Royal Papworth Hospital
NHS Foundation Trust

Performance Committee
Part 1 meeting
Held on 24 April 2025
0930-1100hrs via MS Teams

[Chair: Gavin Robert, Non-executive Director]

UNCONFIRMED MINUTES

Present		
G Robert	GR	Non-executive Director
C Conquest	CC	Non-executive Director
D Jones	DJ	Non-Executive Director
H McEnroe	HMc	Chief Operating Officer
S Harrison	SH	Chief Finance Officer
E Midlane	EM	Chief Executive
O Monkhouse	OM	Director of Workforce and Organisational Development
A Raynes	AR	Chief Information Officer
M Screaton	MS	Chief Nurse
I Smith	IS	Medical Director
In Attendance		
A Colling	AC	Executive Assistant (Minutes)
T Collins	TC	Public Governor, Observer
M Kaiser	MK	Director of Operations Improvement & Delivery
K Mensa-Bonsu	KMB	Associate Director of Corporate Governance
S Rackley	SR	Director of Estates & Facilities
Apologies		
B Davidson	BD	Public Governor, Observer
T Glenn	TG	Deputy CEO & Director for Innovation and Strategy
A Nyama	AN	Deputy Chief Finance Officer

[Note: Minutes in order of discussion, which may not be in Agenda order]

Agenda Item		Action by Whom	Date
1	**WELCOME, APOLOGIES AND OPENING REMARKS**		
25/108	The Chair welcomed all to the meeting and apologies were noted.		
2	**DECLARATIONS OF INTEREST**		
25/109	There is a requirement that Board members raise any specific declarations if these arise during discussions. No specific conflicts were identified in relation to matters on the agenda. A summary of standing declarations of interests are appended to these minutes.		
3	**MINUTES OF THE PREVIOUS MEETING 27 March 2025**		
25/110	**Approved**: The Performance Committee approved the Part 1 minutes of 27 March 2025 meeting and authorised for signature by the Chair as a true record.	Chair	24.04.25

Agenda Item		Action by Whom	Date
4.1	**TIME PLAN OF TODAY'S AGENDA ITEMS**		
25/111	It was agreed to proceed as per the agenda.		
4.2	**ACTION CHECKLIST**		
25/112	The Committee reviewed the Action Checklist and updates were noted.		
	Action 25/85 PIPR: Responsive (CT Backlog) 24.04.25 update: A report has gone to Execs with further work still required. Therefore, defer full report to the May meeting. GR expressed concern on noting in the BAF report that the preferred insourcing contract is waiting for Execs approval. GR had hoped to see a report this month setting out the detailed plan for the outsourcing work. He was concerned that we now have a shortfall between the end of the insourcing contract and the beginning of outsourcing, leading to the backlog increasing. GR asked for a written report next month showing written clarity on what is happening and when. HMc updated: There have been a number of Exec delivery group meetings with the CT team. There have been challenges on communication leading to a miscommunication on approvals. This has been rectified with actions taken last week to mitigate this and provide a stop gap with insourcing. HMc is clear on approval for the digital development work needed for the increase in capacity for both insourcing and outsourcing and this is included in the tender process, along with procurement of extra bandwidth requirements for VPN access (to enable home reporting). GR asked why the insourcing contract had been allowed to come to end and the backlog to increase? HMc advised that the decision was delayed due to communication issues in the team regarding progress on insourcing/outsourcing. The recommendation for renewal of the insourcing service has now been approved (3 weeks lost due to this), along with checking the impact on patients. GR noted his disappointment and concern to be in this position as there was full awareness of contract end dates. CC agreed with GR. She was concerned that miscommunication was the cause of this as there is a Trust process on waivers to follow. EM shared the Committee's frustration explaining that there had been two previous waivers signed for this contract, and this would be a third. The challenge from Execs related to a longer term solution and awareness of other providers in the market. Execs reflected that the current contract did have issues on delivery. This work is now back on track with a push to progress. AR added that there is a huge technical requirement involved to ensure that reduction of the CT backlog is supported along with dealing with 3rd parties. He assured the Committee that work is in hand. GR asked when will the outsourcing be in place so that the stop gap insourcing can come to an end.		

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	HMc explained: ➢ from now it will take 3 months to complete market analysis, ➢ 4 weeks to finalise this and appoint, ➢ then a further 4 weeks to deploy ➢ = 5/6 months away before full deployment. GR asked about the status of the insourcing contract. HMc – this is being taken through the business case process with the waiver expected to be in place early next week. SH confirmed that this will give six months of insourcing. HMc added that at present, we do not have resource to stop the backlog growing. MS noted her declaration of interest regarding the radiology aspect of this. She advised the governance structure was set up 18 months ago. MS had stepped away at that point due to the conflict of interest. It seems that the governance process fell away. There is now tight oversight with Execs. This process needs tight governance in place to be able to support the team and manage communication. The waiting list for CT is growing. On RTT the highest risk is the ability to be able to deliver on CT reporting. There is an impact on many workstreams linked to this. GR suggested that there should there be a 'lessons learned' report to understand what went wrong and to ensure this does not happen in other areas of governance. HMc agreed with this but suggested the need first to concentrate on delivering the plan for insourcing/outsourcing. CC asked what is the harm to patients? Should this be considered by Q&R. She is not assured that this issue will not happen again. MS confirmed that this check is ongoing work with a clinical risk assessment to patients. We do see an impact and these are assessed. The clinical risk and governance elements are receiving close scrutiny by Execs/Clinical Governance team. GR thanked all for this discussion and awaits a written report on the outsourcing and stop gap option.	HMc	29.05.25
5	**DIVISIONAL PRESENTATION**		
	Next due 29 May 2025.		
IN YEAR PERFORMANCE & PROJECTIONS			
6	**REVIEW OF THE BOARD ASSURANCE FRAMEWORK (BAF)**		
25/113	**Received**: A summary of the BAF risks and mitigations in place for risks above target. A copy of the BAF tracker report was attached. **Reported** KMB BAF risk for Cyber Security had been discussed in the earlier confidential Part 2 meeting and the CT backlog risk discussed above. P28 of pack (BAF risk 3009 supply of consumables or services) noted the impact of US tariffs on the supply chain with no significant impact.		

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	Discussed: GR queried continuity of supply where 38% is still to be reviewed – will this be reviewed by next month. SH advised that review will be by end of Q1 (end June), with an update to June's Performance Committee. GR referred to items highlighted in red to show where things had changed in the previous month; there seems to be some items still highlighted red from previous months. KMB will remove the highlighting as discussed. **Noted:** The Performance Committee noted the review of BAF.	SH KMB	26.06.25 26.06.25
7.1	**FINANCIAL REPORT – Month 12 March 2024/25**		
25/114	**Received:** Financial Report which provided oversight of the Trust's financial position as at Month 12, March 2024/25. **Reported:** SH highlighted: M12 delivered a small surplus of £300k; the Trust met the break-even challenge and plan for 24/25 year. This was reflected across the wider system position and unlocked incentive funding on capital and revenue on 25/26 plans. Elective income caps imposed by NHSE, M12 shows year-to-date provision against contract on over-performance, where it will not be possible to be paid for this level of over-performance. We have retained specialised commissioning envelopes into 2025/26, but the ICB position will continue to be stretched and challenged in terms of elective recovery position. The specialised element of the portfolio is the largest share of RPH work. On pay, the M12 includes the national pension adjustment which increases pay in M12. This is matched to funding from NHSE. (£8m at M12). Cash closed year at £75m. We are keeping close eye on this to support the EPR programme. Capital allocations - only 3 schemes (in digital) were not achieved in the 24/25 plan; these are not business or service critical and will be moved to the 25/26 plan. CC had queried prior to today's meeting, on the capital service metric (included in PIPR) which had dipped into the red and gone down to 0.5 – this is a result of non-recurrent deployment of funds and decisions this year which have reduced our operating surplus. This is a planned reduction. GR referred to Private Patients income where one provider continues to be disappointing and seems unprofitable for RPH. SH explained there is a small margin (before contribution to overheads) with this provider. The Trust is working with the provider's new contract managers along with further discussions with consultants. The position will be reviewed again in June. GR thanked SH for this reassurance. **Noted:** The Performance Committee noted the financial position.		

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7.2.1	**A BRIDGE TO EXCELLENCE (CIP) REPORT: Month 12 March 2024/25**		
25/114	**Received:** An update report to Month 12 March 2024/25. **Reported:** HMc. The report was taken as read. The Trust was on plan at M12 on year to date position and forecast. The key priority over the last 2 months has been on 25/26 planning, with focus on filling the pipeline with opportunities, as outlined in the pack. **Discussed:** CC asked about figures on P53/54 not matching – it was confirmed that £2.6m is the correct figure for 24/25 non-recurrent CIP year to date delivered and forecast. - HMc will arrange for this to be corrected. **Noted:** The Performance Committee noted the update on CIP M12 24/25.	HMc	29.05.25
7.2.2	**A BRIDGE TO EXCELLENCE (CIP) 2025/26 PLANNING UPDATE**		
25/115	**Received:** CIP 2025/26 plan update. **Reported:** HMc There is a keen focus on this, noting a £4.2m CIP gap to plan at the point of reporting, with a further anticipated CIP £1.1m going through governance processes before these can be included (anticipated gap £2-3m gap at end of month). Remedial steps are being taken by Execs to improve this position and work with divisions to support this. There is grip to put control processes in. **Discussed:** SH added further regarding the central actions: there is a suite of items to look to put in place to mitigate a £2m gap, with further mitigations worked up by the finance team to deploy to fill the gap in full if required. With regard to delivery of 2025/26 plan, we are still continuing to push on the recurrent CIP element along with mitigations to support delivery of the plan this year. CC was concerned at the position of CIP pipeline not identified as at 1 April 2025 – a £2.3m gap is substantial. Usually by 1st April, the CIP pipeline would be 100% identified. Even acknowledging the financial contingency, a gap at the beginning of year is hard to recover. CC does not feel assured on delivery of this CIP plan, particular with EPR consideration and increases in risk. She suggested that we should be looking at more transformational CIPs, ahead of EPR. HMc concurred with CC. The transformational work would cover items such as redesign of pathways, standardised access to diagnostic service, work with campus partners and would look to increase productivity and efficiency. This work would need substantial governance which is in hand with Execs. SH explained that once the elective recovery schemes are in process, then this becomes the group (Access Board) to look at transformational work; noting a need to consider capacity with regard to the elective recovery programme and waiting list recovery. AR noted prioritisation work in the digital team to ensure that innovations		

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	through digital initiatives align with this plan. GR noted Appendix 2 showing divisional detailed progress was helpful but it is unclear, at which point do these initiatives become included within the pipeline; is it when verified by finance? HMc confirmed the point is when it is validated as a genuine financial delivery and criteria validated, then it enters the pipeline. HMc explained how this is marked on the plan. GR referred to the large potential savings resulting from an expected reduction in agency spend, especially for STA – is this over optimistic? HMc advised that these figures are being scrutinised for STA – the numbers are being risk-assessed and the final number included in the pipeline is likely to be lower. He explained the sign-off process for CIP and feels that final numbers, once approved, are realistic. GR added that he would not want to see an unrealistic CIP pipeline which would provide false assurance at this stage. He noted the internal audit of the CIP process, and the assurance received on this process. **Noted:** The Performance Committee noted the 2025/26 CIP planning update.		
7.3	**INVESTMENT GROUP – Chair's Report**		
25/116	**Received:** Chair's update summarising the meeting held on 14 April 2025. **Reported:** SH The report was taken as read. The Investment Group has seen the first prioritised review and approval of the capital plan for 2025/26 plan. As mentioned under the CIP planning update, work is ongoing on prioritisation of the digital plan to support productivity and elective recovery initiatives, which will come through Investment Group for approval. **Noted:** The Performance Committee noted the update from the Investment Group.		
9	**OPERATIONAL REPORTS**		
9.1	**Elective Care Recovery Priorities**		
25/117 1026hrs MK joined	**Received:** Update on actions to achieve RTT improvement in line with national ask. **Reported:** HMc Explained the scrutiny on this by Execs and divisions to improve delivery of activity, including two meetings already of the new Access Board. Progress since the last report has seen full governance established, including set up of sub- groups to Access Board, with clinical representation at these meetings. The current position sees us move to delivery status where green shoots have been seen in M12. There was a slight improvement on RTT and improvement in cardiology. This is a moving position. **Discussed:** CC understands the wish to not over promise but feel that 67.9% recovery by March 2026 is not ambitious enough; should the push be harder on this?		

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	HMc explained that the overall ambition is 82% recovery, and this is what teams are working to; the 67.9% is today's position validated in the plan, which will improve. He noted that 67.9% is not a target but reflects the schemes in the plan that are currently validated. Work will continue over the next weeks to identify and validate further improvements achievable within year. 2026/27 work will drive further the position to deliver the national 82% standard by the end of 2nd year. CC asked if this can be made clearer in reporting and that all staff are aware of the 82% target. MK assured that divisions are clear on 82% target and there is good engagement from colleagues at all levels. Regarding risk, the team is working with clinicians to understand what is possible in PSI clinics i.e., what is achievable with staff and what support is required to achieve this, being mindful of health and wellbeing within staff groups. DJ referred to associated risks and asked for clarity on the top one or two risks in achieving these ambitions and how these are being managed. HMc explained: 1. RSSC and sleep service: this risk relates to the filling of and activity completion of access through outpatient services. This refers to clinical admin services and booking through digital/clinical admin pathways. 2. RSSC: risk of the availability of teams to be able to do the work. He explained the complexity on rosters and mitigations to work around these. HMc confirmed focus and effort is going into both above risk areas. MK added that he attended the Thoracic divisional meeting yesterday, where the division were positively pushing/challenging the Exec team to ensure the risks are being managed. GR referred to the focus on future reporting to this Committee particularly dashboards and trajectories. He would like to see reporting against pipeline (as done in CIP reporting) along with % recovery on RTT and improvement plans shared. HMc updated that work is underway to compile the dashboard which will come to Committee, to include update on actions, trajectory and risk assessed adjustments and the pipeline of work to reach 82%. GR would be happy to review the dashboard work ahead of the next meeting to ensure reporting is right. **Noted:** The Performance Committee noted the update and discussion.		
10.46hrs	**Agenda timing update:** due to agenda items still to consider and meeting time remaining, GR proposed to take PIPR as read. The Committee had no items to raise regarding PIPR and agreed to move on.		
8.1	**PAPWORTH INTEGRATED PERFORMANCE REPORT (PIPR)**		
25/118	**Received**: PIPR for M12 March 2025. **Reported:** SH Summary of the position was 'Amber', which comprised: • Two 'green' domains: Caring and Finance. • Two 'red' domains: Effective and Responsive. • Two 'amber' domains: Safe and People Management & Culture.		

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	Discussion: The report was taken as read with no items raised for discussion. **Noted:** The Performance Committee noted the PIPR update for M12 March 2024/25.		
FUTURE PLANNING			
10	**QUARTERLY REPORTS**		
10.1	**Corporate Risk Register**		
25/119	**Received:** This report is to provide the Committee with an overview of those risks graded 12 and above that are included on Corporate Risk Register (CRR). **Reported:** MS Going forward, review of the BAF will also include enhanced governance on CRR, especially those risks scoring 12+. It is proposed to set up a Risk Oversight Committee to check and challenge these risks and to understand how they link with BAF and if levels are correct. This was discussed last year, but at that time the Trust was not in a position to introduce the structure; this position has now changed. The new risks on CRR relate to items discussed today and those added as part of RTT recovery programmes. Since reporting, many risks are due for review on mitigations to reduce from extreme risk downwards. Work is ongoing in terms of overdue risks. **Discussed:** CC notes the improved CRR reporting. Of the 18 overdue risks, do any of these cover extreme risks? MS advised that none of the overdue risks are classed as extreme. These are regularly reviewed and discussed at divisional meetings. MS was not able to give a timeframe for reduction to none overdue, but will take away to consider. GR agreed that the report is much easier to understand than previously. **Noted:** The Performance Committee is asked to note the contents of this report.		
11	**POLICY APPROVAL**		
	No items for review.		
12	**ANNUAL REPORTS**		
	No items for review.		
13	**AD-HOC REPORTS**		
13.1	**Integrated Care Board** (6 monthly update)		
25/120	**Received:** The purpose of this paper is to provide the Committee with a 6 monthly update on the performance of the Cambridge and Peterborough Integrated Care System. **Reported:** EM		

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	GR and CC – looking at the number of metrics that we share with ICB, data shows that the ICB is doing better than RPH (i.e., 52w breaches). What is the context for this? EM advised that the full ICB performance report is in the reference pack, with highlights in main paper. Elective recovery has progressed well and focus on long waiting patients from ICS perspective. Specifically referring to the data on recovery of RTT plan, EM advised that the case mix for ICB (high volume, low complexity cases which reduce numbers quickly) is different from RPH which has a much more complex cohort of patients who take longer to treat and discharge. EM gave further detail of the ICB position on activity pre-Covid level; cancer performance; diagnostic recovery, DM01 standard and cardiac imaging. Regarding financial performance, Julian Kelly confirmed the write-off of a £132.2m historic debt, on the basis that the system had delivered the planned break-even position. **Discussed:** GR reflected on the original request for ICB position to be reported to this Committee, where it was felt it would be a useful benchmark against RPH performance. This does not seem to be a realistic benchmark due to the different cohort of patients at RPH. EM noted that it is not easy to make direct comparisons and benchmark with DGHs. The relevance to the report is that we are judged at system level in terms of tiering and performance, therefore it is important to be mindful of this. CC challenged this, giving 52w as an example. Why should RPH not compare on 52w with the system? She challenged that if the rest of ICB is decreasing on this metric, then RPH should be too. What are others doing that RPH could be doing? Therefore, she feels the ICB report is useful to see. **Noted:** The Performance Committee noted the contents of this report.		
14	**ISSUES FOR ESCALATION TO OTHER COMMITTEES**		
25	No items were raised.		
15.1	**COMMITTEE FORWARD PLANNER**		
25/121	**Received**: The updated Forward Planner. **Reported:** KMB **Discussion:** The planner was taken as read. **Noted:** The Performance Committee noted the Committee Forward Planner.		
15.2	**REVIEW OF MEETING AGENDA & OBJECTIVES**		
25/122	GR noted that the meeting has seen some tough challenges but assured all that there is support from this Committee. EM welcomed this challenge as it helps us get underneath some of the issues.		

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15.3	**BAF end of meeting wrap-up**		
	No items were raised.		
15.4	**Emerging Risks**		
25/123	None identified.		
16	**ANY OTHER BUSINESS**		
	No items were raised. The meeting finished at 1101hrs		
	FUTURE MEETING DATES		

2024/25	Time	Venue	Divisional Presentation	Apols rec'd
30 January 2025	0900-1100hrs	MS Teams	**AHPs**	
27 February	0900-1100hrs	MS Teams		
27 March	0900-1100hrs	MS Teams	**PHARMACY**	
25 April	0900-1100hrs	MS Teams		
29 May	0900-1100hrs	MS Teams	**RADIOLOGY**	
June	0900-1100hrs	MS Teams		
July	0900-1100hrs	MS Teams	**CCA**	
August	0900-1100hrs	MS Teams		
September	0900-1100hrs	Face to Face / HLRI	**THORACIC**	
October	0900-1100hrs	MS Teams		
November	0900-1100hrs	MS Teams	**CANCER**	
December	0900-1100hrs	MS Teams		

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Signed

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Date

Abbreviations and Acronyms

BAF	Board Assurance Framework
CIP	Cost Improvement Programme
ERU	Emergency Recovery Unit
ERP	Elective Recovery Programme
ICB	Integrated Care Board
ICS	Integrated Care System
NED	Non-executive Director
PIPR	Papworth Integrated Performance Report
Q&R	Quality & Risk Committee
QIA	Quality Impact Assessment
RPH	Royal Papworth Hospital
RTT	Referral to Treatment
52WW	52 week wait