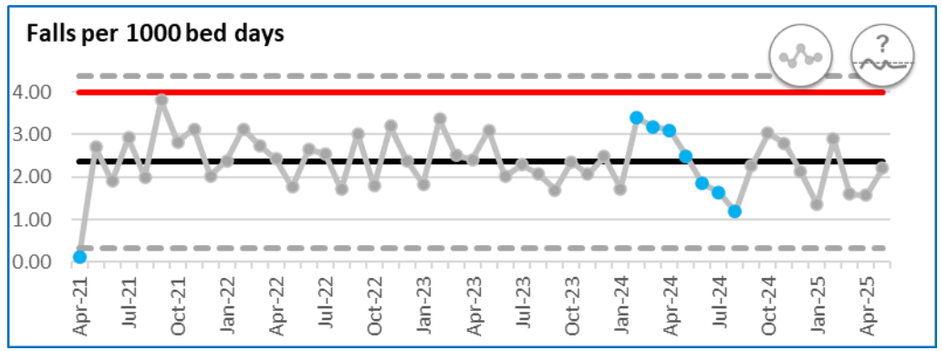
Target
Measure
Concerning special cause
Mean
Process Limit
Improving special cause

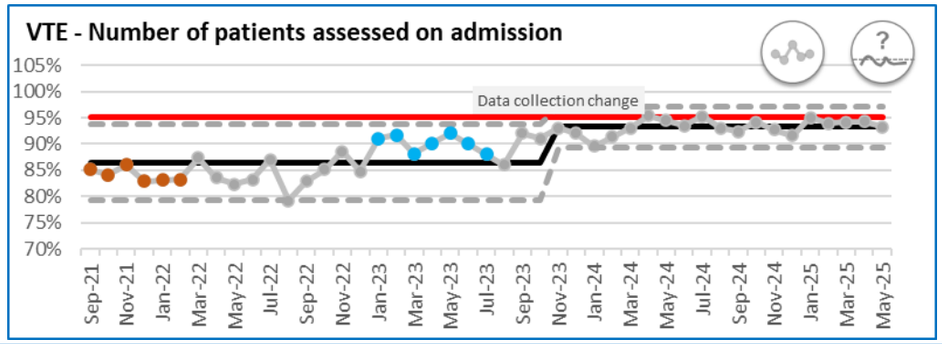
1. Historic trends & metrics



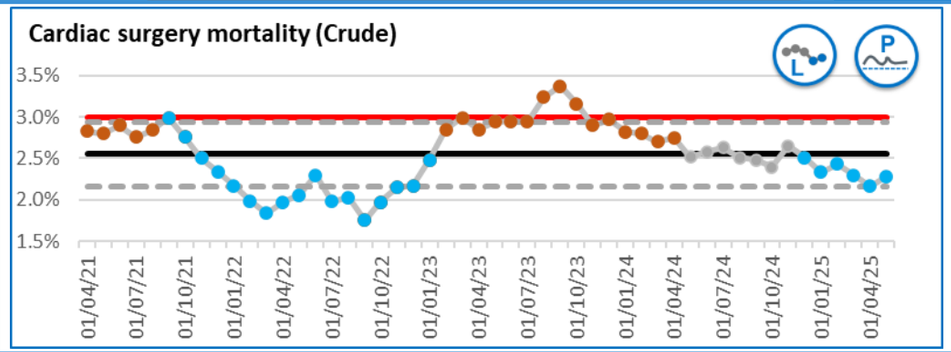
May-25
0
Target (red line)
35 per annum
Variation
Common cause variation
Assurance
Hit and miss on achieving target subject to random variation



May-25
2.21
Target (red line)
4
Variation
Common cause variation
Assurance
Hit and miss on achieving target subject to random variation



May-25
93.3%
Target (red line)
95.0%
Variation
Common cause variation
Assurance
Hit and miss on achieving target subject to random variation



May-25
2.3%
Target (red line)
3.00%
Variation
Special cause variation of an improving nature
Assurance
Has consistently passed the target

2. Action plans / Comments

Patient Safety Incident Investigations (PSII): There were no PSII's commissioned by SIERP in May.

Learning Responses- ***Moderate Harm and above reported as % of total patient safety:*** In Month there were 0.89% (2/254) of incidents that resulted in harm. The 2 graded at SIERP in month, were 1 moderate WEB56393 and 1 severe harm WEB56294 from initial gradings. Final Investigations/grade will be shared at QRMG.

Medication errors causing harm: **21.95** % (9/41) of medication incidents were graded as low harm, remaining no harm or near miss.

All patient incidents per 1000 bed days: There were 40.2 patient safety incidents per 1000 bed days.

Harm Free Care: In May there was 0 (Zero) confirmed Pressure Ulcer of category 2. There were 2.20 falls per 1000 bed days (14 in total, 1 moderate (WEB56393) 10 low harm & 3 no harm), deep dive into effectiveness of falls prevention and management workplan currently under way. Compliance for VTE risk assessment was 93.3%. Those achieving VTE compliance above the 95% target were 3S and Day Ward

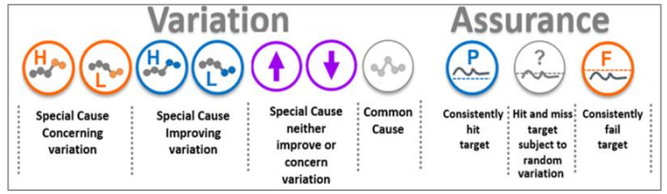
Cardiac Surgery Mortality (crude monitoring): Within expected variation at 2.3% in May.

Alert Organisms: There was one 1 C Difficile, 1 Klebseilla and 1 Ecoli bacteraemias in month

WHO Surgical Checklist: New for PIPR Safe slides in 2025/26, is the monitoring of the World Health Organisation (WHO) surgical checklist, for May this was 91.7% for Theatres and 96.3% for Cath Labs. The target for WHO check list is 100%.

Safe: Safer Staffing

Accountable Executive: *Chief Nurse*
Report Author: *Deputy Chief Nurse / Deputy Director of Quality and Risk*



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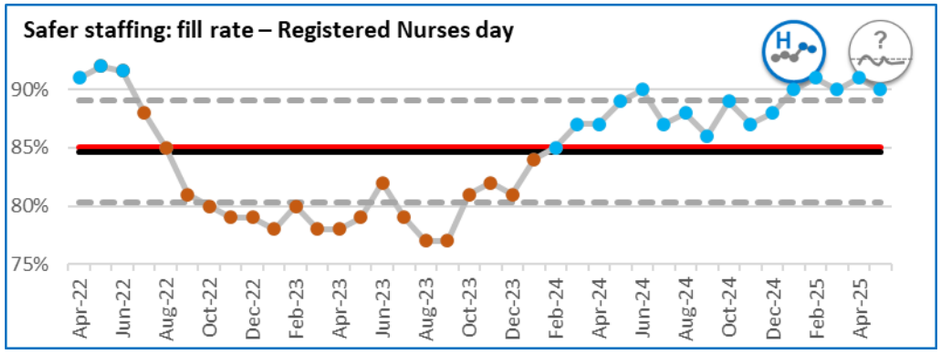
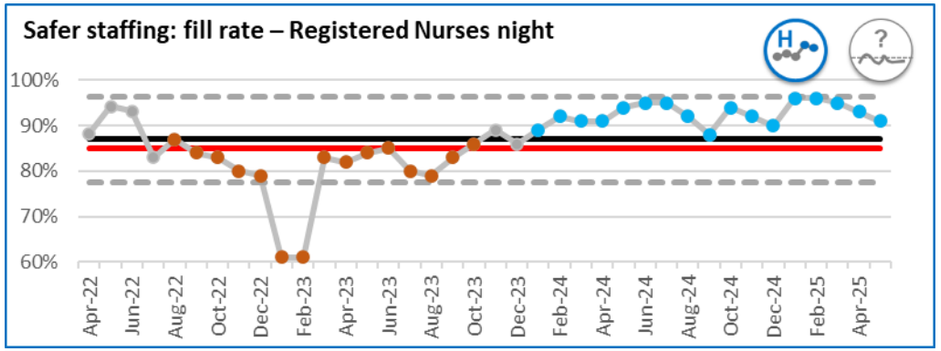
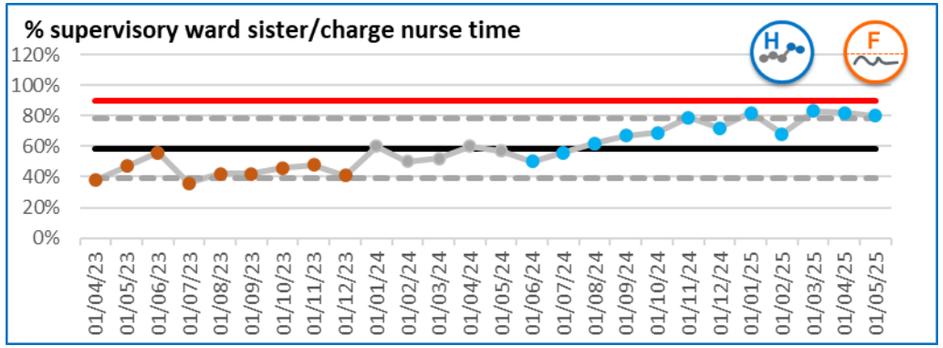
1. Historic trends & metrics



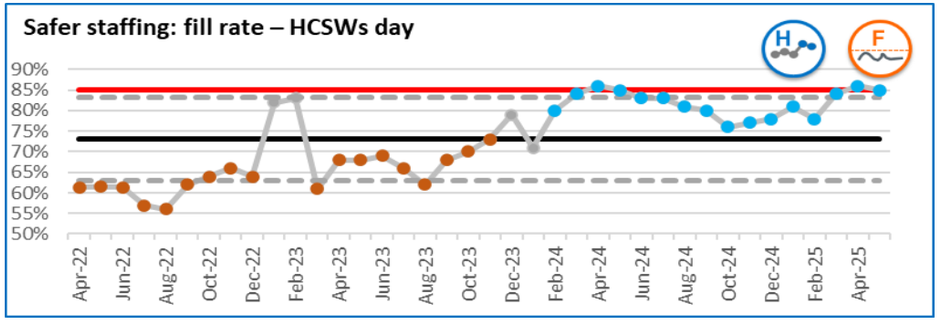
May-25
90%
Target (red line)
85%
Variation
Special cause variation of an improving nature
Assurance
Hit and miss on achieving target subject to random variation



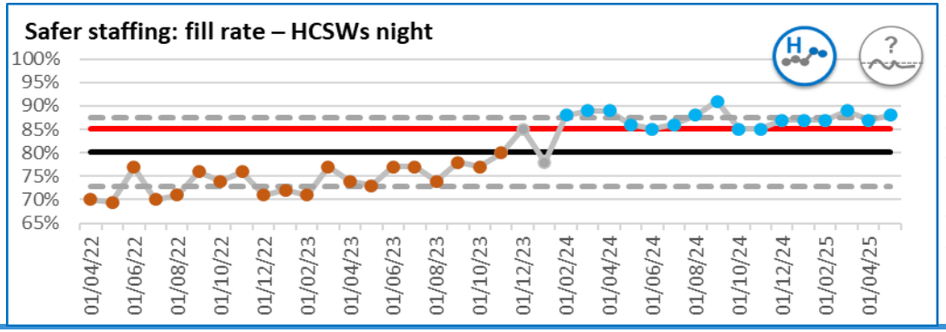
May-25
91%
Target (red line)
85%
Variation
Special cause variation of an improving nature
Assurance
Hit and miss on achieving target subject to random variation



May-25
80%
Target (red line)
90%
Variation
Special cause variation of an improving nature
Assurance
Has consistently failed the target



May-25
85%
Target (red line)
85%
Variation
Special cause variation of an improving nature
Assurance
Has consistently failed the target



May-25
88%
Target (red line)
85%
Variation
Special cause variation of an improving nature
Assurance
Hit and miss on achieving target subject to random variation

2. Action plans / Comments

Safe staffing fill rates:

Registered Nurse (RN) fill rates for day (90%) and night shifts (91%) are above target for May. Safer staffing fill rates for Health Care Support Workers (HCSWs) are at target of 85% for day shifts in May, incremental decrease noted from 86% in April. HCSW fill rates are above target at 88% for night shifts in May. RPH's active recruitment campaign for HCSWs have contributed to fill rate improvement meeting target of 85% and above.
Overall CHPPD (Care Hours Per Patient Day) is 12.4 for May compared to 12.5 reported for April.

Ward supervisory sister (SS)/ charge nurse (CN):

Increasing safer staffing fill rates continue to support increases in SS/ CN time from October 2023 to present; there has been a slight decrease in SS time to 80% in May compared to 82% in April. The highest achieving areas towards SS/ CN time target of 90% are the Outpatient Department who achieved 99% above target, followed by ERU at 87% and Thoracic Ward 4S at 83% . Day Ward has had an increase in SS time from 65% in April to 74% in May. Heads of Nursing and Matrons continue to monitor and report divisional SS/ CN performance to the monthly Clinical Practice Advisory Committee chaired by the Chief Nurse.

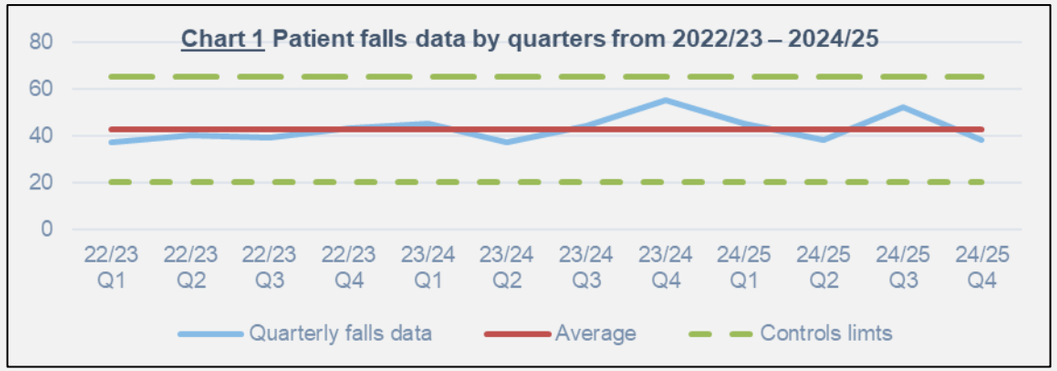
Safe: Key Performance Challenge on Falls Prevention

Accountable Executive: Chief Nurse *Report:* Deputy Chief Nurse and Deputy Director of Quality and Risk *Slide content:* Patient Safety Lead and Falls Nurse Specialist

Royal Papworth Hospital NHS Foundation Trust

Background to Inpatient Falls

A fall is defined as an event whereby an individual comes to rest on the ground and/ or another lower level, in an unintended and uncontrolled manner, with or without loss of consciousness (British Geriatrics Society 2001). NICE Guidelines (NG249, 2025)) state that patients over 65 and those between 50 and 65 (with exception of Transplant and emergency patients) have a falls risk assessment completed by nursing staff on admission (within 24 hrs) or at pre-admission, with onward referral as necessary to the allied health professional teams. Royal Papworth Hospital (RPH) is committed to prevention and reducing the risk of falling and injuries to inpatients during hospital stay in accordance with DN194 Patient Falls Policy for Prevention and Management. The metric at RPH for falls per 1000 bed days is 4 and it is tracked monthly on Papworth Integrated Performance Review/ SAFE.



Q1 2022/23 to Q4 2024/25

The quarterly falls data remains within normal variance **in Chart 1** as illustrated by the green line/ control limits. There was an increase in patient falls in Q4 2023/24 and Q3 2024/25 as evidenced by the blue line/ quarterly falls data.

Patient Falls Data by Quarters from 2022/23 to 2024/25 - Thematic Overview of Incidents

Consistent themes have emerged from thematic analysis requiring improvements from falls incident data including: recognition of risk factors for frailty and appropriate actions, falls risk assessment, mitigating actions for single side rooms such as patients out of view and not always calling for assistance, prioritising and balancing safety with privacy when facilitating personal care, maintenance of safety in bathrooms e.g., using falls alarms. Recognition of risk to patients who have intermittent confusion and /or lack mental capacity, where English is the second language and presence of visual/hearing impairments. Excellent communication from the multi-disciplinary team is essential for managing patients at risk of falling and to putting safety measures in place, with the patient, carer and/ or family who should always be involved in their Care Plan.

Falls Review

Whilst the frequency of inpatient falls remains within normal variation/ Trust target for 2024-25 to date, the risk of patient harm is prevalent warranting timely prevention and targeted intervention. A review of the Falls Prevention and Management Group Workplan was commissioned in May 2025, in response to a higher number of falls with harm reported for April and May 2025. The review provides opportunity to identify what support the Falls Prevention and Management Group requires and how the identified learning and action in the workplan is shared across the organisation by the Falls Prevention and Management Group. 12 recommendations were put forward to the Chief Nurse Office for consideration. Following agreement, an Improvement Plan has been formulated with key stakeholders of the Falls Prevention and Management Group including the Patient Safety Lead Falls Nurse Specialist, and multi-professional team leads for nursing, medicine, allied health professionals and pharmacy.

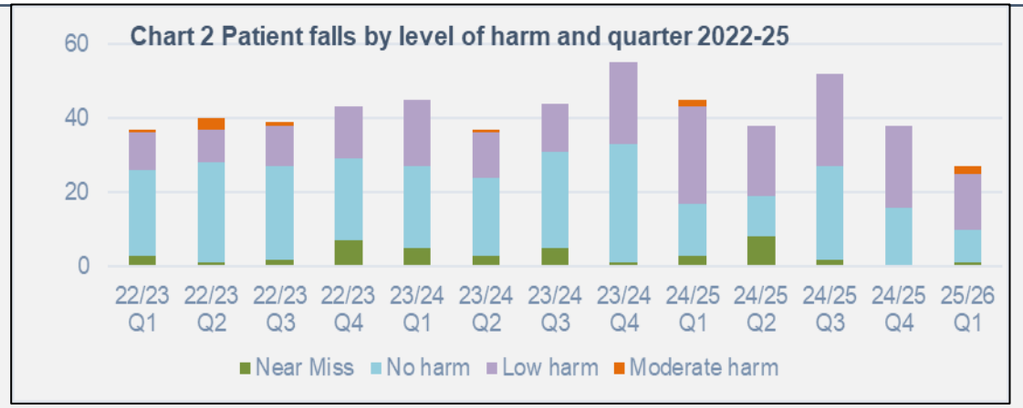


Chart 2 illustrates patient falls by level of harm reported for each Quarter 2022 to 2025. The level of harm reported is mainly no harm (blue) and low harm (purple) as shown across the quarters.

Quarter 1 – 1 April to 10 June 2025

There were 10 patient falls incidents, with 2 graded as severe harm and 1 moderate harm reported in Q1 April 2025; 14 patient falls with 1 graded as moderate harm reported in May 2025.

Quality Improvement Plan for Prevention and Management of Falls

- Meetings and agendas: Terms of Reference for review/ reassess purpose, function, workload.
- **F**alls Champions: redesign of role profile which details responsibilities, timeout for training.
- Information sharing: assurance that learning is shared beyond the Falls group, feedback loop.
- Audit – revisit audit exclusion criteria e.g., include all inpatients (Transplant and Day Ward).
- Patient falls reassessment: share/ adopt 'Ward Huddle' model incl. falls reassessment checks.
- Education and training: communicate what falls training is available on ESR; Area trainers.
- Specialling Policy/ Enhanced Care: review responsibilities of nurse providing 121 patient care with operational input from the Falls Group into the Specialling Policy which is being updated.
- Lying and standing B/P assessments: Task and Finish Group commenced (June) with training and digital requirements necessary for prevention of falls assoc. with orthostatic hypotension.

Governance Oversight / Next Steps

- Patient falls continues to be monitored through the monthly Falls Prevention and Management Group governance structure which report into the quarterly Harm Free Care Panel.
- The Side Room Model of Care Project launched in June 2025 will include falls prevention and management priorities within its project specification.
- A gap analysis is currently underway in response to recently published (Apr.2025) NICE 249 Guidelines Falls; assessment and prevention in older people and in people 50 and over at higher risk; assessing risk of falling and interventions to prevent falls. Implementation of its recommendations will be monitored by the Falls Prevention and Management Group.

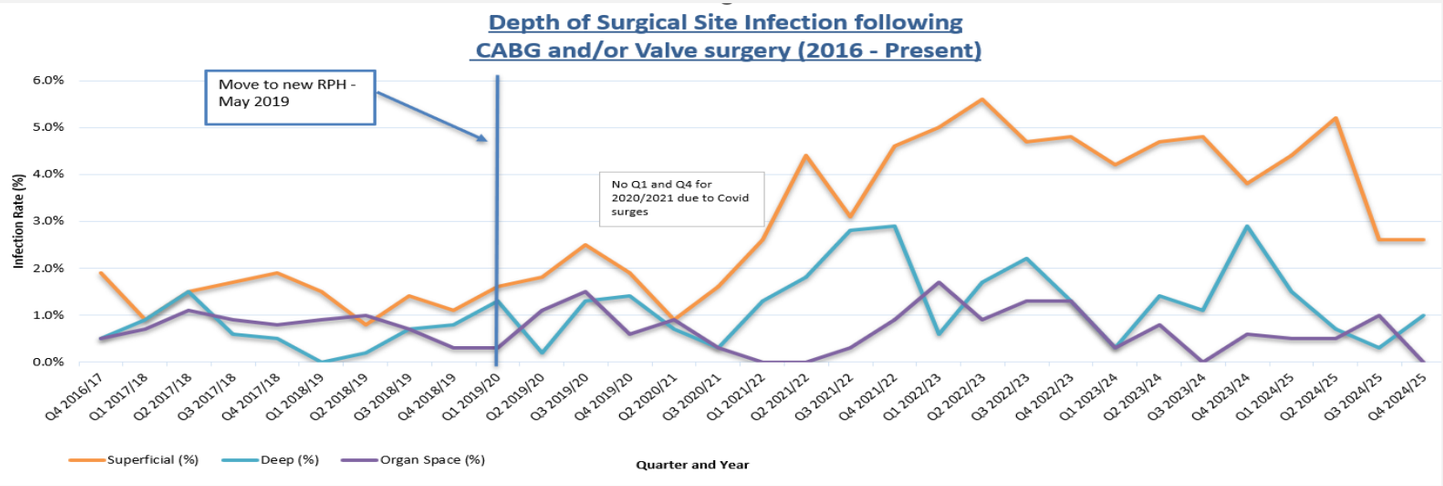
Safe: Spotlight on Surgical Site Infections (SSI) – Annual Update

Royal Papworth Hospital NHS Foundation Trust

Accountable Executive: Chief Nurse *Report:* Deputy Chief Nurse and Deputy Director of Quality and Risk *Slide content:* Wound Care SSI and IPC Teams

Background: SSI rates for **2024-2025** have shown a reduction in surgical site infections (SSI) at Royal Papworth Hospital (RPH). Our annual figures show that following CABG surgery the rate of surgical wound infection is **6.4%** (compared to 8.3% in 2023-2024 and 10.7% in 2022-2023). Deep infections in CABG surgery in particular have consistently reduced every year since 2022. The annual SSI rate for valve surgery is **3.1%**. This rate has slightly declined when compared with previous years of valve SSI data (3.2% in 2023-2024 and 3.6% in 2022-2023).

Graph 1 - Depth of Surgical Site Infection following CABG and/ or Valve surgery 2016 – 2025



All surgery is represented in **Graph 1 above**. Findings illustrate that the rate of deep organ space infection has receded to the levels of deep organ space infection seen at the old RPH site and the current elevated rate is driven by superficial infection at the new RPH site. RPH has welcomed peer reviews and external visits and scrutiny to test our analysis and actions throughout 2022/23 and 2023/24.

Previous highlighted improvements taken to reduce SSI rates:

- Q1 23/24 – Theatre footfall focus, 1st EVH audit, incisional VAC implemented, decontamination lead appointment.
- Q2 23/24 – Skin prep practice refresh, diabetic weight clinic at preassessment, wound photo at discharge.SSI summit with key focus areas followed up, ventilation, diabetes, theatre environment and EVH.
- Q3 23/24 – Sternal band refresh, infected wound Vac practice audit results, swapping out of deconditioned theatre. instruments, chest drain insertion and local wound debridement moved to theatre setting, AMS prophylaxis audit, routine HBA1C testing started in preassessment.
- Q4 23/24 - Pre-op skin decolonisation refresh and focus.
- Q1 24/25 – New sterile instrument provider change over, ERU opens on Critical Care.
- Q2 24/25 – Declutter campaigns begins, double chlorine clean in theatre, theatre capacity reduced from 14 to12 people.

2025/6: New Quality Improvements (SSI Forum) to reduce surgical site infection rates

- RPH data illustrates that the most at-risk group are patients with diabetes and that the lower the HBA1C (Glycated hemoglobin test, measures glucose control levels) on the day of surgery, the lower the risk of infection. From Q1 2025, the diabetes team will review all HBA1C results sent from preadmission clinics and actively direct GP practices to manage the patient's diabetes ahead of admission for surgery.
- There is an increasing evidence base around changing of instruments and gloves at skin closure that can reduce the rate of SSIs. This is referred to as 'a second clean table set up.' Surgery Theatre and Anaesthetics Division through the Clinical Practice Group will be reviewing the introduction of this practice by TVN team at next SSI meeting (July).
- Introduction of door counters. RPH audit has shown that the rate of infection with low footfall at weekends remains significantly lower than during weekdays as shown in **Table 1 below**. It is unclear why this is related to footfall; evaluating traffic through theatre doors using counters may support establishing cause, plan for discussion at next SSI forum.

Table 1 – SSI Surveillance for Surgical Patients 2024-2025

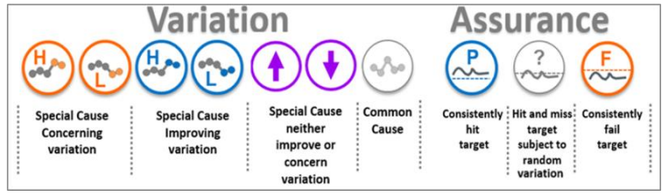
2024-2025	SSI Surveillance patients: CABG, Valve, PTE, Transplants, and other cardiac surgeries						
	No. of SSIs per quarter						
Day of operation	Q1	Q2	Q3	Q4	Total Number of SSIs	Total Number of Operations	Rate of SSI (%)
Monday	6	7	1	2	16	362	**4.4%**
Tuesday	5	4	2	7	18	351	**5.1%**
Wednesday	4	2	7	3	16	336	**4.8%**
Thursday	5	9	1	2	17	344	**4.9%**
Friday	6	5	3	3	17	354	**4.8%**
Saturday	0	0	2	0	2	157	**1.3%**
Sunday	0	1	0	0	1	57	**1.8%**

- Air flow project within the theatre room - review changing the direction of air supply and increase the extract flow to improve the air flow within theatres.
- Project to increase the efficacy of filters within the air handling units (AHU) which will give a higher level of ventilation protection.
- Maintain compliance of decolonisation practices which is monitored through RPH audit.
- Maintain compliance with decontamination of devices and environmental cleanliness used along the surgical pathway.

Governance oversight and monitoring: SSI rates and improvements continue to be monitored through the SSI governance structure; SSI Stakeholder Group is now combined with SSI Clinical Practice Group - agreement reached for this group to be led by the STA Division; and the SSI Environment and Decontamination Group.

Caring: Performance Summary

Accountable Executive: *Chief Nurse*
Report Author: *Deputy Chief Nurse / Deputy Director of Quality and Risk*

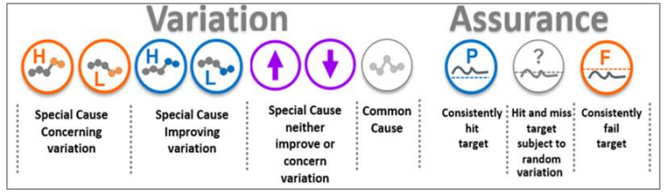


Royal Papworth Hospital
NHS Foundation Trust

	Metric	Latest Performance		Previous	In month vs target	Action and Assurance		
		Trust target	Most recent position	Position		Variation	Assurance	Escalation trigger
Dashboard KPIs	FFT score- Inpatients	95.0%	99.2%	99.2%				Monitor
	FFT score - Outpatients	95.0%	97.4%	98.4%				Monitor
	Mixed sex accommodation breaches	0	0	0				Monitor
	Number of written complaints per 1000 WTE (Rolling 3 mnth average)	12.6	8.1	10.9				Monitor
	% of complaints responded to within agreed timescales	100.0%	66.7%	66.7%				Review
	Duty of candour compliance undertaken within10wd (quarterly)	100.0%	100.0%	100.0%		New	New	Review
Additional KPIs	Friends and Family Test (FFT) inpatient participation rate %	Monitor	44.1%	41.6%				Monitor
	Friends and Family Test (FFT) outpatient participation rate %	Monitor	12.3%	12.9%				Monitor
	Number of complaints upheld / part upheld	3	2	2				Review
	Number of complaints (12 month rolling average)	5	5	5				Review
	Number of complaints	5	5	8				Review
	Number of informal complaints received per month	Monitor	20	12				Monitor
	Number of recorded compliments	Monitor	1945	1820				Monitor

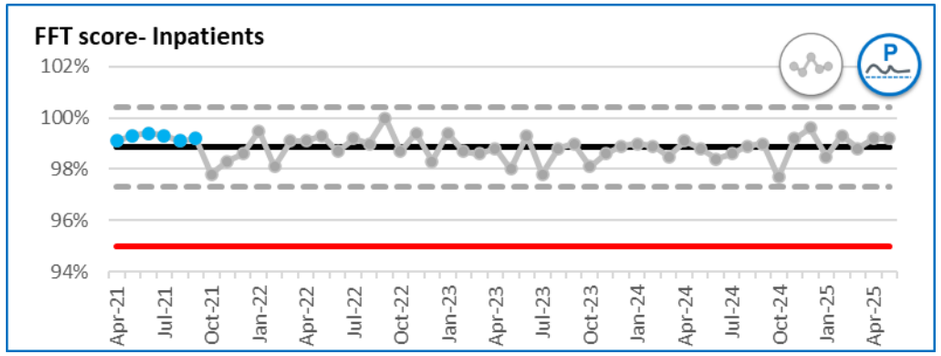
Caring: Patient Experience

Accountable Executive: *Chief Nurse*
Report Author: *Deputy Chief Nurse / Deputy Director of Quality and Risk*

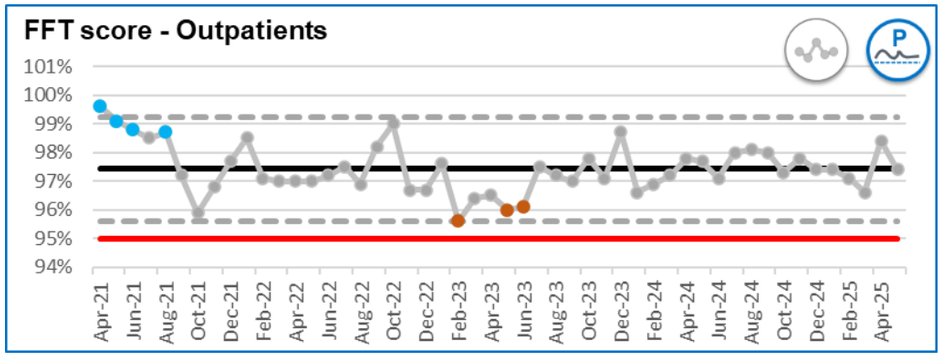


Royal Papworth Hospital
NHS Foundation Trust

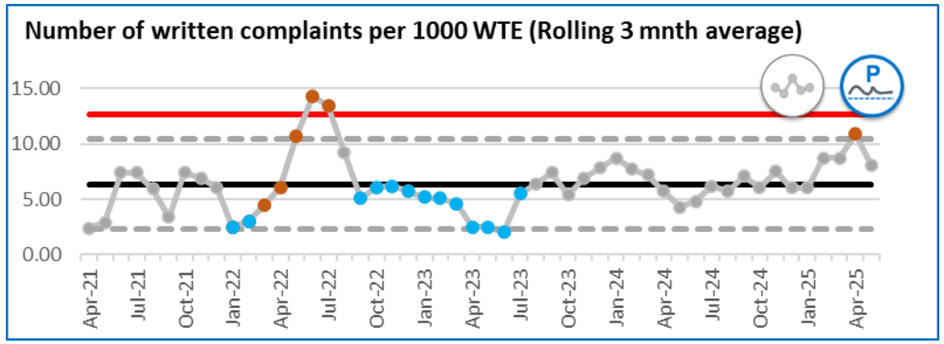
1. Historic trends & metrics



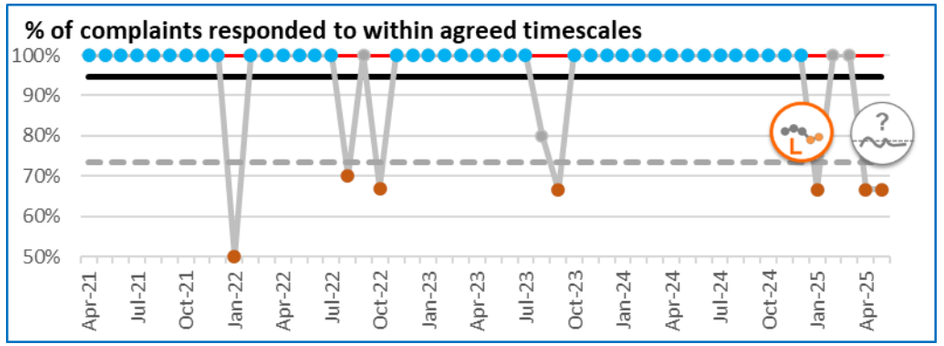
May-25
99.2%
Target (red line)
95.0%
Variation
Common cause variation
Assurance
Has consistently passed the target



May-25
97.4%
Target (red line)
95.0%
Variation
Common cause variation
Assurance
Has consistently passed the target



May-25
8.1
Target (red line)
12.6
Variation
Common cause variation
Assurance
Has consistently passed the target



May-25
66.7%
Target (red line)
100%
Variation
Special cause variation of a concerning nature
Assurance
Hit and miss on achieving target subject to random variation

2. Comments/Action plans

FFT (Friends and Family Test): In summary;

Inpatients: Positive Experience rate was 99.2% in May 2025 for our recommendation score. Participation Rate for surveys was 44.1%.

Outpatients: Positive experience rate was 97.4% in May 2025 and above our 95% target. Participation rate was 12.3%.

Compliments: the number of formally logged compliments received during May 2025 was 1,945. Of these 1,894 were from compliments from FFT surveys and 51 compliments via cards/letters/PALS captured feedback

Responding to Complaints on time: **4 of 6 (66.67%)** complaints responded to in the month were within agreed timescales. There were 2 late responses due to the delayed/completeness in investigation process (1 STA, 1 Cardiology). Of the 4 on time all required extensions as per Policy and Complainants were kept informed and agreed to the required extensions.

Number of written complaints per 1000 staff WTE: is a benchmark figure that used to be provided by NHS Model Health System to enable national benchmarking monthly, this has now ceased. We will continue to have this as an internal metric to aid monitoring. Trust Target is 12.6, we remained within this target at 8.10.

Duty of Candour (DOC) Compliance: The Trust standard is to complete the DOC verbal and written process to those affected or their Next of Kin within 10 days of an event occurring. For the month of May there were 2 initially graded harm events 1 DOC completed in time, achieving 100% compliance. One DOC on hold for further clinical review (WEB56294-Severe harm) due to complexity of case

Caring: Key Performance Challenge - Complaints

Royal Papworth Hospital
NHS Foundation Trust

Accountable Executive: Chief Nurse *Report Author: Deputy Chief Nurse / Deputy Director of Quality and Risk*

Received Complaints in Month (Total of all Informal and Formal): During May, we received 20 informal complaints and 5 formal complaints. The primary subject for formal complaints received was Communication (80%) and Delay in Diagnosis/Treatment or Referral (20%). These subjects are logged on receipt of the complaint and based on the complainant's reported concerns; they may be later changes on completion of the investigation.

Total Complaints Closed in Month: During May 2025, we **closed 19 cases**;13 informal and 6 formal complaints.

Informal Complaints closed: 13 closed in month: These were from the following areas:
STA (Surgery) (3 cases): concerns linked to discharged process; treatment linked to blood being taken, and another where pain management issues were raised, all were resolved by the ward team speaking to the patients to apologise, giving further information and reassure as appropriate.

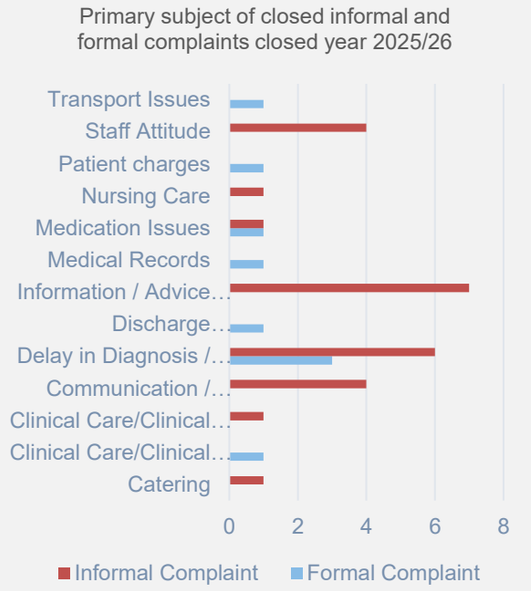
Thoracic and Ambulatory Care (3 cases): a case in which the patient raised concern that there was a lack of diagnosis; another where the patient raised concern that there was a delay in CPAP therapy to start, and one where the patient was concerned the referral had been lost . All 3 cases were resolved by the service teams contacting the patients to reassure and apologise as appropriate.

Estates and Facilities (1 case). An inpatient raised concern that the sandwich they were given was unhealthy and ultra-processed. The catering manager apologised and reassured the patient that additives and E numbers are all approved by the Food Standards Agency (FSA).

Clinical Administration (1 case) Patient raised concern that they were unable to cancel appointment and call handler was unhelpful. The patient was reassured that PALS could forward requests for cancellations and the service manager will arrange for appointment letters to be amended with revised opening times.

Cardiology (5 cases): Two cases related to staff attitude; one case was in relation to not seeing a consultant at outpatient appointment as expected; one where a patient was concerned they needed a procedure they had previously; and one where the patient wanted to feedback their experience of the ward,. All 5 cases were resolved by the service and ward teams speaking with the patients to explain, reassure and apologise as appropriate.

Figure one (right) shows the primary subject (themes) of both closed informal and formal complaints for the Trust for 2025/26, to date. Total M1 & M2 = 25 Informal and 9 Formal



Learning and Actions from Formal Complaints Closed – 6 formal complaints were closed in May. Of these, 4 were not upheld, 2 **partly upheld** and none were **upheld,** details of the 6 are below:

Formal complaint 1 (Thoracic) – NOT UPHELD. Relative of patient querying treatment without discussion with NOK. Explanations and reassurance given that it was in the patient's best interests following advice of specialist team.

Formal complaint 2 (Thoracic) – PART UPHELD. Patient's relative not involved in patient's discharge planning and patient died 4 days after discharge. Overview of patient's condition and admission provided, with reassurances that team discussed options of additional community support. Apologies given that family felt uniformed about discharge plan. Action: Update discharge checklist to include proposed communication with the next of kin about care plans and discharge arrangements

Formal complaint 3 (Cardiology) – PARTLY UPHELD. Patient transport arranged was not suitable for needs. Apologies provided and transport booking coordinators have been reminded of the importance of accurately recording and sharing patient transport needs

Formal complaint 4 (Cardiology) – NOT UPHELD. Patient raising concern about waiting list delay in switching from private care to NHS funded care. Reassurances given that process of switching from private care to NHS care has not incurred an additional waiting period

Formal complaint 5 (Surgery) – NOT UPHELD. Patient concerned that their records may have been inappropriately accessed. Reassurances given that record had not been inappropriately accessed

Formal complaint 6 (Finance) – NOT UPHELD. Patient querying private care costs as much more than was expected. Reassurance given that the further clinical care given on admission could not be foreseen or planned for and therefore the additional fees are payable

Caring: Spotlight On – Informal Complaints

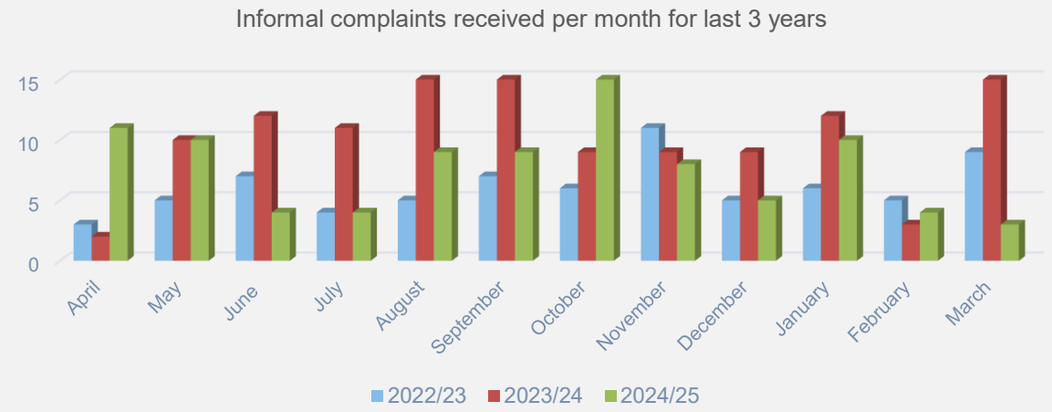
Accountable Executive: Chief Nurse *Report Author: Deputy Chief Nurse / Deputy Director of Quality and Risk*

Informal Complaints

Informal Complaints are issues that the complaint has agreed they would like to resolve through local resolution, without a formal complaint process being followed. The resolution process is a more of a personalised approach to gain resolution to the concerns raised and this is often resolved in person or on the telephone with our clinical team being involved or through our Patient Advice & Liaison Service support.

109 informal complaints were dealt with and resolved at a local level in 2024/25. This figure may include complaints initially received via our formal complaints team but resolved locally in agreement with the complainant/patient.

The below graph show the number of Informal complaints received per month over the last 3 years.



Subjects of Informal Complaints

On closing an informal complaint file, the subjects logged at the time of receiving the complaint are reviewed and updated, to reflect the findings of investigation.
The most frequently occurring primary subjects for informal complaints closed in 2024/25 are:

- Delay in Diagnosis, Treatment or Referral (24%)
- Communication, Information (22%)
- Clinical Care, Clinical Treatment (15%).

Informal complaints are most often received through the Patient Advice & Liaison Service (PALS) and can relate to:

- A service has not been provided that should have been
- A service has not been provided to an appropriate standard
- A request for a service has not been addressed or actioned
- A service being provided is having an immediate negative impact
- An error has been made that can be corrected quickly
- A member of staff was seen as rude or unhelpful

Learning from informal complaints:

Informal complaints are also a way of capturing any learning to improve services for everyone. A selection of learning and actions following an informal complaint is provided below:

Nursing staff have been reminded to review advice and refer to specialist teams on whether stitches are removable or dissolvable

Surgery ward team have been reminded to ensure patients at discharge receive advice and card warning of symptoms of endocarditis

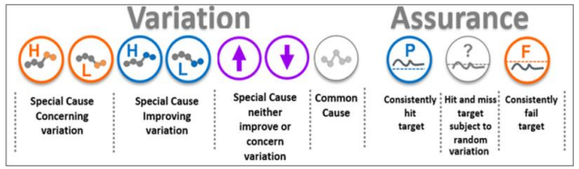
Transplant patient's story shared at Patient Carers Experience Group and with Team to improve awareness of delirium and communication/collaboration between teams.

A lockable deposit box has been installed in main reception for patients to securely leave monitoring devices outside of usual office hours

A wider selection of CPAP masks has been trialled including top-feeder options, to ensure all patients have access to suitable equipment

Effective: Summary

Accountable Executive: *Chief Operating Officer* ***Report Author:*** *Chief Operating Officer*



Royal Papworth Hospital
NHS Foundation Trust

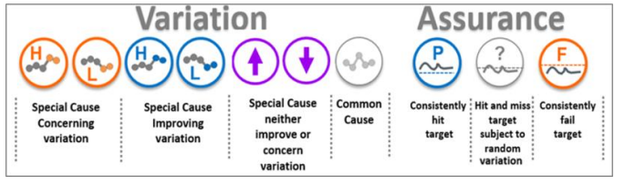
	Metric	Latest Performance		Previous	In month vs target	Action and Assurance		
		Trust target	Most recent position	Position		Variation	Assurance	Escalation trigger
Dashboard KPIs	Bed Occupancy (excluding CCA and sleep lab)	85%	74.8%	73.8%			F	Action Plan
	ICU bed occupancy	85%	79.8%	78.2%			?	Review
	Enhanced Recovery Unit bed occupancy %	85%	56.7%	75.7%			?	Review
	Elective inpatient and day case (NHS only)*	1,770	1767 (0% 19/20)	1687 (110% 19/20)		H	?	Review
	Outpatient First Attends (NHS only)*	2,298	2579 (157% 19/20)	2295 (140% 19/20)		H	?	Review
	Outpatient FUPs (NHS only)*	7,278	7077 (122% 19/20)	7007 (120% 19/20)			?	Review
	% of outpatient FU appointments as PIFU (Patient Initiated Follow up)	5%	12.1%	11.6%			P	Monitor
	Reduction in Follow up appointment by 25% compared to 19/20 activity	-25%	-4.7%	-2.2%		L	F	Action Plan
	% Day cases	85%	76.8%	75.7%		H	F	Action Plan
	Theatre Utilisation (uncapped)**	85%	88%	86%			?	Review
	Cath Lab Utilisation (including 15 min Turn Around Times) ***	85%	85%	83%			?	Review
Additional KPIs	NEL patient count (NHS only)*	Monitor	409 (118% 19/20)	415 (120% 19/20)				Monitor
	ICU length of stay (LOS) (hours) - mean	Monitor	120	165				Monitor
	Enhanced Recovery Unit (LOS) (hours) - mean	Monitor	32	30				Monitor
	Length of Stay – combined (excl. Day cases) days	Monitor	6.2	6.5				Monitor
	Same Day Admissions – Cardiac (eligible patients)	50%	48%	34%			?	Review
	Same Day Admissions - Thoracic (eligible patients)	40%	74%	81%		H	?	Review
	Length of stay – Cardiac Elective – CABG (days)	8.2	7.6	7.9		H	?	Review
	Length of stay – Cardiac Elective – valves (days)	9.7	9.8	10.5			?	Review
	Outpatient DNA rate	6.0%	6.6%	7.0%			?	Review

**1) per SUS billing currency, includes patient counts for ECMO and PCP (not beddays).*

*** from Theatre utilisation is expressed as a % of Trust capacity baseline of 5 theatres from Aug 23 and 5.5 theatres from Sep 23*
**** Cath lab utilisation is provisional pending review of calculation methodology*

Effective: Admitted Activity

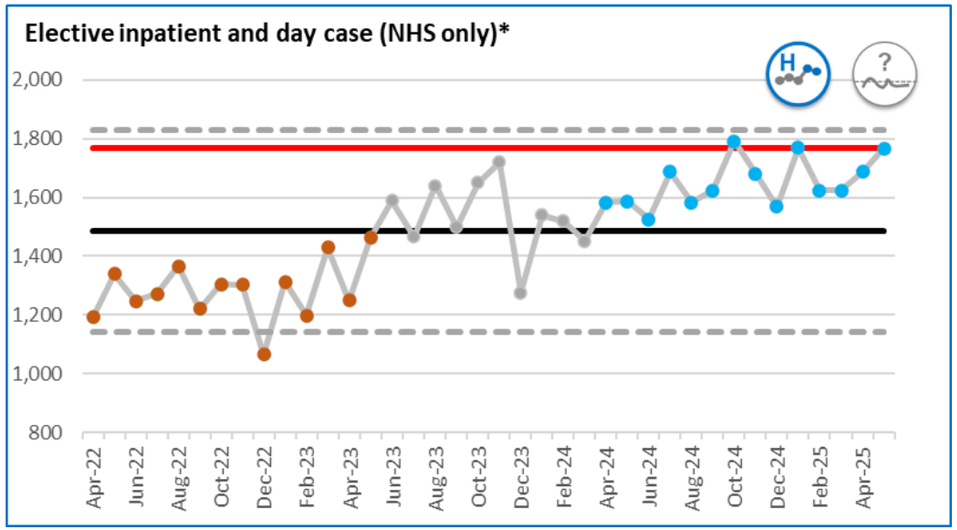
Accountable Executive: *Chief Operating Officer* ***Report Author:*** *Chief Operating Officer*



Target
Measure
Concerning special cause
Mean
Process Limit
Improving special cause

Royal Papworth Hospital
NHS Foundation Trust

1. Historic trends & metrics



May-25
1767
Target* (red line)
1770
Variation
Special cause variation of an improving nature
Assurance
Hit and miss on achieving target subject to random variation

Admitted activity YTD as a % of 19/20 (working day adjusted) by service and point of delivery:

Category		Cardiac Surgery	Cardiology	PTE	RSSC	Thoracic Medicine	Thoracic surgery (exc PTE)	Transplant /VAD
Elective Admitted activity	Inpatients	100%	91%	111%**	58%	97%	108%	147%
	Daycases	22%**	150%	n/a	300%	156%	89%**	1500%**

= YTD activity > 100% of 19/20

2. Action plans / Comments

Elective Inpatient Activity

- Overall factors influencing performance in month include:
  - CCA bed cap. Remained at 36 beds, with 10 ERU beds and 5.5 elective theatre capacity
  - Activity very slightly below target, but April and May have both seen 2 bank holidays which has reduced capacity

Surgery, Theatres & Anaesthetics

- As planned ERU opened to 11 beds on 9 September 2024, ICU opened 26 beds. CCA beds increased to 36 (commissioned number)
- Theatre activity in M2 slightly exceed the target at 88%. Elective activity continues in an upward trajectory with an upward RTT recovery. IHU patients continue to be prioritised to support flow within the system, additional capacity was made available as required.

Thoracic & Ambulatory

- As of M02 the division is above planned activity (158 YTD) and above 2019/20 admitted activity (612 YTD).
- Elective inpatient activity within RSSC is reduced compared to 19/20 activity due to changes in the pathway post COVID whereby daycase activity has increased.
- Daycase activity has been increased within RSSC to provide additional capacity for CPAP starters.

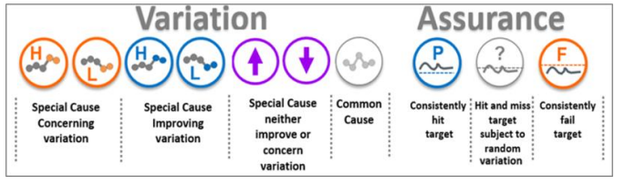
Cardiology

- The division over delivered day cases against provisional planned activity in M2.
- Elective bookings challenged by sickness and recruitment gaps – these have been recruited to, last position to start in June.
- ACS Pathways transferring accepted patients between 24 and 72 hours in M2.
- Activity in areas such as TAVI has seen a reduction in elective activity to create space to protect urgent inpatient pathways and relieve pressure in the system. Plan to increase TAVI capacity through trust wide RTT recovery option appraisal was agreed at Access Board. Additional GA and ODP to work through with STA .

** Target set at average 25/26 demand recovery plan ** 19/20 activity (working day adjusted) < 50*

Effective: Non-admitted Activity

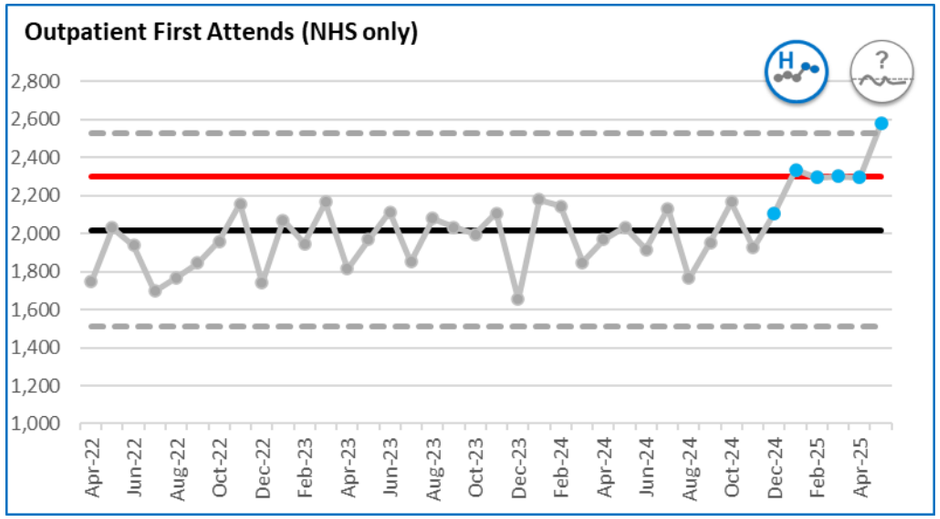
Accountable Executive: *Chief Operating Officer* ***Report Author:*** *Chief Operating Officer*



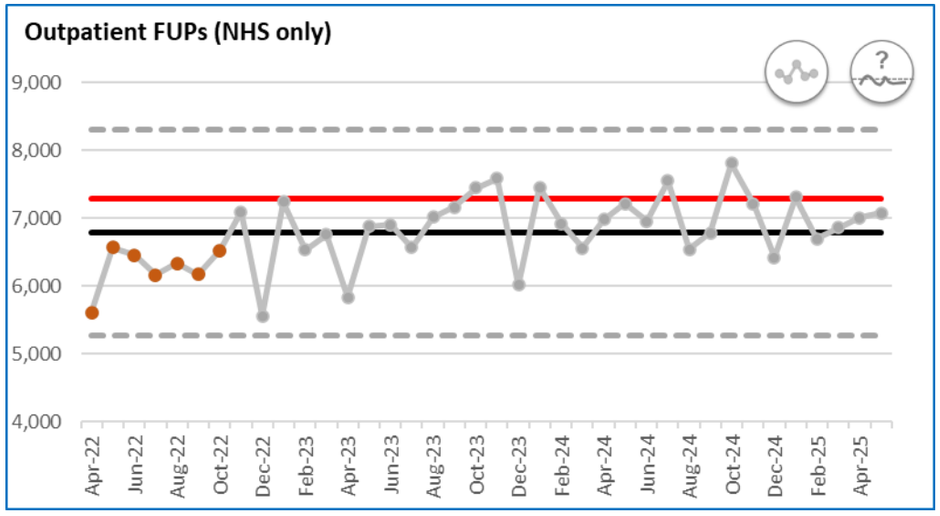
Target
Measure
Concerning special cause
Mean
Process Limit
Improving special cause

NHS
Royal Papworth Hospital
NHS Foundation Trust

1. Historic trends & metrics



May-25
2579
Target (red line)*
2298
Variation
Special cause variation of an improving nature
Assurance
Hit and miss on achieving target subject to random variation



May-25
7077
Target (red line)*
7298
Variation
Common cause variation
Assurance
Hit and miss on achieving target subject to random variation

Non Admitted YTD activity as a % of 19/20 (working day adjusted) by service and point of delivery:

Category		Cardiac Surgery	Cardiology	RSSC	Thoracic Medicine	Thoracic surgery (exc PTE)	Transplant/ VAD
Non Admitted activity	First Outpatients	88%	89%	789%	86%	131%**	147%**
	Follow Up Outpatients	226%	165%	60%	172%	141%	119%

= YTD activity > 100% of 19/20

Action plan / comments

Further PIFU rollout is being incorporated into the elective recovery delivery to ensure appropriate specialties adopt PIFU. 12.1% of outpatient follow up activity is PIFU and this continues to increase.
The Thoracic and Ambulatory division activity is above planned activity (827 YTD) and above 19/20 activity (3,227 YTD). Within M02, there were 411 missed appointments (6%) and 1,101 appointments cancelled by the patient at short notice. Proposal project drafted to reduce patient cancellations & DNAs as part of the RTT recovery, this includes a short notice cancellation and rebooking process and is being led by the Clinical Admin team.

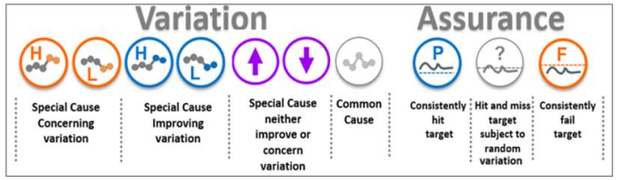
Cardiology delivered above plan within M02 and remains above the 2019/20 non-admitted activity baseline. Current review of delays for first appointments across cardiology specialities in line with RTT objectives. Changes in process to ERS referral bookings have now happened seeing more equitable waits across RTT new patients. Delivery of PSI OPA clincs started in M02 for both 1st OPA and follow ups. Regular review of clinic capacity to ensure utilisation of fallow capacity.

Surgery continue to flex capacity to meet demand for thoracic oncology patients. Focus piece of work to ensure full utilisation of capacity is ongoing.

** Target set at average 25/26 demand recovery plan ** 19/20 activity (working day adjusted) < 100*

Effective: Occupancy

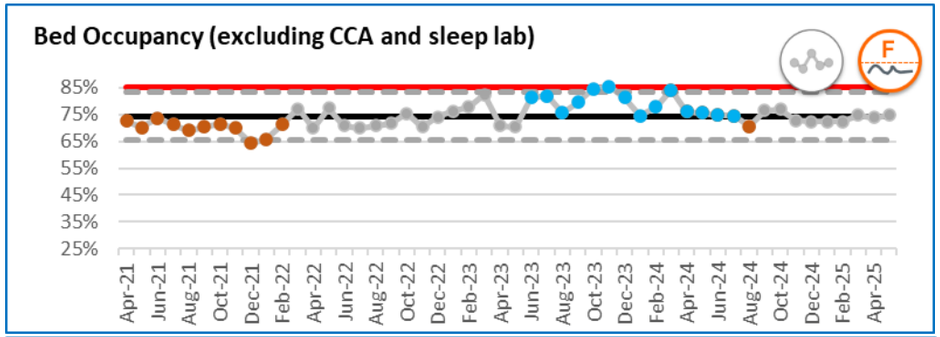
Accountable Executive: *Chief Operating Officer* ***Report Author:*** *Chief Operating Officer*



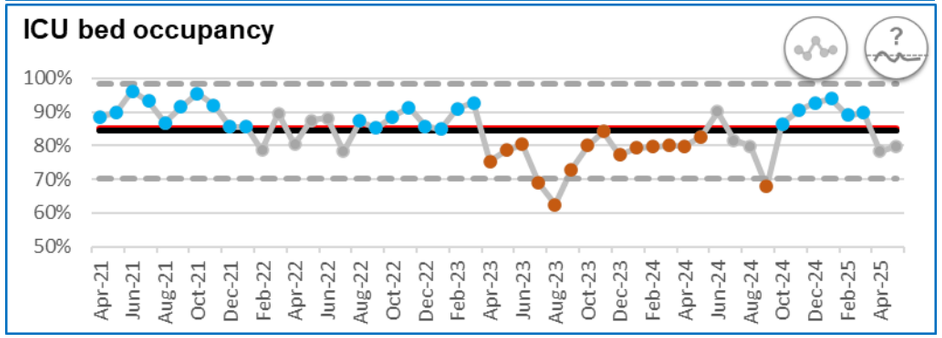
Target
Measure
Concerning special cause
Mean
Process Limit
Improving special cause

Royal Papworth Hospital
NHS Foundation Trust

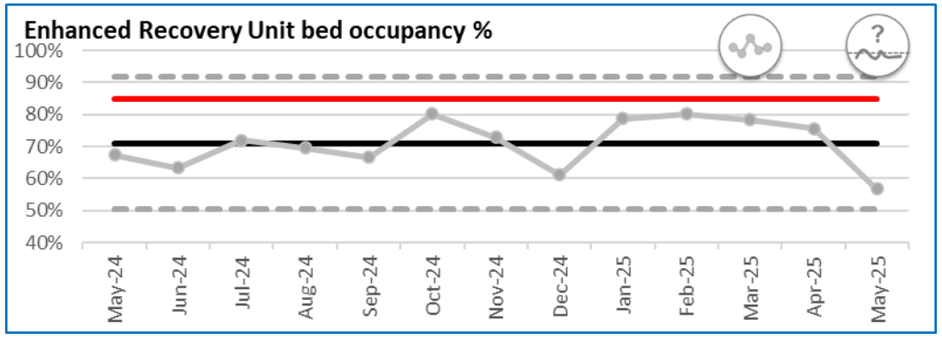
1. Historic trends & metrics



May-25
74.8%
Target (red line)
85%
Variation
Common cause variation
Assurance
Has consistently failed the target



May-25
79.8%
Target (red line)
85%
Variation
Common cause variation
Assurance
Hit and miss on achieving target subject to random variation



May-25
56.7%
Target (red line)
85%
Variation
Common cause variation
Assurance
Hit and miss on achieving target subject to random variation

2. Comments

Bed occupancy (excluding CCA and sleep lab):

- Since the Virtual Ward has opened, there has been an increase in bed capacity on level 5 driven by a total of 442 virtual ward days since opening, saving 160 beds days in May alone. There were 32 patients identified as suitable for the Virtual Ward with 13 referrals and patients admitted.

CCA bed occupancy:

- Bed occupancy for M2 was below target, but there was decreased activity through ERU
- There were no cancellations for 'no CCA' beds in M2, this reflects the collaborative work across the division and improved patient pathway following the opening of ERU and the Virtual ward. This work is being led by the senior leadership team.
- Theatre activity continues to be monitored with detailed oversight continuing from the leadership team and was aided by the case mix management processes implemented in month.

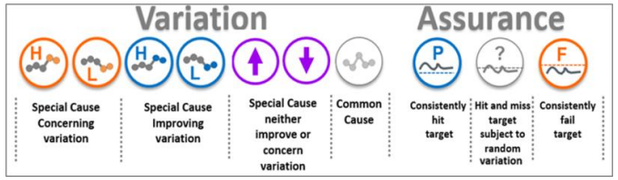
(NB. The denominator for CCA bed occupancy has been reset to 36 commissioned beds from April 2023).

ERU bed occupancy:

- Bed occupancy in M02 was 56.7%.
- This decrease is partly due to unfilled cardiac theatre slots which totalled 8 in May. Thoracic activity was done in lieu of this, but these patients do not go to CCA
- The leadership team are reviewing the ratio of ERU and ICU beds, to ensure the current ratio is correct, this work is ongoing and will be reviewed in M02 once there is sufficient data to analyse.
- A deep dive into activity through ERU has been requested at BU as the admission rate has been dropping steadily over the last 3 months

Effective: Utilisation

Accountable Executive: *Chief Operating Officer* ***Report Author:*** *Chief Operating Officer*

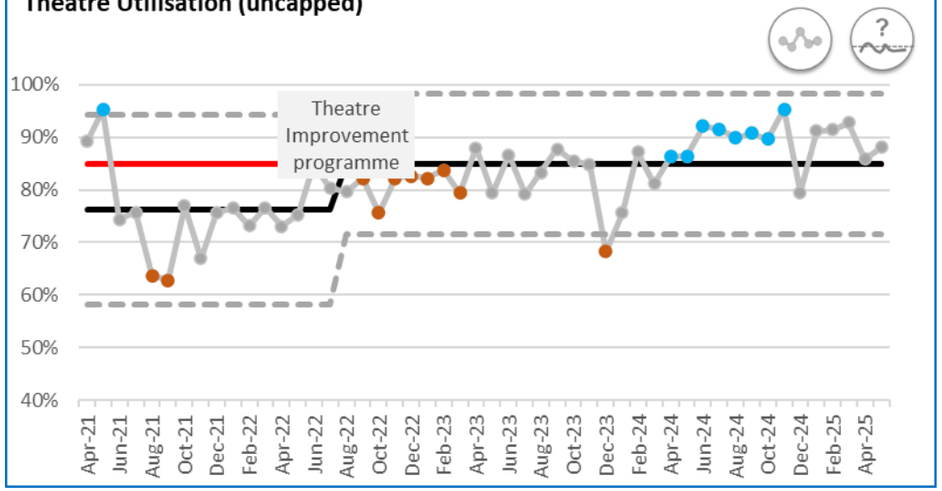


Target
Measure
Concerning special cause
Mean
Process Limit
Improving special cause

Royal Papworth Hospital
NHS Foundation Trust

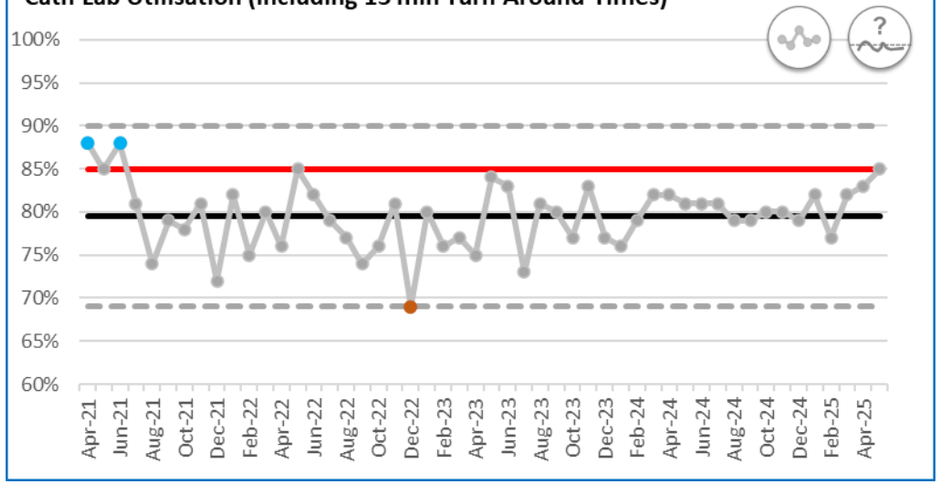
1. Historic trends & metrics

Theatre Utilisation (uncapped)



May-25
88%
Target (red line)
85%
Variation
Common cause variation
Assurance
Hit and miss on achieving target subject to random variation

Cath Lab Utilisation (including 15 min Turn Around Times) ***



May-25
85%
Target (red line)
85%
Variation
Common cause variation
Assurance
Hit and miss on achieving target subject to random variation

2. Action plans / Comments

Theatre Utilisation

- Theatre utilisation was 88% in M02, this remains within variance above KPI. Bank holidays would have impacted theatre utilisation within M02.
- Further work is being done to review start times and efficiency savings within theatres
- The senior leadership team within the division have now embedded the new ways of working for the 10 bedded ERU and 26 bedded ICU, this will bring increased stability to the areas and for the teams whilst not diminishing the collaborative working.
- Protecting the ERU beds ring fences elective activity and benefits continue to be realised.
- RTT remains on an upward trajectory, with a downward trajectory in long waiting patients, waiting over 40 weeks.

Cath Lab Utilisation:

- M02 saw an increase in cath lab activity compared to M01.
- Recent demand and capacity analysis has underscored a persistent trend regarding data accuracy, which impacts the interpretation of perceived utilisation. Metrics currently show labs 1-6, including Hot Lab fallow time between emergencies. Cardiology Ops reviewing with BI Team.
- Larger trust project run by the division looking at Cath Lab optimisation integrating all service users from all divisions to gather an array of options for maximising capacity for all. Quality impact assessments completed and due for approval.

*** from Theatre utilisation is expressed as a % of Trust capacity baseline of 5 theatres from Aug 23 and 5.5 theatres from Sep 23*
**** Cath lab utilisation is provisional pending review of calculation methodology*

Effective: Action plan summary

Accountable Executive: *Chief Operating Officer* ***Report Author:*** *Chief Operating Officer*

Royal Papworth Hospital
NHS Foundation Trust

	Metric	Division	Action	Lead	Update	Timescale for completion	RAG Status
Dashboard KPIs	Bed Occupancy (excluding CCA and sleep lab)	Cardiology	Review of bed base with BI	LM	84.5% in M01 (M02 data at divisional level is not available). Data is still under review.	May-25	
		STA	Virtual ward enabling additional bed capacity and flow	JS	Virtual ward is embedded	Embedded	
			Increasing same day admissions for cardiothoracic surgical patients	JS	Part of Trust wide project, awaiting stakeholder engagement to recommence. Baseline data collated for STA.	TBC	
		Thoracic	Review of bed base with BI	ZR	81.1% in M01 (M02 data at divisional level is not available). Data is still under review.	May-25	
	Enahnced Recovery Unit bed occupancy %	STA	A review of bed use/flow/cancellations/scheduling requested. PIpeline project in elective recovery programme to review flex of beds to match the demand.	JS	Request made to team to initiate project and complete QIA	Aug-25	
	Reduction in follow up appointment by 25% compared to 19/20 activity	Cardiology	PIFU rollout within CRM	LM	Delayed due to PSI role out, PIFU documents gone to service lead to approve	Apr-25	
			Review clinic templates: job planning	LM		Sep-25	
			Review clinic templates: new:FU ratio / clinic size against 19/20	LM	Clinic templates reviewed against 19/20 activity, new to f/u ratio not yet reviewed.	Aug-25	
		STA	Review clinic templates: new:FU ratio / clinic size against 19/20	JS	Clinic templates review completed and ratio changes made to increase new appointments. Further review underway following pilot.	Aug-25	
		Thoracic	Clinic template change to 70:30 new:FU ratio in RSSC	ZR	Completed	Embedded	
			PIFU rollout within CPAP	ZR	Completed	Embedded	
	% Day cases	Cardiology	87.4%: met trust target	LM	84.8% in M12 (M01 data at divisional level is not available)	Embedded	
		STA	12.6%: due to complexities of surgery, minimal day cases within STA. JS to check what is counted as a day case	JS	No update	Jun-25	
		Thoracic	82.8%: Day case activity increased by 10 per week from 10 March	ZR	Following planned increase in Day case activity, thoracic day case rate has improved as expected	Embedded	
	Cath Lab Utilisation (including 15 min Turn Around Times)	Cardiology	Meet with BI to discuss data for metric as includes cath lab 1 (HOT lab)	LM	Delayed awaiting BI input	May-25	

Key
Embedded as Business as Usual
On track / complete
Behind schedule but mitigations in progress and being tracked
Deadline delayed / not started
Date is currently TBC or 'on going' therefore cannot measure status

Responsive: Summary

Accountable Executive: *Chief Operating Officer* ***Report Author:*** *Chief Operating Officer*

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Royal Papworth Hospital
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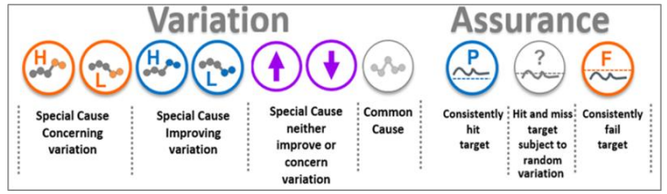
	Metric	Latest Performance		Previous	In month vs target	Action and Assurance		
		Trust target	Most recent position	Position		Variation	Assurance	Escalation trigger
Dashboard KPIs	% diagnostics waiting less than 6 weeks	99%	91.6%	93.2%				Review
	18 weeks RTT (combined)	92%	65.4%	64.5%				Action Plan
	31 days cancer waits	96%	95%	100%				Review
	62 day cancer wait for 1st Treatment from urgent referral	85%	50%	0%				Review
	104 days cancer wait breaches	0	4	5				Review
	Number of patients waiting over 65 weeks for treatment	0	18	15				Action Plan
	Theatre cancellations in month	15	20	28				Review
	% of IHU surgery performed < 7 days of medically fit for surgery	95%	33%	30%				Action Plan
	Acute Coronary Syndrome 3 day transfer %	90%	73%	74%				Review
	Number of patients on waiting list	7075 (25/26 Av)	6796	7141				Review
	52 week RTT breaches	0	65	56				Action Plan
Additional KPIs	% of IHU surgery performed < 10 days of medically fit for surgery	95%	36%	42%				Review
	18 weeks RTT (cardiology)	92%	57.4%	58%				Action Plan
	18 weeks RTT (Cardiac surgery)	92%	72.1%	70%				Action Plan
	18 weeks RTT (Respiratory)	92%	68.7%	67%				Action Plan
	Other urgent Cardiology transfer within 5 days %	90%	78%	91%				Review
	% patients rebooked within 28 days of last minute cancellation	100%	75%	65%				Review
	Urgent operations cancelled for a second time	0	0	0				Review
	Non RTT open pathway total	Monitor	49910	49244				Monitor
	Validation of patients waiting over 12 weeks	95%	35%	30%				Action Plan

Responsive: RTT

Accountable Executive: *Chief Operating Officer* ***Report Author:*** *Chief Operating Officer*



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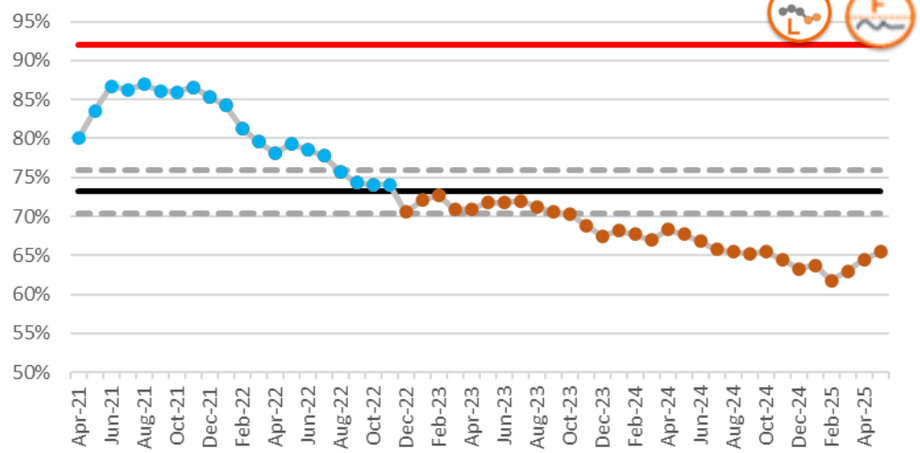
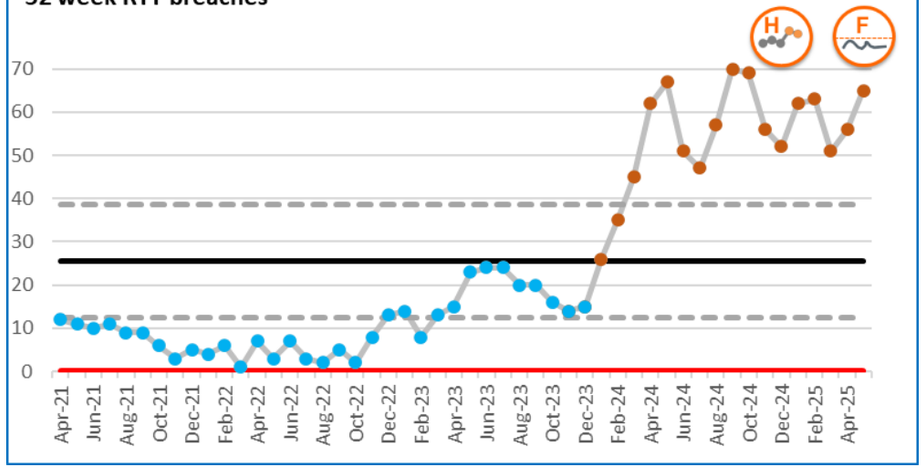
1. Historic trends & metrics

18 weeks RTT (combined)



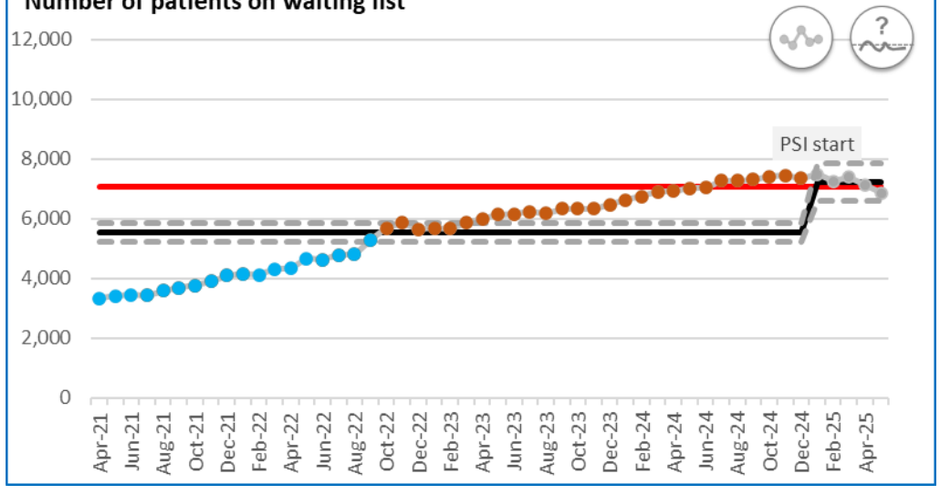
May-25
65.4%
Target (red line)
92.0%
Variation
Special cause variation of a concerning nature
Assurance
Has consistently failed the target

52 week RTT breaches



May-25
65
Target (red line)
0
Variation
Special cause variation of a concerning nature
Assurance
Has consistently failed the target

Number of patients on waiting list



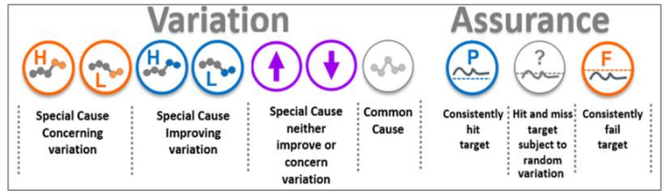
May-25
6796
Target (red line)
7075 (25/26 Av)
Variation
Common cause variation
Assurance
Hit and miss on achieving target subject to random variation

Action plans / Comments

- While the RTT fails to meet the national target, month on month improvements are being noted through the elective recovery delivery group. Initiatives are under continuous review to ensure positive impacts are made, as well as new initiatives being developed and monitored through the elective recovery delivery group and Access Board. With the introduction of PSI lists from M01 and focused validation, the overall number of patients waiting has started to decrease. Enhanced governance is being implemented to ensure scheduling is being optimised 6 weeks in advance, as well oversight of long waiters.
- There were 65 52-week RTT breaches in month, which is an increase of 9 from the previous month.
  52 Week breakdown:
- 51 of the 52-week breaches were in Cardiology. Narrative is prior to May finalisation: 35 of these patients were structural awaiting Tavi or PFO due to sickness in the consultant team. 6 of these were EP, 3 was Intervention, 2 of these were late referrals and 4 missed IPT.
- Nine of the 52-week breaches occurred within the Thoracic and Ambulatory service, four of which were late referrals after 52 weeks and one is a duplicate entry. Of the 8 true breaches, four have been treated and four have dates in place.
- STA: There were 5 patients in May that breached 52 weeks. Narrative is prior to May finalisation: 1 inherited clock start, 1 pt declined first date offered, 1 is dated. Unable to contact one patients and the third had an OPA in June.

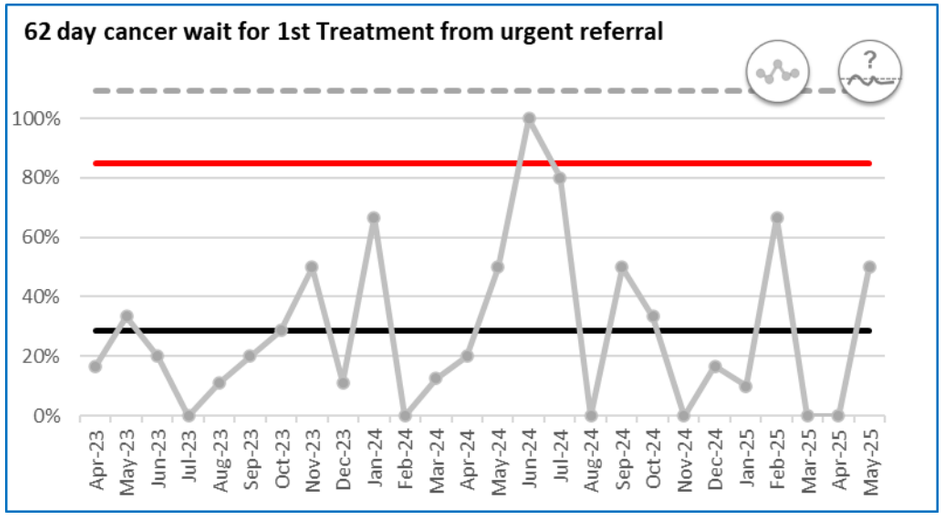
Responsive: Cancer

Accountable Executive: *Chief Operating Officer* ***Report Author:*** *Chief Operating Officer*

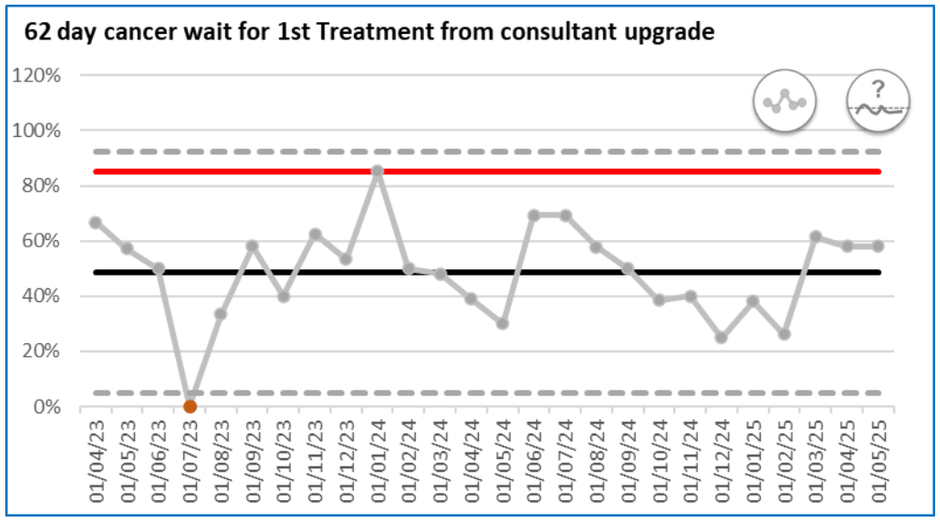


Royal Papworth Hospital
NHS Foundation Trust

1. Historic trends & metrics



May-25
50%
Target (red line)
85%
Variation
Common cause variation
Assurance
Hit and miss on achieving target subject to random variation



May-25
58%
Target (red line)
85%
Variation
Common cause variation
Assurance
Hit and miss on achieving target subject to random variation

Action plans / Comments

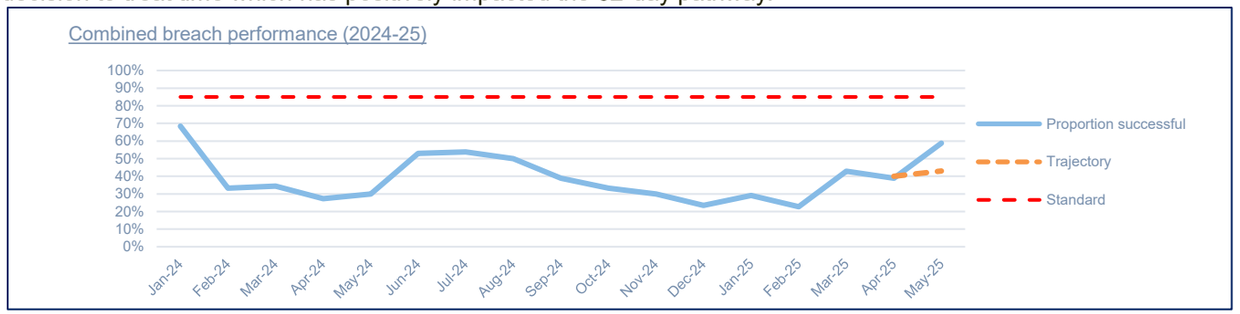
The average day of referral for M02, was 23.9 days (89 referrals received). Fifteen referrals were received after day 38. However, the combined breached performance for 62-days was 59% and above the trajectory.

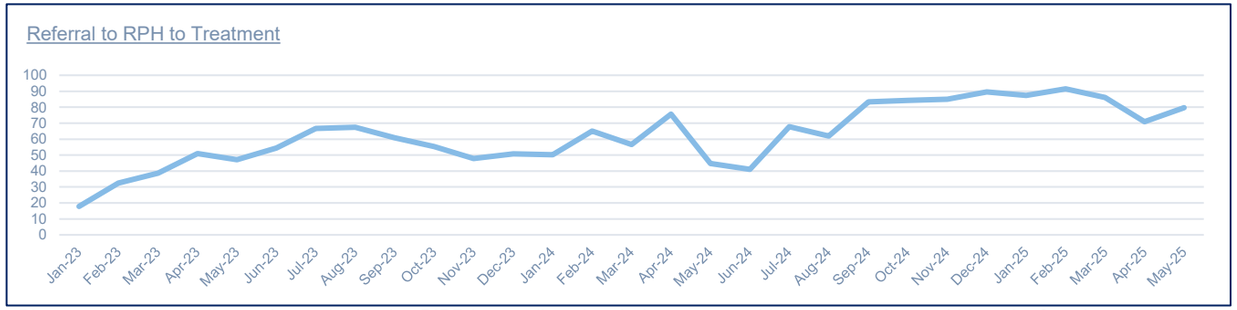
Breach themes include:

- Patient choice / medical reasons leading to delays
- Inability to schedule surgery within timeframe (1 patient which was a joint case)
- Complex multi-diagnostic pathways

Diagnostic pathway bundles were rolled out at the end of M01, effectiveness of the bundled pathway continues to be reviewed to ensure positive impact on patient pathways.

Positively, the implementation of improved scheduling within thoracic surgery has supported a reduced decision to treat time which has positively impacted the 62-day pathway.

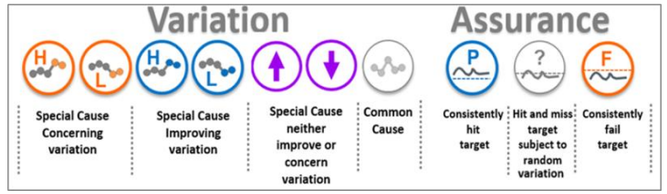




Please note the compliance data submitted to PIPR is pre-allocation. It does not consider patients who would later be found not to have a cancer diagnosis or patients that are referred on for treatments at other trust where breach or treatment allocation are later made.

Responsive: Cancer

Accountable Executive: *Chief Operating Officer* ***Report Author:*** *Chief Operating Officer*



NHS
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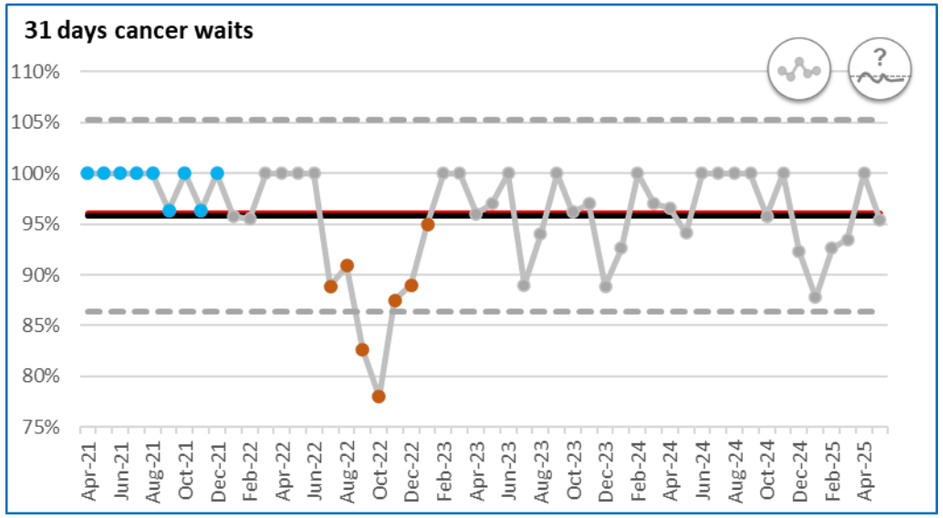
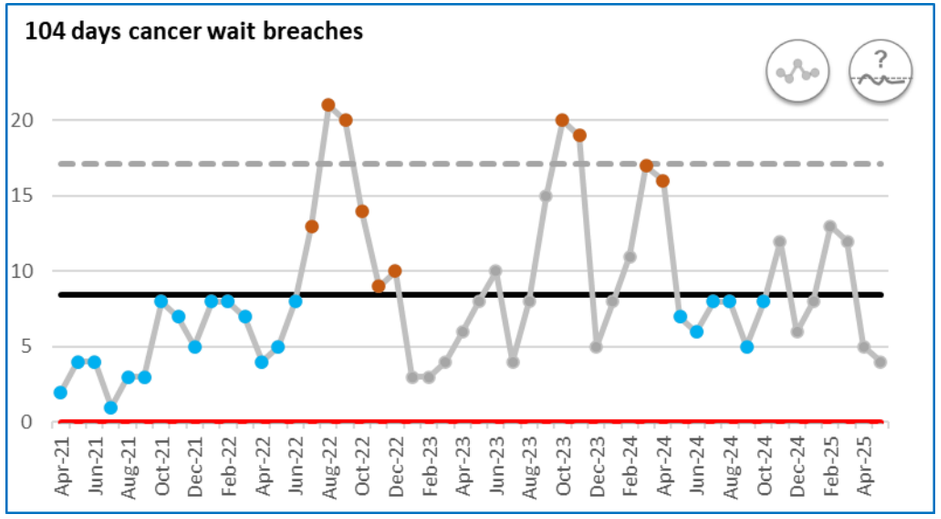
NHS Foundation Trust

1. Historic trends & metrics



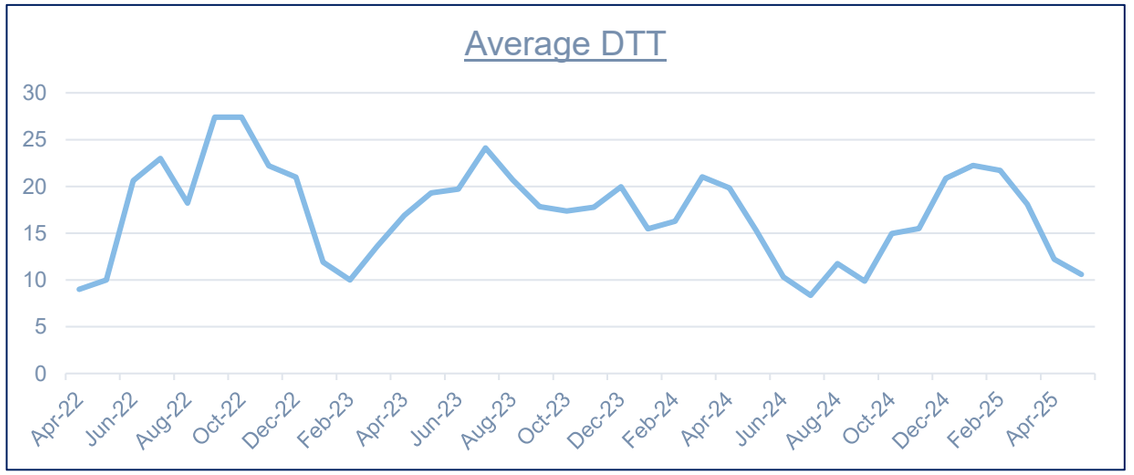
May-25
95.5%
Target (red line)
96%
Variation
Common cause variation
Assurance
Hit and miss on achieving target subject to random variation



May-25
4
Target (red line)
0
Variation
Common cause variation
Assurance
Hit and miss on achieving target subject to random variation

Action plans / Comments

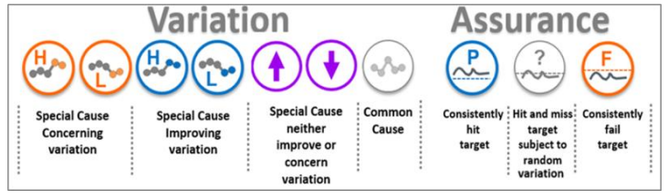
31 Day breaches: The 31-day target was not achieved in M02 with a compliance of 95.5%. However, the averaged decision-to-treat continues to reduce (12.22 days) which is attributed to improved scheduling within thoracic surgery. The 31-day target was not met as one patient breached due to an inability to schedule a joint case with CUH. However, an incident has been reported to ensure lessons are learnt as there may have been missed opportunities to escalate sooner.



104 day breaches: Four breaches within M02. Of these, two were treated within May and a third patient has scheduled surgery in June. The fourth patient requires additional investigations before treatment can be provided.

Responsive: Other metrics

Accountable Executive: *Chief Operating Officer* ***Report Author:*** *Chief Operating Officer*



Target
Measure
Concerning special cause
Mean
Process Limit
Improving special cause

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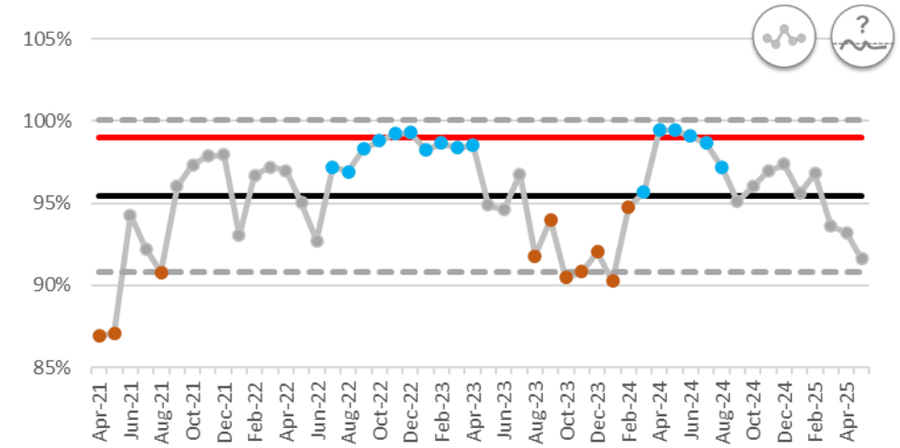
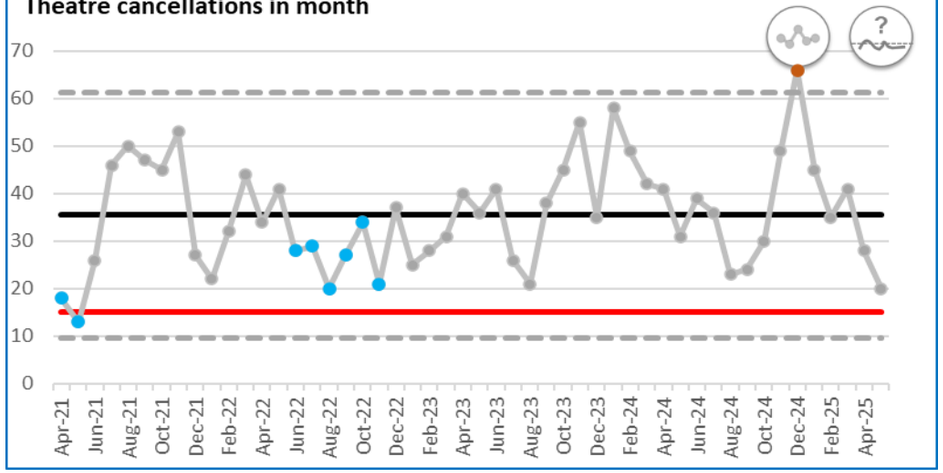
1. Historic trends & metrics

% diagnostics waiting less than 6 weeks



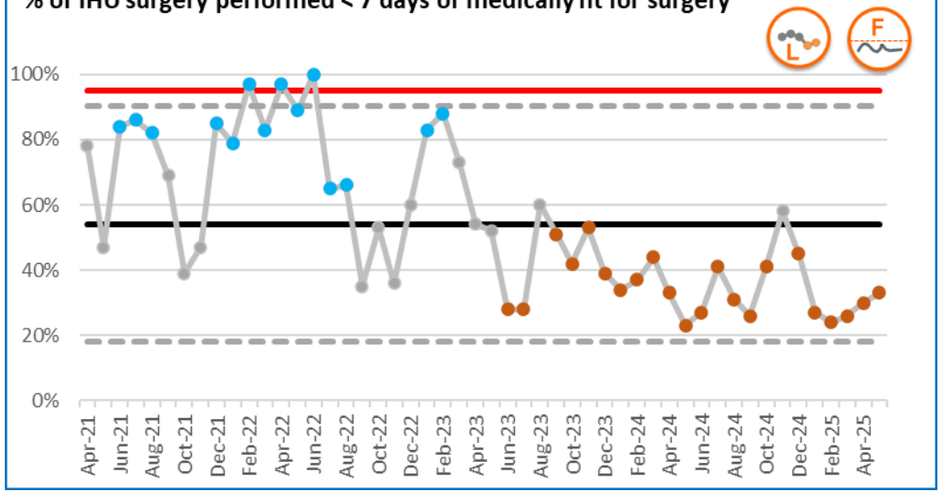
May-25
91.6%
Target (red line)
99%
Variation
Common cause variation
Assurance
Hit and miss on achieving target subject to random variation

Theatre cancellations in month



May-25
20
Target
15
Variation
Common cause variation
Assurance
Hit and miss on achieving target subject to random variation

% of IHU surgery performed < 7 days of medically fit for surgery



May-25
33%
Target (red line)
95%
Variation
Special cause variation of a concerning nature
Assurance
Has consistently failed the target

Action plans / Comments

DM01

•Trust compliance reflects the overall diagnostic position (not just radiology)

•Radiology continues to present a position of long waiters which continues to be primarily driven by longer waits in cardiac MRI and CT scanning

•The waiting times are further exacerbated by external hospitals referring all patients as clinically urgent or high priority due to their waiting time in their local organisation impacting all patients waiting on the RPH list giving longer waiting times for all patients. As these patients take priority, the longer waiting patients continue to wait longer and longer

•Additional weekend lists (2 Saturdays a month) undertaken in MRI to try and support long waiting patients but these have now reduced to once a month to protect staff worklife balance whilst we also support additional weekend cath labs lists

•PTL size is now 3500 and continues to increase

•Validation of the longest wait patients undertaken

•Diagnostic Imaging now involved in the Elective Recovery Programme with data and pathways currently under review

•WatchPAT managed service agreed for 1,000 patients to aid with backlog of sleep studies. PSG and Respiratory Polygraphy studies are improving month on month.

Theatre Cancellations

20 cancellations in M2 and only 2 of these slots went unutilised, which reflects in the overall theatre utilisation data. The most significant reason for cancellation on the day was due to patients being unfit (5) , 66% of these were IHU. This information is shared with the IHU team

The ring fencing of the 10 bedded ERU is supporting the reduction of on the day cancellations t. This work is being led by the leadership team.

In House Urgent patients

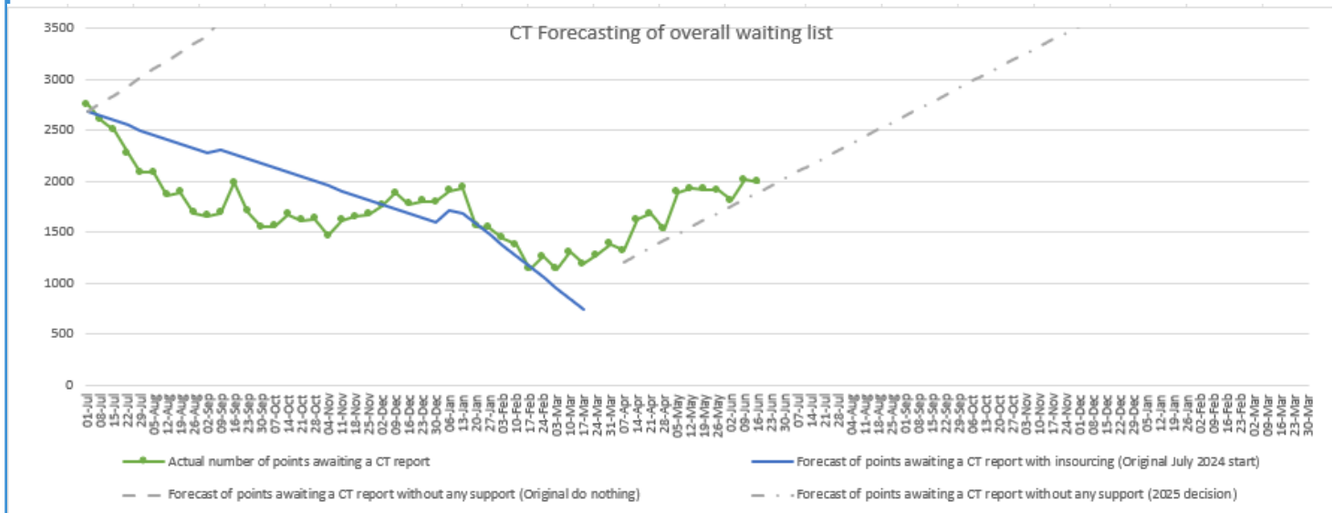
- Capacity for IHU's is flexed. Increased capacity is made available to support flow at RPH and the region, 7 day KPI, continues on an upward trajectory with 61% of patients treated by 10 days and cancellations down to 11%, which is improving month on month
- STA leadership team are working collaboratively with cardiology and clinical admin' on flow and news of working.

Responsive: Spotlight – CT Backlog

Accountable Executive: *Chief Operating Officer* ***Report Author:*** *Chief Operating Officer*

Royal Papworth Hospital
NHS Foundation Trust

			05-May	12-May	19-May	26-May	02-Jun	09-Jun	16-Jun
Impact on the Waiting List	Actual	Actual number of points awaiting a CT report	1885	1922	1918	1909	1812	2011	1993
		Actual points backlog awaiting a CT report **for more than 4 weeks**	869	905	788	787	679	837	753
		Actual points on waiting list for a CT report **waiting less than 4**	1016	1017	1130	1122	1133	1174	1240
		Proportion of CT reports waiting **for more than 4 weeks**	46%	47%	41%	41%	37%	42%	38%
		Number of patients awaiting a CT **report**	682	698	692	677	630	706	699
		Number of patients waiting CT **report** over 4 weeks	261	288	276	212	246	246	220
		Number of patients awaiting a CT scan based on PTL	1067	1187	1238	1722	1744	1754	1758



Recruitment
Remains 9 Consultant Radiologists (8.5 WTE) in post against a budgeted WTE of 13.77
1 substantive Consultant Radiologist successfully appointed (start date Sept 2025)
1 fixed term Consultant Radiologist recruitment underway (potential start date Sept 25)

External Reporting:
Langley Clark (LCI) commenced as external reporters 17/5/25
Where 4 shifts a weekend are completed, there is a downshift in reports awaited. RPH is being flexible with shift patterns and offering weekday reporting workstations if the weekend shifts are not undertaken
Patients waiting over 4 weeks is showing an improving picture

CT report average turnaround time in May – 16 days (range 0-102 days)
This is a decrease of 47 days on the longest wait since April
Programme on plan to achieve recovery by second week of August.

Outsource project update (as of 16/6/25)
Project remains within documented timescales and on plan.
To support all modality reporting, not just CT
Released to market mid-May 2025
Tender process now closed & review process to commence w/c 16/6/25
Scoring & mediation events planned for 15/16 July 2025 after which the preferred bidder will be identified.
VPN line upgrade continuing with expected implementation August 2025 (pipe widening)
Tender & contract to be awarded with implementation to commence Q3 with a view to go-live December 2025B

NWAFT Update (MRI)
Funding agreed to outsource MRI in NWAFT to include staff and reporting from July onwards
This will allow their routine patients to be drawn back and imaged at NWAFT with only the specialist MRI imaging undertaken at RPH as previously

Responsive: Action plan summary

Accountable Executive: *Chief Operating Officer* ***Report Author:*** *Chief Operating Officer*

Royal Papworth Hospital
NHS Foundation Trust

	Metric	Division	Action	Lead	Update	Timescale for completion	RAG Status
Dashboard KPIs	% diagnostics waiting less than 6 weeks	Cardiology	Review of Echo Lab Capacity againt current waiting lists, and clinic templates. Data cleansing taken place through creating of centralised Access Plans.	LM		Dec-25	
		STA	Radiology is now part of the planned care recovery plan, so further actions and tasks will be articulated in due course	HR		TBC	
		Thoracic	Sleep Lab expansion New rPG devices and routine weekly clinics managed by clinical admin CSS appointments are part of the elective recovery delivery, whereby 1,000 patients will receive initial diagnostic via WatchPAT	ZR	Sleep Lab expansion on target for completion New rPG devices in place and embedded WatchPAT provisionally due to commence July 2025. Further improvements to adhere to local policy for business as usual service model	Mar-26	
	18 weeks RTT (combined)	All	Elective care and delivery group and access board stood up to monitor RTT delivery initiative. Detailed improvement plans in place and reported against weekly. Efficiencies in pathways identified as part of additional activity to ensure RTT remains sustainable.	DDOs	New governance in place to report RTT through to Access Board and Performance Committee. Detailed plans in place and reported separately.	Mar-26	
	Number of patients waiting over 65 weeks for treatment	Cardiology	Currently trying to set up Thursday lists to increase capacity, awaiting the go ahead from STA with regards to addtional GA and ODP support.	LM	14 patients on PTL without clock stops, 9 structrual patients awaiting dates, 3 with TCI, 1 TAVI without date and 1 EP patient dated that was an IPT error.	Mar-26	
		STA	Monitor through KLOE weekly updates, pre-PTL and PTL. Escalation policy in place for outstanding diagnostics and unactioned updates, used through pre-PTL. Plan to have no 65 week breaches within RPH control.	JS	As of June,there is one patient over 65 weeks. Missed IPT and inherited closk. Dated 27th June	Jun-25	
		Thoracic	Plan is to have no 65 week breaches within RPH control by end of Quarter 1. Late referrals continue to be received, often post 52 weeks. Appointments are held for clinic and diagnostics to ensure no further delay to long waiting patients.	ZR	As of June, there are two patients over 65 weeks, both referred at 59 weeks. Appointments are in place.	Jun-25	
	Theatre cancellations in month	STA	Monitored through business unit meeting and divisional meeting. On the day cancellations due to patient fitness is audited monthly and information shared with IHU team. Roster improvements in CCA to ensure all beds available.	JS	Decrease in cancellations and decrease in on the day due to fitness cancellations. No cancellations due to CCA bed availability.	Jul-25	
	% of IHU surgery performance < 7 days of medically fit for surgery	STA	Working group between Clinical Admin, STA and Cardiology to review IHU processes. Propose spotlight slide to be shared for June PIPR.	NH/LM	Two trigger and escalation points in place between Cardiology and STA to review those awaiting surgical dates. Detailed action plan to be generated and to be reported via forthcoming new governance for patient flow.	TBC	
	Number of patients on waiting list	Cardiology	Demand increasing within EP, additional lists will help the backlog while sustainable actions identified as part of RTT recovery will aid sustainability	LM	Currently running PSI lists which are helping reduce the backlog	Mar-26	
			Cath lab optimisation project to improve productivity through BAU to support ongoing demand and capacity	LM	Going through Access board, awaiting approval	Mar-26	
			Structural and MTEER has small increase in demand, however has significant impact on waiting list due to resilience in medical team. Cath lab optimisiation project will support demand and capacity	LM	Additional lists are being worked around to catch up on activity, awaiting approval through access board	Mar-26	
		STA	Demand remains stable however waiting list has reduced due to changes in pathways including ERU and virtual ward	JS	Completed	Embedded	
		Thoracic	New capacity within ILD will be available from May 2025 to meet the demand	ZR	Completed	Embedded	
			Reviewing processes to enhance clinic utilisation as part of RTT recovery, including short notice booking procedures and reduction of missed appointments	SC	Initiatives are trustwide and therefore led by Clinical Admin. Initiatives are being developed and agreed as part of the elective care delivery and performance group	Jun-25	
			Demand and capacity review of RSSC to ensure capacity meets growing demand	ZR	Conversion rates completed which needs to be used to complete demand and capacity	Jul-25	
	52 week RTT breaches	Cardiology	Review of process for late additions to waiting list, including IPT corrections	LM	Ongoing collaboration with Clinical Admin to review processes	Jun-25	
		STA	Late referrals are expedited and flexing of capacity is reducing the number above 52 weeks	JS	Completed	Embedded	
		Thoracic	Appointments held to accommodate late additions / IPTs. Liaison with referring DGHs to understand challenges and whether referrals can be made sooner	ZR	Completed	Embedded	
Additional KPIs	18 weeks RTT (cardiology)	All	Non-coronary intervention additional lists alongside additional reporting 33 TAVI lists 14 Structural lists 5 TOE lists	LM	**TAVI PSI lists:** MDT Streamline Triaging working well, additional 28 patients so far put through MDT 8 Treated; 4 Booked for PSI; 12 further available slots for booking in to PSI Thursday lists due to start July 3rd on Hold – GA/ODP Cover **Structural PSI List:** List on hold for July 5th – GA / ODP Cover Thursday lists due to start July 3rd on Hold – GA/ODP Cover **TOE PSI List:** 14/06 list stood down – GA/ODP Cover 1 list confirmed and staffed for August.	Mar-26	
			Additional lists and outpatient clinics in relation to CRM including: 100 EP lists 11 Outpatient first appointment clinics	LM	**EP Outpatient Clinics:** OPFA – 48 Patients seen, 16 Booked OPFU – 30 Patients seen	Mar-26	
	18 weeks RTT (STA)	All	Extended thoracic lists Green lists and 3 pump lists Pre-admission / same day admission	JS	Extended thoracic lists commenced w/c 12 May and occurs every Friday. Green lists is implemented and now business as usual. Pre-admission / same day admission: work continues regarding this and also collaborating with thoracic regarding additional rooms to increase preadmission from 60% to 95% for all surgical patients. RTT is improving	Mar-26	
	18 weeks RTT (Thoracic)	All	Substantive ILD Consultant recruited and will support demand and capacity	ZR	Completed - number of patients waiting over 18 weeks decreasing	Apr-25	
			ATIR / Options appraisal for additional oximeters to meet CSS only backlog	ZR	Preferred option approved and procurement underway to initiate managed service for 1,000 patients	Apr-25	
			RSSC additional list including: Clear CSS only backlog including reporting Outpatient appointments and one-stop clinics to commence treatment as appropriate	ZR	5 PSI SDC clinics completed to date (82 patients). SDC clinics planned each month, however majority of workload will be post managed service for initial diagnostics	Mar-26	
			Additional medical secretary support to discharge patients waiting over 18 weeks	SC	Number of discharge ACDs decreased from 180 to 118.		
	Validation of patients waiting over 12 weeks	All	Administrative validation focuses on patients waiting over 40 weeks	Ops teams	Embedded as business as usual	Embedded	
			Technical validation	BI team	Embedded as business as usual	Embedded	
			Digital validation	ZR	Pilot of 50 patients completed: 60% response rate, 1 confirmed did not want to attend RPH. Process being finalised before rollout date confirmation	Jul-25	
			Validation sprints - detailed action plan to be drafted Q1 in line with national validation sprints	ZR	Validation for quarter 1 was above baseline, quarter 2 sprint to commence in July	Jun-25	
		Thoracic	6 month FTC validator within thoracic to support RTT delivery	ZR	Role is out to advert and bank staff in place to mitigate	Jul-25	

Key
Embedded as Business as Usual
On track / complete
Behind schedule but mitigations in progress and being tracked
Deadline delayed / not started
Date is currently TBC or 'on going' therefore cannot measure status

People, Management & Culture: Summary

Accountable Executive: *Director of Workforce and Organisational Development* ***Report Author:*** *HR Manager Workforce*

Royal Papworth Hospital
NHS Foundation Trust

		Data Quality	Target	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Dashboard KPIs	Voluntary Turnover % **	4	9.0%	7.37%	6.90%	7.48%	9.39%	7.57%	10.03%
	Vacancy rate as % of budget **	4	7.50%	7.95%	7.29%	6.45%	6.01%	5.60%	6.51%
	% of staff with a current IPR	4	90%	76.77%	76.33%	77.74%	77.74%	76.86%	78.04%
	% Medical Appraisals*	3	90%	72.73%	76.61%	79.03%	80.31%	79.53%	75.78%
	Mandatory training %	4	90.00%	88.39%	87.95%	88.07%	87.07%	87.30%	86.97%
	% sickness absence **	5	4.0%	5.26%	5.10%	4.65%	4.39%	4.22%	4.00%
Additional KPIs	FFT – recommend as place to work **	3	72.0%	n/a	n/a	58.00%	n/a	n/a	0.00%
	FFT – recommend as place for treatment	3	90%	n/a	n/a	85.00%	n/a	n/a	0.00%
	Registered nursing vacancy rate (including pre-registered nurses)	4	5.00%	2.72%	2.16%	1.80%	1.77%	1.59%	2.44%
	Unregistered nursing vacancies excluding pre-registered nurses (% total establishment)	4	10.00%	12.92%	12.23%	12.06%	11.01%	7.34%	6.93%
	Long term sickness absence % **	5	1.50%	2.14%	2.10%	1.84%	1.94%	2.08%	1.72%
	Short term sickness absence	5	2.50%	3.12%	2.99%	2.82%	2.45%	2.13%	2.28%
	Agency Usage (wte) Monitor only	5	Monitor only	35.2	33.6	29.2	27.8	17.7	10.9
	Bank Usage (wte) monitor only	5	Monitor only	81.0	96.3	93.9	100.5	95.3	98.2
	Overtime usage (wte) monitor only	5	Monitor only	33.4	41.5	45.5	54.0	26.0	22.8
	Agency spend as % of salary bill	5	2.37%	2.00%	1.90%	2.52%	1.12%	1.44%	1.32%
	Bank spend as % of salary bill	5	2.55%	2.92%	2.68%	3.18%	2.25%	3.00%	3.08%
	% of rosters published 6 weeks in advance	3	Monitor only	48.25%	63.60%	60.60%	57.60%	54.50%	51.50%
	Compliance with headroom for rosters	4	Monitor only	32.00%	29.50%	30.40%	30.10%	29.90%	26.20%
	Band 5 % White background: % BAME background	5	Monitor only	42.00%:56.75 %	n/a	n/a	41.43%:57.38 %	n/a	n/a
	Band 6 % White background: % BAME background	5	Monitor only	64.34%:34.39 %	n/a	n/a	62.31%:36.47 %	n/a	n/a
	Band 7 % White background % BAME background	5	Monitor only	76.63%:20.85 %	n/a	n/a	75.69%:21.76 %	n/a	n/a
	Band 8a % White background % BAME background	5	Monitor only	83.87%:14.52 %	n/a	n/a	85.40%:13.14 %	n/a	n/a
	Band 8b % White background % BAME background	5	Monitor only	85.71%:14.29 %	n/a	n/a	86.21%:13.79 %	n/a	n/a
	Band 8c % White background % BAME background	5	Monitor only	77.78%:22.22 %	n/a	n/a	80.65%:19.35 %	n/a	n/a
	Band 8d % White background % BAME background	5	Monitor only	90.00%:10.00 %	n/a	n/a	90.00%:10.00 %	n/a	n/a
	Time to hire (days)	3	48	45	41	42	38	36	41

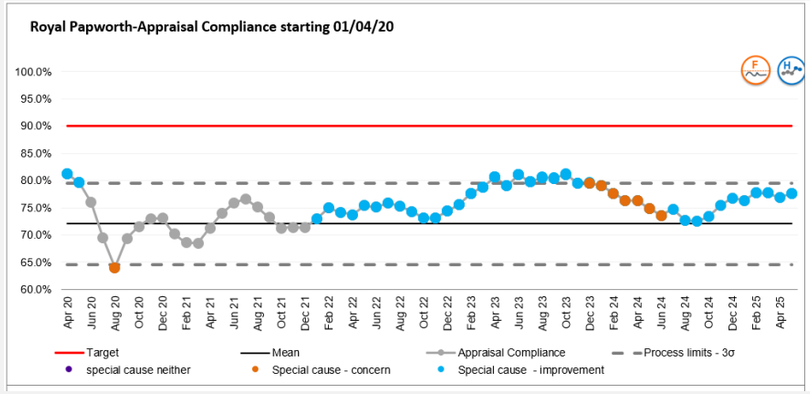
Summary of Performance and Key Messages:

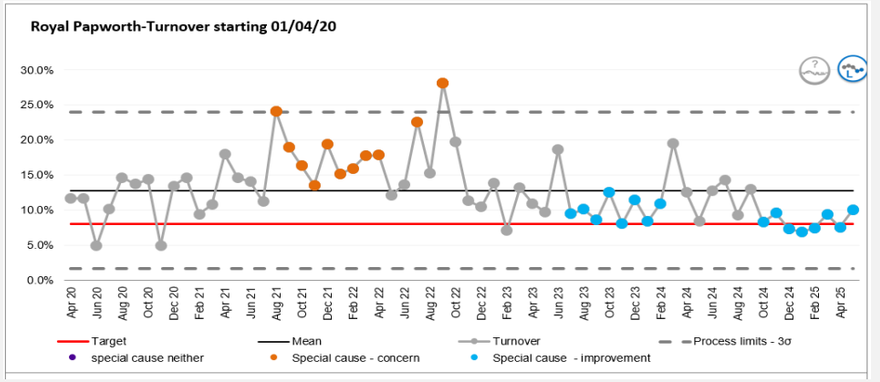
- Turnover was over our KPI at 10%. Of the 25 leavers (20.5 wte) non-medical leavers, 8 were retirements/flexi retirements.
- Our total Trust vacancy rate increased to 6.5% but remained below our KPI. The reason for the increase is that budgeted establishments were increased by 26.2 WTE with the implementation of the 25/26 workforce plan.
- The registered nurse vacancy rate increased to 2.44%, 18.9wte. The reason for the increase was primarily the increase in budgeted establishments. There are 33 registered nurses in our pipeline plus 3 temporary staff. The recruitment team ran a very successful recruitment event in the hospital on 17 May at which 29 offers of employment were made : 14 registered nurses, 2 ODPs, 2 Theatre Scrub Practitioners, 11 HCSWs. We are ensuring strong pipelines in order to maintain low vacancy levels in order to minimise the need to use temporary staffing and support the delivery of high quality care. We will be using “talent pools” to manage candidates who have been appointed and there is no suitable post immediately available. They will be held in the talent pool and offered a post when it becomes vacant. This will enable us to fulfil our commitment to offer posts to newly qualified nurses. The Finance and Workforce teams are developing guidance for managers on roster management when vacancy rates are so low. This will support managers in maintaining pay spend against budget by balancing vacancy rates, headroom, utilisation and temporary staffing.
- The unregistered nurse vacancy rate decreased to 6.9%, 16.2 wte, which remains below our KPI. We currently have 18 Healthcare Support Workers in the pipeline, plus 4 for temporary staffing.
- Our time to hire for April was 41 days and we are maintaining our performance below the national KPI of 48 days. This reflects the effectiveness of the measures implemented. We anticipate that this figure may increase slightly as a result of maintaining a rolling pipeline without immediate vacancies, though some flexibility here is necessary to support our long-term strategy.
- Total sickness absence fell slightly to 4%. The Workforce Directorate continues to support managers through training and the application of absence management protocols. A proposal for an absence management support programme for areas with high absence rates is being developed.
- Temporary Staffing: Agency usage has sharply declined following the decision to stop using agency nurses (with the exception of Theatres for the next 6 months whilst they onboard and train their new recruits) and healthcare support workers except in exceptional circumstances. Overtime also reduced further. Bank usage remains high.
- All SPC charts for the KPIs are showing an improving trend, including sickness absence for the first time in five years. (see next slide)

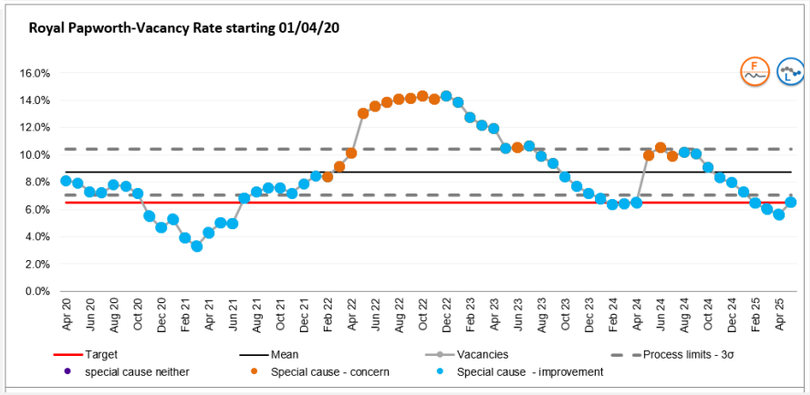
People, Management & Culture: Key performance trends

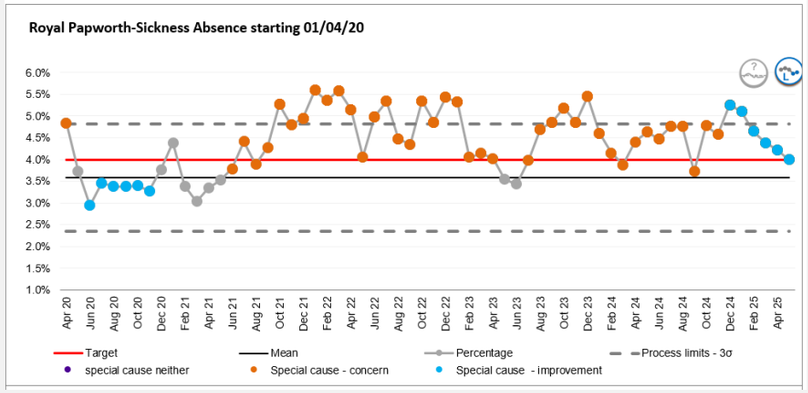
Royal Papworth Hospital
NHS Foundation Trust

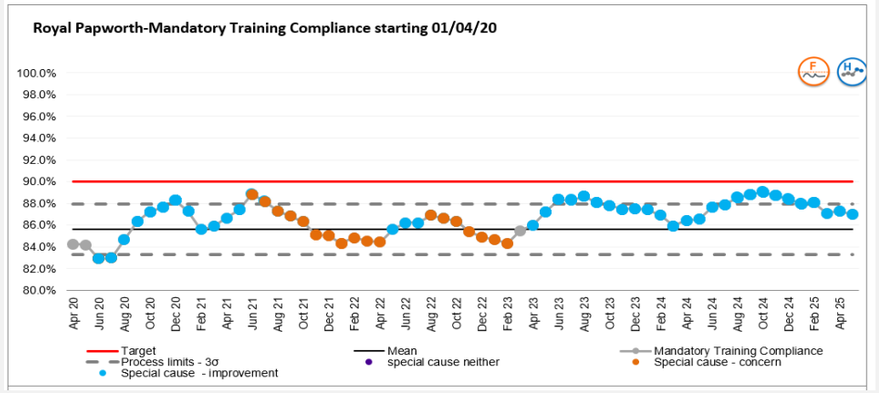
Accountable Executive: *Director of Workforce and Organisational Development* ***Report Author:*** *HR Manager Workforce*







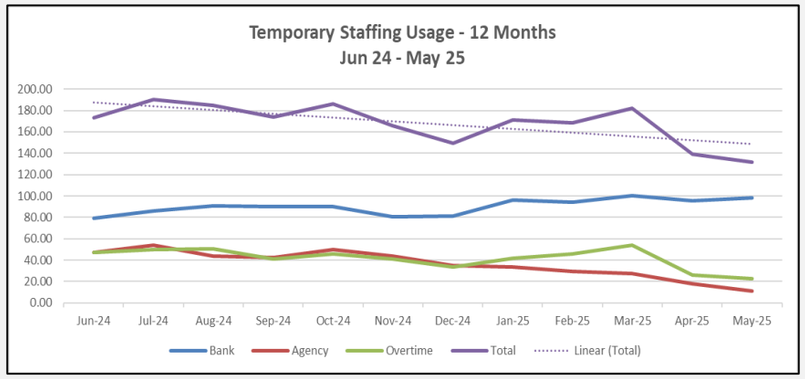


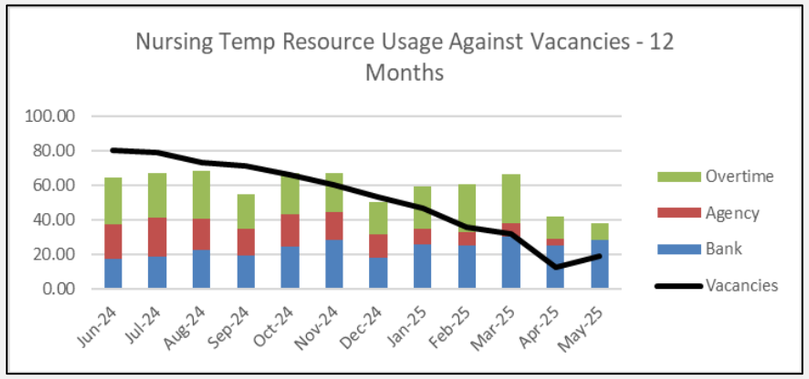


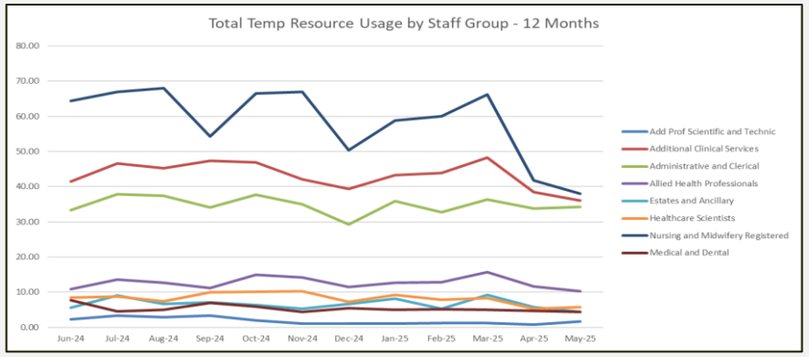
People, Management & Culture: Temporary Staffing usage against budgeted establishment

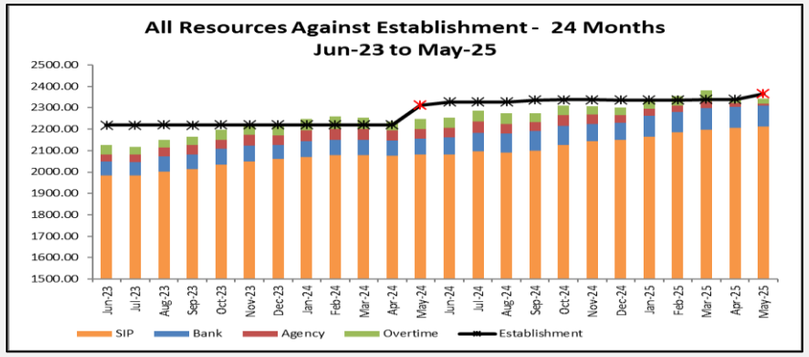
Accountable Executive: *Director of Workforce and Organisational Development* ***Report Author:*** *Head of Workforce Information*

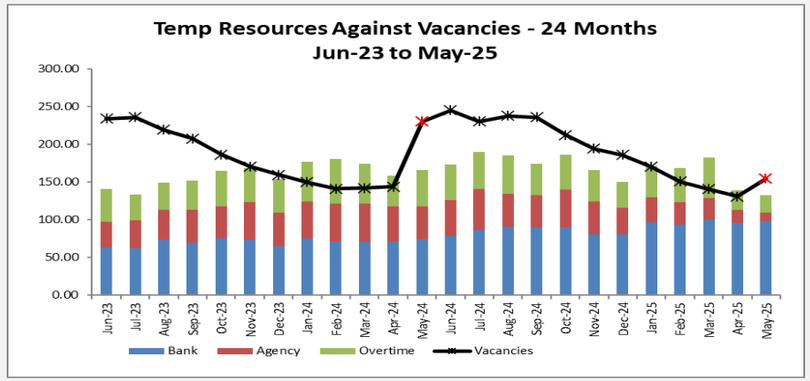
Royal Papworth Hospital
NHS Foundation Trust

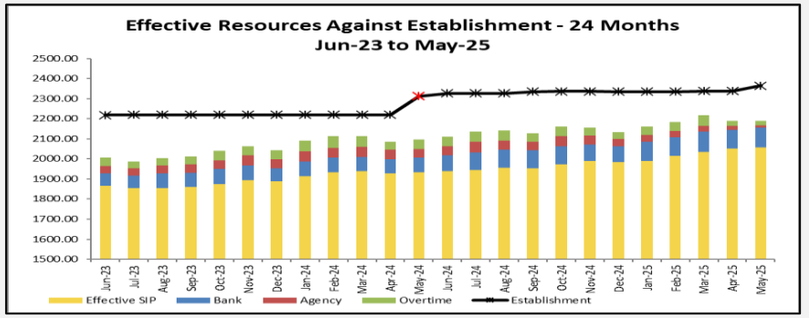












Effective SIP is the Actual Staff in Post minus Sick Leave, Maternity Leave and Other Leave

Temporary Staffing Trends.

Over the last 12 years the total amount of temporary staffing used has been on a downward trend. There has also been a substantial change in the types of temporary staffing being used.

- There has been a sharp decline in the amount of agency workers being used. We are no longer using registered nursing and HCSW agency workers (However, Theatres who are planning to stop using agency by September 25). Agency workers are only being used to cover vacancies in shortage/specialist occupations where recruitment is still problematic or we need short term specialist skills eg Cardiac Physiology, Specialist Pharmacy roles, digital roles.
- Overtime has also significantly reduced with all areas strengthening their controls over its use and only using it for very short notice staffing gaps where cover is required to maintain save staffing. Patient Safety Initiative work is also recorded as overtime.
- Bank use has been increasing with it now making up the majority of temporary staffing being utilised.
- The staff group where there has been the biggest decrease in the amount of temporary staffing being used has unsurprisingly been registered nursing. However the reduction in temporary staffing does not align with the even steeper reduction in the vacancy rate. .

In the period January – April 2025 the total workforce resources being used ie Staff in Post (SIP)+Temporary staff, exceeded the budgeted establishment. However when unavailability (leave) and vacancies are taken into account, there remains a gap between the available workforce and the establishment. For 24/7 rosters the budgeted establishment includes 22% headroom to ensure that safe staffing levels are maintained despite workforce unavailability due to absence. As vacancy rates are now very low it requires careful management of rosters to ensure that cover for absences is managed within the SIP rather than by using temporary staffing otherwise pay costs could exceed budgeted establishment. Workforce and Finance teams are developing guidance for managers on how to manage workforce utilisation and rostering when vacancy rates are low.

Finance: Performance summary

Accountable Executive: *Chief Finance Officer* ***Report Author:*** *Deputy Chief Finance Officer*

Royal Papworth Hospital
NHS Foundation Trust

		Data Quality	Target	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Dashboard KPIs	Year to date surplus/(deficit) adjusted £000s	4	£(91)k	£99k	£140k	£1,044k	£335k	£(29)k	£(58)k
	Cash Position at month end £000s *	5	£75,889k	£81,494k	£74,117k	£76,448k	£75,314k	£79,265k	£75,114k
	Capital Expenditure YTD (BAU from System CDEL) - £000s	4	£232 YTD	£1,905k	£2,322k	£2,506k	£4,918k	£26k	£39k
	CIP – actual achievement YTD - £000s	4	£1,293k	£5,460k	£5,730k	£6,018k	£6,630k	£219k	£438k
	Agency expenditure target £'k	5	£440k	£256k	£239k	£305k	£243k	£188k	£179k
	Bank expenditure target £'k	5	£390k	£374k	£339k	£395k	£491k	£391k	£417k
Additional KPIs	Capital Service Ratio YTD	5	1.0	0.6	0.6	0.5	0.5	0.5	0.2
	Liquidity ratio	5	26	29	29	29	29	29	25
	Year to date EBITDA surplus/(deficit) £000s	5	Monitor only	£9,687k	£10,773k	£10,863k	£11,060k	£944k	£1,888k
	Total debt £000s	5	Monitor only	£3,610k	£4,230k	£4,090k	£6,580k	£5,400k	£4,200k
	Average Debtors days - YTD average	5	Monitor only	4.1	4.8	4.6	7	6	5
	Better payment practice code compliance YTD - Value £ % (Combined NHS/Non-NHS)	5	Monitor only	97%	97%	98%	98%	98%	98%
	Better payment practice code compliance YTD - Volume % (Combined NHS/Non-NHS)	5	Monitor only	97%	97%	97%	97%	97%	86%
	Elective Variable Income YTD £000s	4	£9802k (YTD)	£43,393k	£48,908k	£55,178k	£58,151k	£4,927k	£10,427k
	CIP – Target identified YTD £000s	4	£9630k	£6,632k	£6,632k	£6,632k	£6,632k	£4,650k	£4,727k
	Implied workforce productivity % - compares real terms growth in pay costs from 19/20 against growth in activity from 19/20	5	Monitor only	-1.4%	-1.7%	-0.3%	5.1%	n/a	7.2%

Summary of Performance and Key Messages:

- **At month 2, the YTD finance position is a deficit of £50k, which represents a favourable variance of £50k to plan.** This favourable variance is driven by variable income over-performance within core NHS variable contracts and private patient activity. Also supporting this variance is a favourable budget phasing of planned elective recovery initiatives against spend; alongside phasing of contingency reserves which are offsetting adverse business-as-usual pay and CIP under-delivery pressures within Divisions.
- **Income is £0.7m favourable to plan**, primarily driven by NHS variable and private patient activity overperformance c£0.2m. This position reflects the continuation of the national aligned payment incentive arrangements for activity income, where contracted income comprises of a fixed and a variable component. Contract negotiations are being finalised with commissioners to agree final indicative activity plans and contracts values, following national and contract guidance updates.
- **Pay expenditure is £0.5m adverse to plan**. The Divisional adverse variances have resulted from ongoing temporary staff usages in excess of establishments in a number of ward areas, alongside YTD non-recurrent backdated Medical staff arrears payments for approved additional programme activity from recent job planning exercise. Agency spend reduction delivery against trajectory continues to be sustained in the period overall. Work is ongoing with Divisional teams, as part of the divisional PRM suite of meetings, to understand bank usages over establishment, with action plans being developed to recover the pay position.
- **Operating non-pay spend is adverse to plan by £0.2m.** This has been driven by non-recurrent spend recovered from commissioners within the income position and a CIP under-delivery within Divisional positions (this is partly offset by central contingency and other unspent reserves). CIP remains a key area of focus with enhanced support being provided and further grip and control action in place (see CIP report).
- **Cash closed at £75.1m**, a reduction of c£0.9m on last month's position due to PFI lease payment in the month, alongside a small working capital movement benefit.
- The capital plan for the year resulted from a risk-based prioritisation process undertaken by the Medical Devices Group, Digital and Estates teams with oversight from Investment Group. Spending the EPR capital is the most significant risk (representing over 50% of the programme), and this will continue to be monitored as the Full Business Case progresses. The year-to-date capital delivery is £0.2m behind plan, driven by slippages within medical equipment replacement programme.

Note * Target set at 90% operational plan

Finance: Key Performance – YTD SOCI position

Royal Papworth Hospital
NHS Foundation Trust

Accountable Executive: *Chief Finance Officer* ***Report Author:*** *Deputy Chief Finance Officer*

The YTD adjusted financial performance is £50k deficit, representing a favourable variance to plan of £50k. This position is driven by Income over-performance (of which £0.7m relates to clinical income) and the favourable budget phasing of planned elective recovery initiatives against spend; in addition to contingency reserves phasing, offsetting adverse pay and CIP under-delivery pressures within Divisional budgets.

		YTD £000's Plan	YTD £000's Underlying Actual	YTD £000's Other Non Recurrent Actual	YTD £000's Actual Total	YTD £000's Variance	RAG
Clinical income - in national block framework							
	Fixed at Tariff	£27,106	£18,409	£0	£18,409	(£8,696)	
	Balance to Fixed Payment	£0	£8,696	£0	£8,696	£8,696	
	Variable at Tariff	£9,802	£9,992	£0	£9,992	£189	
	Homecare Pharmacy Drugs	£8,181	£8,231	£0	£8,231	£50	
	High cost drugs	£101	£127	£0	£127	£26	
	Pass through devices	£4,430	£4,460	(£96)	£4,364	(£66)	
	Sub-total	**£49,620**	**£49,915**	**(£96)**	**£49,819**	**£199**	
Clinical income - Outside of national block framework							
	Devices	£249	£251	£0	£251	£2	
	Other clinical income	£295	£474	£0	£474	£180	
	Private patients	£1,706	£2,011	£0	£2,011	£304	
	Sub-total	**£2,250**	**£2,735**	**£0**	**£2,735**	**£486**	
Total clinical income		**£51,870**	**£52,651**	**(£96)**	**£52,555**	**£685**	
Other operating income							
	Other operating income	£3,000	£2,900	£250	£3,150	£150	
Total operating income		**£3,000**	**£2,900**	**£250**	**£3,150**	**£150**	
Total income		**£54,871**	**£55,551**	**£154**	**£55,705**	**£834**	
Pay expenditure							
	Substantive	(£24,315)	(£25,318)	(£115)	(£25,433)	(£1,118)	
	Bank	(£790)	(£691)	£0	(£691)	£98	
	Agency	(£882)	(£402)	£0	(£402)	£480	
	Sub-total	**(£25,987)**	**(£26,411)**	**(£115)**	**(£26,526)**	**(£539)**	
Non-pay expenditure							
	Clinical supplies	(£5,557)	(£5,625)	£0	(£5,625)	(£68)	
	Pass through devices	(£4,864)	(£4,534)	(£227)	(£4,761)	£103	
	Drugs	(£2,396)	(£1,210)	£0	(£1,210)	£1,185	
	Homecare Pharmacy Drugs	(£7,276)	(£8,256)	£0	(£8,256)	(£981)	
	Non-clinical supplies	(£6,972)	(£7,177)	(£250)	(£7,427)	(£455)	
	Depreciation	(£1,830)	(£1,784)	£0	(£1,784)	£45	
	Sub-total	**(£28,894)**	**(£28,587)**	**(£477)**	**(£29,064)**	**(£170)**	
Total operating expenditure		**(£54,881)**	**(£54,998)**	**(£592)**	**(£55,590)**	**(£709)**	
Finance costs							
	Finance income	£639	£578	£0	£578	(£60)	
	Finance costs	(£1,035)	(£1,010)	£0	(£1,010)	£25	
	PDC dividend	(£396)	(£396)	£0	(£396)	£0	
	Revaluations/(Impairments)	£0	£0	£0	£0	£0	
	Gains/(losses) on disposals	£0	£0	£0	£0	£0	
	Sub-total	**(£792)**	**(£828)**	**£0**	**(£828)**	**(£35)**	
Surplus/(Deficit) For The Period/Year		**(£803)**	**(£275)**	**(£438)**	**(£713)**	**£90**	
Adjusted financial performance surplus/(deficit)		**(£91)**	**(£196)**	**(£438)**	**(£45)**	**£46**	

YTD month headlines:

1. **Clinical income is c£0.7m favourable YTD.**
   - Fixed income on a tariff lens is c£8.6m below plan. This shortfall is mitigated by the current block arrangements, which provides a level of security to the Trust's income position.
   - Variable income is favourable to plan by c£0.2m and reflects c109% performance against the expected national baseline. Variable activity delivery remains a key focus for the Trust.
2. **Other Operating Income is £0.2m favourable to plan.** The YTD position is mainly driven by R&D funds and charitable income with a corresponding overspend within expenditure budgets.
3. **Pay expenditure is £0.5m adverse to plan.** Ongoing pay pressures partly offset by profiles reserve benefits (for elective recovery plans against spend), is being managed through the Divisional PRM meeting where the key lines of enquiry remains over-establishments of wards and backdated additional medical programme activity.

   Agency spend reduction continues to deliver against trajectory at Trust level, with variations by area, where plans are being developed to ensure trajectory delivery.
4. **Clinical Supplies is £0.04m favourable to plan**. This is driven by activity and pass-through devices underperformance consistent with the clinical income position.
5. **Drugs is £0.2m favourable to plan overall**, within which, homecare pharmacy spend is broadly offset within the income position.
6. **Non-clinical Supplies is £0.5m adverse to plan**. The position includes expenditure that is offset by R&D and charitable income. CIP under-delivery in Divisional positions is being partly offset by central contingency and other unspent reserves. CIP remains a key area of focus and action (see CIP report).

RAG: ● = adverse to Plan ● = favourable / in line with Plan