Royal Papworth Hospital NHS Foundation Trust

# Performance Committee

**Held on 29 August 2024**
**0900-1100hrs via MS Teams**
**Chair: Gavin Robert, Non-Executive Director**

## MINUTES

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| **Present** | | |
| Ms C Conquest | CC | Non-Executive Director |
| Dr C Paddison | CP | Associate Non-Executive Director |
| Mrs S Harrison | SH | Chief Finance Officer (Interim) |
| Mrs E Midlane | EM | Chief Executive |
| Mr A Raynes | AR | Chief Information Officer |
| Mr G Robert | GR | Non-Executive Director (Chair) |
| Mrs M Screaton | MS | Chief Nurse |
| Dr I Smith | IS | Medical Director |
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| **In Attendance** | | |
| Mr T Collins | TC | Public Governor, Observer |
| Mr B Davidson | BD | Public Governor, Observer |
| Miss R Hall | RH | Executive Support (minute-taker) |
| Mrs L Howard-Jones | LHJ | Deputy Director of Workforce & OD |
| Mr K Mensa-Bonsu | KMB | Associate Director of Corporate Governance |
| Mrs W Walker | WW | Deputy Chief Operating Officer |
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| **Apologies** | | |
| Mr H McEnroe | HMc | Chief Operating Officer |
| Ms O Monkhouse | OM | Director of Workforce and Organisational Development |

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

| Agenda item | | Action by whom | Date |
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| **1.** | **WELCOME, APOLOGIES, AND OPENING REMARKS** | | |
| 24/196 | The chair welcomed all to the meeting and apologies were noted. | | |
| **2.** | **DECLARATIONS OF INTEREST** | | |
| 24/197 | There is a requirement that Board members raise any specific declarations if these arise during discussions. No specific conflicts were identified in relation to matters on the agenda. A summary of standing declarations of interests are appended to these minutes. | | |
| **3.** | **MINUTES FROM PREVIOUS MEETING (25 JULY 2024)** | | |
| 24/198 | **Approved:** The Performance Committee approved the minutes from the 25 July 2024 meeting and authorised for signature by the Chair as a true record. | | |

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| **4. 1** | **TIME PLAN FOR TODAY'S AGENDA ITEMS** | | |
| 24/199 | Agreed to take the items as per the agenda order. | | |
| **4. 2** | **ACTION CHECKLIST** | | |
| | The Committee review the action checklist and updates were noted-<br>• GR asked if a Chair's report would be required for the Trust Board meeting next week. KMB replied that it would as there is a Part 1 scheduled for the 05 September.<br>• CC agreed to deliver the report in GR's absence.<br><br>**24/158**- PIPR General.<br>• SH updated that this action was created as it was not possible to see why the effective response rating was red. Now shown in current PIPR.<br><br>**24/179**- Cost Improvement Plans M03 2024/25<br>• Action will be dealt with next month<br><br>**24/183**- PIPR: Safe: Cancer Referrals<br>MS gave a verbal update-<br>• There is a robust mechanism around harm caused to patients by a delay in the cancer pathway. MS is assured the correct protections are in place and a review was undertaken by the Quality and Risk Committee last month. Any incidents where harm is caused will be discussed by SIERP ( Serious Incident Executive Review Panel).<br><br>**24/185**- PIPR: Effective: TAVI Graph<br>• WW said that the orange line on the graph is a 'do nothing' line and she will pick up later under the TAVI update.<br><br>**24/185**- PIPR- Effective<br>• CC raised that, when issues such as this are discussed offline, it would be helpful to minute that the person asking the question was given sufficient assurance. MS agreed, there was email communication between herself, IS, and CP that they would discuss the issue further.<br>• CP was happy with the response she had received from MS and the invitation to discuss further.<br><br>**24/186**- PIPR: Responsive: CT Backlog Reporting<br>• WW said that, since the last report, a significant amount of work had been undertaken, which will be picked up in more detail by the PIPR update.<br>• GR queried why this action is for Board. It should be an update to this group. EM said it was an action between this Committee and the Board.<br><br>**24/190**- Corporate Risk Register<br>• MS said that the queries had been noted and it would come back to this group in October. | | |

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| **5.** | **DIVISIONAL PRESENTATION** | | |
| 24/201 | Deferred to 26 September 2024. | | |
| **6.** | **REVIEW OF THE BAF** | | |
| 24/202 | **Received:** a summary of the BAF risks and mitigations in place for risk above target. A copy of the BAF tracker report was attached.<br><br>**Reported:** KMB summarised the changes.<br><br>**Key items:**<br>• Risk 1021- the risk of potential major organisational disruption of a cyber-attack has been increased from a 16 to 20. The consequence has been raised from 4 to 5. The risk has come here for review and approval.<br>• WW will update on the progress made with the CT backlog following the implementation of mitigations.<br>• Risk 2829- there has been a significant update on the assurance gap.<br>• Risk 2904- the gap in assurance has been updated.<br>• There have been no changes to the other risk ratings.<br><br>**Discussion:**<br>• EM asked for assurance on why the consequences of a cyber-attack had been increased, and what had deteriorated the team's confidence to make this change. AR replied that the increase in attacks was a national concern; it reflects the vulnerability of the cyber landscape. The consequence has been raised proportionally to the increasing risk posed.<br>• CC said, at the last meeting she felt the risk needed to be raised to reflect the devastating consequences posed by a cyber-attack. AR agreed and had raised the risk. There is an action plan in place to mitigate the potential damage, with the knowledge that there cannot be full assurance that an attack will never happen here.<br>• EM agreed, it is not a question of 'if', but rather 'when'. The impacts need to be mitigated against effectively and robustly.<br>• GR asked for assurance that measures would be put in place to lower the consequence to 4 in the future. 5 indicates that the Trust would be unable to handle the impact of an attack. AR replied that the damage is dependent on the type of attack. He does not want to mislead members into thinking there is better protection than there is. The Trust has an aging estate and requires updates. The evaluation is a fair reflection of where the Trust currently sits.<br>• CP asked when a timeline of the 24-month recovery plan for Risk 678 would come to the Board. WW replied that she would look into this and feed back to CP as it may be an old reference.<br>• GR said that the RTT risk has not come down to target level which is not a surprise as it is a long term risk. | WW | 26.09.24 |
| **7. 1** | **FINANCIAL REPORT- MONTH 4 24/25** | | |
| 24/203 | **Received:** Financial report from M04 2024/25 | | |

**Reported**- SH

**Key highlights**:

- Month 04, the year to date surplus is £700,000
- Continuing to see overperformance and a step change above planned activity levels, for both flow and elective.
- The question of using central items and reserves set aside as contingency on the management of strategic projects and additional investments is a timing piece and they are planning through the position.
- While there have been green shoots in the temporary staffing position, it continues to be an area of focus. Tighter controls for approval by Execs and oversight over agency spending will have an impact and bring down the costs in the long term.
- This position includes the cost for the pay award; however it does not include the additional funding as the national team have not yet provided this information. This is expected in September.
- Cash remains solid, at £77 million, this is a slight increase from last month.
- Capital is spending against the plan. We are slightly behind what was expected, due to the additional allocation coming through the system. This is not a risk at this stage and is being monitored by the Investment Group.
- The pay position is turbulent. The pay deal for Agenda for Change staff should reduce the risk of future strikes, however there is always a risk of Industrial Action (IA).
- The ICS is in a £10.4 million deficit, £8 million adverse to the system plan. £2 million is due to the impact of IA. The cost of IA is likely to be covered, but the loss of activity will need to be swallowed.
- CPFT is in a £5 million deficit and poses a risk to system delivery.
- CFOs have a workshop to focus on 24/25 recovery. There is an understanding that if RPH can help the system then is likely to be support for the adoption of the EPR.
- SH plans to update the BAF risk before the next Committee cycle to highlight the growing risk in the system

**Discussion:**

- CC raised concern for how the system's position will impact RPH. She asked what risk it poses to breaking even at the end of the year. SH replied that the risk to Papworth not breaking even is low. We are maintaining our underlying surplus position.
- EM said that the risk will be to the system as a whole from an oversight perspective, being put into a Tier 1 for Finance would distract the Trust from its strategy development.
- SH said that it would impact the capacity of the whole system, regardless of our individual position, as RPH would lose elements of control and autonomy.
- GR asked SH to identify the green shoots in temporary staffing. SH replied that the agency and bank spending had stabilised, compared to the upward trend they saw last quarter.

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| | • GR asked if this was specific to Cardiology. SH said that Cardiology was an example of the promising work, they have conducted a deep dive and are clear on next steps. Lessons learned will be shared across other divisions. Good rostering practice is key. The changes will start showing an impact in October.<br>• MS said that she had met with STA leads, where this was a big focus. They were taking the learning from Cardiology. A roster charter has been developed for areas, providing a framework for those in charge of shifts to make these decisions.<br><br>**Noted:** the Performance Committee noted the financial position.<br><br><u>Private Patients</u><br>• GR asked whether progress has been made in addressing the large variability in profit between consultants arising from private patients. SH replied that new leadership capacity in private care will be coming online within the next 6 months. A piece on consultant engagement will be developed once this post is in place.<br>• GR asked if this ties in with strategic private patient capacity. SH replied that it does.<br>• GR asked if there is a timeline for when they want to see uplifts in pay rates from Bupa and Aviva. SH replied that negotiations are ongoing, however, there is no timeline yet. She hopes to provide more clarity next month. | | |
| **7. 2** | **A BRIDGE TO EXCELLENCE (CIP) REPORT: MONTH 4 24/25** | | |
| 24/204 | **Received**: An update report to Month 04 2024/25<br><br>**Reported**: SH<br><br>**Discussed**: as per discussions under Financial Report<br><br>**Key points**:<br>• A deep dive into recurrent and non-recurrent split has been undertaken and will be brought to the Committee next month.<br>• CIP planning for next year has started, highlighting the capacity of the teams with the new EPR and other projects. These items are less transactional, harder to obtain and so consuming more time.<br>• Cardiology have shown progress on their pipeline of schemes. SH has been working with them and has assurance, which will be fed into next month's report.<br><br>**Noted**: the Performance Committee noted the update on CIP for M04 24/25. | | |
| **7. 3** | **INVESTMENT GROUP- CHAIR'S REPORT** | | |
| 24/205 | **Received**: Chair's update summarising the meeting held 05 August 2024.<br><br>**Reported**: SH<br><br>**Discussed**: the report was taken as read and noted. | | |

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| | **Noted**: The Performance Committee noted the update from the Investment Group | | |
| **8.** | **PAPWORTH INTEGRATED PERFORMANCE REPORT** | | |
| 24/206 | **Received**: PIPR for M04 2024/2025<br><br>**Reported**: SH<br><br>**Key points**:<br>• Overall performance has moved from Red to Amber<br>• Finance has moved from Amber to Green<br>• Safe has moved from Red to Amber.<br><br>The month experienced the tail end of the industrial action that tipped over into July and so plays into some of the metrics for M04.<br><br>**Discussion**: each sector was noted below.<br><br><u>Safe</u> (Amber) MS<br>• MS noted the recent CPE outbreak, which remains under control. There have been no new cases since the 22nd of July.<br>• 32 cases were originally confirmed; however the number has since dropped to 31 following testing.<br>• They are continuing with the infection control measures in place but have pulled back on the enhanced cleaning.<br>• The area on PIPR flagging red is the ward supervisory sister/charge nurse time. Heads of Nursing have been asked to do a deep dive into their divisions.<br><br><u>Caring</u> (Green) MS<br>• No items raised.<br><br><u>Effective</u> (Red) WW<br>• Reflective of the CPE outbreak and the end of the period of industrial action.<br>• The outbreak gave an opportunity to focus on treating patients who were already in the hospital.<br>• Theatre utilisation has improved, helped by the new ERU beds, and are on track to increase to 10 by September.<br>• There is increased activity in outpatients, day patients and flow.<br>• GR asked what the reference to 'structural services' meant. IS said that it is used when referring to Patent Foramen Ovale (PFO,) which is a hole in the heart and so a structural issue. It is not an emergency procedure and is often the first thing to be delayed. The Trust has one operator at the moment, which is contributing to long waits for patients. WW replied that there are a large number of PFO cases waiting over 52 weeks. They are working with the lead consultant to increase capacity and reduce the wait.<br>• There has been good progress overall on the CT reporting backlog. Included in the report are the number of scans done by external and | | |

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| | internal reporters. The report is shared on a weekly basis with the Executive Directors (EDs).<br>• GR queried the sustainability of improvements given the dependence on in-sourcing.<br>• WW said that there are between 3-4 reporting shifts undertaken every weekend. Shifts over the weekend are more productive because they are undisturbed. They rely on a mix of substantive and in-sourcing to clear the backlog.<br>• They have recruited 1 consultant in the last month and have gone out to advertise for a new radiologist.<br>• GR asked how long the current arrangements will continue for. WW replied that this was planned to run until March, however she expects they will not require the contract beyond February as they are ahead of the trajectory.<br>• SH said that the in-sourcing arrangement is running until the end of January based on current improvements. They will re-assess in September to determine when it can be stopped. She is keen to see what a sustainable position will look like.<br>• GR asked when the longer term plan will come back to the Committee. WW said that the October meeting would be reasonable.<br>• CC said the number of patients waiting for CT based on PTL was not consistent with the other factors. WW replied that the graph element does not reflect the current or expected position. PTL is stable and sits between 1027 and 1082 patients, so it is within the expected range.<br>• GR asked if they are expecting this number of patients to reduce. WW replied that they are not.<br>• IS said that the issue is with the delay in reporting of these scans, rather than the number of patients on the list. They have reached their target of scanning 90% of patients in the expected amount of time.<br>• AR said that digital support had been made readily available to support the teams in the imaging space and ensuring they feel comfortable with the technology. Work has been done to ensure all the Gold PAC machines work and look the same and have been testing VDI (Virtual Desktop Infrastructure) so radiologists can work from home. In July, Brainomics was introduced, using AI to look for possible signs of stroke.<br>• BD asked whether harm reviews were done for late referrals to pathways other than the cancer one. MS replied that they were, to an extent. There is admin support looking back on all patients waiting beyond 40 weeks. There are systems in place to support teams to develop and they have shown keenness to progress. If a patient deteriorates rapidly on any pathway, there is quick access to services to treat them.<br>• GR asked what specific plans were in place to deal with long waiters. WW replied that they are developing a plan to undertake Patient Safety Indicators (PSIs ) to reduce the long waits, as well as the TAVI work and PFO structure list. She expects this to be finalised in the next few weeks, with a focus on surgical electives and outpatient appointments to allow patients onto pathways earlier. | **HMc** | **31.10.24** |

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| | • There is a still a stream of late referrals to the Trust, particularly from NWAFT. These are picked up in weekly meetings and fed back to colleagues who are referring to us.<br>• IS said that some of the long wait is caused by particular surgeons. It has been agreed that these surgeons will stop taking new patients until they have managed their lists, and some of the long waiters will be distributed to other surgeons. They have asked referrers to refer to the Trust generally, rather than to particular surgeons. This work has contributed to a decline in the number of long waiters.<br><br><u>Responsive</u> (Red) WW<br>• Month 4 was impacted by the tail end of the Industrial Action, continued late deferrals from DGH's, and the CPE outbreak. These combined impacted on the ability to treat electives and RTT performance.<br>• The (Patient Tracking List) PTL continued to be reviewed regularly and there are weekly meetings, led by HM, focusing on reducing the over-40 week waits.<br><br><u>People Management and Culture</u> (Red) LHJ<br>• There are no specific issues to raise.<br>• Temporary staffing usage has decreased, which is encouraging following the work they have done on this.<br>• Retention is now a key focus since recruitment has improved.<br>• CP asked if there is a plan in place for the deep dive into long term sickness absence in Bands 2 and 3. LHJ replied that a deep dive is expected at the Senior Workforce Team in mid-September. If they have sufficient material, they intend for it to come to the Workforce Committee in September.<br>• CP asked for more insight on the reason why there was an 'unknown cause' for illnesses selection on Healthroster. LHJ replied that they are working to have this removed as a category.<br><br>**Noted**: the Performance Committee noted the contents of the report. | | |
| **9.** | **OPERATIONAL REPORTS** | | |
| **9. 1** | **ELECTIVE CARE PRIORITIES 23/24 (QUARTERLY UPDATE)** | | |
| 24/207 | **Received**: Quarterly update on the elective care priorities for 23/24.<br><br>**Reported**: WW<br><br>**Discussed**:<br>• Zoe Robinson is leading on this project, which feeds into the outpatient workstream.<br>• The project team have met, agreed the scope of the project and the first key action is to understand the capabilities of existing systems available within the Trust and whether they meet the requirements. The team are keen to learn from other Trusts that have implemented these systems, to scope the impact on relevant teams if implemented.<br>• Two providers are currently being explored; DrDoctor and PatientAide. | | |

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| | • A quality impact assessment will be undertaken to assess the impact and review staff capacity. This will form part of the ATIR seeking approval for investment.<br>• The team will develop an options appraisal for system providers being considered by the Outpatients Transformational Board and Patient Flow Steering Group. This is expected to be completed for the Steering Group meeting in October.<br><br>**Noted**: the Performance Committee noted the content of this report. | | |
| **9. 2** | **PATIENT FLOW IMPROVEMENT PROGRAMME (BI-MONTHLY UPDATE)** | | |
| 24/208 | **Received**: Bi-monthly update on the patient flow improvement programme, utilising metrics and narrative to highlight process, areas of focus, and next steps.<br><br>**Reported**: WW<br><br>**Discussed**:<br>• A significant amount of work has gone into this programme and the paper. There has been good engagement and ownership from key stakeholders supported by ongoing refinement of supporting datasets and reporting capabilities.<br>• They are starting to see progress in terms of impact; however, it will take time to see proper results.<br>• Task and Finish Groups have been set up to focus on areas which are not seeing the expected rate of improvement, such as the Transport Task and Finish Group, the Discharge Lounge Task and Finish Group, and the Digital Validation Project.<br>• Current performance indicates an ongoing trend towards the target of 900 discharges per month.<br>• STA's collaboration with CUH is on track to launch the first cohort of patients through CUH's Virtual Ward in September 2024.<br>• The ERU has increased its bed base from 5 to 7, with the intention to extend to 10 beds by September. 90% of patients are discharged from the ERU within the 48 hour target. Patients that exceed this often have complex issues.<br>• In house urgent performance remains challenged, with the pathway under significant pressure.<br>• HM identified a new project after it was highlighted that there are concerns with the variation in the organisation's referral management processes and the inherent risk of how we are managing inbound referrals from primary, secondary, and internal referral bases. The aim of this review is to move to a standard route, via a central management process. A meeting has been scheduled on the 19 September to discuss next steps.<br><br>**Noted**: the Performance Committee noted the content of this report. | | |
| **9. 3** | **PRODUCTIVITY- DISCUSSION PAPER** | | |
| 24/209 | **Received**: Productivity discussion paper- for information<br><br>**Reported**: SH | | |

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| | **Discussed**:<br>• The purpose of this paper is to brief Performance Committee on the productivity metrics and tools released by NHS and the Trust's response and actions.<br>• Productivity from 2023/24 from the acute sector data indicates that it is around 15% lower than it was pre-pandemic. This means that growth in expenditure and in the workforce has not been matched by growth in activity levels.<br>• The headline productivity metric puts the Trust at a declining productivity of -27%. There are 2 material technical accounting changes that have been escalated to NHSE that materially impact this calculation: homecare drugs and high cost pass-through devices visible cost model.<br>• This information does not come as a surprise. The information is being fed down into divisions, getting them familiar with the metrics and planning for next year.<br>• GR said it was alarming to be in the lowest quartile for productivity. He asked if stripping out the two elements would raise the Trust from this position. SH said that these elements are out of the Trust's control and the decision not to include them has been recognised by the national and regional teams.<br>• GR asked if everyone has received this chart with RPH at the bottom. SH replied that she is trying to get NHS England to change this.<br>• CP asked for an explanation for the 8% gap between RPH and Liverpool Heart and Chest. SH replied that we have a greater proportion of home care drug costs, which has contributed to a material change of £45-50 million. This is something Liverpool does not have.<br>• GR referenced to Appendix 2, highlighting that we are in a better position for the workforce productivity metric. SH replied that she was pleased we are at a similar level to Liverpool H&C for this metric, and this aligns with the internal work going on. The Trust is focusing on the right things, such as reducing the premium costs of temporary staffing and agency.<br>• CC asked why NHS England had changed their minds on including high cost devices. SH said that these were previously not recorded in the books, but now are to help Trusts understand the true costs of individual procedures, enabling more accurate benchmarking and tie Trusts to supplier negotiations.<br><br>**Noted**: the Performance Committee noted the national metrics on productivity as supplementary to the internal work. | | |
| **10.** | **QUARTERLY UPDATE REPORTS** | | |
| **10. 1** | **CYBER RISK (INCORPORATING BUSINESS CONTINUITY PLANNING)** | | |
| 24/210 | This is reported under a separate part 2 confidential minute. | | |
| **11.** | **ANNUAL/AD HOC REPORTS** | | |
| **11. 1** | **MEDIUM TERM FINANCIAL PLANNING** | | |
| 24/211 | **Received:** the Medium Term Financial Planning paper. | | |

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| | **Reported**: SH<br><br>**Discussed**:<br>• The Trust undertakes regular updates to its long term financial projections to understand the shape of the next 3-5 years and the actions the Trust could take to support mitigations over the medium term to secure a sustainable financial position that supports ongoing delivery of the Trust's strategic objectives.<br>• Next steps involve the ongoing work across the ICS to refine assumptions for the medium term plan and ensure a clear narrative for the regional team and refining the EPR case ahead of OBC sign off, which will be translated into the medium term projection.<br>• SH said an updated medium term projection will be brought to the October Performance Committee, alongside detail of the recovery initiatives, actions underway, and the work that will be undertaken as part of the 25/26 planning to quantify further productivity gains.<br>• The Trust will be required to show a case that closes the affordability gap when going out for procurement, whilst maintaining the case for national funding. They will pitch a submission at a small deficit.<br>• GR agreed to park this discussion for now, making more time to discuss it at the October meeting.<br><br>**Noted**: the Performance Committee noted the approach to the medium term projection development, the approach of the ICS medium term financial projection submission and the next steps. | | |
| **12.** | **POLICY APPROVAL** | | |
| 24/212 | No items to review | | |
| **13.** | **ISSUES FOR ESCALATION TO/FROM OTHER COMMITTEES** | | |
| 24/213 | No items raised. | | |
| **14. 1** | **COMMITTEE FORWARD PLANNER- REVIEW** | | |
| 24/214 | **Received**: The updated Forward Planner<br><br>**Reported**: KMB<br><br>**Discussed**: The planner was taken as read.<br><br>**Noted**: the Performance Committee noted the Forward Planner | | |
| **14. 2** | **REVIEW OF MEETING AGEND AND OBJECTIVES** | | |
| 24/215 | Objectives and discussions were appropriate. | | |
| **14. 3** | **BAF: END OF MEETING WRAP UP** | | |
| 24/216 | • SH highlighted the financial risk within the system, which will be reflected in the BAF next month.<br>• GR asked if this was a system risk, or a risk with an impact on RPH. SH replied that it will be a risk to the hospital, considering whether the financial risk for us has increased. | | |

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| | • SH explained that the risk if the ICS does not achieve a financial balance by the end of the year will impact RPH, making us subject to regulatory action and limiting our ability as a centre to provide sustainable services. | | |
| **14. 4** | **EMERGING RISKS** | | |
| 24/217 | None raised. | | |
| **15.** | **ANY OTHER BUSINESS** | | |
| 24/218 | **Next meeting**: 26 September, Rooms 88+89 HLRI F2F | | |

| **2024** | **Time** | **Venue** | **Divisional Presentation** | **Apols rec'd** |
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| 25 January | 0900-1100hrs | MS Teams | | |
| 29 February | 0845-1045hrs | HLRI Rooms 88 + 89 / **face-to-face** | **CCA** | |
| 28 March | 0900-1100hrs | MS Teams | | |
| 25 April | 0900-1100hrs | MS Teams | **THORACIC** | |
| 30 May | 0900-1100hrs | MS Teams | | T Collins |
| 29 June | 0900-1100hrs | MS Teams | **CANCER*** | |
| 25 July | 0900-1100hrs | MS Teams | **CANCER*** | G Robert |
| 29 August | 0900-1100hrs | MS Teams | | |
| 26 September | 0900-1100hrs | HLRI Rooms 88 + 89 / **face-to-face** | **TBC** | |
| 31 October | 0900-1100hrs | MS Teams | | |
| 28 November | 0900-1100hrs | MS Teams | **STA** | |
| 19 December | 0900-1100hrs | MS Teams | | |
| 30 January 2025 | 0900-1100hrs | MS Teams | **AHPs** | |
| 27 February 2025 | 0900-1100hrs | MS Teams | | |
| 27 March 2025 | 0900-1100hrs | MS Teams | **PHARMACY** | |
| 25 April 2025 | 0900-1100hrs | MS Teams | | |
| 29 May 2025 | 0900-1100hrs | MS Teams | **RADIOLOGY** | |

The meeting finished at 10.57 hrs.


Date: 26 September 2024



**Abbreviations and Acronyms**

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| ATIR | Authority to Invest Request |
| BAF | Board Assurance Framework |
| CCA | Critical Care Area |
| CIP | Cost Improvement Programme |
| CUH | Cambridge University Hospitals NHS |

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| EVH | Endoscopic Vein Harvesting |
| IA | Industrial Action |
| ICB | Integrated Care Board |
| ICS | Integrated Care System |
| IHU | In-House Urgent |
| NED | Non-executive Director |
| PIPR | Papworth Integrated Performance Report |
| Q&R | Quality & Risk Committee |
| RPH | Royal Papworth Hospital |
| RSSC | Respiratory Support and Sleep Centre |
| RTT | Referral to Treatment |
| STA | Surgery, Transplant, Anaesthetics Division |
| TAVI | Transcatheter Aortic Valve Implantation |
| 52WW | 52 week wait |