



**Royal Papworth Hospital NHS Foundation Trust**  
**Annual Report and Accounts**  
**April 2024 to March 2025**

Presented to Parliament pursuant to Schedule 7, paragraph 25(4)  
(a) of the National Health Service Act 2006



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The 2024/25 Quality Account is to be published by 30 June 2025 and will be made available for review on the Trust's website.

### Annual Accounts

This report is based on guidelines issued by NHS England and was approved by the Board of Directors on 24 June 2025.



# 1. Performance Report

## 1.1 Overview of Performance

### Statement from Chief Executive Officer

As I reflect on 2024/25, the NHS feels in a very different place at the end of the year compared to where it was 12 months ago. This transition has been driven by the new government, who since taking office in July 2024 have commissioned a report into the state of the NHS (Lord Darzi's report), launched a 10-year plan consultation and, more recently, announced that NHS England is to be abolished and subsumed by the Department of Health and Social Care over the next two years.

This has shifted focus for everyone in the NHS with two clear priorities: reducing waiting lists and waiting times for patients and financial stability. That is no different for our teams at Royal Papworth Hospital as we move into 2025/26.

### What our teams have been up to this year

We started the year by completing a series of moves within our hospital to make better use of the space. We had only been in our new hospital for about nine months when the Covid-19 pandemic arrived, meaning we had not yet fully understood how our people could best work in their new spaces. As we exited the pandemic and began to get back to normal, there were clear challenges for teams who felt either isolated or disjointed.

By re-purposing spaces and shifting wards around, we have been able to bring people together to improve the sense of teamwork, staff morale and ultimately patient experience. For example, our most unwell cardiology patients are now cared for in a dedicated area at the end of the ward rather than in the middle of a busy unit, and our CPAP (continuous positive airway pressure) team have moved to dedicated accommodation on the ground floor of our hospital, adjacent to the entrance to make it accessible for patients to drop-off equipment without needing to walk too far from the car park.

In May, the new enhanced recovery unit (ERU) opened, which was also part of this stream of work. The ERU is based within critical care and is designed for patients undergoing cardiac surgery who are predicted to stay in critical care for 48 hours or fewer. This has helped to protect beds for elective heart surgery, reducing the risk of cancellations at the expense of urgent or emergency activity.

I referred to all of this work in my opening statement last year, and I am immensely proud of all our teams involved that I can now report on this work having finished.

In June we had a further round of junior doctor industrial action by the British Medical Association, but with the arrival of the new government the pay dispute with the BMA was soon resolved and the strikes brought to an end.

Our hospital has, since being founded in 1918, gained an international reputation for clinical excellence and innovation. This reputation for pushing the boundaries of medicine was further evidenced in July when our team performed a UK first lung transplant using a new machine. Ex-vivo lung perfusion (EVLP) takes donated lungs that are considered marginal and perfuses them outside the body, making them transplantable. Using the XPS™ system from XVIVO, our transplant team performed the first clinical case in the UK with this machine and have since carried out several more transplants using this technology.

Our catheter laboratory team also performed the first ablation procedures in the UK using novel cardiac 3D mapping and navigation, designed to improve patient outcomes and efficiency. More recently, the same team has been pushing the boundaries of productivity with same-day discharges for patients undergoing transcatheter aortic valve implantation (TAVI)

Alongside clinical innovation, our teams have continued to strive for the highest standards of clinical excellence:

- In August, we were named as one of the best hospitals in the country for inpatient care with an average rating of 9.2 out of 10, putting our hospital in the top ranking.
- In October, a national report by NHS Blood & Transplant (NHSBT) on mechanical circulatory support (MCS), used for patients in the UK as a bridge to heart transplantation, highlighted major achievements by our team in heart transplantation rates and outcomes, further cementing our position as the UK's leading cardiothoracic transplant centre.
- In November, our antimicrobial stewardship (AMS) team received recognition for its excellence in achieving two key targets for antibiotic usage which means that our patients are benefitting from safer care through best practice in antibiotic usage.

This status as a centre of excellence continues to be reflected in our patient survey scores, with high levels of satisfaction through the friends and family test (FFT), and we were again named as one of the world's best specialised hospitals in the annual report by American magazine *Newsweek*.

In addition to these examples of high patient satisfaction and quality care, we are committed to ensuring our hospital is a safe environment, free from harm.

Responding quickly and efficiently to hospital-acquired infections is crucial to contain spread. We declared an outbreak of carbapenemase-producing enterobacterales

(CPE) in the summer, but thanks to the hard work of our infection prevention and control, microbiology, critical care and ward teams, the spread was contained.

We have also continued to keep open all lines of enquiry to bring down our elevated rates of wound infection post-surgery. There has been positive progress during the year, with the rates reducing both in frequency and severity. We continue to work hard to maintain this progress and further reduce the risk for our patients.

As we end the year with both the government's mandate to reduce waiting times and the recommendations of the Darzi report fresh in our minds, I am proud of all the work taking place in our hospital to treat as many patients as possible and work in new ways. One final example to share is our new respiratory outreach clinic which opened in February and is bringing specialist hospital-level care to people's own homes, saving them a trip to hospital.

## Our people and culture

We recognise that to create high-performing teams who deliver outstanding care, we must continue to embed a culture where staff feel safe, valued, included and genuinely listened to.

Our Leadership and Management Development Programme has now had around 200 graduates. This is a nine-month, in-house training course which continues to be well received by current and aspiring leaders who develop important leadership skills such as accountability, feedback, inclusion and active listening.

We also celebrated the completion of cohort two of our Transformational and Reciprocal Mentoring Programme, which pairs together senior leaders with people who have a lived experience of disability or race. Thirty people completed cohort two, adding to the 24 from cohort one. A further 33 people started cohort 3 in January 2025.

Continuing our commitment to create a compassionate and inclusive culture, in September 2024 we launched a new vision for inclusive leadership. One hundred leaders across the trust came together to discuss a new behaviour framework and put into place actions to address concerns around bullying, discrimination and harassment as reported in the NHS Staff Survey results.

A second, follow-up leadership event was scheduled for April 2025 to report on progress and learn from each other's successes and challenges.

With all of this in mind, it was very pleasing to see improvements across all nine of the key themes in the 2024 NHS Staff Survey results, continuing a steady upward trend since 2023.

We saw significant improvements in scores for 'having enough staff', 'approaching my manager to talk about flexible working', 'health and wellbeing' and 'having access to

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nutritious and affordable food', which can be linked to initiatives such as our staff restaurant discount, the excellent work of our wellbeing team and the success of our recent recruitment campaigns.

Our 'recommender as a place to be treated' score also remains among the highest in the country, with 90.8% of our staff who responded to the survey saying they would be happy if a friend or family member needed treatment.

## The year ahead

As we look ahead to 2025/26, I am excited by what we can achieve at Royal Papworth Hospital NHS Foundation Trust despite the challenges the NHS faces.

We must deliver for today's heart and lung patients by reducing our waiting lists and waiting times, all within our existing financial footprint; at the same time we are busy planning for tomorrow as we prepare to embark on wide-reaching engagement to develop our 2026-2031 strategy.

A key enabler to successfully delivering this strategy will be our new electronic patient record (EPR) system. The main contract for our current EPR ends in 2027. This product is being discontinued and so we must move to a new system. I am thankful to the project team for the vast amount of work they have done throughout the year in getting our outline business case written, submitted and approved. We are now moving forwards with our procurement and full business case which will take us closer to implementing a new EPR which will improve our staff experience and lead to better care for our patients.

## Overview of Performance

The purpose of the Overview is to give the user a short summary that provides them with sufficient information to understand the organisation, its purpose, the key risks to the achievement of its objectives and how it has performed during the year.

### Hospital History and Statutory Background

Royal Papworth Hospital NHS Foundation Trust ("Royal Papworth Hospital" or "the Trust") is the UK's largest specialist cardiothoracic hospital and the country's main heart and lung transplant centre. We have an extraordinary commitment to delivering the highest levels of clinical quality and outcomes and for providing the best possible standards of personalised care to our patients.

Royal Papworth Hospital was one of the first foundation trusts to be authorised under the Health and Social Care (Community Health and Standards) Act 2003 and came into existence in July 2004 as Papworth Hospital NHS Foundation Trust. Since then, it has been licenced by the Regulator (previously named Monitor, now NHS England). From 2018 we became Royal Papworth Hospital NHS Foundation Trust.

Royal Papworth Hospital has an associated charity – Royal Papworth Hospital NHS Foundation Trust Charity (Royal Papworth Hospital Charity) registered Charity number 1049224. From 2013/14, Royal Papworth Hospital has been required to produce group accounts which include the charity. Funds are still retained in the Charity which produces a separate annual report and accounts and continues to be regulated by the Charity Commission.

Royal Papworth Hospital is a founder member of Cambridge University Health Partners (CUHP). It is a strategic partnership aiming to improve patient care, patient outcomes and population health through innovation and the integration of service delivery, health research and clinical education across the Cambridgeshire region and beyond. CUHP is a not-for-profit Company Limited by Guarantee. The partners are Anglia Ruskin University (ARU), Cambridge and Peterborough NHS Foundation Trust, Cambridge University Hospitals NHS Foundation Trust, Royal Papworth Hospital NHS Foundation Trust and the University of Cambridge. Its most recent partner, Anglia Ruskin University, is the largest provider of Nursing, Midwifery, Health and Social Care students in England, and is among the UK's leading universities for degree apprenticeship provision, working with hundreds of employers across the UK. These are key strategic partners, and our joint working will ensure patients reap the benefits of the world class research, clinicians and industry which are based in Cambridge and the surrounding area.

### Our Services

Whilst Royal Papworth Hospital is a regional centre for the diagnosis and treatment of cardiothoracic disease, it is also a national centre for a range of specialist services, including heart and lung transplantation, pulmonary endarterectomy (PEA) and Extra Corporeal Membrane Oxygenation (ECMO). Royal Papworth Hospital has the largest respiratory support and sleep centre (RSSC) in the UK.

In 2024/25, the Trust continued to focus on recovery from the COVID pandemic, working in partnership with the local system to manage of the waiting lists and making effective use of our available capacity. The Trust continued to provide regional and national support in Critical Care, ECMO and Respiratory services.

Our role within the ICS has seen us leading the development of the Shared Care Record and chairing the system Diagnostics Board. We also led the development of the system's Cardiovascular Disease Strategy. Collaborative working with Cambridge University Hospitals

(CUH) has continued, including developing a virtual ward for Royal Papworth Hospital within the CUH virtual footprint.

In 2024/2025 the hospital treated 25,144 inpatient/day cases and delivered 112,150 outpatient contacts to patients from across the UK.

Royal Papworth Hospital's services are internationally recognised and include cardiology, respiratory medicine, cardiothoracic surgery, and transplantation.

### **Royal Papworth Hospital**

Royal Papworth Hospital is located on the Cambridge Biomedical Campus and offers cutting-edge facilities for patients requiring heart and lung treatment in a bespoke building. The facilities include:

- 310 beds, with virtually all being single rooms with en-suites
- 46-bed critical care area including enhanced recovery unit
- 6 state-of-the-art theatres
- 6 catheter laboratories
- 6 inpatient wards and a 24-bed day ward
- A centrally located, ground-floor outpatient unit
- State-of-the-art diagnostic and treatment facilities

Information about the hospital can be found on the Trust's website:

<https://royalpapworth.nhs.uk/>

### **Heart and Lung Research Institute**

2022/23 saw our staff move into the Heart and Lung Research Institute which we share with the University of Cambridge. The Trust and the UoC have overseen the development of the HLRI through the joint Project Board which managed all aspects of the project including specification, construction, financial controls, equipment fit-out and building operational management arrangements. In this year work has continued with the University and partners to finalise governance structures for the HLRI and the HLRI Clinical Research Facility to ensure that it is fully enabled to deliver against the ambitions of the development.

Trust teams from research and development, and education were able to move into the new facility in April 2022 along with their university partners. This move brought teams back together from the hospital and Royal Papworth House in Huntingdon and being on site together will bring opportunity and benefits in collaboration and team working.

Our clinical research facility opened in 2022/23 and received its first research participants through the facility in March 2023. The CRF facility was registered with the Care Quality Commission in September 2022.

This marks the completion of another milestone for the Trust with this world-class facility bringing together the University's expertise in cardiovascular and respiratory science and Royal Papworth Hospital's expertise in treating heart and lung disease. The HLRI has established one of the largest concentrations of biomedical and scientific research into heart and lung disease in the UK and will mean new treatments will be created, tested and delivered all on one site. The Institute will allow for significant expansion of basic and clinical research capacity in Cambridge and will also enable the co-location of research groups that are currently dispersed across Cambridgeshire.

Diseases of the heart and lung are some of the biggest killers worldwide. Despite a growing awareness of risk factors, such as smoking and poor diet, the prevalence of such diseases is increasing. The HLRI will provide a unique opportunity to establish a world-leading centre of

excellence for heart and lung research and will be used by the Trust for research, clinical trials and education facilities.

### **Recruitment and Research Activity**

During 2024/25 we enrolled 2,205 patients across a balanced portfolio of 77 studies that were open to recruitment. In addition to this recruitment activity, we managed the follow up visits for over 100 ongoing studies.

The Trust has a balanced portfolio of observational and interventional studies across a range of specialities and patient populations including bronchiectasis, Motor neurone disease, interventional cardiology, thoracic oncology, cardiac surgery, and sleep medicine. The Trust continues to sponsor a number of single and multi-centre studies. Staff across the organisation are involved in research either directly involved in the research teams or by supporting research activity.

### **Research and Development Highlights**

RPH were successful in getting 2 grants from the CRN to carry out projects aimed at increasing diversity in patients taking part in research. Multiple events were held gathering information about barriers to research. This has culminated in the creation of a Research Champion role, which will be rolled out across the Trust in 2025, where staff members will act as a link between their area and R&D, enabling them to highlight opportunities in research, as well as speak to staff and patients about the benefits of RPH being a research active organisation. Following on from this work, the RPH charity have funded a 1 year EDI Research Facilitator post to bed in the work that has been started.

Patient and public involvement in research has increased during 2024/25 with PPI representatives joining the Tissue Bank Operational Group and the Research Governance approval meeting to give valuable lay input on projects as they are being reviewed.

RPH continues to have a diverse portfolio of commercial and non-commercial studies. We have seen a significant increase in the number of early phase studies that are active in the Trust, many supported by the VPD-HLRI Clinical Research facility.

In collaboration with the UoC, the Trust have purchased a Xenon polariser (with a grant from the NIHR) which will allow research to be undertaken offering imaging capabilities that are not available through any other methods. As such it is unique in providing detailed functional biomarkers in airway, interstitial and pulmonary vascular diseases improving our understanding of the pathophysiology and impact of treatments. This will open up important avenues of research for the region as it will be the first Xenon hyperpolariser in the East of England, and the fourth in the UK.

The European Cystic Fibrosis Society-Clinical Trial Network (ECFS-CTN) recently released their annual report which shows RPH as consistently in the high tertile of European centres for numbers of studies enrolling patients and numbers of patients recruited. Impressively, over 10% of the RPH CF population were enrolled in clinical studies over the 12 months.

The Royal Papworth Charity supported Innovation Fund had its highest number of applications this year (22) of which 7 were funded, both clinical and non-clinical projects. Of note, is that 5 out of the 7 successful applicants were non-medics, highlighting the progress the Trust is making in supporting research for all staff.

### **Research Impact and Publications**

Over 239 papers with Royal Papworth Hospital authors were published during 2024/25 across a breadth of clinical disciplines and published in a range of journals, reflecting a sustained commitment to publishing data and knowledge from the Trust.

The Trust remains committed to improving patient outcomes by undertaking clinical research that will lead to better treatments in the NHS. We would like to say thank you to all those who participated in our research over the past year.

### **Royal Papworth Hospital Charity**

Royal Papworth Hospital NHS Foundation Trust is the Corporate Trustee of Royal Papworth Hospital Charity (Registered Charity Number: 1049224). The Corporate Trustee of Royal Papworth Charity via the Trustee Board has complied with the duty in Section 17 of the Charities Act 2011 and has paid due regard to Charity Commission guidance on public benefit in deciding what activities the Charity should undertake.

In 2024 – 2025, our Charity supporters helped us raise £1.3m. This allowed us to award 283 grants with a value of £1.3m. Grants that support the hospital in a variety of ways including, purchase of medical equipment, patient support services, staff training and education and research and welfare initiatives.

The Charity welcomed new members of the staff to the team this year. Krystyna Grant joined us as our new Managing Director alongside Shelley Green, Fundraising and Stewardship Manager, Jeanette Threadgold, Communications Officer, Zoe Noyes, Community Fundraiser and Fionn Cremin, Head of Philanthropy. The team expansion will allow the Charity to identify new fundraising initiatives, help grow and strengthen our brand reputation and develop new ways to engage our donors.

The Charity has had a wonderful year from April 2024 to March 2025, most notably running the Christmas appeal “Bringing Families Closer Together”. The appeal which culminated in a well-attended Carol Concert with carols performed by The Balsham Singers, requested donations to help pay for family members to stay in local accommodation whilst loved ones are being treated at the hospital. The month-long appeal raised £7k and featured Matt who spent eight-months waiting for his successful heart transplant. Matt’s wife spent eight months travelling from Brighton to Cambridge every weekend to be with her husband. When she had annual leave from work, our Charity was able to alleviate the strain Lucy was under, by paying for a five-night stay in Pemberton House – an on-site accommodation for relatives of patients admitted to Royal Papworth Hospital.

Throughout the year, our supporters have helped to raise over £181k taking on a range of different challenges and hosting events. We have supported them as they crossed the finish line of marathons across the country and witnessed them take on exhilarating skydives. We never cease to be amazed by what our supporters are willing to take on to raise money for our Charity. This year we have helped supporters of all ages in promoting challenges that involved completing one hundred squats a day, walking fifty miles in two days and 162km of hill running within three months. We have aided them in promoting innovative ways to raise money, including Charity days, bake sales and requesting donations instead of wedding gifts.

In March, we had forty-eight runners take part in the Cambridge Half Marathon and raise over £22,000 for our Charity.

On Blue Monday, the third Monday of January noted to be the most depressing day of the year, we held a Thankathon. The Charity team called and emailed as many of our supporters as we could to brighten up their day and say thank you for their donations and/or fundraising activities.

Our community groups and corporate partners have played a significant role in championing our cause in the past year.

North Bedfordshire Young Farmers Club held an Auction of Promises in memory of club founder Joe Bates. The auction with an impressive 77 Lots and twenty-five raffle prizes and raised over £16,000 for the Clinical Research Facility at the Heart and Lung Research Institute. The money raised will support clinical research into the cause and prevention of heart and lung diseases.

Our unique partnership with Brick Prize Draws where people can enter rolling prize draws to win their dream LEGO® model, went from strength to strength this year. We had our first-year anniversary in March and were pleased to announce that we raised over £10,500.

The Charity are continuously working hard to prepare for the future, mitigate the impact of the economic situation, and ensure we can continue to support the needs of patients and staff at the Hospital.

With this in mind, we are proud to have provided grants to Royal Papworth Hospital for various projects that support our patients and staff. Grants approved this year for projects across the hospital, including emergency accommodation for families, medical equipment, training and education courses for staff, wellbeing activities for patients, and pioneering research. The health and wellbeing of our staff is an important strategic aim of the Charity, and therefore we are committed to supporting our four staff networks who drive change and strive for a truly equitable and inclusive workplace.

The continued generosity and kindness from our supporters make a difference to the lives of patients and staff at Royal Papworth Hospital.

We invite you to explore the Charity's Annual Report and Accounts for the year ending 31 March 2025, which will be published separately and will be available on the Charity's website after they are submitted to the Charity Commission in January 2026. Come join us and be a part of the amazing work we are delivering together.

Further information on Royal Papworth Hospital Charity is available at:

[www.royalpapworthcharity.com](http://www.royalpapworthcharity.com)

### **Cambridge University Health Partners (CUHP)**

Cambridge University Health Partners (CUHP) was established as a Limited Company in 2009. It is one of eight Academic Health Science Centres in England whose mission is to improve patient healthcare by bringing together the NHS, industry and academia.

The Chair and the Chief Executive of Royal Papworth Hospital NHS Foundation Trust are ex officio Directors of CUHP, as are the Chair and Chief Executive of CUH and CPFT, the Vice-Chancellor of the University of Cambridge, the University Registrar and the Regius Professor of Physic, the Vice Chancellor and the Deputy Vice Chancellor (Research and Innovation) of Anglia Ruskin University. There are also three further Directors with both clinical and academic responsibilities, linked with the member NHS Trusts.

In April 2020 CUHP was re-designated as a National Institute for Health Research – NHS England/Improvement (NIHR-NHSE/I) Academic Health Sciences Centre (AHSC) for a further five years.

By inspiring and organising collaboration, CUHP aims to ensure patients reap the benefits of the world class research, clinicians and industry which are based in Cambridge and the surrounding area.

For more information on CUHP see <http://www.cuhp.org.uk/>

### **Trust highlights and achievements 2024/25:**

April 24	Patients, current staff and former staff were invited to a special event marking 40 years since Royal Papworth Hospital performed the first successful heart-lung transplant in Europe, in April 1984. Four patients attended the occasion, two of whom had their heart-lung transplants more than 35 years ago and are now among the longest-surviving patients in the world.
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A team at Royal Papworth Hospital perform the first ablation procedures in the UK using a new cardiac 3D mapping platform, aimed at improving patient outcomes and efficiency.

Medical Director Dr Ian Smith was appointed Interim Deputy CEO until November 2024, as cover for Tim Glenn's secondment to East Kent Hospitals University NHS Foundation Trust.

May 24 A new unit opened in the hospital, aimed at reducing the length of time patients stay in hospital after cardiac surgery. The enhanced recovery unit is for people who are predicted to be in critical care for fewer than 48 hours following their heart surgery. The unit was opened by staff and a former cardiac surgery patient.

Jun 24 The latest round of British Medical Association junior doctor strikes took place, from 27 June to 2 July.

A student who suffered a cardiac arrest while running in the Cambridge half marathon returns to Royal Papworth Hospital to thank one of the NHS consultants who saved his life. Dr Greg Mellor was one of three passing runners, all of whom were NHS employees, who stopped to perform life-saving CPR on George, who was then admitted to Royal Papworth where Dr Mellor implanted a new type of defibrillator (ICD) to protect George in future.

July 24 A man from Northampton became the first person in the UK to receive a double-lung transplant using a new machine in a technique called ex-vivo lung perfusion (EVLP). EVLP takes donated lungs which are initially considered marginally acceptable or marginally unacceptable for transplant. The lungs were reconditioned outside the body in a special machine - the XPSTM system from XVIVO – which made them suitable for donation.

The hospital's in-house stop smoking service celebrated a highly successful first year, in which two thirds of patients referred onto the programme quit smoking. From August 2023 to July 2024, 450 people were helped to quit smoking.

Aug 24 A new campaign was launched to celebrate the importance of medical breakthroughs and raise awareness about healthcare research. 'Love Research' is a collaboration between Royal Papworth Hospital NHS Foundation Trust, Cambridge University Hospitals NHS Foundation Trust and Cambridge and Peterborough NHS Foundation Trust.

Transplant patients from Royal Papworth Hospital won 49 medals at the British Transplant Games and also retained the 'best heart and lung team' trophy after a successful sporting weekend in Nottingham.

Royal Papworth Hospital was named as one of the top NHS trusts in the country for inpatient care. According to the Care Quality Commission's Adult Inpatient Survey, patients rated their overall experience as 9.2 out of 10, which placed the hospital in the top ranking compared to the average. It is the fifth year-in-a-row that the hospital has been named in the top category.

The government announced a pay deal for NHS staff, putting to an end the long-running industrial action.

- Sep 24      A new organ donation book is published, featuring contributions from a Royal Papworth surgeon and nurse. 'The Story of a Heart', by Dr Rachel Clarke, tells the real story of Max and Keira whose families campaigned for a change in the law. Consultant transplant surgeon Mr Pradeep Kaul and transplant nurse Clair Ellis were interviewed for the book, due to their role in retrieving Keira's heart for Max's transplant.
- The trust's annual meeting of members takes place, featuring presentations about the highly successful stop smoking service and the new enhanced recovery unit.
- Oct 24      Clinicians at Royal Papworth Hospital NHS Foundation Trust began using artificial intelligence technology to help deliver faster and more accurate diagnoses of strokes. AI algorithms used by the Brainomix e-Stroke system help interpret CT scans taken at Royal Papworth, providing real-time information for hospital staff and NHS colleagues delivering care at specialist stroke units nationwide.
- The Trust Board of Directors approved the outline business case (OBC) for a new electronic patient record (EPR).
- Nov 24      Royal Papworth's antimicrobial stewardship team was recognised for its excellence in achieving two key targets for antibiotic usage: 'prompt and appropriate switching of antimicrobials from intravenous to oral' and 'a 10% reduction in the use of watch/reserve antibiotics'. This means that patients at our hospital are benefitting from safer care through best practice in antibiotic usage.
- Dec 24      A national report by NHS Blood & Transplant (NHSBT) on mechanical circulatory support (MCS), which is used in patients in the UK as a bridge to heart transplantation, highlighted three major achievements at Royal Papworth Hospital. The report showed that Royal Papworth had an exceptionally rate of transplanting patients, and exceptionally high survival rates for patients on support and post-implant with a mechanical device.
- Deputy CEO Tim Glenn returned to Royal Papworth NHS Foundation Trust after 12-month secondment at East Kent Hospitals University NHS Foundation Trust.
- The annual staff awards were held at Homerton College in Cambridge, celebrating people and teams for their achievements during the past 12 months.
- The family of famous singer-songwriter, Tom Grennan, returned to Royal Papworth to thank the staff who saved his grandad's life. The family also donated signed copies of his most recent album.



- Jan 25      A month's worth of transplant activity (four heart transplants; three lung transplants) is performed in just seven days during a 'bumper' week of emergency activity.
- The trust was recognised for its continued support for ex-service personnel by receiving reaccreditation as a Veteran Aware organisation.
- Feb 25      A new respiratory outreach clinic is launched, providing specialist hospital-level care closer to people's homes.
- Teams at the hospital perform their first same-day discharge for TAVI (transcatheter aortic valve implantation). The minimally invasive procedure allows patients to undergo treatment when surgery is deemed too high risk. Patients can now benefit from being treated and discharged on the same day, avoiding the need for a stay in hospital.
- With input from two Royal Papworth hospital respiratory consultants, the NHS England national lung cancer screening programme launched in Peterborough and Huntingdon. The scheme targets current and former smokers aged between 55 to 74, with the aim of detecting cancer earlier and therefore saving lives.
- Mar 25      More than 400 people, comprising friends and family of staff, patients and members of the public, attend the hospital's second open day as part of the Cambridge Festival.
- A woman who gave birth to twins when she was in a coma being treated for Covid-19 returned to Royal Papworth to thank the NHS staff who saved her life, five years on from the start of the pandemic.

### **Cardiovascular Outcomes – NICOR 2024 report for 2021-2024**

Royal Papworth Hospital continues to contribute to the National Cardiac Audit Programme (NCAP) which aims to drive quality improvement in the design and delivery of cardiovascular services.

For the latest data period published (2024) by the national cardiac audit (NICOR), 1/4/21-31/3/24, and from our internal audit 3-year data to 31/3/24, Royal Papworth hospital performed a total of 3820 cardiac surgical procedures, with an estimated recalibrated EuroSCORE predicted mortality of 2.3% and a significantly lower actual mortality of 1.6% (95% CI 1.2-2.1%). In total, during this period (including all emergencies and cases excluded by NICOR), we performed 4298 cardiac operations with a EuroSCORE II predicted mortality of 4.8% and a significantly lower actual mortality of 2.5% (95% CI 2.0-3.0%). This is an increase in volume and improvement in patient outcome compared with the previous 3-year period that overlapped the COVID era.

National comparisons from NICOR demonstrate that we performed the third highest volume of cardiac surgery in the UK (national average 757 cases per annum), and that the majority of hospitals had not returned to pre COVID pandemic levels of activity in this period (in 22/23 the average was 85% of 19/20 activity), and this was exactly our activity. We performed the second highest volume of aortic and mitral valve surgery, and the second highest volume of emergency aortic surgery (over double the national average). For the process outcomes, our waiting times were similar to the national average in 22/23, and we had the third highest day of surgery admission rate, and average length of stay. For the morbidity outcomes we

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compared much better than average with low rates of post operative bleeding, lower than average rate of intervention for deep sternal wound infection, average stroke rate, but higher than average requirement for post operative renal support.

### **Annual Report on Cardiothoracic Organ Transplantation**

Royal Papworth Hospital is one of the UK's top-performing hospitals for heart and lung transplants, according to a report published by NHS Blood and Transplant (NHSBT) in September 2024.

According to NHSBT's Annual Report on Cardiothoracic Organ Transplantation, Royal Papworth Hospital performed more cardiothoracic transplants in 2024/25 than any other hospital in the UK. It also had the lowest decline rate for donor organs, meaning that we accept a higher proportion of organs offered for transplantation than any other UK centre.

Patients have a shorter wait for transplantation at RPH than any other UK cardiothoracic transplant centre. The median national waiting times for heart transplantation are 867 days on the routine list (RPH 185 days), The median national waiting time for lung transplantation is 537 days (RPH 267 days).

Survival after heart transplantation at RPH is excellent. National 90-day survival after adult DBD heart transplantation was 92% and ranged from 86.6% to 95.8% between centres (RPH 94%). National 1-year survival was 87.7% and ranged from 79.2% to 91.6% between centres (RPH 91.6 % risk-adjusted). National 5-year survival was 74% and ranged from 67.2% to 78.3% between centres (RPH 78.3% risk-adjusted).

Survival after lung transplantation at RPH is also excellent. National 90-day survival after adult lung transplantation was 88.7% and ranged from 84.8% to 92.1% between centres (RPH 92.1%). National 1-year survival was 80.7% and ranged from 76.6% to 86.4% between centres (RPH 81%). National 5-year survival was 58.2% and ranged from 45.3% to 67.6% between centres (RPH 54.7%).

### **Strategy and operational plans**

We launched our five-year strategy for the years 2020-25 in September 2020. This followed a re-examination of our strategy in the light of COVID-19 and whilst we recognised that this would change the way we do some things and would bring some of our plans forward, our key priorities for the future remained the same. This strategy will guide our work, as we recover from the pandemic and focus again on our core purpose: to bring tomorrow's treatments to today's patients. The strategy will help us build on our strengths, address our challenges and realise the potential of our new hospital and our exceptional staff.

Clinical excellence and innovation are at the heart of everything we do, but how we do things is just as important, and our strategy is clear about improving our staff experience and building meaningful partnerships with organisations who share common goals, as we work to deliver benefit across our system as a provider, an anchor organisation and key employer. The global pandemic reinforced the importance of our work and made us more determined to tackle the heart and lung conditions that affect so many lives.

We are excited about the opening of the Heart and Lung Research Institute, which completes our building transformation and enables the delivery of our plans for enhanced education and research over the next five years.

We know that the expertise, commitment and compassion displayed by our staff will continue to make a huge difference to patients here and across the world over the next five years.

Our strategy sets out a clear direction of travel for the future. It will guide our decisions on priorities and investments and steer the ongoing development of both services and

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partnerships. In light of the strategic context, the key questions facing us, and the direction in which we want to travel, we have defined six strategic goals that underpin our work.

**Figure 5: Strategic Goals 2020 – 2025**



The implementation of our strategy aims to ensure that Royal Papworth Hospital maintains its position as a cardiothoracic centre of international standing and supports our new state of the art hospital and research centre on the Cambridge Biomedical Campus.

We have agreed Corporate Objectives for 2022/24 that support the delivery of our strategic goals. These are set out in the table below together with the method of measurement:

### Corporate Objectives

Strategic Goal	Corporate Objectives 2022/24:
<b>1. Deliver clinical excellence</b>	<p>To deliver an excellent care, experience and outcomes for our patients, we will:</p> <ul style="list-style-type: none"> <li>• Continue to develop our Quality Strategy with a focus on embedding principles of quality improvement being key to ways of working.</li> <li>• Work with stakeholders to develop our quality ambitions for 2023-2026.</li> <li>• Utilise our programmes and partnerships to deliver an improved patient and staff digital experience and protect our services from cyber-attack threats.</li> <li>• Use our resources optimally to safely treat patients waiting for care as quickly as possible.</li> </ul>
<b>2. Grow pathways with partners</b>	<p>In order to develop services with partners and patients, we will:</p> <ul style="list-style-type: none"> <li>• Collaborate with our Integrated Care System partners (ICS) to support the delivery of our collective system plan.</li> <li>• Continue to work with commissioning partners regionally and nationally to deliver specialised services that are patient focused and seamlessly joined up with</li> </ul>

	<p>the wider health service, to offer the best possible patient outcomes and experience.</p> <ul style="list-style-type: none"> <li>• Continue to identify and invest in meaningful relationships with industry and educational partners to support the delivery of the national Life Sciences strategy.</li> </ul>
<b>3. Offer a positive staff experience</b>	<p>To ensure an open and inclusive working environment where we understand, encourage and celebrate diversity, making the NHS a place where all feel they belong and are respected, we will:</p> <ul style="list-style-type: none"> <li>• We make the wellbeing of our staff a priority.</li> <li>• Continue to implement our 'Compassionate and Collective' leadership programme to ensure that we build a positive culture that enhances staff experience and enables the delivery of high equality and safe care.</li> <li>• Ensure equitable leadership and people practices to embed equality, diversity and inclusion into everything we do.</li> </ul>
<b>4. Share and educate</b>	<p>Grow Pathways with Partners. In order to develop services with partners and patients we will:</p> <ul style="list-style-type: none"> <li>• Provide an educational environment to enable growing our own for a sustainable highly skilled workforce.</li> <li>• Respond to specialist workforce supply gaps by working with stakeholders to address.</li> <li>• Review our Strategy to develop a Royal Papworth School and identify the best way to deliver its' original objectives.</li> </ul>
<b>5. Research and innovate</b>	<p>To develop the Trust as a centre for research and development, we will:</p> <ul style="list-style-type: none"> <li>• Develop the Heart and Lung Research Institute (HLRI) opening the Clinical Research Facility and building the research study portfolio.</li> <li>• Encourage greater research involvement from staff across our many professions, supported by the Royal Papworth Hospital Charity's Research Innovation Fund.</li> <li>• Work collaboratively with research partners and industry to enable the HLRI to become a leading centre of cardiovascular research.</li> <li>• Invest in researchers and research delivery capacity to create a self-sustaining environment for clinical research.</li> <li>• Encourage greater involvement from staff across our many professions, supported by the Royal Papworth Hospital Charity's Research and Innovation Fund.</li> <li>• Apply in collaboration with the University for national funding to support new research networks in MedTech and imaging.</li> </ul>
<b>6. Achieve sustainability</b>	<p>To establish a sustainable operational and financial position, we will:</p> <ul style="list-style-type: none"> <li>• Deliver our financial and operational plan.</li> </ul>

- Improve the health of our local population as part of our ICS, by bringing our experience and expertise to system programmes of work.
- Take steps on our five-year plan to provide sustainable healthcare to our patients, in line with NHS ambitions to deliver a net zero National Health Service.

For further information on the Trust Strategy 2020-25 is published on our website:  
[Royal Papworth Hospital NHS Foundation Trust](#)

Further regulatory information about Royal Papworth Hospital NHS Foundation Trust is published at:  
<https://www.england.nhs.uk/publication/royal-papworth-hospital-nhs-foundation-trust/>

## Key issues and risks for 2024/25:

Principal Risks
<b>PR1 Workforce:</b> Failure to maintain an engaged and skilled workforce in adequate numbers to support delivery of harm free care and positive patient experience, through staff that are well supported and aligned to our shared values, behaviours and purpose.
<b>PR2 Productivity:</b> Failure to achieve sufficient patient throughput to support timely and equitable access to care, and achieve financial stability, through optimising the productivity of our people and facilities.
<b>PR3 Finances:</b> Failure to deliver our financial plan on a sustainable basis and deliver our contribution to the wider system through rigorous financial management and an effective response to uncertainties in the future mechanisms for commissioning and innovation in specialised services.
<b>PR4 Cyber security and data loss:</b> Failure to prioritise cyber resilience through the implementation of up-to-date cyber security controls, training, surveillance, risk management, business continuity and recovery planning increases the risk of a major cyber event causing data loss, key system failure, and prolonged disruption to services.

We recognise the importance of a positive staff experience to everything that we aspire to deliver. This year we have attempted to address the discrepancy between the world class experience of our patients and what our staff have told us it feels like to work here in the wake of a monumental pandemic response. This year's staff survey results and our recent workforce metrics have begun to show signs of improvement, but this will remain a key focus for the coming year in order to continue to recruit and retain the high calibre, engaged staff that are needed to deliver our specialist services and clinical excellence, research, and innovation.

Inextricably linked to our staff experience and sense of inclusion within the organisation is the need to drive forward clinical productivity to reduce our growing waiting list. Although there has been little evidence of harm to patients waiting for our services that can be directly attributed to longer waiting times, we know because of the nature of the patients we serve that there is a higher risk of poorer outcomes for patients who wait for treatment for excessive periods of time. In the past year we have seen some improvement in theatre and cath lab utilisation and we have launched a flow programme which will optimise the use of our bed base over the coming year. The intent is to achieve productivity gains not through working our people harder and into burnout, but by unblocking the frustrating barriers they come across each day that stop them delivering the care for our patients that they desire.

When we began the year, we continued to prioritise water safety and in particular Mycobacterium Abscessus (M. Abs). M. Abs is a rare infection which can cause problems for people with specific underlying respiratory conditions or who are immunosuppressed. Over the past few years, a huge body of knowledge and understanding of the organism has been amassed and with cadence of the new governance approach to managing this issue, along with clinical practice, we have been able to assure ourselves and stakeholders that we understand how to protect our vulnerable patients.

We have also been working to address higher levels of surgical site infections in our patients since the hospital move. No specific, single cause for this has been identified but all of our teams have worked hard under the direction of the director of infection, prevention and control to put measures in place to reduce this risk to our surgical patients. We are pleased to see that this work has begun to bear fruit and we continue to monitor the effectiveness of all interventions.

We remain vigilant to the ever-present risk of malicious cyber activity. To date we have been fortunate not to be impacted but this has only been due to the diligence of our cyber security team and every member of our staff.

As an organisation, we are proud of the financial grip of our leaders as we deliver a breakeven financial position this year. However, it is recognised that the delegation of the commissioning of specialist services to Integrated Care Systems (ICS) has the potential to offer both risk and opportunity. In the East of England region, it has been decided that the Bedford and Milton Keynes Integrated Care system will host the commissioning of these services on behalf of all systems in the region and it is anticipated that commissioning arrangements will operate in shadow form for the first twelve months. The late publication of operational planning guidance for the year 2024 – 2025 may pose a more material risk for the coming year as funding arrangements for patients accessing regional and national services from outside the Cambridge and Peterborough ICS have yet to be finalised.

Finally, we continue to work closely with our system partners, actively collaborating and supporting with mutual aid where possible, in the best interests of all of the citizens of Cambridge and Peterborough. In particular, a programme of work is underway to streamline patient pathways between Royal Papworth Hospital and our campus partners Addenbrooke's. There is a perception amongst clinical staff that the management of patients on two separate electronic patient records (EPR) is a material barrier to this. We will be looking to address effective flows of patient information between clinical settings in the procurement of our next EPR, a project which has been initiated and which should be concluded by 2027.

Further information on the principal risks to the Trust and the mitigations, and internal control processes are included in the Annual Governance Statement (AGS) section of the Annual Report.

Other factors not set out within this summary could also impact on the trust and accordingly, this summary should not be considered to represent an exhaustive list of all the potential risks and uncertainties, both positive and negative that may affect the trust.

### **Going Concern**

There is no presumption of going concern status for NHS foundation trusts. Directors must decide each year whether or not it is appropriate for the NHS foundation trust to prepare its accounts on the going concern basis, taking into account best estimates of future activity and cash flows.

After making enquiries, the directors have a reasonable expectation that the services provided by Royal Papworth Hospital NHS foundation trust will continue to be provided by the public sector for the foreseeable future. For this reason, the directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual, the key driver being the continuation of services.

Further information is available in the Annual Accounts – Accounting Policies.



## 1.2 Performance Analysis

The purpose of the “Performance analysis” is to provide a detailed performance summary of how Royal Papworth Hospital measures its performance, more detailed integrated performance analysis and long-term trends. It should be noted that our performance against NHS standards continues to be affected by the pandemic with increases in waiting lists and some continued pressures from COVID related absence. Further information will be provided in our 2024/25 Quality Account.

### Meeting Specialist Healthcare Needs

In 2024/25 we continued to work closely with our system partners and are the NHS provider representative on the Integrated Care Board (ICB) which ensures that we deliver an effective contribution linked to the ICB strategy and operational delivery.

The number of patient episodes (including private patients) seen at the hospital was 137,294 (2023/24:133,887;2022/23:124,081) and the tables below provide a breakdown of this demand across our services.

### Inpatients and day cases

	2024/25	2023/24	2022/23	2021/22
Cardiology	8595	8,221	7,945	8,231
Cardiac Surgery	1969	1,673	1,704	1,712
Thoracic Surgery (including PTE)	1066	914	835	851
Respiratory Support and Sleep Centre	7051	6,557	6,128	5,649
Transplant/Ventricular Assist Devices	512	521	531	643
Thoracic Medicine	5951	5,780	3,654	3,527
<b>Total</b>	<b>25,144</b>	<b>23,666</b>	<b>20,797</b>	<b>20,613</b>

### Outpatients

	2024/25	2023/24	2022/23	2021/22
Cardiology	47,044	47,163	44,268	44,676
Cardiac Surgery	6,980	5,966	5,344	5,466
Thoracic Surgery	1,523	1,555	1,192	1,201
Respiratory Support and Sleep Centre	23,291	23,658	20,518	18,856
Transplant/Ventricular Assist Devices	3,477	3,484	3,440	3,335
Thoracic Medicine	29,835	28,395	28,522	27,587
<b>Total</b>	<b>112,150</b>	<b>110,221</b>	<b>103,284</b>	<b>101,121</b>



## Control of Infection

### MRSA bacteraemia and *C. difficile* trajectory infection rates\*

During 2024/25 there were a total of 16 cases of *Clostridioides difficile* (*C.diff*), with 15 of these being within the criteria for inclusion, (positive cases confirmed after 2 days admission or within 28 days of discharge). The number of cases was below the threshold set by UKHSA of 18. There were no outbreaks of *C diff* in 2024/25. There has been an increase in the incidence of *C Diff* regionally and nationally in 2024/25. The single room facility at RPH has been pivotal in containing the spread of *c diff* and hence the reduced incidence in comparison to other Trusts.

There were zero cases of MRSA bacteraemia for 2024/25, attaining threshold of zero as set by UKHSA.

All MRSA bacteraemia's and *C. difficile* cases are reported to our integrated ICB, and post infection reviews (PIR) for each case is completed, to review the events and identify improvement.

Goals 2022/23	Outcome 2022/23	Goals 2023/24	Outcome 2023/24	Goals 2024/25	Outcome 2024/25
No MRSA bacteraemia	1 MRSA bacteraemia	No MRSA bacteraemia	2 MRSA bacteraemia	0 MRSA bacteraemia	0 MRSA bacteraemia
No more than 12 <i>C. difficile</i> .	8 cases of <i>C. difficile</i> for the year = 4 cases below the threshold.	No more than 7 <i>C. difficile</i> .	19 cases of <i>C.difficile</i> for the year = 10 over threshold.	No More than 18 <i>C.difficile</i>	15 cases of <i>C.difficile</i> = 3 below the threshold.

Data Source: Mandatory Enhanced Surveillance System (MESS) and PHE Health Care Associated Infection Data Capture System. \*Please note: The figures reported in the table are the number of *C. difficile* cases and MRSA bacteraemia attributed to the Trust and added to our trajectory/ yearly threshold.

### Carbapenemase-producing Enterobacteriaceae (CPE)

Carbapenemases are enzymes that destroy carbapenem antibiotics, conferring resistance. Predominantly, they are made by a small but growing number of Enterobacteriaceae strains, in many cases, carbapenem antibiotics are our last effective defence against infections caused by multi-resistant bacteria. Many countries and specific regions of the UK now have a high reported prevalence of healthcare-associated CPE. RPH has a robust procedure in place to ensure that screening all inpatient and isolation of patients in relation to CPE is carried out to minimise the risk of spread.

During 2024/25 an CPE outbreak was declared at RPH with a total of 33 cases identified. This outbreak was managed through an incident management team response involving multidisciplinary teams. The outbreak was declared on the 01 July 2024 and most cases were identified within the first 2 weeks. IPC enhanced control measures were put in place and monitoring assurance meaning the reduction of cases was noted after 2 weeks of enhanced screening. The outbreak was stood down on the 02 October 2024, but ongoing screening continued so we could monitor the control measures remained effective. A total of 50 cases of CPE have been reported for 2024/25 with three of these cases found in clinical sites and not through screening alone.

### **Mycobacterium Abscessus**

This is a rare infection which can cause problems for people with specific underlying respiratory conditions or who are immunosuppressed. Following routine testing in 2019, we launched an investigation into some cases of patients acquiring M. abscessus.

We immediately put in place safety measures with regular reviews of their effectiveness. Since implementing these additional and robust water safety measures, alongside continued education for staff and patients, we have significantly reduced the number of M. abscessus cases. In 2024/25, three cases of M. abscessus have been identified related to our water. Enhanced governance and management remain in place with input from external stakeholders i.e. UKHSA, NHSE, CQC.

### Performance of Trust against selected metrics

Throughout 2024/25 we have continued to measure our quality performance against a number of metrics. The Table below sets out our performance against the national operational metrics identified in Appendix 3 to NHS Improvement's (NHSI's) Single Oversight Framework which are applicable to Royal Papworth Hospital.

### Operational performance Metrics

Indicator	Target pa	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	YTD actual
18 weeks Referral to Treatment (RTT)*	>92%	68.28 %	67.69%	66.84%	65.76%	65.46%	65.21%	65.45%	64.52%	63.30%	63.72%	61.79%	62.97%	62.97%
62 day wait for 1st Treatment from urgent referral	>85%	20.00 %	50.00%	100.00%	80.00%	0.00%	50.00%	33.30%	0.00%	16.70%	10.00%	66.70%	0.00%	35.56%
62 day wait for 1st Treatment from consultant upgrade	>85%	38.90 %	30.00%	69.20%	69.20%	57.90%	50.00%	38.50%	40.00%	25.00%	38.10%	26.30%	61.50%	45.38%
31 day cancer wait	>96%	96.60 %	94.10%	100.00%	100.00 %	100.00 %	100.00 %	95.80%	100.00 %	92.30%	87.80%	92.60%	93.50%	96.06%
6 week wait for diagnostic	>99%	99.43 %	99.43%	99.08%	98.64%	97.16%	95.10%	96.01%	96.95%	97.39%	95.61%	96.79%	93.61%	97.10%
Monitoring C.Diff (toxin positive)	Less than 18 pa	3	1	0	1	2	0	2	2	1	1	1	1	15
Number of patients assessed for VTE on admission	>95%	95.40 %	94.50%	93.50%	95.30%	93.10%	92.40%	94.20%	92.70%	91.60%	95.10%	93.90%	94.20%	94.20%

\*The definition of this indicator can be found in Annex 4 to the 2024/25 Quality Account (to be published by 30 June 2025).

### **Equality of Service Delivery**

We will ensure patients have access to the right care at the right time through this quality improvement work our approach will focus on addressing any equality and health inequalities for patients.

To determine its Quality Priorities for the coming year the Trust reviewed clinical performance indicators and identified a long list of improvement proposals that were considered with input from clinical teams, our Patient & Public Involvement Committee and the Quality & Risk Committee before the final priorities were selected.

Progress and achievement of goals in relation to our priorities will be reported and monitored by the Quality & Risk Committee (a Committee of the Board of Directors). Reports will also be presented to the PPI Committee and the Council of Governors.

Further information on our quality priorities is included in our 2024/25 Quality Account.

### **RTT and Waiting List Prioritisation**

In England, under the NHS Constitution, patients 'have the right to access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer a range of suitable alternative providers if this is not possible'. The NHS Constitution sets out that patients should wait no longer than 18 weeks from GP referral to treatment. The fundamental principle underpinning this is that all decisions about a patient's waiting time should be made with the patient's best clinical interests in mind and in accordance with national legally binding Referral to Treatment (RTT) Rules.

Demand has continued to increase in some services, specifically within Cardiology and Respiratory Medicine, therefore the number of patients waiting for treatment continues to increase. Restoration of elective activity is one of the highest priorities for NHS England and greater emphasis is being put on ensuring there is no unnecessary delay to non-RTT applicable pathways as well as RTT pathways.

The Trust has in place arrangements to clinically assess and prioritise patients on the RTT waiting list and undertakes regular monitoring of patients waiting for elective care and diagnostic investigations.

Standard operating procedures outline the process of continued validation and ensure the priority codes allocated against each waiting patient are accurate and up to date with clinical changes in condition. This includes defining triggers for review, escalation processes and definitions of priority codes to ensure consistency.

The Trust assures the quality of its RTT waiting time data through the validation of the patient tracking list (PTL) which is available daily through Patient Pathway Plus (PP+) and is the validation and reporting system employed by the Trust. Patients are checked on both Lorenzo and other clinical systems to ensure that their waiting time is valid. Corrections to Lorenzo are made where required, which feed into the following day's PTL. A weekly meeting is held to discuss in detail the longer waiting patients on the PTL and this is further minuted in the Trust's weekly Access meetings.

The average Trust performance against the 18-week RTT standard through the year was 65.6% and our ability to achieve the 92% target has been hampered by higher-than-expected number of missed appointments and short notice cancellations. Several improvement programmes are in place to focus on outpatient and inpatient productivity to ensure we are maximising the use of our available resources.

## Care Quality Commission (CQC)

The last CQC inspection was undertaken in June & July 2019. The rating of the trust improved, and it received an overall rating of Outstanding. It was rated as outstanding because:

- Safe effective, caring, responsive and well-led were rated as outstanding at core service level.
- Medical care, surgery and diagnostic imaging were rated as outstanding overall.
- Critical care and outpatients were rated as good overall.
- The rating reflected the previous inspection for end-of-life care services which was rated as good overall.

The aggregated rating for well-led at core service level was outstanding and the CQC rated well-led at trust-wide level as outstanding. When aggregated with the core services, this gave a rating of outstanding for the overall trust.

This achievement is a reflection of the dedication of the staff at RPH to get it right first time and every time for the patients within their care. RPH has a commitment to work in an open and transparent way with staff and patients and takes engagement very seriously ensuring that we continuously learn and develop.

Following the 2019 inspection the Trust was given six recommendations for improvement. Progress against these was regularly monitored over the intervening time but interrupted by the pandemic when monitoring was paused. During 2022 improvement plans resulting from the recommendations continued to be monitored at a local level as business as usual.

The ratings for Royal Papworth Hospital against the five key questions used by the CQC in their inspections of services are shown in the following table:

Ratings	
Overall rating for this trust	Outstanding ☆
Are services safe?	Outstanding ☆
Are services effective?	Outstanding ☆
Are services caring?	Outstanding ☆
Are services responsive?	Outstanding ☆
Are services well-led?	Outstanding ☆

The full inspection report is available at <https://www.cqc.org.uk/provider/RGM/reports>

## Heart Lung Research Institute (HLRI)

CQC registration of the HLRI was successfully achieved in September 2019.

All patients attending the unit will be taking part in clinical Trials that have full regulatory approvals and are consented and recruited to in accordance with the approved protocol.

## Patient Safety Incident Trends and Actions

There were 3160 patient safety incidents and near misses reported on the Trust's incident management system (Datix) that occurred in the financial year 2024/25. This is within our expected variations for incidents reported in year and 74 more than last year when 3086 were reported. There continues to be a healthy safety culture within the Trust and an understanding

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of the importance of learning from incidents and the CQC requirements to report all incidents under the Safe Domain.

Those graded as near miss, no/low harm over the last 12 months (99%) demonstrate a continuous readiness to report and learn from all types of incidents. The Trust culture ensures staff report incidents to demonstrate an open and fair culture of learning. This process also captures the clinical consideration given to all types of incidents.

Further information on patient safety incident trends and actions can be found in our 2024/25 Quality Account.

### 2024 National Adult Inpatient Survey

The national adult inpatient survey looks at the experiences of adults who have been an inpatient at NHS hospitals at least once in the 6 months to August 2024. The survey report will be published in August 2025.

The report on the results of the 2023 national adult inpatient survey was published in August 2024 and indicated that for the fifth consecutive year, the Royal Papworth Hospital was one of the top NHS Trusts in the country for inpatient care. On average, patients rated their overall experience of the hospital as 9.2 out of 10.

Further information on the national adult inpatient surveys can be found in our 2024/25 Quality Account.

### Oncology/62-day cancer waits

Like all other hospital trusts, Royal Papworth Hospital is expected to treat 85% of patients referred on a 'fast track' pathway with suspected lung cancer within 62 days of referral. As Royal Papworth only treats lung cancer and is never the first hospital on a patient's pathway the achievement of the 85% single cancer site-specific target continued to be challenging and in 2024/25 this standard was not achieved. In year, the Trust performance has been hampered by a combination of late referrals, patients needing more than one diagnostic and discussion in the MDT and capacity within surgery. Throughout 2024/25, the Trust has continued to work with partners to identify and address delays overseen by the Cancer Transformation Board. Small improvements have been made to the patient pathway, however, has had limited impact on achieving the 62-day cancer standard.

In line with the national priorities for 2025/26, a trajectory has been developed aiming to treat 75% of patients referred within 62 days of referral.

### Financial Review 2024/25

This part of the Annual Report provides a review of the financial performance for the year ending 31 March 2025.

#### Summary of financial performance

As at 31 March 2025, the Trust had delivered the following performance:

	Plan	Year end
EBITDA *	£14.9m	£11.0m
Year-end surplus / (deficit)	(£0.9m)	(£3.2m)

\*Earnings Before Interest, Tax and Amortisation

The plan figures represent the Trust's full year plan following as part of the ICS planning submission in 2024/25.

The year-end deficit of (£3.2m) is unfavourable to plan by £2.3m. The unfavourable position is predominantly driven by the impact of PFI accounting transition to IFRS 16. This is an adverse impact of £3.2m however this is adjusted out in the Trust bottom line position to arrive at the 'adjusted financial performance' which is the measure used by NHSE to monitor performance against its breakeven requirement.

Total capital programme spend in year on Business As Usual (BAU) was £4.9m. The majority of this was spent on medical equipment as part of the Trust's planned replacement programme and IT equipment.

The end of year cash balance was £75.3m. This is an increase of £3.5m from the prior year and is driven by payments received from commissioners under the national financial framework and other one off non clinical income receipts.

	2024/25 £000
NHS England*	142,776
Cambridgeshire and Peterborough ICB**	70,810
Norfolk & Waveney ICB**	24,128
NHS Suffolk and North East Essex ICB**	28,459
NHS Bedfordshire, Luton and Milton Keynes ICB**	10,411
NHS Lincolnshire ICB**	7,335
NHS Hertfordshire and West Essex ICB**	7,800
Other ICBs**	6,621
Other NHS	3,008
<b>Subtotal</b>	<b>301,348</b>
Welsh Health Boards	934
Scottish Health Board	180
Northern Ireland Health Boards	126
Private patients	10,010
Other non-NHS	56
<b>Total revenue from patient care activities per note 2.1</b>	<b>312,654</b>

### Environmental matters

See sustainability section of Annual Report.

### Social, community and human rights matters

See Staff Report and Sustainability Report.

### Policies to Counter Fraud and Corruption

In common with all NHS organisations, Royal Papworth Hospital takes a very robust approach to fraud and bribery. Trust policies provide details of the points of contact for any members of staff who suspect fraud and bribery is taking place. The Trust has a dedicated counter fraud officer who, amongst other areas of counter fraud work, works on behalf of the Board to inform and involve staff of the Trust's anti-fraud stance as well as seeking the prevention and detection of fraud. Any concerns reported are investigated at the earliest opportunity by the Local Counter Fraud Specialist (LCFS), in conjunction with the Trust

Management. The LCFS provides reports to the Audit Committee on the concerns raised and the action taken.

#### **Operations outside of the United Kingdom (UK)**

Royal Papworth Hospital NHS Foundation Trust has no branches outside the UK.

#### **Any important events since end of the financial year affecting Royal Papworth Hospital**

There have been no important events since the end of the financial year affecting Royal Papworth Hospital.



Eilish Midlane  
Chief Executive and Accounting Officer  
25 June 2025



## 2. Accountability Report

### 2.1 Directors' Report

#### Composition of the Board

The Board consists of eight Non-executive Directors (NEDs) one of whom is the Non-executive Chair and eight Executive Directors (EDs), one of whom is the Chief Executive and one of whom is non-voting.

#### Non-executive Directors

The Council of Governors has responsibility for appointing the Chair and NEDs. One of the NEDs is a clinical representative nominated by the University of Cambridge.

#### Register of Interests

At the time of their appointment, all Directors are asked to declare any interests on the Register of Directors' Interests. There is a standing item on all Board of Directors and Committee meetings to confirm/update declarations of interest. The register is held by the Trust Secretary and updated annually or as required during the year and interests are recorded in the minutes of the Board. The register is available to the public and published on the Trust website. Anyone who wishes to see the Register of Directors' Interests should make enquiries to the Associate Director of Corporate Governance at the following address: The Associate Director of Corporate Governance, Royal Papworth Hospital, Papworth Road, Cambridge Biomedical Campus Cambridge, CB2 0AY.

#### Political Donations

No political donations have been made by Royal Papworth Hospital NHS Foundation Trust in the 2024/25 financial year. No political donations were made in previous years.

#### Cost allocation and charging

During the year 2024/25, the Trust has complied with the cost allocation and charging guidance issued by HM Treasury.

#### Better Payment Practice Code

The Better Payment Practice Code requires the Trust to aim to pay all valid invoices by the due date or within thirty days of receipt of goods or a valid invoice, whichever is later. Furthermore, the Trust has made efforts to play its part in assisting small and medium sized enterprises in these more challenging financial times through aiming to make payment within ten days where possible.

The Trust endeavours to make payments within the timescales required by the Code and aims to pay 95% of invoices within 30 days or within agreed contract terms. Performance for 2024/25 and 2023/24 is summarised in the table below. The Trust paid £ nil (2023/24 £293.16) of interest under the Late Payment of Commercial Debts (Interest) Act 1998 during 2024/25.

Better Payment Practice Code	2024/25		2023/24	
	Number	£	Number	£
Non-NHS				
Total invoices paid in year	35,156	174,336	34,246	157,820

Total invoices paid within 30 days or agreed contract terms	34,117	169,464	32,831	154,786
Percentage of invoices paid within target	97.04%	97.21%	95.90%	98.10%
<b>NHS</b>				
Total invoices paid in year	1,176	12,179	1,053	10,248
Total invoices paid within 30 days or agreed contract terms	1099	11,744	997	9,458
Percentage of invoices paid within target	93.45%	96.43%	94.70%	92.30%
<b>Total</b>				
Total invoices paid in year	36,332	186,515	35,299	168,068
Total invoices paid within 30 days or agreed contract terms	35,216	181,208	33,828	164,244
Percentage of invoices paid within target	96.93%	97.15%	95.80%	97.70%

### Income disclosure required by Section 43(2A) of the NHS Act

The income from the provision of goods and services for the purposes of the health service in England during 2024/25 was greater than the income from the provision of goods and services for any other purposes. Private patient income was £10m (£9.8m 2023/24) or 3.2% (3.5% 2023/24) of total patient income.

## Quality and Risk

We want quality improvement and continuous improvement to be our core philosophy and to be at the heart of every decision that we make. Our expertise, reputation, and network places us in a unique position to lead the way in delivering excellence in care through our cardiothoracic, respiratory and transplant services with outstanding:

- Patient experience and engagement; developing and improving our services for and with the patients who need them.
- Patient safety; with a focus on eliminating avoidable harm to patients.
- Effectiveness of care; using clear, consistent processes and standards to deliver successful treatment assessed by clinical outcome measures and the patient's experience.

### Quality Governance

The Trust has a Quality and Risk Management Group (QRMG) and as part of its framework the group ensures that it has in place a system to support the continuous improvement in the quality of care. The Group approves and monitors policies and procedures to safeguard patient care and promotes an organisational culture that encourages patients, visitors and staff to report any concerns they may have or make suggestions for improvement. The Royal Papworth Hospital NHS Foundation Trust Annual Report & Accounts 2024/25

QRMG meets every month and is chaired by the Associate Medical Director for Clinical Governance. A quarterly Quality and Risk report is published on the Trust's public website. The objective of this document is to ensure that the Trust can demonstrate a robust system for the analysis and communication of clinical governance activity across the whole organisation. This includes a systematic approach to the analysis of incidents, complaints, claims and resulting actions.

### **Approach to Quality Improvement**

The Trust intends to build quality improvement capability from novice to expert. It is recognised that progress with quality improvement capability has been affected by the pandemic. Our approach is now to re-focus taking into account the National Quality Improvement (QI) agenda, NHS Impact continuous improvement work, current QI research and National QI leadership programmes. This includes the Trust Board continued endorsement to support the ongoing Culture and Leadership Programme, which continues to build our leaders with the skills and behaviour required compassionate, collaborative and inclusive leadership.

For further information see the Quality and Risk Quarterly and Annual Reports on our web site <https://royalpapworth.nhs.uk/our-hospital/information-we-publish>

### **Commissioning for Quality and Innovation (CQUIN) framework**

In 2024/25, the NHS Payment System and the NHS Standard Contract provided a temporary pause to national CQUIN schemes. The pause had been made in respect of the national drive to focussing efforts on the recovery of services. As such, the Trust did not undertake CQUIN in 2024/25.

From 2023/24, funding associated with CQUIN (1.25% of activity income) was rolled in to tariff and paid to providers upfront via the contract. Under this model, commissioners reserved the right to reclaim a proportion of CQUIN funding in the event of non-achievement. As CQUIN schemes were suspended in 2024/25, no such reclaim could be claimed, and providers therefore retained CQUIN funding in full.

### **Royal Papworth Hospital's Quality Account Priorities 2024/25**

The Trust's Quality Priorities for 2023/24 were agreed as:

- Safe care and improvement in the management of patients with Diabetes
- To improve patient experience with nutrition and hydration
- To Improve outcomes for patients who experience delirium or have dementia

Further information will be included in the 2024/25 Quality Account.

### **Royal Papworth Hospital's Quality Account Priorities 2025/26**

To determine priorities for 2025/26 the Trust reviewed clinical performance indicators for the year and the feedback from on-going consultation with service users on the range and quality of services provided. A wide range of methods are used to gather information, including national patient surveys, real-time patient feedback from the Trust-wide patient experience data collection tool, concerns, compliments and complaints. Having identified potential priorities, the Trust consulted with clinical teams, Quality and Risk Committee and the Patient & Public Involvement Committee, which includes Governor and patient representatives, to determine our priorities for 2025/26. The priorities for 2025/26 reflect the domains of quality improvement and patient safety; clinical effectiveness and responsiveness; patient experience and well led. They are:

<b>Priority 1</b>	Waiting Lists and reducing harm for those waiting.
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<b>Priority 2</b>	Discharge Assurance
<b>Priority 3</b>	Health Inequalities and Equality and Diversity of our Patients and families/carers.

Further information will be published in the 2024/25 Quality Account.

### **NHS England's Well-Led Framework**

The NHSE Well Led Framework focuses on strong integrated governance and leadership across quality, finance and operations. In 2024/25 national priorities continued to focus on investing in our workforce, delivering more elective care, tackling backlogs and reducing waiting times to access services. In addition, we continued our focus on the health, wellbeing and safety of our staff. We recognise the need for more people, working differently in a compassionate and inclusive culture where leaders at all levels inspire, empower, and enable them to deliver high quality care in the most effective and efficient way. Our annual governance statement, corporate governance statement and Quality Account detail the Trusts approach to governance and leadership across quality, finance and operations. They detail the governance and performance framework against which the Board and leadership team assures itself that risks are appropriately identified, escalated and mitigated.

In 2019 the Trust had a CQC Well Led review and was rated as Outstanding following that review. However, we recognise that there were and are areas of improvement that we would want to focus on improving our staff engagement and Workforce Race Equality Standard measures.

In 2022 we commissioned an external review against the Well Led framework and recommendations from the review were presented to the Board in May 2022. This review identified areas of focus to help the Trust maintain its outstanding rating assessment and an action plan is in place with progress reported to the Board on a regular basis.

We have worked to embed our Values and Behaviours framework through workshops which all Board members, staff and Governors have attended. These workshops have provided an opportunity to explore the benefits of Royal Papworth's Values and Behaviours for individuals, teams and the whole organisation. This has helped us to understand how staff experiences impact patient experience, and how our Values and Behaviours can help to leverage strengths in our teams. The workshops have also brought attention to what we could be better and helped us to reflect on what we want to do differently to make our working lives even more satisfying.

The performance review cycle for the Board ensures that all Executive and Non-Executive Directors have performance reviews completed by the end of the financial year and objectives set for the coming year in line with the Corporate Objectives. These objectives are then cascaded to individual Executive Directors' teams. The performance review cycle includes gathering multisource feedback and in 2024/25 six of our directors received feedback from 89 participants providing valuable commentary and insight on their role from staff and partners across the local system.

## **Patient Experience**

### **Patient Led Assessments of the Care Environment (PLACE) Programme**

The PLACE programme is an assessment of how the environment supports patients' privacy and dignity, food, cleanliness, and general building maintenance. The report on the 2024 assessments undertaken in September 2024, was published in February 2025 and is available at:

## [Patient-Led Assessments of the Care Environment \(PLACE\), 2024 - England - NHS England Digital](#)

Further information on the PLACE Programme is included in our 2024/25 Quality Account.

### **Patient and Public Involvement**

Royal Papworth Hospital has a Patient and Public Involvement Committee (PPI) of the Council of Governors which monitors patient experience and is involved in setting the priorities for the Quality Account for the year. The Trust also has a Patient and Carer Experience Group (PCEG) with membership including patient and support group representatives and representation from Healthwatch, and they are represented on the PPI Committee.

The Trust also has strong relationships with patient support groups including:

- Norfolk Zipper Club
- Transplant Patients Group
- Transplant Sport UK
- Cardiomyopathy UK
- Mesothelioma Support Group
- Royal Papworth Hospital Pulmonary Fibrosis Support Group
- UK Transplant
- Pulmonary Hypertension Association
- Royal Papworth Pulmonary Hypertension Support Group

Further information on our patient support groups is available at:

<https://royalpapworth.nhs.uk/patients-and-visitors/pals/patient-support-groups>

Further information will be available in the 2024/25 Quality Account.

### **Listening to Patient Experience and Complaints**

Listening to the patient experience and taking action following investigation of concerns and complaints is an important part of our Quality Improvement framework and provides an opportunity for the Trust to learn from valuable patient feedback to improve the services we provide.

The patient experience team set some local goals to be achieved during the period 2024/25.

The first was to build resilience within the Patient Experience Team by improving cross-cover to ensure no loss of service during periods of staff annual leave and sickness. We have been successful in securing funding to recruit a part-time Volunteer Coordinator, and the team have some cross-cover of roles to cover core-functions of PALS, Complaints, Friends and Family testing (FFT) and Volunteer Services.

The second goal was to continue to proactively engage with service users to resolve PALS enquiries at point of contact and to provide assurance that issues are dealt with appropriately. This has been achieved with 1289 PALS enquiries being received and addressed in 2024/25 compared to 1151 enquiries recorded in 2023/24.

A third goal achieved this year was that since November 2024, our Patient Advice & Liaison Service (PALS) have been collaboratively working with the Medical Examiner's Office to ensure a seamless and more joined-up service for our bereaved families, to better support and guide them through the process following the death of their loved-one.

In 2024/25, 95 informal complaints were dealt with and resolved at a local level, compared to 127 in the 2023/24. Informal complaints are issues that the complaint has agreed that they would like to resolve through local resolution, without a formal complaint process being followed. The resolution process is a more of a personalised approach to gain resolution to the concerns raised and this is often resolved with our clinical team being involved or through our PALS support.

In 2024/25 57 complaints were received in the compared to 52 complaints in 2023/24.

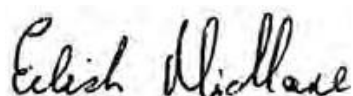
Further information on the management of patient complaints will be available in the 2024/25 Quality Account.

## Disclosures to Auditors

So far as the Directors are aware, there is no relevant audit information of which the Trust's auditor is unaware, and each Director has taken all of the steps that they ought to have taken as a Director in order to make themselves aware of any relevant audit information and to establish that the Trust's auditor is aware of that information.

The Directors' Report is presented in the name of the following directors who occupied Board positions during the year 2024/25:

Jag Ahluwalia	Chairman
Michael Blastland	Non-Executive Director
Cynthia Conquest	Non-Executive Director
Amanda Fadero	Non-Executive Director
Gavin Robert	Non-Executive Director
Ian Wilkinson	Non-Executive Director
Diane Leacock	Non-Executive Director
Charlotte Paddison	Non-Executive Director (Interim - from 01 December 2024)
Eilish Midlane	Chief Executive
Tim Glenn	Deputy Chief Executive and Executive Director of Commercial Development, Strategy and Innovation (Returned from secondment on 01 December 2024)
Sophie Harrison	Chief Finance Officer (Interim – From 05 November 2023)
Oonagh Monkhouse	Director of Workforce and Organisational Development
Maura Screaton	Chief Nurse
Ian Smith	Medical Director
Harvey McEnroe	Chief Operating Officer
Andrew Raynes	Chief Information Officer



Eilish Midlane  
Chief Executive and Accounting Officer  
25 June 2025



## 2.2 Remuneration Report

During 2024/25 the Chief Finance and Commercial Officer, who in November 2023 had gone on secondment to another NHS provider, returned on 01 December 2024 to a new role as the Deputy Chief Executive and Executive Director of Commercial Development, Strategy and Innovation. As the Deputy Chief Executive role was made a member of the Trust Board of Directors, the Associate Non-Executive Director was promoted to a full Non-Executive Director role on an interim basis. The interim promotion was undertaken to maintain the constitutionally mandated non-executive majority on the Trust Board,

These appointments, which increased the number of Trust Board members from 15 to 16, were both approved at an Extraordinary Council of Governors meeting on 14 October 2024 and ratified at a Special Members' Meeting held on 07 November 2024. The Trust Constitution was revised to reflect that the number of directors on the Trust Board had increased from 15 to 16.

The Trust has two Committees contributing to the process of remuneration of members of the Board of Directors:

- Executive Remuneration and Nominations Committee of the Board of Directors, comprising the Chair and all the Non-Executive Directors (NEDs). This Committee is responsible for Executive Director performance and remuneration;
- Appointments (NED Nomination and Remuneration) Committee of the Council of Governors, comprising elected Governors. This Committee is responsible for NED, including the Chair, performance and remuneration. It is also responsible for recommendation to the full Council of Governors on the appointment of the Chief Executive.

### Annual Statement on Remuneration from the Chair of the Executive Remuneration Committee

#### Major decisions on senior managers' remuneration

Remuneration and performance appraisal for the Trust's most senior managers (Executive Directors who are members of the Board of Directors) is determined by the Board of Director's Executive Remuneration and Nominations Committee. The only non-cash element of senior managers' remuneration packages is pension related benefits accrued under the NHS Pensions Scheme. Contributions are made by both the employer and employee in accordance with the rules of the national scheme which applies to all NHS staff in the scheme. The Trust's strategy and business planning process sets key business objectives which in turn inform individual objectives for senior managers. Performance is closely monitored and discussed through both an annual and ongoing appraisal process.

The Remuneration Committee considered executive remuneration in the light of national benchmarking data and against the national uplift that had applied to other staff groups. It took a strategic view on the requirements for executive salary, being informed by the national benchmarking, maintaining an appropriate differential from the top of the Agenda for Change (AfC) pay bands as well as considering the impact and likely views of any award on other staff groups.

Senior managers are employed on contracts of employment and are substantive employees of the Trust. Their contracts are open ended and can be terminated by either party with six months' notice. The Trust's normal disciplinary policies apply to senior managers, including the sanction of summary dismissal for gross misconduct. The Trust's redundancy policy is consistent with NHS redundancy terms for all staff and has no specific provision for any loss of office payments.

### Senior Managers' remuneration policy (Executive Directors who are Board members)

**Future Policy Table – Executive Directors:** The table below summarises each of the components of the remuneration package for senior managers which comprise the senior managers' remuneration policy.

Remuneration component	Applicable to	Jurisdiction	Relevance to Trust's long and short term objectives	Amount payable
Basic salary	All senior managers	Remuneration Committee	Recommendations in respect of basic salary are made to the Remuneration Committee by the Chief Executive (for Executive Directors) and the Chair (for the Chief Executive) on the basis of internal and external relativities, the scope of responsibilities, where appropriate performance and the annual cost of living assessment.	Any increases are agreed with reference to external benchmarks and advice as required. No Executive Director has been released for Board duties at another trust for which they have received an additional payment. <sup>5</sup>
Payments over £150,000	Two Senior Managers	Remuneration Committee. NHSI opinion sought and considered where above £150k. <sup>1</sup> National Terms and Conditions – Consultants (England) 2003	When determining salary levels, an individual's role, and experience together with independently sourced data are considered. For medical staff National terms and conditions for consultants apply.	See table 1- Remuneration to March 2023.
Pension	All senior managers	Terms of membership as specified by the NHS Pension Scheme administered by the NHS Pensions Agency	Not Applicable	Existing Executive Directors are covered by the provisions of the NHS Pension Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at <a href="http://www.nhsbsa.nhs.uk/pensions">www.nhsbsa.nhs.uk/pensions</a> .
Clinical Excellence Award Scheme	Medical Director	Determined by Local and National Awards Committees in accordance with medical employment contracts; these are not awarded by Remuneration Committee	Awards are determined by the Local and National Awards Committees in accordance with an agreed scheme that recognises clinical excellence. Analysis of the scheme demonstrates a linkage to the Trust's strategic objectives including the leadership and delivery of clinical services, teaching, training and research.	Level 9 award is the maximum that can be awarded locally.
Diversity and inclusion	All senior managers	Remuneration Committee	Delivery of the NHS Workforce Race Equality Standard aspirational goals	WRES aspirational goals in TOR and reflected in the recruitment process.

Accompanying notes:

- (1) The Remuneration Committee considered and agreed not to apply the 10% clawback to the Chief Executive appointment going forward.
- (2) There have been no other additions or changes to the components of the remuneration package paid during 2022/23.
- (3) There are no significant differences in 2022/23 between the remuneration policy for senior managers and the general policy for employees' remuneration.
- (4) The remuneration policy for 2022/23 does not include provision for performance-related bonuses or other such schemes.
- (5) There is provision for the recovery of performance sums paid to directors.



## Non-executive director remuneration policy

Element	Purpose and link to strategy	Overview
Fees	To provide an inclusive flat rate fee that is competitive with those paid by other NHS organisations of equivalent size and complexity.	The remuneration and expenses for the Trust Chair and Non-Executive Directors are determined by the Council of Governors. The procedure for determining the remuneration was revised to bring it in line with the national guidance issued by NHS England 'Structure to align remuneration for chairs and non-executive directors of NHS trusts and NHS foundation trusts' in November 2019.
Appointment		The Council of Governors appoints the Non-Executive Directors. This is usually for an initial term of office of 3 years, with the opportunity to be reappointed subject to satisfactory performance and the Council of Governors' approval.

## Terms of Office of members of the Board of Directors during 2024/25

		First Appointed	Re-appointed From	Expiry/End of Term of Office
<b>Jag Ahluwalia</b>	Chair	01 Feb 2024		31 Jan 2027
	Non-executive Director	1 Nov 2019	1 Nov 2022	
<b>Harvey McEnroe</b>	Chief Operating Officer	01 April 2023	Not Applicable	6 month notice period
<b>Michael Blastland</b>	Non-executive Director	22 Mar 2019	1 April 2022	31 Mar 2025
<b>Cynthia Conquest</b>	Non-executive Director	1 Jan 2019	1 March 2021 29 Feb 2024	28 Feb 2027
<b>Amanda Fadero</b>	Non-executive Director	1 Dec 2020	30 Nov 2023	30 Nov 2026
<b>Gavin Robert</b>	Non-executive Director	1 Nov 2019	1 Nov 2022	31 Oct 2025
<b>Ian Wilkinson</b>	Non-executive Director	1 Jan 2020	1 Jan 2023	31 Dec 2025
<b>Diane Leacock</b>	Associate Non-executive Director	1 Dec 2020	1 June 2022	
	Non-executive Director	1 Feb 2024		31 Jan 2027
<b>Charlotte Paddison</b>	Associate Non-executive Director	31 Jan 2024		30 Jan 2027
	Non-executive Director (Interim)	01 Dec 2024		-
<b>Tim Glenn</b>	Chief Finance and Commercial Officer	14 April 2020	31 Oct 2023	Secondment
	Deputy Chief Executive and Executive Director of Commercial Development, Strategy and Innovation	01 Dec 2024	End of Secondment – 01 December 2024	6 month notice period
<b>Eilish Midlane</b>	Chief Executive	1 Sep 2022	Not Applicable	6 month notice period
<b>Oonagh Monkhouse</b>	Director of Workforce and OD	1 Oct 2017	Not Applicable	6 month notice period

<b>Maura Screaton</b>	Chief Nurse	1 Aug 2021	Not Applicable	6 month notice period
<b>Ian Smith</b>	Medical Director	18 Apr 2022	Not Applicable	6 month notice period
<b>Andrew Raynes (Advisory Non-Voting Member)</b>	Chief Information Officer	01 April 2018	Not Applicable	6 month notice period
<b>Sophie Harrison</b>	Chief Finance Officer (Interim)	05 Nov 2023	Not Applicable	6 month notice period

### Attendance of Non-executive Directors at Executive Remuneration Committee Meetings

Name		03/06/24	03/10/24	04/11/24	19/12/24
<b>Jag Ahluwalia</b>	Chair	✓	✓	✓	✓
<b>Michael Blastland</b>	Non-Executive Director	✓	✗	✓	✓
<b>Cynthia Conquest</b>	Non-Executive Director	✓	✓	✓	✓
<b>Amanda Fadero</b>	Non-Executive Director	✓	✓	✓	✓
<b>Diane Leacock</b>	Non-Executive Director	✓	✓	✓	✓
<b>Gavin Robert</b>	Non-Executive Director	✓	✓	✗	✓
<b>Ian Wilkinson</b>	Non-Executive Director	✓	✓	✗	✗
<b>Charlotte Paddison</b>	Non-Executive Director (Interim)	✗	✗	✗	✗

✓ Attended meeting      ✗ Apologies received      Not a member ☐

The Committee was advised by the Director of Workforce and OD

### Attendance of Governors at Appointments Committee Meetings

Governor Members	Category	23/05/24	10/10/24	12/12/24
<b>Abi Halstead (Chair and Lead Governor)</b>	Public	✓	✓	✓
<b>Trevor Collins</b>	Public	✓	✓	✓
<b>Marlene Hotchkiss</b>	Public	✓	✓	✓
<b>Chris McCorquodale</b>	Staff	✗	✓	✓
<b>Josevine McClean</b>	Staff	✓	✓	✓
<b>Clive Glazebrook</b>	Public	✓	✓	✗

✓ Attended meeting      ✗ Apologies received

The Chair, Trust Secretary and Director of Workforce and OD were in attendance at these meetings

NEDs also receive work mileage expenses. For values see the Remuneration table.

### Disclosures required by the Health and Social Care Act 2012

1 Director received expenses for 2024/2 of £1,737.76 (2023/24: 6: £5,175.32). Expenses to the value of are a reimbursement of amounts directly incurred in the performance of an individual Director's duties. In the Remuneration Report tables on remuneration for Directors, note 2 states that benefits in kind will include any taxable benefit on mileage.

Two directors received a taxable benefit in relation to lease cars, £2898.89 (2023/24: £2,390.86).

The Board consists of 16 Directors (including one non-voting Director). In year there were a total of 16 (2023/24: 17) serving Directors, one of whom returned from secondment to East Kent Hospitals University NHS Foundation Trust.

8 Governors received expenses of £1,718.25 for 2024/25 of (2023/24:£1,442.20). Expenses are a reimbursement of amounts directly incurred in the performance of an individual Governor's duties.

On 31 March 2025 the Council consisted of 27 (2024: 27) Governors, and due to changes in the year there were a total of 31 (2023/24: 32) serving Governors.

## **Remuneration Report** (Audited Information)

### **Remuneration received**

The remuneration of the Board of Directors appointed or leaving during the year is included in respect of their period of membership only. The report includes two non-voting Directors (\*) who have served in year in an advisory capacity to the Board.

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the benefit being a member of the pension scheme could provide.

The pension benefit table provides further information on the pension benefits accruing to the individual.

## Remuneration Report (Audited Information)

**Table 1: Year ended 31 March 2025 (audited information):**

Name and Title	Salary and Fees <sup>1</sup>	Taxable Benefits <sup>2</sup>	All Pension-related Benefits	Total
	(bands of £5,000)	(total to the nearest £100)	(bands of £2,500)	(bands of £5,000)
	£'000	£	£'000	£'000
Dr J Ahluwalia – Chair	45 - 50	-	-	45 - 50
Mr M Blastland – Non-executive Director (to 31 <sup>st</sup> March 2025)	10 - 15	-	-	10 - 15
Mrs C Conquest – Non-executive Director	10 - 15	-	-	10 - 15
Ms A Fadero – Non-executive Director	10 - 15	-	-	10 - 15
Ms D Leacock – Non-executive Director	10 - 15	-	-	10 - 15
Mr G Robert – Non-executive Director	10 - 15	-	-	10 - 15
Prof I Wilkinson – Non-executive Director	10 - 15	-	-	10 - 15
Mrs C Paddison – Associate Non-executive Director	10 - 15	-	-	10 - 15
Mrs E Midlane – Chief Executive <sup>10</sup>	200 - 205	-	-	200 - 205
Mrs S Harrison – Chief Finance Officer	145 - 150	-	37.5 - 40	185 - 190
Mr T Glenn – Deputy Chief Executive (from 1 <sup>st</sup> December 2024)	55 - 60	400	17.5 - 20	75 - 80
Dr I Smith – Medical Director <sup>9</sup>	290 - 295	-	-	290 - 295
Mrs O Monkhouse – Director of Workforce and OD	135 - 140	-	-	135 - 140
Mrs M Screatton – Chief Nurse	135 - 140	-	27.5 - 30	160 - 165
*Mr A Raynes (Advisory non-voting member)	135 - 140	1700	10 - 12.5	145 - 150
Mr H McEnroe – Chief Operating Officer <sup>10</sup>	135 - 140	-	-	135 - 140

### Remuneration received

The remuneration of the Board of Directors appointed or leaving during the year is included in respect of their period of membership only. The report includes a non-voting Director (\*) who has served in year in an advisory capacity to the Board.

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the benefit being a member of the pension scheme could provide.

The pension benefit table provides further information on the pension benefits accruing to the individual.

**Notes to Table**

1. Salary and other remuneration excludes the employer's pension contribution and is gross of pay charges to other NHS Trusts.
2. Taxable Benefits relate to a taxable benefit on lease cars.
3. No payments were made in respect of 'golden hellos', compensation for loss of office or for an annual/long term performance related bonus.
4. No compensation payments were made to past Executive or Non-executive Directors.
5. No Executive Director served as a Non-executive Director elsewhere.
6. No performance related remuneration was paid in 2022/23.
7. Includes a 10% non-consolidated/non pensionable element at risk of claw-back.
8. The pension-related benefit has been calculated using the information provided by NHS Pensions and the Greenbury guidance.
9. Salary and Fees are representative of the period in post and include £101,868 relating to additional clinical duties and £43,365 relating to a Clinical Excellence Award.
10. No pension payments were made during the 2024-25 financial year.

## Remuneration Report (Audited Information)

**Table 2: Year ended 31 March 2024 (audited information):**

Name and Title	Salary and Fees <sup>1</sup>	Taxable Benefits <sup>2</sup>	All Pension-related Benefits	Total
	(bands of £5,000)	(total to the nearest £100)	(bands of £2,500)	(bands of £5,000)
	£'000	£	£'000	£'000
Prof. J Wallwork – Chair (to 31 <sup>st</sup> January 2024)	35 - 40	-	-	35 - 40
Dr J Ahluwalia – Non-executive Director (to 31 <sup>st</sup> January 2024) Chair (from 1 <sup>st</sup> February 2024)	15 - 20	-	-	15 - 20
Mr M Blastland – Non-executive Director	10 - 15	-	-	10 - 15
Mrs C Conquest – Non-executive Director	10 - 15	-	-	10 - 15
Ms A Fadero – Non-executive Director	10 - 15	-	-	10 - 15
Ms D Leacock – Non-executive Director	10 - 15	-	-	10 - 15
Mr G Robert – Non-executive Director	10 - 15	-	-	10 - 15
Prof I Wilkinson – Non-executive Director	10 - 15	-	-	10 - 15
Mrs C Paddison – Associate Non-executive Director <sup>11</sup>	-	-	-	-
Mrs E Midlane – Chief Executive <sup>10</sup>	190 - 195	-	-	190 - 195
Mrs S Harrison – Chief Finance Officer (from 5 <sup>th</sup> November 2023)	55 - 60	-	12.5 - 15	70 - 75
Mr T Glenn – Chief Finance Officer (to 4 <sup>th</sup> November 2023)	80 - 85	900	55 – 57.5	135 - 140
Dr I Smith –Medical Director <sup>9</sup>	280 - 285	-	-	280 - 285
Mrs O Monkhouse – Director of Workforce and OD	125 - 130	-	-	125 - 130
Mrs M Screatton – Chief Nurse	120 - 125	-	45 – 47.5	165 - 170
*Mr A Raynes (Advisory non-voting member)	125 - 130	1500	27.5 - 30	160 - 165
Mr H McEnroe – Chief Operating Officer (from 1 <sup>st</sup> April 2023) <sup>10</sup>	125 - 130	-	142.5 -145	270 - 275

### Remuneration received

The remuneration of the Board of Directors appointed or leaving during the year is included in respect of their period of membership only. The report includes a non-voting Director (\*) who has served in year in an advisory capacity to the Board.

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the benefit being a member of the pension scheme could provide.

The pension benefit table provides further information on the pension benefits accruing to the individual.

**Notes to Table**

1. Salary and other remuneration excludes the employer's pension contribution and is gross of pay charges to other NHS Trusts.
2. Taxable Benefits relate to a taxable benefit on lease cars.
3. No payments were made in respect of 'golden hellos', compensation for loss of office or for an annual/long term performance related bonus.
4. No compensation payments were made to past Executive or Non-executive Directors.
5. No Executive Director served as a Non-executive Director elsewhere.
6. No performance related remuneration was paid in 2022/23.
7. Includes a 10% non-consolidated/non pensionable element at risk of claw-back.
8. The pension-related benefit has been calculated using the information provided by NHS Pensions and the Greenbury guidance.
9. Salary and Fees are representative of the period in post and include £126,281 relating to clinical duties and £51,799 relating to a Clinical Excellence Award.
10. No pension payments were made during the 2023-24 financial year.
11. There were no salary payments for C Paddison during the 2023-24 financial year

**Table 3: Pension Entitlements of Senior Managers 31 March 2025 (audited information):**

Name and Title	Real Increase in Pension at pension age	Real Increase in Pension Lump Sum at pension age	Total Accrued Pension at pension age at 31 March 2025	Lump Sum at pension age Related to Accrued Pension at 31 March 2025	Cash Equivalent Transfer Value at 1 April 2024	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2025
	(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)			
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Mrs E Midlane – Chief Executive	-	-	-	-	-	-	-
Mr T Glenn – Deputy Chief Executive	0 – 2.5	-	40 - 45	-	502	34	608
Mrs S Harrison – Chief Finance & Commercial Officer	2.5 - 5	-	15 - 20	-	171	17	223
Dr I Smith – Medical Director	0 – 2.5	-	95 - 100	250 - 255	118	39	193
Mrs O Monkhouse – Director of Workforce and OD	0 – 2.5	-	50 - 55	135 - 140	115	14	1258
Mr H McEnroe – Chief Operating Officer	-	-	-	-	-	-	-
Mrs M Screaton – Chief Nurse & IPC Director	2.5 - 5	-	55 - 60	155 - 160	1241	60	1442
Mr A Raynes (Advisory non-voting member)	0 – 2.5	-	30 - 35	20 - 25	482	12	558

**Notes to Table**

- 1 Non-executive Directors do not receive pensionable remuneration therefore there are no entries in respect of pensions for Non-executive Directors.
- 2 Information contained within this note is based on figures provided by the NHS Pension Agency. The Cash Equivalent Transfer Value (CETV) is the actuarially assessed capitalised value of the pension scheme benefits accumulated by a member at a particular point in time.
- 3 The benefits valued are the members' accumulated benefits and any contingent spouse's pension payable from the scheme. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.
- 4 The current inflation rate applied to pensions by the NHS Pension Agency is 6.7%.
- 5 In calculating the actuarial value of the CETV as at 31 March 2025 the NHS Pensions Agency has used factors which include the indexation of pension benefits in line with the Consumer Price Index (CPI) and not the Retail Price Index (RPI). This follows the Government announcement in July 2010 that pension benefits from 2011 will be indexed in line with CPI and not RPI. The change in inflation assumption led to a decrease in the CETV value as at 31 March 2011 compared with the CETV as at 31 March 2010.
- 6 The factors used to calculate a CETV increased on 29 October 2018. This has affected the calculation of the real increase in CETV. CETVs are calculated in accordance with SI 2008 No 1050 Occupational Pension Schemes (Transfer Values) Regulations 2008. Revised guidance was issued by HM Treasury on 26 October 2011 regarding the calculation of CETVs in public service pension schemes. Based on this guidance the NHS Pensions Agency, with effect from 8 December 2011, has used revised and updated actuarial factors produced by GAD when calculating CETVs within the NHS Pension Scheme.
- 7 There are no employers' contributions to stakeholder pensions.
- 8 E Midlane and H McEnroe were not in the pension scheme in the financial year of 2024-25 and is shown as zero in the table above.
- 9 The start date for S Harrison was 5<sup>th</sup> November 2023.
- 10 T Glenn went on secondment at East Kent Hospitals University NHS Foundation Trust between 1<sup>st</sup> April 2024 to 30<sup>th</sup> November 2024.



**Table 4: Pension Entitlements of Senior Managers 31 March 2024 (audited information):**

Name and Title	Real Increase in Pension at pension age (bands of £2,500) £'000	Real Increase in Pension Lump Sum at pension age (bands of £2,500) £'000	Total Accrued Pension at pension age at 31 March 2024 (bands of £5,000) £'000	Lump Sum at pension age Related to Accrued Pension at 31 March 2024 (bands of £5,000) £'000	Cash Equivalent Transfer Value at 1 April 2023 £'000	Real increase in Cash Equivalent Transfer Value £'000	Cash Equivalent Transfer Value at 31 March 2024 £'000
Mrs E Midlane – Chief Executive	-	-	55 - 60	120 - 125	1179	-	1179
Mr T Glenn – Chief Finance & Commercial Officer	2.5 - 5	-	35 - 40	-	287	98	502
Mrs S Harrison – Chief Finance & Commercial Officer	0 – 2.5	-	15 - 20	-	128	6	171
Dr I Smith – Medical Director	-	-	80 - 85	230 - 235	51	38	118
Mrs O Monkhouse – Director of Workforce and OD	-	27.5 - 30	45 - 50	125 - 130	926	83	1115
Mr H McEnroe – Chief Operating Officer	-	142.5 - 145	-	140 - 145	-	-	-
Mrs M Screaton – Chief Nurse & IPC Director	2.5 - 5	2.5 - 5	45 - 50	140 - 145	980	153	1241
Mr A Raynes (Advisory non-voting member)	0 – 2.5	0 – 2.5	25 – 30	20 - 25	350	81	482

**Notes to Table**

- 1 Non-executive Directors do not receive pensionable remuneration therefore there are no entries in respect of pensions for Non-executive Directors.
- 2 Information contained within this note is based on figures provided by the NHS Pension Agency. The Cash Equivalent Transfer Value (CETV) is the actuarially assessed capitalised value of the pension scheme benefits accumulated by a member at a particular point in time.
- 3 The benefits valued are the members' accumulated benefits and any contingent spouse's pension payable from the scheme. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.
- 4 The current inflation rate applied to pensions by the NHS Pension Agency is 10.1%.
- 5 In calculating the actuarial value of the CETV as at 31 March 2024 the NHS Pensions Agency has used factors which include the indexation of pension benefits in line with the Consumer Price Index (CPI) and not the Retail Price Index (RPI). This follows the Government announcement in July 2010 that pension benefits from 2011 will be indexed in line with CPI and not RPI. The change in inflation assumption led to a decrease in the CETV value as at 31 March 2011 compared with the CETV as at 31 March 2010.
- 6 The factors used to calculate a CETV increased on 29 October 2018. This has affected the calculation of the real increase in CETV. CETVs are calculated in accordance with SI 2008 No 1050 Occupational Pension Schemes (Transfer Values) Regulations 2008. Revised guidance was issued by HM Treasury on 26 October 2011 regarding the calculation of CETVs in public service pension schemes. Based on this guidance the NHS Pensions Agency, with effect from 8 December 2011, has used revised and updated actuarial factors produced by GAD when calculating CETVs within the NHS Pension Scheme.
- 7 There are no employers' contributions to stakeholder pensions.
- 8 E Midlane and H McEnroe were not in the pension scheme in the financial year of 2023-24 and is shown as zero in the table above.
- 9 The start date for S Harrison was 5<sup>th</sup> November 2023.
- 10 T Glenn went on secondment at East Kent Hospitals University NHS Foundation Trust on 4<sup>th</sup> November 2023.

- 11 The start date for H McEnroe was 1<sup>st</sup> April 2023.
- 12 H McEnroe and E Midlane were not in the pension scheme in the financial year of 2023-24.

## Fair Pay Multiple (audited information)

NHS foundation trusts are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the lower quartile, median and upper quartile remuneration of the organisation's workforce.

### Pay ratio information table

2024-25	25th percentile	Median	75th percentile
All staff remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff)	29,114	40,016	52,864
Salary component of 'all staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff)	29,114	39,974	52,809
<b>All staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff): Mid-Point of band of highest paid director</b>	11:1	7:1	6:1

2023-24	25th percentile	Median	75th percentile
All staff remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff)	27,866	39,627	50,277
Salary component of 'all staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff)	27,879	39,801	50,316
<b>All staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff): Mid-Point of band of highest paid director</b>	10:1	7:1	5:1

These ratios compare the total annual remuneration of the highest-paid director or employee in the organisation with the median remuneration of the Trust's workforce (on a full-time equivalent basis), for the 25<sup>th</sup>, 50<sup>th</sup> and 75<sup>th</sup> percentiles.

It illustrates how much more the most senior executive is paid relative to the mid-point employee, providing insight into pay equity and organisational hierarchy.

A higher ratio may suggest a steeper pay differential between executive and frontline roles, whilst a lower or reducing ratio indicates a more equitable pay structure.

Year on year change for the highest paid director has been driven by the impact on Pay award settlement in the year (2024/25), in addition to agreed consultant reform payment settlement for 2023/24, and annual pay progression.

## Percentage change in remuneration of highest paid director

2024-25	% change from previous financial year in salary and allowances	% change from previous financial year in performance pay and bonuses
Highest paid director	7%	N/A*
All employees (excluding highest paid director)	5%	N/A*

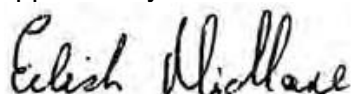
2023-24	% change from previous financial year in salary and allowances	% change from previous financial year in performance pay and bonuses
Highest paid director	8%	N/A*
All employees (excluding highest paid director)	5%	N/A*

The banded remuneration of the highest-paid director in the organisation in the financial year 2024/25 was £297,500 (2023/24, £277,500). This is a change between years of 7%. The highest-paid director salary relates the Medical Director who was appointed on the 18 April 2022. The incoming Medical Director established a more distributive model of working, with more extensive input from the Deputy and Associated Medical Directors planned to support this appointment and so has retained a higher level of clinical programmed activities including a continued on-call commitment. He also has a continuing research contribution and a higher-level national award.

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

For employees of the NHS Foundation Trust as a whole, the range of remuneration in 2024/25 was from £1,058 to £335,439 (2023/24 £13,000 to £332,599). The percentage change in average employee remuneration (based on total for all employees on an annualised basis divided by full time equivalent number of employees) between years is 5% (2023/24 – 5%). 7 employees received remuneration in excess of the highest-paid director in 2024/25 (2023/24: 5).

Approved by the Board and signed by the Chief Executive



Eilish Midlane  
Chief Executive  
25 June 2025

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## 2.3 Staff Report

### Recruitment and Retention

In 2024/25, we have seen a positive improvement in staff turnover, with sustained reductions in vacancies for both registered and unregistered nursing roles — traditionally hard-to-fill areas. Strong recruitment pipelines are now in place for nursing, enabling us to shift our focus in 2025/26 towards strengthening retention and targeting recruitment efforts on Allied Health Professional (AHP) and Healthcare Science roles, where skills shortages remain a challenge locally and nationally.

Through our Resourcing & Retention Improvement Board, we have progressed six strategic workstreams, including:

- Embedding fair and inclusive recruitment processes
- Strengthening talent management and career development
- Improving workforce data to better support managers
- Enhancing the appraisal process
- Embedding flexible working practices

A key achievement has been the development of our Trust-wide Career Pathways Programme, providing greater clarity on role expectations, required competencies, and progression opportunities for all pre-registered and registered nursing roles.

Challenges remain in managing sickness absence, with overall rates remaining high and an upward trend seen across 2023/24 and 2024/25. Sickness levels have remained stable within Registered Nursing but have increased significantly in Additional Clinical Services and Healthcare Scientist groups. Mental health continues to be the leading cause of absence, and this will remain a key focus for targeted wellbeing interventions in the year ahead.

The Trust's is currently reviewing its Strategy and the workforce strategy that was published in 2023 will be aligned to it in due course. For now we continue to work to the current strategy which set out a workplan against six domains:

1. **Compassionate and collective culture** – creating a positive, engaging working environment, developing skilled and compassionate leaders and keeping colleagues safe, healthy and well
2. **Belonging and inclusion for all** - ensuring we are an organisation where everyone is welcome, everyone is respected, everyone can grow and everyone feels their voices are heard.
3. **Developing the Workforce** - helping people to realise their true potential for the benefits of our patients, protecting us from national skill shortages and helping us be more effective and efficient than ever before.
4. **Growing the Workforce** - being a place where people want to work, where they can develop and expand their roles and careers, developing new innovative roles.
5. **Efficient and effective workforce processes** – ensuring that guidance and support for colleagues and line managers is accessible and high quality, and that our policies, processes and practices align with our values and the principles of a just culture.
6. **Working with partners** – collaborating and learning from partner organisations both in our system but also regionally and nationally.

### Staff Engagement, Consultation and Involvement

Staff engagement remains a key priority for the Trust, ensuring we create opportunities for colleagues to share their experiences, shape improvements, and feel connected to the organisation.

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Our Staff Networks continue to develop and provide an important forum for colleagues to share their perspectives, raise issues, and work collaboratively to improve the working environment. In addition, the Networks lead and support a wide range of webinars and events throughout the year, promoting learning, inclusion, and awareness. The Health and Wellbeing Collaborative has been instrumental in bringing together staff from across the Trust with a shared commitment to supporting wellbeing. This group provides a space for collaboration, sharing ideas, and co-producing initiatives that enhance the health and wellbeing offer for staff.

Effective communication remains a priority. Our weekly Staff Briefing sessions, supported by regular electronic updates, continue to attract high levels of engagement from line managers and staff across the organisation. The Chief Nursing Officer's "Message of the Week" provides a dedicated communication channel for clinical and ward-based staff, ensuring they receive key updates and information relevant to their roles.

Formal consultation and staff involvement is supported through the Joint Staff Council (JSC), which provides a structured forum for engagement with recognised Trade Unions and Professional Organisations. The inclusion of Staff Governors in JSC meetings ensures that all staff, regardless of union membership, have a voice in discussions about employment policy, organisational change, and workforce matters.

We continue to strengthen our Freedom to Speak Up (FTSU) arrangements. The growing network of Freedom to Speak Up Champions, working alongside the Trust's Freedom to Speak Up Guardian, provides accessible and trusted routes for staff to raise concerns or provide feedback. Regular reporting to the Trust Board, including quarterly FTSU reports and bimonthly staff stories at Board and Workforce Committee meetings, ensures that staff experience and feedback are visible at the highest levels of the organisation.

### Valuing Staff/Celebrating Success

Recognising and valuing the contribution of our staff remains a fundamental part of our approach to staff engagement and organisational culture. In October 2024, we were proud to host our annual Long Service Awards, recognising the dedication and commitment of colleagues who have contributed many years of service to the Trust. This was followed in December 2024 by our Royal Papworth Staff Awards Celebration, a key event which celebrated individuals and teams who have demonstrated exceptional commitment to our Trust's values and behaviours.

Throughout the year, and with the support of Royal Papworth Charity, we delivered a number of initiatives and events to thank staff for their hard work and dedication. Recognition is also embedded in our day-to-day communications. Achievements of individuals and teams are regularly shared through our weekly and monthly staff newsletters, as well as across our social media platforms, helping to foster a culture of appreciation and pride across the organisation.

The Trust Board and its Committees continue to receive regular reporting on the volume of compliments received from patients, families and colleagues, providing valuable insight into the positive impact of our staff.

The Trust's *Laudit* system has continued to grow in popularity as an easy and visible way for staff and managers to say thank you and recognise colleagues who demonstrate excellent practice or go above and beyond in their roles. To further support this, a monthly prize draw offers a small gesture of appreciation, with *Laudit* recipients selected at random to receive a gift voucher, reinforcing a culture where recognition is part of everyday working life.

### Staff Survey

Staff engagement remains a key priority for the Trust, recognising the well-established link between an engaged workforce and the delivery of safe, high-quality patient care.

Alongside participation in the annual national NHS Staff Survey, the Trust undertakes quarterly staff Pulse surveys to monitor levels of staff engagement and gather feedback on the working experience. These surveys provide valuable insight to inform our organisational development plans and help shape targeted actions to address key themes and areas for improvement.

Royal Papworth Hospital NHS Foundation Trust Annual Report & Accounts 2024/25

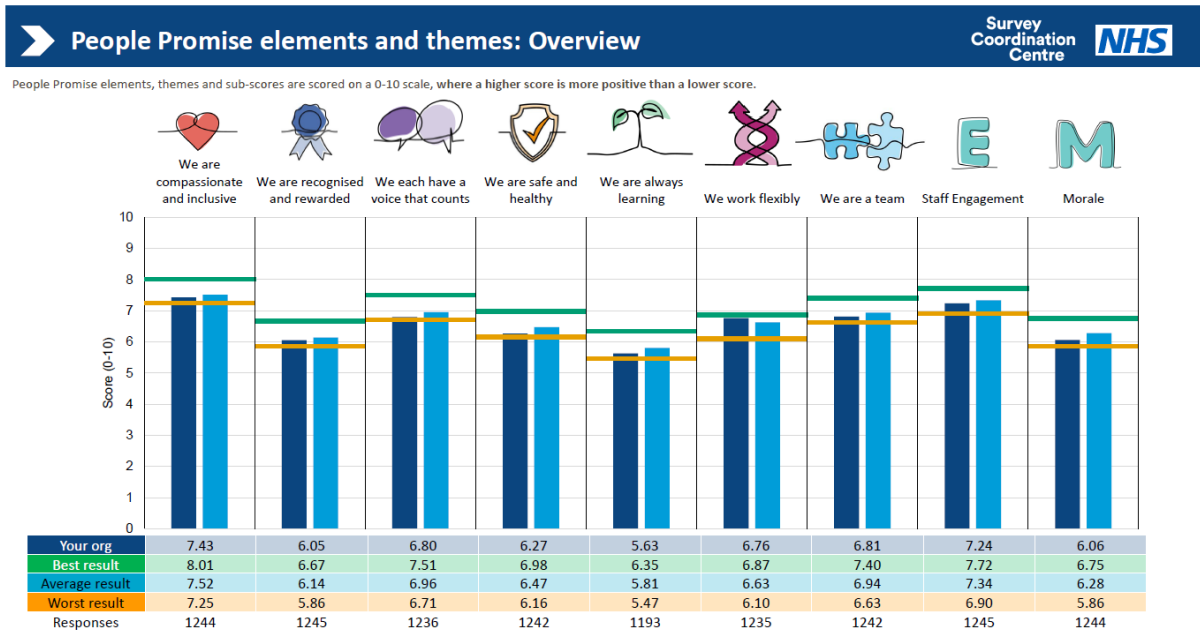
In October and November 2024, we participated in the national NHS Staff Survey, which all NHS organisations are required to complete. We achieved a response rate of 58%, an improvement on our 2024 response rate (56%) and higher than the national average for our peer group (57%). This improvement reflects the ongoing efforts across the Trust to encourage staff voice and involvement in shaping our culture and future priorities.

Our results are benchmarked against a peer group of 13 other acute specialist organisations. Data are weighted to allow for comparisons between organisations. The questions are themed to align them to the People Promise which is made up of seven elements:

- We are compassionate and inclusive
- We are recognised and rewarded
- We each have a voice that counts
- We are safe and healthy
- We are always learning
- We work flexibly
- We are a team
- Staff Engagement
- Morale

All themes are scored on a scale that ranges from 0 (worst) to 10 (best).

The chart below provides an overview of our results benchmarked against our peer group:



In 2023, the Trust saw a marked improvement in staff recommender scores — both as a place to work and as a place to receive care. This positive trend continued in 2024, with our recommender score as a place to work increasing to 70.66% and our score as a place to be treated rising to 90.8%.

While our score as a place to work remains below the peer group average of 73.34%, it reflects continued progress and our commitment to improving the working experience for all staff. Encouragingly, our score as a place to be treated remains above the peer group average of 89.44%, demonstrating the ongoing dedication of our workforce to delivering high-quality patient care.



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Three key themes were identifiable in our survey results as a focus for improvement during 25/26:

- I. Appraisal: Improving the appraisal process and its role in talent management/career progression and staff feeling valued.
- II. Staff taking personal responsibility for treating each other with respect and showing each other appreciation.
- III. Bullying and discrimination: The continuing high levels of staff reporting bullying and discrimination, from colleagues and line managers is particularly concerning particularly the differential experience between white staff and staff from a BAME background. There is for the first time a question on staff experience of unwanted behaviour of a sexual nature and the percentage of staff reporting this type of behaviour, both from patients/relatives and colleagues is higher than our peers and national results.

### **Future priorities and targets**

Following the publication of the staff survey results, detailed information packs have been shared with Divisional Managers, providing directorate-level data and insights. Divisional teams are now responsible for developing targeted action plans to address priority themes within their areas, with progress and delivery monitored through the Trust's established monthly performance review meetings.

The survey results have also been communicated more broadly to staff through our internal communication channels, including staff briefings and line manager updates. In addition, the results have been shared and discussed with our Staff Networks to ensure diverse perspectives inform local action planning.

The findings from the survey continue to shape the work of the Trust's Organisational Development team and feed into the Resourcing and Retention Improvement Programme Board. They also reaffirm the importance of key Trust-wide initiatives designed to support a positive and inclusive workplace culture, including our Reciprocal Mentoring Programme, Cultural Ambassadors network, leadership and management development programmes, and the Civility and Micro-Aggression Workshops.

### **Disability Information**

We are recognised by the Government's Department for Work and Pensions as a 'Disability Confident' employer. The 'Disability Confident' scheme aims to help employers make the most of the opportunities provided by employing disabled people.

As a Disability Confident Level 2 Confident Employer, we have committed to:

- ensure our recruitment process is inclusive and accessible.
- communicating and promoting vacancies
- offering an interview to disabled people who meet the minimum criteria for the job.
- anticipating and providing reasonable adjustments as required
- supporting any existing employee who acquires a disability or long-term health condition, enabling them to stay in work.
- at least one activity that will make a difference for disabled people.

For staff who become disabled whilst in work, either temporarily or permanently, we have proactive, supportive policies and procedures in place to enable their skills and experience to be retained within the Trust. These include the use of external organisations to undertake detailed workplace assessments and, where appropriate, to advise on specialist equipment to facilitate adjustments to working practices.



The number of staff who reported themselves as having a disability at the end of 2024/25 was 126 (5.32% of the workforce). Further information in connection with Equality and Diversity can be found in the Equality and Diversity section of the Annual Report.

The Disability and Difference Network supports the Trust with developing and implementing the Workforce Disability Equality System (WDES) action plan.

**Occupational Health Services**

Royal Papworth Hospital’s Occupational Health Service is delivered by Cambridge Health at Work (CHaW). CHaW are SEQOHS (Safe Effective Quality Occupational Health Service) accredited. They provide a full range of occupational health services to staff and are integral to the pro-active management of sickness absence and in the promotion of health and well-being initiatives.

The Trust provides a flu and Covid-19 vaccination programme for staff. Vaccination remains an important patient and staff safety measure. It was supported with a proactive communication campaign with a particular focus on providing information and reassurance to staff who had concerns about vaccination.

**Employee Assistance Programme**

Managers play a critical role in fostering a supportive and compassionate working environment, ensuring that staff feel valued and are able to access help and advice when needed. The Trust’s approach encourages managers to take proactive steps in supporting staff wellbeing, including facilitating early referral to Occupational Health services. In line with the Trust’s Management of Sickness Absence Procedure, all cases of anxiety, stress, and depression are referred to Occupational Health to ensure timely intervention, recognising that early support is key to preventing escalation and promoting recovery.

All staff have access to a comprehensive Employee Assistance Programme (EAP), provided by CiC Wellbeing from January 2025, following the conclusion of our previous contract with Health Assured. This confidential service offers staff and their immediate families access to advice and support on a wide range of issues, including mental health, financial wellbeing, and family concerns.

In addition to our EAP provision, staff are able to access a range of local and national support resources, often signposted through Occupational Health or line managers. The Trust’s Mental Health and Wellbeing Practitioner provides first-line counselling support and acts as a key coordinator of the broader suite of wellbeing services available to staff.

We continue to support a proactive network of trained Mental Health First Aiders who work alongside managers and staff to provide guidance, support, and signposting to appropriate services. The Trust also delivers regular resilience and wellbeing training sessions throughout the year, helping to equip staff with practical strategies to manage stress and maintain wellbeing both in and outside of work.

**Breakdown at the year end of the number of male and female Directors, other senior managers and employees**

We remain committed to having a diverse Board in terms of gender as well as diversity of experience, skills, knowledge, and background. There were 16 members of the Trust Board at the end of March 2025, of whom eight were male and eight were female.

	Female	Male	Total
Directors (includes Non-executive Directors)	8	8	16
Senior Managers (as per occupation codes)	22	15	37

Other Employees	1657	657	2314
Total	1687	680	2367

Notes:

1. National occupation code used to define senior managers (non-clinical).
2. Non-executive Directors are included in totals but are not defined as employees.
3. Executive Directors includes one non-voting Board member.
4. Non-Executive Directors includes one non-voting Board member.

## Sickness absence rate of staff

It is a Treasury FReM requirement that all public bodies report their sickness absence rate. This must be reported for the calendar year to allow reconciliation with already published data.

Figures Converted by DH to Best Estimates of Required Data Items			Statistics Published by NHS Digital from ESR Data Warehouse	
Average FTE for 2024	Adjusted FTE days lost to Cabinet Office definitions	Average Sick Days per FTE	FTE-Days Available	FTE-Days recorded Sickness Absence
2,103	21,799	10.4	767,761	35,364

Source: NHS Digital - Sickness Absence and Workforce Publications - based on data from the ESR Data Warehouse  
Period covered: January to December 2024  
FTE = Full Time Equivalent

2024/25 absence information can be found on line at: <https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates>

Maintaining low levels of absence and supporting the health of staff remains a key priority for the Trust. The Trust continues to work towards improving the health and wellbeing of our staff, reducing sickness absence levels and improving line manager capability, together with delivering improved patient care and outcomes

## Staff Turnover

Information on staff turnover can be found at:  
<https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics>

## Expenditure on consultancy

The expenditure on consultancy in 2024/25 was £573k (£368k 2023/24). During 2024/25 the Trust engaged Consultants to undertake work on a number of projects including: PFI matters including technical advice and independent reviews and team development programmes.

## Staff Exit Packages (audited information)

Foundation trusts are required to disclose summary information of their use of exit packages agreed in the year, as required by the FReM (paragraph 5.3.27(h)). There were no exit packages agreed in 2024/25 (2023/24: 0).

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000	-	-	-
£10,00 – £25,000	-	-	-
£25,001 – £50,000	-	-	-
£50,001 – £100,000	-	-	-
£100,000 – £150,000	-	-	-
£150,001 – £200,000	-	-	-

>£200,001	-	-	-
Total number of exit packages by type	-	-	-
Total resource cost	£0k (2023/24: £0k)	£0k (2023/24 £0k)	£0k (2023/24 £0k)

#### Exit packages: non-compulsory departure payments.

	Agreements Number	Total Value of Agreements £000
Voluntary redundancies including early retirement contractual costs	-	-
Mutually agreed resignations (MARS) contractual costs	-	-
Early retirements in the efficiency of the service contractual costs	-	-
Contractual payments in lieu of notice	-	-
Exit payments following Employment Tribunals or court orders	-	-
Non-contractual payments requiring HMT approval	-	-
<b>Total</b>	-	-
Of which: non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary	-	-

#### Reporting high paid off-payroll arrangements

**Table 1: Highly paid off-payroll worker engagements as at 31 March 2025 earning £245 per day or greater**

No. of existing engagements as of 31 March 2025	1
Of which...	0
No. that have existed for less than one year at time of reporting.	1
No. that have existed for between one and two years at time of reporting.	0
No. that have existed for between two and three years at time of reporting.	0
No. that have existed for between three and four years at time of reporting.	0
No. that have existed for four or more years at time of reporting.	0

The Trust engaged with all off-payroll contractors in light of the new IR35 arrangements to ensure an assessment of their role was undertaken and if necessary, arrangements for deducting tax and NI put in place from 6 April 2017.

**Table 2: All highly paid off-payroll workers engaged at any point during the year ended 31 March 2025 earning £245 per day or greater**

Number of off-payroll workers engaged during the year ended 31 March 2025	3
Of which:	
Not subject to off-payroll legislation *	0
Subject to off-payroll legislation and determined as in-scope of IR35 *	0
Subject to off-payroll legislation and determined as out-of-scope of IR35 *	3
Number of engagements reassessed for compliance or assurance purposes during the year	0
Of which: number of engagements that saw a change to IR35 status following review	0

**Table 3: For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 April 2024 and 31 March 2025**

Number of off-payroll engagements of board members, and/or senior officials with significant financial responsibility, during the financial year.	0
Number of individuals that have been deemed “board members and/or senior officials with significant financial responsibility” during the financial year. This figure must include both off-payroll and on-payroll engagements.	15

**Table 4: Employee Costs**

	Group			
			2024/25	2023/24
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	112,565	6,457	119,022	104,597
Social security costs	12,306	0	12,306	11,373
Employer's contributions to NHS pensions and other	12,946		12,946	11,553
Employer's contributions to NHS pensions paid by NHSE	8,424	0	8,424	5,019
Apprenticeship levy	561	0	561	513
Termination Benefit	0		0	0
Agency/contract staff	0	3,611	3,611	2,823
<b>Total gross staff costs</b>	<b>146,802</b>	<b>10,068</b>	<b>156,870</b>	<b>135,878</b>
Recoveries in respect of seconded staff	0	0	0	0
<b>Total staff costs</b>	<b>146,802</b>	<b>10,068</b>	<b>156,870</b>	<b>135,878</b>
<b>Of which</b>				
Costs capitalised as part of assets	0	0	0	0

**Table 5: Average number of employees (WTE basis – audited information)**

	Group					
	Permanent Number	Other Number	2024/25 Total Number	Permanent Number	Other Number	2023/24 Total Number
Medical and dental	271	18	289	262	14	276
Ambulance staff			0			0
Administration and estates	471	32	503	450	26	476
Healthcare assistants and other support staff	397	37	434	394	32	426
Nursing, midwifery and health visiting staff	718	36	754	665	34	699
Nursing, midwifery and health visiting learners						
Scientific, therapeutic and technical staff	193	11	204	180	10	190
Healthcare science staff	82	7	89	81	6	87
Social care staff			0			0
Other	0		0	0		0
<b>Total average numbers</b>	<b>2,274</b>	<b>142</b>	<b>2,274</b>	<b>2,032</b>	<b>122</b>	<b>2,154</b>

Of which:					
Number of employees (WTE) engaged on capital projects			0		0

## 2.4 Disclosures required under the Code of Governance for NHS Provider Trusts

### Code of Governance for NHS Provider Trusts

The new Code of Governance for NHS Provider Trusts was published on 27 October 2022 and became applicable from 1 April 2023.

#### Directors

The Board of Directors is responsible for ensuring proper standards of corporate governance are maintained. The Board, since November 2024, is made up of the Chair, seven Non-executive Directors (NEDs), and eight Executive Directors and is collectively responsible for the success of the Trust. The Board of Directors considers all of the current Non-executive Directors (NEDs), including the Chair, to be independent. All appointments to the Board are the result of open competition.

Details of the composition of the Board and the experience of the Directors are contained within the Board of Directors section of the Annual Report which also includes information about the standing Committees of the Board, the membership of those Committees, and attendance.

The Board considers strategic issues. The Board meets regularly and has a formal schedule of matters specifically reserved for its decision. The Board delegates other matters to the Executive Directors and other senior management. The Board had six formal meetings in public in 2024/25. The Chair of the Trust is Chair of the Board of Directors and Council of Governors and leads both groups on strategy and monitoring. The Chief Executive has responsibility for the implementation of strategy and the day-to-day operations of the Trust.

The Directors are given accurate, timely and clear information so that they can maintain full and effective control over strategic, financial, operational, compliance and governance issues. The Directors have a range of skills and experience, and each brings independent judgement and knowledge to the Board's discussions and determinations.

The Trust has arranged appropriate insurance cover in respect of legal proceedings and other claims against its Directors. Independent professional advice is available as required to the Board or its standing committees.

#### Board Independence

All the Non-executive Directors who have served during the year are considered to be independent according to the principles of the Code of Governance for NHS Provider Trusts. During 2009, the Trust became a partner in one of the first Academic Health Science Centres designated by the Department of Health, Cambridge University Health Partners (CUHP). The Chair and Chief Executive are members of the Board of this separate legal entity as part of their Royal Papworth roles. The Board of Directors do not consider this to affect the independence of these Directors.

Independence is kept under review and is based on whether each Director is independent in character, judgement and behaviour. Also considered are factors such as participation and performance on both the Board and Board Committees. Non-executive Directors (NEDs), including the Chair, are not NHS employees and do not contribute to the NHS pension scheme in their NED role. Non-executive Directors have confirmed their willingness to provide the necessary time for their duties. The Chair and NED terms of office are subject to approval by the Council of Royal Papworth Hospital NHS Foundation Trust Annual Report & Accounts 2024/25

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Governors. The Board is satisfied that no individual or group has unfettered powers or unequal access to information. The Board has received confirmation from all Directors that no conflicts of interest exist with their duties as Directors.

The Chair holds meetings with the Non-executive Directors without the Executive Directors being present. The Senior Independent Director (SID) also holds meetings with the other Non-executive Directors without the Chair being present.

### **Policy for Raising Matters of Concern**

Arrangements have been put in place by which the Trust's employees may in confidence raise matters of concern. These arrangements are covered in the Trust's "Freedom To Speak Up: Raising Concerns policy" commonly known as a "Whistle-blowing Policy".

### **Governors**

The general duties of the Council of Governors are:

- to hold the Non-executive Directors individually and collectively to account for the performance of the Board of Directors; and
- to represent the interests of the Trust's members as a whole and the interests of the public.

Since April 2013, the Council of Governors consists of 18 elected public members, seven elected staff members and four appointed stakeholder representatives. The Council of Governors meets formally four times a year and has a nominated Lead Governor. Details of the composition of the Council of Governors and attendance at meetings are contained within the Council of Governors section of the Annual Report.

### **Board Performance Evaluation**

The process for Board members appraisal is that the appraisal of NEDs is carried out by the Trust Chair for report to the Appointments (NED Nomination and Remuneration) Committee of the Council of Governors. The appraisal of the Chair is co-ordinated by the Senior Independent Director following the Framework for conducting annual appraisals of NHS provider chairs and the Provider Chair Competency Framework. This uses input from the Lead Governor and the Chief Executive along with input through a multisource review process. The Lead Governor is also the Chair of the Appointments Committee of the Council of Governors. Board meetings are open to the public and Governor attendance is encouraged.

During 2021/22 the Trust undertook a developmental review to assess the leadership and governance of the Trust as described in the well-led framework published by NHS England. An action plan was developed to address the recommendations from the review, and this was monitored by the Board during 2022/23. This review was undertaken by Arden & Gem CSU. Arden & Gem CSU have no other connection with the Trust.

### **Compliance Statement**

Royal Papworth Hospital NHS Foundation Trust has applied the principles of the new Code of Governance for NHS Provider Trusts on a comply or explain basis. The Code was published on 27 October 2022 and became applicable from 1 April 2023 and was based on the principles of the UK Corporate Governance Code issued in 2012.

The Board of Directors considers that it complies with the main and supporting principles of the Code of Governance. This includes the issue of whether or not all of the NEDs are independent in accordance with code provision B.2.6. In relation to the more detailed provisions of the Code of Governance, the Trust is compliant with the provisions, with the following exceptions:

**D, 2.1** The Trust Board of Directors has agreed that the Senior Independent Director continue in their role of Chair of the Audit Committee during their term of office as a Non-executive Director.

**E, 2.2** Recommendations made to the Council of Governors on remuneration levels of the Chair and other Non-executive Directors. The remuneration and expenses for the Trust Chair and Non-Executive Directors are determined by the Council of Governors. The procedure for determining

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the remuneration was revised to bring it in line with the national guidance issued by NHS England 'Structure to align remuneration for chairs and non-executive directors of NHS trusts and NHS foundation trusts' in November 2019.

**E, 2.7** The Chief Executive has determined that the definition of "senior management" for the purposes of the Remuneration Report should be limited to Board members only.

The following provisions require a supporting explanation, even in the case that the NHS Foundation Trust is compliant with the provision. Where the information is already contained within the Annual Report, a reference to its location is provided to avoid unnecessary duplication.

**Table of supporting explanation for required disclosures**

<b>Code of Governance for NHS Provider Trusts reference</b>	<b>Summary of requirement</b>	<b>Disclosure</b>
A.2.1	The board of directors should assess the basis on which the trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB, and place-based partnerships. The board of directors should ensure the trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as provider collaboratives. The trust should describe in its annual report how opportunities and risks to future sustainability have been considered and addressed, and how its governance is contributing to the delivery of its strategy.	See Annual Governance Statement
A.2.3	The board of directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the trust's vision, values and strategy, it should seek assurance that management has taken corrective action. The annual report should explain the board's activities and any action taken, and the trust's approach to investing in, rewarding and promoting the wellbeing of its workforce	See Staff Report
A.2.8	The board of directors should describe in the annual report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision-making, and set out the key partnerships for collaboration with other providers into which the trust has entered. The board of directors should keep engagement mechanisms under review so that they remain effective. The board should set out how the organisation's governance processes oversee its collaboration with other organisations and any associated risk management arrangements	See Overview of Performance – Strategy and Operational Plans
B.2.6	The board of directors should identify in the annual report each non-executive director it considers to be independent. Circumstances which are likely to impair, or could appear to impair, a non-executive director's independence include, but are not limited to, whether a director: <ul style="list-style-type: none"> <li>• has been an employee of the trust within the last two years</li> <li>• has, or has had within the last two years, a material business relationship with the trust either directly or as a partner, shareholder, director or senior employee of a body that has such a relationship with the trust</li> <li>• has received or receives remuneration from the trust apart from a director's fee, participates in the trust's performance-related pay scheme or is a member of the trust's pension scheme</li> </ul>	See earlier in this section

	<ul style="list-style-type: none"> <li>• has close family ties with any of the trust's advisers, directors or senior employees</li> <li>• holds cross-directorships or has significant links with other directors through involvement with other companies or bodies</li> <li>• has served on the trust board for more than six years from the date of their first appointment</li> <li>• is an appointed representative of the trust's university medical or dental school.</li> </ul> <p>Where any of these or other relevant circumstances apply, and the board of directors nonetheless considers that the non-executive director is independent, it needs to be clearly explained why</p>	
B.2.13	The annual report should give the number of times the board and its committees met, and individual director attendance.	See Directors' Report.
B.2.17	For foundation trusts, this schedule should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by the board, the council of governors, board committees and the types of decisions which are delegated to the executive management of the board of directors	The schedule contains a statement on separate roles. The Council of Governors and Board of Directors have an agreed interaction process that describes how disagreements would be resolved.
C.2.5	If an external consultancy is engaged, (in the recruitment of the Chair or NEDs) it should be identified in the annual report. alongside a statement about any other connection, it has with the trust or individual directors	See earlier in this section
C.2.8	The annual report should describe the process followed by the council of governors to appoint the chair and non-executive directors. The main role and responsibilities of the nominations committee should be set out in publicly available written terms of reference	See earlier in this section
C.4.2	The board of directors should include in its annual report a description of each director's skills, expertise and experience. Alongside this, in the annual report, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS foundation trust.	See Board of Directors section.
C.4.7	All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the trust or individual directors	External review 2021/22. See earlier in this section.
C.4.13	<p>The annual report should describe the work of the nominations committee(s), including:</p> <ul style="list-style-type: none"> <li>• the process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline</li> <li>• how the board has been evaluated, the nature and extent of an external evaluator's contact with the board of directors and individual directors, the outcomes and actions taken, and how these have or will influence board composition</li> <li>• the policy on diversity and inclusion including in relation to disability, its objectives and linkage to trust vision, how it has been implemented and progress on achieving the objectives</li> <li>• the ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the board reflects the ethnic diversity of the trust's workforce and communities served</li> <li>• the gender balance of senior management and their direct</li> </ul>	<ul style="list-style-type: none"> <li>• See Remuneration Report section</li> <li>• External review 2021/22. See earlier in this section.</li> <li>• See Equality and Diversity Report section</li> </ul>



	reports.	
C.5.15	Foundation trust governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied	See Membership Plans and Interaction
D.2.4	The annual report should include: <ul style="list-style-type: none"> <li>• the significant issues relating to the financial statements that the audit committee considered, and how these issues were addressed</li> <li>• an explanation of how the audit committee has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans</li> <li>• an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services</li> </ul>	See Audit Committee section
D.2.6	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy	See Director's Report
D.2.7	The board of directors should carry out a robust assessment of the trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report.	See the Annual Governance Statement
D.2.8	The board of directors should monitor the trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The board should report on internal control through the annual governance statement in the annual report.	See Audit Committee section and Annual Governance Statement.
D.2.9	In the annual accounts, the board of directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the DHSC group accounting manual and NHS foundation trust annual reporting manual which explain that this assessment should be based on whether a trust anticipates it will continue to provide its services in the public sector. As a result, material uncertainties over going concern are expected to be rare.	<ul style="list-style-type: none"> <li>• See Overview of Performance – Going Concern and</li> <li>• Annual Accounts – Accounting Policies</li> </ul>
E.2.3	Where a trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.	No Director was released in 2024/25.
Appendix B, para 2.3	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor.	See Council of Governors section.
Appendix B, para 2.15	The board of directors should state in the annual report the steps they have taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, for example through attendance at meetings of the council of governors, direct face-to-face	See Council of Governor section.

	contact, surveys of members' opinions and consultations.	
Additional requirement of FT ARM	<p>If, during the financial year, the Governors have exercised their power under paragraph 10C of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report.</p> <p>* Power to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the foundation trust's or directors' performance).</p> <p>** As inserted by section 151 (6) of the Health and Social Care Act 2012) "</p>	Governors have not exercised this power.

## 2.5 NHS Oversight Framework

### NHS Oversight Framework

NHS England's NHS Oversight Framework provides the framework for overseeing systems including providers and identifying potential support needs. NHS organisations are allocated to one of four segments.

A segmentation decision indicates the scale and general nature of support needs, from no specific support needs (segment 1) to a requirement for mandated intensive support (segment 4). A segment does not determine specific support requirements. By default, all NHS organisations are allocated to segment 2 unless the criteria for moving into another segment are met. These criteria have two components:

- a) objective and measurable eligibility criteria based on performance against the six oversight themes using the relevant oversight metrics (the themes are: quality of care, access and outcomes; people; preventing ill-health and reducing inequalities; leadership and capability; finance and use of resources; local strategic priorities)
- b) additional considerations focused on the assessment of system leadership and behaviours, and improvement capability and capacity.

An NHS foundation trust will be in segment 3 or 4 only where it has been found to be in breach or suspected breach of its licence conditions.

### Segmentation

NHS England has allocated Royal Papworth Hospital NHS Foundation Trust to Segment 1: Consistently high performing across the five national oversight themes and playing an active leadership role in supporting and driving key local place based and overall ICB priorities. *No specific support needs identified.*

The Cambridgeshire & Peterborough ICB remained in Segment 3 in 2024/25: Significant support needs against one or more of the six oversight themes. Significant gaps in the capability and capacity required to deliver on the statutory and wider responsibilities of an ICB.

This segmentation information is the Trust's position as of 12 April 2024. Current segmentation information for NHS Trusts and Foundation Trusts is published on the NHS England website: <https://www.england.nhs.uk/publication/nhs-system-oversight-framework-segmentation>.

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## 2.6 Board of Directors

### The Board of Directors

The Board's responsibilities are as follows:

- setting the overall strategic direction of the Trust, within the context of NHS priorities and taking into account views of the Council of Governors and other key stakeholders;
- to set strategic objectives;
- to provide high quality, effective and patient focused healthcare services required under its contracts with commissioners and other organisations;
- to ensure appropriate governance and performance arrangements are in place to deliver the Trust's strategic objectives;
- to ensure the quality and safety of all healthcare services, research and development, education and training;
- promoting effective dialogue between the Trust and the communities it serves;
- ensuring high standards of corporate governance and personal conduct; and
- ensuring that the Trust complies with the terms of its licence from the Regulator, its constitution, relevant legislation, mandatory guidance and other relevant obligations.

The licence from NHS England and the constitution govern the operation of the Trust. The schedule of decisions reserved for the Board and scheme of delegation set out the types of decisions that must be taken by the Board of Directors and those which can be delegated to management. The constitution defines which decisions must be taken by the Council of Governors and the standing orders of the Board of Directors describe how disagreements between the Board and the Council should be resolved.

Further information on Royal Papworth Hospital services can be obtained from our website <https://www.royalpapworth.nhs.uk/>

### Dr Jag Ahluwalia, Chair

Jag succeeded as Chair of the Trust Board of Directors in February 2024.

Jag received his undergraduate training in medicine at Cambridge and London and postgraduate training in London, East of England and Melbourne. He was appointed as a consultant neonatologist at CUHFT in 1996 where he was director of the neonatal service for many years as well as a practising clinician. Jag's leadership and management experience includes nearly 10 years as the Executive Medical Director at Cambridge University Hospitals with a portfolio including professional medical governance and leadership, executive lead for Research and Development, executive lead for Postgraduate Medical Education, lead for patient safety and Director of Infection Prevention and Control.

Jag was co-Chief Operating Officer for over three years and was Director of Digital at CUHFT between 2017 and 2019, overseeing extensive development of their IT programmes as well as chair of the Cambridgeshire and Peterborough STP digital group.

In addition to his acute hospital roles, Jag has had many years' experience leading, supporting and managing change and leadership and strategy challenges across the wider NHS. He is a highly experienced teacher and lecturer with a two-decade track record of delivering lectures and training across the fields of clinical practice, developing future clinical leaders, managing large-scale change, and implementing clinical IT systems.

Jag has consulted independently in the field of clinical governance and published over 40 articles including original research.

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Outside of the NHS, Jag is Chief Clinical Advisor at Health Innovation East, a Trustee of Macmillan Cancer Support, an Honorary Fellow of the Cambridge Judge Business School and Chair of THIS Labs, a Cambridge-based startup.

#### **Mr Michael Blastland, Non-executive Director**

Michael is a writer and broadcaster. For nearly twenty years, he was a BBC current-affairs presenter and producer, devising programmes including *More or Less* on Radio 4 – about numbers in public argument - of which he was also the first producer (with Andrew Dilnot the original presenter). He can still be heard as an occasional presenter on BBC Radio 4 and the BBC World Service. In 2022-23 he was the co-chair of a review into the impartiality of BBC coverage of fiscal policy.

He has written four books, including *The Tiger that Isn't*, a guide to numbers in the news and politics. His other books are about risk, about his son's autism, and, most recently, *The Hidden Half – How the World Conceals its Secrets*, about uncertainty.

He teaches, advises and presents widely, in schools, to business, government and academia. Current health-related roles include advisor to a large meta-analysis of the potential adverse effects of statins. He is also a board member of the Cambridge-based Winton Centre for Risk and Evidence Communication.

#### **Mrs Cynthia Conquest, Non-executive Director**

Cynthia is an experienced ex-NHS Director of Finance with a wide portfolio of NHS experience covering 46 years. She has worked in all aspects of financial services and in all types of healthcare settings: large acute teaching hospitals, specialist hospitals, mental health and community services. She has a high level of experience in all financial and healthcare processes with a specialty in financial management and transformation.

Cynthia's diverse experience includes the education sector either through charity work or paid employment as an interim or consultant and the hospice sector through her voluntary work. Cynthia was the Chair of the Audit Committee for a GP Confederation in London until January 2020 and Deputy Director of Finance and Performance at the Norfolk Community Health & Care NHS Trust until January 2021. Occasional contract work and her current appointment as a School Governor for a Pupil Referral Unit has added to her experience and diverse portfolio.

She has a master's degree in Business Administration (MBA) from Warwick University and is a Fellow Member of the professional body, the Chartered Institute of Public Finance & Accountancy (CIPFA).

#### **Mrs Amanda Fadero, Non-executive Director**

Amanda joined the Board on the 1 December 2020 having enjoyed an extensive, varied and rewarding career in the NHS for over 40 years. Her career started in London where she trained and worked as a Paediatric and general nurse, moving into senior nursing leadership and management roles before moving into general management in 1992. Amanda undertook an MBA and held a variety of senior management roles before moving into a strategic joint leadership role across the acute, community and primary care sector in 2005.

She has held a number of Executive roles including leading the commissioning system in Sussex as the Chief Executive of NHS Sussex. She has worked as part of the senior team in NHS England as the Area Director for Surrey and Sussex before returning to the provider sector in 2014 as the Deputy Chief Executive and Director of Strategy of a large University Hospitals Trust where she also acted as the Chief Executive.

Amanda possesses valuable experience in leading transformation, managing complexity, using problem solving and conflict resolution to progress and manage change. She values relationships and partnerships which she believes to be essential, supported by strong governance, rigorous assurance processes and using appreciative enquiry, to secure safe, effective and efficient services for the members of the public who require them.

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### **Mr Gavin Robert, Non-executive Director**

Gavin has many years' experience as a private practice lawyer specialising in competition law. He is currently a senior consultant with boutique competition law firm Euclid Law, and teaches competition law at Cambridge University as part of a Masters programme. Gavin was previously a Panel Member of the UK Competition & Markets Authority, where he decided complex merger, market and antitrust cases, for five years until March 2018. Before that, Gavin was a partner for 14 years with the international law firm Linklaters, advising senior executives and the boards of leading global companies and financial institutions on competition compliance and managing risk.

Gavin has an enduring interest in healthcare. He has advised global healthcare companies throughout his career, and his decisions at the UK Competition & Markets Authority included the merger of NHS Foundation Trusts.

Gavin is also Chair of REAch2 Academy Trust, the largest primary-only multi-academy trust in the country with just over 60 primary academies across England. REAch2 is dedicated to ensuring that every child is given the highest quality education that REAch2 can offer, regardless of their background, so they get the best start in life.

### **Professor Ian Wilkinson, Non-executive Director**

Ian is a Clinical Pharmacologist and Professor of Therapeutics in the University of Cambridge. He directs the Cambridge Clinical Trials Unit, and office of Translational Research, and leads the division of Experimental Medicine and Immunotherapeutics at the University of Cambridge. His main research interests are clinical/experimental studies designed to understand the mechanisms causing hypertension and cardiovascular disease, and to develop new treatments.

He is lead investigator on the Medical Research Council/British Heart Foundation (MRC/BHF)-funded Ancestry and biological Informative Markers for stratification of Hypertension (AIM HY)-INFORM trial, which will determine the most effective antihypertensive treatment for different ethnic groups in the UK, and a number of early phase trials run in collaboration with Industry partners.

Ian is the President of the British and Irish Hypertension Society (BIHS), which is the leading professional forum for hypertension and cardiovascular disease in the UK and Ireland. The BIHS delivers internationally recognised guidelines, supports clinical research, and is the authoritative voice in hypertension prevention and management.

Ian also leads the Cambridge Experimental Medicine Training Initiative which aims to create the next generation of clinical researchers to develop the medicines of the future.

### **Ms Diane Leacock, Non-Executive Director**

Diane's career has spanned several industries. She has held Finance Director roles at various commercial organisations in the information and publishing, insurance broking and legal sectors where she has streamlined, grown and transformed business units.

Diane has a keen interest in healthcare and people issues and served as a non-executive director within the NHS for several years prior to joining the board of the Royal Papworth Hospital.

Currently, Diane is a fractional Chief Financial Officer, working with growing businesses. She is also a non-executive director at Essex Partnership University NHS Foundation Trust and sits on the Board of Trustees at the East of England's award-winning contemporary visual arts gallery, Firstsite.

An Economics graduate of the University of Waterloo (Canada), Diane holds a Masters in Business Administration from Henley Business School and is a Fellow of the Association of Chartered Certified Accountants.

### **Dr Charlotte Paddison, Non-Executive Director (Interim)**

Charlotte joined Royal Papworth Hospital NHS Foundation Trust as associate non-executive director in January 2024. She brings more than a decade of experience working in senior

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leadership roles in health services research and health policy. Charlotte has experience as a public governor for a community mental health trust, Cambridgeshire and Peterborough NHS Foundation Trust, and is a member of the British Medical Association patient liaison group.

Charlotte completed her PhD in New Zealand in 2007 before taking a post-doctoral position in behavioural science at the University of Cambridge. Since 2010, much of her professional work has focused on improving patients' experiences of health and social care through academic research and policy influence. Her academic work has been published across a range of internationally leading journals in clinical medicine, behavioural science, and public health – receiving both national and international awards including the Royal College of General Practitioners Health Services and Public Health Paper of the Year (2016) for work on the primary care experiences of unpaid carers.

### **Mr Tim Glenn, Deputy Chief Executive & Director of Commercial Development, Strategy and Innovation**

Tim joined Royal Papworth Hospital as Chief Finance Officer on 14 April 2020. He was previously with Cambridge University Hospitals NHS Foundation Trust where he was Director of Finance.

Tim is a chartered accountant with 15 years' of senior financial leadership experience working across community, acute and specialist NHS organisations as well as in the private sector.

Tim took on the role of Deputy Chief Executive in 2022/23.

Tim went on secondment to East Kent Hospitals University NHS Foundation Trust on 31 October 2023 and returned to the Trust on 01 December 2024.

### **Mrs Eilish Midlane, Chief Executive**

Eilish was appointed as Chief Executive on the 1 September 2022 following a rigorous appointments process undertaken by the Board and approved by the Council of Governors.

Eilish is a strategic and system leader in the Cambridgeshire and Peterborough Integrated Care System and is a voting member of the Integrated Care Board representing NHS providers and Trusts. She is also Chair of the Cambridgeshire and Peterborough Diagnostic Board and leads the system transformation programme.

Eilish is a 'well led' Executive reviewer for NHS Trust's on behalf of the CQC and is a Director of Cambridge University Health Partners, an academic health science centre with the mission of improving patient care by bringing together the NHS, industry and academia.

Eilish has worked in the NHS for over 30 years and has considerable expertise in patient safety, clinical governance and service improvement planning. Eilish joined the Trust in April 2017 being appointed to the role of Chief Operating Officer. She had previously worked as Divisional Director of Clinical Support Services at the East and North Hertfordshire NHS Trust.

Eilish is a biomedical scientist by background and holds a wealth of experience spanning strategy, operational leadership and delivery and hospital and clinical services reconfiguration.

### **Ms Oonagh Monkhouse, Director of Workforce and Organisational Development**

Oonagh was appointed as Director of Workforce and Organisational Development in October 2017 having held the same role at Bedford Hospitals NHS Foundation Trust. Oonagh worked previously at Cambridge University Teaching Hospitals, where she undertook a number of senior human resources roles including Deputy Director of Workforce and interim Director of Workforce.

She is currently co-chair of the East of England Human Resources Director Network and in April 2023 became the Chair of the NHS Staff Council Employers side and Co-Chair of the Staff Council.

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Oonagh is originally from Northern Ireland and worked in a number of NHS organisations in Belfast before moving to Cambridge in 1993.

### **Mrs Maura Screatton, Chief Nurse**

Maura was appointed Chief Nurse at Royal Papworth Hospital NHS Foundation Trust in August 2021. Maura was previously Deputy Chief Nurse at Cambridge University Hospitals NHS Foundation Trust and has a long career in nursing having first joined Papworth in 1995 as a critical care nurse, before this she has worked in cardio thoracic nursing in London and Australia and brings a wealth of experience and leadership to her role.

Maura is the professional lead for nursing, Allied Health Professionals (AHPs) and Scientists, is the Director of Infection Prevention and Control and is the Caldicott Guardian for the Trust. She is also the executive lead for clinical quality including patient experience and patient safety, safeguarding vulnerable people including dementia services, clinical governance and risk management, and clinical education.

### **Dr Ian Smith, Medical Director**

Ian was appointed as Medical Director in April 2022, having been one of our Deputy Medical Directors, leading the Research and Development Directorate.

Ian is a chest physician specialising in ventilatory failure and sleep medicine and Director of Royal Papworth Hospital's Respiratory Support and Sleep Centre (RSSC), the first accredited by the European and British Sleep Societies.

Ian was a founder the regional Motor Neurone Disease care network and was a co-author on the recent NICE guidelines for people with MND. He is Vice Chair of the UK Association of Respiratory Technicians and Physiologists sleep section, and he co-authored the British Thoracic Society position statement on driving and sleep apnoea. He is the current President of the East Anglian Thoracic Society.

Ian is an Affiliated Associate Professor to the University of Cambridge and has held a number of key educational posts including Programme Director for respiratory medicine in East Anglia, Attachment Director for respiratory and cardiology undergraduate training and Clinical Tutor for the Royal College of Physicians. As Clinical Director of Thoracic Services he oversaw expansion in each of the subspecialties, the establishment of the Interstitial Lung Disease Service and the National Adult Ataxia Telangiectasia Service.

### **Mr Andrew Raynes, Chief Information Officer**

Andrew joined Royal Papworth Hospital NHS Foundation Trust in 2017 following his former role as IT Programme Director at Barking, Havering and Redbridge University Hospitals NHS Trust. Andrew has over 20 years' experience working in the health and private sectors, including overseas; this includes leading a number of high-profile projects such as the implementation of IT in a GP-led practice at HMP Thameside on the Belmarsh Prison Estate and the implementation of Liquidlogic, a children and adult social care system while at Leicester City Council. Andrew is a graduate of the Oxford Said Executive Leadership programme and has a Master's degree in Healthcare Informatics specialising in education. He is a former Chair of the Cambridgeshire and Peterborough Integrated Care System (ICS) Digital Enabling Group. Andrew has several publications, is a member of the National GS1 UK Health Advisory Board and is a CHIME Certified Healthcare Chief Information Officer (CHCIO), a Fellow of the British Computer Society (BCS) and Leading Practitioner in the Federation of Informatics Professionals (FedIP).

In 2021 his Digital team won the 2021 HTN Now Award for 'Rapid response to Covid19' and in 2022 Andrew was awarded one of the CIO UK 100.

Andrew is a non-voting member of the Board.

### **Mrs Sophie Harrison, Chief Finance Officer (Interim)**

Sophie became Chief Finance and Commercial Officer (interim) at Royal Papworth Hospital in November 2023, having previously been Deputy Chief Finance officer for four years.

Sophie is a chartered accountant and a member of the Institute of Chartered Accountants in England and Wales. She brings over 10 years of experience of senior financial leadership across the public sector and prior to joining Royal Papworth she held a number of roles at Monitor (now NHS England) with a focus on supporting organisations and systems to develop long term plans to ensure financial sustainability.

In her role at Royal Papworth Sophie leads on financial aspects of the Trust's work, including the development of the Trust's financial plans, financial reporting, the Trust's commercial strategy and procurement. In addition to her role at Royal Papworth, Sophie is a member of the following groups:

- the Federation of Specialist Hospitals
- the Cambridgeshire and Peterborough Integrated Care System Chief Finance Officers group
- Cambridge Biomedical Campus Strategy Group

### **Table of Attendance at Board and Committee Meetings**

The following table shows the number of Board of Director and Committee meetings held during the year and the attendance of individual Non-executive Directors (NEDs) where they were members.

	<b>Board<sup>A</sup> (Meetings in Public)</b>	<b>Audit<sup>B</sup></b>	<b>Performance<sup>C</sup></b>	<b>Quality &amp; Risk<sup>D</sup></b>	<b>Strategic Projects<sup>E</sup></b>	<b>Executive Remuneration<sup>F</sup></b>	<b>Workforce</b>
<b>Number of meetings 2024/25</b>	6	7	12	12	6	4	7
Jag Ahluwalia	6/6					4/4	
Michael Blastland	6/6	6/7		12/12		3/4	
Cynthia Conquest	5/6	7/7	12/12	1/1		4/4	
Amanda Fadero	5/6			11/12		4/4	7/7
Gavin Robert	4/6		11/12		6/6	3/4	
Ian Wilkinson	6/6			7/12	5/6	2/4	
Diane Leacock	5/6	6/7			6/6	4/4	7/7
Charlotte Paddison	6/6		9/12		5/6	0/4	5/7
Eilish Midlane	6/6	6/7	12/12	12/12	5/6	4/4	6/7
Andrew Raynes	6/6	6/7	10/12	9/12	5/6		
Harvey McEnroe	5/6	6/7	10/12		5/6		6/7
Tim Glenn (From	2/2	0/1	3/4	2/4	1/2		



December 2024) <sup>1</sup>							
Sophie Harrison	4/6	7/7	12/12		6/6		7/7
Oonagh Monkhouse	6/6	6/7	8/12	9/12	3/6	4/4	6/7
Maura Screaton	6/6	4/7	12/12	12/12	6/6		7/7
Ian Smith	6/6	4/7	12/12	11/12	6/6		6/7

<p>Not members of the Committee, however Directors attend meetings of committees of which they are not members either as regular attendees or as required.</p> <p><sup>1</sup> Part year membership of Board Committees/Trust Board of Directors</p>	<p>A All Directors are members.</p> <p>B 3 NEDs members. See Audit Committee section of Annual Report.</p> <p>C Membership 3 NEDs plus Chief Executive, Chief Finance Officer, Director of Workforce and OD and Chief Operating Officer.</p> <p>D Membership 3 NEDs plus Medical Director, Chief Nurse, Chief Executive Officer and Director of Workforce and OD.</p> <p>E Membership 3 NEDs, all Executive Directors.</p> <p>F Membership only Chair and NEDs. See Remuneration section of Annual Report.</p>
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**The dates of the Board of Directors' meetings in public in 2024/25 were:**

04 April 2024	06 June 2024	05 September 2024
07 November 2024	09 January 2025	06 March 2025

**Contacting the Directors**

Directors can be contacted through the Associate Director of Corporate Governance at the Chief Executive's Office.

Email: [papworth.corporateservices@nhs.net](mailto:papworth.corporateservices@nhs.net)

## 2.7 Audit Committee

### Composition of the Audit Committee

As required under NHS Improvement's Code of Governance for NHS Providers the membership of this Committee is three independent Non-executive Directors. For the purposes of the Code of Governance for NHS Provider Trusts, Cynthia Conquest and Diane Leacock are considered by the Board of Directors to have recent and relevant financial experience as detailed in the biographies in the Board of Directors section of this report. The membership of the Committee during 2024/25 was:

Cynthia Conquest (Chair)  
Michael Blastland  
Diane Leacock

### Meetings and Attendance of Members

Name	23.05.24	20.06.24	18.07.24	17.10.24	26.11.24	23.01.25	11.03.25
Cynthia Conquest	✓	✓	✓	✓	✓	✓	✓
Michael Blastland	✓	✗	✓	✓	✓	✓	✓
Diane Leacock	✓	✓	✓	✓	✗	✓	✓

✓ Attended meeting

✗ Apologies were received

To assist the Audit Committee in fulfilling its role the following are in attendance at all meetings: Chief Finance Officer, Associate Director of Corporate Governors, representatives from the External Auditors, representatives from the Internal Auditors and the Local Counter Fraud Specialist. Two Governors also attend the Audit Committee and contribute to discussions. Executive Directors attend during the year as business requires. Members of the Audit Committee meet separately with the External and Internal Auditors.

### Role of the Audit Committee

The Audit Committee's role is to review the adequacy of the Trust's risk and control environment, particularly in relation to:

- Internal Audit, including reports and audit plans;
- External Audit and annual financial statements; and
- Counter Fraud Services.

The Committee also receives/reviews assurance that the Trust's overall governance and assurance frameworks are robust and that there are appropriate structures, processes and responsibilities for identifying and managing key risks facing the organisation.

The Audit Committee undertook a self-assessment of its performance against its delegated responsibilities as set out in its terms of reference using the National Audit Office's Audit and Risk Assurance Committee effectiveness tool published in May 2022. The Committee, supported by the Board, has considered its role in relation to risk with that of the Quality and Risk Committee, the Performance Committee, Workforce Committee and the Strategic Projects Committee.

The conclusions of finalised Internal Audit reports are reported to the Audit Committee. The Committee can, and does, challenge assurances provided, and requests additional information, clarification or follow-up work if considered necessary. All Internal Audit reports are discussed individually with the Audit Committee. A system whereby Internal Audit recommendations are followed-up is in place. Progress towards the implementation of agreed recommendations is reported (including details of all outstanding recommendations).

The Audit Committee is responsible for considering the appointment of the Internal Audit service and Counter Fraud service and reviewing their audit fees. In 2020/21 the contract for Internal Audit and Counter Fraud services was awarded to BDO LLP for a period of three years from 1 April

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2021 till 31 March 2024. This followed a formal tendering process under the NHS Shared Business Services framework agreement: SBS/20/MA/ZY/10024.

In 2023/24 the Trust exercised an option to extend this contract for one year till 31 March 2025, and in 2024/25, the final contract extension option was exercised to extend the contract till 31 March 2026.

The Audit Committee carried out an assessment on the effectiveness of Internal Audit during 2024/25 and after looking at the evidence, the overall assessment is that the Internal Audit function and Local Counter Fraud Service performed by BDO LLP is effective. The plan is to carry this assessment on an annual basis.

The Audit Committee also reviews the External Audit service and makes recommendations to the Council of Governors on the appointment and re-appointment of the External Auditor. To aid assurance two Governors are attendees at Audit Committee.

In 2021/22 the Council of Governors reappointed KPMG LLP as the Trust's external auditors for three years from the 1 January 2022. The 3-year value of the contract for the Trust Audit is £294,000. The contract covers services for the NHS Statutory Audit and Annual Report and the Charity Annual Report and Accounts. It followed a formal tendering process under the NHS Shared Business Services framework agreement: SBS/20/MA/ZY/10024. Two Governors were members of the interview panel for the appointment of the External Auditor.

In 2024/25 the Trust exercised an option to extend this contract for one year till 31 December 2025.

### **Annual Governance Statement (AGS)**

The AGS provides information on the Trust's system of internal control and the risk and control framework. The AGS can be found in the last section of the Annual Report. Both the Audit Committee and the Quality and Risk (Q&R) Committee considered the Trust's draft AGS for 2024/25. Audit Committee members, Q&R Committee members together with the Trust's External and Internal Auditors, had the opportunity to provide comments on the draft statement. The final AGS was approved by the Audit Committee 19 June 2025 and Board of Directors on the 25 June 2025

In the opinion of the Audit Committee the AGS is fair and provides assurance to the Accounting Officer that there were no unmanaged risks to the Trust during the year.

### **Specific Audit Committee Issues – 2024/25**

During 2024/25, the Audit Committee received regular reports from Internal Auditors, External Auditors and Local Counter Fraud Specialist and reviewed their annual work plans and strategies as appropriate.

Principal matters considered were:

- The draft Annual Report and Accounts and the External Auditors' ISA 260 (including letter of representation and formal independence letter);
- The Annual Governance Statement (AGS);
- The Internal Audit Annual Report and Head of Internal Audit Opinion;
- The External Audit Plan for the Foundation Trust;
- External Audit Plan, engagement letter and ISA 260 for the Charity Annual Report and Accounts;
- Reports as required on losses and special payments, waived tender schedule and bad debts;
- The Internal Audit Plan and progress report, including log of audit actions;
- Counter Fraud Annual Report, progress report and benchmark report;
- Counter Fraud & Bribery Policy update and policy;
- Board Assurance Framework;

- Contracts for Internal Audit and Counter Fraud Services;
- Annual review of Standing Financial Instructions, Standing Orders and Scheme of Delegation;
- Reports from Committee Chairs;
- Annual review of the Audit Committee's terms of reference, Annual Self-Assessment and Committee forward Planner.
- Salary overpayments report
- Compliance with Clinical Audit Report

Information on internal audit reviews undertaken by the Internal Auditors for 2024/25 can be found in the Annual Governance Statement section of the Annual Report.

Action plans to address recommendations have been drawn up and will be subject to review as part of the Audit Committee standard review of the audit action log.

### Whistleblowing

The Trust has a Whistleblower's Procedure (Raising Issues of Concern) which explains how members of staff should raise any matters of concern which may impact adversely on the safety and/or well-being of our patients/our staff or the public at large or may be detrimental to the Trust as a whole. It is consistent with the 'Freedom to Speak Up' Report published by Sir Robert Francis QC. Any concern raised is treated seriously and investigated thoroughly. Every effort is made to ensure confidentiality and feedback is provided to the person who raised the issue. As part of the process, individuals have the right to contact our Freedom to Speak Up (FTSU) Guardian, senior officers of the Trust as listed in the procedure, an identified Executive, and Non-Executive Director lead who also has regular review meetings with the FTSU Guardian. In addition, our policy provides information on how staff can raise concerns with the CQC, NHS England and Health Education England. The Procedure is agreed with the Trust's recognised Trade Unions.

The Trust's FTSU Guardian promotes the role across the Trust meeting new starters and undertaking regular walkabouts both in the Hospital site and at Royal Papworth House. They meet regularly with the Director of Workforce, the Chief Executive Officer, and the Senior Independent Director to discuss themes emerging from concerns raised. The Guardian is required to report all concerns raised to the National Guardian's Office on a quarterly basis. In 2024/25 the Guardian has reported 156 concerns (137: 2023/24). The Trust also has 42 Freedom To Speak Up Champions, and this is now an established and effective provision. Our Champions have supported the FTSU Guardian role extending support across the organisation ensuring that staff are encouraged and know how to raise concerns. Champions are supported through a network approach maintaining regular contact including bi-monthly meetings with case study discussions. Concerns raised are responded to on an individual basis working appropriately with the input of Workforce and Governance leads as needed. Feedback on the emerging themes is provided to managers and staff to ensure that we learn from the concerns raised. This is delivered in Trust wide briefings and communications. The FTSU Guardian also links into our staff networks and has had the opportunity to engage more regularly with operational leads within the triumvirates to ensure representation of the role as well as helping staff to speak up.

### External Auditors

The External Auditors of Royal Papworth Hospital NHS Foundation Trust are: KPMG LLP (UK) 20 Station Road Cambridge CB1 2JD. They report to the Council of Governors through the Audit Committee. Non-audit work may be performed by the Trust's external auditors where the work is clearly audit-related and external auditors are best placed to do that work. For such assignments Audit Committee approval ensures that auditor objectivity and independence is safeguarded. The total cost of audit services for the year was £134,000 (2023/24: £124,950) excluding VAT. This is the fee for an audit in accordance with the National Audit Office Code of Audit Practice 2024.

As part of reviewing the content of the proposed external audit plan for each year, the Audit Committee satisfies itself that the auditors' independence has not been compromised.

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The Foundation Trust is responsible for preparing the Annual Report, the Directors' Remuneration Report and the financial statements in accordance with directions issued by the Independent Regulator of Foundation Trusts ("NHS Improvement") under the National Health Service Act 2006.

The External Auditors' accompanying opinion on the financial statements is based on their audit conducted under the National Health Service Act 2006 and in accordance with NHS Improvement's Audit Code for NHS Foundation Trusts and International Standards on Auditing (UK and Ireland) and sets out their reporting responsibilities.

## 2.8 Council of Governors

As an NHS foundation trust, Royal Papworth has a Council of Governors as required by legislation. The Council comprises 18 public and seven staff members, all elected from the membership, together with four representatives nominated from local organisations. The responsibility for the operational and financial management of the Trust on a day-to-day basis rest with the Board of Directors, and all the powers of the Trust are vested in them. In accordance with the National Health Service Acts the specific responsibilities of the Governors at a General Meeting are to:

- Appoint or remove the Chair and the other Non-Executive Directors;
- Approve the appointment (by the Non-Executive Directors) of the Chief Executive;
- Decide the remuneration and the other terms and conditions of office of the Chair and Non-Executive Directors; and
- Appoint or remove the External Auditor.

They must also be presented with:

- the annual financial accounts;
- any report of the auditor on them;
- the annual report; and
- the quality account.

Other statutory roles and responsibilities of the Council of Governors are to:

- Hold the non-executive directors, individually and collectively, to account for the performance of the board of directors;
- Represent the interests of the members of the Trust as a whole and the interests of the public;
- Approve “significant transactions”;
- Approve an application by the Trust to enter into a merger, acquisition, separation or dissolution;
- Decide whether the Trust’s non-NHS work would significantly interfere with its principal purpose, which is to provide goods and services for the health service in England, or performing its other functions, and
- Approve amendments to the Trust’s constitution in consultation with the Board of Directors.

As required under NHS England’s code there is an agreed interaction process for dealing with any conflict, should this arise, between the Board of Directors and the Council of Governors. This states that the normal channels of communication via the Chair, Associate Director of Corporate Governance, Lead Governor or Senior Independent Director would be used in the first instance. There has never been any occasion for the process to be used.

The Council of Governors supports the work of the Trust outside of its formal meetings, advised by the Chair and Executive Directors. Council of Governors’ Committees play an important role, with the skills and experience of individual Governors providing a valuable asset to the Trust. Through the Committees, Governors have the opportunity to concentrate on specific issues in greater detail than is possible at a full meeting of the Council of Governors.

The Council of Governors has the following Committees:

- Forward Planning, which reviews the development of the draft Strategic Plan (five-year plan), the development of the draft enabling strategies, which underpin the Trust 5 Year Strategy, and receives updates on the development and implementation of Trust’s annual operational plans; Appointments [Non-executive Director Nomination and Remuneration], which leads on the appointment, re-appointment and remuneration of NEDs. The Committee is chaired by the Lead Governor; Patient and Public Involvement (PPI), which considers the process by which the Trust discharges its duty to make arrangements to involve and consult patients and the

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public in decisions regarding planning services and developing proposals for changes in the way services are provided;

- Governors' Assurance which monitors for the Council of Governors, compliance with all aspects of the Governor statutory duties as set out in the 2013 Reference Guide for NHS FT Governors and the 2022 NHSE Addendum to the Statutory Duties; Access and Facilities Group, which monitors and reviews patient and public access to and within the hospital site, as well as the provision of accommodation facilities for patients' relatives.

## **Members of the Council of Governors as at 31 March 2024:**

### **Cambridgeshire**

#### **Rachel Mahony**

Rachel became a governor to continue to assist people in her community, going beyond her role as a barrister. She has lived in Cambridgeshire all her life.

She completed an access to medicine course and holds a master's degree in Global Health, Law, and Ethics.

Rachel studied immunology and infectious diseases at Cambridge University. During the COVID-19 pandemic, she applied to become an HCA Band 3, taking COVID-19 swabs in London and East Anglia, including Norfolk, Papworth, and Hinchingbrooke.

She also has a phlebotomy qualification and has been immunizing people as a Band 4 for the COVID-19 vaccinations at the East of England Showground.

Rachel completed the NHS Care Certificate and holds Higher Development Awards at Level 3 from Health Education England, NHS. In 2016, she volunteered as a Community First Responder (CFR) with the Greenwich & Bexley Unit.

Additionally, she is a commissioned officer in the Army Reserves and serves as an Army Chemical, Biological, Radiological, and Nuclear instructor. Previously, she was a Medical Support Officer, responsible for administering the field support hospital in the 335 Medical Evacuation Unit, specializing in pre-hospital care within the Royal Army Medical Corps.

#### **Dr Susan Bullivant**

Following a research and academic career in applied/engineering mathematics, Susan established and ran an organisation and management development consultancy working with Government Departments and private sector companies. She supported women in STEM initiatives at national level. She was a Patient Governor of Addenbrooke's Hospital for 8 years and chaired the Director/Governor Forward Planning Group. Just elected she wants to find out more about RPH and where she can best contribute. She has lupus, a chronic illness.

#### **Abigail Halstead**

I have been under the care of the Royal Papworth Adult Cystic Fibrosis unit since 2011. During this time, I have received regular care from all areas of both the inpatient and outpatient departments. I feel well placed to empathise and help offer ideas for improvement based on my own positive and negative experiences of patient life and challenges. As my care at Royal Papworth will be lifelong, I will also be able to feedback on changes as they occur. I have experience working in branding and marketing and I want to use these skills to help improve patient experience, especially in the new world of virtual healthcare.

Abi was elected to the position of Lead Governor in April 2022 and took up role from September 2023.

#### **Ian Harvey**

Ian has taught biology at Hills Road SFC since 1975 and from 1980-2012 was a tutor for the Open University. His interest is in education, communication, and engagement. In 2012 he established Big Biology Day for professional biologists to engage with the public and share their enthusiasm



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and is Special Advisor for Education at the Cambridge Science Centre. He's had several links with Papworth including one of his best friends with CF receiving a double lung transplant in 2019. In 2019 Ian helped to organize the shipment of unwanted equipment from "Old Papworth" to the only free hospital in Sierra Leone.

### **Bill Davidson**

Bill trained as a civil engineer and worked as a consultant and in state owned organisations that provide essential public services - water and rail. He has been a volunteer at Addenbrooke's for about 8 years, firstly in Oncology providing information and support for patients and their families, and now as a Ward volunteer.

He was a Governor at Cambridge University Hospitals from 2019 to 2022. During that time, he learned a lot about the role, the management of a large hospital and the best ways for a Governor to help support the Trust.

Bill plays a lot of sport, particularly hockey, golf and tennis. He lives locally and is married with one son.

### **Suffolk**

#### **Angela Atkinson**

Angela has recently retired from a senior management role in the position of Head of Business Support, serving 27 years with Antec International Limited (currently owned by Lanxess Limited), a disinfectant manufacturer for both animal and human health products based in Suffolk. Previously serving 23 years with BASF as Human Resources Manager for the Agrochemical Division.

Throughout her career she has been very people orientated, engaging with them and most importantly listening with empathy and compassion. She welcomes this opportunity to support the Trust's strong values of Compassion, Excellence and Collaboration.

Angela is married with one son, who is currently based in the USA, and has a keen interest in fitness and the world of equestrian. She has had an association with the NHS all her life undergoing major back surgery at The National Hospital for Neurology and Neurosurgery, London as well as other members of my family who have health issues. She is forever grateful for the treatment and support she has received over the years.

#### **Vivienne Bush**

Vivienne has been a patient at Royal Papworth Hospital for many years, due to a chronic lung disease, bronchiectasis. She has been under the care of the Lung Defence team during this time, both as an outpatient and an inpatient. As a Patient Governor, she wants to use her experience of healthcare to share the many positive aspects and also some of the challenges faced as a patient, aiming to help make improvements.

She is a Chartered Accountant and has worked in audit practice and in senior roles in industries such as aerospace and software development. With her financial background, she hopes to bring experienced and informed oversight, where necessary, to the role of Governor.

Currently, Vivienne is studying for a Health Science degree with The Open University. In her spare time, she volunteers for the National Trust and sings in a local choir.

#### **Trevor McLeese**

Trevor retired as an equity partner due to ill health from an accountancy practice in 2014. He suffers from Beckers Muscular Dystrophy and Asthma and is a patient of Papworth Hospital. Trevor has been fitted with a defibrillator and has also experienced treatment in the Sleep Study Centre. He uses an electric wheelchair and understands the issues and needs of the less abled.

Trevor feels extremely privileged and honoured to undertake the role as a Governor for Suffolk. He has been reliant on the NHS since a child having spent 10 months in Great Ormond Street Hospital where his treatment gave him the gift of living and has had a close relationship with the NHS ever



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since. This has inspired him to succeed in life and share his experiences to inspire others. Trevor hopes to make a difference to the patients and the hospital by his input as a Governor and is committed to the role and regularly attends various meetings with a view to achieve Royal Papworth Hospital's vision and values.

### **Dr Joe Pajak**

Joe was born in Cambridge and has lived and worked in Suffolk and Cambridgeshire for many years. His professional experience includes research and development with British Aerospace, followed by a career in public services. He has served as head of a Cambridgeshire community college, as a local authority director of education, and as a director of a national children's charity.

He is passionate about serving local communities and has several years' experience at board level, including time as a trustee for the Papworth Trust, as a member of the professional standards committee for the Royal Society of Chemistry, and as a governor at West Suffolk Hospital NHS Foundation Trust.

He has a PhD in physical chemistry (researching air entrainment), and has a particular interest in infection, prevention and control, air pollution, and the impact of airborne particles on health.

### **Norfolk**

#### **Paul Berry**

Paul has been a volunteer at Royal Papworth Hospital since 2017 following a successful pulmonary endarterectomy (PEA) at Papworth Everard. His duties include meeting, greeting, assisting and signposting patients and visitors in the atrium and outpatient areas; and offering phone support to PEA candidates, nationwide, referred by the PEA specialist nurse team.

He is a qualified teacher and worked as a local newspaper reporter and for Norfolk Social Services.

Prior to early retirement, he worked for an NHS substance misuse service where he helped design and deliver pioneering drug education programmes at schools and colleges in West Norfolk and North Cambridgeshire.

Born and nurtured in Norfolk, Paul lives near King's Lynn.

#### **Deborah Cooper**

Deborah has been an allergy patient at Addenbrooke's since 2000 and has a relative who is a sleep apnoea patient at Papworth for a similar length of time.

She is trained in mental health first aid and is an A&E volunteer at the NNUH.

Deborah is the author of a two-part series on Science/Religion (parallel to her ancestor Charles Babbage's similar works), focusing on her generation's struggles with misinformation and modernisation.

She was previously visually impaired, and she set mountaineering records during this time and has since become an active ambassador for the RNIB.

She has been openly supportive of inclusivity, equality and diversity, and has appeared on BBC Radio and various national outlets abroad, (particularly in Rwanda) to discuss this. Deborah is also a member of the United Nations Association.

As an avid classical musician, she believes in access to music for all patients.

#### **John Fitchew**

John joined the Governors as a long standing and grateful patient, having had a mitral valve repaired in 2004, and a heart transplant in 2013. He was in the building trade all of his working life. John is married and between us we have 5 children and 12 grandchildren.

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After receiving his new heart in 2013 he felt that he needed to give something back. He had a new zest for life. He joined The Norfolk Zipper Club (NZC) in July 2013, and was elected as Co Chair in 2016. The Norfolk Zipper Club raises money that goes towards buying much needed medical equipment. It has been in existence for approximately 30 years and has raised more than £1.5 million.

Whilst being involved with NZC he has on occasions spoken one to one with patients who have been awaiting cardiac procedures to help with any worries that they may have. John hopes to continue with this work in the future.

### **Martin Hardy-Shepherd**

Martin Hardy-Shepherd has been a Royal Papworth patient since 1990 and is living with a rare heart and lung condition.

Originally trained as an electrician, he transitioned into electronics when his health declined.

Additionally, he pursued studies in art history, with a strong passion for history in general. Martin had been married to his wife, Gill, for 42 years, and together they had two children and four grandchildren.

### **Rest of England and Wales**

#### **Trevor Colins**

Trevor was diagnosed with Dilated Cardio Myopathy in 2001. The condition was managed with medication and frequent monitoring with the care and attention of the NHS. He maintained an active life until it was necessary for him to have further treatment.

Trevor has been a service-user at the Royal Papworth Hospital since 2016, having had a Heart Transplant in 2017 at the old site. Previously he worked in local government in Social Services and retired in 2016.

As a Hospital Volunteer since 2019, Trevor has a keen interest in supporting the patients journey to their recovery. Trevor is on the NHS Blood & Transplant Patient & Public Advisory Group, offering advice and knowledge as to the perspective of a service user.

Trevor also won two medals when he represented Royal Papworth Hospital at the 2019 Transplant Games in Newport, Wales.

#### **Marlene Hotchkiss**

Marlene's background is in education. She has been a headteacher, consultant leader, Ofsted inspector and independent education consultant.

Marlene has been involved with Royal Papworth Hospital since 2015 when a close relative underwent extensive open-heart surgery. Since then, her involvement has continued on a regular basis and is predominantly with the respiratory departments.

#### **Lesley Howe**

Lesley has been in the NHS healthcare system since she was eight years old due to a chronic lung disease. As a patient at Royal Papworth Hospital, Lesley has personal experience and insight to the needs of patients as well as the medical teams who care for us all.

She is now retired but worked as a Practice Manager in a Private Medical Practice where communicating with patients and medical professionals was a top priority. Lesley held various Managerial Posts in various organisations involving liaising with clients and delivering time management training.

She is a fully qualified TEFL tutor teaching English to different nationalities which requires empathy and understanding of our diverse cultures across the world an important aspect in the NHS. She is a strong communicator and therefore, believes that she can make a valuable contribution with her experience and knowledge for the good of the hospital.

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As a patient of the Trust Lesley is honoured to be a Governor and fully embraces the important role and will do her utmost to fulfil her duty with dignity, respect, and professionalism to all people.

As a patient and a Governor Lesley can be a voice for patients whether as an in-patient or as an out-patient to ensure care, understanding and empathy is delivered to all who maybe daunted at the prospect of a hospital stay, as well as acknowledging the challenges of the Medical Teams and other personnel at the hospital.

### **Dr Harvey Perkins**

Harvey is a retired business consultant and professional engineer and brings to the Council of Governors a wide range of general management, commercial, and financial skills. Harvey served as a Governor from 2004 to 2014, during which time he held several positions including Chair of the Forward Planning Committee, Chair of the Appointments Committee, Chair of the Governance Committee, and Lead Governor. He returned as a Governor in 2016.

### **Dr Clive Glazebrook**

Clive trained in medicine at Guys and Kings in London and qualified in 1973. He was appointed as consultant anaesthetist at Addenbrookes Cambridge in 1982 after periods of training in Cambridge, Papworth (Old), Newfoundland, Oxford, and New Zealand.

Clive specialised in anaesthesia for obstetrics, ENT, plastic and transplantation. During the period as consultant, he was head of department and chairman of consultant staff council.

He retired from practice in 2013.

Clive married Patricia, a midwife, in 1973 and has three children, five grandchildren and two dogs. Since retirement, he does more of the housework, shopping, cooking and gardening. He moved near Saffron Walden on retirement and is the honorary treasurer of friends of Audley End.

### **Staff Governors**

#### **Josevine McClean, Nurses**

Josevine started working as a student nurse in Hemingford ward when the hospital was located in Papworth Everard.

After moving to the Biomedical Campus, she was redeployed to critical care from the beginning of the pandemic and has stayed on since.

In her role, she has witnessed the positive progress that has been made in staff care as well as the areas for improvement at Royal Papworth Hospital that she is passionate about making an impact in.

The importance of equality, diversity and inclusion and staff experiences are two of many factors that Josevine believes should be top of the list for improvements. Ensuring all staff are shown compassion, listened to in collaboration and understood is essential, regardless of any protected characteristics.

She believes that by providing high quality staff care, we are sure to see a standard of excellence reflected in care for our patients.

#### **Sarah Brooks, Administrative, Clerical & Managers**

Sarah is the Staff Governor representing Admin, Clerical and Managers at Royal Papworth Hospital. Sarah joined the NHS in 2005 and progressed through several roles before joining Royal Papworth in 2017 where she currently works as part of the operational team based in Cardiology.

Sarah has a keen interest in service development and as part of her role regularly collaborates with system partners to shape the services, we offer to our patients collectively. She has also been able to support other tertiary and regional centres in developing their services through shared

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experience. Sarah works hard to engage with our workforce and ensure that the patient voice is considered in everything we do to ensure we can continue to deliver safe and excellent care.

Sarah is currently studying towards an MBA at Henley Business School.

### **Lynne Williams, Doctors**

Dr Lynne Williams has worked as a full-time Consultant Cardiologist at Royal Papworth Hospital since 2013, having moved to develop a specialist inherited heart muscle disease service for patients in the East of England. She has also helped shape and develop a specialist service for patients with cardiac sarcoidosis.

In her clinical role, Dr Williams is fortunate to work within excellent multidisciplinary clinical teams incorporating colleagues from the spectrum of medical, nursing, and allied health professional backgrounds. In addition, the roles she undertakes in the regional and national sphere have helped her to gain perspective of the challenges faced by the wider health services and share expertise.

As a staff governor, Lynne strives to provide a voice of representation for her colleagues as we look towards building our future Trust vision together.

### **Andrew Hadley-Brown, Nurses**

Andrew joined Critical Care 2014 as a newly qualified staff nurse. Since 2017 he has worked as an ECMO Retrieval Nurse, ECMO Specialist, and is currently a Deputy Charge Nurse.

The last few years Andrew has served to emphasize the skill and dynamism within workforce, and he firmly believes our staff are our greatest asset. He became a governor to advocate for staff across the Trust in pursuit of our common goal of delivering the highest quality care for our patients.

### **Rhys Hurst, Allied Health Professionals**

Rhys is Staff Governor for Royal Papworth Hospital representing the Allied Health Professionals (AHP). He is a qualified and HCPC registered Physiotherapist and Clinical Physiotherapy Lead for the Cambridge Centre for Lung Infection and has worked at Royal Papworth in two stints first in 2007 and now since 2018. Rhys has over 20 years of experience in the NHS and has lived and worked in the East of England for the last 12 years in a variety of positions. Part of his role has been to shape the AHP strategy for Royal Papworth Hospital, enhancing his insight into the AHP services moving forwards and he is looking forward to representing this at Governor level. He is currently undertaking his MSc in Advanced Clinical Practice at Anglia Ruskin University.

### **Christopher McCorquodale, Scientific & Technical**

Chris joined Royal Papworth Hospital in June 2012 as a Rotational Pharmacist and has undertaken a range of pharmacy roles over the last nine years. He has developed a clinical interest in transplant medicine and played a major role in the implementation of the Lorenzo electronic prescribing system across the Trust. As Deputy Chief Pharmacist, Chris now holds a leadership role within the pharmacy team, and also spends some time seconded to the Digital department, where he focuses on digital medicines and the clinical safety of IT systems.

### **Appointed Governors**

**Mr Justin Davies**, Deputy Medical Director, Cambridge University Hospitals

**Cllr Philippa Slatter**, Cambridgeshire County Council

**Dr Caroline Edmonds**, Secretary of the School of Clinical Medicine, University of Cambridge

## Terms of Office of Governors as at 31 March 2025

<b>Elected Public Constituency</b>	<b>Name</b>	<b>First Elected</b>	<b>Re-Elected</b>	<b>End of Current Term of office</b>
<b>Cambridgeshire</b>	Ian Harvey	Sept 2021	Sept 2024	Sept 2027
	Rachel Mahony	Sept 2024		Sept 2027
	Susan Bullivant	Sept 2019	Sept 2022	Sept 2025
	Abigail Halstead	Sept 2020	Sept 2023	Sept 2026
	Bill Davidson	Sept 2023	-	Sept 2026
<b>Suffolk</b>	Trevor McLeese	Sept 2017	Sept 2020 Sept 2021 Sept 2024	Sept 2027
	Vivienne Bush	Sept 2024	-	Sept 2027
	Angela Atkinson	Sept 2022	-	Sept 2025
	Joe Pajak	Sept 2023	-	Sept 2026
<b>Rest of England and Wales</b>	Marlene Hotchkiss	Sept 2021	Sept 2022	Sept 2025
	Harvey Perkins	Sept 2016	Sept 2019 Sept 2022	Sept 2025
	Lesley Howe	Sept 2022	-	Sept 2025
	Trevor Colins	Sept 2020	Sept 2023	Sept 2026
	Clive Glazebrook	Sept 2023		Sept 2026
<b>Norfolk</b>	Deborah Cooper	Sept 2024	-	Sept 2027
	Paul Berry	Sept 2022	-	Sept 2025
	John Fitchew	Sept 2020	Sept 2023	Sept 2026
	Martin Kenneth Hardy-Shepherd	Sept 2024	-	Sept 2027
<b>Elected Staff Constituency</b>	<b>Name</b>	<b>First Elected</b>	<b>Re-Elected</b>	<b>End of Current Term of office</b>
<b>Doctors</b>	Lynne Williams	Sept 2023	-	Sept 2026
<b>Nurses</b>	Andrew Hadley-Brown	Sept 2022	-	Sept 2025
	Josevine McClean	Sept 2022	-	Sept 2026
<b>Allied Health Professionals</b>	Rhys Hurst	Sept 2020	Sept 2023	Sept 2026
<b>Scientific &amp; Technical</b>	Christopher McCorquodale	Sept 2020	Sept 2023	Sept 2026
<b>Administrative, Clerical &amp; Management</b>	Sarah Brooks	Sept 2022	-	Sept 2025
<b>Ancillary, Estates and Others</b>	Vacancy			
<b>Appointed Governor</b>	<b>Name</b>	<b>Start of Term of Office</b>	<b>Re-appointed</b>	<b>End of Current Term of office</b>
<b>University of Cambridge</b>	Caroline Edmonds	Oct 2016	Sept 2019	As agreed between organisations
<b>Cambridge University Hospitals NHS FT</b>	Justin Davies	June 2024	n/a	As agreed between organisations
<b>Cambridgeshire County Council</b>	Councillor Phillipa Slatter	May 2021	-	As agreed between organisations
<b>South Cambs District Council</b>	Vacancy	-	-	As agreed between organisations

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### Register of Interests

The Trust's Constitution requires the Trust to maintain a register of Governors' interests. All Governors are asked to declare any interests at the time of their appointment and annually thereafter. There is a standing item on all Council of Governors and Committee meetings to confirm/update declarations of interest. The register is held by the Associate Director of Corporate Governance. The register is available to the public on request. Anyone who wishes to see the Register of Governors' Interests should make enquiries to the Associate Director of Corporate Governance at the following address: The Associate Director of Corporate Governance, Royal Papworth Hospital, Papworth Road, Cambridge Biomedical Campus Cambridge, CB2 0AY.

### Contacting the Governors

Governors can be contacted via the Chair's Office, by telephoning 01223 639833 or by writing to: The Chair's Office, Royal Papworth Hospital, Papworth Road, Cambridge Biomedical Campus Cambridge, CB2 0AY.

### Governor Election Results

CIVCA acted as the returning officer and independent scrutineer for the election process during 2024. There were vacancies for Governors in four of our public constituencies and four staff constituencies. The results of the elections are set out below:

#### **Information on election results:**

<b>Constituency</b>	<b>Vacancies</b>	<b>Nominations</b>	<b>Election</b>
Cambridgeshire	Two	Eleven	Election held
Norfolk	Two	Two	Uncontested
Suffolk	Two	Three	Election held
Rest of England and Wales	No Election held in 2024/25		
Administrative, Clerical & Management:	No Election held in 2024/25		
Ancillary, Estates and Others	No Election held in 2024/25		
Allied Health Professionals	No Election held in 2024/25		
Nurses	No Election held in 2024/25		
Doctors	No Election held in 2024/25		
Scientific and Technical	No Election held in 2024/25		

### Involving and understanding the views of the Governors and Members

The Board of Directors welcomes all opportunities to involve and listen to the views of Governors and Members. Listed below are some of the activities that demonstrate this commitment:

- Members voting (and standing for election) in elections for the Council of Governors;
- Five main Governor/Director Committees: Forward Planning, Appointments [Non-executive Director Nomination & Remuneration], Patient/Public Involvement (PPI), Governors' Assurance and Access and Facilities
- Governor attendance at Audit Committee, Quality and Risk Committee, Performance Committee and open Board meetings;
- Governor attendance at Patient Safety Visibility Rounds and PLACE inspections
- Governor being 'Peer Reviewers' for Fundamentals of Care reviews
- Governors' attendance at events such as the Annual Members' Meeting and annual Staff Awards Ceremony;
- Norfolk Governors have leading roles in Norfolk Zipper Club, which supports patients and their families and actively fundraises for the Trust;
- Governor membership on the Patient and Carer Experience Group (PCEG), Reading Panel;



- Member engagement through PALS (Patient Liaison and Advice Service) and the RPH Charity which writes to members and seeks new members from patients who have recently been treated by the Trust.
- Active social media presence on our website and Facebook pages.
- Active Volunteer structure.

**Table of Attendance of Directors at Council of Governors' Meetings**

Council of Governors (EDs/NEDs)	12-Jun-24	18-Sep-24	13-Nov-24	19-Mar-25
Jag Ahluwalia (Chair)	✓	✓	✓	✓
Eilish Midlane (CEO)	✓	✓	✓	✓
Tim Glenn (Returned from secondment on 01 December 2024)				✓
Harvey McEnroe	✓	✓	✓	✓
Oonagh Monkhouse	✓	✓	✓	✓
Andy Raynes	✓	✓	✓	✓
Maura Screaton	✓	✓	✓	✓
Ian Smith	✓	✓	✗	✗
Sophie Harrison	✓	✓	✓	✓
Michael Blastland	✓	✓	✗	✓
Cynthia Conquest	✓	✓	✓	✓
Amanda Fadero	✓	✓	✓	✓
Diane Leacock	✓	✓	✓	✓
Gavin Robert	✗	✗	✓	✓
Ian Wilkinson	✓	✗	✓	✓
Charlotte Paddison	✗	✗	✗	✗

✓ Indicates attendance at meeting.

✗ Indicates did not attend.

Royal Papworth Hospital is a Trust with a small management team. Whilst Executive and Non-executive Directors are keen to understand the views of Governors, they rationalise attendance at all Trust meetings based on the content of the agenda. Council of Governor Meetings returned to face-to-face meetings in November 2022 which was welcomed by Governors and the Board. However, we have maintained online access to the meetings to ensure that all members of the Board and Council of Governors are able to take part. Governors also attend our Trust Board meetings-in-public as observers and are invited to attend other Governor briefings and Trust Board Committee meetings, where they contribute to discussions.



**Table of Governor Attendance at Council of Governors' Meetings 2024/25**

Council of Governors	12-Jun-24	18-Sep-24	13-Nov-24	19-Mar-25
Atkinson, Angela	✓	x	✓	✓
Berry Paul	✓	✓	✓	✓
Brooks, Sarah	✓	x	✓	✓
Brown, Stephen	✓	✓		
Bullivant, Susan	✓	✓	✓	✓
Burnay, Roger	x	x		
Burns, Doug	✓	✓		
Bush, Vivienne			x	✓
Collins, Trevor	✓	✓	✓	✓
Cooper, Deborah			✓	✓
Davidson, Bill	✓	✓	✓	✓
Davies, Justin	✓	x	x	x
Dunham, Yvonne	x	x		
Edmonds, Caroline	✓	x	✓	✓
Fitchew, John	✓	x	x	✓
Glazebrook, Clive	✓	✓	✓	x
Hadeley Brown, Andrew	x	✓	x	x
Hardy-Shepherd, Martin			✓	✓
Halstead, Abigail	✓	✓	✓	✓
Harvey, Ian	✓	✓	✓	✓
Hotchkiss, Marlene	✓	✓	✓	✓
Howe, Lesley	✓	✓	✓	x
Hurst, Rhys	✓	✓	x	✓
Mahony, Rachel			x	x
McClean, Josevine	✓	✓	✓	✓
McLeese, Trevor	✓	✓	✓	✓
McCorquodale, Christopher	✓	✓	✓	✓
Pajak, Joe	✓	✓	✓	✓
Perkins, Harvey	✓	✓	✓	✓
S Cambs DC – Vacant				
Slatter, Philippa	✓	✓	x	✓
Williams, Lynne	x	x	✓	x

 Not a Governor\*   
 ✓ In attendance   
 X Apologies received

## 2.9 Foundation Trust Membership

Royal Papworth Hospital has always been a patient-centred organisation and as an NHS foundation trust strongly believes that greater public participation in the affairs of the hospital combined with the freedoms afforded to foundation trusts will help to deliver even better services to patients. In creating a membership the Trust was clear that it was more important to build an active and engaged membership rather than merely adding numbers.

### Public and Staff constituencies

Following changes to its Constitution agreed by Members at our Annual Members' Meeting in September 2007, the Trust's public constituencies cover the whole of England and Wales allowing anyone over the age of 16 to join. Constituencies have been split to reflect Royal Papworth's regional and national catchment areas. No changes have been made to the constituencies for membership since 2007. The Trust has no patient constituency. Public Constituencies are: Cambridgeshire; Norfolk; Suffolk; and The Rest of England and Wales. Staff constituencies reflect professional groupings using the old Whitley Council classifications: Doctors, Nurses, Allied Health Professionals, Scientific and Technical, Administrative, Clerical and Managers, Ancillary, Estates and Others.

### Membership by constituency as at 31 March 2025:

Membership by constituency as at 31 March 2025		
Public Membership Profile	Number of Members	
Cambridgeshire	1608	38.5%
Norfolk	615	14.7%
Suffolk	537	12.8%
Rest of England and Wales	1420	34%
Sub total:	4180	100.00%
Constituencies – Staff*	Number of Members	% of total
Nurses	1296	46.6%
Doctors	385	13.9%
Allied Health Professionals	145	5.2%
Scientific & Technical	201	7.2%
Ancillary, Estates & Others	102	3.7%
Administrative, Clerical & Management	650	23.4%
Sub-total	2,779	100.00%
Total Membership	6,959	

\*Note: Numbers are individual members of staff, not whole time equivalent

### Membership Plans and Interaction

A membership strategy, which set out the strategic objectives for membership, was approved by the Council of Governors in September 2020. The implementation of the strategy was, however, impacted by the limitations of the COVID-19 pandemic. The drafting of a new strategy was commenced at the end of 2024 and is being progressed through the appropriate governance processes. The new strategy will support governors in discharging their duty to represent the public, and to take account of the interests of the public at large. This includes the population of the local system of which the Trust is part and the whole population of England as served by the wider NHS. The strategy includes plans for Governors and the Trust to provide regular and effective communication with members, to keep them informed about what is happening at the Trust and, crucially, improve engagement with stakeholders.

During 2024/25 Governors have interacted with both members and the public and represented any views expressed at the Patient/Public Involvement (PPI) Committee and Council of Governors meetings, which are attended by members of the Board of Directors. The Governors have also directly submitted questions to be answered at meetings of the Board of Directors.

### Annual Members' Meeting

The Trust held its Annual Members' Meeting (AMM) on Wednesday, 18 September 2024.

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Presentations were received from our Chief Executive, who spoke about the importance of our Trust Values and Behaviours. The Lead Governor spoke on the role of Governors, and the Chief Nurse spoke on our Quality Priorities and the hospital's clinical performance over 2024/25. Finally, the Chief Finance Officer presented on our financial performance over the last 12 months.

### Thanking our volunteers

The contribution of the Volunteers to Royal Papworth hospital is invaluable. Their involvement brings such a positive influence on both our patients and staff ensuring we continue to focus on the very best in patient care as a Trust.

Our volunteer policy demonstrates the Trust's commitment to the development of a volunteer service that improves patient experience by making a difference to service delivery or by being an advocate for positive change. This promotes and gives opportunities for people to volunteer and develops partnership and networking with national, charitable and third sector organisations including volunteer support groups.

Through the valuable support of the charity team, this year has seen funding secured to allow continued employment of a Volunteer co-ordinator. In addition to supporting the PALS team, this has allowed a dedicated member of staff to focus on what has been a significant recruitment drive over the last year and beyond. The numbers in the team mean that the hours volunteered each month is now achieving on par with pre-pandemic levels.

Our volunteers support a range of roles across the Trust such as Ward Visiting, Meet and Greet, Chaplaincy support, Research Ambassador, Pharmacy Support, Reading Panel, Charity Ambassador, and being part of our Peer Review Quality Accreditation process on our wards. New roles have this year been introduced, specifically targeting areas that are seeking support. This includes working with the Treating Tobacco Dependency Programme, as well as an aimed focus on assisting the wards with the patient FFT survey participation. We also now have three volunteer Patient Safety Partners (PSPs) who are supporting Dementia & Delirium, Food & Nutrition, & Diabetes. Further information about PSPs is included in section xx of this report.

In November 2024, all our volunteers on site were provided with a new Jade polo shirt and branded fleece, kindly supported by our Charity.

This year we have also signed up with the Pets as Therapy (PAT) Dogs charity. Our recruitment of PAT Dogs and their handlers is underway, and we hope to see the on our wards soon.

Since April 2024, our amazing volunteers have contributed a total of 3,908 hours in supporting our staff make a real difference to our patients, their families, friends, and relatives. This compares to 2,477 hours in 2023/24.

If you are interested in hearing more about the work of Royal Papworth's volunteers please contact the PALS team via the PALS Office, by emailing [papworth.pals@nhs.net](mailto:papworth.pals@nhs.net) or by telephoning 01223 638896.

Further information on volunteering can also be found in our 2024/25 Quality Account.

## 2.10 Sustainability Report

Our vision for sustainability is to provide on-going healthcare with the innovation and determination necessary to ensure best outcomes for our patients of today whilst protecting the health and the resources of our patients of tomorrow. This vision is embedded within the Trust's strategic aims and objectives.

To support with the delivery of our vision for sustainability, in September 2021 we published our [Sustainability Strategy 2021-26](#). This five-year plan, which was fully approved by the Board, outlines the Trust's core focus for delivering sustainable healthcare to the communities we serve. Whilst the strategy operates for a five-year period, it is also subject to annual review by a committee of the Board to ensure that it remains relevant.

Within our sustainability strategy, we have identified the following as our key areas of focus for future sustainable development:

- Maximising our assets
- Minimising use of resources
- Achieving net zero carbon emissions
- Caring sustainably
- Building responsibly
- Minimising journeys
- Developing green space
- Helping our communities
- Adapting to climate change

To further support our sustainability journey, in 2022 we published the first edition of our [Green Plan 2022-24](#). Our Green Plan was produced in accordance with National Greener NHS Guidelines and in collaboration with staff, service users and our wider stakeholder community. It outlines how the Trust will contribute to the wider Greener NHS agenda and to the national target of a Net Zero NHS by 2040.

Whilst our drive is to be a sustainable organisation in the broadest sense, it is essential that we are aware of and taking active steps to reduce our carbon footprint. Our Green Plan helps us contribute to the [national NHS Net Zero targets](#) and in that regard, our current share of the carbon footprint (building energy, anaesthetic gases, metered dose inhalers, water, waste, business travel and fleet) is summarised by the Greener NHS Programme as 4,648 tonnes CO<sub>2</sub>e. Within the pattern of this data, we recognise that the move from our former site in 2019 to a modern premises at the Cambridge Biomedical Campus had a beneficial impact upon the carbon emissions that we produce. We also recognise that the drive to decarbonise the national electricity supply is already helping to improve the carbon impact of our energy usage. Continued implementation, operation and update of our Green Plan will then be the main tool by which we address the other elements of our carbon footprint.

### Green Plan Progress

The Trust is continuously evaluating the progress made on the commitments outlined within our Green Plan. We have recently undergone an internal process to review the progress we have made against our Green Plan and identify areas for future development and focus. Such review will be used to develop the next iteration of our Green Plan, being that planned to operate for 2025 to 2027. Building on the established work, this financial year we have undertaken a wide variety of activities and projects to help us meet the requirements and targets outlined within our Green Plan. Our Green Plan is currently comprised of nine key areas which include: workforce, digital, travel and transport and supply chain and procurement.

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## Workforce and Staff Engagement

In recognition that sustainability can only be achieved through trust-wide action, we launched our new Green Champions Network in January 2024. Our Green Champion Network is open to all staff within the Trust regardless of their role, grade or experience, who are passionate about sustainability and want to make a real and meaningful contribution to the sustainability and environmental outcomes of the Trust. The network has enabled staff to connect with new people, raise awareness for sustainability issues and help become a voice of change.

To further enhance staff engagement in sustainability, since January 2024 sustainability has been included within the Trust's induction programme. Through including sustainability within the programme, all new starters are now informed on the intersection between health and the environment, the national Greener NHS agenda and sustainable activities that the Trust has undertaken. These sessions encourage and inspire new staff members to take a leading role in sustainability.

## Digital

The Trust has continued to implement the DrDoctor Portal, a new system to send patient letters digitally. Using this portal, patients can securely view letters digitally via email and text within minutes of the letter being sent rather than having to wait for it to arrive in the post. Implementing this new system has led to substantial financial and environmental savings through a reduction in printing, paper, usage and delivery.

This project was announced as a finalist in the Environment and Sustainable Project of the Year category at the Health Service Journal Partnership Awards 2024.

## Travel and Transport

Our commitment to sustainable travel and transport is evident within our employee benefits package. Since 2022, we have provided free bus travel for our staff between the Cambridge Biomedical Campus, Cambridge Railway Station and the Trumpington and Babraham Road Park and Ride Sites. Our benefits package also includes a generous 30% discount on bus travel across Stagecoach East Routes. To further support sustainable transport and transport, the Trust has included a cycle to work scheme as part of our salary sacrifice scheme. In addition, the Trust's salary sacrifice scheme with NHS Fleet Solutions enables staff to lease electric and hybrid vehicles. We are delighted that these benefits will continue in the 2025/26 financial year.

In May 2023 we decided to extend our provision of sustainable travel options to include a new daily subsidised bus service from our staff accommodation site at Waterbeach to the hospital. This new service has enabled our staff to travel collectively, reducing the emissions associated with staff travel. To support sustainable travel and transport options around the Cambridge Biomedical Campus we participate in the Cambridge Biomedical Campus Travel and Transport Group. The role of group is to bring together representatives from organisations across the CBC to discuss sustainable travel and transport initiatives and projects taking place across the CBC. Through this group, we were involved in consultations regarding the planning of Cambridge South railway station which is currently under construction directly adjacent to the campus.

To further support sustainable travel and transport, the Trust is also a member of Cambridge Ahead, which promotes sustainable and inclusive growth of the city of Cambridge. The Trust is actively involved in this group, which is focusing on developing plans for a future transport system that is accessible, affordable, sustainable and reliable. The Trust actively participates in the Cambridge Ahead Transport Group analyses the provision of new transport infrastructure to support public transport usage and active travel.

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## Estates and Facilities

### Energy and Waste

The Trust measures and monitors its water, gas and electricity consumption. In line with NHS England requirements, we report on our consumption figures through the Estates Return Information Collection (ERIC). This process enables benchmarking with peer organisations.

We work closely with our PFI and commercial providers to identify ways in which we can reduce our consumption of water, gas and electricity. A joint group is currently working on the development of a decarbonisation plan for our hospital. Since April 2023 we have capitalised on an opportunity to reduce the Trust's gas consumption by turning off the heating at our staff accommodation site at Waterbeach between April- September.

The Trust closely manages and measures waste production. We actively measure and monitor our patient food waste to identify opportunities for reduction. To encourage increased rates of recycling, we have increased the number of recycling bins located around the Trust. We have also implemented new internal processes to improve the recycling rate of batteries and toner cartridges.

Reducing the use of single use items is a key area of focus for the Trust. We have undertaken several initiatives to reduce the number of single use items within our day-to-day operations. These include removing hand towels from toilets, switching from plastic to paper bags within the pharmacy department and replacing plastic cutlery in the restaurant with wooden alternatives. An incentive scheme also operates for staff to utilise their own reusable cups for beverages purchased from the restaurant/café areas.

### Biodiversity

We are working continuously to improve the rates of biodiversity across the Trust, recognising that access to nature and green space can have restorative effects for staff, patients and visitors improving their psychological health, physical health and overall wellbeing.

In recognition of the benefits that nature provides to individuals, we created a reflection garden within the Trust's grounds. In addition to providing a space for staff, patients and visitors to contemplate, relax and reflect, the garden also increases the rate of biodiversity across the Trust's site.

In addition, a planter outside the entrance to the hospital enables us to grow a wide variety of herbs including rosemary, thyme, chives and coriander. These herbs serve the Trust's restaurant and are included within a wide array of recipes. Alongside providing the Trust with locally produced food, the herb planter helps to increase the rate of biodiversity across our site.

In September 2024 we planted ten new trees. These were received from NHS Forest, which helps healthcare sites plan, plant and manage trees, woodlands and green spaces to create habitats for wildlife. Increasing the number of trees onsite will help improve the rate of biodiversity across the Trust.

To further support access to nature and biodiversity, we organise a series of staff nature walks during the spring and summer months. Between June-September 2024 we organised three guided nature walks where staff were able to immerse themselves in biodiversity and learn about local habitats and wildlife populations.

### Supply Chain and Procurement

We recognise the importance of developing strong connections with companies and organisations operating across the Trust's supply chain. In keeping with the Trust's values of collaboration, we aim to adopt a partnership approach with our suppliers. In line with NHS England procurement requirements, we have incorporated a 10% social value weighting into all tenders.



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## Taskforce for Climate Related Financial Disclosures (TCDF) Report

TCFD is a principle-based reporting framework which allows us to effectively analyse, understand and disclose our climate related risks and opportunities. Under TCFD requirements, we are obliged to report under a comply or explain basis.

NHS England has adopted a phased approach to incorporating TCFD recommended disclosures into annual reporting requirements.

Under this guidance, local NHS bodies are not required to disclose scope 1,2 and 3 greenhouse gas emissions under TCFD as these are computed nationally by the NHS.

This phased approach incorporates the disclosure requirements of the governance and risk management pillar for the 2024/25 reporting period.

The Trust recognises that climate change will have extensive impacts on our operations. Climate change threatens the foundations of good health, with direct and immediate consequences for our patients, staff and the organisation. By taking action to reduce carbon emission we can help improve health and save lives through reducing cases of asthma, cancer and heart disease.

In recognition of the profound and growing threat to health by climate change, in October 2020 the NHS became the world's first health service to commit to reaching carbon net zero.

The NHS has committed to the following targets:

- For emissions we control directly (NHS Carbon Footprint) achieve net zero by 2040.
- For emissions we can influence (our NHS Carbon Footprint Plus) net zero by 2045.

## Governance

Our governance structure for sustainability and climate related risks and opportunities is as follows:



## How climate related risks and opportunities are managed at board level.

The Trust's Chief Executive Officer is formally responsible for providing oversight for sustainability and climate related risks and opportunities. They are responsible for overseeing the progress made to the commitments outlined within the Trust's Green Plan.



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Sustainability is reported to the Trust Board through both the Performance Committee and the Strategic Projects Committee.

### Performance Committee

The Trust's Performance Committee is comprised of both executive and non-executive directors and is responsible for overseeing the performance of the Trust. As part of that role, it is charged with overseeing the Trust's sustainability progress as measured by its Green Plan.

The Performance Committee receives an update regarding the Trust's sustainability progress every six months. During the 2024/25 reporting period the Performance Committee:

- Reviewed the Trust's Green Plan progress.
- Assessed the Trust's Sustainability risks.
- Oversaw the reconstitution of the Trust's Sustainability Board.

### Strategic Projects Committee

The Trust's Strategic Projects Committee provides a formal forum for the collective ownership and oversight of the Trust's strategic projects and transformation. The Committee is comprised of all executive directors alongside a representation of non-executive directors.

The Strategic Projects Committee is responsible for overseeing the annual review and update process of the Trust's Sustainability Strategy.

## **How climate related risks and opportunities are managed at a management level.**

### Sustainability Board

In October 2024 we reconstituted the Trust's Sustainability Board. The Sustainability Board is now comprised of executive directors and senior management from a range of different business functions including procurement, workforce, digital, estates and facilities, finance and corporate governance along with senior representatives from all clinical functions.

The board is responsible for overseeing both sustainability and Green Plan progress at management level and reports into the Performance Committee.

The Sustainability Board meets on a quarterly basis. During the 2024/25 reporting period the Sustainability Board:

- Agreed upon membership requirements and the terms of reference.
- Contributed to the progress of the Trust's Green Plan.
- Discussed upcoming sustainability activities.
- Assessed the Trust's sustainability risks
- Agreed the process and priorities for the next iteration of the Green Plan.

### Green Champions

Our Green Champions network provides an opportunity for all staff regardless of their grade, role or experience to engage in sustainability and climate related issues within a structured environment. Through the network staff can connect with other members, ask questions, suggest new ideas and share examples of best practice. The network is overseen by the Trust's sustainability team.

## **Risk Management**

In November 2024 the Trust developed a Board Assurance Framework (BAF) risk specific to sustainability. The development of this level of risk identifies sustainability as being one of the most

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material risks for the organisation. This risk is monitored by the Trust Board, Performance Committee and the Sustainability Board and is reviewed every six months.

To mitigate against the BAF risk, the Trust has developed a programme for sustainability activity. Under this programme we have developed our [Sustainability Strategy](#) which outlines the Trust's core focus for delivering sustainable healthcare to the communities we serve.

To achieve implementation of our sustainability programme, we developed a [Green Plan for the period 2022-24](#). This plan outlines how the Trust will contribute to the wider Greener NHS agenda and to the national target of a Net Zero NHS by 2040. The Trust has identified five corporate risks associated with the delivery of the Green Plan. These risks are monitored by the Sustainability Board and the Sustainability team. They are reviewed monthly.

All risks are recorded on the Trust's Datix risk management system, which is used across all NHS Trusts to record, assess and monitor risks.

## 2.11 Equality and Diversity Report

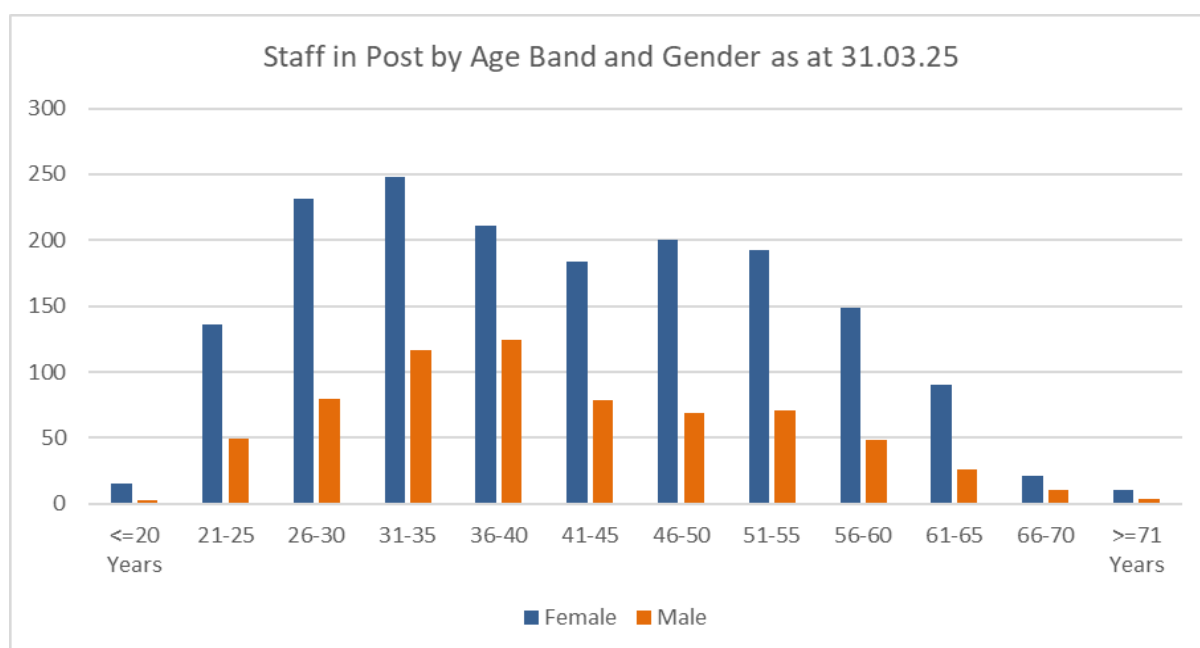
### Workforce Profile – 31<sup>st</sup> March 2025

The following overview of the profile of our workforce is taken from data held on the Electronic Staff Record and is self-declared by the member of staff.

The hospital had 2367 employees, as at 31<sup>st</sup> March 2025 excluding hosted services, of which, 1763 were full time employees and 604 were part time.

#### Gender

Gender	Full Time		Part Time		Grand Total	
	Headcount	% of Full Time	Headcount	% of Part Time	Headcount	% of Workforce
Female	1173	66.53%	514	85.10%	1687	71.27%
Male	590	33.47%	90	14.90%	680	28.73%
<b>Grand Total</b>	<b>1763</b>	<b>100.00%</b>	<b>604</b>	<b>100.00%</b>	<b>2367</b>	<b>100.00%</b>
% of Total Workforce who are FT &		<b>74.48%</b>			<b>25.52%</b>	



Age Band	Female		Male		Grand Total	
	Headcount	% of Female	Headcount	% of Male	Headcount	% of Workforce
<=20 Years	15	0.89%	3	0.44%	18	0.76%
21-25	136	8.06%	49	7.21%	185	7.82%
26-30	231	13.69%	80	11.76%	311	13.14%
31-35	248	14.70%	117	17.21%	365	15.42%
36-40	211	12.51%	124	18.24%	335	14.15%
41-45	184	10.91%	79	11.62%	263	11.11%
46-50	200	11.86%	69	10.15%	269	11.36%
51-55	192	11.38%	71	10.44%	263	11.11%
56-60	149	8.83%	48	7.06%	197	8.32%
61-65	90	5.33%	26	3.82%	116	4.90%
66-70	21	1.24%	10	1.47%	31	1.31%
>=71 Years	10	0.59%	4	0.59%	14	0.59%
<b>Grand Total</b>	<b>1687</b>	<b>100.00%</b>	<b>680</b>	<b>100.00%</b>	<b>2367</b>	<b>100.00%</b>
<b>% of Total Workforce who are Female &amp; M</b>		<b>71.27%</b>		<b>28.73%</b>		

Age Band	Female		Male		Grand Total	
	Headcount	% of Female	Headcount	% of Male	Headcount	% of Workforce
<=20 Years	10	0.62%	2	0.33%	12	0.54%
21-25	129	8.03%	31	5.12%	160	7.24%
26-30	233	14.51%	69	11.40%	302	13.66%
31-35	223	13.89%	98	16.20%	321	14.52%
36-40	187	11.64%	101	16.69%	288	13.03%
41-45	193	12.02%	83	13.72%	276	12.48%
46-50	183	11.39%	74	12.23%	257	11.62%
51-55	192	11.96%	62	10.25%	254	11.49%
56-60	152	9.46%	48	7.93%	200	9.05%
61-65	80	4.98%	21	3.47%	101	4.57%
66-70	16	1.00%	12	1.98%	28	1.27%
>=71 Years	8	0.50%	4	0.66%	12	0.54%
<b>Grand Total</b>	<b>1606</b>	<b>100.00%</b>	<b>605</b>	<b>100.00%</b>	<b>2211</b>	<b>100.00%</b>
<b>% of Total Workforce who are Female &amp; Male:</b>		<b>72.64%</b>		<b>27.36%</b>		

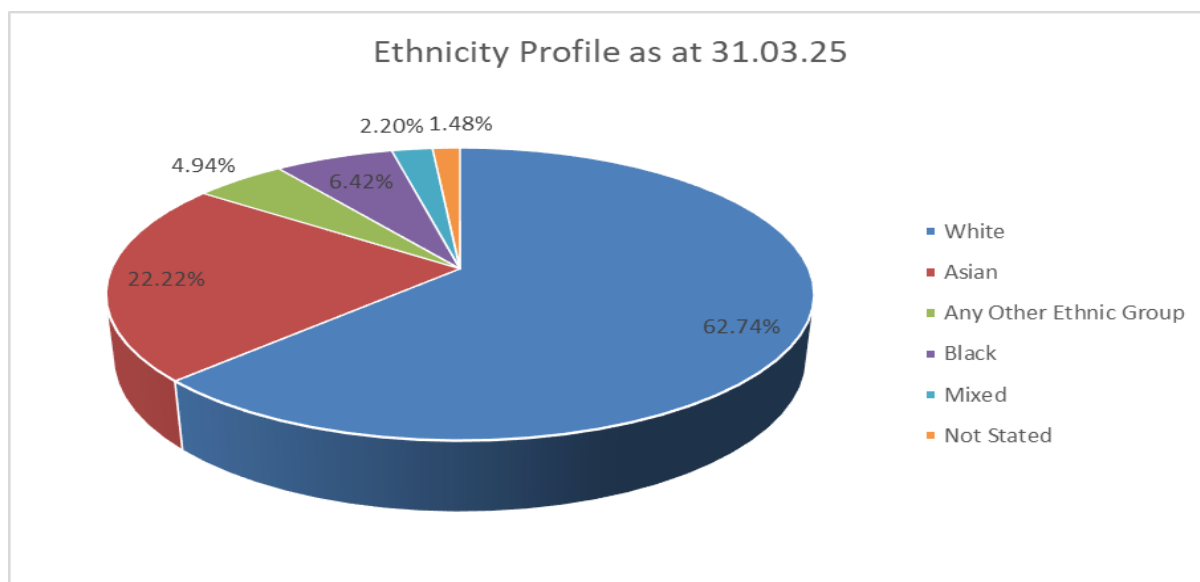
## Gender Pay Gap

The Trust has complied with the reporting requirements in relation to the gender pay and have developed an action plan to ensure that we better understand historical reasons for the gender balance in particular areas, that we share data with our staff, and that we put in place measures, including training and support, that will allow us to address issues that are identified.

Royal Papworth Hospital NHS FT	ORDINARY PAY										BONUS PAY			
	Mean pay gap %	Median Pay gap %	Quartile 4 (Top quartile)		Quartile 3 (Upper Middle Quartile)		Quartile 2 (lower middle quartile)		Quartile 1 (Lower quartile)		Mean Bonus pay gap %	Median Bonus Pay gap %	Proportion of males and females receiving a bonus payment	
			Men	Women	Men	Women	Men	Women	Men	Women			Men	Women
Year ending														
2024	21.69%	11.09%	42.27%	57.73%	19.18%	80.82%	23.33%	76.67%	26.39%	73.61%	51.86%	41.63%	9.64%	2.16%

## Ethnicity

Ethnicity	Female		Male		Grand Total	
	Headcount	% of Female	Headcount	% of Male	Headcount	% of Workforce
White	1144	67.81%	341	50.15%	1485	62.74%
Asian	326	19.32%	200	29.41%	526	22.22%
Any Other Ethnic Group	71	4.21%	46	6.76%	117	4.94%
Black	95	5.63%	57	8.38%	152	6.42%
Mixed	35	2.07%	17	2.50%	52	2.20%
Not Stated	16	0.95%	19	2.79%	35	1.48%
<b>Grand Total</b>	<b>1687</b>	<b>100.00%</b>	<b>680</b>	<b>100.00%</b>	<b>2367</b>	<b>100.00%</b>



## Disability

Disability	Female		Male		Grand Total	
	Headcount	% of Female	Headcount	% of Male	Headcount	% of Workforce
No	1404	83.22%	556	81.76%	1960	82.81%
Not Declared	176	10.43%	95	13.97%	271	11.45%
Prefer Not To Answer	8	0.47%	2	0.29%	10	0.42%
Yes	99	5.87%	27	3.97%	126	5.32%
<b>Grand Total</b>	<b>1687</b>	<b>100.00%</b>	<b>680</b>	<b>100.00%</b>	<b>2367</b>	<b>100.00%</b>

## Sexual Orientation

Sexual Orientation	Headcount	% of Workforce
Heterosexual or Straight	1973	83.35%
Not stated (person asked but declined to provide a response)	293	12.38%
Bisexual	48	2.03%
Gay or Lesbian	41	1.73%
Other sexual orientation not listed	8	0.34%
Undecided	4	0.17%
<b>Grand Total</b>	<b>2367</b>	<b>100.00%</b>

## Religious Belief

Religious Belief	Headcount	% of Workforce
Christianity	1166	49.26%
I do not wish to disclose my religion/belief	478	20.19%
Atheism	381	16.10%
Other	134	5.66%
Hinduism	85	3.59%
Islam	83	3.51%
Buddhism	30	1.27%
Sikhism	5	0.21%
Judaism	4	0.17%
Jainism	1	0.04%
<b>Grand Total</b>	<b>2367</b>	<b>100.00%</b>

### NHS equality delivery system (EDS2)

The EDS is an improvement tool for patients, staff, and leaders of the NHS. It supports NHS organisations in England - in active conversations with patients, public, staff, staff networks, community groups and trade unions - to review and develop their approach in addressing health inequalities through three domains: Services, Workforce and Leadership. It is driven by data, evidence, engagement, and insight.

RPH is required to carry out EDS reviews, creating improvement plans and act on completed EDS reviews and their action plans in conjunction with our WRES, WDES and GPG action plans. EDS reviews should be carried out annually with the result of the review published on organisation websites by 28th February. The improvement tool focuses on three domains, the first domain looks at how we provide services to our patients, i.e., looking at access, if their needs are met, experience etc. Domain two looks at the health and wellbeing of RPH's workforce, and domain three requires the Trust to look at its Inclusive leadership in partnership with another organisation.

Following the very comprehensive approach taken in 2023-24 across all three Domains, the decision was taken by the Trust to review only Domain 3 (Inclusive Leadership) in 2024-25. The primary reason for this is the insufficient duration between the establishment of the Trust action plans from the previous review and the scheduled next review. This limited timeframe did not allow for a comprehensive assessment of the progress and impact of the action plans in Domains 1 and 2.

The Trust Board, along with senior leaders from both clinical and non-clinical backgrounds, have been actively involved in co-ordinating and implementing these action plans. Their efforts have been focused on ensuring that the strategies set forth are effectively integrated into the Trust's operations. This co-ordinated approach reflects the Trust's commitment to fostering an inclusive leadership culture, even as it continues to work towards achieving its broader goals in service provision and workforce well-being. As in 2023-24 we partnered with Cambridge and Peterborough NHS Foundation and North West Anglia NHS Foundation Trust to undertake the peer review process to our approach to inclusive leadership.

### Annual Reporting

The Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) are audits completed every May using data as at 31 March each year and from the annual staff survey and NHS Jobs. From the reporting the Trust compiles action plans that focus on issues identified. These action plans, once approved by the Board, are published externally on our Trust website.

Royal Papworth Hospital NHS Foundation Trust Annual Report & Accounts 2024/25



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## **Workforce Race Equality Standard (WRES)**

Our WRES indicators clearly indicate that the priority areas of focus for the Trust are the experiences of BAME staff members of discrimination and bullying from their colleagues and line managers and that our BAME colleagues are less likely to believe we provide equal opportunity for career progression compared to their white colleagues. Only 52.83% of staff from a BAME background believe that there is equality of opportunity. Our overall BAME workforce is broadly representative (35.78%) of our communities, however, this representation is not present in our senior posts nor at a board level.

The WRES action plan sets out how we will be addressing these specific areas and this plan is regularly reviewed and updated by the BAME Network which meets bi-monthly. The Equality and Diversity Steering Group oversees the delivery of the WRES action plan and there is a quarterly report to the Quality and Risk Committee.

## **Workforce Disability Equality Standard**

The WDES action plan is published on our Trust website. This plan is developed, and progress reviewed by the Disability and Difference and Working Carers Network. Delivery is overseen by the EDI Steering Committee which reports to the Workforce Committee. The focus of our plan is to improve self-declaration of disability status in order to improve our knowledge of our workforce and where we need to focus our attention. The plan also seeks to address bullying and harassment, line manager development to support staff with health conditions and career development. These have been done through a variety of routes such as comms declaration campaigns, Line managers development Programmes (Inclusion In Action), Civility and microaggressions workshops etc.

## **Disability Information**

We are recognised by the Government's Department for Work and Pensions as a 'Disability Confident' employer. The 'Disability Confident' scheme aims to help employers make the most of the opportunities provided by employing disabled people.

As a Disability Confident Level 2 Confident Employer, we have committed to:

- ensure our recruitment process is inclusive and accessible.
- communicating and promoting vacancies
- offering an interview to disabled people who meet the minimum criteria for the job.
- anticipating and providing reasonable adjustments as required
- supporting any existing employee who acquires a disability or long-term health condition, enabling them to stay in work.
- at least one activity that will make a difference for disabled people.

For staff who become disabled whilst in work, either temporarily or permanently, we have proactive, supportive policies and procedures in place to enable their skills and experience to be retained within the Trust. These include the use of external organisations to undertake detailed workplace assessments and, where appropriate, to advise on specialist equipment to facilitate adjustments to working practices.

The number of staff who reported themselves as having a disability at the end of 2024/25 was 126 (5.32% of the workforce). Further information in connection with Equality and Diversity can be found in the Equality and Diversity section of the Annual Report.

The Disability and Difference Network supports the Trust with developing and implementing the Workforce Disability Equality System (WDES) action plan.

## **Staff Networks**

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The Trust has four staff networks:

- Race Equality Network
- LGBT+ Network
- Disability and Difference and Working Carers Network
- Women's Network

These Networks are an essential part of the Trust's EDI infrastructure and are instrumental in driving the equality agenda. During 2024/25 the Networks have held a number of Trustwide engagement and learning/training events and have driving initiatives such as the publication of our first Trans Inclusion Procedure, International Women's Day.

The Network Chairs and Deputies meet regularly with the Head of EDI and the Director of Workforce and Organisational Development.

The Networks all have Executive sponsors who attend the meetings and contribute in raising the Networks profile at Board level.

### **Equality, Diversity and Inclusion Steering Committee.**

The Equality, Diversity and Inclusion Steering Committee meets bi-monthly and reports to Workforce Committee. It is chaired by the Director of Workforce and Organisational Development, and all staff networks and EDI team report into this committee.

### **Engagement and Involvement**

Throughout 2024/25 there has been numerous engagement and inclusion sessions,

- Ramadan care packages – April 2024
- Women's Network Lunch – May 2024
- Disability and Difference Network presents -Mental Health awareness week event – Virtual – May 2024
- Happy Pride Month – June 2024
- South Asian Heritage Month EDI and REN event – July 2024
- Women's Network – Menopause discussion virtual event – August 2024
- TRMIP Cohort 2 celebration events – September 2024
- Menopause Café – October 2024
- Black History Month Reclaiming Narratives – October 2024
- Diwali celebrations – November 2024
- Women's Network drop-in café – December 2024
- TRMIP Cohort 3 started – January 2025
- Respectful Relationships & Sexual Safety training – January 2025
- SignLive re-instated – January 2025
- World Cancer Day – February 2025
- Race Equality Week #EveryActionMatters – February 2025
- LGBTQ+ History month – February 2025
- New REN chairs – February 2025
- Ramadan – care packages and awareness event – March 2025
- Springboard – March 2025
- Neurodiversity Celebration Week and Launch of neurodiversity programme, including training programme with Lexxic – March 2025
- International Women's Day celebration event – March 2025
- Civility and Microaggression workshops

- Board Stories
- Line Managers Development Programme (Inclusion In Action)
- Staff Induction

### Equality monitoring

As required by the public sector equality duty, the Trust's workforce equality monitoring information is published on the Royal Papworth public website.

This includes:

- the profile of our staff by age band, disability, race, religion, sex, sexual orientation and marital status
- ethnic profile of our staff compared to the local population
- recruitment data by age band, disability, race, religion, sex, sexual orientation and marital status (those applying, shortlisted and appointed)
- staff in post by pay band by age, disability, race, sex and sexual orientation
- the number attending training courses by age band, disability, race and sex
- the number of leavers by age band, disability, race and sex
- employee relations cases (disciplinary, capability, performance and sickness bullying and harassment) cases by age band, disability, race and sex

We also use this section of our website to publish our WRES, WDES and Gender Pay Gap action plans:

<https://royalpapworth.nhs.uk/our-hospital/information-we-publish/equality-diversity-and-inclusion>.

### Trade Union Facility Time Publication Requirements

The Trust complied with the submission of the Disclosure of Trade Union Facility Time as set out in Schedule 2 to The Trade Union (Facility Time Publication Requirements) Regulations 2017 in 2024/25.

The Trade Union Facility Time data is set out below:

8 employees were Relevant Union Officials during the relevant period (2024/25) and this equated to 7.3 FTE employees.

The percentage of time spent on facility time was:-

	%	WTE
A	0%	0
B	1%-50%	8
C	51%-99%	0
D	100%	0

The percentage of pay bill spent on facility time during the reference period:		
A	Total cost of pay bill on facility time	£6706.00
B	Total pay bill	£136,000,000.00
C	Total pay bill spent on facility time	0%

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D	Time spent on paid trade union activities as a percentage of total paid facility time hours	46.93%
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## 2.12 Statement of Accounting Officer's responsibilities

### STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTING OFFICER OF ROYAL PAPWORTH HOSPITAL NHS FOUNDATION TRUST

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by NHS England.

NHS England, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Royal Papworth Hospital NHS foundation trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Royal Papworth Hospital NHS foundation trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care's Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* (and the *Department of Health and Social Care Group Accounting Manual*) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

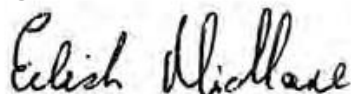
The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable them to ensure that the accounts comply with requirements outlined in the above-mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the Foundation Trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

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To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

Signed:

A handwritten signature in black ink, appearing to read 'Eilish Midlane', written over a light grey rectangular background.

Eilish Midlane  
Chief Executive  
25 June 2025

## 2.13 Annual Governance Statement

### Executive summary

My annual governance review of 2024/25 confirms that Royal Papworth Hospital NHS Foundation Trust has a generally sound system of internal control that supports the achievement of its organisation's objectives. The Trust has a programme that regularly monitors and tests various aspects of its governance and risk management structures to ensure they remain fit for purpose. Overall, no significant internal control issues have been identified that would impact on the delivery of the Trust's strategic and annual objectives. The Trust recognises that the internal control environment can always be strengthened, and this work will continue in 2025/26. The document below summarises the key areas that informed this opinion.

### Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

In undertaking this role I, and my team, have developed and maintained strong links with NHS England, clinical commissioning groups, and partner organisations both in the local health economy and nationwide.

### The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Royal Papworth Hospital NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Royal Papworth Hospital NHS Foundation Trust for the year ended 31 March 2025 and up to the date of approval of the Annual Report and Accounts.

### Capacity to handle risk

The Board of Directors leads the management of risk within the Trust. The Trust has in place a Risk Management Strategy which sets out the accountability and reporting arrangements to the Board of Directors for risk management within the Trust. Operational responsibility for the implementation of risk management has been delegated to Executive Directors. The Operational Plan sets out the Trust's principal aims for the year ahead. Executive Directors have the responsibility for identifying any risks that could compromise the Trust from achieving these aims.

All new staff joining the Trust are required to attend corporate induction which covers clinical governance and risk management, including use of the Datix Incident Reporting System. The Trust learns from good practice through a range of mechanisms including root cause analysis of identified incidents, clinical supervision and reflective practice, individual and peer reviews, performance management, continuing professional development, clinical audit and application of evidenced based practice. All relevant policies are available on the Trust intranet.

### The risk and control framework

Quality governance and risk management is central to the effective running of the



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organisation. The Risk Management Strategy and supporting procedure sets out the key responsibilities for managing risk within the organisation, including ways in which risk is identified, evaluated and controlled. The overall aim of the Risk Management Strategy is to achieve a Trust wide corporate approach to risk management supported by effective and efficient systems and processes which ensure the organisation is one which:

- Recognises that risk is present in all activities both clinical and non-clinical and is fully aware of its risks – where risk management is embedded within our culture and integrated into the working practices of all grades and disciplines of staff;
- Encourages the open reporting of accidents, concerns, incidents and near miss events by fostering a fair and just culture that learns from such events, puts actions into place to prevent recurrence, recognises the effects of Human Factors, provides feedback to staff and offers sensitive and fair investigation of the organisation and individuals' contribution to the event;
- Accepts that risk management is everyone's responsibility;
- Achieves organisation wide understanding of the challenges arising from the implementation of Clinical and Quality Governance;
- Facilitates change through multidisciplinary ownership of identified plans and work streams;
- Ensures the Trust achieves set targets relating to clinical quality and safety;
- Adopts a pro-active approach to risk management and endeavours to identify opportunities and risks for all projects and tasks;
- Ensures by pro-active management that effective action plans are in place to mitigate risks which will minimise any actual harm or loss;
- Advocates honesty and transparency in its communications with patients, staff, contractors and visitors and acknowledges our liability for harm or loss in any instance where we have been negligent in our duties.

The Board of Directors is responsible for identifying and assessing the Trust's principal risks (i.e. those that threaten the achievement of the Trust's corporate objectives). A risk management matrix is used to support a consistent approach to assessing and responding to clinical and non-clinical risks and incidents.

Risk assessment information is held in an organisation wide risk register (Datix Risk Management system). There are regular Corporate and Board Assurance Framework (BAF) risk reports to the Executive Directors which includes a BAF tracker dashboard. All Serious Incidents (SIs) are reviewed by the Serious Incident Executive Review Panel and are reported to the Board via the Chief Nurse, Medical Director or Chief Operating Officer. All staff are responsible for responding to incidents, risks, complaints and near misses in accordance with the appropriate policies. Incident reporting is co-ordinated by the Department of Clinical Governance and Risk Management. Staff are encouraged to report incidents and there continues to be a healthy incident reporting culture which is demonstrated by the percentage of near miss reports against actual incidents with the majority of incidents graded as low or no harm and these are reviewed to identify common themes and consider whether there is further learning that could be shared. Information on patient safety incident trends and actions are discussed in the monthly Quality and Risk Management Group (QRMG) which is chaired by the Clinical Governance Lead – a Consultant Physician, who is a member of the Board's Quality and Risk (Q&R) Committee. Information on staff, visitor and organisational incidents and risks are shared at the Health and Safety Committee and disseminated across the Committee structure. Information on patient safety incident trends and actions are also placed on the Trust's external website in the quarterly Quality and Risk Report. The QRMG reports to the Q&R Committee.

Board of Director Committees consisted in the year of:

- Audit Committee
- Quality and Risk (Q&R) Committee
- Performance Committee
- Strategic Projects Committee
- Workforce Committee
- Executive Remuneration Committee
- Charitable Funds Committee (Trustee Board)

Membership of the Q&R Committee, Performance Committee, Workforce Committee and Strategic Projects Committee consists of Non-executive Directors (NEDs) and Executive Directors, the Chairs are NEDs. Other Executive Directors attend as business requires. Two Governors are also in attendance at the Q&R Committee, the Audit Committee, the Performance Committee and the Workforce Committee. During the year the Workforce Committee met seven times, the Strategic Projects Committee met six times and the Quality and Risk Committee and Performance Committee each met twelve times. All Committees report to the Board through minutes and written Chairs' reports.

In 2024/25 the Q&R Committee was delegated with providing assurance to the Board that there is an effective structure, process and system of control for:

- Clinical Governance (including Board compliance statements on Care Quality Commission, Quality Strategy and Quality Governance)
- Research Governance
- Information Governance
- Non-Financial Resource Governance
- Clinical and Non-clinical Risk Management
- Quality Reporting to support assurance for the annual Quality Report
- Data Quality
- Board Assurance Framework to support the clinical/quality statements in the Annual Governance Statement
- Health & Safety

In year we reviewed the management of workforce matters across Board and Committees and following review it was agreed a Workforce Committee would be established and it has been delegated with providing assurance to the Board that there is an effective structure, process and system of control for:

- Education and Training
- Education Governance
- Equality, Diversity, and Inclusion (EDI)
- Leadership Development
- Resourcing & Retention
- Staff health and Well-being
- Workforce Health & Safety
- Workforce Planning

The role of the Performance Committee is to provide assurance, overview and monitoring for the Board on financial governance and reporting, including the cost improvement programme/service improvement programme (CIP/SIP). The Performance Committee provides in year scrutiny for matters affecting the overall business, performance and reputation of the Trust, including:

- Financial sustainability;
- Cost Improvement Programme (CIP);
- In-year patient activity and access standard performance;
- Environmental sustainability;
- Cyber security;
- Business cases of over £500k and agreement of profit or revenue or other share of intellectual property with Trust employees where the expected value is over £500k.

The Investment Group, chaired by the Chief Finance & Commercial Officer, supports the Performance Committee and has the remit of ensuring that all major investment, disinvestment and development decisions (both revenue and capital) receive appropriate overview and scrutiny. The key aims of the group are to establish the overall methodology and controls which govern the Trust's investment and development decisions; ensure that robust processes are followed (e.g., evaluation of fit with the Trust strategy); and evaluate, recommend/approve, scrutinise and monitor investments and developments.

The Strategic Projects Committee provides assurance on the Trust's strategic projects/transformation plans in respect of the following programmes:

- Estates Action Plan escalations
- Sustainability/Green Plan
- Working with our Partners
- Integrated Care System Development
- Heart and Lung Research Institute including the Clinical Research Facility
- Strategic Digital Projects, including the Electronic Patient Record

For information on the Audit Committee see the Audit Committee section of this Annual Report. For information on the Executive Remuneration Committee see the Remuneration section of this Annual Report. For information on the Charitable Funds Committee see the Charity Annual Report and Accounts, published separately. Please see the Charity Commission website at [RPH Charity Annual Report and Accounts](#).

The Trust is a patient centred organisation and places a high priority on the quality of its clinical outcomes, patient safety and patient experience and abides by the principles outlined in NHS England's quality governance framework and/or Well-led, as follows:

- We want quality improvement and continuous improvement to be our core philosophy and to be at the heart of every decision that we make. Our expertise, reputation, and network places us in a unique position to lead the way in delivering excellence in care through our cardiothoracic, respiratory and transplant services with outstanding:
  - a. Patient experience and engagement; developing and improving our services for and with the patients who need them.
  - b. Patient safety; with a focus on eliminating avoidable harm to patients.
  - c. Effectiveness of care; using clear, consistent processes and standards to deliver successful treatment assessed by clinical outcome measures and the patient's experience.
- Risks to quality are listed in the Board Assurance Framework (BAF) and in the risk register. The Medical Director and Chief Nurse review the Quality Impact Assessments for all new Service Improvement (CIP/SIP) projects;

- Capabilities and culture: The Trust has achieved Non-executive Director (NED) engagement in quality through the Quality and Risk Committee (Q&R) and Governor engagement through the Patient and Public Involvement (PPI) Committee and Q&R Committee. The Board of Directors and Council of Governors receive and review the PIPR, including patient safety and patient experience at every meeting. The Trust had an external Well Led Review in 2022 had has a Board level action plan to address the key findings.
- Structures and processes: Quality, in the form of patient quality and safety, and patient experience are standing items for all meetings of the Board of Directors and Council of Governors. The Q&R Committee reviews actions to address quality performance issues. The Trust has engaged with its key external stakeholders on quality through the quality reporting process and has requested input from system partners including our NHS Commissioners, Cambridgeshire County Council Adults and Health Committee and Healthwatch Cambridgeshire and Peterborough.
- There is a Guardian of Safe Working Hours who reports directly to the Trust Board of Directors.
- There is a Freedom to Speak Up Guardian who reports directly to the Trust Board of Directors, and who is supported by a team of FTSU Champions.
- We have established networks for our staff with lived experience including Black and Minority Ethnic staff, Disability and Difference, LGBTQ+ and our Women's network.
- We have established Lead Healthcare Scientist and Chief Allied Health Professional roles.
- Measurement: The Board reviews its performance metrics through the PIPR, and these are linked to the Trust's strategic objectives, national priority indicators, NHS England (NHSE) governance ratings, Commissioning for Quality and Innovation (CQUIN) and local priorities. The PIPR is used to report on quality to the Board on a monthly basis alongside operational and finance performance. The quality elements are informed from the directorate quality reports and the Matrons monthly ward and departmental score card. The Trust has worked with Commissioners on quality matters and meets with the Commissioner's quality team to review the Commissioning Quality dashboard. There have been no quality derogations recorded. The Trust has submitted and will continue to submit evidence for the NHS Quality Surveillance Program and the Specialised services quality dashboard (SSQD). The Trust has a SSQD gatekeeper (Quality Compliance Officer) and Executive lead (Chief Nurse) sign off for the QST portal.

## **Risk**

The risk management function is managed by the department of Clinical Governance and Risk Management, which reports to the Chief Nurse. The Chief Nurse is the Caldicott Guardian. The department of Clinical Governance and Risk Management is supported by a number of Committees which report through the Quality and Risk Management Group (QRMG) to the Quality & Risk (Q&R) Committee of the Board. The Audit Committee reviews the establishment and maintenance of the system of integrated governance, risk management and internal control, across the whole of the Royal Papworth Hospital's activities and gains Assurance from the Quality & Risk Committee for the Risk Assurance Framework. There are a range of policies in place to describe the roles and responsibilities of staff in identifying and managing risk and these policies set out clear lines of responsibility and accountability. All relevant policies are available for viewing on the intranet and are regularly updated and this has been an area of focus in 2024/25. The Trust has successfully embraced and continues to improve electronic reporting of all risks and has developed new divisional dashboards to support local review and reporting. We

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have also developed and delivered training on Risk Management and Governance and Board Assurance as a part of our line managers leadership development programme.

All new risks are identified in-year and escalated to the risk register and reported via the Board Assurance Framework (BAF) where the residual risk rating is extreme, and the risk cannot be controlled to an acceptable level. Once identified, all risks are assessed with a consistent approach utilising the Trust 5x5 severity and likelihood matrix. During the review process, all risks (financial, safety, clinical, project, business management, health safety and environmental) are afforded the correct level of priority dependent on the Residual Risk Rating (RRR) following any recognised control measures which have been identified. Risks confirmed with a RRR of between 1 and 12 are managed by the responsible Directorate. Risks with a rating of 12 and above are included in the Corporate Risk Register. Corporate risks are managed at a Division and Department level with oversight through the Quality & Risk Management structure supported by quarterly review through the Performance Committee. Risks, resulting in a RRR of 15 or more are reviewed by the Lead Executive to provide assurance that the control measures put in place, are effective and that actions are developed to reduce the risk. Where the risk remains high, it is considered for escalation to the BAF for review by the appropriate Board Committee and the Audit Committee has requested detailed scrutiny by the Committee for all risks with a residual rating of 20 or above. All risks are also reviewed by the respective divisional and directorate management groups, with the Quality and Risk Management Group continuing to monitor the process via the dashboard on a quarterly basis.

The Risk Strategy describes the reporting and role responsibilities from department to the Board. Open risks are discussed at business unit and divisional meetings, the corporate risk register and the BAF are considered by the Executive Team and Board Committees, with a report going to Audit Committee at each meeting.

The Trust's principal risks (in-year and future) are summarised below together with mitigations.

<b>PR1 Workforce:</b> Failure to maintain an engaged and skilled workforce in adequate numbers to support delivery of harm free care and positive patient experience, through staff that are well supported and aligned to our shared values, behaviours and purpose.
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<b>Mitigations</b>
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<p>The Compassionate and Collective Leadership Programme is the vehicle for reducing turnover through improving staff engagement and building a positive and compassionate culture. The programme focuses on leadership, EDI, health and wellbeing and staff development. In July 2021 we launched the Trust's revised values and behaviour framework. The Reciprocal Mentoring programme has been launched and commenced in June 2022 and is a vehicle for addressing inequality and discrimination.</p>
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<p>We have significantly increased the H&amp;WB support for staff in recognition and appreciation of the efforts of staff. In June 2022 we introduced a Staff Support Scheme which provided subsidised travel and food for staff. We further increased these subsidies in October and paid a £100 payment to support in November 2022 to help with increased cost of living. These subsidies were continued in 2023/24 and have been approved for 2024/25.</p>
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<p>We have continued to focus on communication and thanking staff for their contributions.</p>
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<p>The line management CCL Programme commenced in April 2022. The purpose of this programme is to develop the skills of line managers to lead in a compassionate way.</p>
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<p>We have established a Resourcing and Retention Improvement Programme to provide a structured and systematic approach to working collaboratively on a range of projects to improve retention.</p>
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<p>The 2023-25 Workforce Strategy has been approved by the Trust Board and the 2024/25 workplan has been signed off. The workplan includes action to improve the quality of</p>
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appraisals, updating of nursing job descriptions and review of bandings, development of nursing career pathways and improvements in talent management processes.

A revised structure is being implemented in the Workforce Directorate which will include a dedicated team for talent management and career pathways.

An improved process for collecting feedback from leavers is being implemented.

**PR2 Productivity:** Failure to achieve sufficient patient throughput to support timely and equitable access to care, and achieve financial stability, through optimising the productivity of our people and facilities.

**Mitigations:**

An operational improvement plan (incorporated into the Flow Programme) has been developed to deliver the following outcomes:

- Reduce length of stay and improve discharge profile.
- Improve theatre utilisation
- Reduce Do Not Attends (by patients)
- Assess capacity and demand
- Deliver alternative models of care.
- Increase day case utilisation.
- Ensure delivery of 23/24 operational plan.

The programme will monitor progress against these objectives and report to the Performance Committee on a monthly basis.

Activity delivered is monitored on a weekly basis against plan and 19/20 levels. Remedial action is identified proactively and escalated via the trust access meeting.

Surgical, Theatre and Anaesthetic Continuous Improvement (STA CI) Programme focused on in day productivity (reporting via Performance Committee). Clinical Admin processes being reviewed re booking of theatre lists and closing down 2 weeks in advance with no cancellation 72 hours prior.

Patient Safety Initiative lists now embedded within the hospital's Divisions.

Dedicated operational support for the Cancer Pathway.

**PR3 Finances:** Failure to deliver our financial plan on a sustainable basis and deliver our contribution to the wider system through rigorous financial management and an effective response to uncertainties in the future mechanisms for commissioning and innovation in specialised services.

**Mitigation**

2024/25 saw further iterations of the financial framework to embed recovery initiatives for core services and restore productivity. Overall, the 2024/25 framework has supported the continued delivery of a sustainable financial position for the Trust.

2025/26 will see a change in the financial framework with the notable update to the elective funding framework and the next phase of the delegation of specialised commissioning functions to ICBs nationally. These changes aim to improve patient outcomes by enabling cohesive planning and commissioning of services at a population level across whole pathways of care, across both specialised and non-specialised services. This is a new way of working and introduces both opportunity and risk for specialist centres like the Trust. 2025/26 will be a year of transition and the Trust will work with its ICS and regional partners to enact the change, and both assess and mitigate material financial risk.

Our plans to mitigate the risks include:

- Monthly reporting of cash, I&E and activity position through Performance Committee and Trust Board
- Daily cash flow forecasting over rolling 12-month period
- Part-block clinical income contracts with NHSE and key ICB partners
- Activity recovery plans being implemented where necessary through operational and service teams. These plans are being monitored through Performance Committee
- Cost investment controls through weekly vacancy control panel, monthly Investment Group and Performance Committee cycles
- Long term financial modelling updates
- rust working with specialised commissioning on future funding frameworks and strategy for NHSE
- Potential for utilisation of non-recurrent financial recovery initiatives to support breakeven position
- Current national funding mechanism is providing additional support through the Trust's fixed income arrangements to mitigate the 24/25 position
- EPR replacement programme ongoing with business case process expected to clarify the financial implications as well as possible mitigations
- Development of proposals for the growth of private care to support longer term financial sustainability
- Strengthening of control environment for agency and temporary staffing

**PR4 Cyber security and data loss:** Failure to prioritise cyber resilience through the implementation of up-to-date cyber security controls, training, surveillance, risk management, business continuity and recovery planning increases the risk of a major cyber event causing data loss, key system failure, and prolonged disruption to services.

#### **Mitigation**

The Trust continues to see a growth in digital technology to support new ways of working with many staff now working remotely and a significant increase in clinical and support services that are delivered through virtual platforms. These services have been established with appropriate safeguards in place to ensure that our teams and staff have access to the right technologies to support our patients working with them safely and securely.

We minimise the risk to our systems by:

- Ensuring that our Board and staff are trained and alert to the risk of Cyber-attack.
- Having a Cyber Security communications plan to ensure current themes are regularly and consistently shared across the organisation through our leadership teams such as the Weekly Brief, NewsBites and business partners attending directorate meetings with key messages.
- User friendly reporting to highlight awareness, show progress and improve grip including the IT Health Dashboard. Quarterly Cyber Security report to the Performance Committee and monthly Cyber Security Reports to the Information Governance Steering Group.
- Improved surveillance measures with a full time dedicated Cyber Security specialist role.
- Acting on all Cyber Security notifications from NHS England, incorporating High Severity Alerts, Incidents/Alerts from Microsoft Defender for Endpoint and BitSight. All notifications are reviewed and completed, and actions taken are reported back.
- Implementation of a backup as a service solution (BaaS) backing up data from our estate and servers.
- On-going migration off legacy servers and endpoints.
- Prioritised investment to ensure that wherever possible all application versions are fully supported to reduce our vulnerability to cyber-attack and are appropriately



patched as per supplier guidance and industry best practice. Where this is not possible all vulnerable systems will be air-gaped from the rest of the network.

- Ensuring all new systems added to the network meet DTAC standards as set out by NHS England

In the last year the actions we have implemented to mitigate the risk of a cyber incident have included:

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- Critical systems being identified as per the business needs
- Systems being backed up at regular intervals. Tapes are also being stored in safe locations, so they can be accessed when required
- Ensuring a Disaster Recovery Plan is in place to guide the restoration of data back to production systems.
- Ensuring a continuous reviews are being conducted to update business impact analysis and to maintain the business continuity plans
- Ensuring that regular engagements and communications are undertaken between the business, emergency response and digital teams
- Keeping staff informed about the Business Continuity Plan (BCP) process via monthly staff briefing. Messages are also communicated to staff using the intranet, NewsBites and through Screensavers.

### **Safe staffing and Skill Mix**

Trust Boards have a duty to ensure safe staffing levels are in place and patients have a right to be cared for by appropriately qualified and experienced staff in a safe environment. These rights are set out within the National Health Service (NHS) Constitution, and the Health and Social Care Act (2012) which make explicit the Trust Board corporate accountability for quality and safety.

Developing workforce safeguards (NHS England, 2018) state that effective workforce planning is vital to ensure appropriate levels and skills of staff are available to deliver safe, high-quality care to patients and service users.

At RPH the setting of establishments should triangulate from different sources using evidence-based tools where possible. Establishment setting must be done annually, with a mid-year review, and should take account of:

- Patient needs-based information using an acuity and dependency scoring evidence-based tool such as Safer Nursing Care tool (SNCT, 2023).
- Professional judgement
- Activity levels including seasonal variation in service demand
- Service developments and any changes to delivery
- Contract commissioning
- Staff supply and experience issues
- Where Temporary Staff has been required above the set planned establishment
- Patient and staff outcome measures
- Benchmarking with other 'like' organisations

Please see the 2024/25 Quality Account for the full report,

### **Surgical Site Infection (SSI) Rates 2024-2025**

Surgical Site Surveillance at Royal Papworth Hospital (RPH) consists of identifying cardiac surgery patients that develop a surgical wound infection. To be classified as having a surgical site infection (SSI) they must meet the SSI criteria set by the UK Health Security Agency (UKHSA). At Royal Papworth we have historically conducted surveillance just on patients who underwent Coronary Artery Bypass Grafts (CABG) and heart valve surgery. However, as a result of the increased SSI rates reported at RPH, October 2023 saw the commencement of surveillance on additional cardiothoracic surgeries. This includes pulmonary

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endarterectomy (PTE) surgery (PTE only - excluding in addition to CABG/valve/other); heart, lung or both transplantations and other cardiac surgeries (non-CABG and non-valve). Please note this also does not include surgeries for the implantation of mechanical devices and does not include thoracic surgeries.

At Royal Papworth we report our CABG infection rates to UKHSA quarterly. As of March 2024, we additionally submit our valve and other cardiac surgery rates under the 'non-CABG' category. This reporting category includes all valve surgeries and other surgical procedures on the heart. Transplants, aortic and PTE surgeries are not included in the UKHSA categories for reporting SSIs, so rates of infection in these groups are for internal monitoring only.

Please see the 2024/25 Quality Account for the full report.

### **Compliance Statements**

The Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission. The last CQC announced inspection was in June and July 2019 and this assessed the overall rating as 'Outstanding', with the five overall assessments rated as 'Outstanding'.

The Trust last undertook a CQC mock inspection for the whole organisation in February 2020 which assessed against the CQC key lines of enquiry (KLOE). The Trust had planned to undertake a further mock inspection in October 2020, however due to the Coronavirus pandemic, it was necessary to reduce the size of the inspection. Acknowledging that the 2019 CQC inspection did not independently rate End of Life Care, the trust therefore decided to focus the October 2020 mock inspection on End of Life Care and revisited this inspection in July 2021.

The Trust has revised its approach to self-assessment against the CQC Fundamental Standards in 24/25. The fundamental standards are the standards below which our care must never fail so these are an integral part of our internal monitoring process. The Trust is piloting a two-step approach: through Divisional self-assessments against the CQC's single assessment framework, and a new peer review approach using a quality accreditation assessment against the standards assessed by a multi-disciplinary team and patient safety partner.

The Foundation Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to this guidance) within the past twelve months, as required by the *'Managing Conflicts of Interest in the NHS'* guidance.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme Regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The Foundation Trust has undertaken risk assessments and has plans in place which take account of the 'Delivering a Net Zero Health Service' report under the Greener NHS programme. The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

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## **Review of economy, efficiency and effectiveness of the use of resources**

2024/25 saw further iterations of the financial framework to embed recovery initiatives for core services and restore productivity. Overall, the 2024/25 framework has supported the continued delivery of a sustainable financial position for the Trust.

2025/26 will see a change in the financial framework with the notable update to the elective funding framework and the next phase of the delegation of specialised commissioning functions to ICBs nationally. These changes aim to improve patient outcomes by enabling cohesive planning and commissioning of services at a population level across whole pathways of care, across both specialised and non-specialised services. This is a new way of working and introduces both opportunity and risk for specialist centres like the Trust. 2025/26 will be a year of transition and the Trust will work with its ICS and regional partners to enact the change, and both assess and mitigate material financial risk.

The Trust undertook a planning exercise for 2024/25 covering activity, finance, quality and workforce domains. These plans were approved by the Board of Directors and submitted as part of the wide Integrated Care System Plan to NHS England (NHSE) and reflected finance, workforce and activity requirements. Progress against delivery of these variables has been monitored throughout the year and updates are presented to sub-Board assurance Committees such as the Performance Committee, and ultimately the Board of Directors via reports covering activity, capacity, people management and culture, patient safety, patient experience, clinical effectiveness, finance and risk.

The Trust has continued to report and monitor its performance against these domains throughout the year and has a framework for decision making throughout the organisation that ensures sufficient consideration of value for money through committee oversight on strategic initiatives and material investments. These processes and frameworks ensure that resources are used economically, efficiently, and effectively across the Trust. This includes directorate and divisional reviews with deep dives into particular services where required, the regular monitoring of clinical indicators covering quality and safety and triangulation of metrics across multiple domains to drive the best possible value from the Trust's resources.

The Trust achieved its financial plan at the end of the year and supported colleagues across the ICS to achieve the same result. This is a significant achievement in the current context and is a result of a continued focus on value for money and use of resources.

The Trust has and continues to review its position with regard to Getting it Right First Time (GIRFT), agency and temporary staffing spend, procurement and efficiencies, as well as working closely with local and regional partners to deliver transformational changes that support the delivery of a value for money efficient service as part of the local health economy. This includes work to understand the changes to the Trust's operating model since COVID-19 and work to recover service capacity to pre pandemic levels and beyond. This focus on productivity and flow has supported improvements in elective care delivery in year and this remains a focus for the Trust going into the 2025/26 financial year.

As part of their annual audit, our external auditors are required to satisfy themselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and report by exception if in their opinion the Trust has not. Please see the Independent Auditor's Report included within the Annual Accounts for their opinion on the use of resources and a description of the work performed. The objectives set out in the Trust's Internal Audit Plan include ensuring the economical, effective and efficient use of resources and this consideration is applied across all audits. The findings of internal audit reports are reported to the Audit Committee (see later in this Annual Governance Statement).

### **Information Governance**

The Trust has a suite of Information Governance policies in place including a Data Protection Policy and a Digital Acceptable Use Policy. These set out the Trust's

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commitment to ensuring that information is efficiently and effectively handled, managed and safeguarded. The policies establish an information governance framework which includes up to date policies, procedures and accountabilities. Managers within the Trust are responsible for ensuring that the policies and supporting standards and guidelines are built into Directorate processes and that there is on-going compliance.

The Trust annually assesses compliance with the requirements of the NHS England Data Security and Protection Toolkit for the management and control of risks to information. The Trust's Director of Digital is the Senior Information Risk Owner (SIRO) and the Chief Nurse is the Caldicott Guardian, both reporting to the Board.

Senior managers across the Trust are information asset owners accountable for a particular group of information assets as part of the Information Governance Management Framework. A regular update on information governance is received by the Quality and Risk (Q&R) Committee of the Board of Directors, which is tasked with providing assurance to the Board. There is an Information Governance Steering Group (IGSG) chaired by the SIRO which reviews/approves policies and procedures/action plans relevant to information governance. The SIRO reports any issues to the Q&R Committee and the Board. The Trust submitted its last Data Security and Protection (DS&P) Toolkit in June 2024, which included requirements relating to the Statement of Compliance and all assurances were declared as met.

In April 2025 BDO (Internal Audit) will undertake a review of assertions against the five Cyber Assurance Framework Standards. The 2024/25 DS&P Toolkit submission will be made by the deadline of 30 June 2025.

In 2024/25 there were 2 serious incidents relating to information governance, including data loss or confidentiality breach that were classified as Level 2 in the Information Governance Incident Reporting Tool. These were notified to NHS England but did not breach the threshold for reporting to the ICO.

### **Data Quality and Governance**

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare quality accounts for each financial year. These are to be published by 30 June 2024.

The assessment of quality indicators is integrated into the Trust's performance management system, and hence they are subject to review by operational and managerial staff on a monthly basis in a structured framework of performance review. The Trust uses the same systems and process to collect, validate, analyse and report on data in the Quality Account as it does for other reporting requirements. Specified indicators are subject to external audit. Reporting in year has also been supported by the PIPR.

The Trust has a 'live' (updated every 24 hours) Access and Data Quality Dashboard which reflects the data held in Lorenzo. Access to this system is available for all members of staff and trend information is shared with business units weekly, showing error rates for a number of key issues.

The Trust assures the quality of its RTT waiting time data through the validation of the patient tracking list (PTL) which is available daily through Patient Pathway Plus (PP+) and is the validation and reporting system employed by the Trust. Patients are checked on both Lorenzo and other clinical systems to ensure that their waiting time is valid. Corrections to Lorenzo are made where required, which feed into the following day's PTL. A weekly meeting is held to discuss in detail the longer waiting patients on the PTL and this is further minuted in the Trust's weekly Access meetings.

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The number of RTT data quality errors remains an issue at the Trust, due to the lack of formalised RTT training and limited resources available for RTT training. For these reasons a bespoke 18 week learning package was purchased, and the following RTT training was approved for use by the Executive team:

1. RTT to be discussed at local induction
2. Basic RTT e-learning training provided by NHSI to be completed by new staff members within the first week of joining the trust if applicable to their role.
3. Bespoke RTT eLearning package with compulsory modules needing to be completed by new staff members within 1-3 months of joining the trust. All existing staff members will also be required to complete the training where it forms part of their job role

The central RTT and Data Quality team continue to support the operational teams in providing RTT error data and identifying areas for improvement. Departmental errors are discussed in monthly business meetings with team leaders, to work collaboratively on strategies for improvement. A summary of this data is circulated to operational teams monthly and issues discussed at the weekly Trust Access meeting. The team also provide group and 1:1 training when required.

Information to support the quality metrics used in the Quality Report is held in a number of trust systems, including Lorenzo and Datix (electronic risk management system).

### **Annual Quality Account**

The Chief Nurse is the nominated Trust Executive for the Quality Account. The Board of Directors has agreed that the Quality Account will be considered and recommended by the Quality and Risk (Q&R) Committee of the Board. The Q&R Committee was also responsible for deliberating on priorities for inclusion in the Quality Account which are set out in this Annual Report. The quality priorities were developed in consultation with a range of stakeholders including the Patient and Public Involvement (PPI) Committee of the Council of Governors and clinical colleagues.

No Never Event was reported in 2024/25 (2023/24: 1).

The Trust's Quality Account is to be published by 30 June 2025 and will contain further information on performance against the 2024/25 Quality Priorities and our 2025/26 Quality Priorities.

### **Review of effectiveness**

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed by the work of the internal auditors, clinical audit, and the executive managers and clinical leads within the NHS foundation trust that have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the draft 2024/25 Quality Account; PIPR, and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the results of my review of the effectiveness of the system of internal control by the Board, the Audit Committee, the Quality and Risk Committee, the Performance Committee and Strategic Projects Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

Work has been commissioned from the Internal Audit service to review the adequacy and effectiveness of the controls and to develop improvements within the governance process. The work included identifying and evaluating controls and testing their effectiveness, in accordance with NHS Internal Audit Standards. The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework on the controls reviewed as part of the internal audit work programme.



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The Head of Internal Audit (HOIA) Opinion for 2024/25 is that: “overall” there is: “Moderate Assurance that there is a sound system of internal controls, designed to meet the Trust’s objectives, that controls are being applied consistently across various services.”.

During the year, internal audits were conducted: all reported audits received either limited, substantial or moderate assurance opinions which provided assurance over the effectiveness of controls in place for those areas. One audit was an advisory review with no formal opinion provided. Full findings of all internal audit reviews undertaken for 2024/25 are given below:

Moderate/Limited Assurance

Agency Expenditure and Temporary Staff (Design: Moderate/Operational Effectiveness: Limited)

Moderate/Limited Assurance (Design: Moderate/Operational Effectiveness: Limited)  
Cyber Security

High/High Assurance

Data Security and Protection Toolkit (Overall Risk Rating – High; Overall Confidence Rating - High)

Advisory

Electronic Patient Record Advisory Review

Substantial/Moderate

Key Financial Systems – Cost Improvement Plans (Design: Substantial/Operational Effectiveness: Moderate)

Moderate/Moderate

Outpatients (Design: Moderate/Operational Effectiveness: Moderate)

Moderate/Substantial

Performance Reporting Framework (PIPR) (Design: Moderate/Operational Effectiveness: Substantial)

Moderate/Moderate

Private Patients (Design: Moderate/Operational Effectiveness: Moderate)

Factors and findings which informed the HOIA opinion were that:

- BDO, the internal auditors, completed a total of eight reviews (six assurance audits and two advisory reviews).
- For the six assurance audits, one was rated substantial and five were rated moderate in respect of the design of the controls. This is similar to the prior year when three out of eight assurance reviews were rated substantial and five were moderate.
- One audit was rated substantial, three moderate and two limited in their operational effectiveness of the controls in place. This is similar to the prior year when one was rated substantial, five moderate and two limited.
- The limited opinions related to Agency Expenditure and Temporary Staff, and Cyber Security. Both of these areas are challenging areas for the Trust, and key BAF risks. Whilst the frameworks in place were generally well designed, the application and monitoring of key controls across the Trust and its divisions was variable, putting the system objectives at risk.
- Eight internal audit reports for the year resulted in a total of 33 recommendations (High: three, Medium: 21 and Low: nine). This compares to 26 recommendations the year before (High: seven, Medium: 17 and Low: two).

- The Trust has performed satisfactorily in implementing the internal auditors' recommendations within the specified timeframes, with an implementation rate of 84% of recommendations. There were eight recommendations in progress (High: two, Medium: six) and six recommendations that were overdue (all Medium).
- As is the case across the NHS, the Trust has faced financial and operational challenges during the year. The Trust reported to the Board that as at the end of March 2025, the full year finance position is an adjusted surplus of £0.3m, representing a £0.3m favourable variance to plan. Key drivers of this variance position include better than planned interest income (due to a higher than planned cash balance and interest rates), variable elective activity over-performance and PFI technical accounting upside from the national requirement to move from IFRS to UK GAAP accounting for the calculation of an adjusted finance position. The financial position reflects the continuation of the national aligned payment incentive arrangements where the Trust's contracted income comprises of a fixed and a variable element. The Trust had a revised 2024/25 capital allocation (total CDEL) of £6.5m for the year which includes allocation for right of use assets, PFI residual interest capital charges and additional PDC. The full year capital expenditure position against CDEL was £6.4m, which was an underspend of £0.1m.
- The Trust reported in its Papworth Integrated Performance Report in March 2025 an overall Amber rating, with Caring and Finance assessed as Green, Safe and People, Management & Culture assessed as Amber. Effective and Responsive were assessed as Red. Key areas requiring improvement included delays in response to complaints, 52-week referral to treatment (RTT) breaches, a downward trajectory in Diagnostic reporting in radiology and higher than KPI sickness absence rates

My review of effectiveness is also informed in a number of ways, including:

- Head of Internal Audit Opinion – see above;
- Dialogue with Executive Managers within the organisation who have responsibility for the development and maintenance of the system of internal control, the risk management system and the assurance framework;
- The last Care Quality Commission (CQC) Inspection Report dated 16 October 2019 which rated the Trust as “Outstanding”;
- Clinical governance reports, including the quarterly and annual Quality and Risk Report (see public website);
- Clinical audit programme (see Quality Account);
- Consultation with Patient and Public Involvement groups, e.g. Patient Carer Experience Group and Patient & Public Involvement Committee of the Council of Governors;
- The results of patient surveys (see Quality Account);
- The results of staff surveys (See Staff Report);
- External Audit management letter and other reports;
- Continued monitoring and reporting on financial performance, including CIP;
- Maintaining cash flow and liquidity;



- 
- Information governance assurance framework including the NHS Digital Data Security and Protection Toolkit;
  - Investigation reports and action plans following serious incidents.

### **Conclusion**

The overall opinion is that no significant control issues (i.e. issues where the risk could not be effectively controlled) have been identified that would impact on the delivery of the Trust's strategic and annual objectives.

My review confirms that Royal Papworth Hospital NHS Foundation Trust has a generally sound system of internal control that supports the achievement of its organisational objectives. The Trust recognises that the internal control environment can always be strengthened, and this work will continue in 2025/26.

The Audit Committee has reviewed the overall framework for internal control and has recommended this statement to the Board of Directors.

Approved by the Board and signed by the Chief Executive

Signed:



Eilish Midlane  
Chief Executive  
25 June 2025

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# **Royal Papworth Hospital NHS Foundation Trust**

## **Group accounts for the year ended 31 March 2025**

Presented to Parliament pursuant to  
Schedule 7, paragraphs 24 and 25 of the  
National Health Service Act 2006

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# INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF ROYAL PAPWORTH HOSPITAL NHS FOUNDATION TRUST

## REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

### Opinion

We have audited the financial statements of Royal Papworth Hospital NHS Foundation Trust ("the Trust") for the year ended 31 March 2025 which comprise the Group and Trust Statements of Comprehensive Income, Group and Trust Statements of Financial Position, Group and Trust Statements of Changes in Taxpayers' Equity and Group and Trust Statements of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Group and the Trust as at 31 March 2025 and of the Group's and the Trust's income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by NHS England with the consent of the Secretary of State in February 2025 as being relevant to NHS Foundation Trusts and included in the Department of Health and Social Care Group Accounting Manual 2024/25; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006 (as amended).

### Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Group in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

### Going concern

The Accounting Officer has prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to either cease the Group and the Trust's services or dissolve the Group and the Trust without the transfer of their services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over their ability to continue as a going concern for [at least a year] from the date of approval of the financial statements ("the going concern period").

In our evaluation of the Accounting Officer's conclusions, we considered the inherent risks associated with the continuity of services provided by the Group and the Trust over the going concern period.

Our conclusions based on this work:

- we consider that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate; and
- we have not identified and concur with the Accounting Officer's assessment that there is not, a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the Group's and the Trust's ability to continue as a going concern for the going concern period.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the above conclusions are not a guarantee that the Group and the Trust will continue in operation.

***Identifying and responding to risks of material misstatement due to fraud***

To identify risks of material misstatement due to fraud (“fraud risks”) we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, and internal audit as to the Group’s high-level policies and procedures to prevent and detect fraud, including the internal audit function, and the Group’s channel for “whistleblowing”, as well as whether they have knowledge of any actual, suspected, or alleged fraud.
- Reading Board and Audit Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.
- Reading the Group’s accounting policies

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards and taking into account possible pressures to meet delegated targets, we performed procedures to address the risk of management override of controls in particular the risk that Group management may be in a position to make inappropriate accounting entries. On this audit we did not identify a fraud risk related to revenue recognition due to the block nature of majority of the funding provided to the Trust during the year, and that other income streams are high volume transactions with a low value, and with simple recognition criteria which present minimal year end cut off risk. We therefore assessed that there was limited opportunity for the Trust to manipulate the income that was reported

We also identified a fraud risk related to the cut off-of non-pay, non-depreciation expenditure in response to incentives to manipulate the results of the Trust and System to meet the expectations or performance targets set by the government or external regulators and the opportunity to manipulate the non-pay non-depreciation expenditure around the year end, particularly in relation to accruals. In response to this fraud risk, we carried out the following procedures:

- Inspection of a sample of invoices to expenditure in the period around 31 March 2025, to determine whether expenditure has been recognised in the correct accounting period.
- Selection of a sample of year end accruals and inspection of evidence in regard to the actual amount paid after year end in order to assess whether the accrual exists and has been accurately recorded. We did not identify any additional fraud risks

We also performed procedures including:

- Identifying journal entries to test based on risk criteria and comparing the identified entries to supporting documentation. These included unexpected postings to cash and expense codes
- Assessing whether the judgements made in making accounting estimates are indicative of a potential bias

***Identifying and responding to risks of material misstatement related to compliance with laws and regulations***

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the Accounting Officer (as required by auditing standards) and discussed with the Accounting Officer the policies and procedures regarding compliance with laws and regulations.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

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Firstly, the Group is subject to laws and regulations that directly affect the financial statements, including the financial reporting aspects of NHS legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

Secondly, the Group is subject to many other laws and regulations where the consequences of non-compliance could have a material effect on amounts or disclosures in the financial statements, for instance through the imposition of fines or litigation. We identified the following areas as those most likely to have such an effect: health and safety, data protection laws (GDPR), fraud, corruption and bribery legislation, employment law, money laundering and environmental protection legislation, recognising the nature of the Trust's activities. Auditing standards limit the required audit procedures to identify non-compliance with these laws and regulations to enquiry of the Accounting Officer and other management and inspection of regulatory and legal correspondence, if any. Therefore, if a breach of operational regulations is not disclosed to us or evident from relevant correspondence, an audit will not detect that breach.

### ***Context of the ability of the audit to detect fraud or breaches of law or regulation***

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

### **Other information in the Annual Report**

The Accounting Officer is responsible for the other information, which comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information; and
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

### ***Remuneration and Staff Reports***

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared, in all material respects, in accordance with the NHS Foundation Trust Annual Reporting Manual 2024/25.

### **Accounting Officer's responsibilities**

As explained more fully in the statement set out on page 104, the Accounting Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Group's and the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to either cease the services provided by the Group and the Trust or dissolve the Group and the Trust without the transfer of their services to another public sector entity.

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## **Auditor's responsibilities**

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at [www.frc.org.uk/auditorsresponsibilities](http://www.frc.org.uk/auditorsresponsibilities).

## **REPORT ON OTHER LEGAL AND REGULATORY MATTERS**

### **Report on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources**

Under the Code of Audit Practice, we are required to report if we identify any significant weaknesses in the arrangements that have been made by the Trust to secure economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

### **Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources**

As explained more fully in the statement set out on page 116, the Accounting Officer is responsible for ensuring that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Under Section 62(1) and paragraph 1(d) of Schedule 10 of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We planned our work and undertook our review in accordance with the Code of Audit Practice and related statutory guidance, having regard to whether the Trust had proper arrangements in place to ensure financial sustainability, proper governance and to use information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

## **Statutory reporting matters**

We are required by Schedule 2 to the Code of Audit Practice to report to you if:

- we issue a report in the public interest under paragraph 3 of Schedule 10 of the National Health Service Act 2006; or
- we make a referral to the Regulator under paragraph 6 of Schedule 10 of the National Health Service Act 2006 because we have reason to believe that the Trust, or a director or officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of expenditure which is unlawful, or is about to take, or has taken, a course of action which, if pursued to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in these respects.

## **THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES**

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's Royal Papworth Hospital NHS Foundation Trust Annual Report & Accounts 2024/25

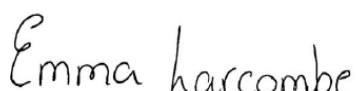
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report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

## **DELAY IN CERTIFICATION OF COMPLETION OF THE AUDIT<sup>2</sup>**

As at the date of this audit report, we are unable to confirm that we have completed our work in respect of the trust accounts consolidation pack of the Trust for the year ended 31 March 2025 because we have not received confirmation from the NAO that the NAO's audit of the Department of Health and Social Care accounts is complete.

Until we have completed this work, we are unable to certify that we have completed the audit of Royal Papworth Hospital NHS Foundation Trust for the year ended 31 March 2025 in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the NAO Code of Audit Practice.



**Emma Larcombe**

**for and on behalf of KPMG LLP**

*Chartered Accountants*

20 Station Road  
Cambridge  
CB1 2JD

26 June 2025



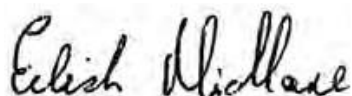
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## FOREWORD TO THE ACCOUNTS

### ROYAL PAPWORTH HOSPITAL NHS FOUNDATION TRUST

These accounts for the year ended 31 March 2025 have been prepared by the Royal Papworth Hospital NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 within the National Health Service Act 2006.

Signed:

A handwritten signature in black ink, appearing to read 'Eilish Midlane', is written over a light grey rectangular background.

Eilish Midlane  
Chief Executive  
Date: 25 June 2025

# CONSOLIDATED AND TRUST STATEMENT OF COMPREHENSIVE INCOME

## FOR THE YEAR ENDED 31 MARCH 2025

		Group 2024/25	Trust 2024/25	Group 2023/24	Trust 2023/24
	NOTE	£000	£000	£000	£000
<b>OPERATING INCOME</b>					
Operating income from patient care activities	2	312,654	312,654	282,033	282,033
Other operating income	3	23,188	21,880	20,558	20,168
<b>TOTAL OPERATING INCOME FROM CONTINUING OPERATIONS</b>		<b>335,842</b>	<b>334,534</b>	302,591	302,201
Operating expenses	4-5	(333,933)	(333,913)	(298,802)	(298,556)
<b>OPERATING SURPLUS FROM CONTINUING OPERATIONS</b>		<b>1,909</b>	<b>621</b>	3,789	3,645
Finance income	6	4,253	4,068	4,235	3,966
Finance expenses	7	(6,057)	(6,057)	(7,509)	(7,509)
Public Dividend Capital dividends payable	25	(1,799)	(1,799)	(1,905)	(1,905)
<b>NET FINANCE COSTS</b>		<b>(3,603)</b>	<b>(3,788)</b>	(5,179)	(5,448)
Loss on disposal of non-current assets	8	738	(26)	(166)	(167)
Movement in fair value of investments	12	(189)	-	306	-
<b>SURPLUS/(DEFICIT) FOR THE YEAR</b>		<b>(1,145)</b>	<b>(3,193)</b>	(1,250)	(1,970)
<b>OTHER COMPREHENSIVE INCOME</b>					
Gain on revaluations	10	625	625	5,694	5,694
<b>TOTAL COMPREHENSIVE EXPENSE FOR THE YEAR</b>		<b>(520)</b>	<b>(2,568)</b>	4,444	3,724

The notes on pages 134 to 187 form part of these accounts.

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**Adjusted financial performance****Trust  
2024/25****£000**

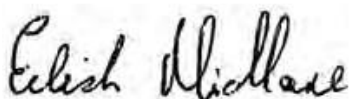
Surplus / (deficit) for the period (before consolidation of charity)	<b>(3,193)</b>
Remove capital donations / grants / peppercorn lease I&E impact	<b>328</b>
Remove PFI revenue costs on an IFRS 16 basis	<b>21,058</b>
Remove actual IFRIC 12 scheme finance costs - remeasurement	<b><u>(17,886)</u></b>
Adjusted financial performance surplus / (deficit)	<b><u>307</u></b>

# CONSOLIDATED AND TRUST STATEMENT OF FINANCIAL POSITION

AS AT 31 MARCH 2025

		Group 31 March 2025	Trust 31 March 2025	Group 31 March 2024	Trust 31 March 2024
	NOTE	£000	£000	£000	£000
<b>NON-CURRENT ASSETS</b>					
Intangible assets	9	1,699	1,699	576	576
Property, plant and equipment	10	180,908	180,908	184,262	184,262
Right of use assets	11	18,472	18,472	19,332	19,332
Investments	12	5,815	-	5,915	-
Trade and other receivables	14	3,446	3,446	2,675	2,675
<b>Total non-current assets</b>		<b>210,340</b>	<b>204,525</b>	212,760	206,845
<b>CURRENT ASSETS</b>					
Inventories	13	8,948	8,913	8,164	8,126
Trade and other receivables	14	18,256	15,332	16,887	15,622
Cash and cash equivalents	15	76,782	75,314	80,479	78,860
<b>Total current assets</b>		<b>103,986</b>	<b>99,559</b>	105,530	102,608
<b>TOTAL ASSETS</b>		<b>314,326</b>	<b>304,084</b>	318,290	309,453
<b>CURRENT LIABILITIES</b>					
Trade and other payables	16	(50,796)	(50,687)	(54,759)	(54,736)
Other liabilities	17	(5,503)	(5,503)	(4,531)	(4,531)
Borrowings	18	(5,721)	(5,721)	(5,422)	(5,422)
Provisions	19	(6,215)	(6,215)	(3,841)	(3,841)
<b>Total current liabilities</b>		<b>(68,235)</b>	<b>(68,126)</b>	(68,553)	(68,530)
<b>TOTAL ASSETS LESS CURRENT LIABILITIES</b>		<b>246,091</b>	<b>235,958</b>	249,737	240,923
<b>NON-CURRENT LIABILITIES</b>					
Other liabilities	17	(1,415)	(1,415)	(2,030)	(2,030)
Borrowings	18	(99,951)	(99,951)	(103,123)	(103,123)
Provisions	19	(940)	(940)	(902)	(902)
<b>Total non-current liabilities</b>		<b>(102,306)</b>	<b>(102,306)</b>	(106,055)	(106,055)
<b>TOTAL ASSETS EMPLOYED</b>		<b>143,785</b>	<b>133,652</b>	143,682	134,868
<b>FINANCED BY:</b>					
<b>TAXPAYERS' EQUITY</b>					
Public dividend capital	25	125,975	125,975	125,352	125,352
Revaluation reserve		52,664	52,664	51,310	51,310
Income and expenditure reserve		(44,987)	(44,987)	(41,794)	(41,794)
<b>OTHERS' EQUITY</b>					
Charitable fund reserves	33	10,133	-	8,814	-
<b>TOTAL TAX PAYERS' AND OTHER'S EQUITY</b>		<b>143,785</b>	<b>133,652</b>	143,682	134,868

The financial accounts on pages 129 to 187 were approved by the Board on the 24 06 2024 and signed on its behalf by:



Eilish Midlane, Chief Executive

Date: 25 June 2025

# CONSOLIDATED AND TRUST STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2025

	Public Dividend Capital £000	Trust Income and Expenditure Reserve £000	Revaluation Reserve £000	Total Reserves £000	Charitable Fund Reserves £000	Group Total Reserves £000
<b>Taxpayers' and others' equity at 1 April 2023</b>	125,265	(37,140)	45,616	133,741	8,094	<b>141,835</b>
<b>Changes in taxpayers' equity for 2023/24</b>						
Application of IFRS 16		(2,684)		(2,684)		<b>(2,684)</b>
Total Comprehensive expense/(income) for the year	-	(1,970)	-	(1,970)	720	<b>(1,250)</b>
Revaluations - Property, Plant and Equipment	-	-	5,615	5,615	-	<b>5,615</b>
Revaluations - right of use assets	-	-	79	79	-	<b>79</b>
Public dividend capital received	87	-	-	87		<b>87</b>
<b>Taxpayers' and others' equity at 31 March 2024</b>	<b>125,352</b>	<b>(41,794)</b>	<b>51,310</b>	<b>134,868</b>	<b>8,814</b>	<b>143,682</b>
 <b>Taxpayers' and others' equity at 1 April 2024</b>	 <b>125,352</b>	 <b>(41,794)</b>	 <b>51,310</b>	 <b>134,868</b>	 <b>8,814</b>	 <b>143,682</b>
<b>Changes in taxpayers' equity for 2024/25</b>						
Surplus/(deficit) for the year		(3,193)		(3,193)	1,319	<b>(1,874)</b>
Impairment	-		(53)	(53)		<b>(53)</b>
Revaluations - Property, Plant and Equipment	-	-	1,407	1,407		<b>1,407</b>
Public dividend capital received	710	-	-	710		<b>710</b>
Public dividend capital repaid	(87)			(87)		<b>(87)</b>
<b>Taxpayers' and others' equity at 31 March</b>	<b>125,975</b>	<b>(44,987)</b>	<b>52,664</b>	<b>133,652</b>	<b>10,133</b>	<b>143,785</b>

The notes on pages 134 to 187 form part of these accounts.

## CONSOLIDATED AND TRUST STATEMENT OF CASH FLOWS

### FOR THE YEAR ENDED 31 MARCH 2025

		Group 2024/25	Group 2023/24	Trust 2024/25	Trust 2023/24
	NOTE	£000	£000	£000	£000
<b>CASH FLOWS FROM OPERATING ACTIVITIES</b>					
Operating surplus		1,909	3,789	621	3,645
<b>NON CASH INCOME AND EXPENSE:</b>					
Depreciation and amortisation	9/10/11	10,576	11,485	10,576	11,485
Income recognised in respect of capital donations		(143)	(18)	(171)	(18)
(Increase) in inventories		(787)	(223)	(787)	(223)
Decrease/(increase) in receivables and other assets		203	2,116	524	2,010
Increase in trade and other payables		(5,753)	6,335	(5,753)	6,335
Increase other liabilities		357	718	357	718
(Decrease)/increase in provisions		2,418	(1,525)	2,418	(1,525)
NHS Charitable fund – net movements in working capital, non-cash transactions, non operating cash flows		(1,269)	(821)	-	-
<b>Net cash generated from operating activities</b>		<b>7,511</b>	<b>21,856</b>	<b>7,785</b>	<b>22,427</b>
<b>Cash flows from investing activities</b>					
Interest received		4,132	3,851	4,132	3,851
Payments for land, property, plant and equipment		(3,480)	(3,712)	(3,480)	(3,712)
Proceeds from disposal of property, plant and equipment		-	-	-	-
Receipt of cash donations to purchase capital assets		143	-	151	-
Initial direct costs or up front payments in respect of new right of use assets		-	-	-	-
Payments for intangible assets		(1,143)	(126)	(1,143)	(126)
NHS Charitable fund – net cash flows from investing activities		131	269	-	-
<b>Net cash (used)/from investing activities</b>		<b>(217)</b>	<b>282</b>	<b>(340)</b>	<b>13</b>
<b>Net cash inflow before financing</b>		<b>7,294</b>	<b>22,138</b>	<b>7,445</b>	<b>22,440</b>
<b>Cash flows from financing activities</b>					
Public dividend capital received		710	87	710	87
Public dividend capital repaid		(87)	-	(87)	-
Other loans paid		(424)	(424)	(424)	(424)
Capital element of lease liability repayments		(874)	(806)	(874)	(806)
Capital element of PFI payments		(2,634)	(2,422)	(2,634)	(2,422)
Interest paid		(52)	(55)	(52)	(55)
Interest paid on lease liability repayments		(171)	(170)	(171)	(170)
Interest paid on PFI obligations		(5,152)	(5,263)	(5,152)	(5,263)
PDC dividends paid		(2,307)	(1,837)	(2,307)	(1,837)
<b>Net cash used in financing activities</b>		<b>(10,991)</b>	<b>(10,890)</b>	<b>(10,991)</b>	<b>(10,890)</b>
<b>Increase in cash and cash equivalents</b>		<b>(3,697)</b>	<b>11,248</b>	<b>(3,546)</b>	<b>11,550</b>
<b>Cash and cash equivalents at 1 April</b>		<b>80,479</b>	<b>69,231</b>	<b>78,860</b>	<b>67,310</b>
<b>Cash and cash equivalents at 31 March</b>	16	<b>76,782</b>	<b>80,479</b>	<b>75,314</b>	<b>78,860</b>

The notes on page 134 to 187 form part of these accounts.

Royal Papworth Hospital NHS Foundation Trust Annual Report & Accounts 2024/25

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## NOTES TO THE ACCOUNTS

### 1. ACCOUNTING POLICIES

#### Basis of preparation

NHS England has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2024/25 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

#### Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

#### Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

International Accounting Standard (IAS) 1 requires management to assess, as part of the accounts preparation process, the NHS Foundation Trust's ability to continue as a going concern. The financial statements should be prepared on a going concern basis unless management intends, or has no alternative but, to apply to the Secretary of State for the NHS Foundation Trust's dissolution without the transfer of its services to another entity.

Key matters relating to the Trust's financial position are:

- The Trust reported a financial surplus of £0.3m, on an adjusted performance basis which removes the impact of PFI accounting transition from UK GAAP to IFRS 16, impairment, donated assets and donated consumables, for the 2024/25 financial year;
- The Trust reported a closing cash position for the 2024/25 financial year of £75.3m.

Royal Papworth Hospital NHS Foundation Trust's Board of Directors has carefully considered the principle of 'Going Concern' and after making enquiries, the Directors have a reasonable expectation that the Trust will have access to adequate resources to continue in operational existence for the going concern period. For this reason, they continue to adopt the going concern basis in preparing the accounts.



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## 1.1 Consolidation of Subsidiary

The NHS Foundation Trust is the Corporate Trustee of the Royal Papworth Hospital Charitable Fund, a registered charity. The NHS Foundation Trust has assessed its relationship to the Charitable Fund and determined it to be a subsidiary because the NHS Foundation Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the Charitable Fund and has the ability to affect those returns and other benefits through its power over the fund.

The Charitable Fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

- recognise and measure them in accordance with the NHS Foundation Trust's accounting policies; and
- eliminate intra-group transactions, balances, gains and losses.

The Charitable Fund includes all incoming resources in full in the Statement of Financial Activities as soon as the following three factors are met: entitlement, probable receipt and measurement.

Legacy income is accounted for as incoming resources once the receipt of the legacy becomes probable. Receipt is normally probable when:

- there has been a grant of probate;
- the executors have established that there are sufficient assets in the estate, after settling any liabilities, to pay the legacy; and
- any conditions attached to the legacy are either within the control of the charity or have been met.

The Charitable Fund financial statements are prepared in accordance with the accruals concept. A liability (and consequently, expenditure) is recognised in the financial statements when there is a legal or constructive obligation, capable of reliable measurement, arising from a past event.

Investment comprises of shares traded on a daily basis where the valuation is based on the market value at the date of the Statement of Financial Position and also cash held with the investment managers for future investment in equity.

All gains and losses on investment are taken to the Statement of Comprehensive Income as they arise. Realised gains and losses on investments are calculated as the difference between sale proceeds and opening market value (or date of purchase if later).

## 1.2 Associate entities

Associate entities are those over which the NHS Foundation Trust has the power to exercise a significant influence. Associate entities are recognised in the NHS Foundation Trust's financial statement using the equity method. The investment is initially recognised at cost. It is increased or decreased subsequently to reflect the NHS Foundation Trust's share of the entity's profit or loss or other gains and losses (e.g. revaluation gains on the entity's property, plant and equipment) following acquisition. It is also reduced when any distribution e.g. share dividends are received by the NHS Foundation Trust from the associate.

However, where the NHS Foundation Trust's proportion of an associate's cumulative profits or losses at year end are less than £50,000; no adjustment is made to the cost of the investment

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on the basis of immateriality. The NHS Foundation Trust does not have any material associates.

### **1.3 Revenue recognition**

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The DHSC GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of services provided is recognised when performance obligations are satisfied by transferring promised services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end the NHS Foundation Trust accrues income relating to performance obligations satisfied in that year. Where the NHS Foundation Trust's entitlement to consideration for those services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than a passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

#### **Revenue from NHS contracts**

The main source of income for Royal Papworth NHS Foundation Trust is covered under the NHS Standard Contract agreed with NHS commissioners. Funding envelopes are set at both an Integrated Care System (ICS) and NHS England Direct Commissioning level. The majority of the Trust's NHS income is earned under the Aligned Payment Incentive mechanism (API).

The NHS Payment Scheme (NHSPS) sets out rules to establish the payment mechanisms and values paid to NHS Trusts for NHS-funded secondary elective healthcare.

Aligned payment and incentive contracts form the main payment mechanism under the NHSPS. API contracts contain both a fixed and variable element. Under the variable element, providers earn income for elective activity (both ordinary and day case), out-patient procedures, out-patient first attendances, diagnostic imaging and nuclear medicine, and chemotherapy delivery activity. The precise definition of these activities is given in the NHSPS. Income is earned at NHSPS prices based on actual activity. The fixed element includes income for all other services covered by the NHSPS assuming an agreed level of activity with 'fixed' in this context meaning not varying based on units of activity. Elements within this are accounted for as variable consideration under IFRS 15 as explained below.

The Trust also receives income from commissioners under Commissioning for Quality Innovation (CQUIN) and Best Practice Tariff (BPT) schemes. Delivery under these schemes is part of how care is provided to patients. As such CQUIN and BPT payments are not considered distinct performance obligations in their own right; instead, they form part of the transaction price for performance obligations under the overall contract with the commissioner and are accounted for as variable consideration under IFRS 15. Payment for CQUIN and BPT on non-elective services is included in the fixed element of API contracts with adjustments for actual achievement being made at the end of the year. BPT earned on elective activity is included in the variable element of API contracts and paid in line with actual activity performed.

Elective recovery funding provides additional funding to integrated care boards to fund the commissioning of elective services within their systems. Trusts do not directly earn elective recovery funding, instead earning income for actual activity performed under API contract arrangements as explained above. The level of activity delivered by the trust contributes to system performance and therefore the availability of funding to the trust's commissioners.

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## **Revenue from research contracts**

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases, it is assessed that the NHS Foundation Trust's interim performance does not create an asset with alternative use for the NHS Foundation Trust, and the NHS Foundation Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the NHS Foundation Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

## **NHS injury cost recovery scheme**

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

## **Revenue from the sale of non-current assets**

Income from the sale of non-current assets is recognised only when all of the following conditions of the sale have been met, and is measured as the sums due under the sale contract:

- the entity has transferred to the buyer the significant risks and rewards of ownership of the asset;
- the entity retains neither continuing managerial involvement to the degree usually associated with ownership nor effective control over the assets sold;
- the amount of revenue can be measured reliably;
- it is probable that the economic benefits associated with the transaction will flow to the entity;
- the costs incurred or to be incurred in respect of the transaction can be measured reliably.

## **Grants and donations**

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure, it is credited to the Consolidated Statement of Comprehensive Income once conditions to the grant have been met. Donations are treated in the same way as government grants.

## **Apprenticeship service income**

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

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## 1.4 Short-term employee benefits

Salaries, wages and employment related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

## 1.5 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at [www.nhsbsa.nhs.uk/pensions](http://www.nhsbsa.nhs.uk/pensions). Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”.

An outline of these follows:

### a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2025, is based on valuation data as at 31 March 2023, updated to 31 March 2025 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

### b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

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The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

## **1.6 Expenditure on other goods and services**

Expenditure on goods and services is recognised when and to the extent that they have been received and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

## **1.7 Property, Plant and Equipment**

### ***Recognition***

Property, plant and equipment assets are capitalised if they are capable of being used for a period which exceeds one year and:

- It is held for use in delivering services or for administrative purposes.
- it is probable that future economic benefits will flow to, or service potential be provided to the NHS Foundation Trust.
- the cost of the item can be measured reliably.
- individually have a cost of at least £5,000; or
- form a group of assets which individually have a cost of more than £250, collectively have a cost of at least £5,000, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control.
- form part of the initial setting-up cost of a new building or refurbishment of a ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different lives e.g., plant and equipment, then these components are treated as separate assets and depreciated over their own economic lives.

### **Subsequent expenditure**

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs, and maintenance is charged to the Statement of Comprehensive Income in the period in which it is incurred.

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## Measurement

### *Valuation*

All property, plant and equipment assets are initially measured at cost (for leased assets, fair value) including any costs directly attributable to acquiring or constructing the asset and bringing them to a location and condition necessary for them to be capable of operating in the manner intended by the NHS Foundation Trust.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

### *Property*

All land and buildings used for the NHS Foundation Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Valuations are carried out by professionally qualified valuers in accordance with the Valuation Standards published by the Royal Institution of Chartered Surveyors (previously the RICS Appraisal and Valuations Standards). Revaluations are performed on with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. The timing of these valuations will be adjusted, to become more frequent or less frequent, depending on the situation in the market. Current value in existing use is determined as follows:

- Land - market value for existing use value
- Non-specialised buildings – market value for existing use value (see below)
- Specialised buildings - depreciated replacement cost based on a modern equivalent basis.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on the alternative site basis where this would meet the location requirements.

Non-specialist operational assets fair value is based on an assumption of a continuation of the existing use, derived from relevant market evidence. For the main part, these comprise the NHS Foundation Trust's operational land.

For non-operational properties including surplus land, the valuations are carried out at fair value based on alternative use.

A desktop valuation of the Royal Papworth Hospital site on the Cambridge Biomedical Campus was carried out in 2024/25 by the Trust's externally appointed independent valuer, Gerald Eve LLP, Chartered Surveyors. The effective date of valuation was the 31 March 2025 and is accounted for in the 2024/25 accounts. See Note 10.

Valuation guidance issued by the Royal Institution of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity. This basis has been applied to the NHS Foundation Trust's Private Finance Initiative (PFI) scheme where



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the construction was completed by a special purpose vehicle and the costs have recoverable VAT for the NHS Foundation Trust.

### *Assets in the Course of Construction*

Properties in the course of construction for service or administration purposes are valued at cost, less any impairment loss and are valued by professional valuers when they are brought into use. Cost includes professional fees and where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued and depreciation on these assets commences when the asset is brought into use.

### *Equipment*

IT equipment, transport equipment, furniture and fittings, and plant and equipment held for operation use are valued at depreciated historical cost where these assets have short useful lives or low value or both, as this is considered to be a satisfactory proxy for current value. For non-IT operational equipment depreciated historical cost is considered to be a satisfactory proxy for current value but this will be kept under review and advice on fair value sought from external sources if considered appropriate. Equipment surplus to requirements is valued at net recoverable amount.

### **Depreciation**

Items of property, plant and equipment assets are depreciated on a straight-line basis over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have infinite life and is not depreciated.

The estimated useful life of an asset is the period over which the NHS Foundation Trust expects to obtain economic benefits or service potential from it.

Property, plant and equipment assets which have been reclassified as 'Held for sale' cease to be depreciated upon reclassification.

Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the NHS Foundation Trust, respectively.

### **Revaluation gains and losses**

Revaluation gains are recognised in the revaluation reserve, except where and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income. A revaluation gain due to an increase in general market price does not represent a reversal of a previous economic benefit/service potential impairment and is therefore accounted for as a revaluation gain rather than a reversal of a past economic benefit impairment.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'Other Comprehensive Income'.

### **Impairments**

In accordance with the DHSC GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure



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reserve of an amount equal to the lower of (i) the impairment charged to operating expenses: and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

The carrying values of property, plant and equipment assets are reviewed for impairments in periods if events or changes in circumstances indicate carrying values may not be recoverable.

### **De-recognition**

Assets intended for disposal are reclassified as 'Held for Sale' once the criteria in IFRS 5 below are met:

- i. The asset is available for immediate sale in its present condition subject only to the terms which are usual and customary for such sales;
- ii. The sale must be highly probable i.e.:
  - management are committed to a plan to sell the asset;
  - an active programme has begun to find a buyer and complete the sale;
  - the asset is being actively marketed at a reasonable price;
  - the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'; and
  - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell.' Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amounts. Assets are de-recognised when all material sale contract conditions have been met.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount less cost of sale and is recognised in operating income or operating expenses respectively. On disposal, the balance for the asset in the revaluation reserve is transferred to the income and expenditure reserve.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

### **Donated, government grant and other grant funded assets**

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the economic benefits embodied in the donation/grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as purchased items of property, plant and equipment.

This includes assets donated to the NHS Foundation Trust by the Department of Health and Social Care as part of the response to the coronavirus pandemic. As defined in the GAM, the NHS Foundation Trust applies the principle of donated asset accounting to assets that the NHS Foundation Trust controls and is obtaining economic benefits from at the year end.

### **Private Finance Initiative (PFI) transactions**

PFI transactions which meet the IFRIC12 definition of service concession, as interpreted in HM Treasury's FREM, are accounted for as 'on Statement of Financial Position' by the NHS Foundation Trust. In accordance with HM Treasury's FREM, the underlying assets are recognised as property, plant and equipment when they are brought into use, together with an equivalent liability. Initial measurement of the asset and liability are in accordance with the initial measurement principles of IFRS 16 (see leases accounting policy).

Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate and measured at current value in existing use.

The annual contract payments are apportioned between the repayment of the liability, a finance cost, the charges for services and lifecycle replacement of components of the asset. The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as a finance cost as incurred.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

### **Initial application of IFRS 16 liability measurement principles to PFI and LIFT liabilities in 2023/24**

IFRS 16 liability measurement principles were applied to PFI, LIFT and other service concession arrangement liabilities in these financial statements from 1 April 2023. The change in measurement basis was applied using a modified retrospective approach with the cumulative impact of remeasuring the liability on 1 April 2023 recognised in the income and expenditure reserve.

### **Useful economic life**

Buildings, installations and fittings are depreciated on their current value over the estimated remaining life of the asset as advised by the NHS Foundation Trust's professional valuers.

The current ranges of estimated lives being used are:

	<b>Min Life Years</b>	<b>Max Life Years</b>
Buildings	25	85

Leaseholds are depreciated over primary lease term.

Finance-leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term unless the NHS Foundation Trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Equipment is depreciated on current cost evenly over the estimated life of the asset using the following lives:

	<b>Min Life Months</b>	<b>Max Life Months</b>
Medical Equipment and Engineering Plant and Equipment	36	180
Furniture	54	180
Soft Furnishings	54	84
Office and Information Technology Equipment	42	60
Set-up Costs in New Buildings	60	60
Vehicles	60	60

## 1.8 Intangible assets

### ***Recognition***

Intangible assets are non-monetary assets without physical substance controlled by the Trust. They are capable of being sold separately from the rest of the Trust's business or arise from contractual or other legal rights. Intangible assets are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

### ***Internally generated intangible assets***

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised. Expenditure on development is capitalised when it meets the requirements set out in IAS 38.

### ***Software***

Purchased computer software, where expenditure of at least £5,000 is incurred, which is integral to the operation of hardware e.g., an operating system is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g., application software, is capitalised as an intangible asset.

### **Measurement**

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by the NHS Foundation Trust.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Intangible assets held for sale are measured at the lower of their carrying amount or "fair value less costs to sell."

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## Amortisation

Intangible assets are amortised over their expected useful economic lives on a straight-line basis or in the case of software the shorter of the term of the licence or the expected useful economic life using the following lives:

	<b>Min Life Months</b>	<b>Max Life Months</b>
Software	36	60

### 1.9 Revenue government and other grants

Government grants are grants from government bodies other than income from commissioners or NHS Trusts for the provision of services. Grants from the Department of Health and Social Care are accounted for as government grants, as are grants from the Big Lottery Fund.

Government grants for capital purposes are credited directly to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

Where the government grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

### 1.10 Grant expenditure

When entering into grant agreements to support the NHS Foundation Trust's strategic objectives of "working with partners" and supporting "research and innovation", the NHS Foundation Trust applies IAS 37 Provisions, Contingent Liabilities and Contingent Assets as the relevant applicable standard. IAS 37 does not provide specific guidance regarding grants however this is considered to be the applicable standard as the economic substance of the grant agreements is the creation of a liability and outflow of resources.

### 1.11 Inventories

Inventories are valued at the lower of cost and net realisable value using the *first-in-first-out* cost (FIFO) method. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

Between 2020/21 and 2023/24 the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department. Distribution of inventories by the Department ceased in March 2024.

### 1.12 Financial Instruments and financial liabilities

#### **Recognition**

Financial assets and financial liabilities arise where the NHS Foundation Trust is party to the contractual provisions of a financial instrument and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The DHSC GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other aspects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

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This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the NHS Foundation Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or service is made.

Financial assets and financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with accounting policy for leases described below at note 1.14.

All other financial assets and financial liabilities are recognised when the NHS Foundation Trust becomes a party to the contractual provisions of the instrument.

### ***De-recognition***

All financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the NHS Foundation Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

### ***Classification and Measurement***

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price or otherwise determined by reference to quoted market process or valuation techniques.

Financial assets are classified as subsequently measured at amortised cost. Financial liabilities are classified as subsequently measured at amortised cost.

### ***Financial assets and financial liabilities at amortised cost***

Financial assets and financial liabilities at amortised costs are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income as a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

### ***Impairment of financial assets***

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets the NHS Foundation Trust recognises an allowance for expected credit losses.

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The NHS Foundation Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

Expected credit losses for private patient activity are determined through a review of existing outstanding debt. For all other categories of debt, the expected credit losses are determined using historic debt write off data.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate. The NHS Foundation Trust does not recognise loss allowances for stage 1 or stage 2 impairments against other government bodies.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

A receivable will be written off when either all avenues of collection have been exhausted or it is no longer economically viable to pursue the outstanding amount.

### ***Derecognition***

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

## **1.13 Cash and cash equivalents**

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts, that are repayable on demand and that form an integral part of the NHS Foundation Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

These balances exclude monies held in the NHS Foundation Trust's bank account belonging to patients (see note 30). Account balances are only off set where a formal agreement has been made with the bank to do so.

## **1.14 Leases**

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The NHS Foundation Trust does not apply lease accounting to new contracts for the use of intangible assets.



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The NHS Foundation Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the NHS Foundation Trust is reasonably certain to exercise.

### ***The NHS Foundation Trust as a Lessee***

#### ***Recognition and Initial Measurement***

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments include fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.72% applied to new leases commencing in 2024 and 4.81% to new leases commencing in 2025.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term. Irrecoverable VAT on lease payments is expensed as it falls due.

#### ***Subsequent measurement***

As required by a HM Treasury interpretation of the accounting standard for the public sector, the NHS Foundation Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The NHS Foundation Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

A valuation of the non-residential property right of use assets was carried out in 2024/25 by the NHS Foundation Trust's externally appointed independent valuer, Gerald Eve LLP, Chartered Surveyors. The effective date of valuation was the 31 March 2025 and is accounted for in the 2024/25 accounts. See Note 11.



## 1.15 Provisions

The NHS Foundation Trust recognises a provision where it has a present legal or constructive obligation that is of uncertain timing or amount for which it is probable that there will be a future outflow of cash or other resource and that a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resource required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective for 31 March 2025:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	4.03%	4.26%
Medium-term	After 5 years up to 10 years	4.07%	4.03%
Long-term	After 10 years up to 40 years	4.81%	4.72%
Very long-term	Exceeding 40 years	4.55%	4.40%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective 31 March 2025:

	Inflation rate	Prior year rate
Year 1	2.60%	3.60%
Year 2	2.30%	1.80%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.40% in real terms (prior year: 2.45%).

### Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the NHS Foundation Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS Foundation Trust. The total value of clinical negligence provisions carried by the NHS Resolution on behalf of the NHS Foundation Trust is disclosed at note 20 but is not recognised in the NHS Foundation Trust's accounts.

### Non-clinical risk pooling

The NHS Foundation Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the NHS Foundation Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The NHS Foundation Trust does not include any amounts in its financial statements relating to these cases. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

## 1.16 Contingent assets and liabilities

Contingent assets (that is, assets arising from past events and whose existence will only be confirmed by one or more future events not wholly within NHS Foundation Trust's control) are not recognised as assets but disclosed in note 20 to the financial statements where an inflow of economic benefits is probable.

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Contingent liabilities are not recognised but are disclosed in note 20 unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficiently reliability.

### **1.17 Public dividend capital**

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined in the PDC dividend policy issued by the Department of Health and Social Care. This policy is available at <https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts>.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

### **1.18 Value added tax (VAT)**

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

### **1.19 Corporation tax**

A NHS Foundation Trust is a Health Service Body within the meaning of s519A of the Income and Corporation Tax Act 1988 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this. There is a power for HM Treasury to dis-apply the exemption in relation to specified activities of a Foundation Trust (s519A (3) to (8) of the Income and Corporation Taxes Act 1988). Accordingly, a Foundation Trust is potentially within the scope of corporation tax in respect of activities which are not related to, or ancillary to, the provision of healthcare, and where the profits from these activities exceed £50k per annum. There are no such profits and therefore no liability for corporation tax in relation to the year ended 31 March 2025 or prior periods.

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## 1.20 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

## 1.21 Foreign exchange

The functional and presentational currency of the NHS Foundation Trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the NHS Foundation Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items (other than financial instruments measured at “fair value through income and expenditure”) are translated at the spot exchange rate at 31 March.
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

## 1.22 Third party assets

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts since the NHS Foundation Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirement of the HM Treasury Financial reporting Manual (FReM). See note 30.

## 1.23 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS foundation trusts not been bearing their own risks (with insurance premiums then being incurred as normal revenue expenditure). See note 31.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

## 1.24 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated

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transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

## **1.25 Segmental reporting**

Operating segments are reported in a manner consistent with the internal reporting provided to the chief operating decision-maker. The chief operating decision-maker, who is responsible for allocating resources and assessing performance of the operating segments, has been identified as the Board of Directors, who are responsible for making strategic decisions.

## **1.26 Carbon reduction commitment**

The NHS Foundation Trust has a strategy in place outlining the aims and objectives for sustainable development and has in place the Green Plan for delivering the strategy across financial years 2022/24 to 2024/25.

The plan will enable the NHS Foundation Trust to contribute to the national target of a 'net zero' NHS.

## **1.27 Early adoption of standards, amendments and interpretations**

No new accounting standards or revisions to existing standards have been early adopted in 2024/25.

## **1.28 Accounting standards that have been issued but have not yet been adopted**

The DHSC GAM does not require the following IFRS Standards to be applied in 2024/25:

IFRS 17 Insurance Contracts – The Standard is effective for accounting periods beginning on or after 1 January 2023. IFRS 17 has been adopted by the FReM from 1 April 2025. Adoption of the Standard for NHS bodies will therefore be in 2025/26. The Standard revises the accounting for insurance contracts for the issuers of insurance. Application of this standard from 2025/26 is not expected to have a material impact on the financial statements.

IFRS 18 Presentation and Disclosure in Financial Statements - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

Changes to non-investment asset valuation – Following a thematic review of non-current asset valuations for financial reporting in the public sector, HM Treasury has made a number of changes to valuation frequency, valuation methodology and classification which are effective in the public sector from 1 April 2025 with a 5-year transition period. NHS bodies are adopting these changes to an alternative timeline.

Changes to subsequent measurement of intangible assets and PPE classification / terminology to be implemented for NHS bodies from 1 April 2025:

- Withdrawal of the revaluation model for intangible assets. Carrying values of existing intangible assets measured under a previous revaluation will be taken forward as deemed historic cost.

- Removal of the distinction between specialised and non-specialised assets held for their service potential. Assets will be classified according to whether they are held for their operational capacity.

These changes are not expected to have a material impact on these financial statements.

Changes to valuation cycles and methodology to be implemented for NHS bodies in later periods:

- A mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years.
- Removal of the alternative site assumption for buildings valued at depreciated replacement cost on a modern equivalent asset basis. The approach for land has not yet been finalised by HM Treasury.

## **1.29 Critical judgements and key sources of estimation uncertainty**

In the application of the NHS Foundation Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

### **Property valuation**

The NHS Foundation Trust's estate has been valued as explained at note 1.7.

It is impracticable to disclose the extent of the possible effects of an assumption or another source of estimation uncertainty at the end of the reported period. On the basis of existing knowledge, outcomes within the next financial year that are different from the assumption around the valuation of our land, property, plant and equipment could require a material adjustment to the carrying amount of the asset or liability recorded in note 10.1.

### **Intangible assets**

The intangible assets balance is composed entirely of software under development and software licences. These are stated at historic depreciated cost on the basis that this is not materially different from their fair value.

### **Allowances for impaired receivables**

Allowances are made for impaired receivables for estimated losses arising from the subsequent inability or refusal of patients or commissioners to make the required payment. Further detail is given at notes 14.2 and 14.3.

### **Private Finance Initiative**

An assessment of the NHS Foundation Trust's Private Finance Initiative (PFI) scheme has been made, and it has been determined that the PFI scheme in respect of the new hospital building should be accounted for as an on-Statement of Financial Position asset under IFRIC 12. This requires a judgement to be made around how to model the scheme in order to determine the required accounting entries. The key judgements were to initially value the hospital at the cost of construction, to attribute asset lives up to 80 years on certain

components and to identify the components of the hospital subject to lifecycle maintenance, which should be accounted for separately.

An estimate has also been used to determine total future obligations under PFI contracts as disclosed in note 23, in relation to future rates of inflation. The estimate does not affect the carrying value of liabilities in the Statement of Financial Position at 31 March 2025, or the amounts charged through the Statement of Comprehensive Income.

## 2. OPERATING INCOME FROM PATIENT CARE ACTIVITIES

### 2.1 Income from patient care activities (by nature)

#### 2.1 Income from patient care activities (by nature)

	2024/25	2023/24
	£000	£000
Aligned payment & incentive (API) contract income/system block income*	210,510	194,041
Homecare drugs income	52,327	47,768
Other high cost drugs and pass through devices income from commissioners **	24,371	18,426
Other NHS clinical income***	6,537	6,581
Private patient income	10,010	9,858
National pay award central funding****	419	99
Additional pension contribution central funding*****	8,424	5,019
Other clinical income	56	241
<b>Total income from patient care activities</b>	<b>312,654</b>	<b>282,033</b>

\* Aligned payment & incentive (API) includes fixed and variable income

\*\* Additional income received for cost and volume drugs and visible cost model (VCM) devices.

\*\*\* Income received from NHS Blood & Transplant, Welsh, Scottish and Northern Ireland Health Boards.

\*\*\*\* Additional funding was made available directly to providers by NHS England in 2024/25 and 2023/24 for implementing the backdated element of pay awards where government offers were finalised after the end of the financial year. NHS Payment Scheme prices and API contracts are updated for the weighted uplift in in-year pay costs when awards are finalised.

\*\*\*\*\* The additional pension contribution central funding relates to the additional 9.4% pension contributions paid by NHS England on behalf of the NHS Foundation Trust. The related expenditure is included in note 4.1 Operating expenses under staff costs.

### 2.2 Patient income by source

	2024/25	2023/24
	£000	£000
NHS England	142,776	215,772
Integrated Care Boards*	155,564	51,372
NHS Trusts	0	12
NHS Other	4,248	4,791
Non NHS:		
- Private patients	10,010	9,858
- Overseas chargeable patients	56	228
<b>Total revenue from patient care activities</b>	<b>312,654</b>	<b>282,033</b>

NHS England income includes reimbursement for homecare drugs which has been reported on a gross basis. This was in response to the Coronavirus pandemic which moved reimbursement of homecare drugs to a mixed model of block and cost and volume. The central funding for the Agenda for Change pay offer is also included in this figure.

The Trust has not included partially completed patient spells in its patient activity income in 2024/25, with the exception of highly specialised services.

## 2.3 Operating segments

IFRS 8 requires income and expenditure to be broken down into the operating segments reported to the chief operating decision maker. The NHS Foundation Trust considers the Board to be the chief operating decision maker because it is responsible for approving its budgets and hence responsible for allocating resources to operating segments and assessing their performance.

For 2024/25 the NHS Foundation Trust considers that it only has one operating segment, healthcare. The Board of Directors receives financial reports that analyse financial performance across the Trust as one operating segment and this has been reinforced by the revised financial framework that came into place at the start of 2024/25.

All income for each patient service above is received from external commissioners as follows:

### 2.3 Income by external commissioners

	2024/25	2023/24
	£000	£000
NHS England*	142,776	215,772
Cambridgeshire and Peterborough ICB**	70,810	27,832
Norfolk & Waveney ICB**	24,128	5,382
NHS Suffolk and North East Essex ICB**	28,459	7,061
NHS Bedfordshire, Luton and Milton Keynes ICB**	10,411	3,167
NHS Lincolnshire ICB**	7,335	2,036
NHS Hertfordshire and West Essex ICB**	7,800	3,565
Other ICBs**	6,621	2,329
Other NHS	3,008	3,785
<b>Subtotal</b>	<b>301,348</b>	<b>270,929</b>
Welsh Health Boards	934	876
Scottish Health Board	180	91
Northern Ireland Health Boards	126	51
Private patients	10,010	9,858
Other non-NHS	56	228
<b>Total revenue from patient care activities per note 2.1</b>	<b>312,654</b>	<b>282,033</b>

\* In 2024/25, NHSE Delegated commissioning of some specialised activity to Integrated Care Boards ICBs

\*\* Integrated Care Boards (ICBs) paid for delegated specialised activity in 2024/25

### 2.3 Income from activities arising from commissioner requested services

Under the terms of its license, the NHS Foundation Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the trust license and are services that commissioners believe would need to be protected in the event of trust failure. This information is provided in the table below:



	2024/25	2023/24
	£000	£000
Income from services designated (or grandfathered) as commissioner requested	312,654	282,033

## 2.4 Overseas visitors (relating to patients charged directly by the NHS Foundation Trust)

	2024/25	2023/24
	£000	£000
Income recognised this year	56	228
Cash payments received in-year	102	230
Amounts added to provision for impairment of receivables	56	35
Amounts written off in-year	-	0

## 2.5 Private patient income

As a result of the Health and Social Care Act 2012 changes to the way the cap on private patient income of NHS Foundation Trusts is enforced came into effect during 2012/13.

As from 1 October 2012 Foundation Trusts are obliged to make sure that the income they receive from providing goods and services for the NHS (their principal purpose) is greater than their income from other sources (e.g. private patient work).

This effectively means that the former private patient cap has been removed.

## 3. OTHER OPERATING INCOME

	Group		Trust	
	2024/25	2023/24	2024/25	2023/24
	£000	£000	£000	£000
Research and development NHS Levy	3,200	2,767	3,200	2,767
Education and training *	7,229	6,369	7,229	6,369
Charitable and other contributions to expenditure	20	18	364	2,095
Merit award funding	1,276	1,132	1,276	1,132
Staff lodging	1,073	963	1,073	963
Staff recharges **	2,028	1,735	2,028	1,735
Research and development gross up ***	3,269	2,660	3,269	2,660
NHS Charitable income:				
Incoming resource excluding investment income	2,706	2,467	-	-
Covid Response funding reimbursement	-	-	-	-
Contributions to expenditure from DHSC group bodies	-	158	-	158
Other income	2,387	2,289	3,441	2,289
	<b>23,188</b>	<b>20,558</b>	<b>21,880</b>	<b>20,168</b>

\* Includes notional income from apprenticeship fund £339k (2023/24 - £389k).

\*\* Staff recharges have been shown gross in income and expenditure.

\*\*\* Funding received to cover costs of research and development incurred in the year.

## 4. OPERATING EXPENSES

### 4.1 Operating expenses comprise:

	Group		Trust	
	2024/25	2023/24	2024/25	2023/24
	£000	£000	£000	£000
Executive Directors' costs	1,522	1,364	1,522	1,364
Non-Executive Directors' costs	153	144	153	144
Staff costs	155,348	134,514	155,348	134,514
Drug costs	57,414	52,075	57,414	52,075
Supplies and services - clinical	68,559	59,938	68,559	59,938
Supplies and services - clinical: utilisation of consumables donated from DHSC group bodies for COVID response	-	192	-	192
Supplies and services - general	2,231	2,260	2,231	2,260
Inventories written down (consumables donated from DHSC bodies for COVID response)	-	2	-	2
Establishment	2,114	1,958	2,114	1,958
Research & Development	3,004	1,782	3,004	1,782
Transport	871	747	871	747
Premises	12,280	11,392	12,280	11,392
Increase/(decrease) in provisions for impairments of receivables	35	5	35	5
Depreciation of property, plant and equipment	10,225	10,727	10,225	10,727
Amortisation of intangible assets	351	758	351	758
Audit services - statutory audit	148	125	148	125
NHS Charitable Funds - statutory audit services	20	14	-	-
Consultancy	573	368	573	368
Internal audit and counter fraud services	98	80	98	80
Clinical negligence	2,487	2,213	2,487	2,213
Charges to operating expenditure for on-SoFP IFRIC 12 PFI schemes on IFRS basis	9,785	9,668	9,785	9,668
Research Grants *	-	2,000	-	2,000
Other	6,715	6,244	6,715	6,244
NHS Charitable Funds - other resources expended	-	232	-	-
	<b>333,933</b>	<b>298,802</b>	<b>333,913</b>	<b>298,556</b>

\*The Trust has made a grant to the University of Cambridge to leverage the University's research expertise, as part of its joint working to strategically improve patient care in the future. The proposed grant agreement covers health inequalities and tackling major cardiovascular disease burdens through the application and translation of research activity into trials.

### 4.2 Audit services

The Council of Governors has appointed KPMG LLP (KPMG) as external auditors of the NHS Foundation Trust from 1 April 2015. The audit fee for the statutory audit is £134,000 (2023/24: £124,950), excluding VAT. This is the fee for an audit in accordance with the Audit Code issued by Monitor in March 2011. The audit fees above includes additional fee for IFRS 16.

The engagement letter signed on 12 May 2021 states that the liability of KPMG, its members, partners and staff (whether in contract, negligence or otherwise) in respect of services provided in

connection with or arising out of the audit shall in no circumstances exceed £1 million (2023/24: £1 million) in the aggregate in respect of all such services.

External auditors will also receive remuneration of £20K (2023/24: £14,000), excluding VAT, for the statutory audit of the NHS Charity.

## 4.3 Operating leases

### 4.3.1 As lessee

#### Payments recognised as an expense

	2024/25 £000	2023/24 £000
Minimum lease payments	7	55

## 5 EMPLOYEE COSTS AND NUMBERS

### 5.1 Employee costs

	Group		Trust	
	2024/25 £000	2023/24 £000	2024/25 £000	2023/24 £000
Salaries and wages	112,565	101,639	112,565	101,639
Social security costs	12,306	11,373	12,306	11,373
Apprenticeship levy	561	513	561	513
Employer contributions to NHS Pensions Agency	12,929	11,536	12,929	11,536
Pension cost - employer contribution paid by NHSE on provider's behalf (9.4%) **	8,424	5,019	8,424	5,019
Pension cost - other	17	17	17	17
Termination benefits	-	-	-	-
Temporary staff (including agency/bank)	10,068	5,781	10,068	5,781
<b>Employee benefit expenses</b>	<b>156,870</b>	<b>135,878</b>	<b>156,870</b>	<b>135,878</b>

\* Excludes Non-Executive Directors' salary costs. These salary costs are included in note 4.1. The total value of annual leave accrual for the year is £407k (2023/24: £352k).

\*\* The additional pension contribution central funding relates to the additional 9.4% pension contributions paid by NHS England on behalf of the NHS Foundation Trust. The related income is included in note 2 Operating Income.

All employee benefit expenses have been charged to revenue.

### Pension Costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at [www.nhsbsa.nhs.uk/pensions](http://www.nhsbsa.nhs.uk/pensions). Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years.” An outline of these follows:

***a) Accounting valuation***

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2025, is based on valuation data as 31 March 2023, updated to 31 March 2025 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

***b) Full actuarial (funding) valuation***

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The actuarial valuation as at 31 March 2020 is currently underway and will set the new employer contribution rate due to be implemented from April 2024.

***c) Scheme provisions***

The NHS Pension Scheme provided defined benefits, which are summarised below. The list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

***Annual Pensions***

The Scheme is a “final salary” scheme. Annual pensions are normally based on 1/80<sup>th</sup> for the 1995 section and of the best of the last three years’ pensionable pay for each year of service, and 1/60<sup>th</sup> for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax-free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as ‘pension commutation.’

***Pensions Indexation***

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971 and are based on changes in Retail Prices in the 12 months ending 30<sup>th</sup> September in the previous calendar year. From 2011/12, the Consumer Price Index (CPI) has been used to replace the Retail Prices Index (RPI).

### *Ill-health Retirement*

Early payment of a pension, with enhancement, is available to members of the Scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity.

### *Death Benefits*

A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

### *Early Retirement*

For early retirements other than those due to ill-health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

### *Additional Voluntary Contributions (AVC's)*

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

NEST is a Workplace Pension Scheme operated by the Government; it is an alternative pension scheme (to the Superannuation Scheme) which is not NHS specific. It is a defined contribution, off statement of financial position scheme (as it is not exclusively NHS). The number of employees opting in and the value of contributions have been negligible.

## **5.2 Staff Exit Packages**

	Number of compulsory redundancies	Cost of compulsory redundancies £k	2024/25 Number of other departures agreed	Cost of other departures agreed £k	Total number of exit packages by cost band	Total cost of exit packages by cost band £k
£10,000-£25,000	-	-	-	-	-	-
£25,001-£50,000	-	-	-	-	-	-
Total number of exit packages by type	-	-	-	-	-	-
						£000
Total resource cost						-
	Number of compulsory redundancies	Cost of compulsory redundancies £k	2023/24 Number of other departures agreed	Cost of other departures agreed £k	Total number of exit packages by cost band	Total cost of exit packages by cost band £k
£10,000-£25,000	-	-	-	-	-	-
£25,001-£50,000	-	-	-	-	-	-
Total number of exit packages by type	-	-	-	-	-	-
						£000
Total resource cost						-

Exit packages are agreed with due regards to national terms and conditions, adherence to local policies and procedures and a risk assessment.

### 5.3 Average number of persons employed

	Group		Trust	
	2024/25	2023/24	2024/25	2023/24
	Total	Total	Total	Total
	Number	Number	Number	Number
<b>Permanently Employed</b>				
Medical and dental	271	262	271	262
Administration and estates	471	450	471	450
Healthcare assistants and other support staff	397	394	397	394
Nursing, midwifery and health visiting staff	718	665	718	665
Scientific, therapeutic and technical staff	193	180	193	180
Health care science staff	82	81	82	81
<b>Other</b>				
Bank staff	88	70	88	70
Agency/contract staff	41	42	41	42
Other	12	10	12	10
<b>Total</b>	<b>2,274</b>	<b>2,154</b>	<b>2,274</b>	<b>2,154</b>

### 5.4 Retirements due to ill-health

In the year to 31 March 2025, there were nil early retirements agreed on the grounds of ill-health (31 March 2024: 0). The estimated additional pension liability in respect of early retirements agreed on the grounds of ill-health is £nil (31 March 2024: £nil); the cost of which is borne by the NHS Business Services Authority – Pensions Division. This information has been supplied by NHS Pensions.

### 5.5 Directors' remuneration

The aggregate amounts payable to directors were:

	Group		Trust	
	2024/25	2023/24	2024/25	2023/24
	Total	Total	Total	Total
	£000	£000	£000	£000
Salary	1,556	1,266	1,556	1,266
Taxable benefits	5	2	5	2
Employer's pension contributions	114	88	114	88
<b>Total</b>	<b>1,675</b>	<b>1,356</b>	<b>1,675</b>	<b>1,356</b>

Further details of directors' remuneration can be found in the remuneration report.

## 6 FINANCE INCOME

	Group		Trust	
	2024/25	2023/24	2024/25	2023/24
	£000	£000	£000	£0
Interest revenue:				
Investments in listed equities	185	244	-	
Bank accounts	4,068	3,991	4,068	3,966
	<b>4,253</b>	<b>4,235</b>	<b>4,068</b>	<b>3,966</b>

## 7 FINANCE EXPENSES

	Group		Trust	
	2024/25	2023/24	2024/25	2023/24
	£000	£000	£000	£000
Loans from the Department of Health and Social Care	52	54	52	54
Interest on lease obligations	171	170	171	170
Main finance costs on PFI scheme obligations	5,152	5,263	5,152	5,263
Unwinding of discount on provisions	(6)	0	(6)	-
Remeasurement of PFI / other service concession liability resulting from change in index or rate	688	2,022	688	2,022
	<b>6,057</b>	<b>7,509</b>	<b>6,057</b>	<b>7,509</b>

## 8 GAINS/(LOSSES) ON NON-CURRENT ASSETS DISPOSAL

Gains/Losses on non current assets

	Group		Trust	
	2024/25	2023/24	2024/25	2023/24
	£000	£000	£000	£000
Gain on disposal of property, plant and equipment	8	-	8	-
Loss on disposal of property plant and equipment	(12)	(159)	(12)	(159)
Loss on disposal of intangibles	(22)	(8)	(22)	(8)
Gain on disposal of charitable funds investments	764	1	-	-
	<b>738</b>	<b>(166)</b>	<b>(26)</b>	<b>(167)</b>



## 9 INTANGIBLE ASSETS

<b>2024/25</b>	<b>Computer Software Purchased £000</b>	<b>Total Intangible Assets £000</b>
Gross cost at 1 April 2024	6,422	<b>6,422</b>
Additions purchased - Trust	1,496	<b>1,496</b>
Disposals	(58)	<b>(58)</b>
<b>Gross cost at 31 March 2025</b>	<b>7,860</b>	<b>7,860</b>
Accumulated amortisation at 1 April 2024	5,846	<b>5,846</b>
Provided during the year	351	<b>351</b>
Disposals	(36)	<b>(36)</b>
<b>Accumulated amortisation at 31 March 2025</b>	<b>6,161</b>	<b>6,161</b>
<b>Net book value</b>		
- Purchased at 31 March 2025	1,699	<b>1,699</b>
- Donated at 31 March 2025	-	<b>-</b>
<b>Total at 31 March 2025</b>	<b>1,699</b>	<b>1,699</b>
 <b>2023/24</b>	 <b>Computer Software Purchased £000</b>	 <b>Total Intangible Assets £000</b>
Gross cost at 1 April 2023	6,415	<b>6,415</b>
Additions purchased - Trust	120	<b>120</b>
Disposals	(113)	<b>(113)</b>
<b>Gross cost at 31 March 2024</b>	<b>6,422</b>	<b>6,422</b>
Accumulated amortisation at 1 April 2023	5,193	<b>5,193</b>
Provided during the year	758	<b>758</b>
Disposals	(105)	<b>(105)</b>
<b>Accumulated amortisation at 31 March 2024</b>	<b>5,846</b>	<b>5,846</b>
<b>Net book value</b>		
- Purchased at 31 March 2024	574	<b>574</b>
- Donated at 31 March 2024	2	<b>2</b>
<b>Total at 31 March 2024</b>	<b>576</b>	<b>576</b>

## 10 PROPERTY, PLANT AND EQUIPMENT

### 10.1 Property, plant and equipment at the financial year end comprise the following elements:

	Land	Buildings excluding dwellings	Assets under construction and payments on account	Plant and machinery	Transport Equipment	Information Technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
<b>2024/25</b>								
Cost/valuation at 1 April 2024	16,064	152,306	49	38,207	27	7,375	3,684	217,712
Additions purchased - Trust	-	491	53	2,355	-	1,232	-	4,131
Additions - donations of physical assets	-	-	-	20	-	-	-	20
Additions purchased - cash donations	-	-	-	151	-	-	-	151
Revaluations*	1	(2,139)	(102)	-	-	-	-	(2,240)
Disposals	-	-	-	(303)	-	-	-	(303)
<b>At 31 March 2025</b>	<b>16,065</b>	<b>150,658</b>	<b>0</b>	<b>40,430</b>	<b>27</b>	<b>8,607</b>	<b>3,684</b>	<b>219,471</b>
Accumulated depreciation at 1 April 2024	-	-	-	25,653	21	5,262	2,514	33,450
Provided during the year	-	3,640	-	4,469	3	729	198	9,039
Revaluations*	-	(3,640)	-	-	-	-	-	(3,640)
Disposals	-	-	-	(286)	-	-	-	(286)
<b>Accumulated depreciation at 31 March 2025</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>29,836</b>	<b>24</b>	<b>5,991</b>	<b>2,712</b>	<b>38,563</b>
<b>Net book value</b>								
- Purchased at 31 March 2025 - Trust	16,065	202	-	9,364	3	2,616	918	29,168
- On-SoFP PFI contract at 31 March 2025	-	150,456	-	-	-	-	-	150,456
- Donated at 31 March 2025	-	-	-	919	-	-	54	973
- Donated from DHSC for COVID response at 31 March 2025	-	-	-	311	-	-	-	311
<b>Total at 31 March 2025</b>	<b>16,065</b>	<b>150,658</b>	<b>0</b>	<b>10,594</b>	<b>3</b>	<b>2,616</b>	<b>972</b>	<b>180,908</b>

\* The revaluation gain relates to the revaluation of the PFI asset. The gain of £1,501k is made up of an decrease in the cost value of £2,139k and the reversal of the cumulative depreciation of £3,640k.

Donated assets from DHSC for COVID response have been included within donated assets at 31 March 2025, £311k.

## 10.2 Property, plant and equipment at the financial year end comprise the following elements:

	Land	Buildings excluding dwellings	Assets under construction and payments on account	Plant and machinery	Transport Equipment	Information Technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
<b>2023/24</b>								
Cost/valuation at 1 April 2023	15,960	149,994	-	37,557	27	6,324	3,684	213,546
Additions purchased - Trust	-	198	49	1,146	-	1,155	-	2,548
Additions purchased - cash donations	-	-	-	18	-	-	-	18
Impairments charged to revaluation reserve	104	0	-	-	-	-	-	104
Revaluations*	-	2,114	-	-	-	-	-	2,114
Disposals	-	-	-	(514)	-	(104)	-	(618)
<b>At 31 March 2024</b>	<b>16,064</b>	<b>152,306</b>	<b>49</b>	<b>38,207</b>	<b>27</b>	<b>7,375</b>	<b>3,684</b>	<b>217,712</b>
Accumulated depreciation at 1 April 2023	-	-	-	21,327	19	4,412	2,052	27,810
Provided during the year	-	3,501	-	4,688	2	947	462	9,600
Revaluations*	-	(3,501)	-	-	-	-	-	(3,501)
Disposals	-	-	-	(362)	-	(97)	-	(459)
<b>Accumulated depreciation at 31 March 2024</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>25,653</b>	<b>21</b>	<b>5,262</b>	<b>2,514</b>	<b>33,450</b>
<b>Net book value</b>								
- Purchased at 31 March 2024 - Trust	16,064	205	49	10,946	6	2,103	1,109	30,482
- On-SoFP PFI contract at 31 March 2024	-	152,101	-	-	-	-	-	152,101
- Donated at 31 March 2024	-	-	-	1,228	-	10	61	1,299
- Donated from DHSC for COVID response at 31 March 2024	-	-	-	380	-	-	-	380
<b>Total at 31 March 2024</b>	<b>16,064</b>	<b>152,306</b>	<b>49</b>	<b>12,554</b>	<b>6</b>	<b>2,113</b>	<b>1,170</b>	<b>184,262</b>

\* The revaluation gain relates to the revaluation of the PFI asset. The gain of £5,615k is made up of an increase in the cost value of £2,114k and the reversal of the cumulative depreciation of £3,501k.

Donated assets from DHSC for COVID response have been included within donated assets at 31 March 2024, £380k.

## 11 RIGHT OF USE ASSETS

### 11.1 Property, plant and equipment at the financial year end comprise the following elements:

	Property (land and buildings excl dwellings)	Property (land and dwellings)	Plant and machinery	Information technology	Total	Of which: Leases within the DHSC Group
	£000	£000	£000	£000	£000	£000
<b>2024/25</b>						
<b>Cost/valuation at 1 April 2024</b>	2,639	17,516	402	742	21,299	123
Additions - lease liability	-	-	-	95	95	-
Remeasurement of lease liability *	-	277	-	-	277	-
Revaluations **	(26)	-	-	-	(26)	(26)
Impairments charged to revaluation reserve ***	(142)	-	-	-	(142)	-
<b>At 31 March 2025</b>	<b>2,471</b>	<b>17,793</b>	<b>402</b>	<b>837</b>	<b>21,503</b>	<b>97</b>
<b>Accumulated depreciation at 1 April 2024</b>	1	1,626	128	212	1,967	-
Provided during the year - right of use asset	123	836	64	163	1,186	33
Revaluations **	(33)	-	-	-	(33)	(33)
Impairments charged to revaluation reserve	(89)	-	-	-	(89)	-
<b>Accumulated depreciation at 31 March 2025</b>	<b>2</b>	<b>2,462</b>	<b>192</b>	<b>375</b>	<b>3,031</b>	<b>0</b>
<b>Net book value</b>						
<b>Total at 31 March 2025</b>	<b>2,469</b>	<b>15,331</b>	<b>210</b>	<b>462</b>	<b>18,472</b>	<b>97</b>

Included in the balances above are right of use assets for staff accommodation, off site office space, PACS IT system, pathology managed services, photocopier managed service, franking machine and a radiology server

\* The remeasurement relates to staff accommodation at Waterbeach and is in line with the contract.

\*\* The revaluation gain relates to the revaluation of the off site office space (lease within the DHSC Group). The gain of £6k is made up of an decrease in the cost value of £26k and the reversal of the cumulative depreciation of £33k.

\*\*\* The impairment charged to revaluation reserve relates to the HLRI. The impairment of £53k is made up of £142k decrease in the cost value and the reversal of cumulative depreciation of £89k.

	Property (land and buildings excl dwellings)	Property (land and dwellings)	Plant and machinery	Information technology	Total	Of which: Leases within the DHSC Group
	£000	£000	£000	£000	£000	£000
<b>2023/24</b>						
<b>Cost/valuation at 1 April 2024</b>	2,679	17,181	394	600	20,854	152
Additions - lease liability	-	-	8	142	150	-
Remeasurement of lease liability *	-	335	-	-	335	-
Revaluations **	(40)	-	-	-	(40)	(29)
<b>At 31 March 2024</b>	<b>2,639</b>	<b>17,516</b>	<b>402</b>	<b>742</b>	<b>21,299</b>	<b>123</b>
<b>Accumulated depreciation at 1 April 2024</b>	1	805	63	90	959	-
Provided during the year - right of use asset	119	821	65	122	1,127	32
Revaluations **	(119)	-	-	-	(119)	(32)
<b>Accumulated depreciation at 31 March 2024</b>	<b>1</b>	<b>1,626</b>	<b>128</b>	<b>212</b>	<b>1,967</b>	<b>0</b>
<b>Net book value</b>						
<b>Total at 31 March 2024</b>	<b>2,638</b>	<b>15,890</b>	<b>274</b>	<b>530</b>	<b>19,332</b>	<b>123</b>

Carrying value of right of use assets split by counterparty	31 March 2025	31 March 2024
	£000	£000
Leased from NHS Providers	97	123

Included in the balances above are right of use assets for staff accommodation, off site office space, PACS IT system, pathology managed services, photocopier managed service and a franking machine

\* The remeasurement relates to staff accommodation at Waterbeach and is in line with the contract.

\*\* The revaluation gain relates to the revaluation of the HLRI and off site office space (lease within the DHSC Group). The gain of £79k is made up of an decrease in the cost value of £40k and the reversal of the cumulative depreciation of £119k.

## 11.2 Revaluation of right of use assets

In line with the NHS Foundation Trusts accounting policies (see note 1.14) a valuation of the right of use assets for property was carried out during the financial year ended 31 March 2025. The valuation was carried out by the NHS Foundation Trust's externally appointed valuers Gerald Eve LLP, Chartered Surveyors in accordance with the Royal Institution of Chartered Surveyors (RICS) Appraisal and Valuation Manual. The effective date of valuation was the 31 March 2025.

## 11.3 Maturity of lease liabilities

	Group 31 March 2025 £000	Trust 31 March 2025 £000	Of which: Leases within the DHSC Group 31 March 2025 £000	Group 31 March 2024 £000	Trust 31 March 2024 £000	Of which: Leases within the DHSC Group 31 March 2024 £000
<b>Undiscounted future lease payments payable in:</b>						
- not later than one year;	2,972	2,903	69	2,917	2,917	69
- later than one year and not later than five years;	3,927	3,807	120	3,967	3,967	190
- later than five years.	12,975	12,975	-	13,629	13,629	-
<b>Total gross future lease payments</b>	<b>19,874</b>	<b>19,685</b>	<b>189</b>	<b>20,513</b>	<b>20,513</b>	<b>259</b>
Finance charges allocated to future periods	(1,503)	(1,495)	(8)	(1,640)	(1,640)	(16)
<b>Net lease liabilities</b>	<b>18,371</b>	<b>18,190</b>	<b>181</b>	<b>18,873</b>	<b>18,873</b>	<b>243</b>
Included in:						
Current lease liabilities	2,802	2,738	64	2,917	2,917	69
Non-current lease liabilities	15,569	15,452	117	15,956	15,956	174
	<b>18,371</b>	<b>18,190</b>	<b>181</b>	<b>18,873</b>	<b>18,873</b>	<b>243</b>

Lease liabilities split by counterparty	31 March 2025 £000	31 March 2024
Leased from NHS Providers	181	243

## 12 INVESTMENTS

The investments relate to the NHS Charity and comprise of shares, and also cash held with the investment managers for future investment in equity.

	<b>31 March 2025 £000</b>	<b>31 March 2024 £000</b>
<b>Investment Managers</b>		
Market value at 1 April	<b>5,915</b>	5,618
Less: Disposals at carrying value	<b>(5,186)</b>	(9)
Additions	<b>6,004</b>	-
Net gain/(loss) on revaluation	<b>(918)</b>	306
<b>Market value at 31 March (shares only)</b>	<b>5,815</b>	5,915
Cash held with Investment Managers at 31 March	-	-
<b>Total value of investments</b>	<b>5,815</b>	5,915
Historic cost at 31 March (shares only)	<b>6,004</b>	5,186

The valuation of the investments is at 31 March 2025 and may not be realised at the date the investments are disposed of.

At 31 March 2025 1,121,844 shares (31 March 2024 – 10,506,184 shares) were held in COIF Charities Ethical Investment Fund Account with a market value of £5,814,520 (31 March 2024 - £5,914,982).

The historic cost represents the value of shares after purchases and sales at 31 March 2025 before the shares were revalued.

At 31 March 2025, the NHS Foundation Trust's investment managers are holding £nil (31 March 2024 - £nil) of cash within the investment portfolio.

## 13 INVENTORIES

	<b>Group</b>		<b>Trust</b>	
	<b>31 March 2025 £000</b>	<b>31 March 2024 £000</b>	<b>31 March 2025 £000</b>	<b>31 March 2024 £000</b>
Drugs	<b>1,334</b>	559	<b>1,334</b>	559
Consumables	<b>7,579</b>	7,567	<b>7,579</b>	7,567
NHS Charity - merchandise	<b>35</b>	38	-	-
<b>TOTAL</b>	<b>8,948</b>	8,164	<b>8,913</b>	8,126

The cost of inventories recognised as an expense and included in 'operating expenses' amounted to £57,615k (2023/24: £87,422k).

The value of inventories recognised as a write-down expense during the year was £0k (2023/24: £60k).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2023/24 the Trust received £158k of items purchased by DHSC. Distribution of inventory by the Department ceased in March 2024.

## 14 TRADE AND OTHER RECEIVABLES

### Current

	Group		Trust	
	31 March	31 March	31 March	31 March
	2025	2024	2025	2024
	£000	£000	£000	£000
Contract receivables: invoiced NHS	2,144	1,639	2,144	1,639
Contract receivables: invoiced other	3,154	3,397	3,321	3,885
VAT receivables	934	808	934	808
Contract receivables: not yet invoiced	8,540	6,818	5,449	5,065
Allowance for the impaired contract receivables	(238)	(203)	(238)	(203)
Interest receivable	304	368	304	368
PDC dividend receivable	309	-	309	-
Prepayments other	3,090	4,023	3,090	4,023
Clinician pension tax provisions reimbursement funding from NHSE	6	6	6	6
Other receivables	13	31	13	31
<b>TOTAL</b>	<b>18,256</b>	<b>16,887</b>	<b>15,332</b>	<b>15,622</b>

### Non-current

Clinician pension tax provisions reimbursement funding from NHSE	560	537	560	537
PFI lifecycle prepayments	2,886	2,138	2,886	2,138
<b>TOTAL</b>	<b>3,446</b>	<b>2,675</b>	<b>3,446</b>	<b>2,675</b>

### 14.1 Allowances for credit losses

	Total trade receivables £000	Other trade receivables £000
At 1 April 2024	203	203
Impact of IFRS 9 implementation on 1 April 2018 balance		
New allowance arising	55	55
Changes in the calculation of existing allowances	32	32
Reversals of allowances	(52)	(52)
<b>At 31 March 2025</b>	<b>238</b>	<b>238</b>
	Total trade receivables £000	Other trade receivables £000
At 1 April 2023	272	272
Impact of IFRS 9 implementation on 1 April 2018 balance		
New allowance arising	106	106
Receivables written off during the year as uncollectable	(74)	(74)
Reversals of allowances	(101)	(101)
<b>At 31 March 2024</b>	<b>203</b>	<b>203</b>



## 14.2 Analysis of impaired receivables

	31 March 2025 £000	31 March 2024 £000
<b>Ageing of impaired receivables</b>		
Current	0	22
0 - 30 days	1	17
30 - 60 days	-	0
60 - 90 days	0	1
90 - 180 days	7	6
Over 180 days	230	157
<b>TOTAL</b>	<b>238</b>	<b>203</b>

## 14.3 Analysis of non-impaired receivables

	31 March 2025 £000	31 March 2024 £000
<b>Ageing of non-impaired receivables</b>		
Current	4,536	3,082
0 - 30 days	202	(1,064)
30 - 60 days	314	133
60 - 90 days	349	217
90 - 180 days	165	267
Over 180 days	1,017	1,149
<b>TOTAL</b>	<b>6,583</b>	<b>3,784</b>

## 15 CASH AND CASH EQUIVALENTS

	Group		Trust	
	31 March 2025 £000	31 March 2024 £000	31 March 2025 £000	31 March 2024 £000
At 1 April	80,479	69,231	78,860	67,310
Net change in year	(3,697)	11,248	(3,546)	11,550
<b>Balance at 31 March</b>	<b>76,782</b>	<b>80,479</b>	<b>75,314</b>	<b>78,860</b>
<b>Made up of:</b>				
Government Banking Services	74,896	78,148	74,896	78,148
Cash at commercial banks and in hand	1,886	2,331	418	712
<b>Cash and cash equivalents as in statement of cash flows</b>	<b>76,782</b>	<b>80,479</b>	<b>75,314</b>	<b>78,860</b>

The change to the calculation of net cash balances used when calculating the PDC dividend restricts the NHS Foundation Trust's investment options.

Interest earned on these deposits is accrued in the financial statements and is disclosed on the face of the Statement of Comprehensive Income.

Surplus cash balances held by the NHS Charity are either invested in a notice account or invested in short term deposits with a small range of approved commercial banks.

## 16 TRADE AND OTHER PAYABLES

Current	Group		Trust	
	31 March 2025 £000	31 March 2024 £000	31 March 2025 £000	31 March 2024 £000
Contract receivables: invoiced NHS	2,144	1,363	2,144	1,363
Contract receivables: invoiced other	3,154	3,673	3,321	4,161
VAT receivables	934	808	934	808
Contract receivables: not yet invoiced	8,540	6,818	5,449	5,065
Allowance for the impaired contract receivables	(238)	(203)	(238)	(203)
Interest receivable	304	368	304	368
PDC dividend receivable	309	-	309	-
Prepayments other	3,090	4,023	3,090	4,023
Clinician pension tax provisions reimbursement funding from NHSE	6	6	6	6
Other receivables	13	31	13	31
<b>TOTAL</b>	<b>18,256</b>	<b>16,887</b>	<b>15,332</b>	<b>15,622</b>

### Non-current

The Group has no non-current trade and other payables.

## 17 OTHER LIABILITIES

Current	31 March 2025 £000	31 March 2024 £000
Deferred Income	5,503	4,531

Includes funding received as part of the visible cost procurement model, to be matched to medical consumables as they are used and charged to expenditure, funding to cover costs of implementing the new electronic patient system and the current element of deferred income from the PFI contractor following a Deed of Amendment.

Non-current	31 March 2025 £000	31 March 2024 £000
Deferred Income	1,415	2,030

Includes funding to cover costs of implementing the new electronic patient system and the non-current element of the deferral of income received from the PFI contractor following a Deed of Amendment which has been allocated over the remaining term of the contract.

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## 18 BORROWINGS

	Current		Non-current	
	31 March 2025 £000	31 March 2024 £000	31 March 2025 £000	31 March 2024 £000
Loans from Department of Health	442	442	8,480	8,904
Obligations under PFI contract	2,477	2,063	75,902	78,263
Lease liabilities	2,802	2,917	15,569	15,956
	<b>5,721</b>	<b>5,422</b>	<b>99,951</b>	<b>103,123</b>

### 18.1 Reconciliation of liabilities arising from financing activities

	Loans from DHSC £000	PFI and LIFT schemes £000	Lease Liabilities £000	Total £000
<b>Carrying value at 1 April 2024</b>	9,346	80,326	18,873	<b>108,545</b>
<b>Cash movements:</b>				
Financing cash flows - payments and receipts of principal	(424)	(2,634)	(874)	<b>(3,932)</b>
Financing cash flows - payments of interest	(52)	(5,152)	(171)	<b>(5,375)</b>
<b>Non-cash movements:</b>				
Application of IFRS 16 measurement principles to PFI liability on 1 April 2023	-	-	-	-
Additions	-	-	95	<b>95</b>
Lease liability remeasurements	-	-	277	<b>277</b>
Remeasurement of PFI/other service concession liability resulting from change in index or rate	-	688	-	<b>688</b>
Application of effective interest rate	52	5,152	171	<b>5,375</b>
Other changes	-	(1)	-	<b>(1)</b>
<b>Carrying value at 31 March 2025</b>	<b>8,922</b>	<b>78,379</b>	<b>18,371</b>	<b>105,672</b>

	Loans from DHSC £000	PFI and LIFT schemes £000	Lease Liabilities £000	Total £000
<b>Carrying value at 1 April 2023</b>	9,771	78,042	19,194	107,007
<b>Cash movements:</b>				
Financing cash flows - payments and receipts of principal	(424)	(2,422)	(806)	(3,652)
Financing cash flows - payments of interest	(55)	(5,263)	(170)	(5,488)
<b>Non-cash movements:</b>				
Application of IFRS 16 measurement principles to PFI liability on 1 April 2023	-	2,684	-	2,684
Additions	-	-	150	150
Lease liability remeasurements	-	-	335	335
Remeasurement of PFI/other service concession liability resulting from change in index or rate	-	2,022	-	2,022
Application of effective interest rate	54	5,263	170	5,487
<b>Carrying value at 31 March 2024</b>	<b>9,346</b>	<b>80,326</b>	<b>18,873</b>	<b>108,545</b>

The loan from Department of Health and Social Care represents a bridging loan from the Secretary of State for Health against the sale of land at the existing Royal Papworth hospital site at Papworth Everard to support working capital. During 2021/22 NHS Foundation Trust negotiated revised repayment terms for the loan which permitted the NHS Foundation Trust to make a pre-payment against the loan from the disposal proceeds of the Papworth Everard site, £4,400k and repay the remaining outstanding loan balance, £10,600k over a 25-year period commencing after the sale completion date. The final payment is due on 27 November 2045. Interest on the loan is charged at 0.57%.

## 19 PROVISIONS

	31 March 2025			
	Pensions relating to other staff £000	Clinician pension tax reimbursement £000	Other £000	Total £000
<b>At 1 April 2024</b>	<b>410</b>	<b>543</b>	<b>3,790</b>	<b>4,743</b>
Transfers by absorption	-	-	-	-
Change in the discount rate	37	(5)	-	32
Arising during the year	-	20	5,323	5,343
Utilised during the year	(25)	(20)	(1,824)	(1,869)
Reclassified to liabilities held in disposal groups	-	-	-	-
Reversed unused	-	-	(1,116)	(1,116)
Unwinding of discount	(6)	28	-	22
Movement in charitable fund provisions	-	-	-	-
<b>At 31 March 2025</b>	<b>416</b>	<b>566</b>	<b>6,173</b>	<b>7,155</b>
<b>Expected timing of cash flows:</b>				
- not later than one year;	44	6	6,165	6,215
- later than one year and not later than five years;	135	6	-	141
- later than five years.	237	554	8	799
<b>Total</b>	<b>416</b>	<b>566</b>	<b>6,173</b>	<b>7,155</b>

	Pensions relating to other staff £000	Clinician pension tax reimbursement £000	Other £000	Total £000
<b>At 1 April 2023</b>	426	709	5,133	6,268
Change in the discount rate	21	(117)	-	(96)
Arising during the year	-	-	2,190	2,190
Utilised during the year	(37)	-	(1,991)	(2,028)
Reversed unused	-	(84)	(1,542)	(1,626)
Unwinding of discount	-	35	-	35
<b>At 31 March 2024</b>	410	543	3,790	4,743
<b>Expected timing of cash flows:</b>				
- not later than one year;	45	6	3,790	3,841
- later than one year and not later than five years;	135	4	-	139
- later than five years.	230	533	-	763
<b>Total</b>	410	543	3,790	4,743

The balance on provisions relates to staff pension costs for staff who took early retirement, before 6 March 1995 and staff entitled to injury benefit. This is settled by a quarterly charge from the NHS Pensions Agency.

The clinician pension tax reimbursement provision relates to a future contractually binding commitment that the NHS Foundation Trust has to compensate clinicians for an additional tax charge that they will incur on their retirement due to the 2019/20 Scheme Pay deduction.

The amount included in the provision of NHS Resolution at 31 March 2025 in respect of clinical negligence liabilities of the NHS Foundation Trust is £13,558k (31 March 2024: £15,308k).

## 20 CONTINGENT ASSETS AND LIABILITIES

The value of contingent liabilities in respect of NHS Resolution legal claims at 31 March 2025 is £8k (31 March 2024: £8k).

There are no contingent assets.

## 21 CAPITAL AND CONTRACTUAL COMMITMENTS

The value of commitments under capital expenditure contracts at the end of the financial year was £17k (31 March 2024: £197k). There were no commitments under finance leases at the end of financial year 2024/25 (31 March 2023: £nil).

Details of commitments in respect of operating leases can be found at note 4.3.1.

## 22 ON SOFP PFI ARRANGEMENTS

On 12 March 2015, the NHS Foundation Trust concluded contracts under the Private Finance Initiative (PFI) with NPH Healthcare Ltd for the construction of a new 310 bed hospital and the provision of hospital related services.

The PFI scheme was approved by the NHS Executive and HM Treasury as being better value for money than the public sector comparator. Under IFRIC 12, the PFI scheme is deemed to be on-Statement of Financial Position, meaning that the hospital is treated as an asset of the NHS Foundation Trust, being acquired through a finance lease. The payments to NPH Healthcare Ltd in Royal Papworth Hospital NHS Foundation Trust Annual Report & Accounts 2024/25

respect of the facility (New Royal Papworth Hospital) have therefore been analysed into finance lease charges and service charges. The accounting treatment of the PFI scheme is detailed in the accounting policies note.

The service element of the contract was £9.78m (2023/24 £9.67m). The hospital was handed over to the NHS Foundation Trust in February 2018 and became fully operational in May 2019. Payments under the scheme commenced in February 2018. The agreement is due to end in March 2048.

The value of the scheme at inception was £163.6m. The site has subsequently been re-valued using the depreciated replacement cost on a modern equivalent asset basis. A valuation carried out during 2024/25 has re-valued the site to £168m at 31 March 2025.

## 22.1 PFI finance lease obligations

	<b>Group</b>		<b>Trust</b>	
	<b>31 March</b>	31 March	<b>31 March</b>	31 March
	<b>2025</b>	2024	<b>2025</b>	2024
	<b>£000</b>	£000	<b>£000</b>	£000
<b>Gross PFI finance lease liabilities</b>	<b>155,726</b>	163,228	<b>155,726</b>	163,228
<b>Of which liabilities are due</b>				
- not later than one year;	<b>7,841</b>	7,768	<b>7,841</b>	7,768
- later than one year and not later than five years;	<b>28,892</b>	29,491	<b>28,892</b>	29,491
- later than five years.	<b>118,992</b>	125,969	<b>118,992</b>	125,969
Finance charges allocated to future periods	<b>(77,347)</b>	(82,902)	<b>(77,347)</b>	(82,902)
<b>Net PFI liabilities</b>	<b>78,379</b>	80,326	<b>78,379</b>	80,326
- not later than one year;	<b>2,477</b>	2,063	<b>2,477</b>	2,063
- later than one year and not later than five years;	<b>9,166</b>	9,130	<b>9,166</b>	9,130
- later than five years.	<b>66,736</b>	69,133	<b>66,736</b>	69,133

## 22.2 PFI total unitary payments obligations

	<b>Group</b>		<b>Trust</b>	
	<b>31 March</b>	31 March	<b>31 March</b>	31 March
	<b>2025</b>	2024	<b>2025</b>	2024
	<b>£000</b>	£000	<b>£000</b>	£000
Total future payments committed in respect of the PFI arrangement	<b>525,821</b>	541,117	<b>525,821</b>	541,117
<b>Of which liabilities are due</b>				
- not later than one year;	<b>18,663</b>	18,240	<b>18,663</b>	18,240
- later than one year and not later than five years;	<b>78,053</b>	76,273	<b>78,053</b>	76,273
- later than five years.	<b>429,105</b>	446,604	<b>429,105</b>	446,604

## 22.3 Analysis of amounts payable to service concession operator

	Group		Trust	
	31 March 2025 £000	31 March 2024 £000	31 March 2025 £000	31 March 2024 £000
Unitary payment payable to service concession operator	18,318	18,066	18,318	18,066
<b>Consisting of:</b>				
- Interest charge	5,152	5,263	5,152	5,263
- Repayment of finance lease liability	2,634	2,421	2,634	2,421
- Service element and other charges to operating expenditure	9,785	9,668	9,785	9,668
- Capital lifecycle maintenance	-	-	-	-
- Revenue lifecycle maintenance	-	-	-	-
- Contingent rent	-	-	-	-
- Addition to lifecycle prepayment	747	714	747	714
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	-	-	-	-
	<b>18,318</b>	<b>18,066</b>	<b>18,318</b>	<b>18,066</b>

## 23 EVENTS AFTER THE REPORTING YEAR

There are no events after the reporting year.

## 24 PUBLIC DIVIDEND CAPITAL

The dividend payable on public dividend capital (PDC) is based on the pre-audit actual (rather than forecast) average relevant net assets at an annual rate of 3.5% (see note 1.17). The total dividend payable for 2024/25 was £1,799k (2023/24 - £1,905k). The net dividend paid as at 31 March 2025 was £2,307k (2023/24 £1,837k). The outstanding dividend payable at 31 March 2025 was £0k (2023/24 – payable £199k). The outstanding dividend receivable at 31 March 2025 was £309k (2023/24 –£0k).

In 2024/25 the NHS Foundation Trust received £710k of PDC funding (2023/24 - £87k) relating to the Soliton+ Radiology system (£590k) and LED lighting (£120k).

## 25 RELATED PARTY

Royal Papworth Hospital NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health.

The key management personnel of the NHS Foundation Trust are the Executive and Non-Executive Directors of the NHS Foundation Trust. The total number of Directors to whom benefits are accruing under a defined benefit scheme is 7 (2023/24: 6). Included in the numbers for both years are staff members who held the post of Executive Director on an interim basis.



	<b>2024/25 £000</b>	<b>2023/24 £000</b>
Remuneration payment	<b>1,384</b>	1,266
Employer contribution to the NHS Pension Scheme	<b>114</b>	88
Secondment post in to the Trust*	-	-
	<b>1,498</b>	1,354

Further information is available in the Remuneration Report, which is included within the NHS Foundation Trust's Annual Report.

During the year none of the senior managers of the NHS Foundation Trust or parties related to them has undertaken any material transactions with the NHS Foundation Trust.

Dr J Ahluwalia joined the Board on the 1 October 2019 as a Non-Executive Director and holds an Honorary Appointment at the Judge Business School. He is also a Director and shareholder in Ahluwalia Education and Consulting Limited. The NHS Foundation Trust has not made any payments to Ahluwalia Education and Consulting Limited during the year (2023/24: £nil) and had nothing (2023/24: £nil) owing to Ahluwalia Education and Consulting Limited at 31 March 2025.

Dr J Ahluwalia is a Fellow at the Cambridge Judge Business School which is an honorary position. He is also a Non-Executive Director on the board of THISLabs. With effect from 16.02.2022 he became the Chief Clinical Officer at the Eastern Academic Health Science Network. He is also a Co-director and shareholder in Ahluwalia Education and Consulting Limited, member of the C & P Clinical Ethics Committee, member of the Eastern Region Clinical Senate and trustee on the main board of Macmillan Cancer Support.

In partnership with the University of Cambridge, Cambridge University Hospitals NHS Foundation Trust and Cambridgeshire and Peterborough NHS Foundation Trust, the NHS Foundation Trust set up an Academic Health Science Centre. Anglia Ruskin University joined this the partnership during 2023/24. The partnership vehicle, called Cambridge University Health Partners (CUHP) is a company limited by guarantee. The objects of CUHP are to improve patient care, patient outcomes and population health through innovation and the integration of service delivery, health research and clinical education.

The CUHP is regarded as a related party of the NHS Foundation Trust. During the year, the NHS Foundation Trust made a payment of £207K (2023/24: £1,021k) to the CUHP for its share of the CUHP running costs. At 31 March 2025 there was £nil owing by the NHS Foundation Trust to CUHP (31 March 2023: £916k). There were no amounts written off during the year and there are no provisions for doubtful debts at 31 March 2025 in respect of CUHP (31 March 2023: £nil). The Chief Executive and Chairman are 2 out of 12 Directors of the CUHP.

In year, the partners of CUHP established Cambridge Biomedical Campus Limited (CBC Ltd). It is a company limited by guarantee. Its principal activity is to promote the role of the Trust and to influence to the strategic development of the biomedical campus and promote the life sciences agenda. The Trust is a voting member of the company. Mrs E Midlane, the Chief Executive is a Director of CBC Ltd from 6<sup>th</sup> November 2023.

The University of Cambridge (UoC) is regarded as a related party. The NHS Foundation Trust has in partnership with the UoC established the Heart and Lung Research Institute. During the year, the NHS Foundation Trust made payments to the UoC of £3,322k (2023/24 - £4,516k) and had £522k (2023/24 - £58k) owing to the UoC.

Professor I Wilkinson joined the Board on the 1 January 2020 and is Clinical Pharmacologist and Professor of Therapeutics and is an employee of the University of Cambridge

Mrs A Fadero joined the Board on 1 December 2020 as a Non-Executive Director and holds the post of Associate Non-Executive Director at East Sussex Healthcare NHS Trust. The NHS Foundation Trust has made no payments to East Sussex Healthcare NHS Trust during the year.

Ms D Leacock joined the Board on 1 December 2020 as a Non-Executive Director. A relative of Ms Leacock began employment with KPMG London on 4 October 2021 as a trainee chartered accountant.

Mr G Robert joined the Board on 1 September 2019 as a Non-Executive Director. He is an affiliated lecturer, Faculty of Law, at the University of Cambridge.

Mrs E Midlane is a voting member, representing NHS Providers and Trusts on NHS Cambridge and Peterborough ICB Board. She is also Chair of the ICB Diagnostic Board.

Mrs M Screaton is a Director of Cambridge Clinical Imaging Ltd., which provides professional imaging services. The NHS Foundation Trust has made payments to Cambridge Clinical Imaging Ltd. of £nil (2023/24: £nil) and had £nil (2023/24: £nil) owing to Cambridge Clinical Imaging Ltd. at 31 March 2025.

The Department of Health and Social Care is regarded as a related party. During the year Royal Papworth Hospital NHS Foundation Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are listed below:

	<b>Income</b>		<b>Current Receivables</b>	
	<b>2024/25</b>	<b>2023/24</b>	<b>At 31 March 2025</b>	<b>At 31 March 2024</b>
	<b>£000</b>	<b>£000</b>	<b>£000</b>	<b>£000</b>
NHS England	<b>143,122</b>	218,504	-	1
NHS Cambridgeshire and Peterborough ICB	<b>71,546</b>	28,075	<b>1,547</b>	-
NHS Suffolk and North East Essex ICB	<b>28,459</b>	7,061	<b>66</b>	-
NHS Blood and Transplant	-	3,936	-	3,132
NHS Norfolk and Waveney ICB	<b>24,125</b>	5,382	<b>8</b>	-
NHS Hertfordshire and West Essex ICB	<b>7,800</b>	3,566	<b>192</b>	-
NHS Bedfordshire, Luton and Milton Keynes ICB	<b>10,413</b>	3,167	<b>143</b>	-
Department of Health and Social Care	<b>1,656</b>	1,359	<b>10</b>	1,037
NHS Lincolnshire ICB	<b>2,035</b>	2,035	-	-

	<b>Expenditure</b>		<b>Current Payables</b>	
	<b>2024/25</b>	<b>2023/24</b>	<b>At 31 March 2025</b>	<b>At 31 March 2024</b>
	<b>£000</b>	<b>£000</b>	<b>£000</b>	<b>£000</b>
NHS England	<b>9</b>	15	<b>12,850</b>	14,449
NHS Pension Scheme	<b>18,061</b>	16,555	<b>1,917</b>	1,711
HM Revenue & Customs - NI Contributions	<b>9,670</b>	11,886	<b>3,491</b>	3,231
Cambridge University Hospitals NHS Foundation Trust - medical, staffing, pathology and other services	<b>6,968</b>	7,136	<b>4,075</b>	4,167
NHS Resolution	<b>2,497</b>	2,213	-	-

The figures above differ from those in note 2.2 due to the inclusion of other operating income.

The related party organisations listed above are those where income for the year to 31 March 2025 is greater than £1,000k.

Patient activity related income for 2024/25 is based on the financial framework as defined by NHS England/Improvement.

	Expenditure		Current Payables	
	2023/24	2022/23	At 31 March 2024	At 31 March 2023
	£000	£000	£000	£000
NHS England	15	3	14,449	11,495
NHS Pension Scheme	16,555	15,069	1,711	1,510
NHS Cambridgeshire and Peterborough ICB	3	(35)	1,874	11
HM Revenue & Customs - NI Contributions	11,886	10,539	3,231	2,663
Cambridge University Hospitals NHS Foundation Trust - medical, staffing, pathology and other services	7,136	7,331	4,167	4,097
NHS Resolution	2,213	1,878	-	-

The related party organisations listed above are those where expenditure is greater than £500k or payables is greater than £1m for the year to 31 March 2025.

The NHS Foundation Trust is the Corporate Trustee of the Royal Papworth Hospital Charitable Fund, a registered Charity. The NHS Foundation Trust has assessed its relationship to the Charitable Fund and determined it to be a key related party of the NHS Foundation Trust. The NHS Foundation Trust has consolidated the NHS Charity into the NHS Foundation Trust's accounts (see note 1.1).

## 25.1 Department of Health and Social care related parties

The individuals and entities that the Department of Health and Social Care identifies as meeting the definition of Related Parties set out in IAS 24 (Related Party Transactions) are also deemed to be related parties of entities within the Departmental Group. This note therefore sets out the individuals and entities which we have assessed as meeting the IAS 24 definition of Related Parties for the year ending 31 March 2025 to assist group bodies in preparing disclosures compliant with IAS 24.

### Ministers

The Rt Hon Victoria Atkins MP  
 Andrew Stephenson CBE MP  
 Andrea Leadsom MP  
 Helen Whately MP  
 Maria Caulfield MP  
 The Lord Markham CBE  
 The Rt Hon Wes Streeting MP  
 Karin Smyth MP  
 Stephen Kinnock MP  
 Ashley Dalton MP  
 Andrew Gwynne  
 Baroness Gillian Merron

### Senior Officials

Sir Chris Wormald KCB  
Professor Sir Christopher Whitty KCB  
Shona Dunn  
Clara Swinson CB  
Jonathan Marron CB  
Matthew Style  
Michelle Dyson  
Andrew Brittain  
Professor Lucy Chappell  
Jenny Richardson  
Zoe Bishop  
Hugh Harris  
Lorraine Jackson  
Sally Warren  
Catherine Frances CB  
Tom Riordan  
Paul Macnaught

### Non-executive Directors

Gerry Murphy  
Doug Gurr  
Steve Rowe  
Samantha Jones  
Sir Roy Stone  
Will Harris  
The Rt Hon Alan Milburn  
Richard Douglas  
Naomi Eisenstadt CB  
Baroness Camilla Cavendish  
Phil Jordan

Entities linked to the individuals above

Listing provided by DHSC	Categorisation of body added by NHS England	
	Bodies within government control (see GAM para 5.252: fewer disclosures required for these entities as part of the public sector)	Other bodies
ABF Energy Ltd		ABF Energy Ltd
AB Sugar China North Ltd		AB Sugar China North Ltd
AB Sugar China Ltd		AB Sugar China Ltd
AB Sugar China Holdings Ltd		AB Sugar China Holdings Ltd
Accurx Ltd		Accurx Ltd
Advantage Mentoring C.I.C		Advantage Mentoring C.I.C
Alzheimer's Society		Alzheimer's Society
AM Strategy Ltd		AM Strategy Ltd
Andigital Ltd		Andigital Ltd
Anglofive Ltd		Anglofive Ltd
Apax Partners UK Ltd		Apax Partners UK Ltd
Bridge Consulting London Limited		Bridge Consulting London Limited
Capital & Regional PLC		Capital & Regional PLC
Chock Professional Services Ltd		Chock Professional Services Ltd
CommentSold		CommentSold
Competition & Markets Authority	Competition & Markets Authority	
CRN Thames Valley and South Midlands Partnership	CRN Thames Valley and South Midlands Partnership <sup>1</sup>	
Currys Plc		Currys Plc
Demelza Hospice Care for Children		Demelza Hospice Care for Children
Estover Energy Ltd		Estover Energy Ltd
Extra Time Partners Ltd		Extra Time Partners Ltd
Fareshare		Fareshare
Farnborough Park Consulting Ltd		Farnborough Park Consulting Ltd
Forton Firewood and Sawmill Ltd		Forton Firewood and Sawmill Ltd
GrowUp Group Ltd		GrowUp Group Ltd

Listing provided by DHSC	Categorisation of body added by NHS England	
	Bodies within government control (see GAM para 5.252: fewer disclosures required for these entities as part of the public sector)	Other bodies
Hope Enterprises (Northampton) CIC		Hope Enterprises (Northampton) CIC
Island Research LLP		Island Research LLP
IVC Evidensia		IVC Evidensia
Keys Group Limited		Keys Group Limited
Kindling Transformative Interventions Ltd		Kindling Transformative Interventions Ltd
Macmillan Cancer Support		Macmillan Cancer Support
Natural History Museum	Natural History Museum	
Newhaven Fishing Community Interest Company		Newhaven Fishing Community Interest Company
NHS Confederation		NHS Confederation
NHS Employers Policy Board		NHS Employers Policy Board
Nichols and Harris LLP		Nichols and Harris LLP
Northampton Hope Centre		Northampton Hope Centre
Norwood Ravenswood		Norwood Ravenswood
@PVJCIO Ltd		@PVJCIO Ltd
Penneys XI Ltd		Penneys XI Ltd
Place2Be		Place2Be
R2B H Ltd		R2B H Ltd
Samantha Jones Limited		Samantha Jones Limited
Seed Developments Ltd		Seed Developments Ltd
Seed Invesco Ltd		Seed Invesco Ltd
Sightsavers (registered in the UK as Royal Commonwealth Society for the Blind)		Sightsavers (registered in the UK as Royal Commonwealth Society for the Blind)
Social Mobility Foundation		Social Mobility Foundation
South East Medical Services Ltd		South East Medical Services Ltd
Smith Whitty International Consultants Ltd		Smith Whitty International Consultants Ltd
The Alan Turing Institute		The Alan Turing Institute
Top Up TV 2 Ltd		Top Up TV 2 Ltd
Top Up TV Europe Ltd		Top Up TV Europe Ltd
Top Up TV Holdings Ltd		Top Up TV Holdings Ltd
UK Biobank Ltd		UK Biobank Ltd
Unbiased EC1 Ltd		Unbiased EC1 Ltd
XLinks Ltd		XLinks Ltd
Yorkshire Sculpture Park		Yorkshire Sculpture Park

## 26 FINANCIAL RISK MANAGEMENT

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the year in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Foundation Trust has with NHS commissioning bodies and the way those NHS commissioning bodies are financed, the NHS Foundation Trust is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. Financial assets and

liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Foundation Trust in undertaking its activities.

### **Market risk**

Market risk is the possibility that financial loss might arise as a result of changes in such measures as interest rates and stock market movements. A significant proportion of the NHS Foundation Trust's transactions are undertaken in sterling and so its exposure to foreign exchange risk is minimal. It holds no significant investments other than short-term bank interest and the NHS Foundation Trust's income and operating cash flows are subsequently independent of changes in market interest rates. The Royal Papworth Charity holds equity investments which are managed by an Investment Management company. The equity investments are held in a responsible multi-asset fund, designed specifically for charities which targets a stable and sustainable total return distribution of 4% per annum. With the COVID 19 pandemic there is a potential for higher exposure to market risk. This is mitigated by the fact that the fund is monitored by an Independent Advisory Committee.

### **Credit risk**

Credit risk is the possibility that other parties might fail to pay amounts due to the NHS Foundation Trust. Credit risk arises from deposits with banks and financial institutions as well as credit exposures to the NHS Foundation Trust's commissioners and other receivables. Surplus operating cash is only invested with banks and financial institutions that are rated independently with a minimum score of A1 (Standard and Poor's), P-1 (Moody's) or F1 (Fitch). The NHS Foundation Trust's net operating costs are incurred largely under annual service agreements with NHS commissioning bodies, which are financed from resources voted annually by Parliament. As NHS commissioning bodies are funded by government to buy NHS patient care services, no credit scoring of these is considered necessary.

An analysis of the ageing of receivables and provision for impairments can be found at note 14 'Trade and other receivables'.

### **Liquidity risk**

Liquidity risk is the possibility that the NHS Foundation Trust might not have funds available to meet its commitments to make payments. Prudent liquidity risk management includes maintaining sufficient cash and the availability of funding from an adequate amount of committed credit facilities. NHS Foundation Trusts are required to assess liquidity as one of the two measures in the Continuity of Services Risk rating set out in Monitor's Risk Assessment Framework.



## 27 FINANCIAL ASSETS AND LIABILITIES BY CATEGORY

### Financial assets

	Group		Trust	
	Total	Financial assets at amortised cost	Total	Financial assets at amortised cost
	£000	£000	£000	£000
Receivables with DHSC group bodies	2,144	1,363	2,144	1,363
Receivables not yet invoiced	9,106	5,976	6,015	5,976
Other receivables (net provision for impaired debts)	2,929	3,501	3,096	3,501
Other investments	5,815	6,063	-	-
Cash at bank and in hand	76,782	76,782	75,314	75,314
<b>Total at 31 March 2025</b>	<b>96,776</b>	93,685	<b>86,569</b>	86,154
Receivables with DHSC group bodies	1,363	1,363	1,363	1,363
Receivables not yet invoiced	5,976	5,976	5,976	5,976
Other receivables (net provision for impaired debts)	3,501	3,501	3,501	3,501
Other investments	5,915	5,915	-	-
Cash at bank and in hand	80,479	80,479	78,860	78,860
<b>Total at 31 March 2024</b>	<b>97,234</b>	97,234	<b>89,700</b>	89,700

## Financial liabilities

	Group		Trust	
	Total	Other financial liabilities	Total	Other financial liabilities
	£000	£000	£000	£000
Payables with DHSC group bodies	843	843	843	843
Other payables	7,458	7,458	7,458	7,458
Accruals	35,035	35,035	34,926	34,926
Provisions under contract	7,460	7,460	7,460	7,460
DHSC loans	8,922	8,922	8,922	8,922
Obligations under leases	18,371	18,371	18,371	18,371
Finance leases and PFI liabilities	78,379	78,379	78,379	78,379

### Total at 31 March 2025

156,468	156,468	156,359	156,359
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	Group		Trust	
	Total	Other financial liabilities	Total	Other financial liabilities
	£000	£000	£000	£000
Payables with DHSC group bodies	9,377	9,377	9,377	9,377
Other payables	7,799	7,799	7,799	7,799
Accruals	29,003	29,003	29,003	29,003
Provisions under contract	4,333	4,333	4,333	4,333
DHSC Loans	9,346	9,346	9,346	9,346
Obligations under leases	18,873	18,873	18,873	18,873
Finance leases and PFI liabilities	80,326	80,326	80,326	80,326

### Total at 31 March 2024

159,057	159,057	159,057	159,057
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Notes:

In accordance with IFRS 9, the fair value of the financial assets and liabilities (held at amortised cost) is not considered significantly different to book value.

## 28 MATURITY OF FINANCIAL LIABILITIES

	Group		Trust	
	At 31 March 2025	At 31 March 2024	At 31 March 2024	At 31 March 2024
	£000	£000	£000	£000
Less than one year	58,439	61,183	58,439	61,183
In more than one year but not more than five years	34,840	35,479	34,840	35,479
Greater than five years	140,336	147,929	140,336	147,929
	233,616	244,591	233,616	244,591

## 29 THIRD PARTY ASSETS

The NHS Foundation Trust held £1,017k cash at bank at 31 March 2025 (31 March 2023: £1,017k) relating to Health Enterprise East, a research and development company limited by guarantee for which the NHS Foundation Trust was the host organisation. This amount is held to offset any possible liabilities that might fall to be settled on behalf of Health Enterprise East. These balances are excluded from the cash and cash equivalents figure reported in the NHS Foundation Trust's Statement of Financial Position. £nil cash at bank and in hand at 31 March 2025 (31 March 2023: £nil) was held by the NHS Foundation Trust on behalf of patients.

## 30 LOSSES AND SPECIAL PAYMENTS

	2024/25		2023/24	
	No. of cases	Value of cases £000	No. of cases	Value of cases £000
<b>Losses:</b>				
Private patients	12	-	55	-
Overseas visitors	-	-	-	-
Stores losses *	1	59	-	-
Other	17	41	52	11
<b>Total losses</b>	<b>30</b>	<b>100</b>	<b>107</b>	<b>11</b>
<b>Special payments:</b>				
Loss of personal effects	1	0	14	8
<b>Total special payments</b>	<b>1</b>	<b>0</b>	<b>14</b>	<b>8</b>
<b>Total losses and special payments</b>	<b>31</b>	<b>100</b>	<b>121</b>	<b>19</b>

\* Relates to the write off of expired drugs.

These payments are calculated on an accruals basis but exclude provisions for future losses.

There were no individual cases in 2024/25 (2023/24: nil) where a debt write off exceeded £100k.

## 31 CHARITABLE FUND RESERVE

	* Balance 1 April 2024 £000	Incoming Resources £000	Resources Expenses £000	Balance 31 March 2025 £000
Restricted Fund Balance	3,093	436	(364)	<b>3,165</b>
Unrestricted Fund Balance	5,721	2,455	(1,208)	<b>6,968</b>
<b>Total</b>	<b>8,814</b>	<b>2,891</b>	<b>(1,572)</b>	<b>10,133</b>

	<b>Balance 1 April 2023 £000</b>	<b>Incoming Resources £000</b>	<b>Resources Expenses £000</b>	<b>Balance 31 March 2024 £000</b>
Restricted Fund Balance	3,004	986	(897)	<b>3,093</b>
Unrestricted Fund Balance	5,165	1,980	(1,424)	<b>5,721</b>
<b>Total</b>	<b>8,169</b>	<b>2,966</b>	<b>(2,321)</b>	<b>8,814</b>

The main purpose of the charitable funds held on trust is to apply income for any charitable purpose relating to the National Health Service wholly or mainly for the services provided by the Royal Papworth Hospital NHS Foundation Trust.

Where there is a legal restriction on the purpose to which a fund may be used the fund is classified as a restricted fund. The major funds in this category are for the purpose of research, the transplant service and the treatment of heart patients.

Other funds are classified as unrestricted, which are not legally restricted but which the Trustees of the Charity have chosen to earmark for set purposes. These funds are classified as 'designated' within unrestricted funds and are earmarked for the payment of medical equipment leases contracted for by the NHS Foundation Trust and future payments for the direct benefit of the staff and patients within the NHS Foundation Trust.





## **Governor Committee/Group membership – Current: August 2025**

Please NB: All Governors who are retiring from the Council in September 2025 are highlighted in yellow.

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

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



		Ian Harvey (Public Governor - Cambs)
<b>Charitable Funds Committee</b>	<b>Membership to be determined</b>	Governor Observer - Angel 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.

**Patient and Public Involvement (PPI) Committee**  
**Monday 12 May 2025 at 14:00**  
**via MS Teams**

<b>Present:</b>	<b>Role</b>	
Bullivant Susan	Public Governor	SAB
Collins Trevor	Public Governor	TC
Hardy Shepherd Martin	Public Governor	MHS
Harvey Ian	Public Governor	IH
Hotchkiss Marlene	Public Governor (Chair)	MH
Howe Lesley	Public Governor	LH
Marchington Joanne	Patient Experience Manager	JM
McLeese Trevor	Public Governor	TMc
Sandford Megan	Charity Governance and Engagement Officer	MSa
Screaton Maura	CNO	MS
Wall Julie	Personal Asst. to Chairman (minute taker)	JW
Williams Lynne	Staff Governor for Doctors	LW
<b>In attendance:</b>		
Caroline Weldon	Matron (Patient Story)	CW
<b>Apologies:</b>		
Berry Paul	Public Governor	PB
Halstead Abigail	Public Governor	AH
Mensa-Bonsu Kwame	Assoc. Director Corporate Governance	KMB
Newby Robson Janine	Healthwatch Manager	JNR
Raynes Andy	CIO	AR

		<b>ACTION</b>
<b>1</b>	<b>Welcome and Apologies:</b> The Chair (MH) warmly welcomed everyone to the meeting. Apologies were noted as above.  <i>Discussions did not follow the order of the agenda however for ease of recording these have been noted in the order they appeared on the agenda.</i>	
<b>2.</b>	<b>Declarations of Interest:</b> There were no new Declarations of Interest.	
<b>3.</b>	<b>Ratification of the previous PPI Minutes</b> Minutes from the previous meeting held on 10 February 2025 were ratified as a true record of the meeting.	
<b>4.</b>	<b>Action Log Update and Matters Arising: Maura Screaton</b>  <b>Action Log Updates:</b>  <b>Ward Based Volunteers:</b> The number of volunteers has increased and are being aligned with areas where they are needed. <b>Action closed.</b>  <b>A question was raised by Susan Bullivant regarding interest rates and the impact on the amount of surplus reported by Infographics in December:</b>	

	<p><b>A reply from Sophie Harrison CFO was received via email and was sent out on the Action Log which read:</b></p> <p><i>"Interest income is earned on government bank accounts. Interest rates on government bank accounts fluctuate with changes in base rates and interest earned on cash balances forms part of the Trust's financial position. While changes in interest rates will therefore impact on the Trust's financial position, the overall extent of the impact is not anticipated to have a material bearing on the Trust's financial position."</i></p> <p><b>Action Closed</b></p> <p><b>Explanation of Incidents and themes reported on the Infographics:</b></p> <p>MS explained that through PIPR trends of incidents and specific focuses are investigated monthly. MS asked if there is more information that the Committee is requesting. She suggested an agenda item at the next meeting if this is the case.</p> <p>It was felt that an explanation of the type of incidents was being asked for rather than more data and looking at trends further back in time to see if there is a pattern that is occurring of certain incidents.</p> <p>MS is happy to discuss further at the next meeting.</p> <p><b>Patients on Day ward being mixed, pre and post procedure:</b></p> <p>Conversations have taken place with the Head of Nursing regarding the layout of the Day ward. The Day Ward Team are looking at how they may be able to segregate the ward to address the issue raised of patients who are nil by mouth being mixed with patients who are allowed to eat following their procedure. <b>Ongoing</b></p> <p><b>Patient Parking Fees:</b></p> <p>This was raised as a specific incident. The patient was charged but has since received a refund. It was felt to have been a communication issue, and more information has been given to patients since. There is a lack of availability of parking spaces when patients arrive. Unfortunately, this is a common problem across the Campus at hospitals and organisations. Scoping of parking spaces was undertaken last year, and it was found that the number was what was needed for RPH with some extra allocated spaces, but it seems something has changed for reasons unknown. Staff are also struggling to park on some days. Criteria are being looked at once again to check people who are eligible to park. The issue may be people are leaving later at the end of their shift causing a delay on leaving car park spaces which means the next shift is unable to park. A survey is being repeated to see what has changed and why. These are actions that are being proactively looked at to try to help the situation. <b>Ongoing</b></p> <p>TMcL asked if the increased activity at the hospital could be partly to blame. He also mentioned that there are a lot of new homes being built which has impacted General District Hospitals such as West Suffolk and Ipswich Hospitals.</p> <p>MS commented that generally the extra patients are being contacted online or are coming in at the weekends but agreed that this is a continuous issue.</p>	<p>MS/Add as an agenda item 11/8/25</p> <p>MS</p> <p>MS</p>
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	<p><b>Matters Arising:</b></p> <p><b>The PPI Committee noted that the newly recruited NED Dave Jones has agreed to join the PPI Committee to replace Michael Blastland and will be attending the next meeting on the 11 August 2025.</b></p>	
<b>5.</b>	<b>Current Issues:</b>	
<b>5.1</b>	<p><b>Patient Story: Caroline Weldon Thoracic Matron</b></p> <ul style="list-style-type: none"> <li>• The Patient was admitted to 4 North, and he described his stay as a two-day mini break. He had been well when he was discharged home, but symptoms escalated fast once he was home.</li> <li>• The patient has MND and had become unwell at home. He rang up for advice and was told to come into the hospital. He was coughing and struggling to breathe. He had symptoms of a chest infection.</li> <li>• He was readmitted and spent a further two weeks as an inpatient. He was thankful that RPH had responded when he needed them.</li> <li>• He practised using non-invasive ventilation and on day one only tolerated one minute, after a few days tolerated 5 minutes and can now use it for an hour and a half.</li> <li>• He reported that the nursing staff are good. They are attentive and remarkable. He has now seen the physio and nurses from palliative care. The level of attention to detail about his care is amazing and remarkable and added "that every mile away from home is worth it". He lives in Harlow.</li> <li>• The staff tried to get permission for him to see his dog. They take pride in their work.</li> <li>• He has gluten free meals and mentioned that they are good and tasty, although he would like more green vegetables and rice. The only gripe was that the teabags are very weak. He found the catering team are faultless.</li> <li>• He commented that he had 5-star care in the Jewel of the NHS.</li> <li>• This admission has provided him with the opportunity to discuss his future decisions. His family and the medical team all know what he wants in the future and felt that it would make things easy. He has 2 daughters and a wife.</li> <li>• He remarked that the car parking is not easy, and his wife struggles to park in the car park as do staff.</li> <li>• After being on the ward funding has been agreed for his care and he is waiting for a care agency to provide 24-hour care.</li> <li>• He is having work done at home and a wet room is nearly completed.</li> <li>• The patient's wife commented that knowing the staff and how well they look after her husband gives her great comfort when she leaves the ward.</li> </ul> <p>MS added that it is important that the patients are kept as well as they can be and supported so that they can live the best life possible with their families. This story shows the staff go the extra mile to achieve this.</p> <ul style="list-style-type: none"> <li>• Q: A question was raised about how patients adjust to their diagnosis.</li> </ul>	

	<ul style="list-style-type: none"> <li>• A: The day care unit which is the first route into the hospital have contact with the patient from early stages of their diagnosis although unfortunately some patients are diagnosed after living with MND for some while. Patients have close contact with the unit and are supported. There is an MND coordinator who can advise patients over the phone and give support if needed. To avoid long waiting times Occupational Therapists are involved in the care of the patient to advise about equipment before the patient deteriorates.</li> <li>• Q: It was asked what proportion of patients come from local areas and what proportion are referred from further afield.</li> <li>• A: The majority of RPH referrals are from the Cambridgeshire area and through the MND Centre at CUH.</li> </ul>	
5.2	<p><b>Infographics for March:</b>  <b>The Infographics were not available for the meeting today due to missing data.</b></p> <p><b>MS gave a verbal summary:</b></p> <ul style="list-style-type: none"> <li>• There is continuing focus on the Elective Recovery Programme and making sure that more patients on the waiting list are receiving treatment.</li> <li>• There is a lot of progress being made in all specialties.</li> <li>• Extra lists are being arranged for patient treatment.</li> <li>• Outpatients are being followed up on the phone when appropriate.</li> <li>• The progress is evident on the PIPR which comes out at the end of the month.</li> <li>• Quality and Risk: there have been more patient falls reported recently. This is being investigated and monitored.</li> <li>• Data has been received from the National In Patient Survey.</li> <li>• A company called Picker are used to administer the survey and are responsible for the analysis of the data. The full report will be released by the CQC at the end of June.</li> </ul> <p>MS suggested that she will arrange a presentation on the In-Patient Survey results at the next meeting.</p> <ul style="list-style-type: none"> <li>• Q: A question was raised to ask if the patient fills in the survey while they are at the hospital or when they have gone home and if the survey is online or on paper.</li> <li>• A: The survey is done while the patient is at the hospital and is both online and on paper.</li> <li>• It was raised by a member of the committee that while she was recently a patient at the hospital she was not offered to participate in the survey.</li> <li>• It was explained that the In-Patient Survey takes place over a defined period, the data is captured at all organisations over the same 2 weeks for true comparison. It is not done over the year.</li> <li>• Friends and Family can always be accessed to give feedback. Patients are encouraged to give feedback while on the ward.</li> <li>• Q: A question was raised about if a fire broke out on the 4<sup>th</sup> floor, what the fire procedure would be as no instructions were noted on how or where to evacuate to.</li> </ul>	MS/ presentation 11/8/25

	<ul style="list-style-type: none"> <li>A: An explanation was given that there are very sensitive fire alarms, there is a strict response and procedure to follow once the fire alarm is raised. There is also a clear procedure around evacuation. Some patients will need assistance as they are unable to get out of bed. Patients are moved to a point of safety. The Health and Safety Committee focus and discuss procedures. Staff have practice evacuation drills, and all staff have mandatory training. There is a fire officer in the Trust who does a thorough review of everything. A Specialist review has also taken place from someone outside of the Trust who can provide an independent review on how safe RPH is. There is a nominated person who will take over in the event of a fire alarm going off on each ward. They will give clear instructions, and the ward team will know how, when and where to evacuate to. The fire brigade will attend very quickly. Estates and Facilities also have their procedures to follow when an alarm sounds.</li> </ul>	
<b>5.3</b>	<p><b>Healthwatch Update:</b></p> <p><b>Received:</b> The Committee received updates from Janine Newby Robson in the pack for the meeting</p> <p><b>Recommendation:</b> The Committee is asked to note the contents</p> <p>No questions were raised regarding the information</p>	
<b>6.</b>	<b>Quality: Maura Screaton</b>	
<b>6.1</b>	<p><b>PIPR Safe and Caring - M12</b></p> <p><b>Received:</b> PIPR was circulated for information prior to the meeting.</p> <p><b><u>Safe reported overall Amber</u></b>  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 83% in March compared to 68% in February.  Safe staffing fill rates: Registered Nurse (RN) fill rates for day (90%) and night shifts (95%) were above target for March  Work being implemented around smoking cessation – diseases caused by smoking seen at RPH.</p> <p><b><u>Caring reported overall as Green</u></b></p> <p>FFT (Friends and Family Test): In summary – Inpatients: Positive Experience rate was 98.8% in March 2025 for our recommendation score. Participation Rate for surveys was 42.5%.</p> <ul style="list-style-type: none"> <li>A question was raised about bed occupancy and why this is not showing improvement in the ERU.</li> <li>The ERU has been up and running for one year. This has made a huge impact on referral to treatment. There has been an increase in PTE and bypass surgery on the previous year by having 10 beds ringfenced. Sometimes not all patient who are on the operating list are suitable to go through the ERU, they may need an intensive care bed. In this case there may be an empty bed because the patient is more complex.</li> </ul>	

	<ul style="list-style-type: none"> <li>Throughout the year nursing positions that were vacant have been recruited to enabling the full 10 beds to be open.</li> <li>Overall, the ERU has made a positive effect on treating more patients.</li> </ul>	
6.2	<p><b>Quality Accounts: Maura Screation.</b></p> <p><b>Quality Accounts Report 2024/25 was sent to the Committee Members following the meeting.</b></p> <p><b>MS asked if anyone has any questions or comments regarding the report to please contact her directly.</b></p>	MS/JW Sent out 12.5.25
7.	<p><b>Charity Update: Megan Sandford</b> <b>Received: The Charity End of Year Report which was sent out with the meeting papers.</b></p> <p><b>Highlights:</b></p> <ul style="list-style-type: none"> <li>Royal Papworth Charity is delighted to have raised £1.3million. This was achieved with the support of our fundraisers, supporters and volunteers.</li> <li>Their dedication has allowed the Charity to award 283 grants with a value of £1.3million towards staff education, research, patient support services, medical equipment and welfare initiatives.</li> <li>A team of 48 runners, comprising of staff, patients and their family and friends, completed the Cambridge Half Marathon. Collectively, the team raised over £23,000.</li> <li>We recently reached the one-year anniversary of our partnership with Brick Prize Draws. Brick Prize Draws provides competitions to win rare and retired LEGO sets and the partnership has raised a brilliant £13,000 to date. To celebrate this milestone, Brick Prize Draws is offering the chance of winning a LEGO experience for two at the home of LEGO in Billund, Denmark. The experience includes a four-night stay in a junior suite, flights, day tickets to the resort, fan tour tickets and LEGO house experience tickets. (Tickets are £5 for five entries and the closing date is 15 June.</li> <li>£200,000 was granted by the Trustee Board for research innovation applications. The Research and Development Team hold grant rounds to welcome applications that support feasibility or pilot work and broaden the active research base of Royal Papworth staff. This initiative has been successful over the last two years, with successes in both clinical and non-clinical projects.</li> <li>The Occupational Therapy role with a specialist in music therapy has been granted a one-year extension. This role has provided a real positive impact on patient experience whilst allowing opportunities for staff to upskill in non-pharmacological interventions. The initiative has fostered a culture of collaboration amongst staff and brought to light proven benefits for patient recovery and safety.</li> </ul> <p><b>Discussion:</b> MH asked if there had been an increase in applications for grants noted. MSa commented that an increase had been seen of a wide variety of applications and emphasised that these were for non-clinical staff as</p>	

	<p>well as clinical. There are more clinical application requests than non-clinical received.</p> <p>SAB asked if there is funding for any Training Programmes to be developed.</p> <p>MSa explained that being a charity they are not able to provide private benefits but are looking at a platform where resources could be made available and whether that would work alongside other projects.</p>	
<b>8.</b>	<p><b>Patient Carer Experience Group (PCEG)</b> <b>Update from the recent meeting – Maura Screaton</b></p> <ul style="list-style-type: none"> <li>• <b>The Visiting Procedure:</b> The CQC have changed the regulation of the rules in terms of visiting times to reduce restrictions. This was to enable the patient to have the opportunity to have someone with them, should they wish, throughout the day. This was raised with the Patient Experience Group who are making sure that RPH are allowing it to happen. This should be easily implemented as there are single rooms, and other patients are not being disturbed. Discussion was had regarding consistency and an agreement was reached.</li> <li>• <b>Dayrooms:</b> Some of the rooms have already been reverted to being used for patient use but not all. It is reported that some patients feel lonely being in single rooms and would like company and to be able to talk to people. There are certain infection control precautions for some patients but for those who can leave their rooms having the dayroom available for them to sit and chat to people or share a meal is important. Some day rooms need an uplift. Teams have requested through the charity about brightening these rooms up to improve the patient experience. On the fifth floor there is some gym equipment used by transplant patients</li> </ul> <p>PCEG Minutes to be forwarded to the Committee when available.</p>	
<b>9.</b>	<p><b>Board Meeting Feedback:</b> <b>KMB sent his apologies. No feedback was given today.</b></p> <ul style="list-style-type: none"> <li>• Board papers can be seen on the hospital website for information.</li> <li>• The PART I Public meeting agenda is sent out to all the Governors with the link for the meeting, so they can observe.</li> </ul>	
<b>10.</b>	<p><b>Patient Experience – Complaints &amp; PALS: Joanne Marchington</b> <b>Report to be sent to the Committee.</b></p> <p><b>Summary from the last quarter:</b></p> <ul style="list-style-type: none"> <li>• A total of 17 new formal complaints were received</li> <li>• A total of 20 informal complaints were received</li> <li>• Concerns regarding delay in diagnosis/treatment or referral; clinical care/treatment; and communication, continue to be the primary subjects of complaints received.</li> <li>• A total of 392 PALS enquiries were received</li> <li>• PAT dogs have started to visit wards</li> </ul>	



	<p><b>Volunteers:</b></p> <ul style="list-style-type: none"> <li>• The charity has supported funding which has been secured to allow continued employment of a volunteers' co-ordinator. In addition to supporting the PALS team, this has allowed a dedicated member of staff to focus on what has been a significant recruitment drive over the last year and beyond. The number in the team means that the hours volunteered each month is now achieving pre-pandemic levels.</li> <li>• Our volunteers support a range of roles across the Trust such as Ward Visiting, Meet and Greet, Chaplaincy support, Research Ambassador, Pharmacy Support, Reading Panel, Charity Ambassador, and being part of our Quality Peer Review Assurance process on our wards. New roles have this year been introduced, specifically targeting areas that are seeking support. This includes working with the Treating Tobacco Dependency Programme, as well as an aimed focus on assisting the wards with the patient FFT survey participation.</li> <li>• Volunteers are being recruited to suit different areas, meet and greeters as well as on wards, to sit with and to chat with lonely patients. They cover a variety of shifts on weekdays and at the weekend.</li> <li>• The greatest response of volunteers is from people who are interested in visiting patients on wards.</li> <li>• Volunteers have wards assigned to them. Patients can request a volunteer visit. The nursing staff will ask the volunteer to visit those patients. The nursing staff can also contact the PALS office to request a visit for a particular patient. The volunteer can arrange further visits with a patient once they have met.</li> <li>• Families can request a visit from a volunteer for their relative through PALS.</li> </ul> <p><b>Pets as Therapy (PAT)</b></p> <ul style="list-style-type: none"> <li>• The Pets as Therapy (PAT) initiative is being finalised and onboarding of three volunteers and their dogs has begun. There are also another three volunteers going through the recruitment process and they will be ready to start visiting patients and staff very soon.</li> <li>• Collaborative working between the volunteer co-ordinators at Royal Papworth Hospital and Cambridge University Hospital has ensured that a streamlined recruitment process is available for volunteers that wish to volunteer across both site. This is very positive and has encouraged PAT dog volunteers to support both Trusts.</li> <li>• Visits by specially trained pets to a healthcare setting have been shown to have a beneficial outcome to the emotional, physical and social wellbeing of patients and employees. PAT dogs provide additional social interaction for the patient which will help to reduce anxiety, stress and improve the overall mental wellbeing of the patient - Research has proven this concept brings a huge benefit to patients through much needed social interaction, in turn reducing stress and anxiety.</li> </ul>	
<b>11.</b>	<p><b>Terms of Reference (ToR)</b></p> <p><b>ToR008 – For review at CoG on 4 June 2025</b></p>	

	<p><b>Received: ToR008 was circulated to the Committee for information.</b></p> <ul style="list-style-type: none"> <li>• Discussion was had about the voting membership and clinical representation from either the Medical Director or a representative. This has usually been the Chief Nurse.</li> <li>• It was felt important that there is medical representation at the meeting.</li> <li>• It was suggested that the Chair of the Committee should contact KMB to ask if having the Medical Director listed is of value, and if it is necessary, what would be needed for this to be put in place.</li> </ul> <p><b>Duties of the Committee:</b></p> <ul style="list-style-type: none"> <li>• <b>4.3</b> To oversee the process by which the Patient and Carer Experience Strategy is reviewed and updated annually, with agreed action plans for the forthcoming year.</li> <li>• It was raised that the action plans from PCEG had not been received by the PPI Committee at any previous meetings therefore this duty has not been met to date.</li> </ul> <p><b>Approved: The PPI Committee formally approved the TOR008</b></p> <p><b>Governance:</b> None</p>	<p><b>MH</b></p> <p><b>MH</b></p>
<b>12.</b>	<b>Risk</b>	
	<p>It is recommended to the Committee that this item has been added to all agendas.</p> <ul style="list-style-type: none"> <li>• Emerging Risks – None raised.</li> </ul>	
<b>13.</b>	<p><b>Governor Requested Items:</b></p> <p><b>LH raised the following issues:</b></p> <p>It was found that there were no hangers in some wardrobes on some wards. MS to investigate.</p> <p>There was no stool in some bathrooms for the patient to sit on while having a shower. Stools are given to a patient on an individual basis. Number on each ward not known. MS to investigate.</p> <p>Suggestion of a type of arm covering when showering with an intravenous line. MS to take this to the Infection Control Team.</p> <p>The waste of paper towels because they are packed tightly into the holder and a handful comes out instead of one or two. MS to take back to the Team.</p>	<p><b>MS</b></p> <p><b>MS</b></p> <p><b>MS</b></p> <p><b>MS</b></p>
<b>14.</b>	<p><b>Any Other Business:</b></p> <p><b>Ian Harvey: Update on Quizzes and Membership Strategy</b></p>	

	<p><b>Quizzes:</b></p> <ul style="list-style-type: none"> <li>• IH explained that he writes and runs quizzes. This was shared with the Charity office and the suggestions of quizzes for patients and for staff and public have been approved.</li> <li>• Quizzes for the public will be held to help recruit to the Membership: delivery of this is being discussed. IH to put together a quiz pack so that some members can run quizzes in their own constituency.</li> <li>• Quizzes for patients: delivery is being discussed. Paper versus screens in patient rooms. Not able to gather everyone together due to infection controls. IH to meet with Digital to discuss options.</li> <li>• Feedback from staff has been very positive and agree will benefit patients.</li> </ul> <p>MS commented that Caroline Weldon Matron who feels this is a positive benefit to patient experience would be the person to contact for help.</p> <p><b>Membership Strategy:</b></p> <ul style="list-style-type: none"> <li>• IH explained that Laura Favell (LF) is in post to coordinate the Membership Strategy. LF has drafted the strategy. This now sits with the Governor Assurance Committee to approve before taking it to the Council of Governors on the 4 June 2025 for ratification. It will then be published on the website.</li> </ul> <p>In the meantime, a document has been written of ideas that can now be taken forward. A draft action plan will be made up from the list.</p>	
	<p><b>Future Dates</b></p>	
	<ul style="list-style-type: none"> <li>• <b>The next Council of Governors meeting will be held on Wednesday 4 June 2025 at 10.30am</b></li> <li>• <b>The next PPI Committee Meeting will be Monday 11 August 2025 at 14:00</b></li> </ul> <p><b>Future Meeting Dates:</b></p> <p><b>Monday 3 November 2025</b></p> <p><b>The Chair thanked everyone for their participation and the meeting finished at 15:50</b></p>	

**Meeting of the Access and Facilities Group  
 of the Council of Governors  
 Held on 09 April 2025, 14.00-15.00  
 via MS Teams**

## M I N U T E S

<b><u>Present:</u></b>	Trevor McLeese (TM) – Public Governor (Chair) Trevor Collins (TC) – Public Governor Clive Glazebrook (CG) – Public Governor
<b><u>In Attendance:</u></b>	Oonagh Monkhouse (OM) – Director of Workforce and OD Ali Abdoul (AA) – Head of EDI Naomi Brodowski (NB) – EA to Director of Workforce & OD (minute-taker) Kwame Mensa-Bonsu (KMB) – Associate Director of Corporate Governance Adrian Ward (AW) – Estates and Facilities
<b><u>Apologies:</u></b>	Bill Davidson (BD) - Public Governor Philip Abraham (PA) – EDI Compliance & Assurance Manager Kirsty Mainds (KM) Head of Estates and Facilities

Agenda Item		Action by whom	Date by when
1 .	<b>Welcome, Apologies and Opening Remarks</b>  Apologies of absence were received as above.		
2.	<b>Declarations of Interest</b>  No declarations of interest.		
3.	<b>Minutes of previous meeting &amp; matters arising</b>  The minutes of the last meeting held on the 08 January 2025 were agreed as a true and accurate record of the meeting.		
4.	<b>Summary of Access and Facilities issues action plan</b>  The action plan was updated.		
5.	<b>Workforce update</b>  <u>Transformational Reciprocal Mentoring Programme (TRMP)</u> <ul style="list-style-type: none"> <li>Cohort 3 of the TRMP has officially launched, with the next module scheduled for May.</li> <li>AW, a current participant, shared positive feedback, highlighting the value of connecting with colleagues beyond work discussions. He found it insightful to hear personal</li> </ul>		

Agenda Item		Action by whom	Date by when
	<p>stories of discrimination and learn how to offer better support.</p> <ul style="list-style-type: none"> <li>A dedicated session will be held for line managers of programme participants to help them understand the aims of the TRMP and how to best support their team members.</li> </ul> <p><u>Culture and Leadership Programme</u></p> <ul style="list-style-type: none"> <li>A Board-led session on inclusive leadership and the behaviour framework took place in September 2024, followed by a half-day follow-up on 1 April.</li> <li>The session included presentations from three divisions, showcasing progress since the initial session and reviewing staff survey results.</li> </ul> <p><u>Neurodiversity Programme</u></p> <ul style="list-style-type: none"> <li>Officially launched on 17 March with a one-hour webinar open to all staff.</li> <li>On 19 March, an awareness event was held as part of Neurodiversity Week, during which a toolkit for managers and HR was introduced.</li> <li>As a result of this initiative, two co-chairs have been appointed to the Disability and Carers Network.</li> <li>Staff feedback indicated interest in forming a dedicated neurodiversity group for ongoing support and engagement.</li> </ul> <p><u>Violence Prevention and Reduction (VPR) Standard</u></p> <ul style="list-style-type: none"> <li>Ongoing efforts are in place to reduce violence and aggression towards staff, whether from patients or colleagues.</li> <li>A new version of the VPR Standard has been published. This standard spans Workforce, Patient Care, and Estates.</li> <li>An audit is currently underway to identify any gaps in implementation and ensure alignment with the updated standard.</li> </ul>		

6.	<b>Estates update</b> <ul style="list-style-type: none"> <li>• Broken televisions – there have been ongoing issues with broken TVs and the Estates team is currently investigating and addressing the problem.</li> <li>• Cambridge South Station – the new station is now expected to open in February/March 2026.</li> <li>• XXL scrubs availability – due to supply issues with XXL sized scrubs, the laundry team has been sewing together two large-sized scrubs to maintain stock levels whilst the issues continue.</li> <li>• PPE supplies – mask supplies have been intentionally reduced to prevent unnecessary usage. Members of the group raised concerns around shortage of hand sanitiser and AW will follow this up with OCS. TC suggested supplying QR codes where staff/patients could report low supplies such as hand sanitiser.</li> </ul>	AW/ Estates	09/07/25
7.	<b>Any other business</b>  No other business.		
	<b>Date of next meeting:</b>  Wednesday 09 July 2025, 14.00-15.00, MS Teams		

**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**

<b>PRESENT</b>		
Dr Susan Bullivant	SBu	Public Governor ( <b>Chair</b> )
Dr Harvey Perkins	HP	Public Governor
Vivienne Bush	VB	Public Governor
Trevor McLeese	TMc	Public Governor
Dr Clive Glazebrook	CG	Public Governor
<b>IN ATTENDANCE</b>		
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
<b>APOLOGIES</b>		
Bill Davidson	BD	Public Governor
Christopher McCorquodale	CMc	Staff Governor

Agenda Item		Action by Whom	Date
<b>1.</b>	<b>WELCOME &amp; OPENING REMARKS</b>		
	SBu welcomed all to the meeting.		
<b>i.</b>	<b>APOLOGIES</b>		
	Apologies had been received from BD and CMc.		
<b>ii.</b>	<b>DECLARATIONS OF INTEREST</b>		
	No specific conflicts were identified in relation to matters on the agenda.		
<b>iii.</b>	<b>MINUTES OF THE PREVIOUS MEETING DATED 15 JANUARY 2025</b>		
	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
	<p>should have read "...considered to be a <b><i>“when” rather than an “if”</i></b>.</p> <p>Subject to the above amendment, the Committee <b>approved</b> the minutes from the 15 January 2025 meeting and authorised these for signature by the Chair as a true record.</p>		
iv.	<b>MATTERS ARISING</b>		
	<p><b><i>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.</i></b>  This item was on the agenda for today’s meeting. To be <b>CLOSED</b>.</p> <p><b><i>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).</i></b>  TG would provide an update at today’s meeting. To be <b>CLOSED</b>.</p> <p><b><i>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.</i></b>  This action had been completed. To be <b>CLOSED</b>.</p> <p>The Committee received and <b>approved</b> the updates on the action checklist.</p>		
2.	<b>STRATEGIC PLANNING/DEVELOPMENTS</b>		
i.	National/Local Updates		
	<p>EM presented the National/Local updates.</p> <p>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%.</p> <p>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.</p> <p>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.</p> <p>EM explained that it had been possible to collectively submit a system position</p>		



Agenda Item		Action by Whom	Date
	<p>which was breakeven across all of the NHS provider organisations in the Cambridgeshire and Peterborough (C&amp;P) ICS. The C&amp;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&amp;P ICS to commit to achieving the level of recovery required by the Planning Guidance in relation to urgent and emergency care.</p> <p><b>Discussion:</b></p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>The Committee <b>noted</b> the National/Local updates.</p>		
ii.	Development of the Trust's next 5-Year Strategy (2026 – 2031)		
	<p>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.</p> <p>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.</p> <p>An additional workshop had involved key stakeholders including Governors and other attendees from Cambridge University Hospital, the C&amp;P ICB and North West Anglia NHS Foundation Trust (NWAFT).</p>		

Agenda Item		Action by Whom	Date
	<p>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.</p> <p>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'.</p> <p>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.</p> <p><b>Discussion:</b></p> <p>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.</p> <p>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.</p> <p>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.</p> <p>The Committee <b>noted</b> the Development of the next Trust 5-Year Strategy (2026 – 2031).</p>		
iii.	Progress Update – Workforce Strategy Plan (Recruitment and Retention Activities)		
	<p>OM introduced the Progress Update – Workforce Strategy Plan (Recruitment and Retention Activities).</p> <p>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:</p>		



Agenda Item		Action by Whom	Date
<b>3.</b>	<b>OPERATIONAL PLANS</b>		
i.	Annual 2025/26 Operational Plan		
	<p>SH presented the Annual 2025/26 Operational Plan and shared a relevant presentation with the Committee.</p> <p>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.</p> <p>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.</p> <p>SH reiterated the key headline relating to the financial plan that a breakeven plan had been submitted by both the Trust and the C&amp;P ICS for 2025/26.</p> <p>The following highlights were noted:</p> <ul style="list-style-type: none"> <li>i. A cost improvement delivery of £9.6m.</li> <li>ii. Targeted investment would support elective waiting list improvements and RTT performance of circa. £1.4m.</li> <li>iii. The funding of unavoidable cost pressures would be £1.3m.</li> </ul> <p>HMc provided the Committee with areas of interest in relation to the following:</p> <ul style="list-style-type: none"> <li>i. A projected activity growth of +9%.</li> <li>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.</li> <li>iii. An overall productivity improvement target of +7% was highlighted.</li> </ul> <p>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.</p> <p><b>Discussion:</b> 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.</p>	SH	07/25

Agenda Item		Action by Whom	Date
	The Committee <b>noted</b> the Annual 2025/26 Operational Plan.		
ii.	Nexus EPR Replacement Project – Progress Update		
	<p>HMc presented the Nexus EPR Replacement Project – Progress Update.</p> <p>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.</p> <p>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.</p> <p>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:</p> <ul style="list-style-type: none"> <li>• Introduction and background</li> <li>• Instructions to suppliers</li> <li>• Scope of work / specification of requirements</li> <li>• Contract Terms and Conditions</li> <li>• Evaluation criteria</li> <li>• Pricing and cost breakdown</li> <li>• Compliance and regulatory requirements</li> </ul> <p>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.</p> <p>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.</p> <p>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.</p> <p><b>Discussion:</b>  SBU explained that BD had expressed the wish to understand whether the plan</p>		

Agenda Item		Action by Whom	Date
	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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&amp;P ICB level.</p> <p>The Committee <b>noted</b> the Nexus EPR Replacement Project – Progress Update.</p>		
iii.	Papworth Integrated Performance Report (PIPR) – M11		
	<p>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.</p> <p>Of positive note were low nursing vacancy rates, giving opportunity to address agency usage, which had been driving up costs.</p> <p><b>Discussion:</b></p> <p>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.</p>		

Agenda Item		Action by Whom	Date
	<p><i>IS left the meeting (11:55 hrs).</i></p> <p>The Committee <b>noted</b> the Papworth Integrated Performance Report (PIPR) – M11.</p>		
<b>4.</b>	<b>ASSURANCE</b>		
i.	Abridged Board Assurance Framework (BAF) – Overview of Underlying Risks		
	<p>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.</p> <p>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.</p> <p>EM advised that the BAF would be more user-friendly, after a review had been completed by the Trust Board in May 2025.</p> <p>The Committee <b>noted</b> the Abridged Board Assurance Framework (BAF) – Overview of Underlying Risks.</p>		
<b>5.</b>	<b>GOVERNANCE</b>		
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.		
<b>6.</b>	<p><b>Date and Time of Meetings</b></p> <p>i. 09 July 2025</p> <p>ii. 08 October 2025</p>		

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Signed

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Date

Royal Papworth Hospital NHS Foundation Trust Council of Governors  
Forward Planning Committee Meeting on 9 April 2025.

# Minutes of the Meeting of the Governors' Assurance Committee (GAC) Held on Friday 28 March 2025 10:30 to 11:30 hrs via Microsoft Teams

PRESENT		Role
Bill Davidson	BD	Chair
Abigail Halstead	AH	Lead Governor
Trevor McLeese	TMc	Public Governor
Marlene Hotchkiss	MH	Public Governor
Ian Harvey	IH	Public Governor
Dr Susan Bullivant	SB	Public Governor
IN ATTENDANCE		
Cynthia Conquest	CC	Senior Independent Director (SID)
Laura Favell	LF	Communications and Membership Coordinator
Oonagh Monkhouse	OM	Director of Workforce and OD
Kwame Mensa-Bonsu	KMB	Associate Director of Corporate Governance
APOLOGIES		
Christopher McCorquodale	CMc	Staff Governor

Agenda Item		Action by Whom	Date
<b>1.</b>	<b>WELCOME &amp; OPENING REMARKS</b>		
	The Chair welcomed all to the meeting.		
<b>i.</b>	<b>Apologies</b> Apologies had been received from CMc.		
<b>ii.</b>	<b>Declarations of Interest</b> 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.		
<b>2.</b>	<b>MINUTES AND ACTION CHECKLIST</b>		
<b>2.i</b>	<b>Minutes from the Last Meeting – 13 January 2025</b> The Committee <b>approved</b> the minutes from the 13 January 2025 meeting and authorised these for signature by the Chair as a true record.		
<b>2.ii</b>	<b>Action Checklist</b>  <u>01/25 15 January 2025 – 3.i – Any Other Business &amp; Meeting Review: Current versions of the Trust Constitution and NHS Code of Governance was to be circulated, via email, to those present after 13 January 2025. This had been completed by OM; to be closed.</u>  <u>02/25 15 January 2025 – 3.i – Any Other Business &amp; Meeting Review: OM to confirm arrangements for secretarial support for GAC going forward with KMB and the Chair to be informed.</u> The Chair had been informed that support would be provided via KMB. To		



Agenda Item		Action by Whom	Date
	<p>be <b>closed</b>.</p> <p><u>03/25 15 January 2025 – 3.i - Any Other Business &amp; Meeting Review: OM to take up proposals with KMB for a meeting in March 2025 to be arranged.</u> This had been completed; to be <b>closed</b>.</p> <p><u>04/25 15 January 2025 – 3.i - Any Other Business &amp; Meeting Review: The ToR to be reviewed with particular reference to: ICS functions; formatting; attendance of CoG meetings by Governors cross referenced with the Appointments Committee; frequency of GAC meetings; and abbreviations such as “SID” to be expanded.</u></p> <p>The Chair stated that there was a need to discuss the CoG’s and/or the Committee’s role in how the Trust’s relationship with the ICS was conducted. With the recent announcement of the abolition of NHSE, this item was to remain <b>open</b>.</p> <p>OM noted the addendum which addressed the role of CoG with ICBs; however, further clarity was required around this and a discussion at CoG was deemed appropriate.</p> <p><u>05/25 15 January 2025 – 3.i - Any Other Business &amp; Meeting Review: Agenda Items going forward to be finalised.</u> A verbal update was to be provided at the meeting today. <b>Closed</b></p> <p>The Committee received and <b>approved</b> the updates on the action checklist.</p>		
<b>3.</b>	<b>GOVERNANCE</b>		
<b>i.</b>	<p><b>Committee Terms of Reference (ToR)</b> The Chair acknowledged amendments made to the ToR by KMB. It was requested that the spelling of words such as authorised and recognised be amended as these were presently spelt with a “z” in lieu of an “s”.</p> <p>There was wording referring to NHSE which would require amending as an understanding developed as to procedures going forward without NHSE. The Chair requested feedback from those present.</p> <p><b>Discussion:</b> MH suggested that the document was accepted pending future revisions around the omission of NHSE; the Chair and CC concurred.</p> <p>OM reiterated the lack of understanding around Governors’ support of ICS functions, which had been added to the document. It was suggested that no action was taken in this respect until further news was received as to the ICS and the soon to be dissolved NHSE. It required to be acknowledged that no action would be taken in this regard. AH concurred.</p> <p>The Committee <b>approved</b> the Governors’ Assurance Committee ToR with the knowledge that a further review would be required, pending news around NHSE.</p>		

Agenda Item		Action by Whom	Date
<b>4.</b>	<b>GOVERNOR DEVELOPMENTS</b>		
<b>4.i</b>	<p><b>Draft RPH Governors' Handbook</b></p> <p>The Chair noted that a draft had been circulated by KMB and was presented to the GAC for review.</p> <p>The Chair acknowledged the attachment of appendices relating to the NHSE and statutory guidance, along with a summary of governors' key duties and obligations. KMB confirmed that the latter had been approved at CoG in November 2024.</p> <p><b>Discussion:</b></p> <p>AH queried if a contacts page could be added at the end of the handbook.</p> <p>OM requested a section which concentrated on the model/plan for the induction of governors. KMB agreed.</p> <p>CC outlined a recent course attended for NEDs working with governors and requested that best practice be reviewed in the document. There was often confusion around the role governors played, for example, when observing meetings, and items such as this required clarity.</p> <p>KMB stated that the practice of observers asking questions was in place at RPH and the Chair supported this. SB stated that in attending the Performance Committee, it was not always possible to ask questions, unless specifically invited.</p> <p>OM was not aware that this questioning was prohibited and suggested that KMB advised formally; it was preferable to be able to continue with this practice. KMB clarified that, whilst not prohibited, procedures were different at other Trusts; all agreed that observers were an important aspect of meeting attendance at RPH and that this practice should continue.</p> <p>The importance of governors being invited to contribute and ask questions as observers was requested to be explicitly noted in the Governors' Handbook.</p> <p>SB requested that a page be included in the handbook detailing acronyms. KMB agreed to review. TMc stated that a RPH list of acronyms would be useful for governors to refer to. LF offered to explore the possible exportation of the acronym file from the staff intranet. CC agreed that this would be advantageous.</p> <p>KMB sought clarity around SB's request for acronyms and whether it applied to the governors' handbook only or was a general request. SB stated that the request concerned the handbook primarily.</p> <p><b>Action: RPH Governors' Handbook: draft document to be reviewed and any acronyms expanded when first used, with abbreviations adopted subsequently throughout the document.</b></p> <p>OM sought clarity around action proposed to progress the handbook</p> <p><b>Action: LF to liaise with Sam Edwards regarding the Executive Team adopting the practice of including the acronym in brackets after noting</b></p>	KMB	06/25

Agenda Item		Action by Whom	Date
	<p><b>in full at the start of all Trust documents going forward.</b></p> <p>AH stated that further to a meeting with Jag Ahluwalia and Eilish Midlane, and the handbook would now be approved at the next CoG. All agreed that the handbook be circulated to all governors for final review in advance of this.</p> <p><b>Action: RPH Governors' Handbook: To enable the document to be approved at a future CoG meeting, draft handbook to be circulated to all governors for review in advance of this.</b></p> <p>The Committee <b>reviewed</b> the Draft RPH Governors' Handbook</p>	<p><b>LF</b></p> <p><b>KMB</b></p>	<p><b>06/25</b></p> <p><b>06/25</b></p>
4.ii	<p><b>RPH Membership Strategy – Plan for Development</b></p> <p>The Chair noted that the strategy was not in place and the next stages to develop this required to be agreed and the strategy developed as a matter of urgency. It was highlighted that the governors' role included engaging with members, which was not presently being initiated.</p> <p><b>Discussion:</b></p> <p>OM sought clarity around timescale for the development of this strategy, acknowledging that there was a draft membership strategy; next steps needed to be agreed to develop this to a final document for approval by the CoG. Further agreement would be necessary as to the enactment of the strategy.</p> <p>IH had not expected the strategy to be included on the agenda for approval at the last CoG meeting. The Chair, IH and AH discussed this and agreed that the document was not finalised; as a result, the item was removed from the CoG agenda.</p> <p>IH proposed next steps to comprise: Informal Working Group which first met in 2023, to be expanded to include all interested governors, with a virtual meeting scheduled in conjunction with LF. IH would chair the meeting and proposed additions/omissions/amendments would be suggested in a revised document circulated in advance, for discussion at the meeting.</p> <p>Further considerations with respect to the strategy document were outlined by IH and included a foreword to be submitted by AH, evaluation of previous strategy, specific targets and progress towards these. To further assist progress, IH requested that all attending the proposed meeting consulted the CUH and Liverpool strategies from which much could be learned.</p> <p>It was anticipated that the conclusion of the meeting would provide a list of items to be forwarded to LF to produce a revised draft Strategy document. LF suggested that KMB was to assist with the overarching tasks to draw the final draft together.</p> <p>Once the Working Group had finalised the draft document, it was required to be brought to the GAC, who owned the document, for approval; subject to this, the Strategy would then be ready to be taken to CoG for approval.</p> <p><b>Action: RPH Membership Strategy – plan for development: a virtual meeting to be scheduled for the Informal Working Group, chaired by IH with a view to finalising the document for approval at the next GAC.</b></p>		

Agenda Item		Action by Whom	Date
	<p><b>Existing draft to be circulated in advance of the meeting for comment and to provide a platform for effective amendment.</b></p> <p>CC queried if designated members encompassed NEDs; clarity was required in the NED membership document. OM stated that there should be a process for all staff, including NEDs, to establish if they wished to be a member. This would resolve the issue of a membership list. CC highlighted a document which had been viewed recently, and which described the requirement to be a member of CoG in order to be a NED.</p> <p>KMB clarified that a NED was not required to be a member, although membership was required to take up the position of governor.</p> <p>SB questioned IH as to whether an implementation plan would be attached to the final draft as an appendix at the point of returning to the GAC and CoG. Whilst an action plan had been attached to the last strategy, IH confirmed that the strategy was needed first to enable production of the plan. It was anticipated that ideas relating to the action plan would develop but it was not envisaged that the plan would form part of the strategy.</p> <p>The Chair suggested that with the next GAC meeting scheduled for 16 June, the strategy required development further, with a view to approving it at the June meeting to enable it to proceed to CoG. OM stated that the CoG meeting following this June meeting would be in September 2025.</p> <p>OM emphasised that the action plan required further development, and a timescale decided for presentation at CoG either in September or at the following meeting in 2026. IH to discuss with LV the scheduling of a separate meeting to brainstorm the contents of the action plan.</p> <p>AH queried whether, despite the GAC being after the next CoG in June, whether there was any possibility that the draft strategy could be ready to present to CoG in June. The Chair agreed and noted that advanced agreement of the GAC could be undertaken via email rather than a formal meeting. All concurred and revised dates were to be agreed accordingly; IH to liaise with LF to schedule this with all governors.</p> <p><b>Action: IH and LF to schedule an ad hoc meeting, in advance of the next CoG meeting, to approve the draft strategy and enable it to be presented at CoG for approval in June 2025.</b></p> <p>The Committee <b>discussed</b> the RPH Membership Strategy – Plan for Development.</p>	<p><b>LF/IH/KMB</b></p> <p><b>IH/LF/KMB</b></p>	<p><b>06/25</b></p> <p><b>06/25</b></p>
<b>5.</b>	<b>ANY OTHER BUSINESS</b>		
	With no other business to discuss, the meeting closed at 11:20 hrs.		
<b>6.</b>	<b>DATES OF FUTURE MEETINGS</b>		
<b>ii.</b>	<p><b>Date and Time of Meetings</b></p> <p>i. 16 June 2025</p> <p>ii. 10 November 2025</p>		

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Signed

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Date

Royal Papworth Hospital NHS Foundation Trust  
Governors' Assurance Committee 28 March 2025

# Papworth Integrated Performance Report (PIPR)

**July 2025**

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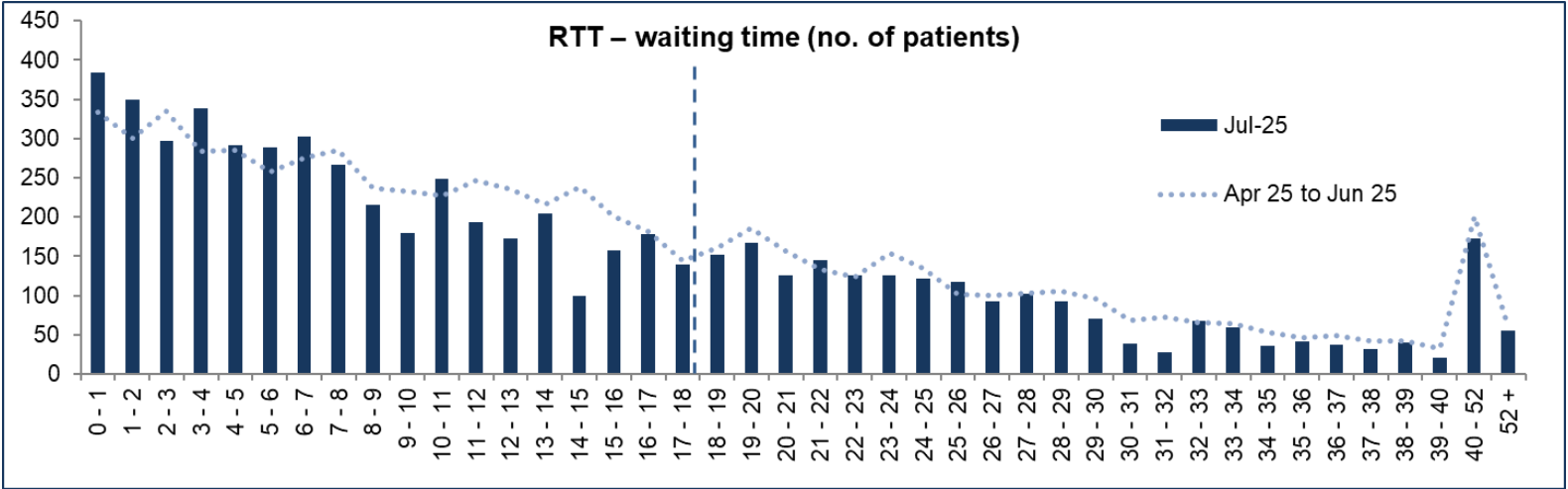
# Context:

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)	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Trend
Cardiac Surgery	147	138	143	147	138	161	
Cardiology	650	679	718	747	709	774	
ECMO	2	8	0	5	4	4	
ITU (COVID)	0	0	0	0	0	0	
PTE operations	9	11	11	9	10	12	
RSSC	536	526	632	726	734	678	
Thoracic Medicine	510	501	497	515	528	564	
Thoracic surgery (exc PTE)	87	82	56	63	66	60	
Transplant/VAD	49	45	45	47	56	39	
Total Admitted Episodes	1,990	1,990	2,102	2,259	2,245	2,292	
Baseline (2019/20 adjusted for working days annual average)	1,830	1,830	1,830	1,830	1,830	1,830	
% Baseline	109%	109%	115%	123%	123%	125%	

Outpatient Attendances (NHS only)	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Trend
Cardiac Surgery	600	573	526	574	558	643	
Cardiology	3,634	3,842	3,945	3,975	4,014	4,218	
RSSC	2,091	2,166	2,096	2,254	2,201	2,987	
Thoracic Medicine	2,285	2,162	2,306	2,459	2,464	2,620	
Thoracic surgery (exc PTE)	125	132	100	110	137	115	
Transplant/VAD	254	281	330	306	346	291	
Total Outpatients	8,989	9,156	9,303	9,678	9,720	10,874	
Baseline (2019/20 adjusted for working days annual average)	7,418	7,418	7,418	7,418	7,418	7,418	
% Baseline	121%	123%	125%	130%	131%	147%	

**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 activity to be coded and submitted to SUS.



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:

Assessme nt 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.

- **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

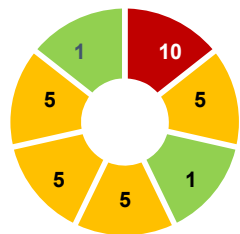
Overall Report Scoring

- **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 <i>quality of reported data</i> . <i>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.</i>
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:** 1) Safer staffing fill rates continue to meet target of 85% since April 2025. 2) Harm Free Care- All metrics are within normal variance; Low level of Pressure Ulcers reported for last 6 months, Falls within expected range however there was 1 fall with severe harm in month, VTE Assessments above target of 95% for last 2 months. 3) Cardiac Surgery Mortality (crude monitoring): Within expected variation at 1.9% in July and has consistently been below the mean since December 2024.

**CARING:** 1) The Trust has continued to achieve high Friends and Family Test (FFT) recommendation scores Inpatients:99.0% and Outpatients:98.1% in July. 2) Duty of Candour was 100% in month.

**EFFECTIVE:** 1) ICU Bed occupancy has improved in M04 and is above the KPI at 88.3%, this is reflective of the increase in transplantation in M04. This trend was also reflected in theatre activity where theatre utilisation was 94%. 2) Outpatient First appointments continue to exceed 19/20 baseline with 194% in M04.

**RESPONSIVE:** RTT - While the RTT fails to meet the national target, month on month improvements continue to be noted through the elective recovery performance and delivery group. The overall number of patients on the waiting list continues to reduce as a result, with enhanced governance ensuring scheduling is optimised 6 weeks in advance, as well as oversight for long-waiter management.

**PEOPLE, MANAGEMENT & CULTURE:** 1) Turnover has significantly reduced to 4.41% in July, there does tend to be a reduction in the summer months and this is the lowest turnover % since pre covid levels. 2) We have seen a reduction in our vacancy rate in July at 6.12%, remaining below the Trust KPI. 3) The time to hire for July was 40 days. This is the 10th consecutive month below the national KPI of 48 days.

**FINANCE:** At month 4, the YTD finance position is a deficit of £8k, which represents a favourable variance of £64k to plan. This favourable variance is mainly driven by variable income over-performance within core NHS variable contracts for England which is now YTD £2m favourable and non-England commissioners. Also supporting this slight favourable variance is a favourable budget phasing of planned elective recovery initiatives and contingency reserves against spend over the period; which offsets adverse business-as-usual pay and CIP under-delivery pressures within clinical divisions.

## ADVERSE PERFORMANCE

**SAFE:** 1) Increasing safer staffing fill rates continue to support increases in Supervisory Sister/Charge Nurse time from October 2023 to present (target 85%), slight increase in SS/CN time to 83% in July compared to 82% in June. 2) Falls within expected range; however, there was 1 fall with severe harm in the month.

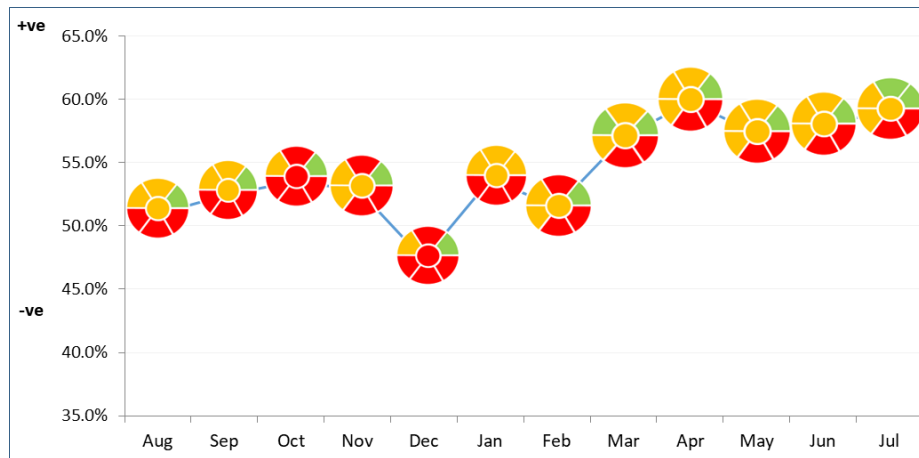
**CARING:** The % of complaints responded to on time is below our target (100%) for the fourth month in a row. In July, 2 of 3 (83.33%) of complaints responded to in the month were within agreed timescales.

**EFFECTIVE:** 1) Reduction in Follow Up appointments remains below the target of 25%, however M04 has seen an improvement from a reduction of 2.5% to 7.2%. 2) General bed occupancy continues to show as below target, however data includes uncommissioned beds and further analysis is being undertaken. ERU remains below the target occupancy levels; however, it has improved from M03 to 60.8%. This is reflective of the increase in thoracic surgery and transplantation and improved efficiencies in ERU.

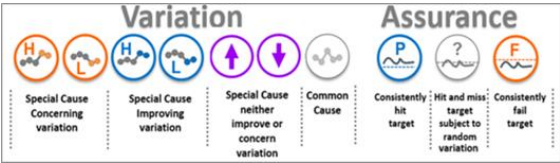
**RESPONSIVE:** 1) ACS – While improvements were noted in M04, delays continue in ACS transfers from DGHs due to limited transport availability, which results in avoidable breaches for the pathway. 2) A large proportion of the 52-week breaches remain within Cardiology (structural); however, plans are in place to ensure all patients within this cohort are treated by the end of October 2025. 3) 62-day cancer performance remains below plan with a detailed improvement plan being drafted and monitored through new cancer recovery performance and delivery group.

**PEOPLE, MANAGEMENT & CULTURE:** Total sickness absence increased to 4.69% which is over our KPI. There has been continued focus from the Workforce Directorate to support managers through training and the application of absence management protocols with enhanced focus following the publication of the NHS 10 Year Plan.

**FINANCE:** Pay expenditure is c£1.8m adverse to the YTD plan (of which c£0.4m relates to backdated pay award settlement, recovered through contract uplifts within the clinical income position). The main drivers are staff over-establishment in clinical divisions of £1.1m, primarily within ward areas, alongside YTD non-recurrent backdated medical staff arrears payments for approved additional programme activity from the recent job planning cycle. Agency spend continues to reduce and deliver against the trajectory for reduction; however, this is offset by increases in bank and overtime spend and over recruitment of staff. A set of new guidelines have now been issued to divisional leadership teams to strengthen and monitor our current grip and control arrangements for over-established areas. The position includes non recurrent costs for pay arrears, costs of industrial action and PSIs.



# At a glance – Balanced scorecard



		Month reported on	Data Quality ***	Plan	Current month score	YTD Actual	Trend / SPC Variation & Assurance	
Safe	Never Events	Jul-25	5	0	0	0		
	Number of Patient Safety Incident Investigations (PSII) commissioners in month	Jul-25	5	0	0	0		
	Learning Responses - Moderate Harm and above as % of total patient safety incidents	Jul-25	5	3%	1.5%	1.6%		
	Number of Trust acquired PU (Category 2 and above)	Jul-25	4	35 pa	1	2		
	Falls per 1000 bed days	Jul-25	5	4	1.8	0.0		
	VTE - Number of patients assessed on admission	Jul-25	5	95%	96%	97%		
	Sepsis - % patients screened and treated (Quarterly) *	Jul-25	3	90%	-	-		
	Trust CHPPD	Jul-25	5	9.6	12.7	12.6		
	Safer staffing: fill rate – Registered Nurses day	Jul-25	5	85%	90.0%	89.8%		
	Safer staffing: fill rate – Registered Nurses night	Jul-25	5	85%	93.0%	91.5%		
	Safer staffing: fill rate – HCSWs day	Jul-25	5	85%	90.0%	87.3%		
	Safer staffing: fill rate – HCSWs night	Jul-25	5	85%	97.0%	90.5%		
	% supervisory ward sister/charge nurse time	Jul-25	New	90%	83.00%	81.8%		
	Cardiac surgery mortality (Crude)	Jul-25	3	3%	1.9%	2.0%		
	MRSA bacteremia	Jul-25	3	0	0	0		
	Monitoring C.Diff (toxin positive)	Jul-25	5	18	2	5		
Caring	FFT score- Inpatients	Jul-25	4	95%	99.00%	99.05%		
	FFT score - Outpatients	Jul-25	4	95%	98.10%	97.98%		
	Mixed sex accommodation breaches	Jul-25	5	0	0	0		
	Number of written complaints per 1000 WTE (Rolling 3 mth average)	Jul-25	4	12.6	9.4	9.4		
	% of complaints responded to within agreed timescales	Jul-25	4	100%	83.33%	75.00%		
	Duty of candour compliance undertaken within 10wd (quarterly)	Jul-25	New	100%	100.0%	100.0%		
People Management & Culture	Voluntary Turnover %	Jul-25	4	9.0%	4.4%	7.3%		
	Vacancy rate as % of budget	Jul-25	4	7.5%	6.1%			
	% of staff with a current IPR	Jul-25	4	90%	80.34%			
	% Medical Appraisals*	Jul-25	3	90%	82.44%			
	Mandatory training %	Jul-25	4	90%	89.77%	88.15%		
	% sickness absence	Jul-25	5	4.00%	4.69%	4.33%		
Effective	Bed Occupancy (inc HDU but exc CCA and sleep lab)	Jul-25	4	85% (Green 80%-90%)	70.00%	72.55%		
	ICU bed occupancy	Jul-25	4	85% (Green 80%-90%)	88.30%	78.18%		
	Enhanced Recovery Unit bed occupancy %	Jul-25	4	85% (Green 80%-90%)	60.80%	61.13%		
	Elective inpatient and day cases (NHS only)****	Jul-25	4	1931	1,878	7,259		
	Outpatient First Attends (NHS only)****	Jul-25	4	2506	3,188	10,459		
	Outpatient FUPs (NHS only)****	Jul-25	4	7939	7,728	29,164		
	% of outpatient FU appointments as PIFU (Patient Initiated Follow up)	Jul-25	4	5%	12.7%	12.2%		
	Reduction in Follow up appointment by 25% compared to 19/20 activity	Jul-25	4	-25%	-7.2%	-4.3%		
	% Day cases	Jul-25	4	85%	74.9%	75.7%		
	Theatre Utilisation (uncapped)	Jul-25	3	85%	94%	90%		
	Cath Lab Utilisation (including 15 min Turn Around Times) ***	Jul-25	3	85%	84%	83%		
Responsive	% diagnostics waiting less than 6 weeks	Jul-25	1	99%	87.0%	90.6%		
	18 weeks RTT (combined)	Jul-25	4	92%	67.6%			
	31 days cancer waits*	Jul-25	5	96%	100%	99%		
	62 day cancer wait for 1st Treatment from urgent referral*	Jul-25	3	85%	0%	13%		
	104 days cancer wait breaches*	Jul-25	5	0	6	18		
	Number of patients waiting over 65 weeks for treatment *	Jul-25	New	0	21			
	Theatre cancellations in month	Jul-25	3	15	41	27		
	% of IHU surgery performed < 7 days of medically fit for surgery	Jul-25	4	95%	58%	42%		
	Acute Coronary Syndrome 3 day transfer %	Jul-25	4	90%	84%	77%		
	Number of patients on waiting list	Jul-25	4	7175	6369			
	52 week RTT breaches	Jul-25	5	0	55	234		
Finance	Year to date surplus/(deficit) adjusted £000s	Jul-25	4	£(75)k	£(7)k			
	Cash Position at month end £000s	Jul-25	5	£68,408k	£77,248k			
	Capital Expenditure YTD (BAU from System CDEL) - £000s	Jul-25	4	£642k	£101k			
	CIP – actual achievement YTD - £000s	Jul-25	4	£2767k	£1,331k			
	Agency expenditure target £'k	Jul-25	5	£157k	£52k			
	Bank expenditure target £'k	Jul-25	5	£367k	£522k			

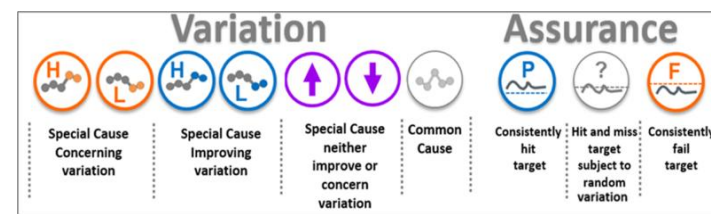
\* Latest month of 62 day and 31 cancer wait metric is still being validated \*\*\*Data Quality scores re-assessed M03 and M08 \*\*\*\* Plan based on 25/26 demand recovery plan.



# Safe: Performance Summary

Accountable Executive: Chief Nurse

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



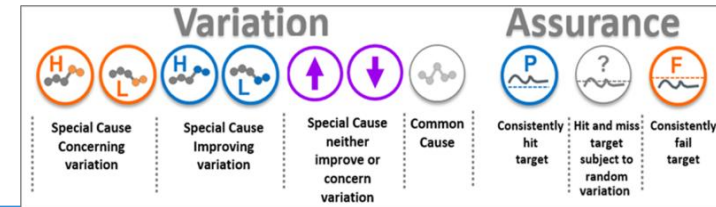
	Metric	Latest Performance		Previous	In month vs target	Action and Assurance		
		Trust target	Most recent position	Position		Variation	Assurance	Escalation trigger
Dashboard KPIs	Never Events	0	0	0				Review
	Number of Patient Safety Incident Investigations (PSII) to commissioners in month	0	0	0				Review
	Learning Responses - Moderate Harm and above as % of total patient safety incidents	3.00%	1.47%	1.90%				
	Number of Trust acquired PU (Category 2 and above)	35 pa	1	0				Review
	Falls per 1000 bed days	4.00	1.85	1.70				Review
	VTE - Number of patients assessed on admission	95.0%	95.8%	96.5%				Review
	Sepsis - % patients screened and treated (Quarterly) *	90%	-	-				Review
	Trust CHPPD	9.6	12.7	12.7				Monitor
	Safer staffing: fill rate – Registered Nurses day	85%	90%	88%				Review
	Safer staffing: fill rate – Registered Nurses night	85%	93%	89%				Review
	Safer staffing: fill rate – HCSWs day	85%	90%	88%				Action Plan
	Safer staffing: fill rate – HCSWs night	85%	97%	90%				Review
	% supervisory ward sister/charge nurse time	90%	83%	82%				Action Plan
	Cardiac surgery mortality (Crude)	3.0%	1.9%	2.0%				Monitor
	MRSA bacteraemia	0	0	0				Review
	Monitoring C.Diff (toxin positive)	7 pa	2	2				Review
Additional KPIs	E coli bacteraemia	Monitor	1	0				Monitor
	Klebsiella bacteraemia	Monitor	0	0				Monitor
	Pseudomonas bacteraemia	Monitor	0	0				Monitor
	Other bacteraemia	Monitor	0	2				Monitor
	% of medication errors causing harm (Low Harm and above)	Monitor	9.3%	21.2%				Monitor
	All patient incidents per 1000 bed days (inc.Near Miss incidents)	Monitor	41.7	34.9				Monitor
	SSI CABG infections (inpatient/outpatients/readmissions %)	2.7%	-	9.0%				Review
	SSI CABG infections patient numbers (inpatient/readmissions)	n/a	-	22				Review
	SSI Valve infections (inc. inpatients/outpatients/readmissions; %)	2.7%	-	3.0%				Review
	SSI Valve infections patient numbers (inpatient/outpatient)	n/a	-	5				Review
	WHO Safety checklist % - Surgery	Monitor	86.0%	89.1%				Monitor
	WHO Safety checklist % - Cath Labs	Monitor	97.4%	97.4%				Monitor



# Safe: Patient Safety/Harm Free Care

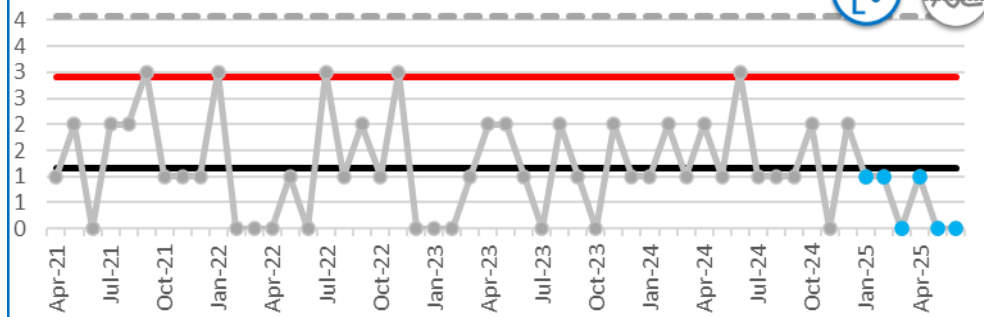
Accountable Executive: Chief Nurse

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



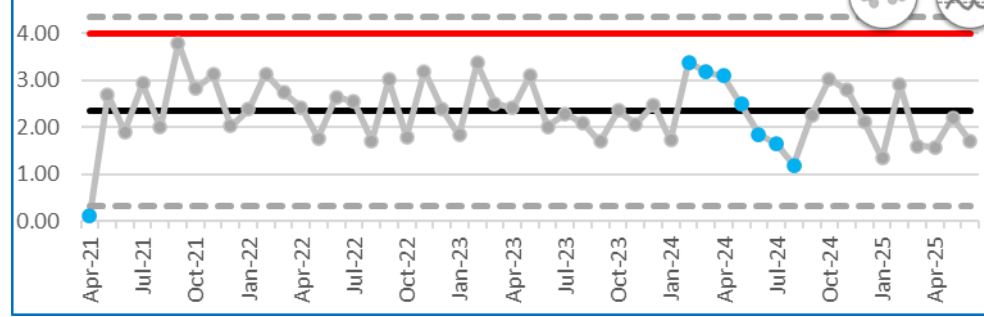
## 1. Historic trends & metrics

Number of Trust acquired PU (Category 2 and above)



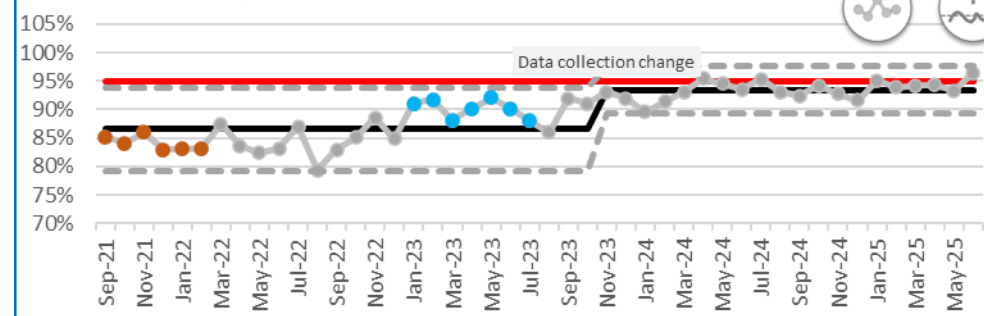
Jul-25
1
Target (red line)
35 per annum
Variation
Special cause variation of an improving nature
Assurance
Hit and miss on achieving target subject to random variation

Falls per 1000 bed days



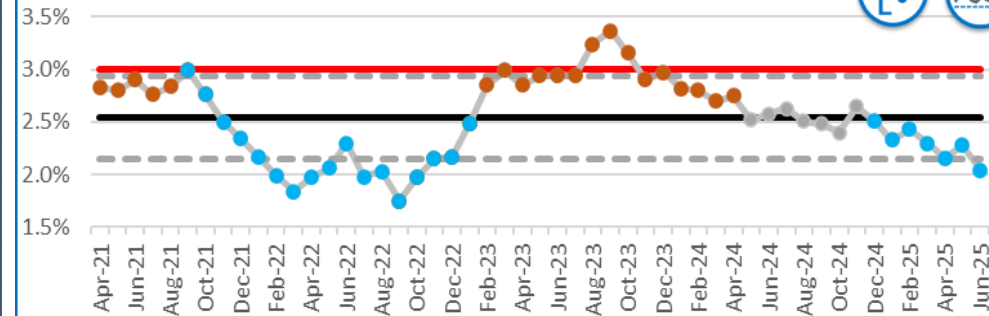
Jul-25
1.85
Target (red line)
4
Variation
Common cause variation
Assurance
Hit and miss on achieving target subject to random variation

VTE - Number of patients assessed on admission



Jul-25
95.8%
Target (red line)
95.0%
Variation
Common cause variation
Assurance
Hit and miss on achieving target subject to random variation

Cardiac surgery mortality (Crude)



Jul-25
1.9%
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 July.

**Learning Responses- Moderate Harm and above reported as % of total patient safety:** In Month there were 1.43% (4/271) of incidents that resulted in harm. The 4 graded at SIERP in month, were 3 moderate harm events (WEB56949, WEB56981, WEB57111) and 1 Severe harm linked to a fall (WEB57154) from initial gradings. Final Investigations/grade will be shared at QRMG.

**Medication errors causing harm:** 9.25% (5/54) of medication incidents were graded as low harm, remaining no harm or near miss. There was a significant improvement in medication reported incidents in month, in June this was 21.15 % (11/52).

**All patient incidents per 1000 bed days:** There were 41.7 patient safety incidents per 1000 bed days.

**Harm Free Care:** In July there was 1 confirmed Pressure Ulcer of category 2 (WEB57201). There were 1.85 falls per 1000 bed days (12 in total, 1 Severe (WEB57154-as reported above), 5 low harm & 6 no harm). The falls group and wards have an active improvement plan in place to support the effectiveness of falls prevention. Compliance for VTE risk assessment was above the target of 95% at 95.8%.

**Cardiac Surgery Mortality (crude monitoring):** Within expected variation at 1.9% in July and has consistently been below our threshold target of 3% and below the mean since December 2024.

**Alert Organisms:** There was 2 C Difficile cases; 1 MSSA and 1 Ecoli bacteraemias reported in month which are all below UKHSA threshold.

**WHO Surgical Checklist:** is the monitoring of the World Health Organisation (WHO) surgical checklist, for July was 86% for Theatres and 93.9% for Cath Labs. The target for WHO check list is 100%.

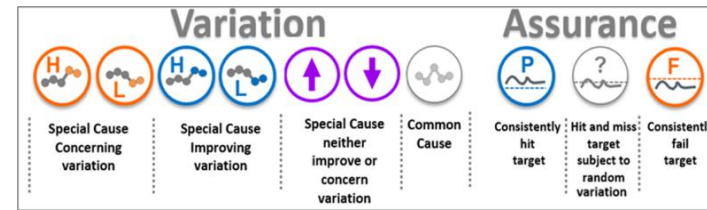




# Safe: Safer Staffing

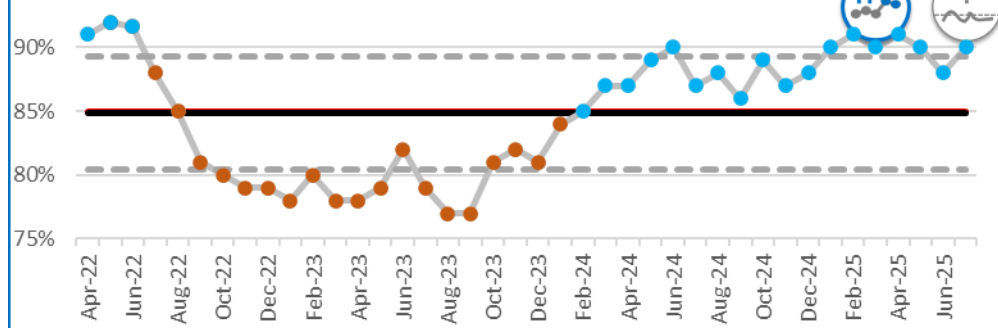
Accountable Executive: Chief Nurse

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



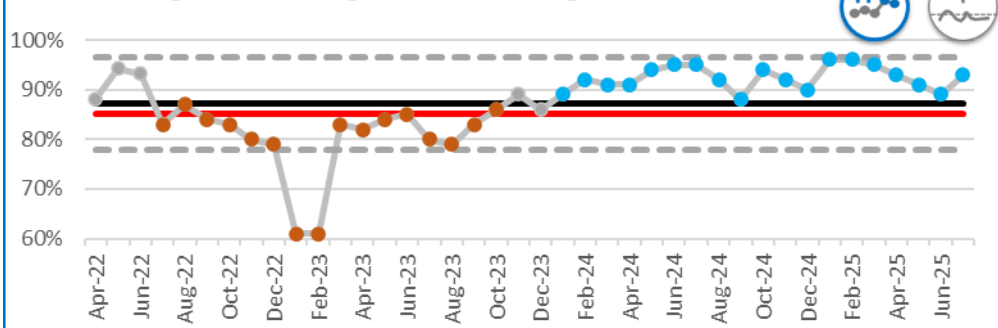
## 1. Historic trends & metrics

Safer staffing: fill rate – Registered Nurses day



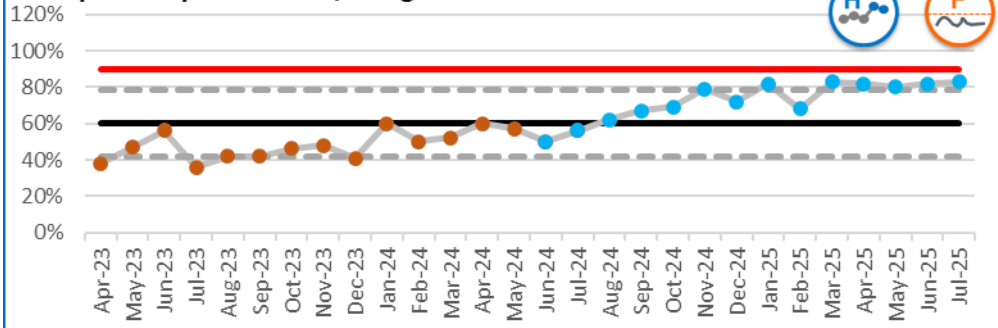
Jul-25
90%
Target (red line)
85%
Variation
Special cause variation of an improving nature
Assurance
Hit and miss on achieving target subject to random variation

Safer staffing: fill rate – Registered Nurses night



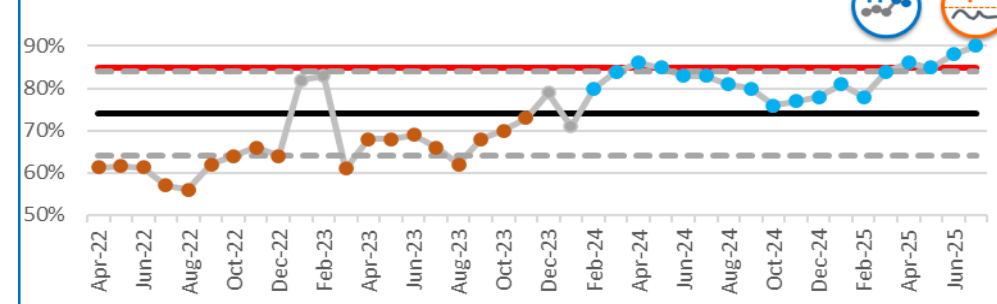
Jul-25
93%
Target (red line)
85%
Variation
Special cause variation of an improving nature
Assurance
Hit and miss on achieving target subject to random variation

% supervisory ward sister/charge nurse time



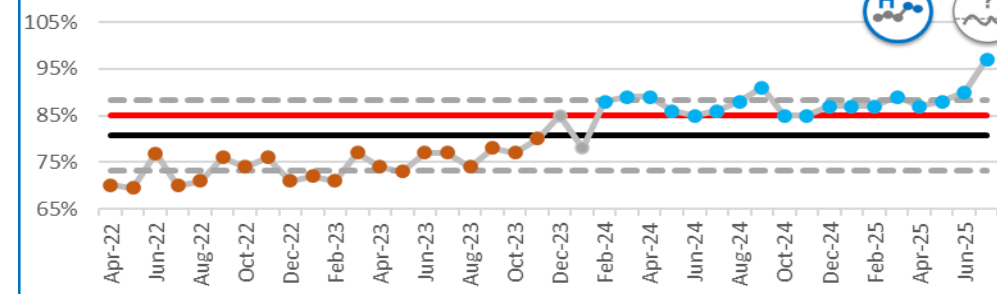
Jul-25
83%
Target (red line)
90%
Variation
Special cause variation of an improving nature
Assurance
Has consistently failed the target

Safer staffing: fill rate – HCSWs day



Jul-25
90%
Target (red line)
85%
Variation
Special cause variation of an improving nature
Assurance
Has consistently failed the target

Safer staffing: fill rate – HCSWs night



Jul-25
97%
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:

Safer staffing fill rates for Registered Nurses (RN) are above target at 90% for day shifts and above target at 93% for night shifts in July. Safer staffing fill rates for Health Care Support Workers (HCSW) are above target at 90% for day shifts and above target at 97% for night shifts in July. RPH's active recruitment campaign for HCSWs has contributed to fill rate improvement meeting target of 85% and above.

**Overall CHPPD (Care Hours Per Patient Day) is 12.7** for July, unchanged CHPPD position as reported in June.

**Ward supervisory sister (SS)/ charge nurse (CN):** Increasing safer staffing fill rates continue to support increases in SS/ CN time from October 2023 to present; there has been a slight increase in SS time to 83% in July compared to 82% in June. The highest achieving areas towards SS/ CN time target of 90% are the Respiratory Ward 4 South who achieved 99%, followed by the Enhanced Recovery Unit at 90% and Surgical Ward 5 North at 82%. Outpatients has had an increase in SS time from 44% in June to 61% in July. 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 Surgical Site Infections (SSI) Surveillance

Accountable Executive: Chief Nurse

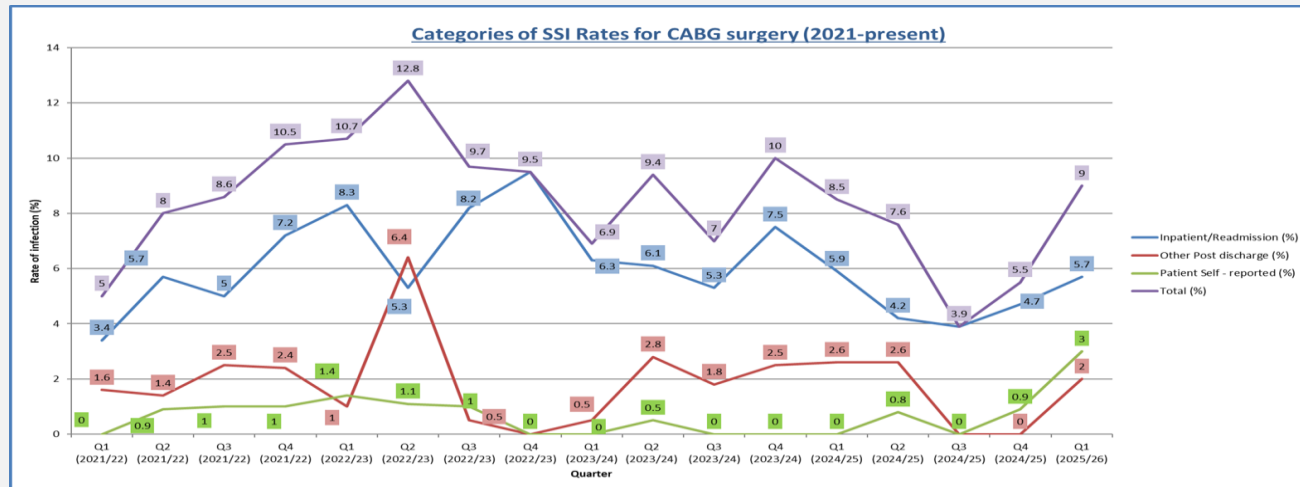
Report Author: Deputy Chief Nurse/Deputy Director for Quality and Risk

Slide Content: IPC team & STA division

**Escalated Key Performance Challenge:** Surgical Site Infection (SSI) surveillance at RPH is an ongoing programme. We have seen an increase in surgical site infection (SSI) in Q1 2025. In particular there has been an increase in the number of CABG patients identified as an inpatient/readmission with an SSI and our current quarterly rate that will be reported to the UK Health Security Agency (UKHSA) in September 2025 is at 5.7% (previous reported Q4 at 4.7%). The monitoring of Inpatient & Readmission rates is used to benchmark RPH against other Trusts performance for SSI by UKHSA. We are still above the national benchmark for CABG surgery currently at 2.7% for UKHSA. Internally, we also monitor other types of surgery and there have been no wound infections in transplants or other cardiac surgery patients in Quarter 1.

During Q1, we have identified so far 5.7% (14/244) Inpatients/Readmission patients that have had a CABG procedure and developed an SSI. There have been 3 organ space infections, 1 deep sternal wound infection and 18 superficial infections (7 sternum, 11 leg wounds). The inpatient/readmission rate so far for the quarter 1 is 5.7% (14/244) with a **total CABG rate of 9% (22/244)**, as seen in the Graph below. Of these 2% were in the post discharge category (e.g. referred to RPH by outpatients' teams; consultants/GPs), with a further 3% infections identified in the self-reported category.

For Valve surgery patients so far for Q1 there has been one organ space infection, and 4 superficial sternal wound infections. The inpatient/readmission rate for the quarter to date is 1.8% (3/164) with a **total value rate of 3% (5/164)**. We have also seen for PTE surgery 2 SSI (1 organ space and 1 superficial) overall for Q1 for **PTE 5.3% (2/38 patients)**. Overall, with 5 organ space SSI this has raised & our SSI improvement work has been enhanced.



## Key Action Improvements Programme – This is being managed through the SSI steering group:

1. Re-review of environment and cleanliness of theatre, ERU and level 5 (surgical wards).
2. Increase the deep clean programme of all theatre rooms
3. Work on embedding changes for footfall within operation room and maximum capacity during procedures.
4. TOE probes and ultrasound cleaning management programmes.
5. Carrying out a deep dive review of sterile services by the decontamination lead.
6. Review and report on the humidity levels in theatre and following the HTM.

## Key Risk Mitigation Actions in Detail:

### 1). Environment & Equipment Cleaning:

Audits are now showing an ongoing improvement since April to July 2025, with a continued focus required on level 5, however improvement made from 39% to 61% as seen in table right (Columns April-July 2025).

Other key improvements are a model of care changed (care notes in the room), daily checks, Patient Environment Assistant (PEA) training, daily double cleaning of equipment implemented, plus additional cleaning of elements within the environment. August surveillance by the clinical, IPC team and Chief Nurse has seen a further improvement on level 5.

>94%	Cleaning & Decontamination- Theatres	75%	100%	100%	95%
70-94%	Cleaning & Decontamination- CCA	71%	89%	88%	95%
<70%	Cleaning & Decontamination - Level 5	95%	90%	94%	95%
	Environmental - CCA	64%	85%	83%	90%
	Environmental-Level 5	77%	39%	66%	61%

**2). Theatre Deep clean:** additional Deep clean programme in place, from every theatre 6 months to 4 monthly. This will be monitored through the Decontamination sub-committee.

**3). Footfall and capacity in Theatre:** This requires further improvement with 50% compliance rate reported in July. Action agreed:

- Footfall information to be included in all induction packs, ensuring new staff are informed.
- All staff receive up-to-date guidance during audit mornings; key discussions on recent trends & key issues.
- Monthly footfall results are discussed at team meetings & targeted communications via matrons & link staff.
- Door counter now implemented in theatre 4, which gives further data to support the reduction in footfall.

**4). Ultrasound and TOE probe decontamination:** Ongoing improvement required as 50% compliance with cleaning standards is low. There is a now an identified lead link for theatres and CCA. Immediate protocol changes reviewed and agreed to better comply with national guidance for Ultrasound and TOE probe cleaning.

**5). Sterile services:** There was an increase in reported issues with Surgical instruments total of 3 in Q1, with 3 in July. Our decontamination lead & STERIS services completed a deep dive review due to the increase organ space infection and sterile instrument issues. Outcome: No link found to the type of SSI infections organisms/sterile instrument issues and a full report will be shared at Decontamination Sub-committee. \*All trays changed and not used on patients once issues found.

**6). Humidity in theatres:** there were identified spikes in humidity identified in theatre during the extreme weather heat, which has the potential to increase infection rates. Compliance of the HTM standard should be 40-60% humidity in theatres, whereas from the review it was found that it was reaching 70% humidity. To aid ongoing monitoring new sensor have been fitted, which now trigger if the humidity reaches above 60%, as per recommended HTM guidance. This is being monitored through the Ventilation safety group with ICPPC committee having oversight.

## Key Ongoing Actions still to be Embedded further in Q2/Q3 Planned:

- Continue the education and embedding best practise on reducing footfall and maximum capacity within theatres. The Door counter will support this work.
- Continue to embed cleaning standards and reduction of clutter within level 5.
- Launch the new way of decontamination of TOE probes.
- Additional cleaning to be embedded in level 5.

**Monitoring;** SSI rates and related improvement initiatives continue to be monitored through the SSI Stakeholder Group, led by the STA division. Input is provided by the SSI Environment and Decontamination Task & Finish (T&F) group, which feeds into the overarching steering group. Oversight is maintained by the ICPPC committee and the QRMG.



## What is Diabetes and why is management of this condition important for patients?

Diabetes occurs where the body can't produce enough insulin, or the body is resistant to the insulin being produced. Different types of diabetes mellitus are based on the underlying pathology: type 1 (autoimmune), type 2 (insulin resistant) and due to the specialities at Royal Papworth Hospital, we also routinely see patients with corticosteroid induced diabetes, and cystic fibrosis related diabetes. Sub-optimal management of diabetes can lead to acute complications such as ketoacidosis and severe hypoglycaemic, while chronic complications include heart attack/stroke, kidney failure, eye problems, foot problems and amputation, infection and poor wound healing.

Diabetes management was one of the Trusts Quality Accounts priorities for 2024/2025 in recognition that there was a need for improvement work required for the care of people with diabetes seen at RPH, particularly those within our surgical pathway. This year of focus has meant significant changes and improvements to our diabetes service, guidelines in practice for our staff to adhere to and how we manage patients with diabetes. This focus slide covers the continuous improvement work and activity for Q1 and our plans for the year of 2025/26.

**What is our new staffing model at Royal Papworth Hospital (RPH)?:** RPH Diabetes Service consist of 3 WTE diabetes specialist nurses, a new diabetes consultant (2 PA/week) started in the team in March 2025 and a diabetes health care support worker, who as a team provide weekday inpatient support and in outpatients with Cystic Fibrosis.

**Referrals:** April to July 2025 (Q1) there were a total 261 referrals to our Diabetes Service requiring between 10 - 90 minutes per patient. Referrals are across all clinical areas (Cardiology, Thoracic Medicine, Surgery and Transplant).

**Patient Incidents Q1:** Total number of incidents related to diabetes from Q1 2025 were 17 (these are graded as low harm or no harm events), with any learning from these incidents being overseen by the Harm Free Care Group.

The main themes were; Insulin prescribing errors including inappropriate timing of doses, absence of insulin on prescription, wrong insulin or dose prescribed and poor management of patients on a Variable Rate Intravenous Insulin Infusion (VRIII), including incorrect background fluids, hypoglycaemia due to inadequate BG checks, omission of basal insulin, and delays stopping the VRIII due to insufficient non-specialist staff knowledge.

The Diabetes team have applied for Trust wide access to Cambridge Diabetes Education Platform (CDEP), which is a high-quality educational resource designed for Health Care Professionals working with people with diabetes. The team believe it will aid a reduction in incidents, as knowledge is key to these types of events. Alongside this bespoke training on Variable Rate Intravenous Insulin Infusion for rotational doctors by Diabetes Specialist Nurses is being planned to aid knowledge and experience.

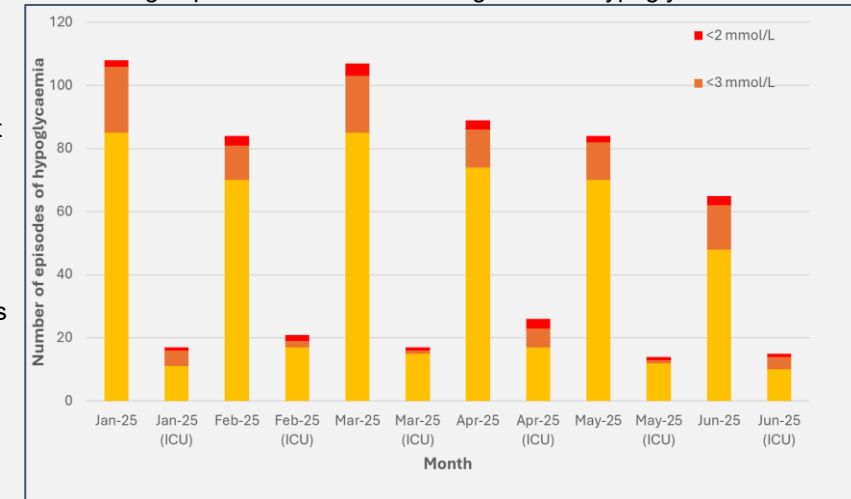
**Current Quality Improvement Activity underway Q1:** Since April 2025, the team have adopted an approach of using the acute admission to our hospital as an opportunity to pro-actively switch people from their existing diabetes therapies to those with proven cardio/renal benefit (SGLT2i and GLP-1RA/Tirzepatide) given the high-risk population at RPH.

In recognition of new diabetes technology and the range of diabetic monitoring devices patient are admitted with, we have started work on how we can continue to promote patient independence when they are admitted to hospital. This requires staff education to up skill on the management of these monitoring devices, alongside securing funding from the RPH Charity to purchase 25 interstitial glucose sensors per month. This will enable consistency of diabetes patient management and facilitate safe and effective care. In addition, it further aids hospital discharge, where patients would otherwise need to have an extra night in hospital, when they are re-started/newly started on this type of monitoring. To support the new way of monitoring we are also developing new guidance "use of diabetes technologies in hospital".

**National Diabetes Inpatient Safety Audit (NDISA):** The Trust commenced submitting data for the NDISA in 2024/2025. It records the details of any adult who has one of four avoidable complications which can occur in inpatients with diabetes. All NHS providers of inpatient care for patients with diabetes in acute settings are expected to participate. Within this data set, the results for RPH indicate that further understanding of prevention and the management of hypoglycaemia is needed.

## Monitoring Hypo/Hyperglycaemic Events

Since the new Consultant Diabetologist joined the team, they are now pulling patient data from Lorenzo on records of hypoglycaemia (blood glucose (BG) <4 mmol/L) and hyperglycaemia (BG > 15 mmol/L) to proactively review high risk patients without waiting for referral to the diabetes team. The graph to the right shows all hypoglycaemic episodes (blood glucose less than 4 mmol/L, with red being <2, orange <3, yellow <4 mmol/L) for Q4/Q1 (6 months) by month for wards and CCA (ITU). It can be seen that the number of overall hypoglycaemic events are reducing.



**Area Currently Under Review:** RPH as a specialist hospital is not fully compliant with all the recommendations as detailed in the Guideline for Perioperative Care for People with Diabetes Mellitus Undergoing Elective and Emergency Surgery (first published 2021, updated last in 2023), produced by Centre for Perioperative Care (CPOC). The main areas of non-compliance link to diabetes input in pre-assessment clinic, inadequate collection of HbA1c at pre-assessment, minimal referral for optimisation, no individualised diabetes care plan and no resources for peri-op diabetes. The Diabetes team are working through these non-compliance areas and have met with the pre-assessment nurses to plan this workstream. The first step is a review of all patients HbA1c results across the hospital to identify those attending pre-assessment clinic where optimisation of diabetes pre-operatively may be possible and to anticipate the resources required to deliver improved for this area of compliance. The Diabetes team will continue to provide updates into Harm free Care and QRMG with the agreed recommendations towards compliance.

**Other Quality improvement initiatives planned:** Monitored through Harm Free Care Panel, reporting to QRMG.

- Patient diabetes satisfactory questionnaire to be implemented in Q3 2025 to better understand the patient experience and areas for improvement.
- Diabetes Specialist Nurses are undertaking the Advanced Skills in Clinical Assessment in preparation to become Non-Medical Prescribers, this will support prescribing in our teams alongside medical prescribing.
- Mapping exercise of resources required to support implementation of high efficacy diabetes medications through the RSSC pathway with the support from the diabetes team.
- Standardised pathway for diagnosis & management of reactive hypoglycaemia in people with cystic fibrosis related diabetes.

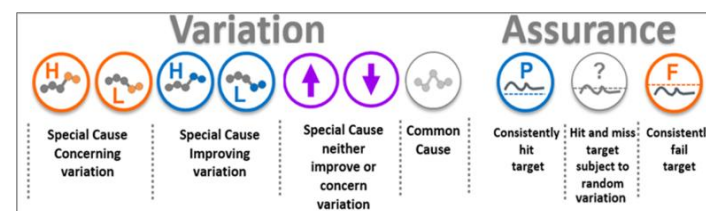




# Caring: Performance Summary

Accountable Executive: Chief Nurse

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



	Metric	Latest Performance		Previous	In month vs target	Action and Assurance		
		Trust target	Most recent position	Position		Variation	Assurance	Escalation trigger
Dashboard KPIs	FFT score- Inpatients	95.0%	99.0%	98.8%			P	Monitor
	FFT score - Outpatients	95.0%	98.1%	98.0%			P	Monitor
	Mixed sex accommodation breaches	0	0	0			P	Monitor
	Number of written complaints per 1000 WTE (Rolling 3 mnth average)	12.6	9.4	9.4		H	P	Review
	% of complaints responded to within agreed timescales	100.0%	83.3%	83.3%			?	Review
	Duty of candour compliance undertaken within 10wd (quarterly)	100.0%	100.0%	100.0%		New	New	Review
Additional KPIs	Friends and Family Test (FFT) inpatient participation rate %	Monitor	42.8%	46.7%				Monitor
	Friends and Family Test (FFT) outpatient participation rate %	Monitor	9.8%	11.4%		L		Monitor
	Number of complaints upheld / part upheld	3	2	3			?	Review
	Number of complaints (12 month rolling average)	5	6	6		H	P	Review
	Number of complaints	5	8	8		H		Review
	Number of informal complaints received per month	Monitor	9	9				Monitor
	Number of recorded compliments	Monitor	1828	1880				Monitor

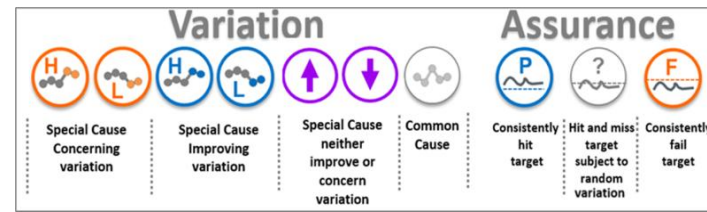




# Caring: Patient Experience

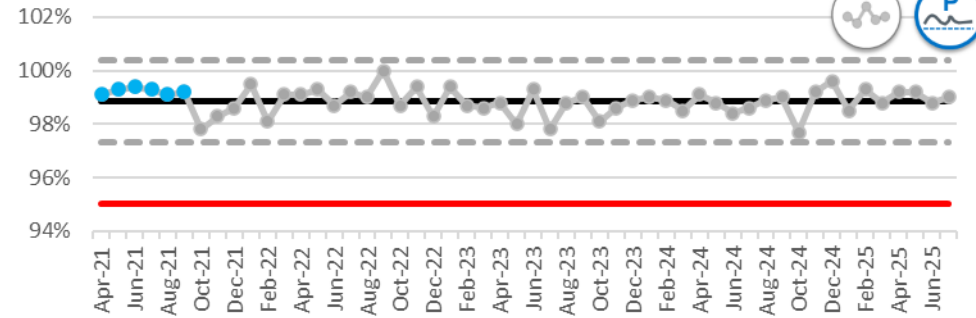
Accountable Executive: Chief Nurse

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



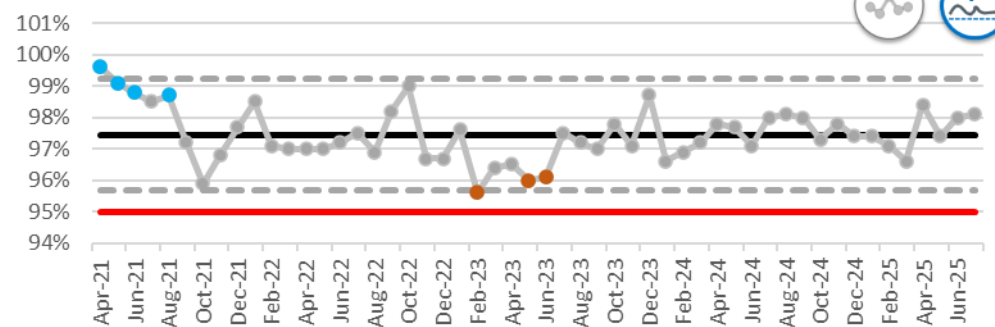
## 1. Historic trends & metrics

### FFT score- Inpatients



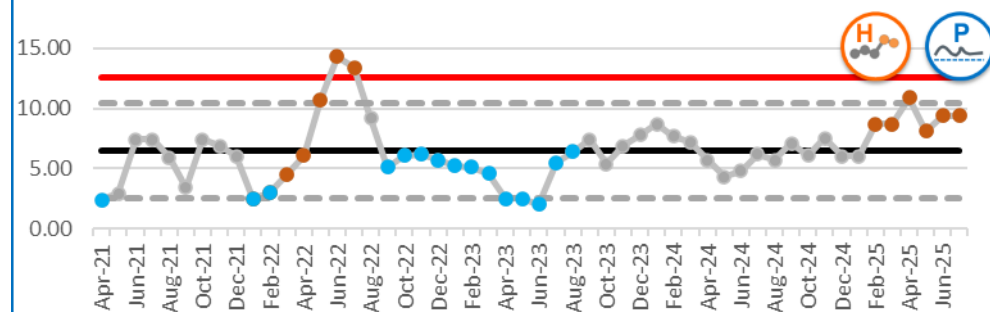
Jul-25
99.0%
Target (red line)
95.0%
Variation
Common cause variation
Assurance
Has consistently passed the target

### FFT score - Outpatients



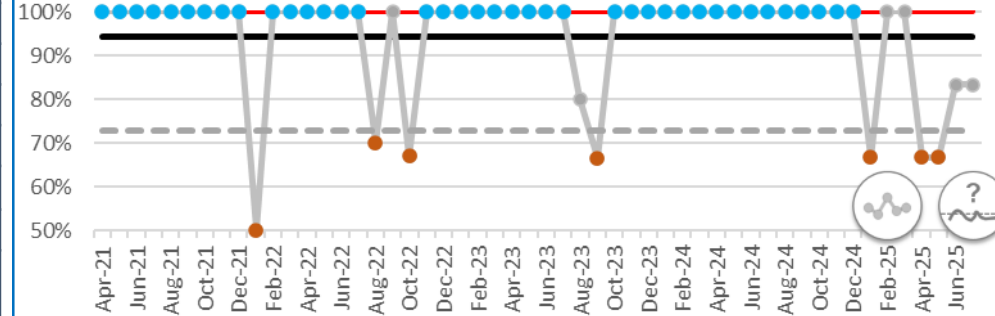
Jul-25
98.1%
Target (red line)
95.0%
Variation
Common cause variation
Assurance
Has consistently passed the target

### Number of written complaints per 1000 WTE (Rolling 3 mnth average)



Jul-25
9.4
Target (red line)
12.6
Variation
Special cause variation of a concerning nature
Assurance
Has consistently passed the target

### % of complaints responded to within agreed timescales



Jul-25
83.3%
Target (red line)
100%
Variation
Common cause variation
Assurance
Hit and miss on achieving target subject to random variation

## 2. Comments/Action plans

### FFT (Friends and Family Test): In summary;

**Inpatients:** Recommendation score was 99.0% for July, with Participation rate for surveys at 42.8%.

**Outpatients:** Recommendation score was 98.1% in July, with Participation rate at 9.8%.

**Compliments:** the number of formally logged compliments received during July 2025 was 1,828. Of these 1,744 were compliments from FFT surveys and 84 compliments via cards/letters/PALS captured feedback.

**Responding to Complaints on time:** In month we have received 8 formal complaints, which is higher than average for month.

**Acknowledging complaints with 3 w/days:** Out of the 8 received, all were acknowledged within the target of 3 days.

**The % of complaints responded to on time:** 2 of 3 (83.33%) of complaints responded to in the month were within agreed timescales. Of the 2 formal complaints responded within agreed timescales (1 required an agreed extension) with the complaints as per policy. There was 1 late response due to the delays in the investigation process (STA), which required extra time owing to clinical pressures and staff availability.

**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 9.40.

**Duty of Candour (DoC) Compliance:** For the month of July there were 4 incidents that met DoC requirements and were fulfilled within 10 working days (WEB56949, WEB56981, WEB57111, WEB57154).



# Caring: Key Performance Challenge – Complaint Themes/learning

Accountable Executive: Chief Nurse

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

**Received Complaints in Month (Total of all Informal and Formal):** During July, we received **9 informal complaints** and **8 formal complaints**. The themes (subjects) linked at the time of receipt for all complaints in July 2025 were related to Communication (35%); Delay in Diagnosis/Treatment and Referral (23%); with Clinical Care/Clinical Treatment, and Staff Attitude (each 15%).

**Themes (Subjects for July 2025):** Table 1 below details further the breakdown of all the 26 subjects (themes-top line in table) linked to the 9 Informal & 8 Formal Complaints, further broken down into the sub-subject per theme (left-hand column) for each subject, for the complaints received July 2025.

	Clinical Care/Clinical Treatment	Communication / Information	Delay in Diagnosis / Treatment or Referral	Environment - Internal	Nursing Care	Privacy or Dignity	Staff Attitude	Total
Abrupt	0	0	0	0	0	0	1	1
Availability of Wifi	0	0	0	1	0	0	0	1
Breach of Confidentiality	0	1	0	0	0	0	0	1
Cancellation of Appointment	0	0	1	0	0	0	0	1
Consent Issues	0	1	0	0	0	0	0	1
Delay in Diagnosis / Treatment	0	0	4	0	0	0	0	4
Dismissive	0	0	0	0	0	0	1	1
Dissatisfied with Medical Care/Treatment/Diagnosis/Outcome	4	0	0	0	0	0	0	3
Dissatisfied with Nursing Care / Treatment	0	0	0	0	1	0	0	1
Incorrect Information Provided	0	1	0	0	0	0	0	1
Information for Patients	0	2	0	0	0	0	0	2
Lack of Information for Patients	0	3	0	0	0	0	0	3
Lack of Privacy / Dignity on Ward	0	0	0	0	0	1	0	1
Other Communication Issues	0	1	0	0	0	0	0	1
Rudeness	0	0	0	0	0	0	1	1
Uncaring	0	0	0	0	0	0	1	1
Waiting Time for Appointment	0	0	1	0	0	0	0	1
Total	4	9	6	1	1	1	4	26

NB: These subjects are based on the complainants' reported concerns logged on receipt of the complaint; there may be later changes on completion of the investigation, and each complaint may have multiple subjects linked.

## Learning from Complaints in month:

**Total Complaints Closed in Month:** During July 2025, we closed 17 complaint files;14 informal and 3 formal complaints.

**Informal Complaints closed in month:** All Informal complaints closed in month were resolved by clinicians, senior nursing staff or service/area managers meeting with or phoning complainants to discuss and address concerns at point of care, including arranging outpatient appointments where appropriate. In all cases, appropriate apologies and reassurance was given, and the issues raised shared with staff for reflection and service improvement.

There was 1 Informal case (Cardiology) with identified learning: In this case where wider opportunity for service improvement for the Pacing service was identified, action was taken and following patient feedback a more robust process in communicating clinic delays has been implemented to ensure outpatient reception staff can keep waiting patients more informed and reduce anxiety in cases of prolonged waiting.

**Formal complaints closed in month:** Of the 3 formal complaints closed in month there was 1 not upheld and 2 were partially upheld; meaning that one or more issues were found to be below expected standards of experience for which appropriate apologies are given, and investigation findings are shared with the Divisional Team for reflection and service improvement.

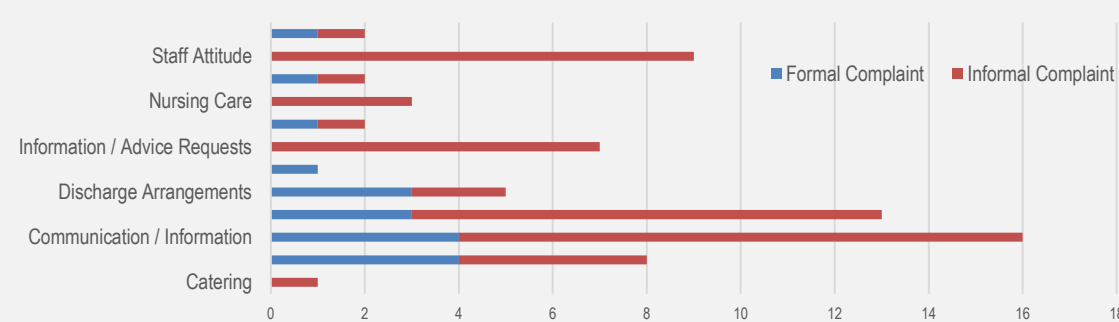
Any actions identified from formal complaints are shared to promote Trust-wide learning and improvement of our services, these action plans are then are logged and monitored for compliance:

## Action/Improvements from Formal complaints closed in July 2025:

Issue: Delay in test results being shared with patient  
Findings: Deep dive showed that these tests are not automatically shared with electronic medical record and rely on manual review, hence were missed.

**Action/improvement (Cardiology):** The service have reviewed this issues and a more robust oversight for these results have been implemented. This will continue to be monitored. Further improvements planned as part of the new Electronic Patient Records Programme that is due to go live in 2027.

Table 2: Displays running total of primary themes (subjects) from closed complaints in year to date: (M01-M04) 2025/26



## Closed Complaints in year (M01-M04) 2025/26.

Total closed to date 69- 18 Formal & 51 informal. In the graph left this shows the final recorded main Themes (subjects) for all the closed responses sent to Complainants on completion of a full investigation.



## Bereavement Services provided by the Patient Advice & Liaison Service (PALS) at RPH

The PALS team continues to provide a seamless bereavement service for our families: PALS staff support and guide bereaved families in the event of a bereavement by providing information on bereavement, bereavement follow-up, the Coroner's process and the Medical Examiner process. As well as supporting families, PALS staff also support staff across the Trust in what is a tremendously confusing, challenging, and difficult time.

### New Hybrid Role – Bereavement and PALS Advisor

The Bereavement and PALS Advisor hybrid role has been in place since November 2024, continuing the collaboration with the Medical Examiner Service for the City of Cambridge, East, and South Cambridgeshire. This role provides dedicated time for the now "Bereavement and PALS Advisor" to focus on all aspects of bereavement, encompassing both the Royal Papworth hospital and within community settings. The introduction of this role has involved upskilling a member of staff and has strengthened the efficiency and partnership between the PALS and Bereavement services.

### Faith burials (Rapid release)

On occasions, due to faith considerations, there is a need for a 'rapid release' of the deceased. In 2024/25 this was 6 deaths and, in all cases, the relevant processes were completed in a timely manner allowing release of the body in <24hrs. In these cases, a fantastic collaborative effort is required. With the dedication of all involved, namely: The ward staff, PALS, Medical Examiners, Medical Examiner Officers, Consultant, Mortuary, and the Coroner, we can provide a real show of support and excellence to the bereaved families.

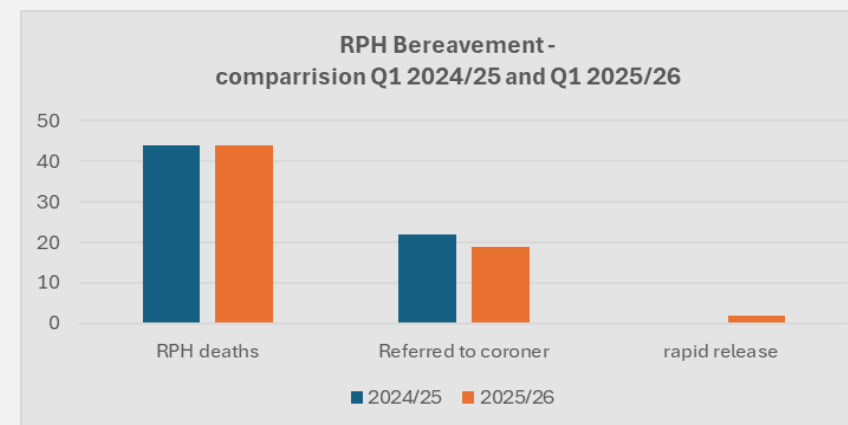
### Update to Standard operating processes:

Since the new statutory process came into operation, and the creation of the new role, all related policies, procedures, and guidance have been updated to accurately take this into account.

## Supporting Bereavements in From Q1 of 2025/2026

Below are some statistics and information based on PALS and their involvement with Bereavement in Q1 of 2025/26:

- **44** patients passed away at RPH in Q1, which is the same number as Q1 2024/25
- **2** Cases required rapid release due to faith considerations, whereas there were zero for the same quarter in 2024/25.
- **19** referrals were made to the coroner by Medical Examiner's Office for consideration and confirmation of cause(s) of death. Of these 19, 4 of which were closed by the coroner and MCCD (death certificate) was issued by RPH
- The PALS team continued to support the mortuary team at CUH with chasing outstanding paperwork and completion of the bereavement process.



The table to the left  
shows data comparison  
for Q1 2025/26 with the  
same period 2024/25

(data from  
Bereavement/RCR  
spreadsheets 20/08/25)

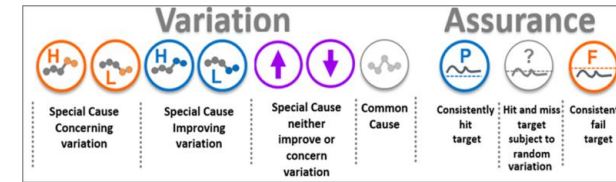
- **21** families were contacted via the Bereavement follow-up process. Each family of a hospital bereavement is sent a letter between 6-8 weeks after the date of bereavement offering them an opportunity to discuss their loved-one's care and death with the medical team. This offers the chance to understand their loved one's medical journey, often providing them with better understanding and providing the opportunity to have any questions they have answered by the care team involved. This can be a hugely important part of the grieving process and helps the families at such a difficult time.
- **13** requests for bereavement follow-up meetings were received
- **9** bereavement meetings were coordinated and attended by the PALS staff.



# Effective: Summary

Accountable Executive: Chief Operating Officer

Report Author: Chief Operating Officer



	Metric	Latest Performance		Previous	In month vs target	Action and Assurance		
		Trust target	Most recent position	Position		Variation	Assurance	Escalation trigger
Dashboard KPIs	Bed Occupancy (excluding CCA and sleep lab)	85%	70.0%	71.6%	Red			Action Plan
	ICU bed occupancy	85%	88.3%	66.4%	Green			Review
	Enhanced Recovery Unit bed occupancy %	85%	60.8%	51.3%	Red			Review
	Elective inpatient and day case (NHS only)*	1,770	1878 (126% 19/20)	1846 (124% 19/20)	Yellow			Review
	Outpatient First Attends (NHS only)*	2,298	3188 (194% 19/20)	2384 (145% 19/20)	Green			Review
	Outpatient FUPs (NHS only)*	7,278	7728 (133% 19/20)	7342 (126% 19/20)	Yellow			Review
	% of outpatient FU appointments as PIFU (Patient Initiated Follow up)	5%	12.7%	12.5%	Green			Monitor
	Reduction in Follow up appointment by 25% compared to 19/20 activity	-25%	-7.2%	-2.5%	Red			Action Plan
	% Day cases	85%	74.9%	75.4%	Red			Action Plan
	Theatre Utilisation (uncapped)**	85%	94%	92%	Green			Review
	Cath Lab Utilisation (including 15 min Turn Around Times) ***	85%	84%	80%	Yellow			Review
Additional KPIs	NEL patient count (NHS only)*	Monitor	414 (120% 19/20)	399 (115% 19/20)				Monitor
	ICU length of stay (LOS) (hours) - mean	Monitor	119	115				Monitor
	Enhanced Recovery Unit (LOS) (hours) - mean	Monitor	34	29				Monitor
	Length of Stay – combined (excl. Day cases) days	Monitor	6.0	5.9				Monitor
	Same Day Admissions – Cardiac (eligible patients)	50%	41%	44%				Review
	Same Day Admissions - Thoracic (eligible patients)	40%	65%	60%				Review
	Length of stay – Cardiac Elective – CABG (days)	8.2	7.7	8.1				Review
	Length of stay – Cardiac Elective – valves (days)	9.7	9.8	9.0				Review
	Outpatient DNA rate	6.0%	6.2%	6.7%				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

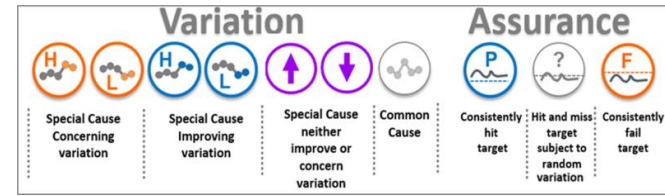




# Effective: Admitted Activity

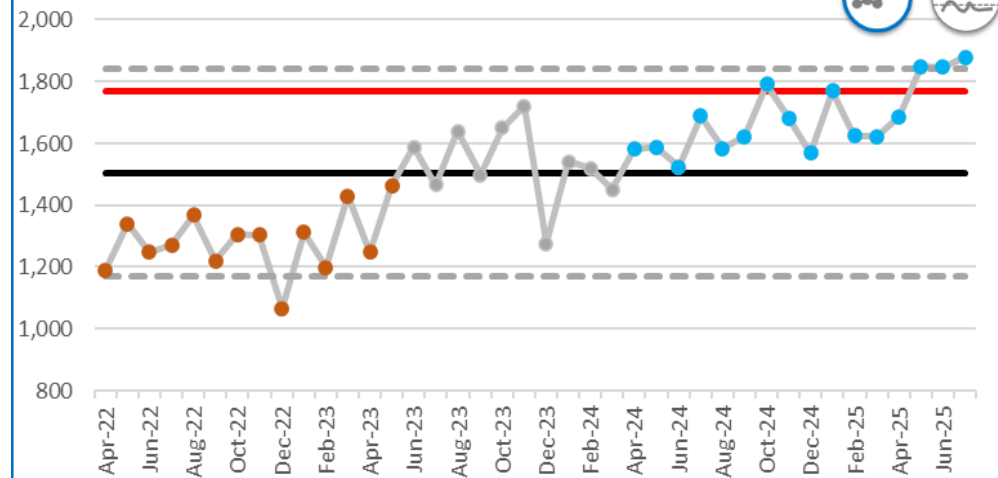
Accountable Executive: Chief Operating Officer

Report Author: Chief Operating Officer



## 1. Historic trends & metrics

### Elective inpatient and day case (NHS only)\*



Jul-25

1878

Target\* (red line)

1770

Variation

Special cause variation of an improving nature

Assurance

Hit and miss on achieving target subject to random variation

## 2. Action plans / Comments

Latest data at division level shows day case activity remains above the trust target within Cardiology (86.4%) and just below the trust target within Thoracic (81.7%).

### Surgery, Theatres & Anaesthetics

- Theatre activity in M04 exceeded the trust KPI of 85% at 94%. Elective activity continues in an upward trajectory.
- IHU patients continue to be prioritised to support flow within the system, additional capacity was made available as required. IHU patients treated within 7 days continues on an upward trajectory at 58% in M04.

### Thoracic & Ambulatory

- As of M04 the division is above planned activity (363 YTD) and above 2019/20 admitted activity (884 YTD).
- Elective inpatient activity within RSSC is reduced compared to 19/20 activity due to changes in the pathway post COVID, but remains above plan. Daycase activity has increased and is above plan. The increase in activity is due to the RTT initiatives to support elective recovery.

### Cardiology

- The division delivered below plan in M04 with some elective scheduling being reallocated to address urgent care for inpatients across Tavi and Structural Services.
- ACS Pathways transferred accepted patients between 24 and 72 hours in M04.
- Capacity has been increased in Tavi with plans to increase structural capacity from September 25.

### 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	89%	101%	84%**	68%	90%	95%	122%
	Daycases	35%**	137%	n/a	262%	156%	97%**	750%**

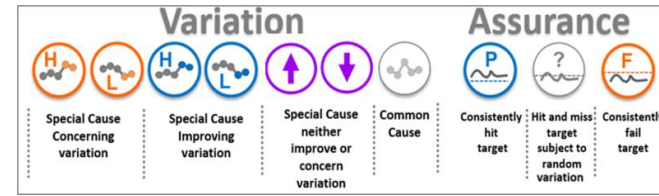
= YTD activity > 100% of 19/20



# Effective: Non-admitted Activity

Accountable Executive: Chief Operating Officer

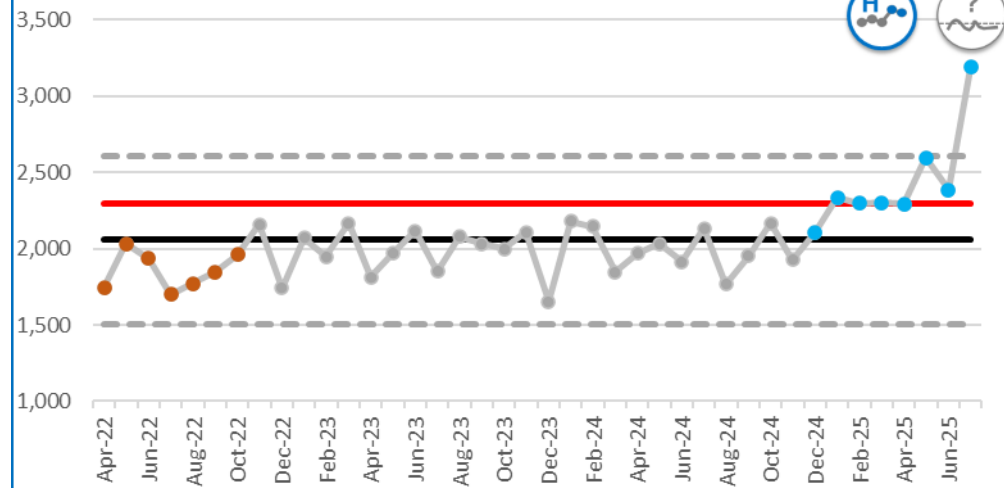
Report Author: Chief Operating Officer



Royal Papworth Hospital  
NHS Foundation Trust

## 1. Historic trends & metrics

### Outpatient First Attends (NHS only)



Jul-25

3188

Target (red line)\*

2298

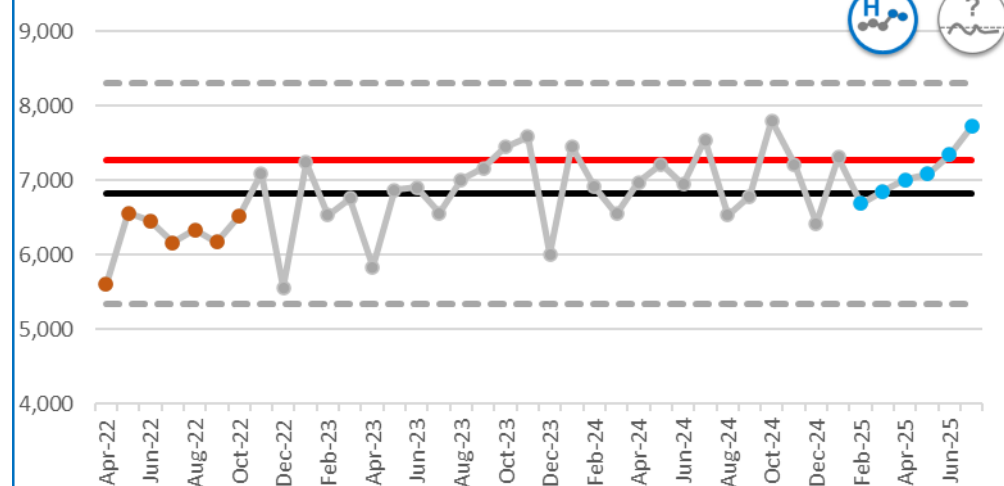
Variation

Special cause variation of an improving nature

Assurance

Hit and miss on achieving target subject to random variation

### Outpatient FUPs (NHS only)



Jul-25

7728

Target (red line)\*

7298

Variation

Special cause variation of an improving nature

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	95%	92%	915%	69%	135%	126%**
	Follow Up Outpatients	180%	155%	64%	176%	153%	117%

= YTD activity > 100% of 19/20

### Action plan / comments

Actions embedded into services so far include:

- Clinic template change to 70:30 new:FU ratio in RSSC
- PIFU rollout within CPAP

Further PIFU rollout is being incorporated into the elective recovery delivery to ensure appropriate specialties adopt PIFU. 12.7% of outpatient follow up activity is PIFU and this continues to increase. A full timescale linked to PIFU rollout is being finalised.

The Thoracic and Ambulatory division activity is above planned activity (9,169 YTD) and above 19/20 activity (5,692 YTD). Within M04, there were 458 missed appointments (10%) and 1,332 appointments cancelled by the patient at short notice. Proposal project drafted to reduce patient cancellations & DNAs as part of the RTT recovery, this includes a short notice cancellation and rebooking process and is being led by the Clinical Admin team, initial draft process has been circulated for comment.

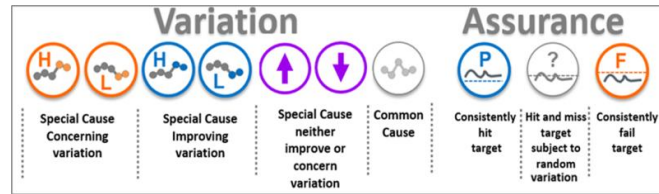
Cardiology delivered below plan within M04 (4,426), due to periods of consultant sickness, emergency leave annual leave that took place. The Division are increasing capacity of OP Appointments through the use of PSI clinics especially focussing on the EP sub speciality.



# Effective: Occupancy

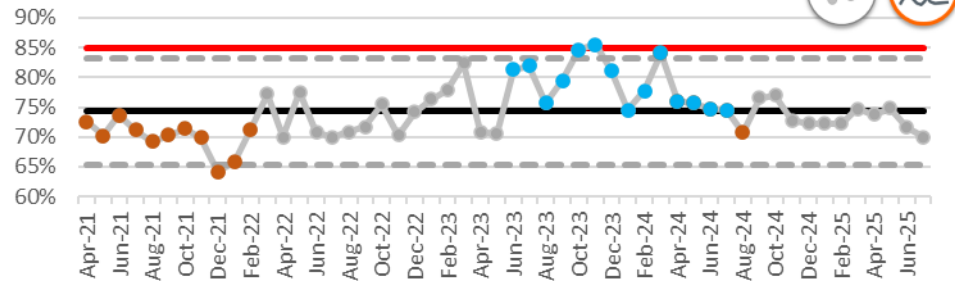
Accountable Executive: Chief Operating Officer

Report Author: Chief Operating Officer



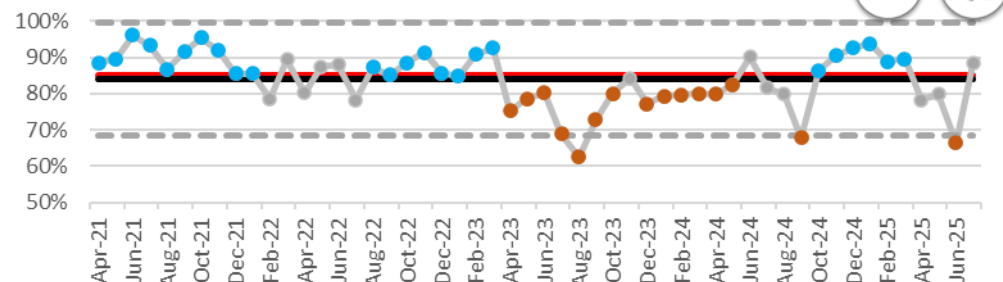
## 1. Historic trends & metrics

### Bed Occupancy (excluding CCA and sleep lab)



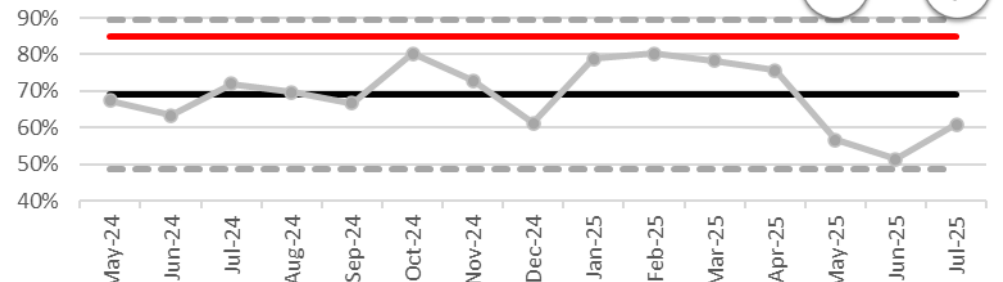
Jul-25
70.0%
Target (red line)
85%
Variation
Common cause variation
Assurance
Has consistently failed the target

### ICU bed occupancy



Jul-25
88.3%
Target (red line)
85%
Variation
Common cause variation
Assurance
Hit and miss on achieving target subject to random variation

### Enhanced Recovery Unit bed occupancy %



Jul-25
60.8%
Target (red line)
85%
Variation
Common cause variation
Assurance
Hit and miss on achieving target subject to random variation

## 2. Comments

Actions embedded into services so far include:

- Virtual ward to enable additional bed capacity and flow

### Bed occupancy (excluding CCA and sleep lab)

- Bed occupancy data currently includes uncommissioned beds. Further analysis to be completed to demonstrate current status for September.
- Since the Virtual Ward has opened, there has been an increase in bed capacity on level 5 driven by a total of 788 virtual ward days since opening. The leadership team are working collaboratively across the divisions to review and develop the service to further recognise the benefits.

### ICU bed occupancy:

- Bed occupancy for M04 was below KPI, however on an upward trajectory at 88.3% reflecting the reduction in cardiac cases, due to increase in transplant patients (6 in M04 the highest number for 4 years) and increased thoracic cases.
- One patient was cancelled for ERU being full and one patient cancelled for ICU being full in M04.
- 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:

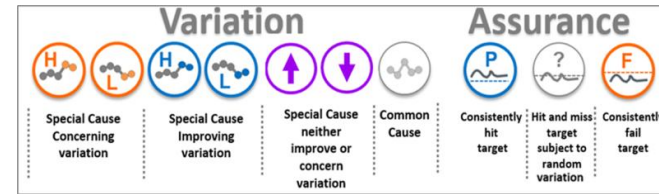
- Bed occupancy in M04 was 60.8% reflecting increased efficiency and increased thoracic cases and transplantation.
- This decrease is partly due to unfilled cardiac theatre slots. Thoracic activity was done in lieu of this, but these patients do not go to ERU. Theatre utilisation increased in month although a change in casemix to all day cases meant that these patients also did not go to ERU.
- As one of the Elective Recovery schemes, the leadership team are looking at ERU optimisation



# Effective: Utilisation

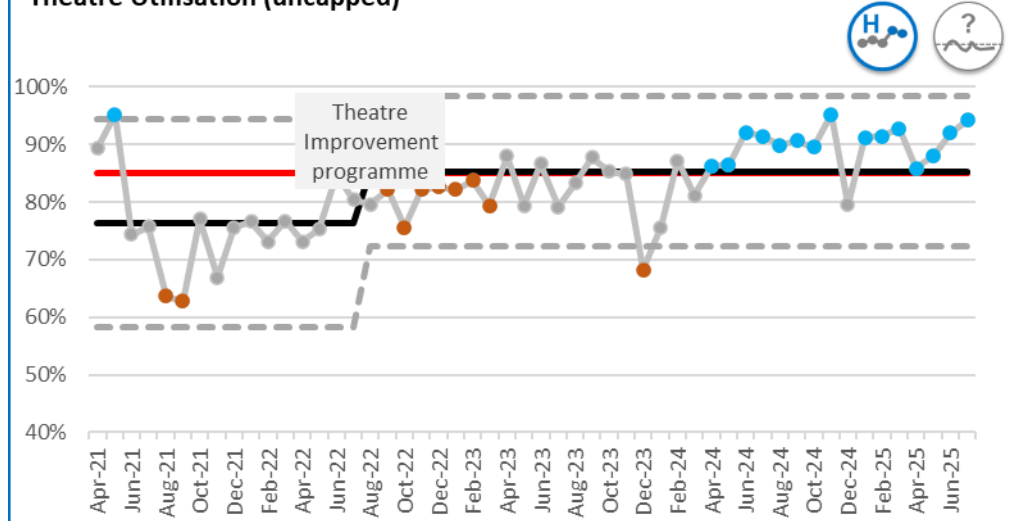
Accountable Executive: Chief Operating Officer

Report Author: Chief Operating Officer



## 1. Historic trends & metrics

### Theatre Utilisation (uncapped)



Jul-25

94%

Target (red line)

85%

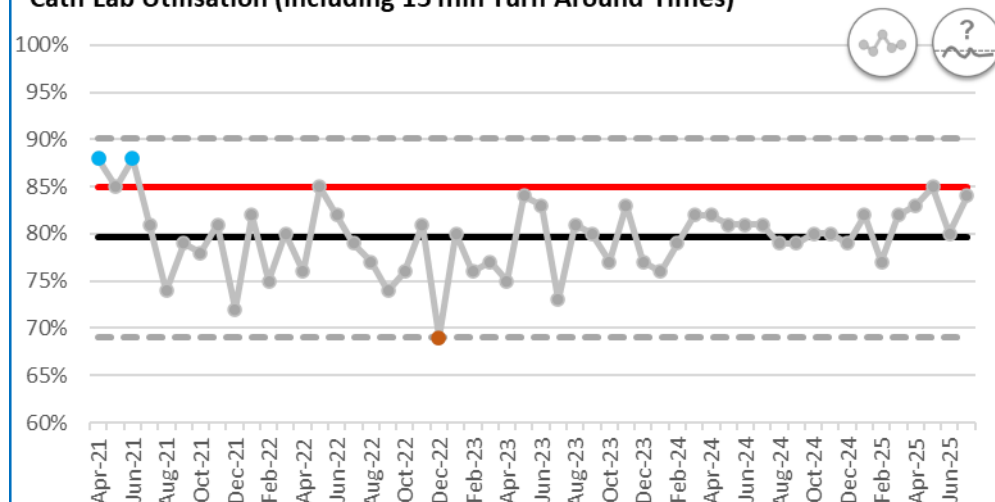
Variation

Special cause variation of an improving nature

Assurance

Hit and miss on achieving target subject to random variation

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



Jul-25

84%

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 94% in M04, this remains within variance above KPI and is on an upward trajectory since April.
- Further work is being done to review start times and efficiency savings within theatres which forms part of the elective care recovery.
- 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.

### Cath Lab Utilisation:

- There was a decrease in lab utilisation M4 compared to the previous month, 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 follow time between emergencies. Activity taking place in minor procedure rooms is also not captured. Cardiology Ops reviewing with BI Team.
- Current work taking place to increase capacity within lists through efficiencies between cases. Time in motion review took place by PMO team within Tavi Labs.





# Effective: Action plan summary

Accountable Executive: Chief Operating Officer

Report Author: Chief Operating Officer

Actions are summarised below for those metrics flagged on the dashboard requiring an action plan under the escalation trigger

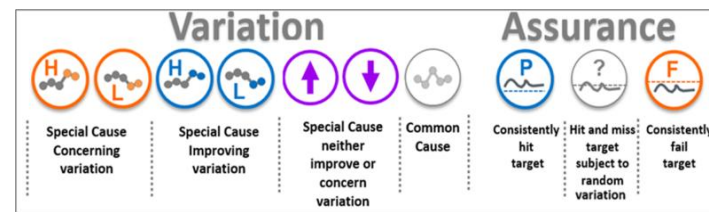
Dashboard KPIs	Metric	Division	Action	Lead	Update	Timescale for completion	RAG Status	Key
	Enhanced Recovery Unit bed occupancy %	STA	A review of bed use/flow/cancellations/scheduling requested. Pipeline project in elective recovery programme to review flex of beds to match the demand.	JS	Request made to team to initiate project and complete QIA	Aug-25	Green	Embedded as Business as Usual
	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 - awaiting Ops resource to roll out	Apr-25	Yellow	On track / complete
			Review clinic templates: job planning	LM		Sep-25	Green	Behind schedule but mitigations in progress and being tracked
			Review clinic templates: new:FU ratio / clinic size against 19/20	LM	Clinic templates reviewed against 19/20 activity, new to f/u ratio not yet reviewed.	Aug-25	Yellow	Deadline delayed / not started
		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	Date is currently TBC or 'on going' therefore cannot measure status
	% Day cases	STA	12.6%: due to complexities of surgery, minimal day cases within STA. JS to check what is counted as a day case	JS	STA daycases predominately thoracic patients, further review being undertaken due to complexities of surgery	Jun-25	Red	
	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	Red	



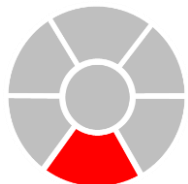
# Responsive: Summary

Accountable Executive: Chief Operating Officer

Report Author: Chief Operating Officer



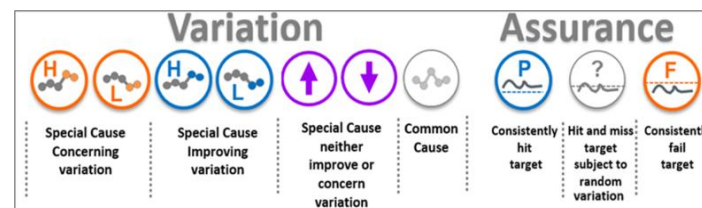
	Metric	Latest Performance		Previous	In month vs target	Action and Assurance		
		Trust target	Most recent position	Position		Variation	Assurance	Escalation trigger
Dashboard KPIs	% diagnostics waiting less than 6 weeks	99%	87.0%	90.7%			?	Review
	18 weeks RTT (combined)	92%	67.6%	67.6%			F	Action Plan
	31 days cancer waits	96%	100%	100%			?	Review
	62 day cancer wait for 1st Treatment from urgent referral	85%	0%	0%			?	Review
	104 days cancer wait breaches	0	6	3			?	Review
	Number of patients waiting over 65 weeks for treatment	0	21	14			F	Action Plan
	Theatre cancellations in month	15	41	17			?	Review
	% of IHU surgery performed < 7 days of medically fit for surgery	95%	58%	48%		H	F	Action Plan
	Acute Coronary Syndrome 3 day transfer %	90%	84%	76%			?	Review
	Number of patients on waiting list	7075 (25/26 Av)	6369	6640			?	Review
	52 week RTT breaches	0	55	58		H	F	Action Plan
Additional KPIs	% of IHU surgery performed < 10 days of medically fit for surgery	95%	67%	64%			?	Review
	18 weeks RTT (cardiology)	92%	60.4%	60%			F	Action Plan
	18 weeks RTT (Cardiac surgery)	92%	73.2%	74%		H	F	Action Plan
	18 weeks RTT (Respiratory)	92%	70.8%	71%			F	Action Plan
	Other urgent Cardiology transfer within 5 days %	90%	70%	73%			?	Review
	% patients rebooked within 28 days of last minute cancellation	100%	100%	86%			?	Review
	Urgent operations cancelled for a second time	0	0	0			?	Review
	Non RTT open pathway total	Monitor	51048	50369		H		Monitor
	Validation of patients waiting over 12 weeks	95%	89%	49%		H	F	Action Plan



# Responsive: RTT

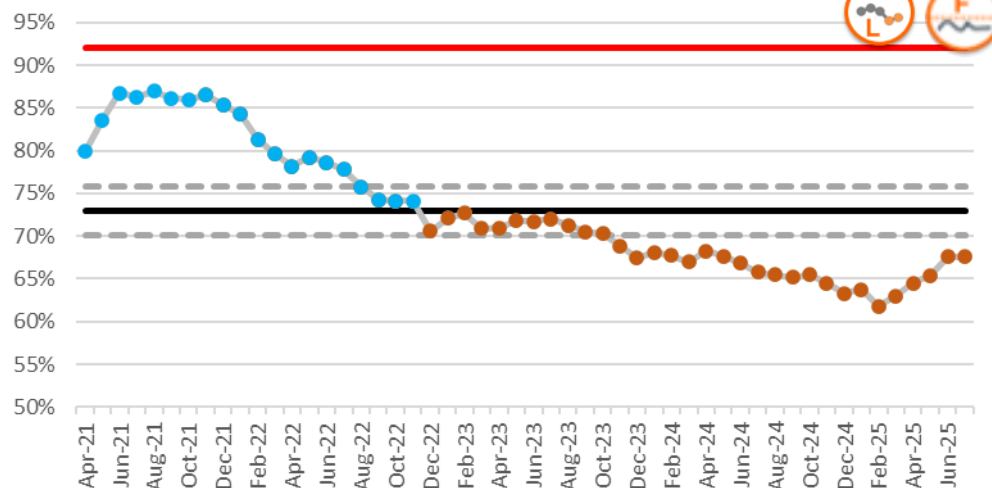
Accountable Executive: Chief Operating Officer

Report Author: Chief Operating Officer



## 1. Historic trends & metrics

### 18 weeks RTT (combined)



Jul-25

67.6%

Target (red line)

92.0%

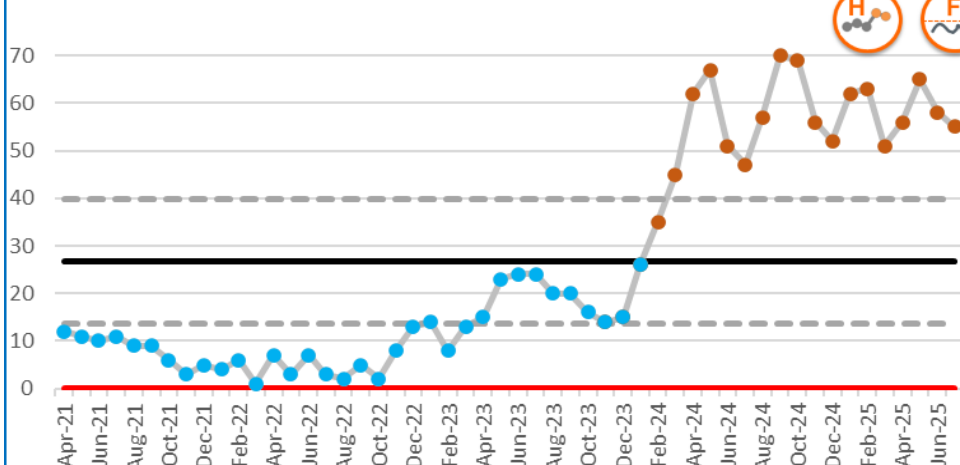
Variation

Special cause variation of a concerning nature

Assurance

Has consistently failed the target

### 52 week RTT breaches



Jul-25

55

Target (red line)

0

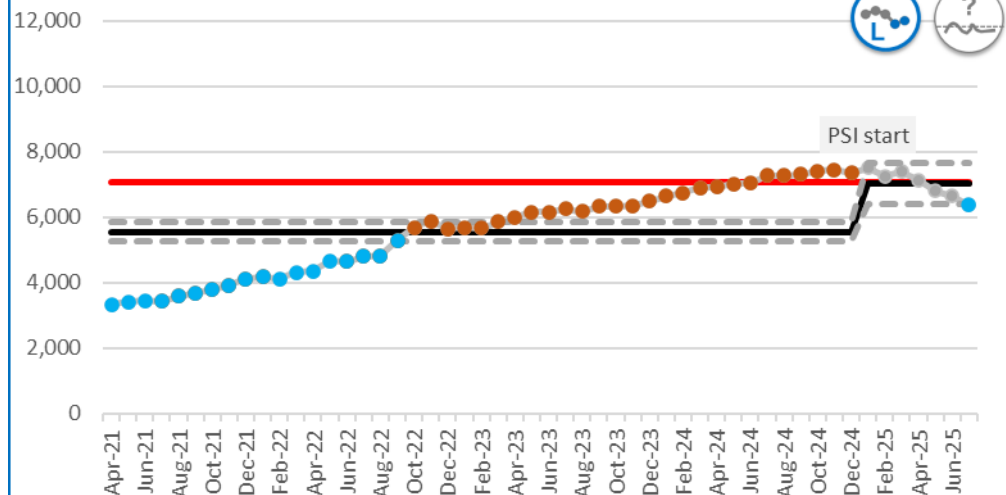
Variation

Special cause variation of a concerning nature

Assurance

Has consistently failed the target

### Number of patients on waiting list



Jul-25

6369

Target (red line)

7075 (25/26 Av)

Variation

Special cause variation of an improving nature

Assurance

Hit and miss on achieving target subject to random variation

### Action plans / Comments

- Month on month improvements continue to be noted through the elective recovery performance and delivery group. The impact is evident through the reduction in the number of patients on the waiting list as well as the improvements within 18 weeks RTT. Enhanced governance continues to ensure scheduling is being optimised 6 weeks in advance, as well as oversight of long waiters to remove.
- There were 55 52-week RTT breaches in month.

#### 52 Week breakdown:

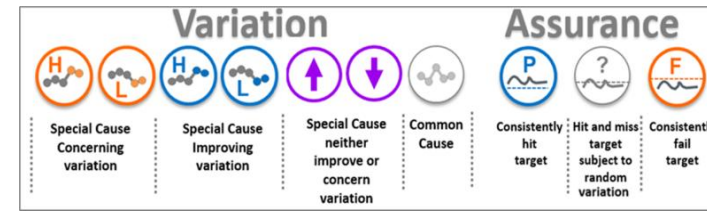
- 47 of the breaches took place in cardiology, 22 Structural, 11 were Tavi, 13 were in EP, and 1 intervention, 7 referrals were incoming late referrals from external referrers, awaiting review after being deferred from surgical pathways for consideration.
- Three of the 52-week breaches occurred within the Thoracic and Ambulatory service, one was a late referral and discharged within three days of receipt. One was delayed due to patient choice and has received treatment and the third was due to a missed appointment and validation error, however the patient has now received treatment.
- STA: There were five patients in M04 that breached 52 weeks. All of which are late inherited clocks with plans in place to treat.



# Responsive: Cancer

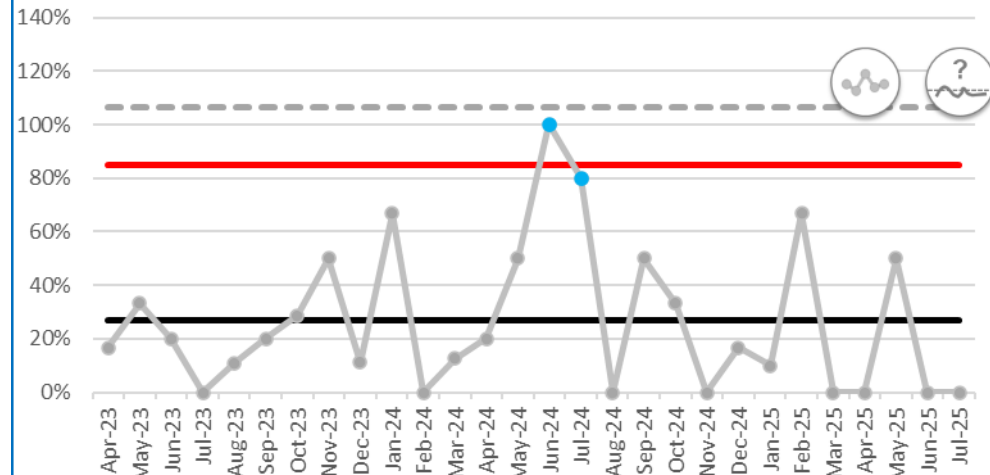
Accountable Executive: Chief Operating Officer

Report Author: Chief Operating Officer



## 1. Historic trends & metrics

### 62 day cancer wait for 1st Treatment from urgent referral



Jul-25

0%

Target (red line)

85%

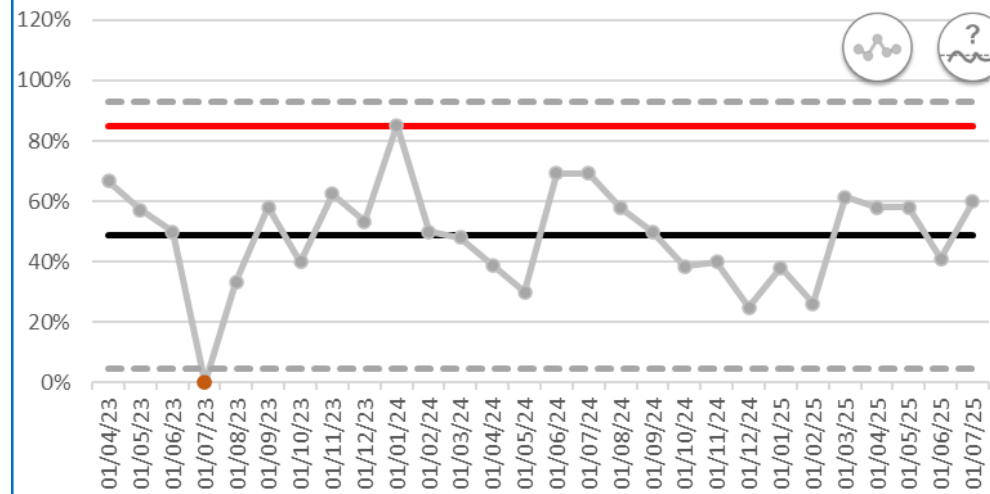
Variation

Common cause variation

Assurance

Hit and miss on achieving target subject to random variation

### 62 day cancer wait for 1st Treatment from consultant upgrade



Jul-25

60%

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 M04, was 27.8 days, the same as M03 (87 referrals received). 18 referrals were received after day 38. The combined breached performance for 62-days was 33% (same as M03) and below the trajectory.

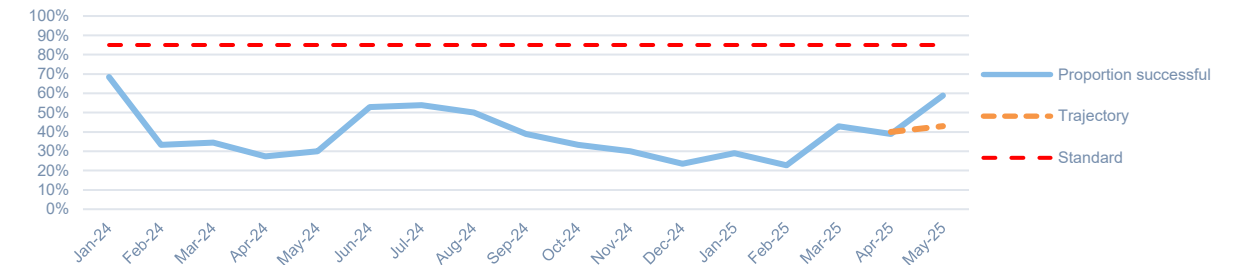
Breach themes include:

- Surgical clinic wait was too long in some of these cases
- Surgical waits were a problem
- Some patients waiting too long for their CTNB
- One patient referred for surgery with an out-of-date CT – this meant we could not achieve the 24-day target

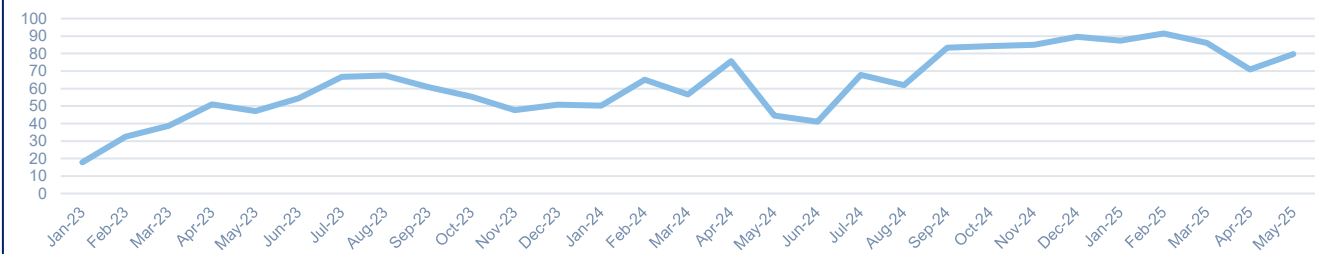
Diagnostic pathway bundles continue to be rolled out and the impact will be assessed through the cancer recovery programme.

Cancer Recovery Delivery Group continues to meeting weekly, with the pipeline schemes to be reviewed on 5th September and a date to be agreed to develop the CTNB pathway.

### Combined breach performance (2024-25)



### Referral to RPH to Treatment



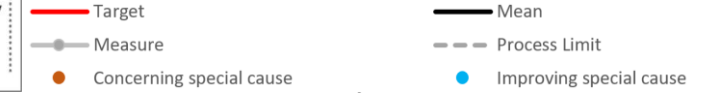
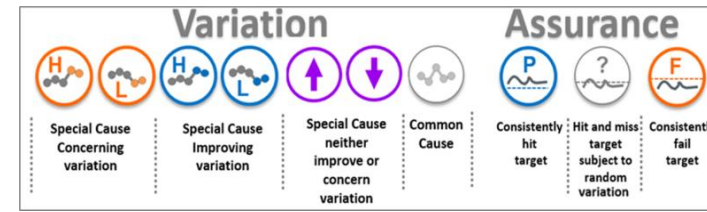




# Responsive: Cancer

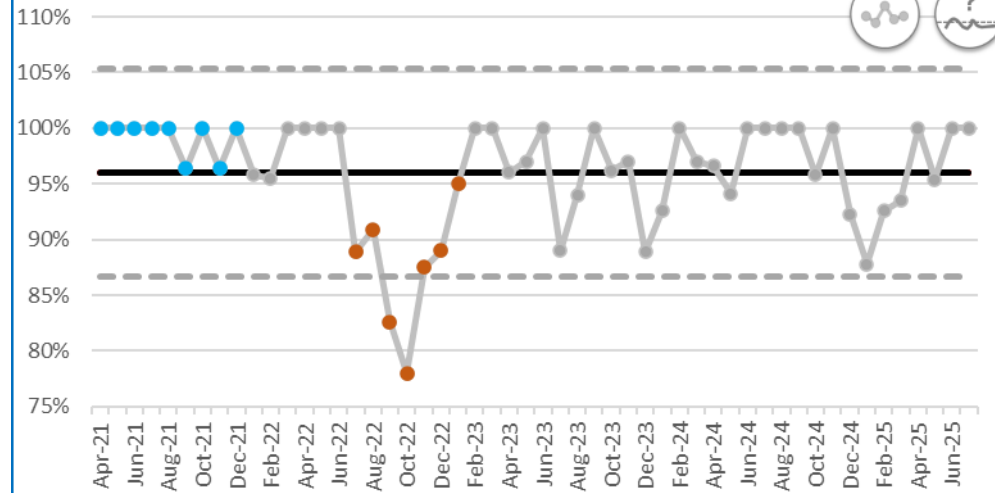
Accountable Executive: Chief Operating Officer

Report Author: Chief Operating Officer



## 1. Historic trends & metrics

### 31 days cancer waits



Jul-25

100%

Target (red line)

96%

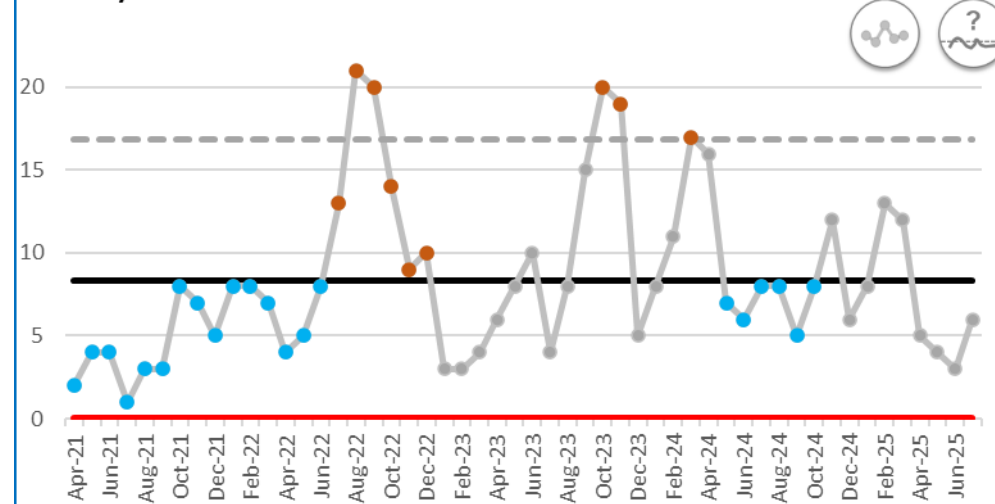
Variation

Common cause variation

Assurance

Hit and miss on achieving target subject to random variation

### 104 days cancer wait breaches



Jul-25

6

Target (red line)

0

Variation

Common cause variation

Assurance

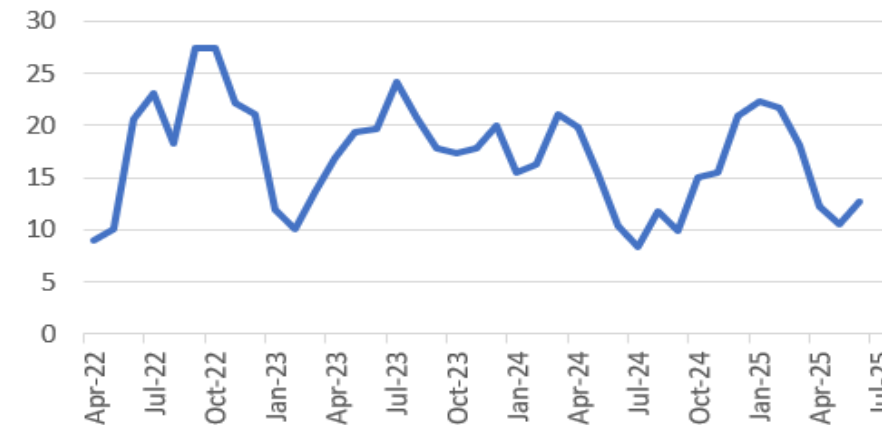
Hit and miss on achieving target subject to random variation

## Action plans / Comments

**31 Day breaches:** The 31-day target was achieved in M04 with a compliance of 100%. However, the averaged decision-to-treat continues to reduce (11.7 days) and is attributed to improved scheduling within thoracic surgery.

### Decision-To-Treat

#### Average DTT



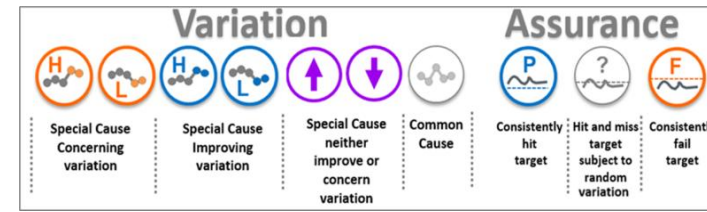
**104 day breaches:** Continued low numbers of 104+ breaches, clear improvement with PTL 6 breaches M04. Of these, 1 was treated in July. All breaches in previous months were treated.



# Responsive: Other metrics

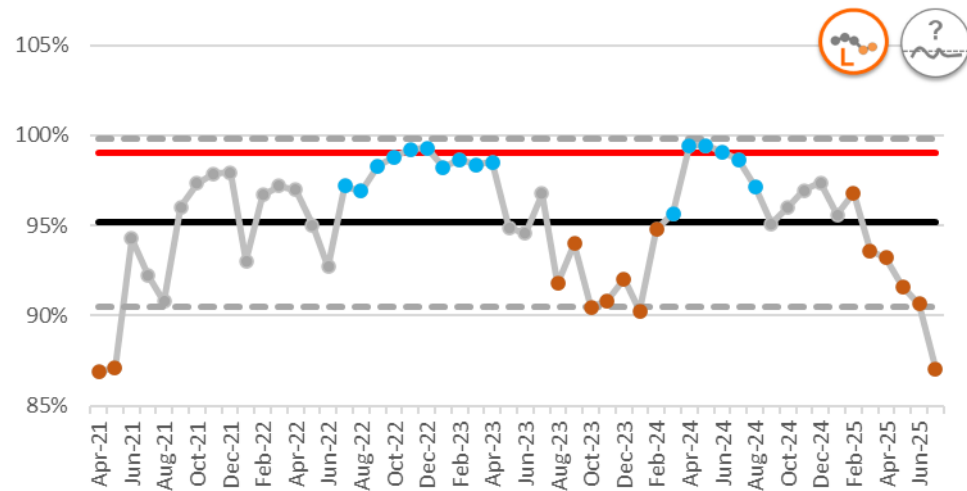
Accountable Executive: Chief Operating Officer

Report Author: Chief Operating Officer



## 1. Historic trends & metrics

### % diagnostics waiting less than 6 weeks



Jul-25

87.0%

Target (red line)

99%

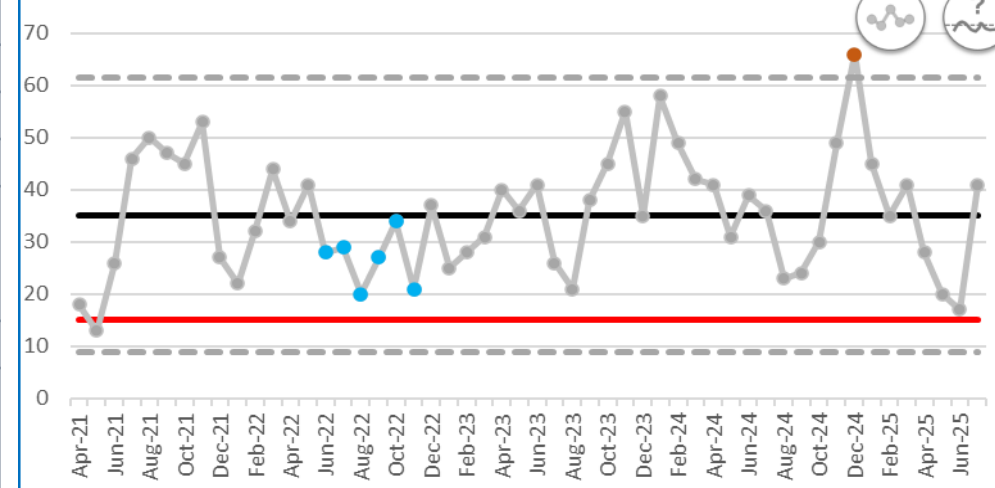
Variation

Special cause variation of a concerning nature

Assurance

Hit and miss on achieving target subject to random variation

### Theatre cancellations in month



Jul-25

41

Target

15

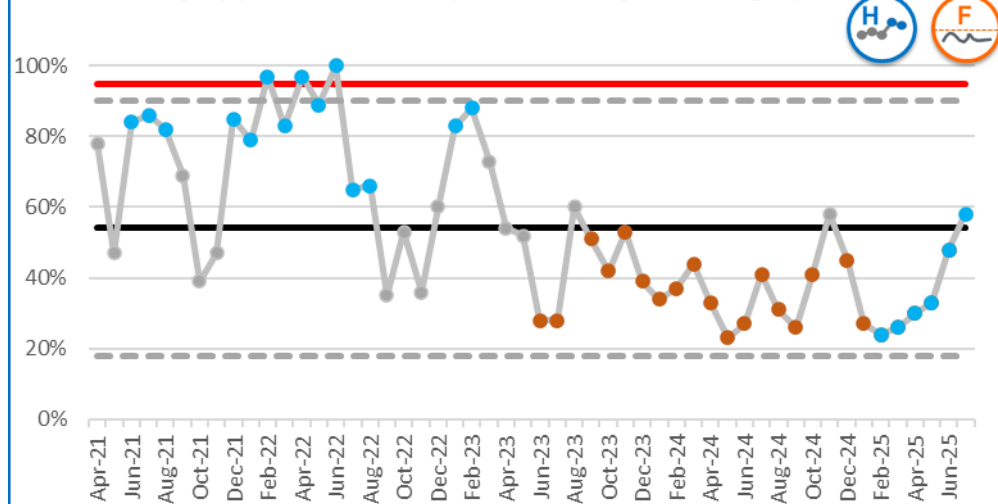
Variation

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



Jul-25

58%

Target (red line)

95%

Variation

Special cause variation of an improving nature

Assurance

Has consistently failed the target

### Action plans / Comments

#### DM01

- Trust compliance reflects the overall diagnostic position (not just radiology).
- Radiology continues to present a position of long waiters which continues to be primarily driven by longer waits in cardiac MRI and CT scanning.
- The additional weekend lists which were being undertaken in MRI to try and support long waiting patients have now reduced to once a month to protect staff work life balance whilst we also support additional weekend cath labs lists that are also drawing on the same finite pool of radiographers.
- PTL size is now circa 3,500 and appears to be stable
- Radiology validator commenced in late July.
- Diagnostic Imaging now involved in the Elective Recovery Programme with data being added to the weekly Huddles
- Meeting planned for 2/9/25 with x3 CDs, STA DDO, Radiology Ops, Radiology CL. Multiple areas of focus on referral management to try and improve patients waiting & waiting times, as well as report management
- WatchPAT managed service commenced in July to aid CSS backlog for RTT patients and therefore anticipate improvement in DM01 specific to sleep in M04. PSG and Respiratory Polygraphy studies are improving month on month. DM01 for thoracic overall

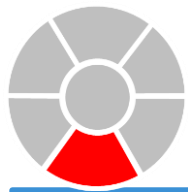
was 95.12%

#### Theatre Cancellations

41 cancellations in M04 an additional 45 major emergency cases were undertaken, which is reflected in the overall theatre utilisation and activity data. The most significant reason for cancellation on the day was due to planned case overruns (13) and additional case took time (6). In addition there were 16 transplants in M04 the highest number for 2 years which impacts elective activity and result in cancellation. There were 4 cancellations in M04 due to excess theatre humidity during the extreme heat wave.

#### In House Urgent patients

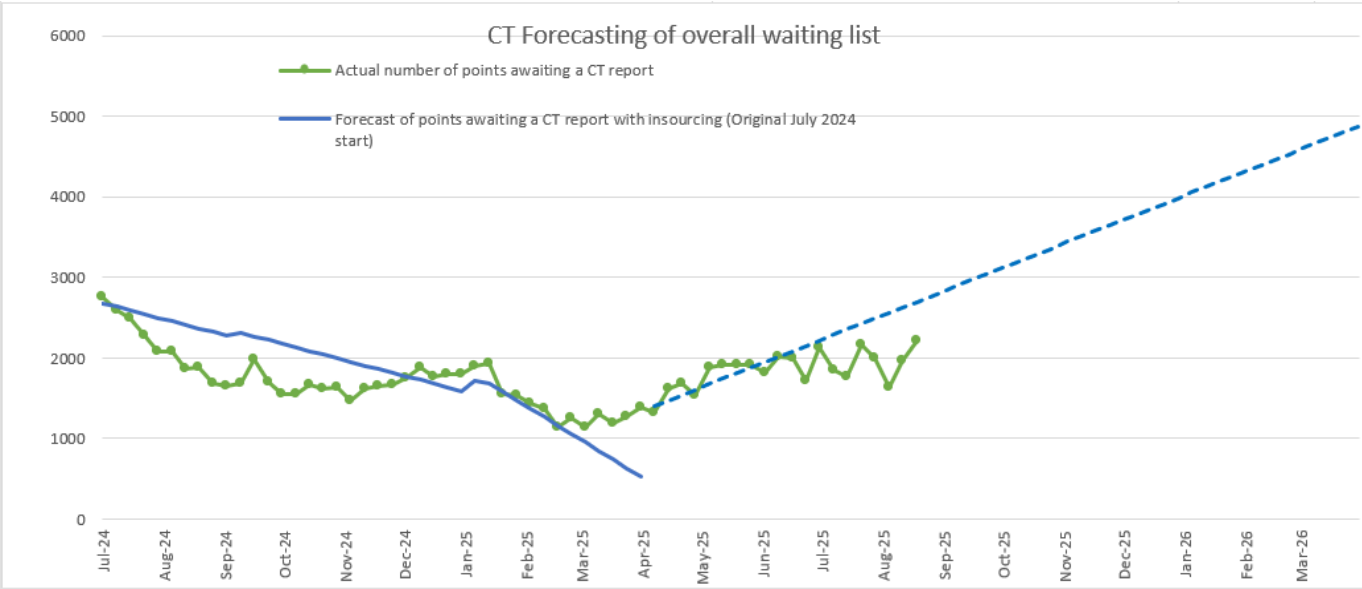
- Capacity for IHU's continues to be flexed. Increased capacity is made available to support flow at RPH and the region, 7 day KPI, continues on an upward trajectory with 58% of patients treated within 7 days.
- STA leadership team are working collaboratively with cardiology and clinical admin on flow and new ways of working.



# Responsive: Spotlight – CT Backlog

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

		07/07/2025	14/07/2025	21/07/2025	28/07/2025	04/08/2025	11/08/2025	18/08/2025
Actual	Actual number of points awaiting a CT report	1846	1764	2166	1998	1640	1968	2205
	Actual points backlog awaiting a CT report for more than 4 weeks	654	639	794	608	495	647	783
	Actual points on waiting list for a CT report waiting less than 4	1192	1125	1372	1390	1145	1321	1422
	Proportion of CT reports waiting for more than 4 weeks	35%	36%	37%	30%	30%	33%	36%
	Number of patients awaiting a CT report	786	749	790	724	697	720	817
	Number of patients waiting CT report over 4 weeks	227	166	262	172	134	187	246
	Number of patients awaiting a CT scan based on PTL	1765	1710	1716	1683	1632	1685	1656



## Recruitment

Remains 9 Consultant Radiologists (8.5 WTE) in post against a budgeted WTE of 13.77

- 1 substantive Consultant Radiologist successfully appointed (start date Sept 2025)
- 1 fixed term Consultant Radiologist recruitment underway ( start date Sept 25)
- 1 substantive Consultant Radiologist resignation, Sept 2025

Advert remains active and available for applicants. Advert also to be placed in the BMJ.

## External Reporting:

Langley Clark (LCI) contract continuing. Additional shifts worked in July to compensate for the reduction in number of shifts during June. August roster for LCI has been fully staffed but this is offset by annual leave within the team of RPH Consultant Radiologists resulting in an overall drop in CT reporting shifts as a combined roster.

Validation of longest wait CT reports down to 4 weeks undertaken twice in the past 4 weeks. Once TAVI scans, DQ issues and pending reviews (reported but need checking) were removed, there were 84 CTs waiting over 4 weeks.

TAVI reporting with an external provider supported by Cardiology has commenced to reduce the backlog of TAVI reports awaiting over 4 weeks.

## CT report average turnaround time in July – 28 days (range 0-175 days)

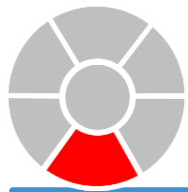
Remains within the 4 week national KPI

Total of 1354 CT reports published in July (180 more than June)

## Outsource project update (as of 19 August 2025)

- Project remains within documented timescales and on plan
- To support all modality reporting, not just CT
- Scoring, financial scoring and mediation completed in July 2025
- Preferred bidder known
- ATIR currently being written (now the preferred bidder & costs are known)
- VPN line upgrade continuing with expected implementation August 2025 (pipe widening), to be followed by VDI re-testing before implementation of remote working shifts for the Consultant Radiologists





# Responsive: Spotlight – 52 week waits

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

As of 20 August 2025, there are 6,218 patients on the PTL. Of these, 56 have been waiting in excess of 52 weeks from their original referral. This equates to 0.9% of the PTL.

Number of patients on RTT	Number of patients on RTT >52w		Number of patients on RTT >52w that are booked	
6218	56	0.9%	45	80.4%

For reference, the RPH plan submitted to NHS England for the number of patients waiting over 52 weeks is below. Regardless of this, RPH are striving to achieve a position where no patient waits in excess of 52 weeks (with the exception of genuinely late referrals):

	April	May	June	July	August	Sept	October	Nov	Dec	January	February	March
Number 52w waiters plan	163	147	132	119	107	96	87	78	70	63	57	51
Number 52w waiters position	56	65	58	55								

Of these 56 patients, 49 are Cardiology patients, 1 is a Thoracic patient and 6 are STA patients.

Number of patients on RTT >52w	Cardiology		Thoracic		STA	
56	49	87.5%	1	1.8%	6	10.7%

The Thoracic patient has been waiting for 53 weeks, all of which were with RPH. This is a unique case.

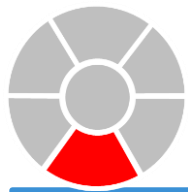
The 6 STA patients were all referred to STA late in their pathway. Of these, 4 have been waiting with RPH for less than 10 weeks to date. The other 2 however were late referrals from Cardiology and have been waiting with RPH for 57.2 and 59.2 weeks. Of these 6 patients, 4 already have their date with STA booked.

Of the 49 Cardiology patients, 10 are EP, 12 are TAVI and 25 are Structural.

Number of patients on RTT >52w	EP		TAVI		Structural		Other	
49	10	20.4%	12	24.5%	25	51.0%	2	980.0%

Of these 49 Cardiology patients, 40 were referred to RPH within 1 week of their original clock starting or are the original referral. The other 9 are 'late referrals'. All 49 have been with RPH in excess of 18 weeks and 42 have been with RPH in excess of 52 weeks.

Of the 49 Cardiology patients, 45 now have their next date booked. This is a result of a targeted operational effort as well as a planned increase in weekly structural capacity from 11 September 2025 onwards. This will see all current structural patients waiting over 52 weeks have their clock stopped by the end of October 2025. The new rotas will continue beyond October to absorb any patients that become 52 week waiters. The additional TAVI and EP work as part of the ECR programme, should result in no patients waiting over 52 weeks for Cardiology services at RPH unless they are referred late in their pathway.



# Responsive: Spotlight – 52 week waits

Accountable Executive: Chief Operating Officer

Report Author: Chief Operating Officer

Patient	Weeks Waiting	Weeks on RPH PTL	Weeks Waiting Before Referral to RPH	Division	Speciality
1	132.1	0.2	131.9	STA	Surgery
2	52.6	1.1	51.5	STA	Surgery
3	90.7	1.6	89.1	STA	Surgery
4	56.3	8.9	47.4	STA	Surgery
5	75.7	21.2	54.5	Cardiology	Structural
6	68.3	28.7	39.6	Cardiology	TAVI
7	54.3	30.9	23.3	Cardiology	TAVI
8	54.6	32.7	21.9	Cardiology	EP
9	55.3	39.6	15.7	Cardiology	TAVI
10	52.7	45.2	7.5	Cardiology	Surgery
11	70.1	47.2	22.9	Cardiology	TAVI
12	52.1	52.1	0.1	Cardiology	TAVI
13	53.7	52.6	1.1	Cardiology	EP
14	52.7	52.6	0.1	Cardiology	Structural
15	52.9	52.8	0.1	Cardiology	EP
16	52.9	52.8	0.1	Cardiology	TAVI
17	53.1	53.1	0.1	Cardiology	TAVI
18	53.7	53.7	0.1	Thoracic	RSSC
19	53.7	53.7	0.0	Cardiology	Structural
20	54.0	53.8	0.2	Cardiology	Structural
21	54.0	53.9	0.1	Cardiology	TAVI
22	54.1	54.1	0.0	Cardiology	Structural
23	69.0	54.2	14.8	Cardiology	Structural
24	57.1	54.2	2.9	Cardiology	Intervention
25	54.3	54.3	0.0	Cardiology	Structural
26	55.0	54.9	0.1	Cardiology	Structural
27	55.1	55.1	0.0	Cardiology	Structural
28	67.0	55.2	11.8	Cardiology	Structural

Patient	Weeks Waiting	Weeks on RPH PTL	Weeks Waiting Before Referral to RPH	Division	Speciality
29	55.9	55.8	0.1	Cardiology	EP
30	60.0	56.2	3.8	Cardiology	TAVI
31	56.3	56.3	0.0	Cardiology	Structural
32	56.7	56.6	0.1	Cardiology	EP
33	57.1	57.1	0.1	Cardiology	EP
34	57.3	57.2	0.1	STA	Surgery
35	58.1	58.1	0.1	Cardiology	Structural
36	67.9	58.4	9.5	Cardiology	TAVI
37	59.3	59.2	0.1	STA	Surgery
38	59.6	59.5	0.1	Cardiology	EP
39	61.1	61.1	0.0	Cardiology	EP
40	63.1	63.1	0.1	Cardiology	Structural
41	63.3	63.3	0.0	Cardiology	EP
42	63.9	63.8	0.1	Cardiology	TAVI
43	64.1	64.1	0.1	Cardiology	Structural
44	64.7	64.6	0.1	Cardiology	Structural
45	66.9	65.8	1.1	Cardiology	Structural
46	66.0	66.0	0.0	Cardiology	Structural
47	66.0	66.0	0.0	Cardiology	Structural
48	67.0	67.0	0.0	Cardiology	Structural
49	67.0	67.0	0.0	Cardiology	Structural
50	68.0	68.0	0.0	Cardiology	EP
51	68.3	68.3	0.0	Cardiology	TAVI
52	69.3	69.3	0.0	Cardiology	Structural
53	69.7	69.7	0.0	Cardiology	Structural
54	73.3	73.3	0.0	Cardiology	Structural
55	74.7	74.7	0.0	Cardiology	Structural
56	81.1	81.1	0.0	Cardiology	Structural



# Responsive: Action plan summary

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

Actions are summarised below for those metrics flagged on the dashboard requiring an action plan under the escalation trigger

	Metric	Division	Action	Lead	Update	Timescale for completion	RAG Status	Key
Dashboard KPIs	% diagnostics waiting less than 6 weeks	Cardiology	Review of Echo Lab Capacity against current waiting lists, and clinic templates.	LM	Data cleansing taken place through creating of centralised Access Plans.	Dec-25		Embedded as Business as Usual
		STA	Radiology is now part of the planned care recovery plan, so further actions and tasks will be articulated in due course	HR		TBC		On track / complete
		Thoracic	Sleep Lab expansion New rPG devices and routine weekly clinics managed by clinical admin CSS appointments are part of the elective recovery delivery, whereby 1,000 patients will receive initial diagnostic via WatchPAT	NH	WatchPat launched the 3rd July. Expansion of sleep lab under way with band 6 appointed and band 5 appointed. Additional equipment being made available from company to ensure enough equipment for demand. Over 700 devices sent out to date (13/8/25) and DM01 has improved as a result	Mar-26		Behind schedule but mitigations in progress and being tracked
	18 weeks RTT (combined)	All	Elective care and delivery group and access board stood up to monitor RTT delivery initiative. Detailed improvement plans in place and reported against weekly. Efficiencies in pathways identified as part of additional activity to ensure RTT remains sustainable.	DDOs	New governance in place to report RTT through to Access Board and Performance Committee. Detailed plans in place and reported separately.	Mar-26		Deadline delayed / not started
	Number of patients waiting over 65 weeks for treatment	Cardiology	Currently trying to set up Thursday lists to increase capacity, awaiting the go ahead from STA with regards to additional GA and ODP support.	LM	Lists now in motion with additional 4 Tavi patients scheduled each week, 3 lists across August and Sept stood down due to Anaesthetic Resource not being available. (Staffed on overtime)	Mar-26		Date is currently TBC or 'on going' therefore cannot measure status
	% of IHU surgery performance < 7 days of medically fit for surgery	STA	Working group between Clinical Admin, STA and Cardiology to review IHU processes. Propose spotlight slide to be shared for June PIPR.	NH/LM	Two trigger and escalation points in place between Cardiology and STA to review those awaiting surgical dates. Detailed action plan to be generated and to be reported via forthcoming new governance for patient flow.	TBC		
Additional KPIs	Number of patients on waiting list	Thoracic	Demand and capacity review of RSSC to ensure capacity meets growing demand	NH	Conversion rates completed which needs to be used to complete demand and capacity. July there is ongoing work for capacity and demand to ensure the service can deliver RTT. An optins appraisal is in development for service provision and modelling once WatchPat is complete	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		
	18 weeks RTT (cardiology)	All	Non-coronary intervention additional lists alongside additional reporting 33 TAVI lists 14 Structural lists 5 TOE lists	LM	<b>TAVI PSI lists:</b> MDT Streamline Triaging working well, additional patients streamlined through MDT each week. 27 additional patients treated through PSI and additional in week capacity. <b>Structural PSI List:</b> 4 MTEERs Treated, Structural Booking plan in place, patients booked from September onwards, MTEER extra capacity planned from October <b>TOE PSI List:</b> Currently using spare in week capacity for the lists. 3 Lists completed.	Mar-26		
			Additional lists and outpatient clinics in relation to CRM including: 100 EP lists 11 Outpatient first appointment clinics	LM	<b>EP Outpatient Clinics:</b> OPFA – 48 Patients seen, 16 Booked OPFU – 30 Patients seen Lab Bookings - 51 Patients Treated	Mar-26		
	18 weeks RTT (STA)	All	Extended thoracic lists Green lists and 3 pump lists Pre-admission / same day admission	JS	Extended thoracic lists commenced w/c 12 May and occurs every Friday. Green lists is implemented and now business as usual. Pre-admission / same day admission: work continues regarding this and also collaborating with thoracic regarding additional rooms to increase preadmission from 60% to 95% for all surgical patients. RTT is improving	Mar-26		
	18 weeks RTT (Thoracic)	All	RSSC additional list including: Clear CSS only backlog including reporting Outpatient appointments and one-stop clinics to commence treatment as appropriate Additional medical secretary support to discharge patients waiting over 18 weeks	NH	WatchPAT commenced in July with SDC clinics in the pipeline. A reduction in conversion to CPAP starter and SDC has been seen, so this will be taken into account in service modelling going forward.	Mar-26		
				SC	Number of discharge ACDs decreased from 180 to 118. Appointed, awaiting start dates	Aug-25		
	Validation of patients waiting over 12 weeks	All	Digital validation	ZR	Pilot of 50 patients completed: 60% response rate, 1 confirmed did not want to attend RPH. Rollout confirmed for end of Quarter 2.	Sep-25		
			Validation sprints - detailed action plan to be drafted Q1 in line with national validation sprints	DDOs	Validation for quarter 1 was above baseline, quarter 2 sprint has commenced and remains above baseline. 100% achieved and maintained over the last month	Jun-25		
		Thoracic	6 month FTC validator within thoracic to support RTT delivery	NH	Role recruited to and validation has improved as a result	Jul-25		



# People, Management & Culture: Summary

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

		Data Quality	Target	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Dashboard KPIs	Voluntary Turnover % **	4	9.0%	7.48%	9.39%	7.57%	10.03%	7.41%	4.41%
	Vacancy rate as % of budget **	4	7.50%	6.45%	6.01%	5.60%	6.51%	6.62%	6.12%
	% of staff with a current IPR	4	90%	77.74%	77.74%	76.86%	78.04%	79.73%	80.34%
	% Medical Appraisals*	3	90%	79.03%	80.31%	79.53%	75.78%	79.53%	82.44%
	Mandatory training %	4	90.00%	88.07%	87.07%	87.30%	86.97%	88.56%	89.77%
	% sickness absence **	5	4.0%	4.65%	4.39%	4.22%	4.00%	4.41%	4.69%
Additional KPIs	FFT – recommend as place to work **	3	72.0%	58.00%	n/a	n/a	n/a	60.00%	n/a
	FFT – recommend as place for treatment	3	90%	85.00%	n/a	n/a	n/a	88.10%	n/a
	Registered nursing vacancy rate (including pre-registered nurses)	4	5.00%	1.80%	1.77%	1.59%	2.44%	2.68%	3.02%
	Unregistered nursing vacancies excluding pre-registered nurses (% total establishment)	4	10.00%	12.06%	11.01%	7.34%	6.93%	7.85%	5.70%
	Long term sickness absence % **	5	1.50%	1.84%	1.94%	2.08%	1.72%	2.16%	2.13%
	Short term sickness absence	5	2.50%	2.82%	2.45%	2.13%	2.28%	2.25%	2.56%
	Agency Usage (wte) Monitor only	5	Monitor only	29.2	27.8	17.7	10.9	10.2	9.9
	Bank Usage (wte) monitor only	5	Monitor only	93.9	100.5	95.3	98.2	95.7	122.1
	Overtime usage (wte) monitor only	5	Monitor only	45.5	54.0	26.0	22.8	19.1	16.3
	Agency spend as % of salary bill	5	2.32%	2.52%	1.12%	1.44%	1.32%	0.70%	0.38%
	Bank spend as % of salary bill	5	2.51%	3.18%	2.25%	3.00%	3.08%	3.90%	3.91%
	% of rosters published 6 weeks in advance	3	Monitor only	60.60%	57.60%	54.50%	51.50%	51.50%	57.60%
	Compliance with headroom for rosters	4	Monitor only	30.40%	30.10%	29.90%	26.20%	27.20%	26.50%
	Band 5 % White background: % BAME background	5	Monitor only	n/a	41.43%:57.38 %	n/a	n/a	39.55%:59.27 %	n/a
	Band 6 % White background: % BAME background	5	Monitor only	n/a	62.31%:36.47 %	n/a	n/a	61.70%:37.13 %	n/a
	Band 7 % White background % BAME background	5	Monitor only	n/a	75.69%:21.76 %	n/a	n/a	75.57%:21.95 %	n/a
	Band 8a % White background % BAME background	5	Monitor only	n/a	85.40%:13.14 %	n/a	n/a	85.31%:13.99 %	n/a
	Band 8b % White background % BAME background	5	Monitor only	n/a	86.21%:13.79 %	n/a	n/a	87.10%:12.90 %	n/a
	Band 8c % White background % BAME background	5	Monitor only	n/a	80.65%:19.35 %	n/a	n/a	78.79%:21.21 %	n/a
	Band 8d % White background % BAME background	5	Monitor only	n/a	90.00%:10.00 %	n/a	n/a	90.91%:9.09%	n/a
	Time to hire (days)	3	48	42	38	36	41	38	40

## Summary of Performance and Key Messages:

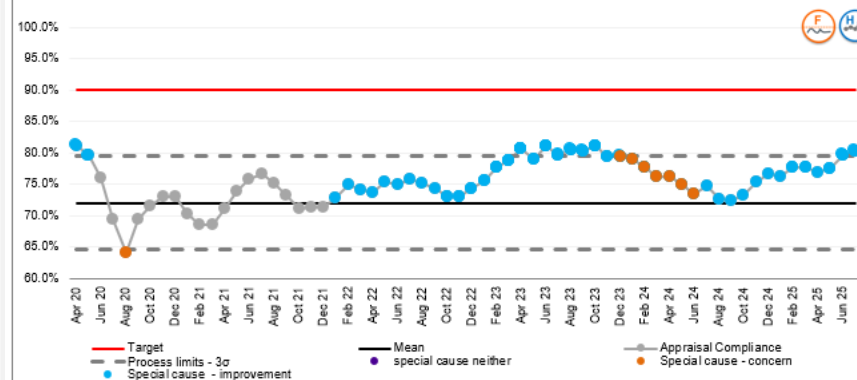
- Turnover has significantly reduced to 4.41% in July, there does tend to be a reduction in the summer months but this is the lowest turnover percentage since pre covid levels as noted in the SPC. There were 14 leavers equating to 12 WTE non medical leavers in July. There were 14 leavers (12.7 wte) non-medical leavers, from across departments and for a range of reasons i.e. there were no themes.
- We are continuing to see an improvement in July in respect of compliance with mandatory training (89.77%) requirements and annual appraisal (80.34%), however both are not achieving the Trust KPI.
- Total sickness absence increased to 4.69% which is over our KPI. There has been continued focus from the Workforce Directorate to support managers through training and the application of absence management protocols with enhanced focus following the publication of the NHS 10 Year Plan. An absence management support programme for areas with high absence rates is being developed initially with Critical Care.
- We have seen a reduction in our vacancy rate in July at 6.12%, remaining below the Trust KPI.
- Registered Nurse vacancy rates increased again for the third consecutive month to 3.02%. This equates to 23.56 WTE vacancies. There are currently 22 registered nurses moving through pre-employment checks to meet this demand plus 7 temporary staffing. The 'talent pool' process has now been set up and we have 4 student nurses currently working through this process. This will allow us to seamlessly appoint candidates as soon as vacancies become available as all pre-employment checks will have been completed.
- The unregistered nurse vacancy rate fell to the lowest on record to 5.7%, 13.38 WTE. Whilst this is a healthy picture, the current pipeline of Healthcare Support Workers is sitting at 3 plus 17 temporary staffing. A more aggressive approach to HCSW recruitment is being applied and we have a recruitment event in September to address the significant deficit in the pipeline.
- The time to hire for July was 40 days. This is the 10th consecutive month below the national KPI of 48 days. We anticipate that this figure will increase slightly as we maintain a rolling pipeline without immediate vacancies, though some flexibility here is necessary to support our long-term strategy.
- Temporary staffing: There is limited agency use across the Trust (only being used in exceptional circumstances), such as Healthcare Support Workers in Theatres. Overtime use has also declined significantly. Bank use increased in July which continues to cause pay costs to exceed budgets. Controls from managers and matrons to ensure additional duties are not being created and greater roster scrutiny should help in managing this issue.



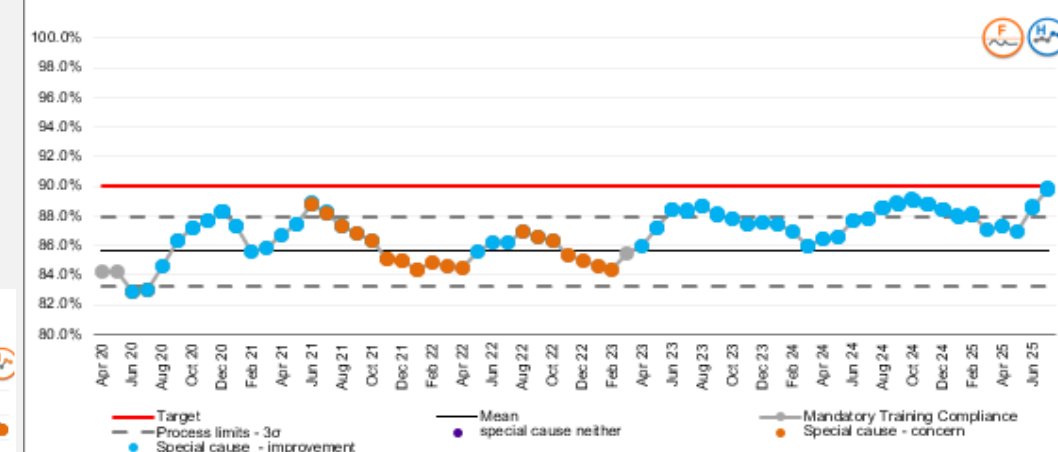
# People, Management & Culture: Key performance trends

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

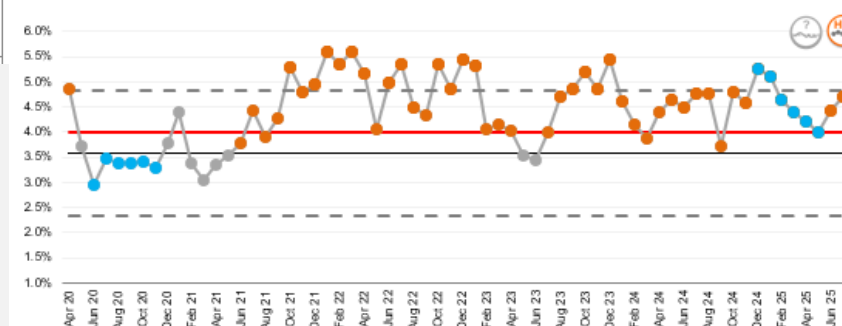
Royal Papworth-Appraisal Compliance starting 01/04/20



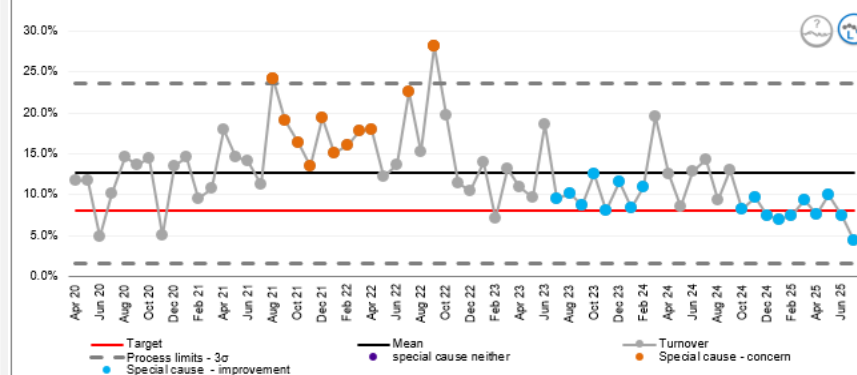
Royal Papworth-Mandatory Training Compliance starting 01/04/20



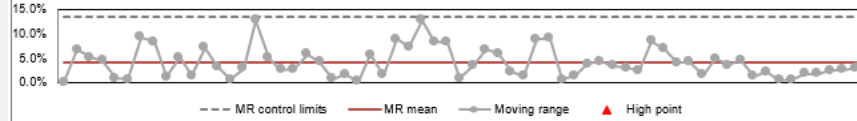
Royal Papworth-Sickness Absence starting 01/04/20



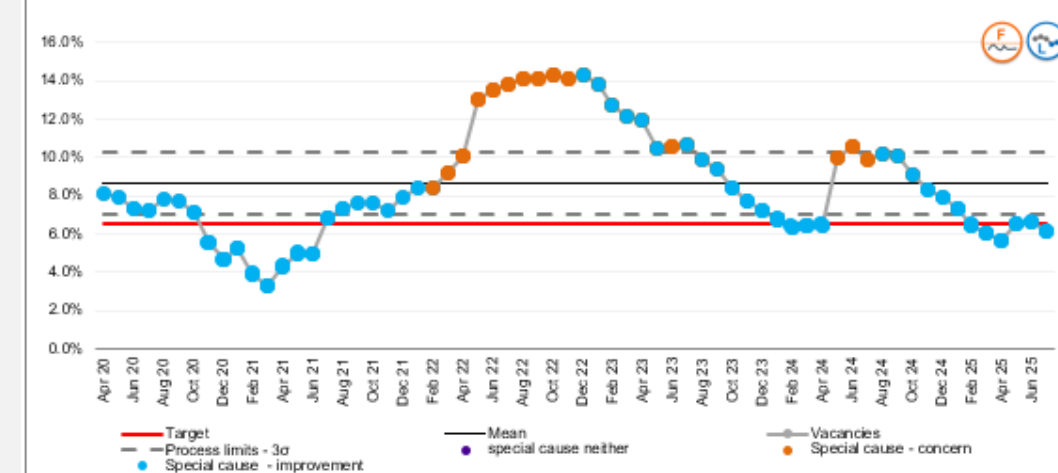
Royal Papworth-Turnover starting 01/04/20



Royal Papworth-Turnover Moving range, starting 01/04/20



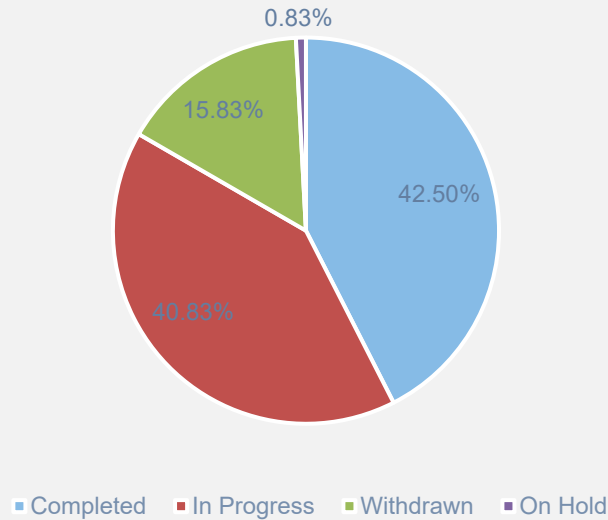
Royal Papworth-Vacancy Rate starting 01/04/20



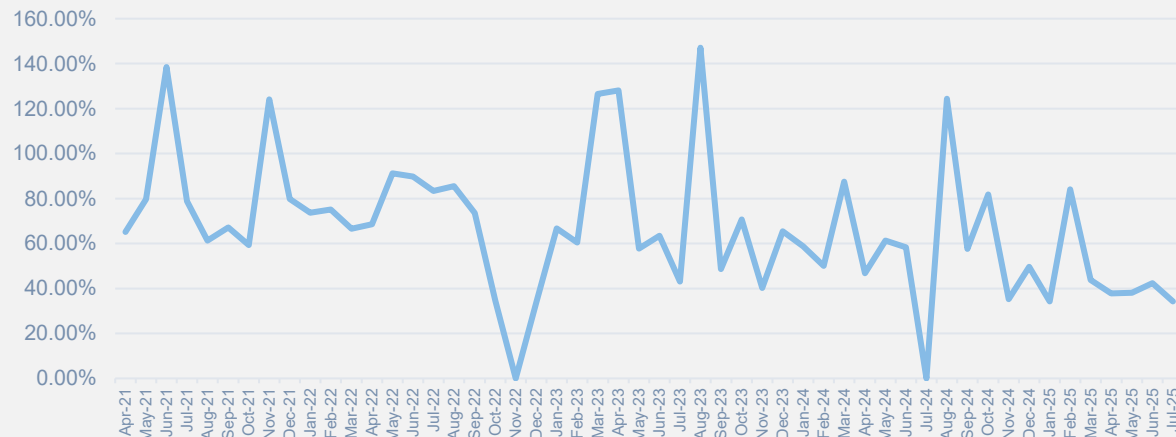




## Apprenticeships by Completion Status since Apr-22



## Levy Spend Percentage by Month - since April 2021



### What is an Apprenticeship?

An Apprenticeship is a paid job combining work with structured training which leads to a nationally recognised qualification, covering a wide range of roles clinical and non-clinical (Level 2-6). Apprenticeships also enable both new recruits and existing staff to gain skills while working. Apprenticeships typically run for between 1–5 years, from a funding perspective, Funding is through the apprenticeship levy or co-investment.

### Recent changes; Level 7 apprenticeships:

Government is stopping Level 7 (Master's level) programmes being funded through the levy. There has been agreement in August 2025, that 5 NHS professions are to receive level 7 funding, with this criteria the one applicable to RPH is Advanced Clinical Practitioner Apprenticeships 'mitigation fund' until 2029. The aim is to ensure levy funds are focused on entry-to-mid-level training, widening access rather than funding senior management qualifications. In respect of our position, this will mean reduced availability for some leadership and advanced practice pathways, requiring us to explore alternative development routes for senior staff.

### The Apprenticeship levy

The apprenticeship levy has been UK-wide government policy since April 2017, employers whose pay bill is over £3m pay 0.5% of that into the levy, these funds are stored in a digital account to pay for apprenticeship training and assessment, unused funds expire after 24 months and are returned to the Treasury. We can also transfer up to 25% of our levy funds to other organisations (e.g., partner trusts, social care providers).

### The Cost Challenge for RPH

Training costs are covered by levy funds, meaning that backfill costs (covering the apprentice's time away from normal duties) are not covered, this is the largest financial barrier to increasing apprenticeship numbers, especially in clinical areas. We pay an apprentice as 1 WTE but are required as part of apprenticeship to have 0.2WTE off the job training each week, some apprenticeships have long term placements away from the Trust.

### Government Legislation, The 10 Year Plan and Next Steps

The NHS Fit for the Future: 10 Year Health Plan emphasises overhauling the NHS workforce. It commits every staff member to a personalised development plan and "skills escalators" for clear career progression – explicitly sets out apprenticeships as a key training route. There is a notable suggested shift in recruitment toward local communities and away from overseas reliance, by increasing earn-while-you-learn routes. These ambitions aim to create an additional 2,000 additional nursing apprenticeships over 3 years, targeting areas of greatest need. These measures show apprenticeships are intended as a core part of future workforce planning. We are currently in the process of reviewing the impact of the removal of Level 7 courses and the impact on our local apprenticeship levy.



# Finance: Performance summary

Accountable Executive: Chief Finance Officer

Report Author: Deputy Chief Finance Officer

		Data Quality	Target	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Dashboard KPIs	Year to date surplus/(deficit) adjusted £000s	4	£(75)k	£1,044k	£335k	£(29)k	£(58)k	£(98)k	£(7)k
	Cash Position at month end £000s *	5	£68,408k	£76,448k	£75,314k	£79,265k	£75,114k	£77,044k	£77,248k
	Capital Expenditure YTD (BAU from System CDEL) - £000s	4	£642 YTD	£2,506k	£4,918k	£26k	£39k	£101k	£101k
	CIP – actual achievement YTD - £000s	4	£2,767k	£6,018k	£6,630k	£226k	£439k	£661k	£1,331k
	Agency expenditure target £'k	5	£157k	£305k	£243k	£188k	£179k	£128k	£52k
	Bank expenditure target £'k	5	£367k	£395k	£491k	£391k	£417k	£523k	£522k
Additional KPIs	Capital Service Ratio YTD	5	1.0	0.5	0.5	0.5	0.2	0.4	0.6
	Liquidity ratio	5	26	29	29	29	25	30	44
	Year to date EBITDA surplus/(deficit) £000s	5	Monitor only	£10,863k	£11,060k	£944k	£1,888k	£2,828k	£3,671k
	Total debt £000s	5	Monitor only	£4,090k	£6,580k	£5,400k	£4,300k	£3,500k	£4,600k
	Average Debtors days - YTD average	5	Monitor only	5	7	6	5	4	5
	Better payment practice code compliance YTD - Value £ % (Combined NHS/Non-NHS)	5	Monitor only	98%	98%	98%	98%	98%	92%
	Better payment practice code compliance YTD - Volume % (Combined NHS/Non-NHS)	5	Monitor only	97%	97%	97%	86%	90%	98%
	Elective Variable Income YTD £000s	4	£0k (YTD)	£55,178k	£58,151k	£4,927k	£10,160k	£15,621k	£21,567k
	CIP – Target identified YTD £000s	4	£9630k	£6,632k	£6,632k	£4,650k	£4,727k	£4,912k	£6,093k
	Implied workforce productivity % - compares real terms growth in pay costs from 19/20 against growth in activity from 19/20	5	Monitor only	-0.3%	5.1%	n/a	7.2%	-2.0%	-5.6%

## Summary of Performance and Key Messages:

- **At month 4, the YTD finance position is a deficit of £8k, which represents a favourable variance of £64k to plan.** This favourable variance is mainly driven by variable income over-performance within core NHS variable contracts for England which is now YTD £2m favourable and non-England commissioners. Also supporting this slight favourable variance is a favourable budget phasing of planned elective recovery initiatives and contingency reserves against spend over the period; which offsets adverse business-as-usual pay and CIP under-delivery pressures within clinical divisions.
- **Income is £3.4m favourable to plan,** primarily driven by NHS variable clinical income. The Trust has now concluded and signed all its ICB commissioner contracts for the year. Other Operating Income is £6m YTD with an over-recovery of £0.53m to budget mainly attributable to staff recharges, R&D and Charitable Income which partly offsets additional expenditure.
- **Pay expenditure is c£1.8m adverse to the YTD plan (of which c£0.4m relates to backdated pay award settlement, recovered through contract uplifts within the clinical income position).** The main drivers are staff over-establishment in clinical divisions of £1.1m, primarily within ward areas, alongside YTD non-recurrent backdated medical staff arrears payments for approved additional programme activity from the recent job planning cycle. Agency spend continues to reduce and deliver against the trajectory for reduction; however, this is offset by increases in bank and overtime spend and over recruitment of staff. A set of new guidelines have now been issued to divisional leadership teams to strengthen and monitor our current grip and control arrangements for over-established areas. The Position includes non recurrent costs for pay arrears, costs of industrial action and PSIs.
- **Operating non-pay spend is adverse to plan by £1.6m.** This has been driven by non-recurrent spend mainly high-cost implants which have associated income from commissioners within the income position. CIP under-delivery is a key driver of this adverse variance, with a year-to-month 4 shortfall of £0.5m. CIP remains a key area of focus for the Trust, with enhanced delivery support provided to divisional teams; alongside further grip and control arrangement (see CIP report).
- **Cash closed at £77.2m,** an increase of £0.2m with no significant change in working capital.
- The capital plan for the year resulted from a risk-based prioritisation process undertaken by the Medical Devices Group, Digital and Estates teams with oversight from Investment Group. Spending the EPR capital is the most significant risk (representing over 50% of the programme and profiled to be spend in Q4), and this will continue to be monitored as the Full Business Case progresses. The year-to-date capital delivery is £0.5m behind plan, driven by slippages within medical equipment and digital replacement programme.





# Finance: Key Performance – YTD SOCI position

Accountable Executive: Chief Finance Officer

Report Author: Deputy Chief Finance Officer

The YTD adjusted financial performance is £8k deficit, representing a favourable variance to plan of £64k. This position is mainly driven by variable activity and pass through income over-performance and the favourable budget phasing of planned elective recovery initiatives and contingency reserves, offsetting adverse pay pressures and CIP under-delivery.

	YTD £000's	YTD £000's	YTD £000's	YTD £000's	YTD £000's	RAG
	Plan	Underlying Actual	Other Non Recurrent Actual	Actual Total	Variance	
<b>Clinical income - in national block framework</b>						
Fixed at Tariff	£54,211	£39,722	£149	£39,871	(£14,341)	●
Balance to Fixed Payment	£0	£14,614	£0	£14,614	£14,614	●
Variable at Tariff	£19,809	£20,871	£1,041	£21,912	£2,104	●
Homecare Pharmacy Drugs	£16,527	£17,356	£0	£17,356	£829	●
High cost drugs	£203	£231	£0	£231	£29	●
Pass through Devices	£8,953	£8,016	£211	£8,227	(£726)	●
Sub-total	£99,702	£100,810	£1,401	£102,211	£2,509	●
<b>Clinical income - Outside of national block framework</b>						
Devices	£498	£652	£0	£652	£154	●
Other clinical income	£592	£922	£0	£922	£330	●
Private patients	£3,448	£3,405	£0	£3,405	(£43)	●
Sub-total	£4,538	£4,979	£0	£4,979	£440	●
<b>Total clinical income</b>	<b>£104,241</b>	<b>£105,789</b>	<b>£1,401</b>	<b>£107,190</b>	<b>£2,949</b>	●
<b>Other operating income</b>						
Other operating income	£5,394	£5,708	£250	£5,958	£564	●
<b>Total operating income</b>	<b>£5,394</b>	<b>£5,708</b>	<b>£250</b>	<b>£5,958</b>	<b>£564</b>	●
<b>Total income</b>	<b>£109,635</b>	<b>£111,497</b>	<b>£1,651</b>	<b>£113,148</b>	<b>£3,513</b>	●
<b>Pay expenditure</b>						
Substantive	(£50,257)	(£50,834)	(£616)	(£51,450)	(£1,193)	●
Bank	(£835)	(£1,741)	£0	(£1,741)	(£906)	●
Agency	(£882)	(£547)	£0	(£547)	£335	●
Sub-total	(£51,974)	(£53,122)	(£616)	(£53,738)	(£1,764)	●
<b>Non-pay expenditure</b>						
Clinical supplies	(£20,842)	(£21,582)	(£538)	(£22,121)	(£1,278)	●
Drugs	(£2,815)	(£2,336)	£0	(£2,336)	£480	●
Homecare Pharmacy Drugs	(£16,527)	(£17,319)	£0	(£17,319)	(£792)	●
Non-clinical supplies	(£13,734)	(£14,997)	£1,032	(£13,965)	(£231)	●
Depreciation	(£3,660)	(£3,569)	£0	(£3,569)	£91	●
Sub-total	(£57,579)	(£59,803)	£494	(£59,309)	(£1,730)	●
<b>Total operating expenditure</b>	<b>(£109,552)</b>	<b>(£112,924)</b>	<b>(£122)</b>	<b>(£113,046)</b>	<b>(£3,494)</b>	●
<b>Finance costs</b>						
Finance income	£1,278	£1,144	£0	£1,144	(£134)	●
Finance costs	(£2,070)	(£1,908)	£0	(£1,908)	£161	●
PDC dividend	(£793)	(£792)	£0	(£792)	£1	●
Revaluations/(Impairments)	£0	£0	£0	£0	£0	●
Gains/(losses) on disposals	£0	£0	£0	£0	£0	●
Sub-total	(£1,585)	(£1,557)	£0	(£1,557)	£28	●
<b>Surplus/(Deficit) For The Period/Year</b>	<b>(£1,502)</b>	<b>(£2,984)</b>	<b>£1,529</b>	<b>(£1,455)</b>	<b>£47</b>	●
<b>Adjusted financial performance surplus/(deficit)</b>	<b>(£75)</b>	<b>(£2,827)</b>	<b>£1,529</b>	<b>(£8)</b>	<b>£67</b>	●

## YTD month headlines:

### 1 Clinical income is c£2.9m favourable YTD.

- Fixed activity (non-elective spells and outpatient follow ups) when priced on tariff basis is £14.3m under the total fixed payment value. Variable income is favourable to plan by c£2.1m and reflects c123% performance against 2019/20 baseline.

### 2 Other Operating Income is c£0.6m favourable to plan

- Other Operating Income is £6m YTD with an over-recovery of £0.5m to budget mainly due to staff recharges, R&D and Charitable Income surpluses to budget which partly offsets additional expenditure.

### 3 Pay expenditure is £1.8m adverse to plan. Ongoing pay pressures driven by over-establishment on ward areas is being actively managed through recently implemented enhance control on temporary staffing booking. The expected benefit from this further grip and control will be monitored weekly for effectiveness. The position includes unachieved CIP, PSI cost offset in income, pay arrears and pay-award which is offset in the income position.

- Agency spend reduction - sustained delivery against planned trajectory at Trust level, continues over the period, with variations within areas being subject to further scrutiny through divisional PRMs.

### 4 Clinical supplies is c£1.3m adverse to plan. This is driven by activity costs as reflected in the income position.

- Drugs including Homecare is in line with plan overall, within which, homecare pharmacy overspend is offset within the income position.

### 5 Non-clinical Supplies is £0.2m adverse to plan. The underlying overspend which includes CIP underachievement, overspend on professional fees, premises costs and establishment costs, including printing and stationery, is offset by unwinding of unused provisions and contingency reserves phasing benefits.