Governor Committee/Group membership – Current

Committee	Approved Membership	Current Governor Membership
Appointments [NED Nomination and Remuneration] Committee of the Council of Governors	Minimum of 6 Governor Members Quorum of 3 Members Membership to Include: 4 Public Governors 2 Staff Governors Maximum: N/A	Abi Halstead (Public & Lead Governor - Cambs) Marlene Hotchkiss (Public Governor- RoE) Trevor Collins (Public Governor RoE) Clive Glazebrook (Public Governor RoE) Chris McCorquodale (Staff Governor S&T) Josevine McLean (Staff Governor – Nurses)
Nominations (Board of Directors) **Selection/interview Panel for NEDs**	Governor Members (In addition to the Chairman, CEO and NED) 1 Governor (usually the Lead Governor) One or more members of the Appointments Committee shall sit on the Nominations Committee of the Board of Directors	To be agreed at the time of recruitment
Forward Planning (Council of Governors)	Minimum of 7 Governor Members Quorum of 3 Members Membership to Include: 5 Public Governors 2 Staff Governors Maximum: not more than eight Governors, of whom two shall be staff Governors.	Susan Bullivant (Chair - Public Governor – Cambs) (Bill Davidson to become Chair once Susan steps down 2025) Harvey Perkins (Public Governor- RoE) Trevor Mc Leese (Public Governor -Suffolk) Christopher McCorquodale (Staff Governor) Clive Glazebrook (Public Governor RoE) Vivienne Bush (Public Governor-Suffolk) Bill Davidson (Public Governor - Cambs) Sarah Brroks (Staff Governor)
Public and Patient Involvement (Council of Governors)	Governor Members and other Members Quorum requires two governors. Membership to include at least seven Governors of the Trust, at least one of whom should be a Staff Governor. Maximum: N/A	Marlene Hotchkiss (Chair - Public Governor – RoE) Trevor Collins (Public Governor – RoE) Martin Hardy-Shepherd (Public Governor – Norfolk) Trevor McLeese (Public Governor – Suffolk) John Fitchew (Public Governor- Norfolk) Ian Harvey (Public Governor- Cambs) Paul Berry (Public Governor - Norfolk) Lesley Howe (Public Governor Norfolk) Susan Bullivant (Public Governor-Cambs) Lynne Williams (Staff Governor)
Governors' Assurance Committee (Council of Governors)	Six Governor Members Also present: Audit Committee Chair (NED) Task and Finish group Maximum: N/A	Bill Davidson (Chair - Public Governor - Cambs) (Chris McCorquodale to Chair once Bill moves to Forward Planning 2025) Trevor McLeese (Public Governor- Suffolk) Abi Halstead (Public Governor - Cambs) Susan Bullivant (Public Governor- Cambs) Marlene Hotchkiss (Public Governor – RoE) Chris McCorquodale (Staff Governor)

Access and Facilities Group	**Six Governor members** Quorum: Four Maximum: N/A	Trevor McLeese (Chair - Public Governor - Suffolk) Trevor Collins (Public Governor – RoE) Josevine McLean (Staff Governor– Nurses) Bill Davidson (Public Governor – Cambs) Lesley Howe (Public Governor - RoE) 1 Vacancy
Board Sub-Committees		
Audit Committee (Board of Directors)	Membership 3 NEDs 2 Governor observers in attendance	Harvey Perkins (Public Governor- RoE) Christopher McCorquodale (Staff Governor) Vivienne Bush (Public Governor-Suffolk)
Performance Committee (Board of Directors)	*Membership 6 Board members including 3 NEDs* 2 Governor observers in attendance	Bill Davidson (Public – Cambs) Trevor Collins (Public RoE) Rachel Mahony (Public Governor – Cambs)
Quality and Risk Committee (Board of Directors)	Membership 3 NEDs, Medical Director, Director of Nursing, Chair of Quality and Risk Management Group, Clinical Lead for Risk Management **2 Governors in attendance (Lead Governor or nominated deputy and Staff Governor)**	Abi Halstead (Public & Lead Governor-Cambs) Rhys Hurst (Staff Governor - AHP) Deborah Cooper (Public Governor - Norfolk)
Workforce Committee	Governor observers in attendance: 1 Public Governor 1 Staff Governor	Angie Atkinson (Public Governor-Suffolk) Marlene Hotchkiss (Public Governor- RoE)
End of Life Care	**Governor representative**	Lesley Howe (Public Governor - RoE) Clive Glazebrook (Public Governor- RoE) Rachel Mahony (Public Governor - Cambs)
Emergency Preparedness Committee	**Governor representative**	Lynne Williams (Staff Governor -Doctors)
Trust's committee for local clinical Excellence Awards (Executive Committee)	**Governor representative**	Appointed Governor – University of Cambridge)
Advisory Appointments Committee on Consultants	-	Rota of non-staff Governors
Digital Strategy Board	**Governor representative**	Trevor Collins (Public Governor-RoE) Lesley Howe (Public Governor-RoE) Rhys Hurst (Staff Governor) Deborah Cooper (Public Governor-Suffolk)
Ethics Committee	**Two lay Governors**	Abi Halstead (Public Governor - Cambs) Ian Harvey (Public Governor - Cambs)

Charitable Funds Committee	**Membership to be determined**	Governor Observer - Angie Atkinson (Public Governor)

Please contact the Associate Director of Corporate Governance, Lead Governor or Chair of a Committee for further information or to join/change Committee.

Royal Papworth Hospital
NHS Foundation Trust

Unconfirmed Minutes of the Forward Planning Committee (FPC) of the Council of Governors
Wednesday, 9 April 2025 at 10:30 am – 12:00 noon
via Microsoft Teams
Royal Papworth Hospital

PRESENT		
Dr Susan Bullivant	SBu	Public Governor **(Chair)**
Dr Harvey Perkins	HP	Public Governor
Vivienne Bush	VB	Public Governor
Trevor McLeese	TMc	Public Governor
Dr Clive Glazebrook	CG	Public Governor
IN ATTENDANCE		
Eilish Midlane	EM	Chief Executive Officer
Tim Glenn	TG	Deputy Chief Executive Officer & Director of Commercial Development, Strategy and Innovation
Sophie Harrison	SH	Chief Finance Officer (Interim)
Dr Ian Smith *(10:30-11:55 hrs)*	IS	Medical Director
Diane Leacock	DL	Non-Executive Director/Chair of the Strategic Projects Committee
Oonagh Monkhouse *(10:30-11:28 hrs)*	OM	Director of Workforce and OD
Andrew Raynes	AR	Chief Information Officer
Harvey McEnroe	HMc	Chief Operating Officer
Kwame Mensa-Bonsu	KMB	Associate Director of Corporate Governance
APOLOGIES		
Bill Davidson	BD	Public Governor
Christopher McCorquodale	CMc	Staff Governor

Agenda Item		Action by Whom	Date
1.	**WELCOME & OPENING REMARKS**		
	SBu welcomed all to the meeting.		
i.	**APOLOGIES**		
	Apologies had been received from BD and CMc.		
ii.	**DECLARATIONS OF INTEREST**		
	No specific conflicts were identified in relation to matters on the agenda.		
iii.	**MINUTES OF THE PREVIOUS MEETING DATED 15 JANUARY 2025**		
	SBu noted that at 4.i “Cyber-readiness remained a concern and was an ever-present danger, with an attack considered to be an “if” rather than a “when”,		

Agenda Item		Action by Whom	Date
	should have read "…considered to be a "***when" rather than an "if".*** Subject to the above amendment, the Committee **approved** the minutes from the 15 January 2025 meeting and authorised these for signature by the Chair as a true record.		
iv.	**MATTERS ARISING**		
	04/24 – 10 July 2024 – 6.ii – Papworth Integrated Performance Report (PIPR) – M02 Update on progress against the Workforce Strategy Workplan – Focus on the actions being implemented. This item was on the agenda for today's meeting. To be **CLOSED**. ***01/25 – 15 January 2025 – 2.ii – Development of the next Trust 5-Year Strategy – Tim Glenn to be invited to attend the next Forward Planning Committee to talk specifically about the Strategy (Development Process).*** TG would provide an update at today's meeting. To be **CLOSED**. ***02/25 – 15 January 2025 – 4.i – Abridged Board Assurance Framework – Updates on the progress of the Nexus Electronic Patient Replacement Project to be made a standing agenda item.*** This action had been completed. To be **CLOSED**. The Committee received and **approved** the updates on the action checklist.		
2.	**STRATEGIC PLANNING/DEVELOPMENTS**		
i.	National/Local Updates		
	EM presented the National/Local updates. The announcement that Amanda Pritchard, CEO of NHS England (NHSE), and her top team would be standing down, prior to NHSE's abolition within two years, were highlighted. The announcement also included the intention to reduce the staffing capacity for Integrated Care Systems (ICSs) by circa 50%. EM noted that the plans to abolish NHSE and reduce the staffing capacity for ICSs had been unexpected. A working party would establish next steps for these plans and there had been discussion around the re-establishment of Regional Health Authorities. Challenges for the ICSs to reduce their staffing capacities, as well as their operational costs, were driving conversations around potential mergers. EM provided headlines in respect of operational planning which included delivery of a breakeven position and delivery of the recovery against the performance standards laid out in the Operational Planning Guidance published at the end of January 2025. This had been possible without the need to establish vacancy freezes or redundancies. The plan was noted to be challenging, but deliverable. EM provided clarity that the term "productivity" did not infer staff working long hours or excessively. EM advised that the term "productivity" rather inferred the reduction of the barriers to the staff's ability to effectively and efficiently treat patients. There was the need to understand these barriers which staff encounter on a day-to-day basis and, where possible, remove them. EM explained that it had been possible to collectively submit a system position		

Agenda Item		Action by Whom	Date
	which was breakeven across all of the NHS provider organisations in the Cambridgeshire and Peterborough (C&P) ICS. The C&P ICS's Operational Plan also aimed at delivering on the requirements of the Operational Planning Guidance in terms of elective and cancer care activity recovery. EM advised that it had not been possible for the C&P ICS to commit to achieving the level of recovery required by the Planning Guidance in relation to urgent and emergency care. **Discussion:** TMc extended thanks to EM for the reassuring delivery of her recent update to all staff on the issue of redundancies in the NHS and questioned whether additional robotic operating facilities would aid productivity. EM responded that though the Trust's robotic operating system was being used effectively, it would require a very significant capital and revenue cost outlay to expand those facilities. EM advised that the alternative solution was thought to be the harnessing of technological advances to reduce back office administrative tasks, with 'Brainomix', a machine-assisted reporting tool, noted by way of example. EM stated that a group had been set up by AR to assess the risks associated with the procurement and harnessing of technological tools in the Trust. HMc was able to offer TMc assurance that the current assessment of this year's Elective Recovery Programme indicated that all was achievable within current capacity. HMc added if the increased utilisation of robotics had been considered more effective, that would have been pursued. TMc highlighted the achievements of robotics in treating cancer patients at Huddersfield Hospital. EM acknowledged this and explained that there was opportunity for general hospitals in respect of high volume/low complexity areas such as urology and gynaecology. EM stated that significantly more complex cardiac surgical procedures were undertaken at the RPH, although there was ambition to undertake lung transplantation robotically. AR referred to the signed-off Digital and Data Strategy which had enabled a roadmap in the near future in terms of what digital tools would be delivered for the Trust. AR reiterated the need to be cautious about exploring AI digital solutions, and assured the Committee that the focus in the Trust was to procure tools which would be specifically useful to RPH operational needs. The Committee **noted** the National/Local updates.		
ii.	Development of the Trust's next 5-Year Strategy (2026 – 2031)		
	TG presented the process being implemented for the development of the Trust's next 5-Year Strategy, providing the Committee with a high-level verbal update on the engagement phase of the process. TG advised that one-to-one interviews had been held with Board members, including Non-Executive Directors (NEDs) and Executives. A workshop had also taken place at which attendees had included thirty members of the Trust Management Executive. An additional workshop had involved key stakeholders including Governors and other attendees from Cambridge University Hospital, the C&P ICB and North West Anglia NHS Foundation Trust (NWAFT).		

Agenda Item		Action by Whom	Date
	TG continued that a questionnaire circulated via 'News Bites' had enabled feedback from staff about their future engagement in the Strategy production process. TG stated that the feedback from staff had clearly established that they wanted the Trust to have a clear purpose and direction which would be communicated by the Strategy. Furthermore, there was a need to ensure the amplification of the cultural change and the leadership work that OM had been leading in the Trust, recognising that this would be a 'turning point' for a number of relationships with both internal and external stakeholders. Work was underway to design how the above would be delivered, with thoughts and deliberations to be presented in a single document which was expected to be published for the Executive Team and presented to the Trust Board towards the end of April 2025. The Launch process would commence in May 2025 with three key strands noted to be 'listening to staff', 'listening to communities and patients' and 'inspiration'. There had been engagement with other NHS organisations and wider afield to establish how those organisations at this point of change, had engaged with their patients and staff during the change process. **Discussion:** EM extended thanks to TG for the work involved in the development of such a holistic engagement process. It was noted that this was different to the previous Strategy development process and mirrored what had been undertaken for the Nexus Electronic Patient Record (EPR) Replacement programme. SBu queried whether, through the process, more staff might be encouraged to stand for elections to become staff governors, noting the historical lack of interest. SBu queried whether there might be mechanisms for gaining feedback from outpatients for which numbers were lower than those obtained from inpatients. In addition, SBu suggested that the process could be an opportunity to attract more members to the Trust. EM, in response, expressed the view that time constraints was a more likely reason for the shortage of staff offering to become staff governors than a lack of interest. In respect of outpatients, there was the need for steps to be taken to increase the level of feedback. TG noted that the need for time and space to engage in the Strategy development processes, and other similar processes, was a current topic of discussion within the staffing body. The Committee **noted** the Development of the next Trust 5-Year Strategy (2026 – 2031).		
iii.	Progress Update – Workforce Strategy Plan (Recruitment and Retention Activities)		
	OM introduced the Progress Update – Workforce Strategy Plan (Recruitment and Retention Activities). OM explained that the Trust's Workforce Strategy had been extended for a further 12 months to align with the development of the Trust 5-year Strategy. A workplan would be developed for 2025/26 to bridge the period until the development of the new Strategy. The Workforce Strategy was noted to be based on six themes, as follows:		

Agenda Item		Action by Whom	Date
	• Compassionate and collective culture • Belonging and inclusion for all • Developing the workforce • Growing the workforce • Efficient and effective workforce processes • Work with partners EM highlighted that the plan encompassed training and development and would be delivered by the entire Executive Team. OM shared details of the intended focus for each theme via relevant slides and provided explanation of each to the Committee. OM advised that feedback on the themes had been received at the Trust Board's Workforce Committee, and this would be reflected within the plan. **Discussion:** BD had submitted a question regarding 'Growing the Workforce' theme, which sought to understand "the number of apprentices to be employed, if there was a plan for an increase in overall numbers of permanent staff and if this was the case, the type of increases in permanent staff numbers being considered. OM replied that the operational plan was not to expand the workforce numbers in 2025/26 but to maintain current low vacancy rates, with development of the skills of the workforce. OM stated that there was also a need to adapt staff skills and competencies to align with the strategic objectives of the Trust. OM explained that a range of apprenticeships existed at RPH, and these would continue to be supported and expanded. OM advised that though there were significant issues with the way the NHS's Apprenticeship Levy was being implemented, apprenticeships at RPH would not be negatively impacted. TMc referred to issues relating to a staff member with a disability who was experiencing issues relating to 'Workforce on Wheels' (WoW) which OM agreed to consider, with support from AR. TMc would send OM/AR the relevant email correspondence. CG raised concern that the workforce would not be expanded in the near future, noting its potential implications in view of the need to improve quality and while managing the expected staff turnover. OM, in response, highlighted the need to balance priorities with respect to the limited finances. The Trust would maintain the strategic objective of providing the best quality and effective services to as wide a number of people as possible. TG raised the importance of maximising what could be done for the public and patients from current headcount, due to the constraints of the financial climate. CG stressed that his concern had been for the psychological wellbeing of patients rather than staff. OM confirmed that the support service had been commissioned for patients and agreed to ask Maura Screaton to provide information to CG on the scope of the services provided. *OM left the meeting (11:28 hrs)* The Committee **noted** the Progress Update – Workforce Strategy Plan (Recruitment and Retention Activities).	TMc OM	07/25 07/25

Agenda Item		Action by Whom	Date
3.	**OPERATIONAL PLANS**		
i.	Annual 2025/26 Operational Plan		
	SH presented the Annual 2025/26 Operational Plan and shared a relevant presentation with the Committee. In respect of the national context, the significant financial challenges across the sector, leading to changes in the financial framework for 2025/26, were highlighted. An area for focussed improvement in this period would be timeliness and experience of care. It was acknowledged that difficult collective decisions would be required to balance operational priorities with the funding available, whilst continuing to lay foundations for future reforms. Locally, there was a focus on reducing waiting times and improving access to care as a priority in 2025/26. There would also be continued work on the EPR programme and Strategy refresh, both of which would play a key role in the organisation's financial and operational future. SH reiterated the key headline relating to the financial plan that a breakeven plan had been submitted by both the Trust and the C&P ICS for 2025/26. The following highlights were noted: i. A cost improvement delivery of £9.6m. ii. Targeted investment would support elective waiting list improvements and RTT performance of circa. £1.4m. iii. The funding of unavoidable cost pressures would be £1.3m. HMc provided the Committee with areas of interest in relation to the following: i. A projected activity growth of +9%. ii. RTT ambitions were projected to deliver the +5% national improvement ask as a minimum, with a target of achieving 72% by March 2026. There was an ambition to progress this further. This would be delivered through a combination of targeted short-term investments, to be overseen by a new Access Board governance structure. iii. An overall productivity improvement target of +7% was highlighted. SH raised the issue of key risks which were noted to comprise the delivery of cost improvement plans, including corporate service costs; delivery of productivity ambitions; delivery of waiting list improvements; ability to manage the costs of elective activity growth and waiting list improvements; and potential for disruption to the EPR programme timeline. **Discussion:** SBu requested that the slide displayed be shared as an addendum to the minutes of this meeting, for the benefit of the committee, which SH agreed to provide.	SH	07/25

Agenda Item		Action by Whom	Date
	The Committee **noted** the Annual 2025/26 Operational Plan.		
ii.	Nexus EPR Replacement Project – Progress Update		
	HMc presented the Nexus EPR Replacement Project – Progress Update. The Outline Business Case (OBC) had been approved by NHS England (NHSE) via the EPR Investment Board (EPRIB) and the project was now noted to be at Pre-Market Engagement (PME) stage. The documentation at the PME stage would enable potential EPR system suppliers to gain a clear understanding of the organisation's objectives, allowing them to make informed decisions on whether to participate in the procurement process. It also provide an opportunity for suppliers to offer feedback on the requirements, suggesting potential refinements before the Trust finalised the procurement documentation. Five suppliers had engaged in the process, with all scheduled to attend one-to-one sessions with the Trust between 03 and 10 April. Initial feedback on the Invitation to Tender (ITT) documentation had also started to be received by the Trust. The feedback from suppliers included questions around further clarification on the Trust's specifications with further queries anticipated as the PME process progressed. The Trust had agreed a clear procurement strategy to support the procurement of the EPR solution. This focused on the ITT which would be issued following the completion of the Cabinet Office approval. The ITT for the supply of an EPR was a formal request for suppliers to submit a proposal to provide and implement the solution at the Trust and documentation included the following: • Introduction and background • Instructions to suppliers • Scope of work / specification of requirements • Contract Terms and Conditions • Evaluation criteria • Pricing and cost breakdown • Compliance and regulatory requirements The Strategy highlighted the stages, scoring and timescales of the procurement the Trust was about to undertake. The details of the sections within the ITT and how they would be scored were included within the paper. To help rate the quality of the EPR solutions, the Trust had developed a number of scenarios. Unlike the OBS, the scenarios at the PME stage simulated workflows within the Trust with the aim of testing each EPR application on both functionality and suitability. The scenario exercised also focussed on the objectives that the OBC had set. Prior to procurement commencing, these scenarios would also be reviewed by patient groups, to enable input to be provided. HMc explained that the timeline had been carefully structured, but there were several risks that could potentially extend the Nexus EPR replacement programme's duration. **Discussion:** SBu explained that BD had expressed the wish to understand whether the plan		

Agenda Item		Action by Whom	Date
	was still to deliver a campus-wide EPR and if so, whether there was a campus-wide Board to deliver that plan. HMc explained that a number of formal arrangements were in place to protect both RPH and CUH through the process, including a Memorandum of Understanding (MOU) for data sharing whilst navigating the process of how RPH and CUH would have a connected EPR product. In addition, a Joint Strategy Board had been established to govern and oversee the Joint Strategy Group whose remit included specifically review the campus-wide EPR version being sought. Attendees included HMc, Dr Sue Broster (SRO for CUH for the EPR), finance colleagues SH and Mike Keech (CUH), TG as Deputy CEO driving strategy, AR and the respective CIO for CUH. This plan was noted to be a significant opportunity to work more effectively with campus partners in sharing information and in aligning digital services in the form of a campus-wide EPR solution. SBu posed a further question. received from BD, around whether any assurance had been received that the abolishing of NHSE would not change any of the project approvals already achieved or the overall replacement project timeline. HMc advised that confirmation had been received from the Frontline Digitisation Programme that RPH's case remained positive, was well written, exemplary in its structure and was looking to be approved. It was not known whether future changes or strategies would impact the commitment to the wider digital agenda or the digital strategy as set by NHSE. However, Frontline Digitisation as a structure had been approved to last until the end of 2027, so that process would endure through the next two financial years to deploy the existing pipeline of Frontline Digitisation projects. CG queried whether there was a fallback position should the Treasury decline the case. HMc advised that the Treasury would have to be specific about which aspects of the case would not be approved, after which there would be opportunity to recycle the OBC. Though there would be a significant risk to the projected timescale for the deployment of an EPR system in the Trust, it would be possible to re-enter the Treasury cycle immediately once such feedback had been received without re-approval at the C&P ICB level. The Committee **noted** the Nexus EPR Replacement Project – Progress Update.		
iii.	Papworth Integrated Performance Report (PIPR) – M11		
	EM introduced the PIPR, and advised that the report reflected that, whilst some benefit had been evident from the Patient Flow Programme and the enhanced utilisation of both theatres and Cath Lab utilisation, there was clearly further work to do. Of positive note were low nursing vacancy rates, giving opportunity to address agency usage, which had been driving up costs. **Discussion:** SBu had observed a number of areas of concern, and EM stated that a significant number of red alerts were evident due to the use of the national standards against which the majority of Trusts had not been delivering since the Covid-19 pandemic. It was felt that the colours created a disproportionate level of alarm, particularly in areas such as 'safe' where there was enhanced sensitivity to anything which might impact on quality.		

Agenda Item		Action by Whom	Date
	IS left the meeting (11:55 hrs). The Committee **noted** the Papworth Integrated Performance Report (PIPR) – M11.		
4.	**ASSURANCE**		
i.	Abridged Board Assurance Framework (BAF) – Overview of Underlying Risks		
	EM introduced the Abridged BAF – Overview of Underlying Risks and advised that a revised version of this document would be presented to the Board, having been reshaped in the context of the changing NHS. SBu noted a significant number of high-rated BAF risks. EM explained that the BAF articulated the existential threats to the organisation and represented risks to strategy delivery. As such, they did not move quickly and had a longer timeframe against them. EM advised that the BAF would be more user-friendly, after a review had been completed by the Trust Board in May 2025. The Committee **noted** the Abridged Board Assurance Framework (BAF) – Overview of Underlying Risks.		
5.	**GOVERNANCE**		
i.	FPC Chair – Matters Arising		
	SBu highlighted her intention to stand down as chair of the FPC and advised that the current solution to fill the role was that BD would relinquish his role as Chair of the Governors' Assurance Committee (GAC) and take up the position of Chair of the FPC, with CMc filling the role as Chair of the GAC.		
ii.	Any Other Business		
	There was no other business and the meeting closed at 12:00 hrs.		
6.	**Date and Time of Meetings** i. 09 July 2025 ii. 08 October 2025		

……………………………………………….
Signed

…………………………………………………..
Date

Royal Papworth Hospital
NHS Foundation Trust

Agenda item 16.1

Report to:	**Performance Committee**	**Date: 29 May 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 April 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 Performance Committee are requested to **note** the contents of the report.

Royal Papworth Hospital
NHS Foundation Trust

Papworth Integrated Performance Report (PIPR)

April 2025

Compassion
Excellence
Collaboration

Royal Papworth Hospital
NHS Foundation Trust

Content

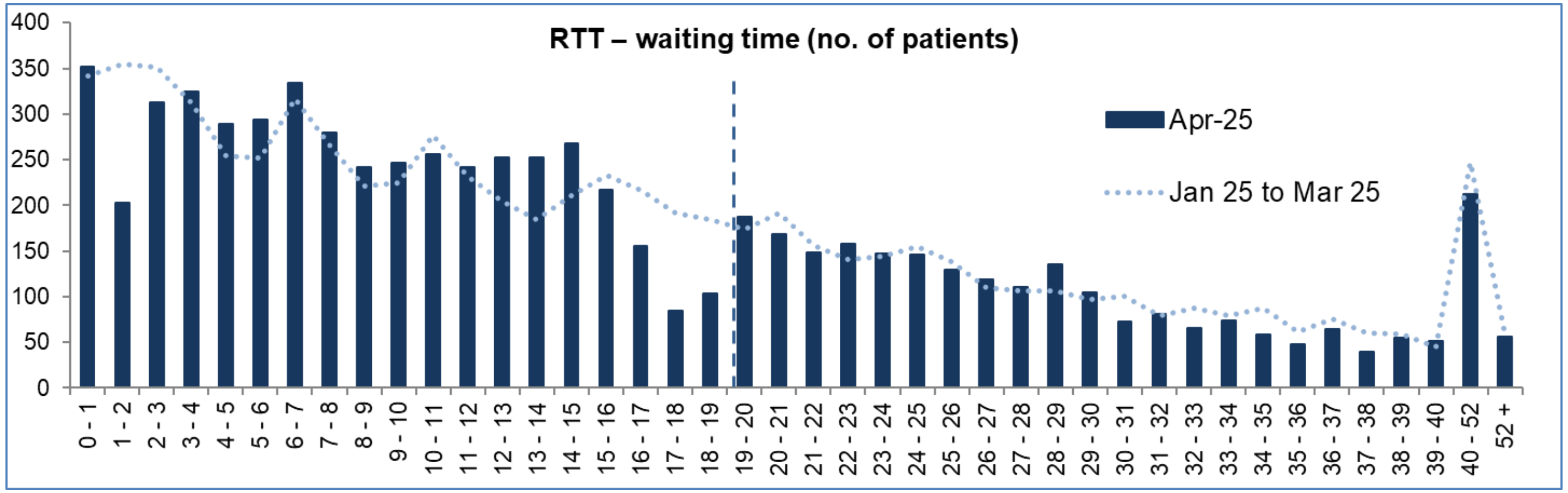
Context:

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)	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	Trend
Cardiac Surgery	147	137	130	147	138	141	
Cardiology	721	638	733	650	679	706	
ECMO	5	4	4	2	8	0	
ITU (COVID)	0	0	0	0	0	0	
PTE operations	10	13	8	9	11	11	
RSSC	586	564	622	536	526	603	
Thoracic Medicine	513	459	549	510	501	494	
Thoracic surgery (exc PTE)	79	96	79	87	82	56	
Transplant/VAD	34	44	40	49	45	45	
Total Admitted Episodes	**2,095**	**1,955**	**2,165**	**1,990**	**1,990**	**2,056**	
Baseline (2019/20 adjusted for working days annual average)	*1,830*	*1,830*	*1,830*	*1,830*	*1,830*	*1,830*	
%Baseline	*114%*	*107%*	*118%*	*109%*	*109%*	*112%*	

Outpatient Attendances (NHS only)	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	Trend
Cardiac Surgery	584	518	559	600	573	525	
Cardiology	3,736	3,505	3,897	3,634	3,842	3,883	
RSSC	1,915	1,848	2,258	2,091	2,166	2,083	
Thoracic Medicine	2,480	2,245	2,480	2,285	2,162	2,305	
Thoracic surgery (exc PTE)	116	135	171	125	132	100	
Transplant/VAD	308	280	269	254	281	328	
Total Outpatients	**9,139**	**8,531**	**9,634**	**8,989**	**9,156**	**9,224**	
Baseline (2019/20 adjusted for working days annual average)	*7,418*	*7,418*	*7,418*	*7,418*	*7,418*	*7,418*	
%Baseline	*123%*	*115%*	*130%*	*121%*	*123%*	*124%*	

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

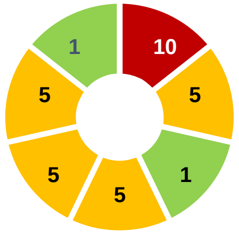
The 'RAG' ratings for each of the individual KPIs included within this report are defined as follows:

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).

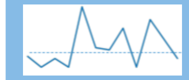
- **Red (10 points) =** 2 or more red KPIs within the category
- **Amber (5 points) =** 1 red KPI rating within the category
- **Green (1) =** No reds and 1 amber or less within the category



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:

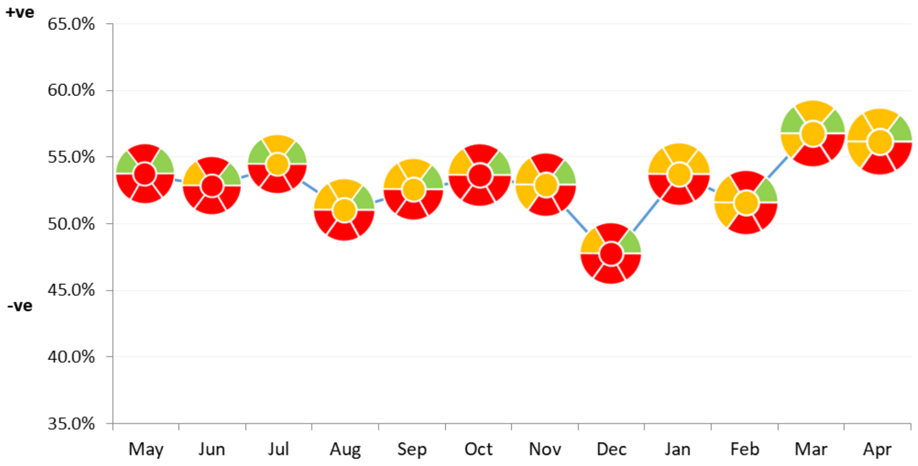
Data Quality Indicator

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

Overall Trust rating - AMBER



FAVOURABLE PERFORMANCE

SAFE: Safe staffing fill rates - Registered Nurse (RN) fill rates for day (91%) and night shifts (93%) are above target for April. Safer staffing fill rates for Health Care Support Workers (HCSWs) are above target at 86% for day shifts in April, an increase noted from 84% in March. HCSW fill rates are above target at 87% for night shifts in April. RPH's active recruitment campaign for HCSWs have contributed to fill rate improvement meeting target of 85% and above.

CARING: FFT (Friends and Family Test): In summary – Inpatients: Positive Experience rate was 99.2% in April 2025 for our recommendation score. Participation Rate for surveys was 41.2%. Outpatients: Positive experience rate was 98.4% in April 2025 and above our 95% target. Participation rate was 12.9%.

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.

PEOPLE, MANAGEMENT & CULTURE: 1) Turnover at 7.6% returned to below our KPI target of 9%. Of the 13wte (15 headcount) non-medical leavers, 8 were in the Administrative and Clerical staff group from across a number of departments. The reason given by 4 of these was linked to retirement. 2) Vacancy rate - our total Trust vacancy rate continued its improving trend reducing to 5.6% which equates to 131wte. 3) Total sickness absence - fell slightly to 4.2%, although it remains above the 4% KPI. The Workforce Directorate continues to support managers through training and the application of absence management protocols.

FINANCE: At month 1, the position is reported a breakeven financial position on an adjusted financial performance basis, representing a favourable variance of £0.3m. 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 business as usual (BAU) adverse pay variances and CIP under-delivery in the Divisions at month 1.

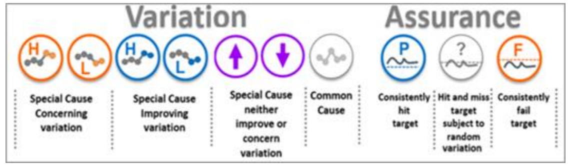
ADVERSE PERFORMANCE

CARING: 2 of 3 (66.67%) complaints were responded to in the month within agreed timescales. Of these 2 were extended with the complainants' agreement and the 3rd was responded to 5 working days late as it required a longer investigation period.

RESPONSIVE: RTT - The PTL continues to be reviewed regularly, and patient prioritisation reviewed daily as late referrals are received or if patients condition changes. There were 56 52-week RTT breaches in month, which is an increase of 5 from the previous month. Trust-wide RTT recovery programme in place to support operational plans for 2025/26. This work has reviewed opportunities already developed and divisions have put together proposals of immediate remedial plans to aid the reduction in the backlog as well as sustainable plans to ensure ongoing demand can be met while reducing pathway waits for patients. New governance structure in place to review delivery and performance, this includes a weekly planned care delivery and performance group and bi-weekly access board.

FINANCE: 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.

At a glance – Balanced scorecard



Royal Papworth Hospital
NHS Foundation Trust

		Month reported on	Data Quality ***	Plan	Current month score	YTD Actual	Trend / SPC Variation & Assurance	
Safe	Never Events	Apr-25	5	0	0	0		
	Number of Patient Safety Incident Invetigations (PSII) commissioners in month	Apr-25	5	0	0	0		
	Learning Responses - Moderate Harm and above as % of total patient safety incidents	Apr-25	5	3%	2.2%	2.2%		
	Number of Trust acquired PU (Catergory 2 and above)	Apr-25	4	35 pa	1	1		
	Falls per 1000 bed days	Apr-25	5	4	1.6	0.0		
	VTE - Number of patients assessed on admission	Apr-25	5	95%	94%	94%		
	Sepsis - % patients screened and treated (Quarterly) *	Apr-25	3	90%	-	-		
	Trust CHPPD	Apr-25	5	9.6	12.5	12.5		
	Safer staffing: fill rate – Registered Nurses day	Apr-25	5	85%	91.0%	91.0%		
	Safer staffing: fill rate – Registered Nurses night	Apr-25	5	85%	93.0%	93.0%		
	Safer staffing: fill rate – HCSWs day	Apr-25	5	85%	86.0%	86.0%		
	Safer staffing: fill rate – HCSWs night	Apr-25	5	85%	87.0%	87.0%		
	% supervisory ward sister/charge nurse time	Apr-25	New	90%	82.00%	82.0%		
	Cardiac surgery mortality (Crude)	Apr-25	3	3%	2.2%	2.2%		
	MRSA bacteremia	Apr-25	3	0	0	0		
	Monitoring C.Diff (toxin positive)	Apr-25	5	7	0	0		
Caring	FFT score- Inpatients	Apr-25	4	95%	99.20%	99.20%		
	FFT score - Outpatients	Apr-25	4	95%	98.40%	98.40%		
	Mixed sex accommodation breaches	Apr-25	5	0	0	0		
	Number of written complaints per 1000 WTE (Rolling 3 mnth average)	Apr-25	4	12.6	10.9	10.9		
	% of complaints responded to within agreed timescales	Apr-25	4	100%	66.67%	66.67%		
	Duty of candour compliance undertaken within10wd (quarterly)	Apr-25	New	100%	100.0%	100.0%		
People Management & Culture	Voluntary Turnover %	Apr-25	4	9.0%	7.6%	7.6%		
	Vacancy rate as % of budget	Apr-25	4	7.5%	5.6%			
	% of staff with a current IPR	Apr-25	4	90%	76.86%			
	% Medical Appraisals*	Apr-25	3	90%	79.53%			
	Mandatory training %	Apr-25	4	90%	87.30%	87.30%		
	% sickness absence	Apr-25	5	4.00%	4.22%	4.22%		

		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)	Apr-25	4	85% (Green 80%- 90%)	73.80%	73.80%		
	ICU bed occupancy	Apr-25	4	85% (Green 80%- 90%)	78.20%	78.20%		
	Enhanced Recovery Unit bed occupancy %	Apr-25	4	85% (Green 80%- 90%)	75.70%	75.70%		
	Elective inpatient and day cases (NHS only)****	Apr-25	4	1679	1,642	1,642		
	Outpatient First Attends (NHS only)****	Apr-25	4	2180	2,233	2,233		
	Outpatient FUPs (NHS only)****	Apr-25	4	6903	6,991	6,991		
	% of outpatient FU appointments as PIFU (Patient Initiated Follow up)	Apr-25	4	5%	11.6%	11.6%		
	Reduction in Follow up appointment by 25% compared to 19/20 activity	Apr-25	4	-25%	-2.2%	-2.2%		
	% Day cases	Apr-25	4	85%	75.7%	75.7%		
	Theatre Utilisation (uncapped)	Apr-25	3	85%	86%	86%		
	Cath Lab Utilisation (including 15 min Turn Around Times) ***	Apr-25	3	85%	83%	83%		
Responsive	% diagnostics waiting less than 6 weeks	Apr-25	1	99%	93.2%	93.2%		
	18 weeks RTT (combined)	Apr-25	4	92%	64.6%			
	31 days cancer waits*	Apr-25	5	96%	100%	100%		
	62 day cancer wait for 1st Treatment from urgent referral*	Apr-25	3	85%	0%	0%		
	104 days cancer wait breaches*	Apr-25	5	0	5	5		
	Number of patients waiting over 65 weeks for treatment *	Apr-25	New	0	16			
	Theatre cancellations in month	Apr-25	3	15	28	28		
	% of IHU surgery performed < 7 days of medically fit for surgery	Apr-25	4	95%	30%	30%		
	Acute Coronary Syndrome 3 day transfer %	Apr-25	4	90%	74%	74%		
	Number of patients on waiting list	Apr-25	4	3851	7150			
	52 week RTT breaches	Apr-25	5	0	56	56		
Finance	Year to date surplus/(deficit) adjusted £000s	Apr-25	4	£(68)k	£2k			
	Cash Position at month end £000s	Apr-25	5	£76,637k	£79,265k			
	Capital Expenditure YTD (BAU from System CDEL) - £000s	Apr-25	4	£116k	£26k			
	CIP – actual achievement YTD - £000s	Apr-25	4	£553k	£219k			

* Latest month of 62 day and 31 cancer w ait 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%	2.21%	0.92%				
	Number of Trust acquired PU (Catergory 2 and above)	35 pa	1	0				Review
	Falls per 1000 bed days	4.00	1.58	1.60				Review
	VTE - Number of patients assessed on admission	95.0%	94.3%	94.2%				Review
	Sepsis - % patients screened and treated (Quarterly) *	90%	-	90%				Review
	Trust CHPPD	9.6	12.5	12.8				Review
	Safer staffing: fill rate – Registered Nurses day	85%	91%	90%				Review
	Safer staffing: fill rate – Registered Nurses night	85%	93%	95%				Review
	Safer staffing: fill rate – HCSWs day	85%	86%	84%				Action Plan
	Safer staffing: fill rate – HCSWs night	85%	87%	89%				Review
	% supervisory ward sister/charge nurse time	90%	82%	83%				Action Plan
	MRSA bacteremia	0	0	0				Review
	Monitoring C.Diff (toxin positive)	7 pa	0	0				Review
	Cardiac surgery mortality (Crude)	3.0%	2.2%	2.3%				Review
Additional KPIs	E coli bacteraemia	Monitor	0	1				Monitor
	Klebsiella bacteraemia	Monitor	1	1				Monitor
	Pseudomonas bacteraemia	Monitor	0	0				Monitor
	Other bacteraemia	Monitor	0	0				Monitor
	% of medication errors causing harm (Low Harm and above)	Monitor	10.5%	15.4%				Monitor
	All patient incidents per 1000 bed days (inc.Near Miss incidents)	Monitor	35.7	34.8				Monitor
	SSI CABG & Valve infections (inpatient/readmissions %)	2.7%	-	3%				Review
	SSI CABG & Valve infections patient numbers (inpatient/readmisisons)	Monitor	-	11				Monitor
	WHO Safety checklist % - Surgery	Monitor	88.8%	0.0%				Monitor
	WHO Safety checklist % - Cath Labs	Monitor	95.4%	0.0%				Monitor

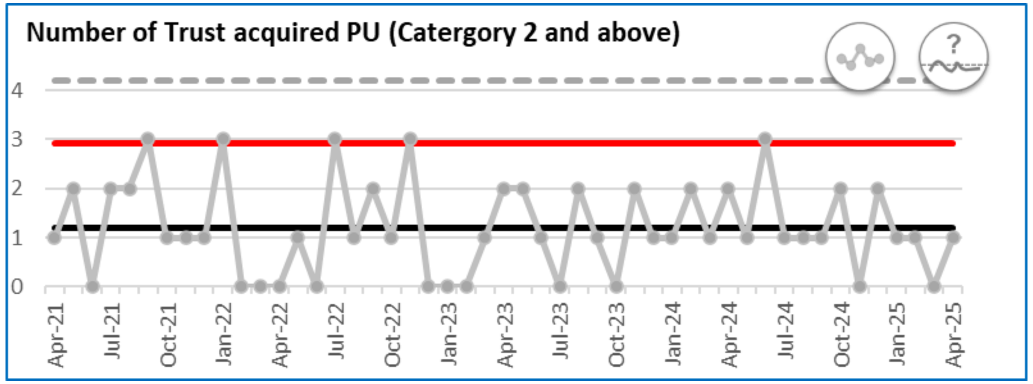
Safe: Patient Safety/Harm Free Care

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

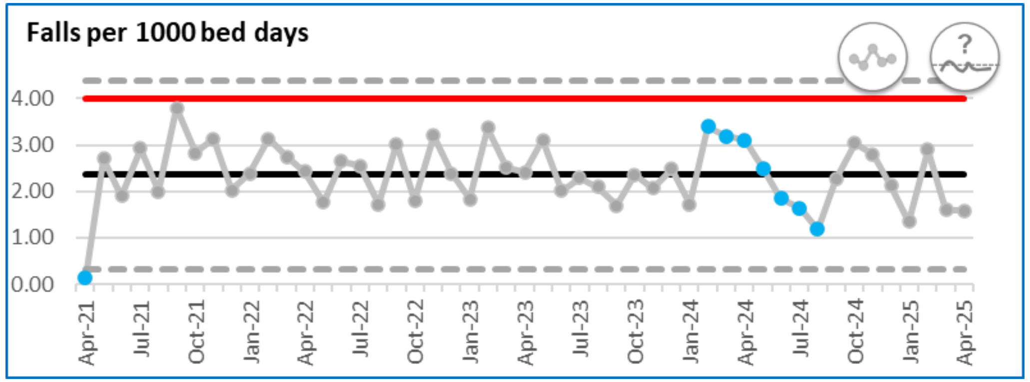
Royal Papworth Hospital
NHS Foundation Trust

Target — Mean — Measure — Process Limit — Concerning special cause — Improving special cause

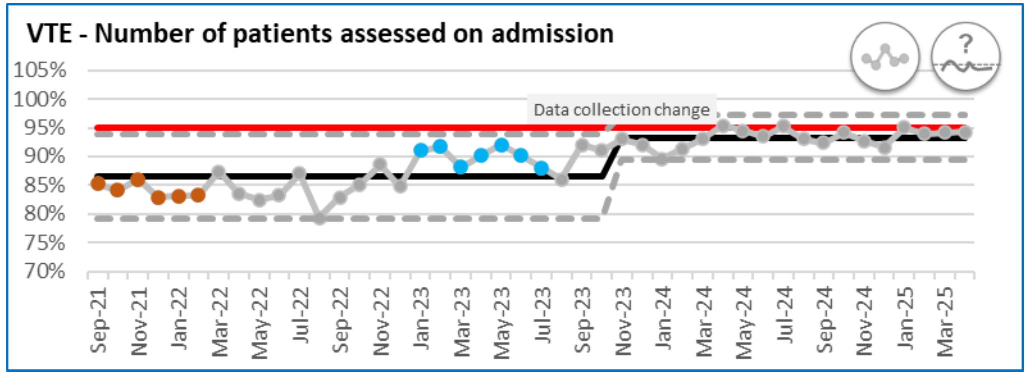
1. Historic trends & metrics



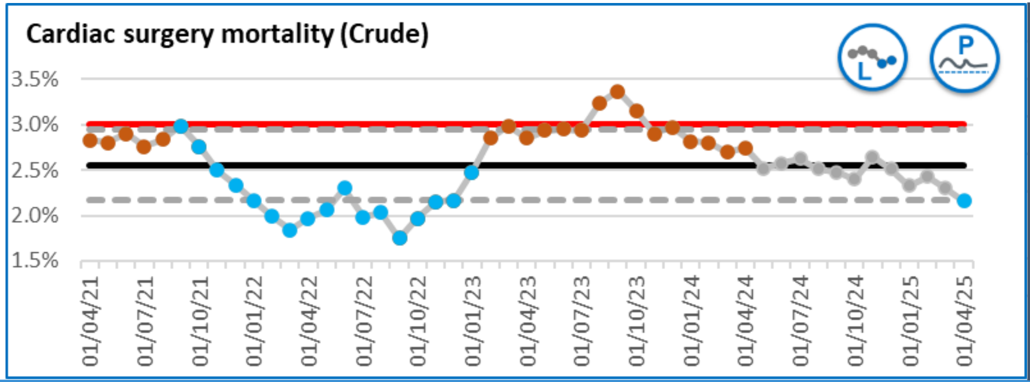
Apr-25
1
Target (red line)
35 per annum
Variation
Common cause variation
Assurance
Hit and miss on achieving target subject to random variation



Apr-25
1.58
Target (red line)
4
Variation
Common cause variation
Assurance
Hit and miss on achieving target subject to random variation



Apr-25
94.3%
Target (red line)
95.0%
Variation
Common cause variation
Assurance
Hit and miss on achieving target subject to random variation



Apr-25
2.2%
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 April.

Learning Responses- *Moderate Harm and above reported as % of total patient safety:* In Month there were 2.21% (5/226) of incidents that resulted in harm. 5 graded at SIERP in month (3 moderate harm (WEB56181, WEB56166, WEB56177) and 2 severe harm events WEB56123, WEB56088) from initial gradings. Final Investigations/grade will be shared at QRMG.

Medication errors causing harm: 10.5% (4/38) of medication incidents were graded as low harm, remaining no harm or near miss.

All patient incidents per 1000 bed days: There were 35.7 patient safety incidents per 1000 bed days.

Harm Free Care: In April there was 1 (WEB56191) confirmed Pressure Ulcer of category 2. There were 1.58 falls per 1000 bed days (10 in total, 1 severe, 2 moderate (these are included in the moderate harm numbers above), 4 low harm & 3 no harm), deep dive into effectiveness of falls prevention and management workplan currently under way. Compliance with VTE risk assessments was slightly below target at 94.3%. Those achieving VTE compliance above the 95% target were 3NE/3S/4N Cath Labs and Day Ward.

Cardiac Surgery Mortality (crude monitoring): Within expected variation at 2.2% in April.

Alert Organisms: There was one E coli and one Klebsiella 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 April this was 88.8% for Theatres and 95.4% for Cath Labs. The target for WHO check list is 100%. There is a further focus on WHO within these safe slides.

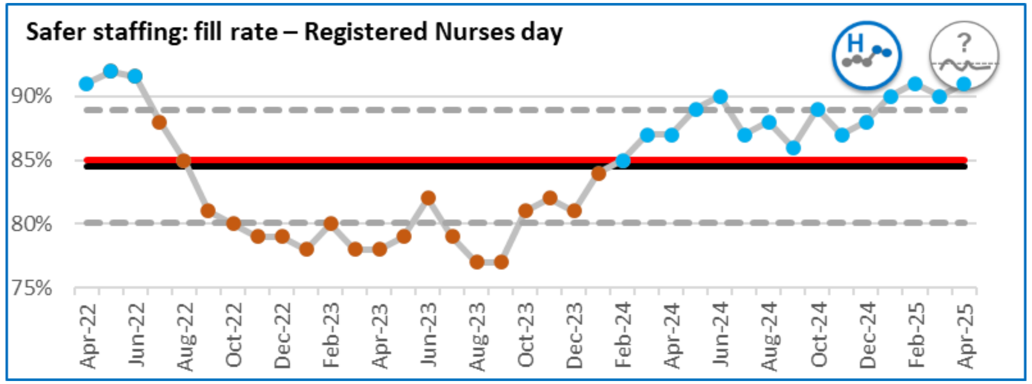
Safe: Safer Staffing

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

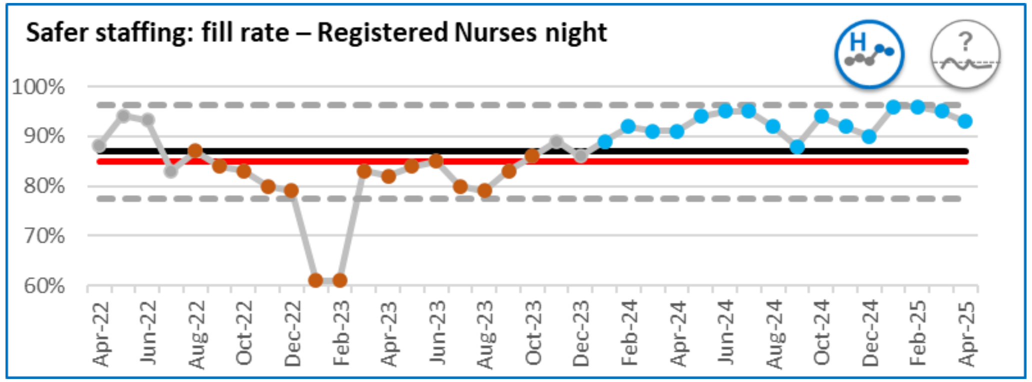
Target
Measure
Concerning special cause
Mean
Process Limit
Improving special cause

Royal Papworth Hospital
NHS Foundation Trust

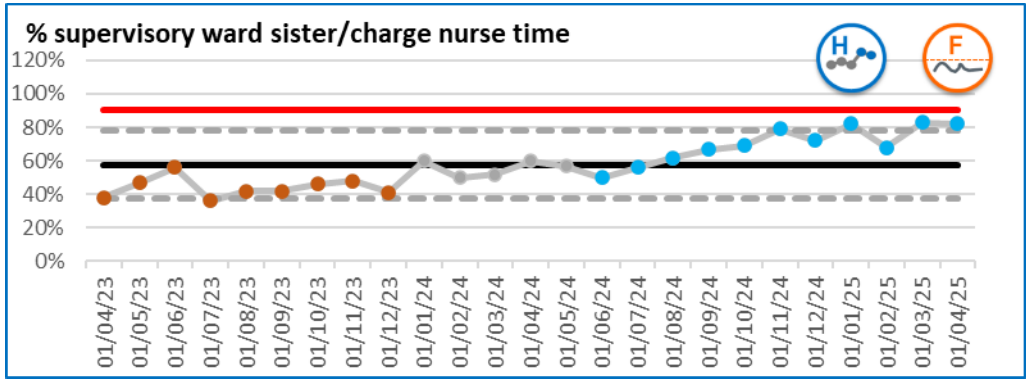
1. Historic trends & metrics



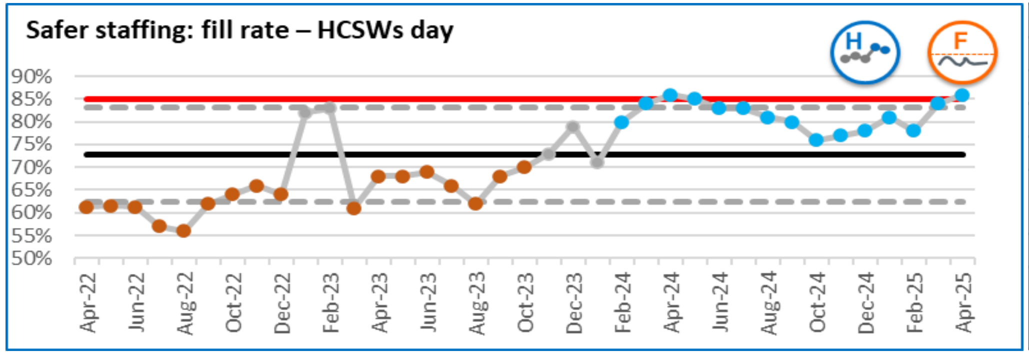
Apr-25
91%
Target (red line)
85%
Variation
Special cause variation of an improving nature
Assurance
Hit and miss on achieving target subject to random variation



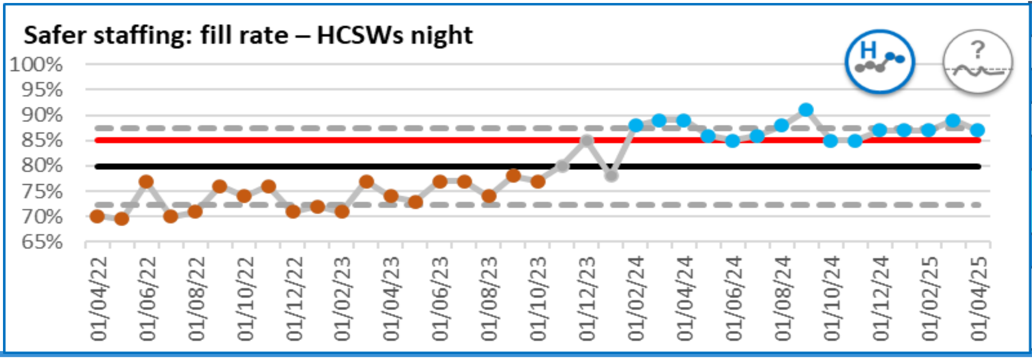
Apr-25
93%
Target (red line)
85%
Variation
Special cause variation of an improving nature
Assurance
Hit and miss on achieving target subject to random variation



Apr-25
82%
Target (red line)
90%
Variation
Special cause variation of an improving nature
Assurance
Has consistently failed the target



Apr-25
86%
Target (red line)
85%
Variation
Special cause variation of an improving nature
Assurance
Has consistently failed the target



Apr-25
87%
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 (91%) and night shifts (93%) are above target for April. Safer staffing fill rates for Health Care Support Workers (HCSWs) are above target at 86% for day shifts in April, an increase noted from 84% in March. HCSW fill rates are above target at 87% for night shifts in April. 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 12.5 for April compared to 12.8 reported for March.

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 an increase in SS time to 82% in April compared to 83% in March. The highest achieving areas towards SS/ CN time target of 90% are the Cardiology Unit who are reported above target at 103%, followed by ERU at 94% and Outpatients at 91% . Ward 4 South has had an increase in SS time from 82% in March to 87% in April. 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: World Health Organisation – Surgical Safety Checklist

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

What is the purpose of the WHO surgical safety checklist?
The WHO checklist aims to decrease errors and adverse events and increase teamwork and communication in surgery thereby improving patient safety. Compliance with the WHO checklist is a mandatory requirement in all NHS hospitals, England and Wales. It is used across Theatre and Cath Lab departments at Royal Papworth hospital (as per DN612 WHO Surgical Safety Checklist procedure; DN702 Local Safety Standard for Operating Theatres (LocSSIP) and DN705 Local Safety Standard for Catheter Labs (LocSSIP). Completion of the checklists are audited monthly for patients undergoing procedures in both areas, with results presented at the appropriate Business Unit meetings. **The Target for Theatres and Cath Lab areas is 100%**

Use of the WHO Checklist in theatres: 3 main parts at specific time points during surgery.
Sign in: completed before administration of anaesthesia to patient **Time out:** completed before start of surgery **Sign out:** completed before patient leaves department.

Key Performance Challenges in Theatres

- Overall compliance has been between 86.3% - 93.4% for the previous 12 months, with 88.8% in April 2025 in **Chart 2.**
- Compliance for patients undergoing procedures in the Elective and Urgent category was between 86% and 94.8% for the previous 12 months, with 91% in April 2025 as shown in **Chart 1.**
- Compliance for patients undergoing procedures in the Emergency and Salvage categories was between 57.1% and 88.9% for the previous 12 months, with 78% in April 2025 as shown in **Chart 1.**

Key actions

- A targeted focus on Emergency and Salvage procedures will continue. New areas of responsibility have been introduced by the Director of Surgery: The Sign in to be the Consultant Anaesthetist, The Time Out to be the Surgeon, and the Sign Out to be the Scrub Practitioner for the case. An additional safety net at time of Sign out will be for the Scrub Practitioner to confirm that the three sections have all been completed before the patient leaves the theatre.
- Education and a team approach on WHO compliance has been a constant at Team Briefings and Theatre Safety briefs.
- Interrogation of the audit to identify reduced compliance allows feedback to individuals and Leads.
- **Data check:** The Sign in check is completed on the Theatre Metavision EPR and the Time out and Sign out on the Lorenzo EPR system. The Digital team are currently checking the Metavision data to provide assurance all Sign in checklists are being pulled into the report.

Use of the WHO Checklist in Cath Labs: 2 parts to the checklist.
Check in: completed pre/procedure **Check out:** completed before patient leaves. The type of procedures taking place in Cath labs are different in length and complexity to those in theatres, and therefore an additional stop and check, such as the Time Out, is not required.

Key Performance Challenges in Cath labs

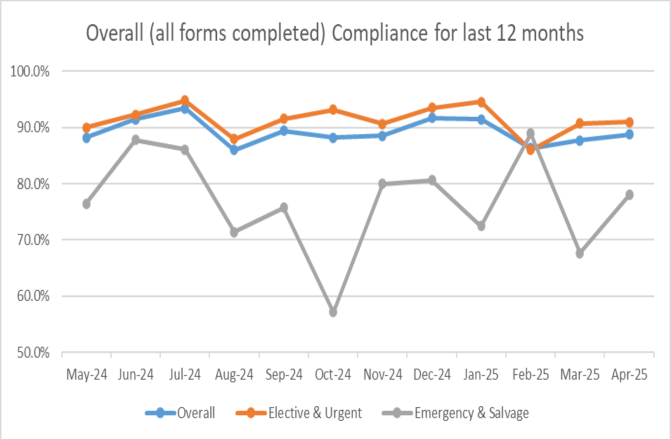
- Overall compliance has been between 94.6% and 96.9% for the previous 12 months as shown in **Graph 2**, with 95.4% overall compliance for April 2025 as shown in **Graph 1**.
- Emergency procedures follow the same process of check in and check out, but this is not currently audited.

Key actions

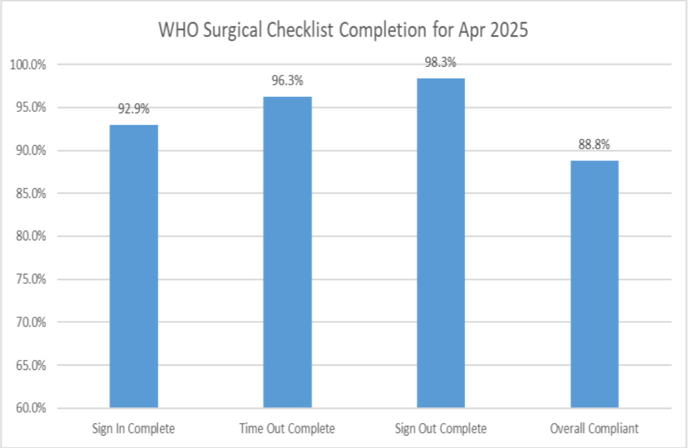
Within Cath Labs, a Working Group has been set up to review the WHO checklist and the Team brief., which takes place at the start of each day for each Cath Lab.
Actions agreed at the first meeting included:

- Devise a template for structured morning brief and improve its use within the Lab.
- Review of the Cath Lab competency with aim to simplify and align terminology with surgical checklist – i.e., use of terms such as check in and sign in. This will lead to consistency across both areas.
- Review of DN705 LocSSIP to reflect changes to WHO checklist format.
- Introduction of an audit of emergency procedures is currently under consideration within the department.

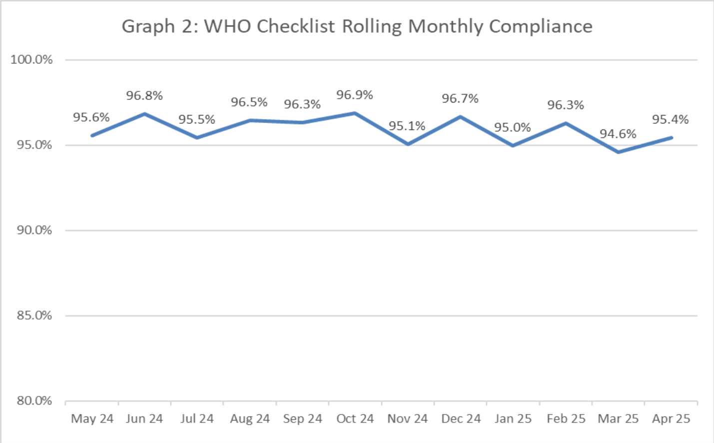
<u>Chart 1</u> Trendline for Elective & Urgent, Emergency & Salvage Compliance May 2024- Apr.2025



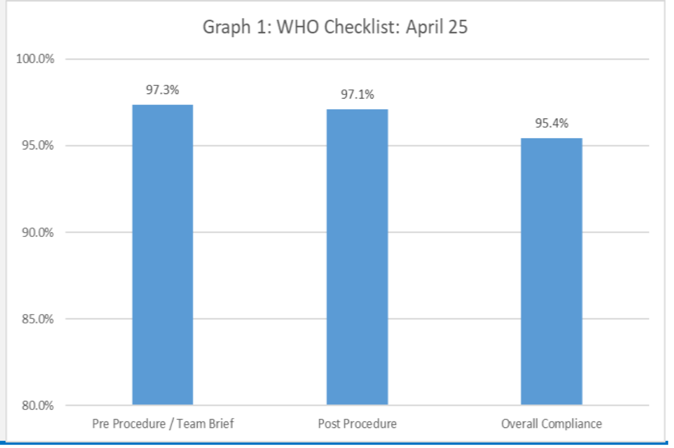
<u>Chart 2</u> WHO Surgical Checklist Completion Apr.2025



<u>Chart 3</u> Cath Lab Rolling WHO Compliance May 204- April 2025



<u>Chart 4</u> Cath Lab WHO Checklist Completion Apr.2025



Safe: Spotlight on: Safe Staffing – Care Hours Per Patient Day (CHPPD)

Accountable Executive: Chief Nurse *Report: Deputy Chief Nurse*

Chart 1 - Run Chart / Unify Submission for Care Hours Per Patient Day (CHPPD) on Inpatient Wards and Critical Care - Required versus Actual CHPPD (Apr. 2024 to Mar. 2025)

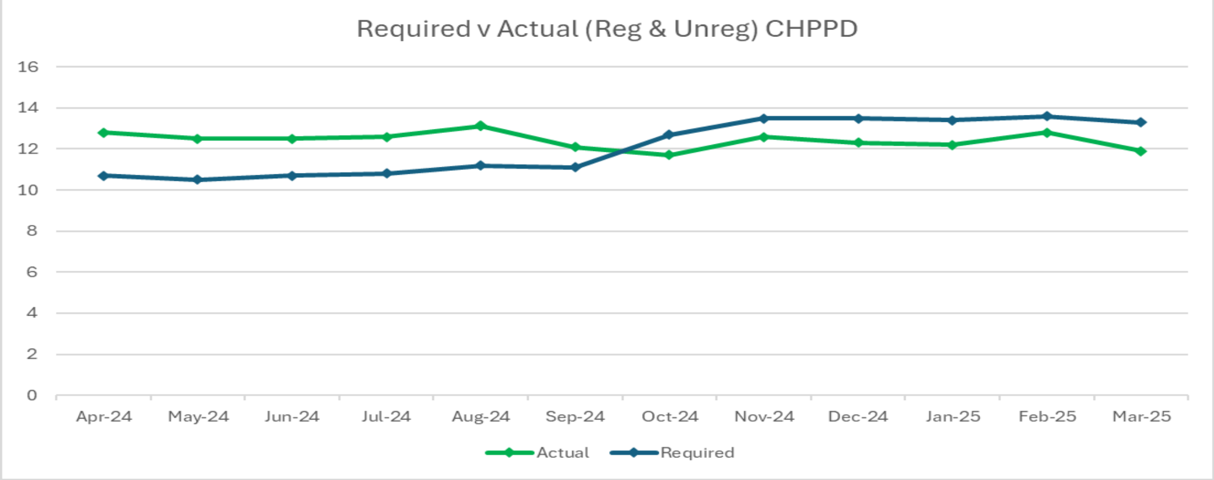
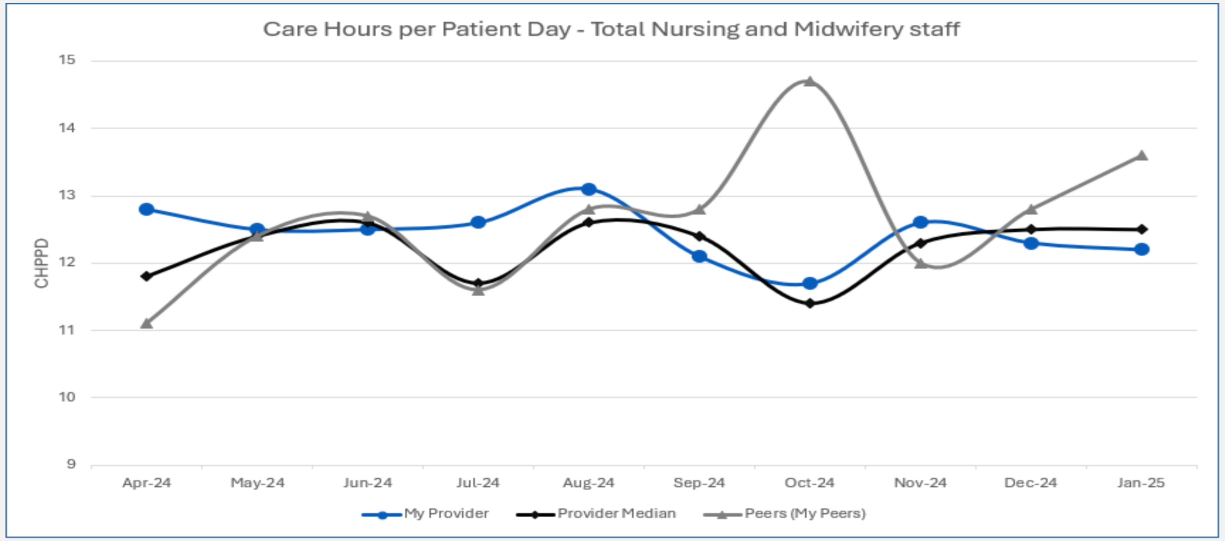


Chart 2 – This Trendline Chart shows RPH (bright blue) against national median (black) and peer median (grey) CHPPD from Apr. 2024 to Jan. 2025 (latest data reported)



Background to Care Hours Per Patient Day (CHPPD): The Francis Report (2013) made recommendations to improve the quality and safety of NHS services, including focusing on staffing levels and skill mix. A key recommendation was to introduce Care Hours Per Patient Day (CHPPD) as a metric to track and improve nursing and healthcare support staff deployments on inpatient wards. It enables wards within a trust, and wards in the same specialty at other trusts, to be compared such as using Model Hospital as a data driven improvement tool. It is calculated as follows, by taking the actual hours worked divided by the number of patients at midnight split by all clinical ward established workforce (registered and unregistered):

$$\text{Care Hours Per Patient Day} = \frac{\text{Hours of registered nurses} + \text{Hours of healthcare support workers}}{\text{Total number of inpatients}}$$

How do we capture and report CHPPD?

- The reporting of CHPPD nationally and what RPH is benchmarked against is the calculation undertaken at midnight. The mandated daily 23:59 bed count is reported monthly on PIPR.

What does the run rate CHPPD chart mean for RPH inpatient areas?

- In **Chart 1**, there is overall minimal discrepancy between actual vs required CHPPD for all inpatient areas.
- From Apr. to Sept. 2024, actual CHPPD was higher than required mainly due to under-utilisation of beds on the Enhanced Recovery Unit (ERU) and Coronary Care Unit (CCU), e.g., patients planned for Monday's Theatre do not arrive on ERU until later in day and at weekends ERU bed capacity is reduced to 7 beds on Saturday and 5 beds on Sunday compared to 10 beds operational Monday to Friday. A higher actual CHPPD versus required on CCU is due to variation in number of patients requiring admission to CCU.
- From October 2024 to Mar 2025, required CHPPD was higher than actual CHPPD due to winter pressures primarily affecting Thoracic Ward 4 South and Critical Care having higher acuity and dependency of patients.

How do we compare nationally with Model Hospital/ peer comparators?

- In **Chart 2** - RPH (blue) Apr. to Aug. CHPPD is higher than peer comparators (includes Liverpool Heart and Chest Hospital, Royal Brompton and Harefield Hospitals (Grey). The trendline of peers fluctuates in comparison to RPH's steadier trendline with higher CHPPD reported in Oct.2024 and Jan.2025. Since Dec. 2024 CHPPD at RPH is below peers and provider median (black/all trusts in the country that submitted data).
- There is minimal variation for RPH with the provider median for CHPPD Apr. 2024 to Jan. 2025.

What are the next steps?

- **CH**PPD is one metric and cannot be used in isolation therefore CHPPD should be triangulated with other safety and quality metrics.
- CHPPD is monitored for each clinical area and reported monthly in the Nurse Safe Staffing Report to CPAC.

Caring: Performance Summary

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

Variation: Special Cause Concerning variation (H / L); Special Cause Improving variation (H / L); Special Cause neither improve or concern variation; Common Cause

Assurance: P – Consistently hit target; ? – Hit and miss target subject to random variation; F – Consistently fail target

Royal Papworth Hospital
NHS Foundation Trust

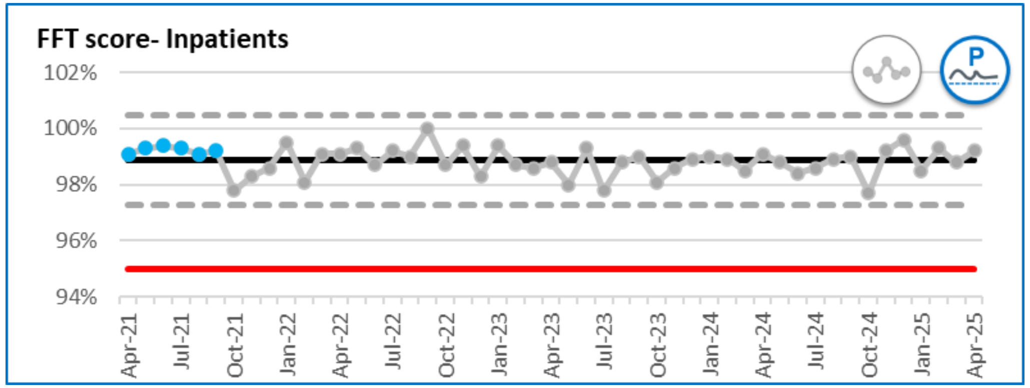
	Metric	Latest Performance: Trust target	Latest Performance: Most recent position	Previous: Position	In month vs target	Action and Assurance: Variation	Action and Assurance: Assurance	Action and Assurance: Escalation trigger
Dashboard KPIs	FFT score- Inpatients	95.0%	99.2%	98.8%			P	Monitor
	FFT score - Outpatients	95.0%	98.4%	96.6%			P	Monitor
	Mixed sex accommodation breaches	0	0	0			P	Monitor
	Number of written complaints per 1000 WTE (Rolling 3 mnth average)	12.6	10.9	8.7		H	P	Review
	% of complaints responded to within agreed timescales	100.0%	66.7%	100.0%		L	?	Review
	Duty of candour compliance undertaken within10wd (quarterly)	100.0%	100.0%	0.0%		New	New	Review
Additional KPIs	Friends and Family Test (FFT) inpatient participation rate %	Monitor	41.6%	42.5%		H		Monitor
	Friends and Family Test (FFT) outpatient participation rate %	Monitor	12.9%	11.9%		H		Monitor
	Number of complaints upheld / part upheld	3	2	4			?	Review
	Number of complaints (12 month rolling average)	5	5	5		H	P	Review
	Number of complaints	5	8	5				Review
	Number of informal complaints received per month	Monitor	12	3				Monitor
	Number of recorded compliments	Monitor	1820	1732				Monitor

Caring: Patient Experience

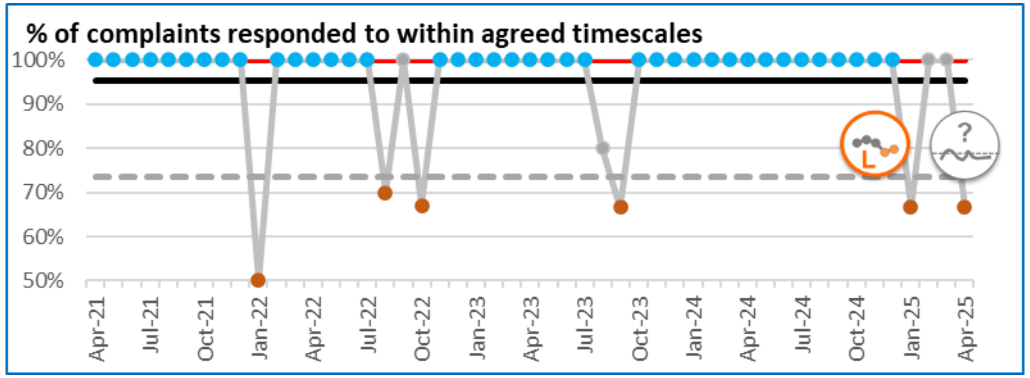
Accountable Executive: *Chief Nurse*
Report Author: *Deputy Chief Nurse / Deputy Director of Quality and Risk*

Royal Papworth Hospital
NHS Foundation Trust

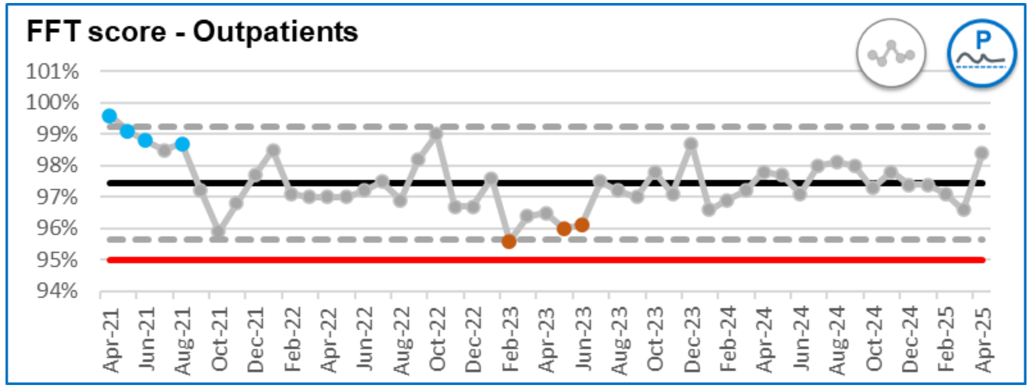
1. Historic trends & metrics



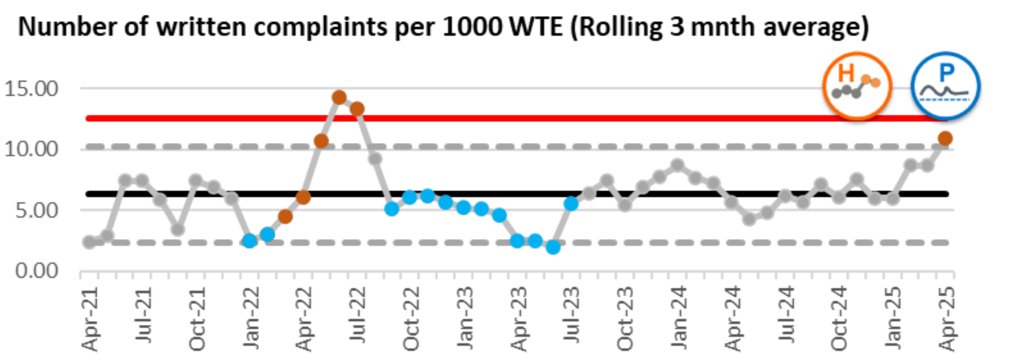
Apr-25
99.2%
Target (red line)
95.0%
Variation
Common cause variation
Assurance
Has consistently passed the target



Apr-25
66.7%
Target (red line)
100%
Variation
Common cause variation
Assurance
Hit and miss on achieving target subject to random variation



Apr-25
98.4%
Target (red line)
95.0%
Variation
Special cause variation of a concerning nature
Assurance
Has consistently passed the target



Apr-25
10.9
Target (red line)
12.6
Variation
Special cause variation of a concerning nature
Assurance
Has consistently passed the target

2. Comments/Action plans

FFT (Friends and Family Test): In summary;

Inpatients: Positive Experience rate was 99.2% in April 2025 for our recommendation score. Participation Rate for surveys was 41.2%.

Outpatients: Positive experience rate was 98.4% in April 2025 and above our 95% target. Participation rate was 12.9%.

Compliments: the number of formally logged compliments received during April 2025 was 1,820 Of these 1,762 were from compliments from FFT surveys and 58 compliments via cards/letters/PALS captured feedback.

Responding to Complaints on time: **2 of 3 (66.67%)** complaints responded to in the month were within agreed timescales. Of these 2 were extended with the complainants' agreement and the 3rd was responded to 5 working days late as it required a longer investigation period.

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 10.9.

Duty of Candour (DOC) Compliance: New for PIPR Caring slides for 2025/26 is the monitoring of DOC on a monthly basis. 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 April all 5 harm events had DOC completed in time, achieving 100% compliance.

Caring: Key Performance Challenge - Complaints

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

Royal Papworth Hospital
NHS Foundation Trust

Received Complaints in Month (Total of all Informal and Formal)

During April 2025, we received 12 informal complaints and 8 formal complaints. The primary subject for formal complaints received was Communication (50%) and Clinical Care/Treatment (38%). These subjects are logged on receipt of the complaint and based on the patient’s reported concerns; they may be later changes on completion of the investigation.

Total Complaints Closed in Month

During April 2025, we **closed 10 cases**; 7 informal and 3 formal complaints.

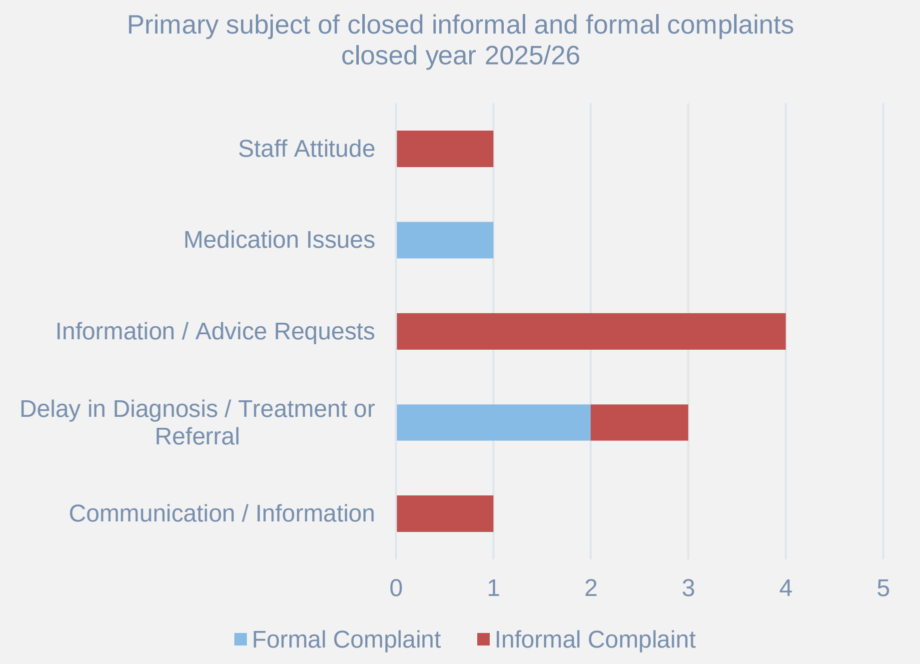
Informal Complaints closed: 7 closed in month:

Cardiology (2 cases): One where the patient was concerned that their follow-up had been delayed, and another where there was some confusion relating to the purpose of the appointment attended. Both were resolved by the service managers offering apologies, clarifying and reassuring the patient by phone call.

STA (Surgery) (3 cases): One related to concerns raised by relative that the patient had been deemed as aggressive and given an informal warning, this was resolved with further explanations. Second, concerns raised by patient that they had been discharged sooner than expected. The last case was general feedback and concerns relating to admission raised by patient. All three cases were resolved by the ward nursing team calling the patients to reassure and apologise as appropriate.

Thoracic and Ambulatory Care (2 cases): One case where the patient felt the Outpatients appointment did not go well, and the other where the patient was concerned that their follow-up had been delayed. Both were resolved by the service managers calling the patients to 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 for M1 = 7 Informal and 3 Formal



Learning and Actions from Formal Complaints Closed – 3 formal complaints were closed in Month. Of these, 1 was not upheld, 1 **partly upheld** and one was **upheld,** details of these 3 are below:

Formal complaint 1 (Thoracic) – NOT UPHELD. Concerns raised by patient that their referral to another specialty was delayed before being rejected. Apologies for delay given, with reassurances and explanations provided that appropriate clinical decision.

Formal complaint 2 (Surgery) – PARTLY UPHELD. Enquirer wished to make a formal complaint in relation to the care received on surgical ward, in relation to lack of assistance, pain not controlled, delay in discharge, preferred medication not provided. Apologies given for the patient's poor experience, including poor communication, lack of preparedness for the procedure, and failure to maintain dignity. Improvement actions are in place from this feedback and being monitored by the Head of Nursing.

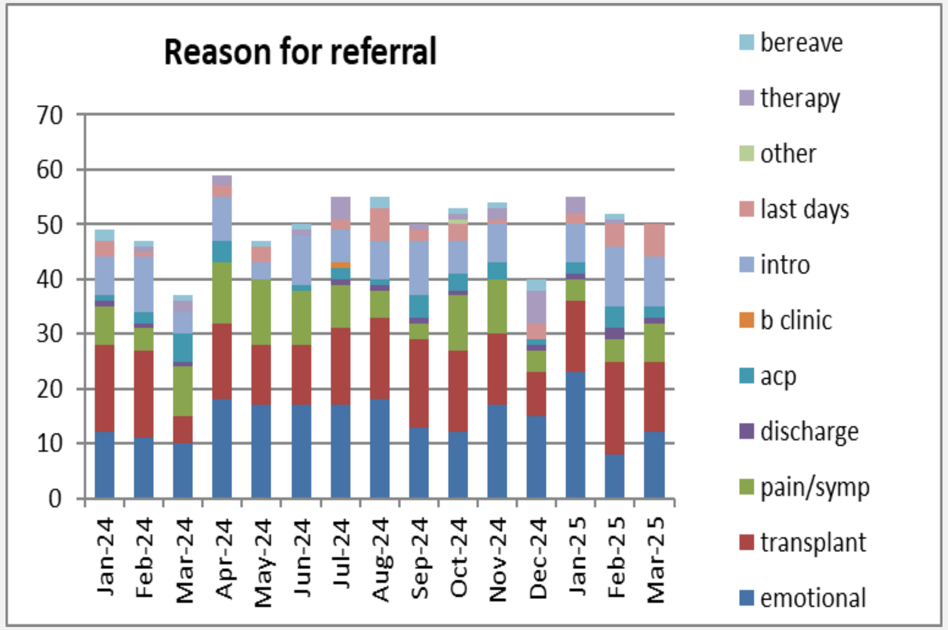
Formal complaint 3 (Cardiology) – UPHELD. Concerns raised that patient’s follow-up had been delayed. Apologies were given that annual reviews are currently delayed due to capacity, patient reassured and provided with appointment date. Reassurance also provided that the service is reviewing how they can provide a regular communication update to those who are waiting for our services to support clear communication and expectations; and they are exploring options to reduce the waiting list of patients for follow up appointments.

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

Supportive and Palliative Care Team (SPCT) Dashboard

This year for 2025/2026, we will be doing a spotlight in the Trusts Caring PIPR for Our Supportive and Palliative Care Team (SPCT). Alongside this the team also monitor performance through a locally produced Dashboard, on a quarterly basis that is discussed at the End-of-Life Steering Group. This PIPR, in line with the quarterly reporting will share an extract of the highlights of updates and information from the Q3 and Q4 2024/25 (Oct to Mar) Dashboard's.

No. referrals Oct 24 to Mar 25 = 304



This chart shows that, out of 304 referrals, the number one reason for referral was emotional support (n=87), followed by transplant assessment clinic (n=79) and introduction to service (n=40).

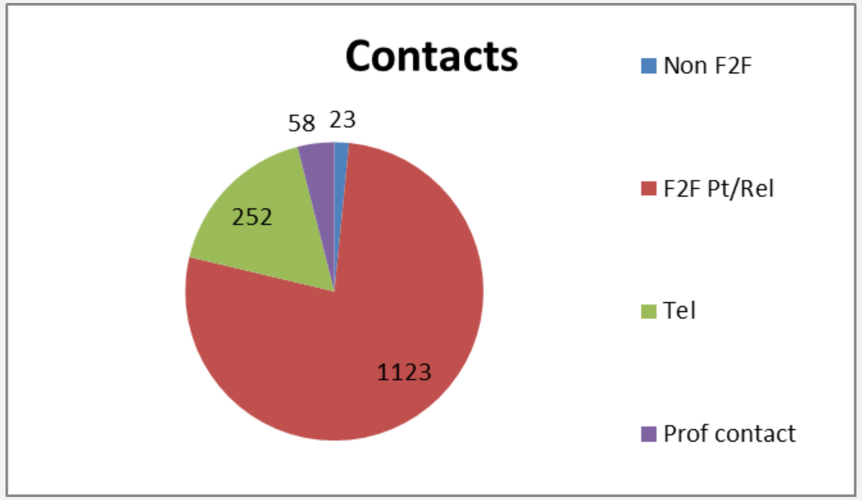
Reason for referral 'last days of life' n = 19. [ACP = advanced care planning, Therapy = acupuncture/reflexology B clinic – breathlessness clinic]

Feedback: As with earlier reports, this is an extract of some of the compliments from the SPCT Dashboard for Q3 & Q4 2024/25 which helps to visualise some of the work the team undertake:

A bereaved relative was keen to express the families most sincere appreciation for everyone involved in (his mother's) care during her recent admission and feeling that everything that could be done was done to ensure that not only her needs were met but that they were supported, stating that as a hospital we could not have done any better.

Contacts Numbers for Q3 and Q4

The SPCT team had 1456 contacts in Q3 &Q4



This pie chart shows a breakdown by type of the 1456 contacts for Q3 & Q4 (Oct to Mar).

The highest contact type remains face to face (F2F) at 1123. The second highest remains telephone contact at 252.

The below shows the outcomes for Q3 & Q4 of the 304 referrals:

Discharged = 215 **Deceased = 41** **Ongoing care = 48**

Further examples of compliments from the SPCT Dashboard for Q3 & Q4 2024/25:

Feedback from bereaved relative during a bereavement follow up call:
They were keen to express their most sincere appreciation for all the care and support that they and his mum received during her recent admission. They felt that they were both very well looked after and couldn't have asked for more. They also expressed that they were given the opportunity to be involved in the last offices, stating that being able to do this for his mother was an honour and a privilege and as a result they left this experience knowing they had done everything they could for her.

Complaints: (Previously reported in PIPR, included here as SPCT 6- month update) relative *of an MND patient complained that her daughter's artificial feed had been stopped without her knowledge. Reassurances given that patient received appropriate and sensitive care to maintain her dignity and comfort at the end life; before she was discharged home to pass, as per the next of kin's wishes.*

Effective: Summary

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

Variation — Special Cause Concerning variation; Special Cause Improving variation; Special Cause neither improve or concern variation; Common Cause

Assurance — Consistently hit target; Hit and miss target subject to random variation; Consistently fail target

Royal Papworth Hospital
NHS Foundation Trust

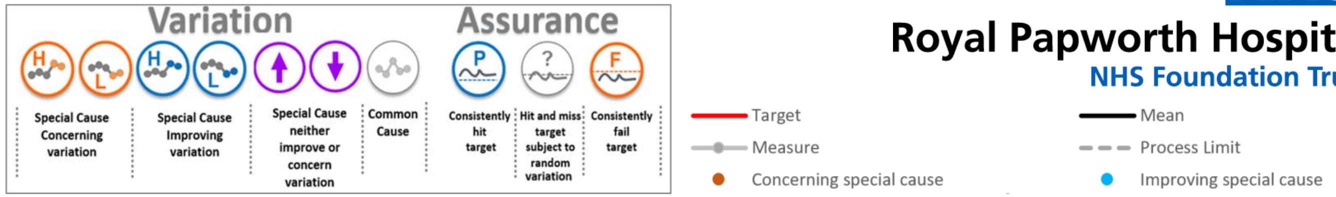
	Metric	Latest Performance: Trust target	Latest Performance: Most recent position	Previous: Position	In month vs target	Action and Assurance: Variation	Action and Assurance: Assurance	Action and Assurance: Escalation trigger
Dashboard KPIs	Bed Occupancy (excluding CCA and sleep lab)	85%	73.8%	74.7%			F	Action Plan
	ICU bed occupancy	85%	78.2%	89.7%			?	Review
	Enhanced Recovery Unit bed occupancy %	85%	75.7%	78.3%			?	Review
	Elective inpatient and day case (NHS only)*	1,770	1642 (110% 19/20)	1623 (109% 19/20)		H	?	Review
	Outpatient First Attends (NHS only)*	2,298	2233 (136% 19/20)	2302 (140% 19/20)			?	Review
	Outpatient FUPs (NHS only)*	7,278	6991 (120% 19/20)	6857 (118% 19/20)			?	Review
	% of outpatient FU appointments as PIFU (Patient Initiated Follow up)	5%	11.6%	11.3%			P	Monitor
	Reduction in Follow up appointment by 25% compared to 19/20 activity	-25%	-2.2%	-3.1%			F	Action Plan
	% Day cases	85%	75.7%	73.8%		H	F	Action Plan
	Theatre Utilisation (uncapped)**	85%	86%	93%			?	Review
	Cath Lab Utilisation (including 15 min Turn Around Times) ***	85%	83%	82%			?	Review
Additional KPIs	NEL patient count (NHS only)*	Monitor	414 (120% 19/20)	367 (106% 19/20)				Monitor
	ICU length of stay (LOS) (hours) - mean	Monitor	165	191				Monitor
	Enhanced Recovery Unit (LOS) (hours) - mean	Monitor	30	35				Monitor
	Length of Stay – combined (excl. Day cases) days	Monitor	6.5	6.9				Monitor
	Same Day Admissions – Cardiac (eligible patients)	50%	34%	41%			?	Review
	Same Day Admissions - Thoracic (eligible patients)	40%	81%	71%		H	?	Review
	Length of stay – Cardiac Elective – CABG (days)	8.2	7.9	9.5		H	?	Review
	Length of stay – Cardiac Elective – valves (days)	9.7	10.5	9.8			?	Review
	Outpatient DNA rate	6.0%	7.0%	7.5%			?	Review

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

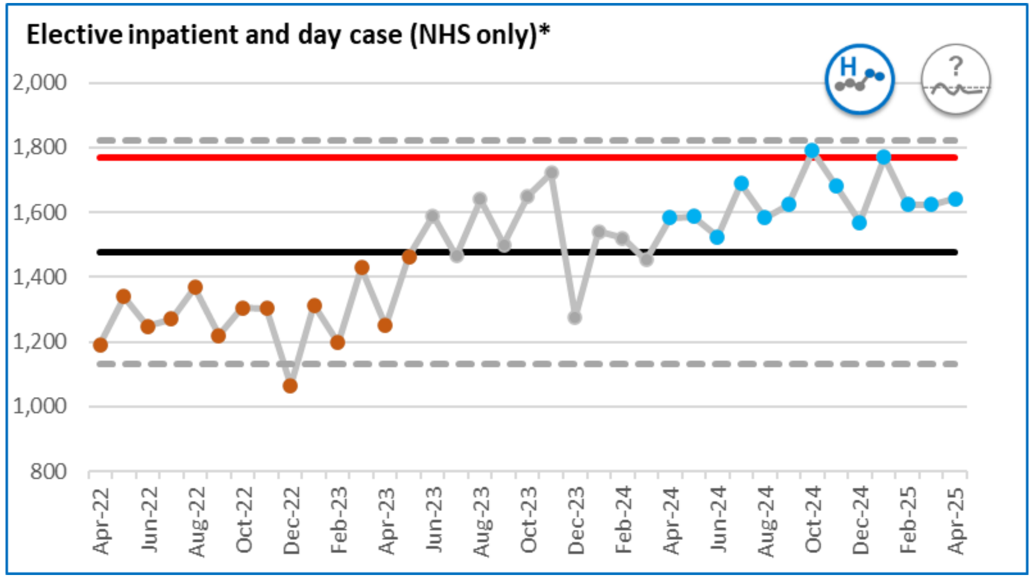
*** from Theatre utilisation is expressed as a % of Trust capacity baseline of 5 theatres from Aug 23 and 5.5 theatres from Sep 23*
**** Cath lab utilisation is provisional pending review of calculation methodology*

Effective: Admitted Activity

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



1. Historic trends & metrics



Apr-25
1642
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	97%	81%	79%**	41%	99%	92%**	117%**
	Daycases	33%**	131%	n/a	240%	155%	40%**	600%**

= 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.

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 M1 remains on target at 85%. 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

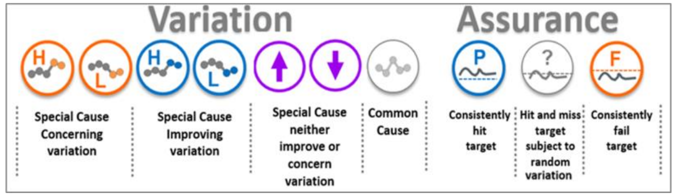
- As of M01 the division is above provisional planned activity (110 YTD) and above 2019/20 admitted activity (209 YTD).

Cardiology

- The division over delivered day cases against provisional planned activity in M1 (97 above plan)
- 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 M1.
- 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 to be agreed at Access Board on 22/05/25.

Effective: Non-admitted Activity

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



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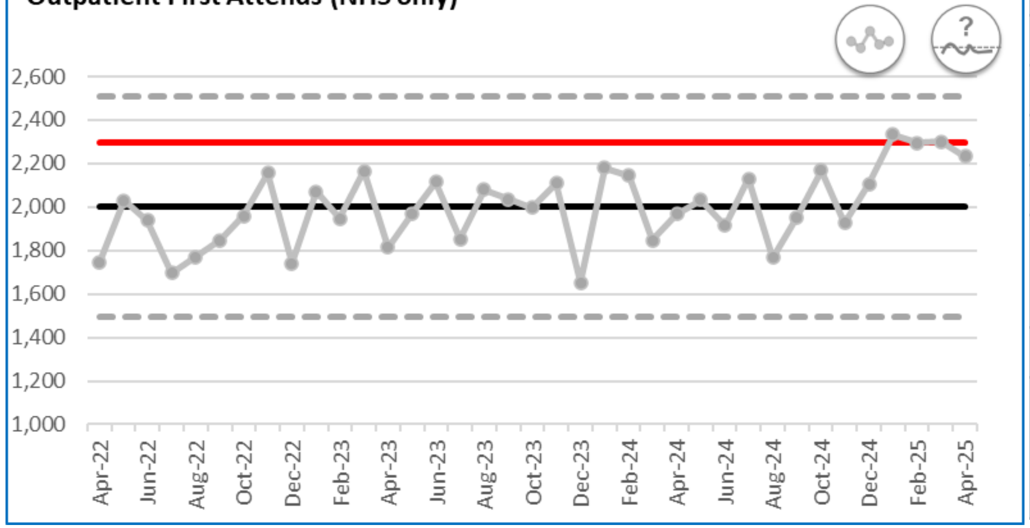
Target
Measure
Concerning special cause
Mean
Process Limit
Improving special cause

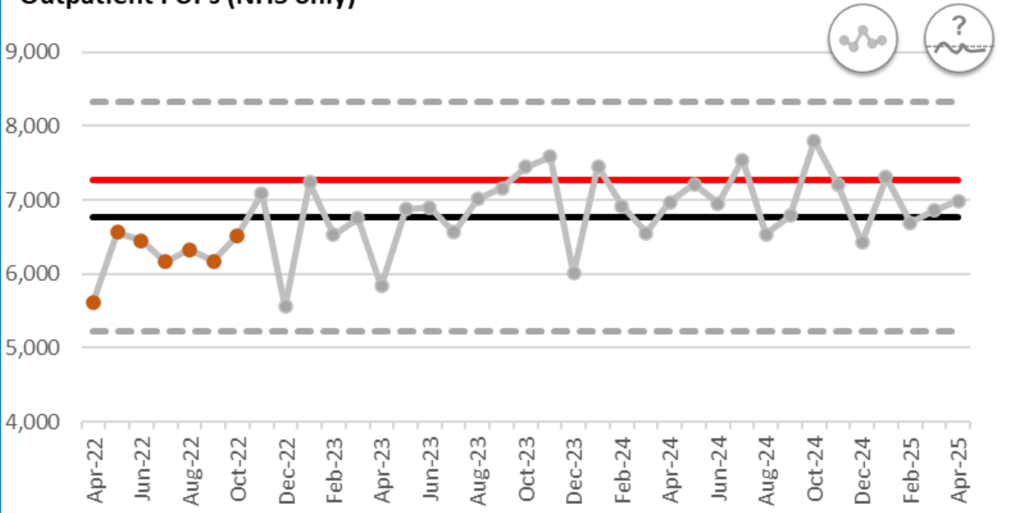
1. Historic trends & metrics

Outpatient First Attends (NHS only)



Apr-25
2233
Target (red line)*
2298
Variation
Common cause variation
Assurance
Hit and miss on achieving target subject to random variation

Outpatient FUPs (NHS only)



Apr-25
6991
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	80%**	77%	579%	108%	131%**	120%**
	Follow Up Outpatients	321%	156%	50%	155%	109%**	104%

= YTD activity > 100% of 19/20

Action plan / comments

PIFU was rolled out successfully within RSSC (CPAP) in M01. Outpatient activity has reduced by 3.1% compared to 2019/20 and additional plans are in place to increase PIFU as appropriate, as well as to review clinic template ratios.

The Thoracic and Ambulatory division activity is above provisional planned activity (185 YTD) and above 19/20 activity (676 YTD). Within M01, there were 449 missed appointments and 829 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.

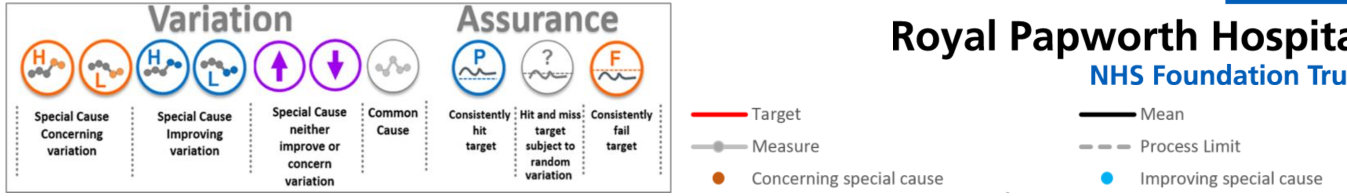
Cardiology delivered above plan within M01 and remains above the 2019/20 non-admitted activity baseline. Current review of delays for first appointments across cardiology specialities in line with RTT objectives. Changes in process to ERS referral bookings have now happened seeing more equitable waits across RTT new patients.

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

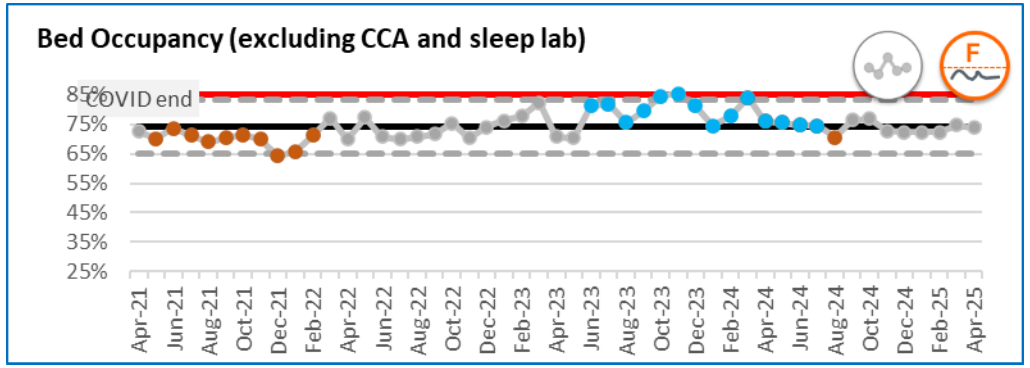
** Target set at average 25/26 demand recovery plan ** 19/20 activity (working day adjusted) < 100*

Effective: Occupancy

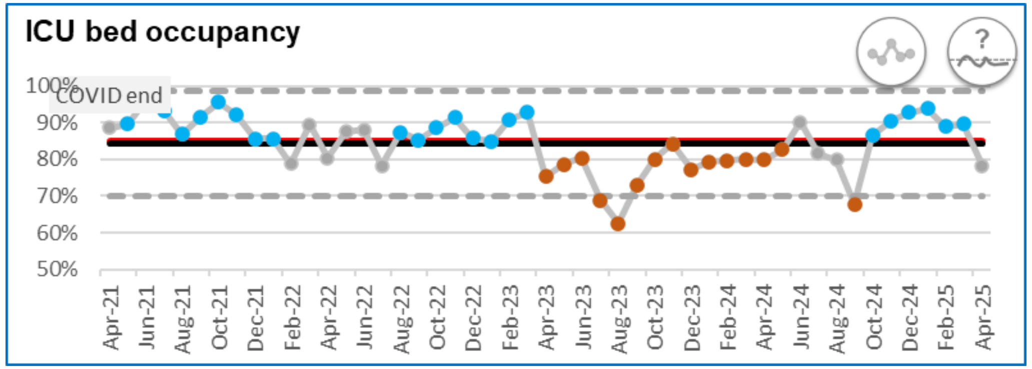
Accountable Executive: *Chief Operating Officer* ***Report Author:*** *Chief Operating Officer*



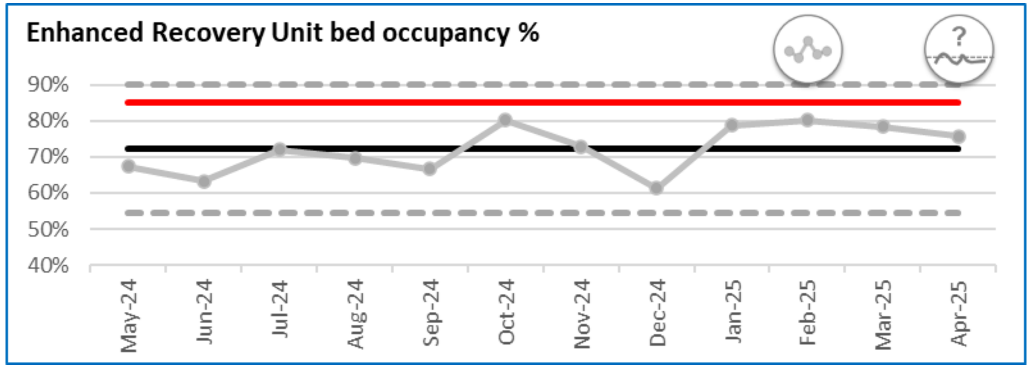
1. Historic trends & metrics



Apr-25
73.8%
Target (red line)
85%
Variation
Common cause variation
Assurance
Has consistently failed the target



Apr-25
78.2%
Target (red line)
85%
Variation
Common cause variation
Assurance
Hit and miss on achieving target subject to random variation



Apr-25
75.7%
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 282 virtual ward days. This has provided additional bed capacity on the wards to support flow through theatres and CCA.

CCA bed occupancy:

- There was only one on the day cancellation in M1 for 'no CCA' beds, 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 M01 was 75.7%.
- The senior leadership team have now embedded with the wider division that the 10 bedded ERU and 26 bedded ICU are independent areas that work collaboratively. By protecting the ERU beds this will ring fence elective activity. This has been cascaded across the organisation at senior management meetings.
- ERU is facilitating an increase in planned activity (including IHU patients) in theatres, flow and reduction in length of stay.
- 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.

Effective: Utilisation

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

Variation: Special Cause Concerning variation; Special Cause Improving variation; Special Cause neither improve or concern variation; Common Cause

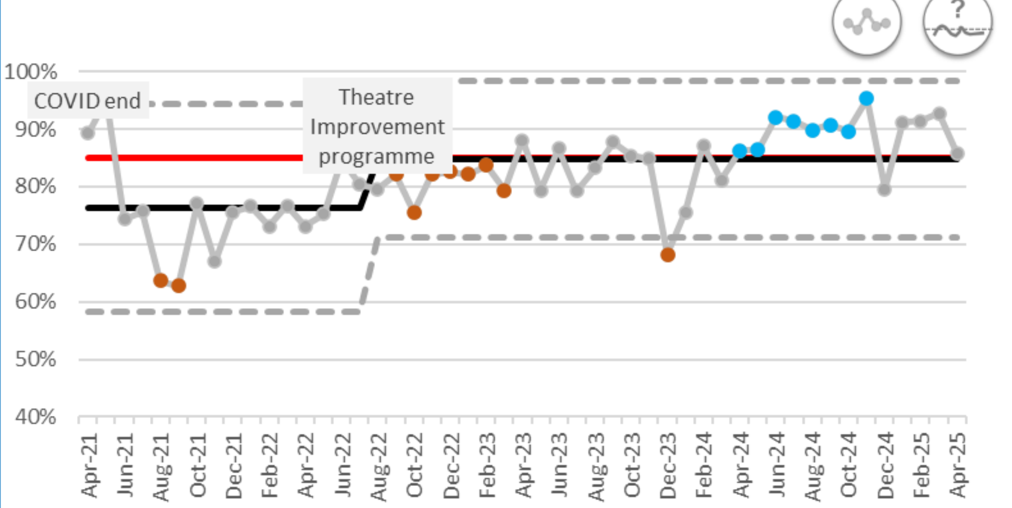
Assurance: Consistently hit target; Hit and miss target subject to random variation; Consistently fail target

Target · Mean · Measure · Process Limit · Concerning special cause · Improving special cause

Royal Papworth Hospital
NHS Foundation Trust

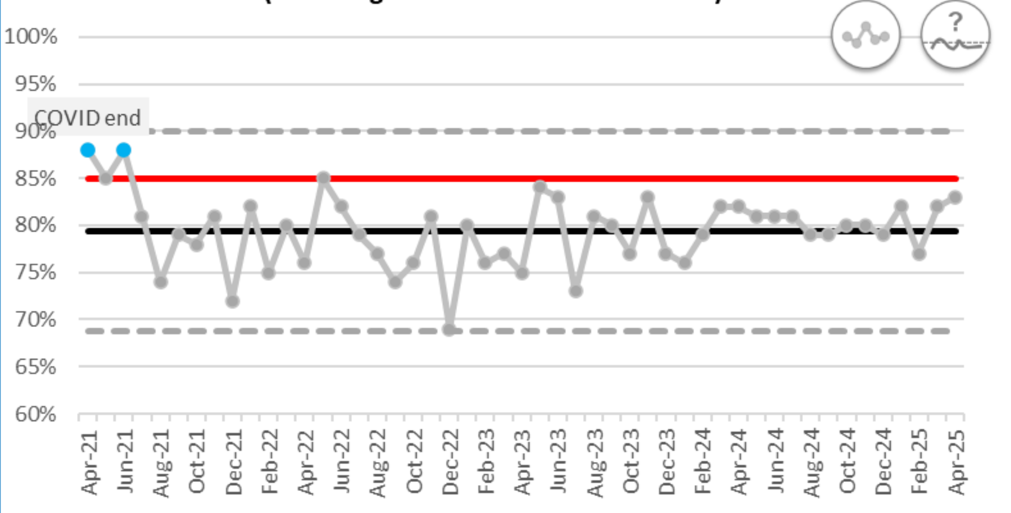
1. Historic trends & metrics

Theatre Utilisation (uncapped)



Apr-25
86%
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) ***



Apr-25
83%
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 86% in M01, this remains within variance above KPI. Bank holidays would have impacted theatre utilisation within M01 for the Easter holidays.
- 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:

- M01 saw an increase in cath lab activity compared to M11.
- 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	88% in M12 (M01 data at divisional level is not available). Data is still under review.	May-25	Green
		STA	Virtual ward enabling additional bed capacity and flow	JS	Virtual ward is embedded	Embedded	Blue
			Increasing same day admissions for cardiothoracic surgical patients	JS		TBC	Amber
		Thoracic	Review of bed base with BI	ZR	83.1% in M12 (M01 data at divisional level is not available). Data is still under review.	May-25	Green
	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	Orange
			Review clinic templates: job planning	LM		Sep-25	Green
			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.	Jun-25	Orange
		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	Green
		Thoracic	Clinic template change to 70:30 new:FU ratio in RSSC	ZR	Completed	Feb-25	Green
			PIFU rollout within CPAP	ZR	Completed	Apr-25	Green
	% Day cases	Cardiology	85.3%: met trust target	LM	84.8% in M12 (M01 data at divisional level is not available)	Embedded	Green
		STA	15.6%: due to complexities of surgery, minimal day cases within STA. JS to check what is counted as a day case	JS	15.7% in M12 (M01 data at divisional level is not available)	Jun-25	Orange
		Thoracic	78.6%: Day case activity increased by 10 per week from 10 March	ZR	Following planned increase in Day case activity, M12 demonstrated a day case rate of 82%. M01 data at divisional level is not available.	Mar-25	Green
	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	Amber

Key
Embedded as Business as Usual
On track / complete
Behind schedule but mitigations in progress and
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*

Royal Papworth Hospital
NHS Foundation Trust

	Metric	Latest Performance: Trust target	Latest Performance: Most recent position	Previous: Position	In month vs target	Action and Assurance: Variation	Action and Assurance: Assurance	Action and Assurance: Escalation trigger
Dashboard KPIs	% diagnostics waiting less than 6 weeks	99%	93.2%	93.6%				Review
	18 weeks RTT (combined)	92%	64.6%	63.0%				Action Plan
	31 days cancer waits	96%	100%	94%				Review
	62 day cancer wait for 1st Treatment from urgent referral	85%	0%	0%				Review
	104 days cancer wait breaches	0	5	12				Action Plan
	Number of patients waiting over 65 weeks for treatment	0	16	10				Review
	Theatre cancellations in month	15	28	41				Review
	% of IHU surgery performed < 7 days of medically fit for surgery	95%	30%	26%				Action Plan
	Acute Coronary Syndrome 3 day transfer %	90%	74%	57%				Review
	Number of patients on waiting list	3851	7150	7403				Action Plan
	52 week RTT breaches	0	56	51				Action Plan
Additional KPIs	% of IHU surgery performed < 10 days of medically fit for surgery	95%	42%	100%				Review
	18 weeks RTT (cardiology)	92%	58.0%	59%				Action Plan
	18 weeks RTT (Cardiac surgery)	92%	70.3%	71%				Action Plan
	18 weeks RTT (Respiratory)	92%	67.0%	64%				Action Plan
	Other urgent Cardiology transfer within 5 days %	90%	91%	80%				Review
	% patients rebooked within 28 days of last minute cancellation	100%	65%	87%				Review
	Urgent operations cancelled for a second time	0	0	0				Review
	Non RTT open pathway total	Monitor	49244	48926				Monitor
	Validation of patients waiting over 12 weeks	95%	30%	30%				Action Plan

Responsive: RTT

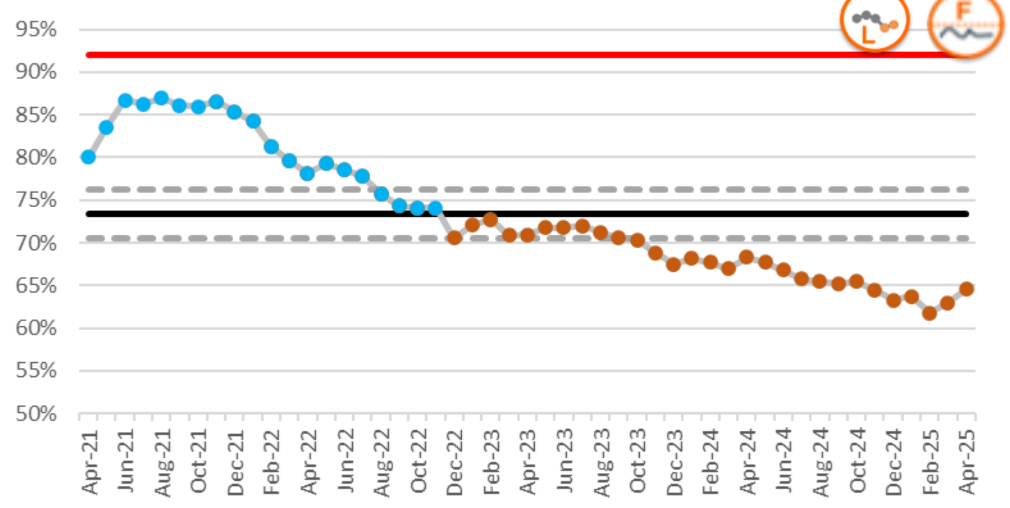
Accountable Executive: *Chief Operating Officer* ***Report Author:*** *Chief Operating Officer*

Variation					Assurance		
Special Cause Concerning variation	Special Cause Improving variation	Special Cause neither improve or concern variation	Common Cause	Consistently hit target	Hit and miss target subject to random variation	Consistently fail target

Target — Measure — Concerning special cause — Mean — Process Limit — Improving special cause

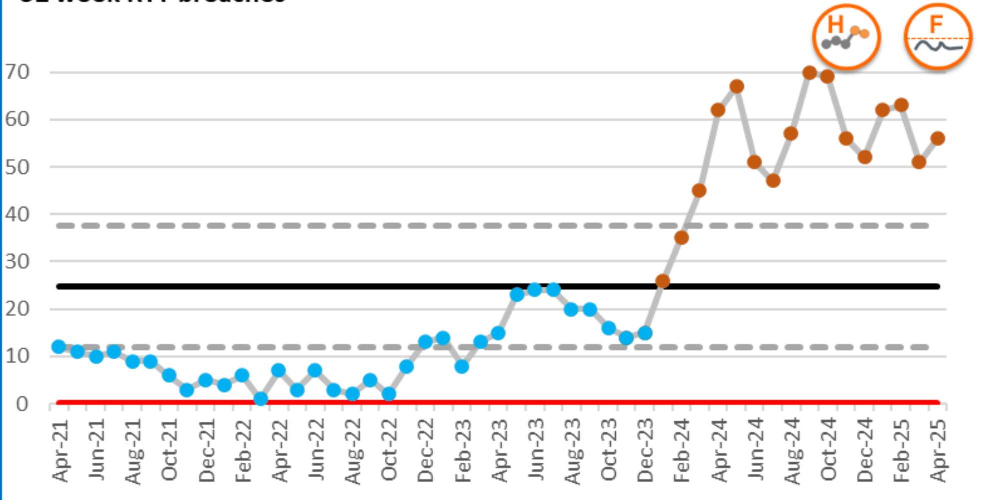
1. Historic trends & metrics

18 weeks RTT (combined)



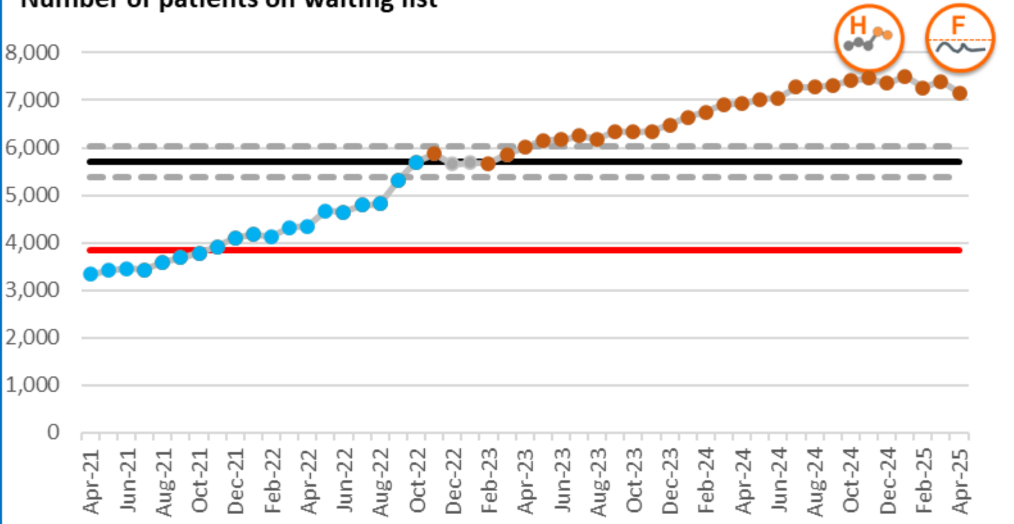
Apr-25
64.6%
Target (red line)
92.0%
Variation
Special cause variation of a concerning nature
Assurance
Has consistently failed the target

52 week RTT breaches



Apr-25
56
Target (red line)
0
Variation
Special cause variation of a concerning nature
Assurance
Has consistently failed the target

Number of patients on waiting list



Apr-25
7150
Target (red line)
3851
Variation
Special cause variation of a concerning nature
Assurance
Has consistently failed the target

Action plans / Comments

- The PTL continues to be reviewed regularly, and patient prioritisation reviewed daily as late referrals are received or if patients condition changes. There were 56 52-week RTT breaches in month, which is an increase of 5 from the previous month.
- Trust-wide RTT recovery programme in place to support operational plans for 2025/26. This work has reviewed opportunities already developed and divisions have put together proposals of immediate remedial plans to aid the reduction in the backlog as well as sustainable plans to ensure ongoing demand can be met while reducing pathway waits for patients.
- New governance structure in place to review delivery and performance, this includes a weekly planned care delivery and performance group and bi-weekly access board.

52 Week breakdown:

- 46 of the 52-week breaches were in Cardiology, 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.
- Four of the 52-week breaches occurred within the Thoracic and Ambulatory service, all of which were carried over from the previous month. Of these all have been discharged.
- Six of the 52 week breaches are in Surgery. 3 late referrals from DGH, 3 patient pathway delayed due to complex pathways and delays in diagnostics. Of the 6 breaches 4 have been treated and 2 dated. RTT remains on an upward trajectory within STA.

Responsive: Cancer

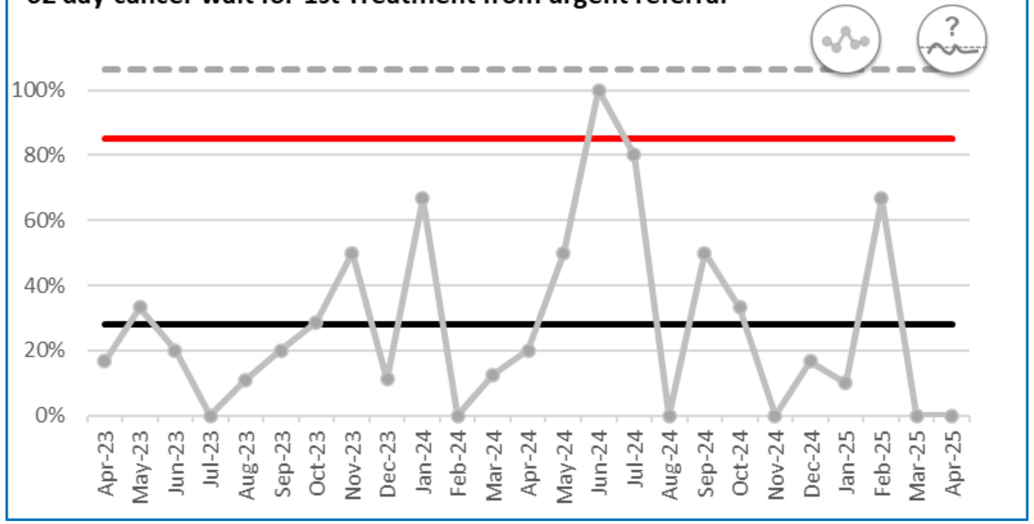
Accountable Executive: *Chief Operating Officer* ***Report Author:*** *Chief Operating Officer*

Target
Measure
Concerning special cause
Mean
Process Limit
Improving special cause

NHS
Royal Papworth Hospital
NHS Foundation Trust

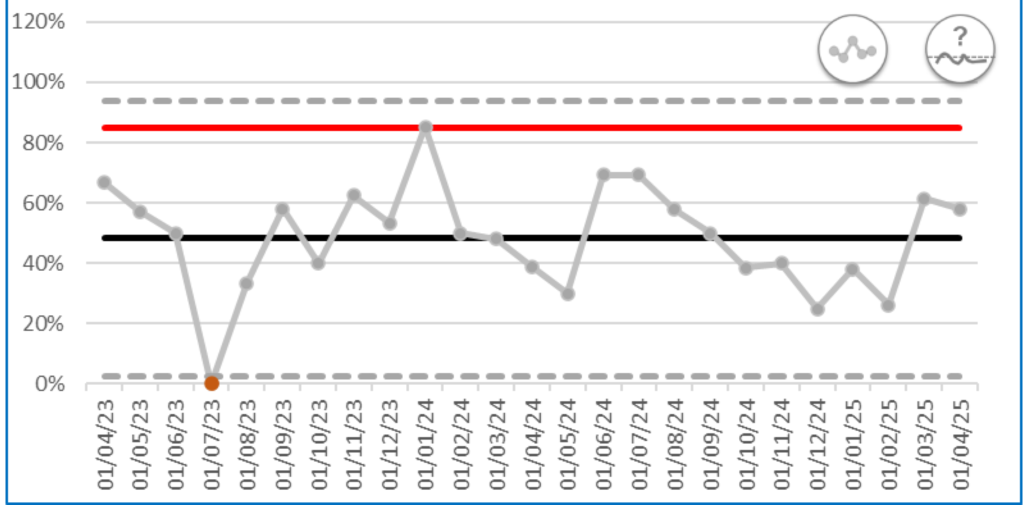
1. Historic trends & metrics

62 day cancer wait for 1st Treatment from urgent referral



Apr-25
0%
Target (red line)
85%
Variation
Common cause variation
Assurance
Hit and miss on achieving target subject to random variation

62 day cancer wait for 1st Treatment from consultant upgrade



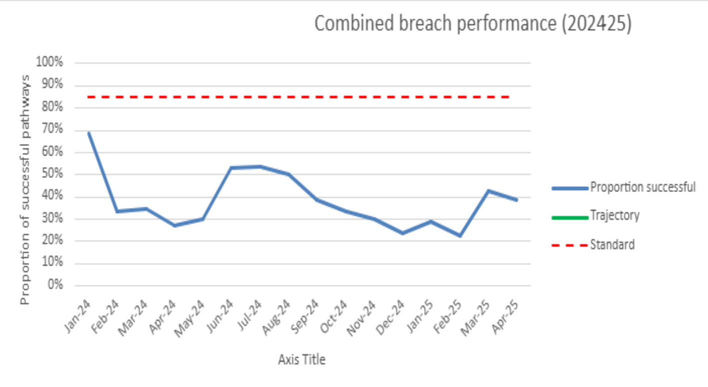
Apr-25
58%
Target (red line)
85%
Variation
Common cause variation
Assurance
Hit and miss on achieving target subject to random variation

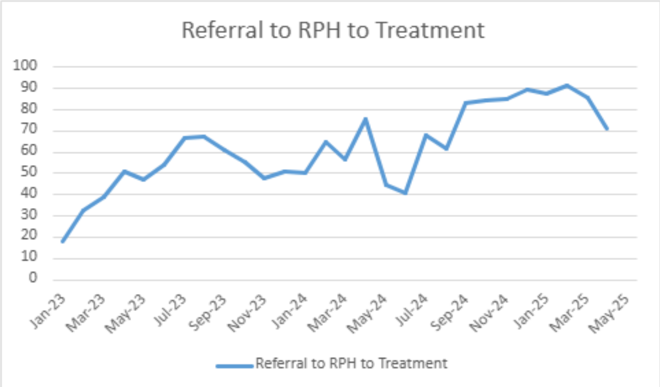
Action plans / Comments

The average day of referral for M01, was 22 days (72 referrals received). Nine referrals were received after day 38. Improvements in 62-day performance is driven by improvements within surgical and diagnostic waits.

62 day breakdown:
1)Referred day 100, DTT day 122, surgery day 126
2)IPT day 95, 12 day wait for clinic, 17 day wait for surgery
3)Referred day 58, CTNB 10 day wait, active monitoring day 80 (>24 days)
4)Referred day 37, MRI and seen at Bedford,

Upgrade:
1)Referred day 21, CTNB&PET&CTNB took 73 days, 23 day wait for surgery
2)Referred day 35, referred to Colchester day 43 and returned day 50, DTT 28 days
3)IPT day 8, 5 day PET, 10 day CTNB, 22 day ait for surgery
4)Referred day 57, 12 day wait for clinic, 6 day wait for surgery, treated under 24 days
5)Referred day 12, 13 day wait for PET, 7 day wait for CTNB, 1 MDT carry over due to histology, 9 day wait for clinic, 13 day wait for surgery
6)PET-CT 7 day wait, (required pacemaker insertion prior to PET-CT, CTNB 9 day wait, 28 day ait DTT
7)Referral day 13, 10 day wait for PET, 12 day wait for CTNB, 8 day wait for EBUS, 9 day wait for surgery





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.

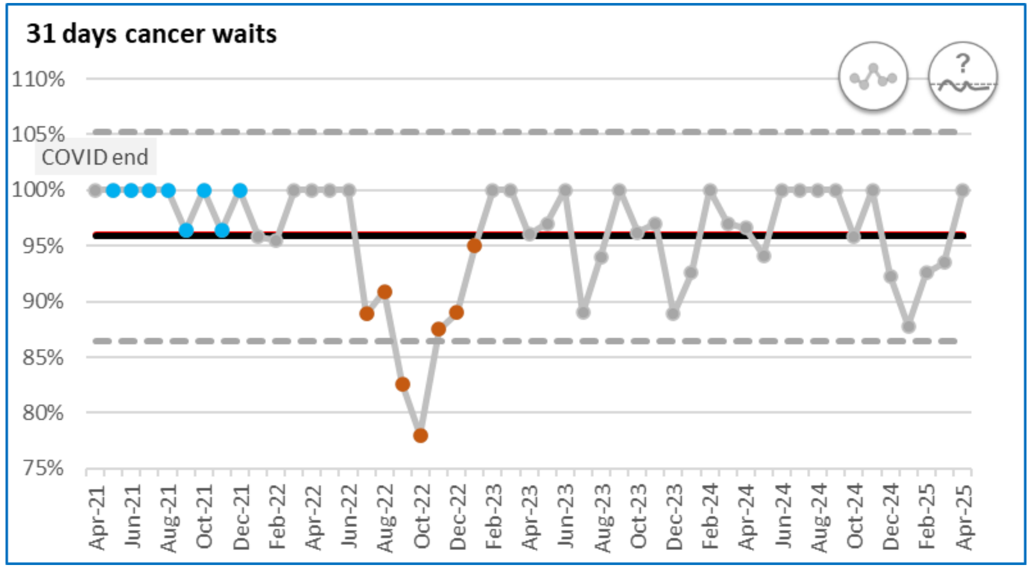
Responsive: Cancer

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

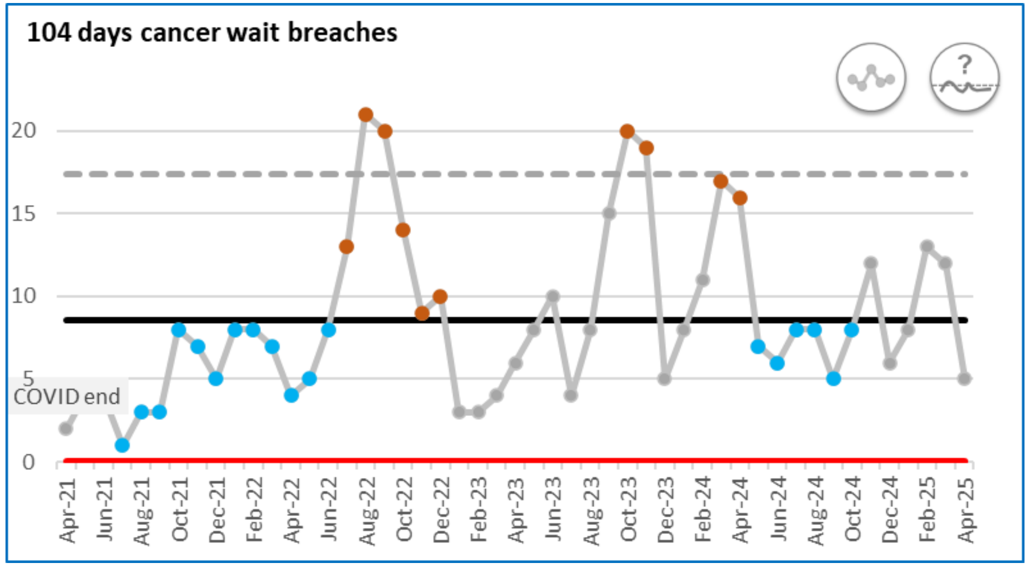
Target — Measure — Concerning special cause — Mean — Process Limit — Improving special cause

NHS Royal Papworth Hospital NHS Foundation Trust

1. Historic trends & metrics



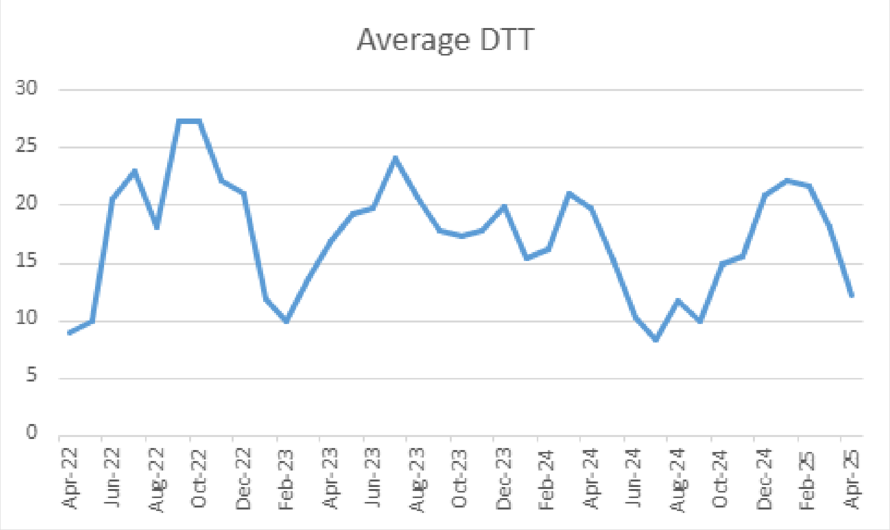
Apr-25
100%
Target (red line)
96%
Variation
Common cause variation
Assurance
Hit and miss on achieving target subject to random variation



Apr-25
5
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: 100% compliance. Surgical business unit meeting in April 2025. Cancer Alliance bid was successful for an additional 84 surgeries within 2025/26, first list will be early May. Scheduling SOP approved in Surgical Business meeting.



104 day breaches: Five breaches within M01. Four 104-day breaches were due to patients being referred after 64 days and one due to neoadjuvant.

Ongoing oversight of long waiters – each Monday a report is sent to medics/nurses/MDT admin team requesting updates for 85 day+ patients.

Responsive: Other metrics

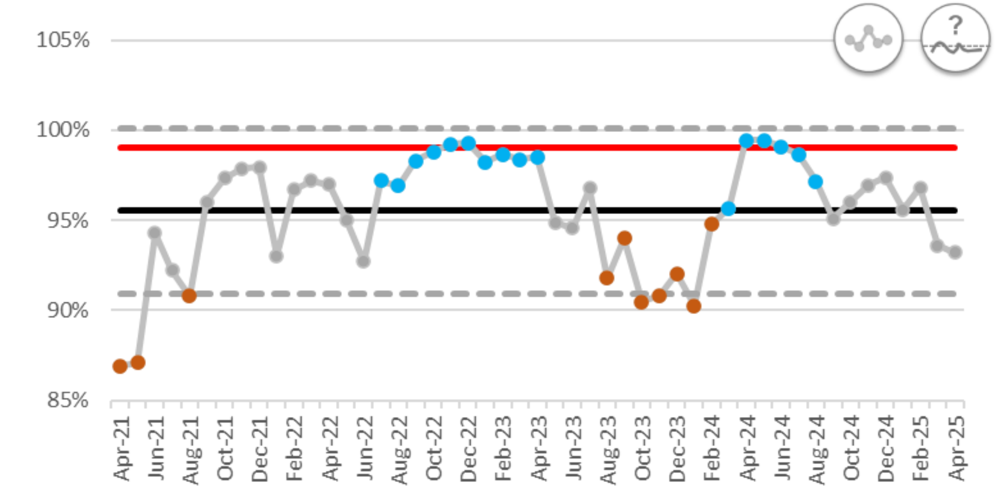
Accountable Executive: *Chief Operating Officer* ***Report Author:*** *Chief Operating Officer*

Target
Measure
Concerning special cause
Mean
Process Limit
Improving special cause

Royal Papworth Hospital
NHS Foundation Trust

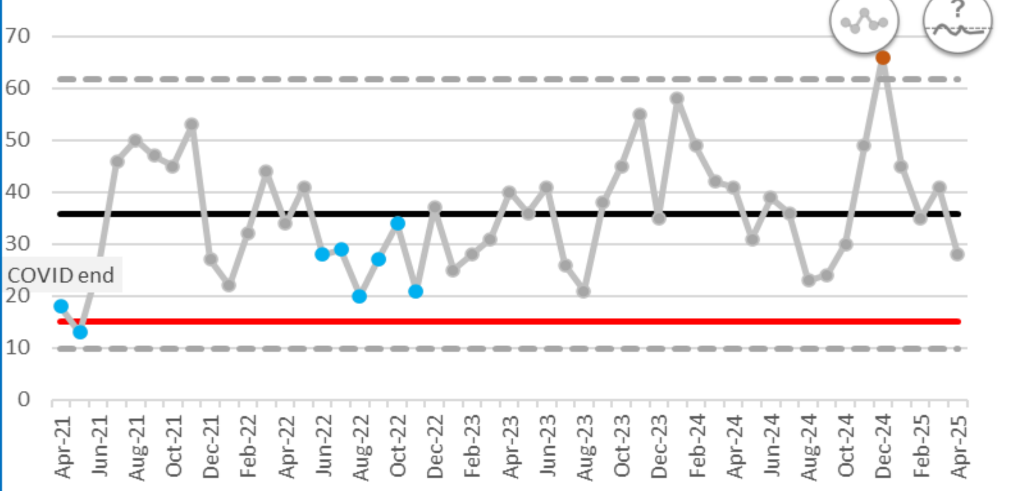
1. Historic trends & metrics

% diagnostics waiting less than 6 weeks



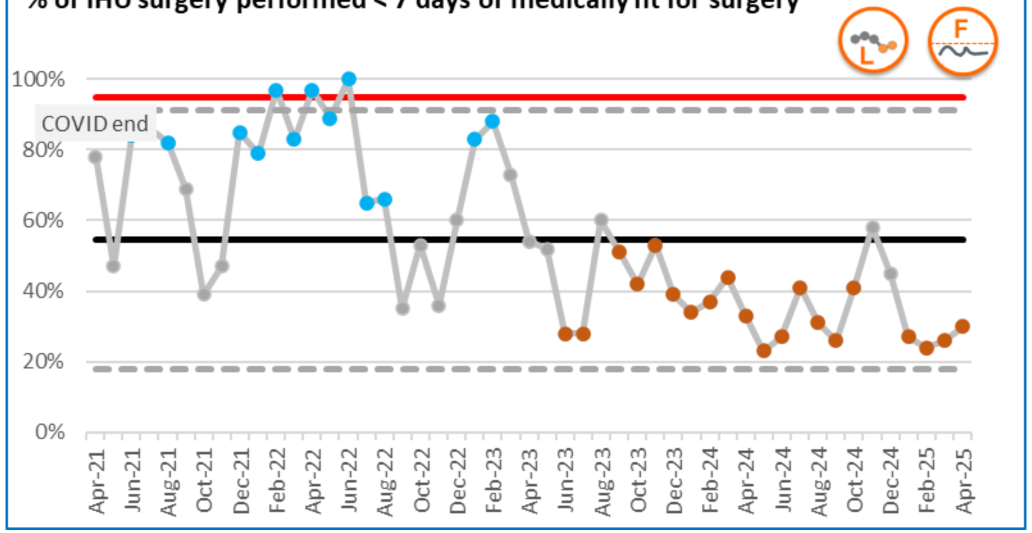
Apr-25
93.2%
Target (red line)
99%
Variation
Common cause variation
Assurance
Hit and miss on achieving target subject to random variation

Theatre cancellations in month



Apr-25
28
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



Apr-25
30%
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 a downward trajectory in M1 with an average compliance of less than 40% on Qlik.
- This decreasing waiting time is primarily being driven by longer waits for 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.
- Additional weekend lists (2 Saturdays a month) underway in MRI to try and support long waiting patients.
- Referral numbers into Radiology continue to increase. Currently circa 500 per month from external hospitals plus all internal radiology requests. PTL size increased by over 1000 patients waiting in the past 12 months. Now at 3200 patients
- 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

28 cancellations in M1 a significant improvement and continued downward trajectory. The most significant reason for cancellation on the day was due to patients being unfit (7)

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.

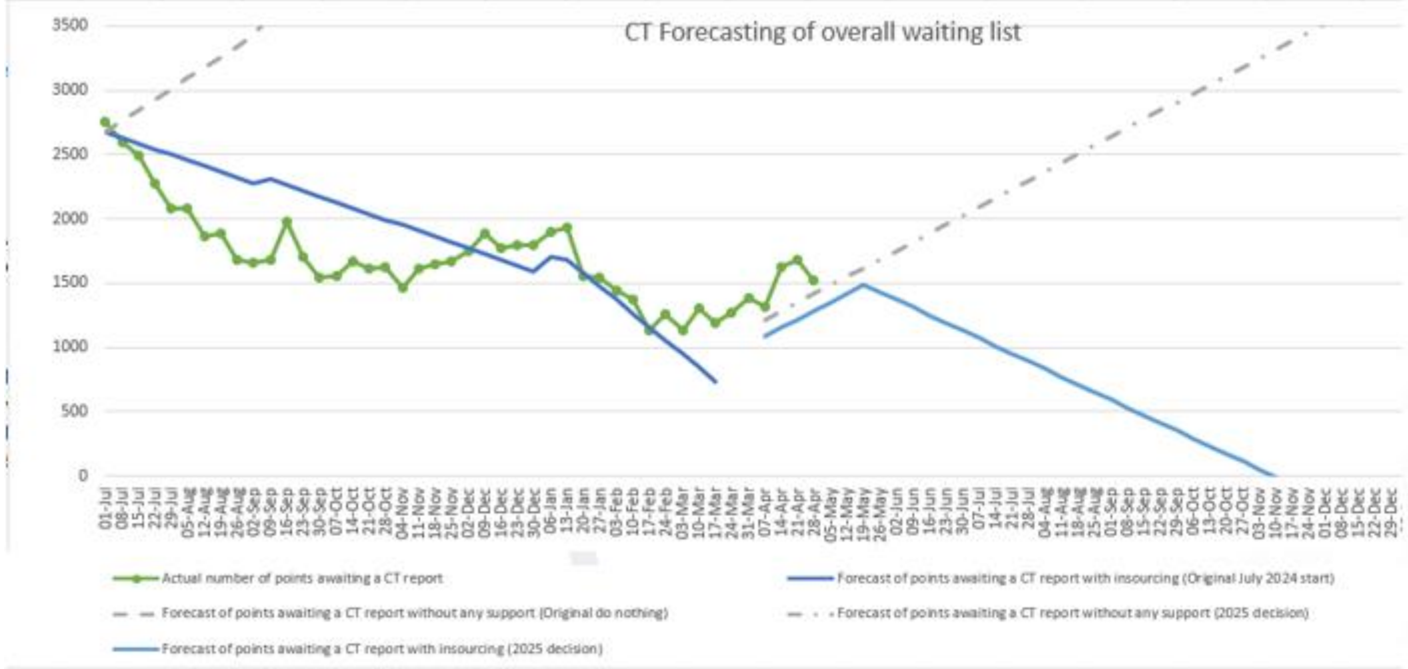
In House Urgent patients

- 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.
- STA leadership team are working collaboratively with cardiology and clinical admin' on flow and news of working.
- The operational team in STA are supporting clinical admin' to manage flow.
- Action plan to be drafted as part of the patient flow programme.

Responsive: Spotlight – CT Backlog

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

			07-Apr	14-Apr	21-Apr	28-Apr	05-May	12-May	19-May
Impact on the Waiting List	Actual	Actual number of points awaiting a CT report	1317	1620	1679	1527	1885	1922	1918
		Actual points backlog awaiting a CT report **for more than 4 weeks**	425	544	605	635	869	905	788
		Actual points on waiting list for a CT report **waiting less than 4**	892	1076	1074	892	1016	1017	1130
		Proportion of CT reports waiting **for more than 4 weeks**	32%	34%	36%	42%	46%	47%	41%
		Number of patients awaiting a **CT report**	547	567	598	633	682	698	692
		Number of patients waiting CT **report** over 4 weeks	137	188	174	215	261	288	276
		Number of patients awaiting a CT scan based on PTL	1071	1071	1038	1060	1067	1187	1238



KEY MESSAGES:
Executive approval received 1/5/25 to recommence Langley Clark (LCI) as external reporters
Remains 9 WTE Consultant Radiologists in post against a budgeted WTE of 13.77
Interview planned for 22/5/25 for a substantive Consultant Radiologist with a potential further locum appointment also underway
Reporting between 1/4/25 and 12/5/25 showed an increase in CT scans awaiting reporting from 547 to 698 with an increase in scans waiting more than 4 weeks increasing from 137 to 288
Expect these numbers to reduce during May and June as the LCI solution commenced 17/5/25
CT report average turnaround time in April – 16 days

Graph:
Blue lines – trajectory
Green line – tracker (actual activity outstanding)
Grey line – do nothing (no insourcing or outsourcing)
Trajectory has been adjusted to reflect insourcing recommencing 17/5/25. Will be further adjusted as recruitment takes place into the consultant radiologist team.

Outsource project update (as of 19/5/25)
Project remains within documented timescales
To support all modality reporting, not just CT
Executive approval received in April to move into the procurement/tender phase
All documentation including the Statement of Requirements finalised with input from all stakeholders
Expected release to market mid-May 2025
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 2025

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	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	Mar-26	
	% 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	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 optimisation project will support demand and capacity	LM	Additional lists are being worked around to catch up on activity, awai	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	May-25	
			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	4 TAVI patients completed in May Structural lists yet to start TOE lists to start in June	Mar-26	
			Additional lists and outpatient clinics in relation to CRM including: 100 EP lists 11 Outpatient first appointment clinics	LM	Completed 1 outpatient 1st appoinment clinic with 9 patinets and another 10 patients due at the end of May Ep lists completed 13 pts in May with another 8 planned	Mar-26	
	18 weeks RTT (STA)	All	Extended thoracic lists Green 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	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	2 PSI SDC clinics completed (37 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	Digital validation pilot commences w/c 26 May 2025	Jul-25	
			Validation sprints - detailed action plan to be drafted Q1 in line with national validation sprints	ZR	Validation for M01 was above baseline	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

Royal Papworth Hospital
NHS Foundation Trust

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

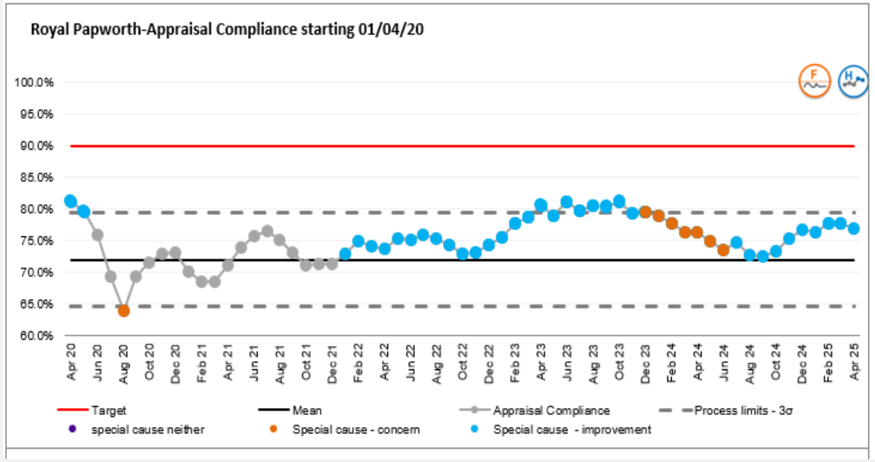
		Data Quality	Target	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
Dashboard KPIs	Voluntary Turnover % **	4	9.0%	9.62%	7.37%	6.90%	7.48%	9.39%	7.57%
	Vacancy rate as % of budget **	4	7.50%	8.31%	7.95%	7.29%	6.45%	6.01%	5.60%
	% of staff with a current IPR	4	90%	75.39%	76.77%	76.33%	77.74%	77.74%	76.86%
	% Medical Appraisals*	3	90%	70.25%	72.73%	76.61%	79.03%	80.31%	79.53%
	Mandatory training %	4	90.00%	88.72%	88.39%	87.95%	88.07%	87.07%	87.30%
	% sickness absence **	5	4.0%	4.58%	5.26%	5.10%	4.65%	4.39%	4.22%
Additional KPIs	FFT – recommend as place to work **	3	72.0%	n/a	n/a	n/a	58.00%	n/a	n/a
	FFT – recommend as place for treatment	3	90%	n/a	n/a	n/a	85.00%	n/a	n/a
	Registered nursing vacancy rate (including pre-registered nurses)	4	5.00%	3.37%	2.72%	2.16%	1.80%	1.77%	1.59%
	Unregistered nursing vacancies excluding pre-registered nurses (% total establishment)	4	10.00%	12.66%	12.92%	12.23%	12.06%	11.01%	7.34%
	Long term sickness absence % **	5	1.50%	1.62%	2.14%	2.10%	1.84%	1.94%	2.08%
	Short term sickness absence	5	2.50%	2.97%	3.12%	2.99%	2.82%	2.45%	2.13%
	Agency Usage (wte) Monitor only	5	Monitor only	43.6	35.2	33.6	29.2	27.8	17.7
	Bank Usage (wte) monitor only	5	Monitor only	80.8	81.0	96.3	93.9	100.5	95.3
	Overtime usage (wte) monitor only	5	Monitor only	41.1	33.4	41.5	45.5	54.0	26.0
	Agency spend as % of salary bill	5	2.36%	2.73%	2.00%	1.90%	2.52%	1.12%	1.44%
	Bank spend as % of salary bill	5	2.54%	2.97%	2.92%	2.68%	3.18%	2.25%	3.00%
	% of rosters published 6 weeks in advance	3	Monitor only	48.50%	48.25%	63.60%	60.60%	57.60%	54.50%
	Compliance with headroom for rosters	4	Monitor only	26.50%	32.00%	29.50%	30.40%	30.10%	29.90%
	Band 5 % White background: % BAME background	5	Monitor only	n/a	42.00%:56.75%	n/a	n/a	41.43%:57.38%	n/a
	Band 6 % White background: % BAME background	5	Monitor only	n/a	64.34%:34.39%	n/a	n/a	62.31%:36.47%	n/a
	Band 7 % White background % BAME background	5	Monitor only	n/a	76.63%:20.85%	n/a	n/a	75.69%:21.76%	n/a
	Band 8a % White background % BAME background	5	Monitor only	n/a	83.87%:14.52%	n/a	n/a	85.40%:13.14%	n/a
	Band 8b % White background % BAME background	5	Monitor only	n/a	85.71%:14.29%	n/a	n/a	86.21%:13.79%	n/a
	Band 8c % White background % BAME background	5	Monitor only	n/a	77.78%:22.22%	n/a	n/a	80.65%:19.35%	n/a
	Band 8d % White background % BAME background	5	Monitor only	n/a	90.00%:10.00%	n/a	n/a	90.00%:10.00%	n/a
	Time to hire (days)	3	48	41	45	41	42	38	36

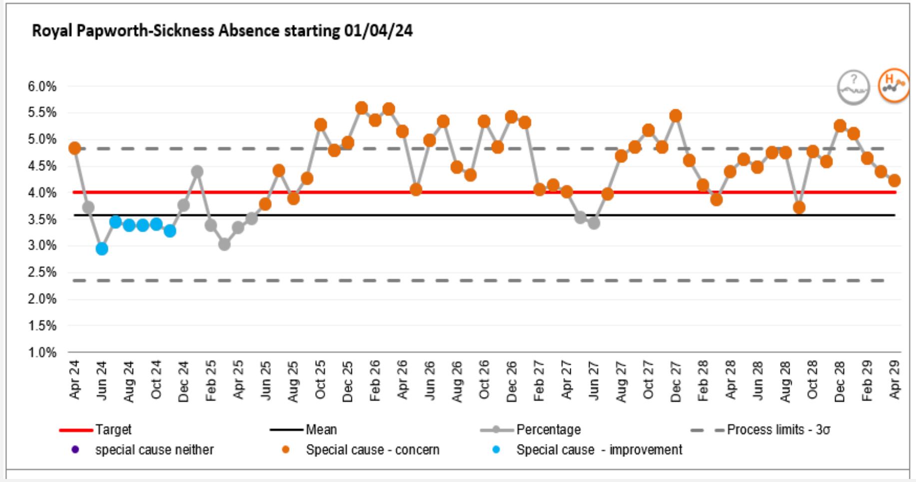
Summary of Performance and Key Messages:

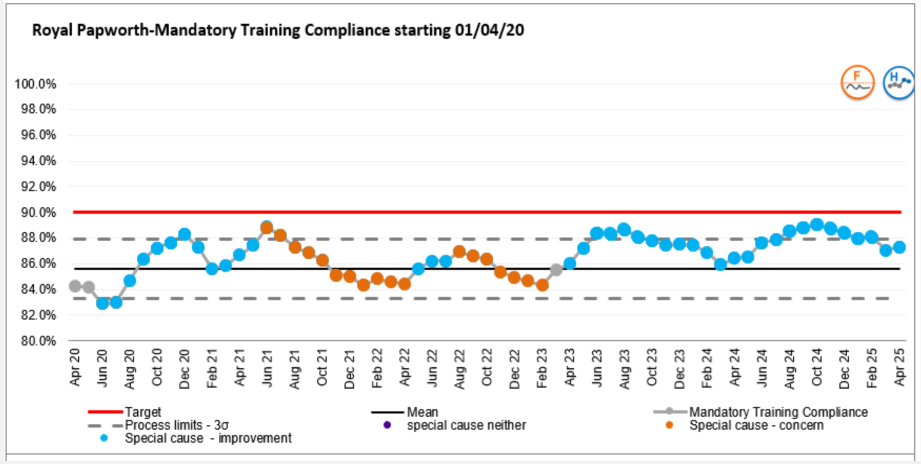
- Turnover returned to below our KPI. Of the 13 wte (15 headcount) non-medical leavers, 8 were in the Administrative and Clerical staff group from across a number of departments. The reason given by 4 of these was linked to retirement.
- Our total Trust vacancy rate continued its improving trend reducing to 5.6% which equates to 131wte.
- The registered nurse vacancy rate reduced to 1.6%, 12.3wte. We are now seeing progress with the Theatres vacancy rates which has taken longer to recover than other areas. Theatre Nurse vacancy rate has reduced to 2 wte and there are 7 Theatre Nurses in the pipeline and 5 ODPs. SCP vacancies rates have reduced significantly from 31.5% 12 months ago to 13.9% (2 wte) and there are 2 new appointees in the pipeline. Overall our pipeline currently includes 22 Band 5 Registered Nurses and 3 for temporary staffing, with an additional 57 candidates for general and Band 6 nursing roles plus 7 for temporary staffing. We are ensuring strong pipelines in order to maintain low vacancy levels as this should minimise the need to use temporary staffing and supports the delivery of high quality care. We will be starting to use “talent pools” to manage candidates who have been appointed but 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 unregistered nurse vacancy rate decreased to 7.35%, 17.1 wte, below our KPI for the first time. We currently have 9 Healthcare Support Workers in the pipeline, plus 10 for temporary staffing.
- Our time to hire for April was 35.5 days and have maintained performance below the national KPI of 48 days for the past six months. 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 4.2%, although it remains above the 4% KPI. The Workforce Directorate continues to support managers through training and the application of absence management protocols.
- Temporary Staffing: Agency usage continues to decline and is at its lowest level for 24 months. We have taken the step of stopping use of nursing (with the exception of Theatres for the next 6 months whilst they onboard and train their new recruits) and healthcare support worker agency usage except in exceptional circumstances. Overtime was also at the lowest level for 24 months. Departments have been moving agency workers onto the bank and also offering bank worker rather than overtime so we have seen a steady increase in bank usage. Further

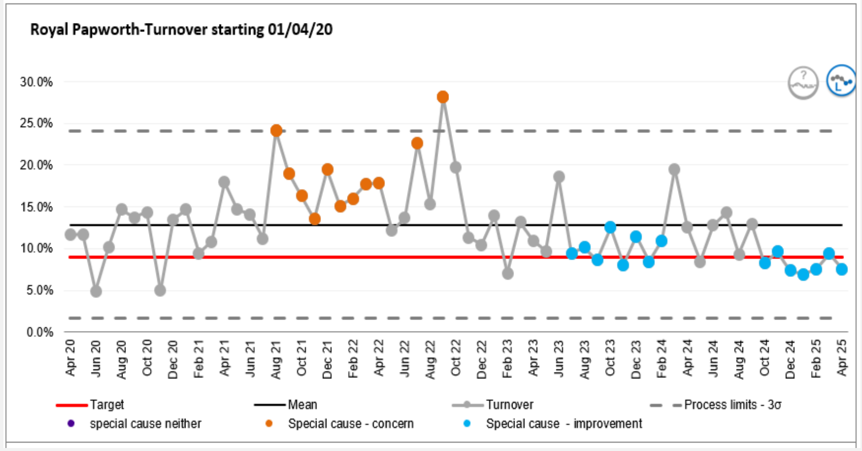
People, Management & Culture: Key performance trends

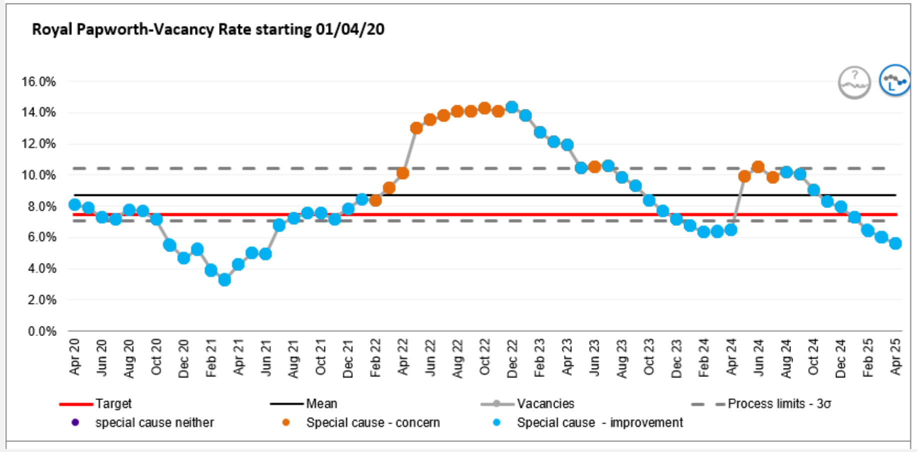
Accountable Executive: *Director of Workforce and Organisational Development* ***Report Author:*** *HR Manager Workforce*







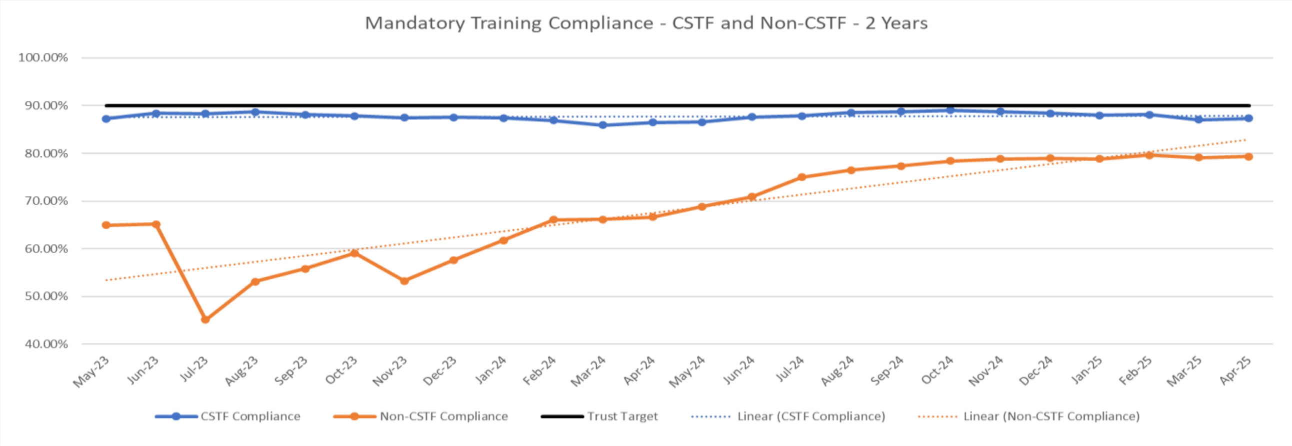




People, Management & Culture: Mandatory Training

Royal Papworth Hospital
NHS Foundation Trust

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



CSTF REQUIREMENTS						
UPDATED COMPETENCY	**AS AT 30.04.22**	**AS AT 30.11.22**	**AS AT 30.06.23**	**AS AT 31.05.24**	**AS AT 30.04.25**	**SPOTLIGHT TREND**
Equality, Diversity and Human Rights	90.68%	90.88%	93.97%	94.03%	92.78%	
Health, Safety and Welfare	89.92%	90.24%	94.17%	93.74%	92.46%	
Conflict Resolution	91.79%	91.79%	93.31%	92.43%	92.37%	
Infection Prevention and Control - Level	89.27%	91.73%	94.07%	93.69%	92.23%	
Preventing Radicalisation - Basic Prever	90.91%	93.64%	96.80%	97.51%	92.15%	
Safeguarding Adults - Level 1	87.00%	89.87%	92.95%	92.19%	89.72%	
Moving and Handling - Level 1	89.07%	87.89%	89.51%	89.13%	88.85%	
Preventing Radicalisation - Prevent Awa	87.48%	85.63%	88.19%	87.86%	88.70%	
Safeguarding Children - Level 1	87.61%	89.76%	92.40%	90.98%	87.89%	
Safeguarding Adults - Level 2	86.27%	89.29%	91.46%	90.23%	87.85%	
Fire Safety	82.67%	86.19%	89.10%	84.09%	86.93%	
Safeguarding Children - Level 2	85.61%	89.86%	90.93%	88.98%	86.78%	
Information Governance and Data Secur	86.40%	88.32%	95.29%	83.70%	86.61%	
Moving and Handling - Level 2	75.70%	71.40%	75.58%	80.80%	85.62%	
Infection Prevention and Control - Level	82.63%	82.53%	86.38%	82.15%	82.71%	
Resuscitation - Level 1	81.91%	81.71%	84.69%	76.13%	82.32%	
Safeguarding Adults - Level 3	32.37%	33.73%	43.91%	67.98%	75.00%	
Safeguarding Children - Level 3	32.37%	33.33%	43.50%	67.23%	74.03%	
Resuscitation - Level 2	72.91%	69.55%	68.61%	62.10%	73.03%	
Resuscitation - Level 3	36.70%	48.68%	49.37%	44.72%	58.01%	
Grand Total	**84.45%**	**85.37%**	**88.36%**	**86.55%**	**87.30%**	

NON-CSTF REQUIREMENTS						
UPDATED COMPETENCY	**AS AT 30.04.22**	**AS AT 30.11.22**	**AS AT 30.06.23**	**AS AT 31.05.24**	**AS AT 30.04.25**	**SPOTLIGHT TREND**
Food Hygiene	87.50%	90.91%	100.00%	95.35%	91.84%	
Patient Safety - Level 1***			32.15%	86.46%	91.43%	
Designated Nursing Officer*		70.00%	76.92%	91.67%	90.91%	
Patient Safety - Level 2***			20.39%	73.79%	82.09%	
Safeguarding People L4	28.57%	12.50%	10.00%	11.11%	80.00%	
Oliver McGowan Training - Part 1**				63.69%	79.18%	
Blood Transfusion	68.12%	58.95%	67.71%	58.20%	77.05%	
Medical Gases	65.64%	60.67%	64.70%	59.46%	69.04%	
Medicines Management	64.41%	60.45%	62.59%	58.82%	61.15%	
Grand Total	**66.12%**	**60.26%**	**65.14%**	**68.83%**	**78.18%**	

*Designated Nursing Officer only went live in October 2022 as a requirement
**Oliver McGowan Training - Part 1 only went live in April 2024 as a requirement
***Patient Safety Level 1 and 2 only went live in June 2023 as a requirement

Improvements that have been made:

- To bring us in line with the NHSE MOU for training interoperability and frequency standardisation we have extended the renewal periods for Fire Safety and Manual Handling. From 1 May 2025 fire safety will be valid for two years and manual handling level one will be valid for three years (both increased by 1 year). Existing records and completion status have been migrated and the new requirements added to ESR.
- The national changes have meant that the Inter Authority Transfer forms we receive from previous employers are now showing more alignment with the MOU (frequencies), and we are not getting as many unofficial attempts at Recognition of Previous Learning from partner organisations. However, there are some outliers whilst others in the NHS network get up to speed with the new rules.
- We undertake annualised review through Induction and Mandatory Training Group by all subject matter experts to assure alignment of our training with CSTF standards (content and allocations)
- There is good confidence in current data enabling admin teams to make advance direct contact with candidates to remind of expiring competence. Ward Sister Assistants are supporting with booking staff onto course and monitoring compliance in their areas.
- Subject Matter Experts for stat/mandatory training subjects have been encouraged to join national communities of practice for their area to have a voice at the wider level and equip us for future changes to training methodologies.
- Data cleansing continues to ensure correct allocations (although not anticipated to significantly alter compliance %).

Areas of Concern:

- Oliver McGowan training rollout: the training programme is being spearheaded by colleagues in CPFT. They have opted for a self-booking facility to reduce friction in getting to courses. However, this programme remains a serious concern as it is likely to drain 1700+ days per year out of our capacity (according to NHSE training calculator). Our approach has been to work with CPFT and the safeguarding team to make staff aware of sessions and support through advertising and communications, but to take a cautious approach to insisting people leave the frontline for the programme. We have added it to the risk register. This concerns is being raised nationally.
- Alongside this, we see an increasing range of subject matter experts/specialist forums seeking awarding of local mandatory training across the organisation - cumulatively this will have significant impact on staff release and resource requirements. We are reviewing the approvals process for this to ensure that there is robust challenge to the requirement for it.
- Compliance for medical staff remains low. In relation to Resus training compliance challenges remain in gaining copies of existing ALS compliance certificates from new medical staff, artificially lowering compliance report (many ALS certifications not on ESR so require manual transfer/reporting).
- Resus: Whilst having seen steady increase in roles requiring L3, compliance has also steadily improved, although below KPI. Recent review of CALS allocation (L3 option for resus) - approved at alert/resus steering group and IMTG. Changes on ESR imminent, anticipated to improve compliance report.. Continued offer of programmed trainings (eALS and ILS), meeting approx 120-130% need annually.DNA for L3 much less than L2, however attendees pre-read/preparation variable thus affecting pass rates. Comms to supporting line managers and applicants re importance of preparation in place alongside in-situ feedback. Growing local faculty and collaborative deliveries with eg CUH supports ability to meet capacity requirements. No reported incidents/patient harm where lack of L3 compliance was identified as causation.
- Safeguarding Level 3: The Safeguarding Committee have agreed changes to improve compliance which include
  - Level 3 training days advertised a year ahead
  - Up to 40 spaces per day
  - Training programme currently undergoing validation by ICB
  - Review of medical staff training and requirements undertaken, MD and CN meeting with CD's and named Dr for safeguarding to discuss further in respect to practicalities

Any improvements we are planning:

- Continued reform of stat/mand. subject delivery to move from a 'train-and-refresh' approach to a 'train-once-assess-competence-regularly-against-stated-outcomes' approach.
- New learning pathways and materials are being made available to increase our toolkit and flexibility in how we offer learning to staff. This should increase both our reach, the effectiveness of the materials/interventions and overall accessibility of the learning.
- All the national work occurring will dovetail seamlessly into our new Learning System to further enhance the experience for staff.

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Finance: Performance summary

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

Royal Papworth Hospital
NHS Foundation Trust

		Data Quality	Target	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
Dashboard KPIs	Year to date surplus/(deficit) adjusted £000s	4	£(68)k	£1,413k	£99k	£140k	£1,044k	£335k	£2k
	Cash Position at month end £000s *	5	£76,637k	£80,260k	£81,494k	£74,117k	£76,448k	£75,314k	£79,265k
	Capital Expenditure YTD (BAU from System CDEL) - £000s	4	£116 YTD	£1,641k	£1,905k	£2,322k	£2,506k	£4,918k	£26k
	CIP – actual achievement YTD - £000s	4	£553k	£5,313k	£5,460k	£5,730k	£6,018k	£6,630k	£219k
Additional KPIs	Capital Service Ratio YTD	5	1.0	1.0	0.6	0.6	0.5	0.5	0.5
	Liquidity ratio	5	26	31	29	29	29	29	29
	Year to date EBITDA surplus/(deficit) £000s	5	Monitor only	£10,190k	£9,687k	£10,773k	£10,863k	£11,060k	n/a
	Total debt £000s	5	Monitor only	£3,720k	£3,610k	£4,230k	£4,090k	£6,580k	£5,400k
	Average Debtors days - YTD average	5	Monitor only	4.2	4.1	4.8	4.6	7	6
	Better payment practice code compliance YTD - Value £ % (Combined NHS/Non-NHS)	5	Monitor only	97%	97%	97%	98%	98%	98%
	Better payment practice code compliance YTD - Volume % (Combined NHS/Non-NHS)	5	Monitor only	97%	97%	97%	97%	97%	97%
	Elective Variable Income YTD £000s	4	£4223k (YTD)	£38,720k	£43,393k	£48,908k	£55,178k	£58,151k	£4,700k
	CIP – Target identified YTD £000s	4	£9630k	£6,632k	£6,632k	£6,632k	£6,632k	£6,632k	£4,650k
	Implied workforce productivity % - compares real terms growth in pay costs from 19/20 against growth in activity from 19/20	5	Monitor only	-2.2%	-1.4%	-1.7%	-0.3%	5.1%	n/a

Summary of Performance and Key Messages:

- **At month 1, the position is reported a breakeven financial position on an adjusted financial performance basis**, representing a favourable variance of £0.3m. 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 business as usual (BAU) adverse pay variances and CIP under-delivery in the Divisions at month 1.
- **Income is £0.2m adverse to plan at month 1**, primarily driven by pass-through device usage which is reflected in spend variances. The 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. Clinical income is adverse due to elective and pass-through device activity being below planned levels. Contract discussions with commissioners are ongoing to agree final indicative activity plans and contracts following updates to the national guidance and contract guidance in April and May.
- **Pay is broadly on plan at month 1**, however 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 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 April spend was the lowest in c16 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.
- **Operating non-pay spend is favourable to plan by £0.2m** at month 1. 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).
- **Cash closed at £76.0m**, an increase of c£0.7m on last month's position due to working capital improvement on stock reduction and debtors cash receipt increases.
- The Trust's 2025/26 BAU capital plan is £4.0m (part of the overall ICS capital budget), and a total capital plan of £9.5m (which includes right of use capital expenditure allocations and EPR replacement capital spend). The plan has been based on a risk-based prioritisation process undertaken by the Medical Devices Group, Digital and Estates teams with oversight from Investment Group. The Digital plan is being re-prioritised following further review by clinical and service teams to ensure alignment to service ambitions and this is expected to be finalised by end May. The plan ramps up spend throughout the year and spend is being overseen by Investment Group. Spending the EPR capital is the most significant risk and this will continue to be monitored as the Full Business Case progresses.

Note * Target set at 90% operational plan

Finance: Key Performance – In month SOCI position

NHS
Royal Papworth Hospital
NHS Foundation Trust

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

At month 1, the position is reported a breakeven financial position on an adjusted financial performance basis, representing a favourable variance of £0.3m. 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 1.

		In month £000's Plan	In month £000's Underlying Actual	In month £000's Other Non Recurrent Actual	In month £000's Actual Total	In month £000's Variance	RAG
Clinical income - in national block framework							
	Fixed at Tariff	£13,553	£8,539	£0	£8,539	(£5,014)	
	Balance to Fixed Payment	£0	£5,014	£0	£5,014	£5,014	
	Variable at Tariff	£4,860	£4,700	£0	£4,700	(£160)	
	Homecare Pharmacy Drugs	£4,057	£4,219	£0	£4,219	£162	
	High cost drugs	£50	£56	£0	£56	£6	
	Pass through Devices	£2,196	£1,966	£0	£1,966	(£230)	
	Sub-total	**£24,716**	**£24,494**	**£0**	**£24,494**	**(£222)**	
Clinical income - Outside of national block framework							
	Devices	£125	£100	£0	£100	(£25)	
	Other clinical income	£147	£245	£0	£245	£98	
	Private patients	£846	£1,012	£0	£1,012	£166	
	Sub-total	**£1,118**	**£1,358**	**£0**	**£1,358**	**£240**	
Total clinical income		**£25,834**	**£25,852**	**£0**	**£25,852**	**£18** 1	
Other operating income							
	Other operating income	£1,627	£1,457	£0	£1,457	(£170)	
Total operating income		**£1,627**	**£1,457**	**£0**	**£1,457**	**(£170)** 2	
Total income		**£27,461**	**£27,309**	**£0**	**£27,309**	**(£152)**	
Pay expenditure							
	Substantive	(£12,152)	(£12,257)	(£210)	(£12,467)	(£315)	
	Bank	(£400)	(£225)	£0	(£300)	£100	
	Agency	(£442)	(£188)	£0	(£188)	£254	
	Sub-total	**(£12,993)**	**(£12,669)**	**(£210)**	**(£12,954)**	**£39** 3	
Non-pay expenditure							
	Clinical supplies	(£5,211)	(£5,035)	£0	(£5,035)	£176 4	
	Drugs	(£779)	(£609)	£0	(£609)	£170	
	Homecare Pharmacy Drugs	(£4,057)	(£4,243)	£0	(£4,243)	(£186)	
	Non-clinical supplies	(£3,508)	(£3,471)	(£30)	(£3,466)	£42	
	Depreciation	(£915)	(£892)	£0	(£892)	£23	
	Sub-total	**(£14,470)**	**(£14,250)**	**(£30)**	**(£14,245)**	**£225**	
Total operating expenditure		**(£27,463)**	**(£26,919)**	**(£240)**	**(£27,199)**	**£264**	
Finance costs							
	Finance income	£319	£291	£0	£291	(£28)	
	Finance costs	(£517)	(£505)	£0	(£505)	£13	
	PDC dividend	(£198)	(£198)	£0	(£198)	£0	
	Revaluations/(Impairments)	£0	£0	£0	£0	£0	
	Gains/(losses) on disposals	£0	£0	£0	£0	£0	
	Sub-total	**(£396)**	**(£412)**	**£0**	**(£412)**	**(£16)**	
Surplus/(Deficit) For The Period/Year		**(£398)**	**(£22)**	**(£240)**	**(£302)**	**£96**	
Adjusted financial performance surplus/(deficit)		**(£42)**	**£282**	**(£240)**	**£2**	**£44**	

In month headlines:

1 **Clinical income is breakeven in the month.**

- Fixed income on a tariff lens is c£5.0m 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 marginally behind current plans (subject to the finalisation of commissioner contracts by the end of the month).

2 • Other Operating Income is driven by a shortfall in training income from Health Education England LDA and R&D, with corresponding underspend in expenditure.

3 **Pay expenditure is marginally favourable to plan** however 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 non-recurrent arrears payments for several medical staff (c£0.1m) and other increases in substantive pay run rates vs previous quarter, particularly for 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 April spend was the lowest in c16 months with Divisional agency trajectories are on track overall. There is variation by area and those areas adverse to trajectory will be asked to develop action plans to mitigate delivery risk where relevant.

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.

4 **Clinical Supplies is £0.2m favourable to plan**. This is driven by activity and pass-through devices underperformance consistent with the clinical income position. 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).

Key actions:

- **CIP:** enhanced support to CIP PMO and divisions to identify CIP schemes and mitigate delivery risk *Owner: COO (CFO). Mechanism: enhanced CIP PMO support and revised governance/oversight structure.*
- **Agency:** ongoing implementation of agency controls and oversight across the Trust. *Owner: Director of Workforce & DO (Deputy CFO). Mechanism: Vacancy control panel and Divisional PRMs.*
- **Agency:** review of agency trajectories with areas that are off plan to develop action plans to mitigate delivery risk. *Owner: Director of Workforce & DO (FBPs). Mechanism: Divisional PRMs.*
- **Bank and substantive staffing:** review of those areas with high levels of bank spend or increasing bank spend that are fully established. *Owner: Chief Nurse (FBPs). Mechanism: Divisional PRMs and staffing review meetings*

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