Royal Papworth Hospital
NHS Foundation Trust

Meeting of the Performance Committee
Held on 27 January 2022
0900-1030hrs via MS Teams

[Chair: Gavin Robert, Non-executive Director]

M I N U T E S

Present		
Mr G Robert (Chair)	GA	Non-executive Director
Mrs C Conquest	CC	Non-executive Director
Ms D Leacock	DL	Associate Non-executive Director
Mr T Glenn	TG	Chief Finance & Commercial Officer
Dr R Hall	RH	Medical Director
Mrs E Midlane	EM	Chief Operating Officer
Ms O Monkhouse	OM	Director of Workforce & Organisational Development
Mr S Posey	SP	Chief Executive
Mr A Raynes	AR	Director of Digital (& Chief Information Officer)
Mrs M Screaton	MS	Chief Nurse
In Attendance		
Ms S Bullivant	SB	Public Governor, Observer
Mrs A Colling	AC	Executive Assistant (Minutes)
Ms A Halstead	AH	Public Governor, Observer
Mrs A Jarvis	AJ	Trust Secretary
Mr C Panes	CP	Deputy Chief Finance Officer
Apologies		
Mr A Selby	AS	Director of Estates & Facilities
Dr I Smith	IS	Deputy Medical Director

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

Agenda Item		Action by Whom	Date
1	**WELCOME, APOLOGIES AND OPENING REMARKS**		
22/01	The Chair welcomed all to the meeting. Apologies were noted as above.		
2	**DECLARATIONS OF INTEREST**		
22/02	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. CC declared a new interest that she is undertaking some paid consultancy work for the Private Patient Unit at Great Ormond Street Hospital. This started on the 5 January 2022. This has been added to the main Trust register.		

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	DL advised that her daughter works for KPMG, who are employed as the Trust's External Auditors. This has been added to the main Trust register.		
3	**MINUTES OF THE PREVIOUS MEETING – 25 November 2022 Part 1 and Part 2**		
22/03	There were some small amendments which were noted. **Approved**: The Performance Committee approved the Part 1 and Part 2 Minutes of the meeting held on 25 November and authorised these for signature the Chair as a true record.		27.01.22
4.1	**TIME PLAN OF TODAY'S AGENDA ITEMS**		
22/04	Due to Covid-19 priorities, some items had been deferred and the meeting shortened to 1.5 hours. SP outlined the regional headlines, which gives context to our performance reporting. ICU admissions continue to reduce. Staff absence also continues to reduce in the region, apart from Cambs & Peterborough, which is currently an outlier. With the reduction in Omicron hospital admissions, RPH is looking to the management of planned care activity. [0905rs AH arrived] At RPH the management of staff absence is key and there is a strong focus on staff wellbeing and welfare. All services should be delivered with this focus at the forefront; this is a balancing act between patients and staff. The Government's current mandatory vaccination for NHS staff rule is being sensitively managed at RPH; there are eight members of staff in this cohort (confirmed as no doctors or nurses). Numbers across the C&P region are 5900. [0908hrs OM joined] CC asked if we could share our best practice of vaccine uptake with C&P? SP advised that there are regular System calls where practices are shared. It was suggested that the Trust's early conversations with staff around this has helped inform staff and keep non-vaccination numbers low. OM acknowledged the help of Digital Team in accessing national data to support this work. OM confirmed previous reports that up to 3% of RPH staff were non-vaccinated included those where RPH did not yet have confirmed data on their vaccination status. Further work has been able to reduce those numbers to just eight, where conversations are ongoing.		
4.2	**ACTION CHECKLIST / MATTERS ARISING**		
22/05	The Committee reviewed the Action Checklist and updates were noted.		
IN YEAR PERFORMANCE & PROJECTIONS			
5	**DIVISIONAL PRESENTATION - Respiratory**		
	Due to Covid-19 priorities, this was deferred to the March meeting.		

Agenda Item		Action by Whom	Date
6	**REVIEW OF THE BAF**		
22/06	This report was introduced by AJ and taken as read. Conversations are ongoing about risk appetite alongside work on the Risk Maturity Audit recommendations. There is a significant variation in risk appetite and how it is assessed; this is under review and will show in next month's reports. Some increases in risk were noted on the risk tracker. The Committee discussed bringing in the 'three lines of defence' process and a grading system for risks. This will be assurance mapped and brought quarterly to Committee. CC referred to the increase in Cyber Risk (ref. 1021) and was surprised not to see an update on progress on the register. AR advised that this was a timing issue which was why it was not shown in the report. He assured the Committee that it is very high on the Digital agenda and is also being reported to the next Audit Committee. DL noted that timing issues with reporting had previously been flagged by Digital; could timings be adjusted to ensure all reporting falls in line, giving better assurance to the Committee. AR will take this away and check with his team. CC referred to Risk 2985 Supplier Shortage and asked if this was having any adverse effect on medical supplies. TG explained that the Trust uses NHS Supply Chain for most of its procurements and there are no items currently being flagged as a supply concern. GR queried whether introducing the concept of target risk rating in addition to risk appetite might over-complicate the analysis given the often thin distinction between them in practice. SP valued the conversations on BAF and agreed with GR; he suggested using the narrative rather than introducing new metrics. AJ added that MB, as Chair of Q&R, had also suggested further discussion on BAF reporting; to align this thinking, it was suggested that all Committee discussions will be brought to the next Board development meeting in March. GR thanked AJ for attaching the BAF policy but queried some aspects. AJ will take away to review and would be happy to discuss with GR before the next Board meeting. GR noted the increase in CIP risk (from 8 to 12) and will take discussion on this under the CIP Report. **Noted:** The Performance Committee noted the review of BAF.	AR AJ AJ	24.2.22 3.2.22 3.2.22
7	**PAPWORTH INTEGRATED PERFORMANCE REPORT (PIPR)**		
22/07	The Committee received PIPR for M09 December 2021/22. TG summarised the position as 'amber', which comprised: • three 'red' domains (Effective, Responsive and People Management & Culture). • Two 'amber' domains (Safe and Finance). • One 'green' domain (Caring) • One new domain (Integrated Care Service – ICS); not currently rated. TG introduced the report. Due to Trust's response to Omicron, it had been agreed to present a summarised PIPR this month. ECMO numbers were still high which had constrained the flow of elective work through Critical		

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	Care Area and was exacerbated by higher staff sickness levels. As discussed, the Trust's response to the national vaccination campaign had been very successful and had seen a positive impact on outpatient flow. CC queried the 'at a glance' forecasting within People Management and Culture. This is flagged as red, but the forecast moves it to amber or green. OM will look at this and review.	OM	Jan 22
22/08	**<u>Safe</u> (Amber)** MS highlighted compliance with the VTE risk assessment where work is ongoing by the team and is being picked up at monthly Divisional performance reviews. She explained that the dip in December may have been because of a change in Junior Doctors and an education gap. MS is speaking with IS in how to stop these dips and this gap in education by having a targeted approach at Junior Doctor time. Safer staff was 'green' throughout December. There was one SI reported which is under investigation. GR noted that SP had earlier mentioned Safer Staffing had flagged amber. MS explained that due to some staff shortages only yesterday, the metric had flagged amber for one day. All metrics are validated weekly. It was noted that RPH staff sickness was running at 6.6%. SP added that when looking at Safer Staffing, the benchmarking context is important. RPH is focused on maintaining green Safer Staffing, which has been achieved over the whole period – this is not the same picture in the region and nationally. This green rating is the result of much hard work by MS and team.		
22/09	**<u>Caring</u> (Green):** MS took the update as read. The Spotlight focussed on the Supportive & Palliative Care Team, their outcomes and workload. GR recognised the outcomes achieved and maintained; the SPCT are commended for this work in these difficult circumstances. GR mentioned that he sits on the End-of-Life Steering Group, which is led by Ivan Graham, Deputy Chief Nurse. They are looking at improving the dashboard data provided to enable the Group and the Performance Committee to monitor and challenge in a more proactive way. This may be trialled first before being reported in PIPR.		
22/10	**<u>Effective</u> (Red):** EM advised that the utilisation of capacity had been adversely affected as already noted, with staff absence a key feature. A third of CCA capacity is used by ECMO patients and when Transplant and VAD activity is also accounted for, this uses approx. half of the available CCA capacity. December saw a stepdown of outpatient activity to enable the running of the public vaccination hub. December also saw the highest number of emergency cardiology primary cases and referrals. Outpatient activity was stood down to approx. two thirds of its normal activity and work is now in hand to recover this position. CC noted that Admitted Patient Care and Outpatient attendances is rated green, but the target is showing as N/A. What is the performance compared to? EM explained this is comparing to NHSE/I target of 95% activity by comparison to previous year. EM will add this target into PIPR.	EM	3.2.22

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22/11	**<u>Responsive</u> (Red):** EM noted again the impact of constrained capacity. She commended Diagnostics, where despite pressures, they had continued to improve the overall performance and still offer support to CUH on cardiac CT. EM noted that CT was prioritised over MRI when capacity is constrained in light of its greater importance for early diagnosis. The overall RTT aggregate number had dropped by 1%. Cardiology maintained RTT position. Cardiac Surgery saw the highest impact due to lack of CCA capacity and is looking to increase this in January as CCA capacity increases. EM referred to the focus on In House Urgents (IHU) and the opportunity to support other organisations by reducing the time IHUs might be waiting in their beds. This does prioritise available capacity to IHUs but is at the expense of elective activity and RTT performance. GR asked how does the decision get taken to focus on IHU at expense of elective activity? EM explained that there is active conversation within Surgery Division on priorities and a daily adjustment on our own cardiology bed base to keep pathways moving. EM explained how the team look at forward views on capacity and how this is divided between IHU and elective cases. There is a review with clinical teams on daily planning of lists to get the balance right. RH added that there is almost no choice as some patients, whichever pathway they are on, need urgent treatment. The hierarchy of priority is emergency cases followed by IHU. The Trust's Clinical Decision Cell discusses how to manage the remaining capacity, which by default is the elective surgery, and this discussion is based on clinical priority. RH explained how the Trust manages this in practice. CC noted only five patients waiting over 52 weeks which is positive. Is this likely to continue (linked into to future planning where it could have an impact). EM advised that this is a constantly changing position and can vary on a day-to-day basis. Most patients are P3 or P4 on the cardiac surgery pathway. There is a constant focus to check on these waiting list patients and draw them through to avoid a deteriorating patient status. SP referred to the IHU discussion and acknowledged that swift decisions do need to be made, but also the need to explain to the Committee on the rationale for these decisions. Matters can be complex and there is no one formula to work on to suit all situations. He felt it would be useful to gain an understanding on how the Executive Team could provide a better response to NEDs on this and suggested that discussions at a Board development session or offline conversations might be helpful. GR thanked SP for this comment and will consider the right approach for this.	GR	24.2.22
22/12	**<u>People Management and Culture</u> (Red)** OM highlighted the high absence rates shown which are currently increasing, due to impact of high local community C-19 infection rates. Staff turnover is over target with no one area standing out. A common reason for staff leaving is noted as lack of opportunities. OM suggested that there is scope to look at career pathways; discussions have started with the Education Team to support this, including review of the IPR process. An increase in the vacancy rate suggests that recruitment is slowing down;		

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	this is reflected by a risk increase on BAF. The Trust is seeing a reduction in applicants and quality of applicants, particularly for admin bands – this is noted across the NHS as a result of a tightening national labour market and increased salaries in the private sector. GR said that reference to 'lack of opportunity' was disappointing to read, but that this is something we can control and improve on. He recognised the importance of the Compassionate and Collective Leadership Programme in achieving this. DL was also disappointed to see the high level of staff turnover but encouraged to see that steps are being taken to see how staff can develop. Referring to the B5 overseas nurse recruitments, how soon can we see overseas nurses joining us? OM advised that the nurses are due to arrive in cohorts of 4-5 in March over successive weeks.		
22/13	**<u>Finance</u> (Amber):** TG responded to PIPR and the Financial Report together. The reports highlight a strong financial performance in year, showing a £400k surplus in month and a year-to-date position on a control total basis of £3m surplus. This is driven in part by CIP; TG noting concerns that although the CIP position is strong, we would want to see a greater proportion of recurrent savings. TG was pleased with Better Payment Practice Code (BPPC) performances, where the target of 95% on non-NHS invoices has been achieved both on volume and value. The target on NHS invoices was realised on value but not yet on volume (1% down). This is a huge improvement from the position reported in August 2021. Capital expenditure has seen a stepped increase for three months in a row. The Investment Group update later notes that orders are now in to achieve the capital profile in plan by year end. There is some risk on Digital items of approx. £150k which is being managed very closely. DL applauded the improvement on BPPC which has been a huge amount of work and offered her thanks to the team. CP had led this work and will relay thanks to his colleagues.		
22/14	**<u>Integrated Care System</u> (ICS)** This is Included for information purposes and to understand how the system is looking. This was discussed at the beginning of the meeting under the general regional outlook.		
	Noted: The Performance Committee noted the PIPR update for M09 2021/22.		
8	**ACTIVITY RESTORATION**		
22/15	GR thanked EM for the revised data and narrative format which are both informative and helpful.		

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	EM added that overall activity was reduced due to constraints already discussed but that on comparison to December 2020, there was an improvement. Remote monitoring on cardiology had worked well. Radiology staffing was challenging but CT activity had been maintained with any ease-back required by reducing MRI activity. Admitted activity had also seen the impact of constraints, especially surgery and cath lab activity which relied on CCA capacity. Key areas of risk highlighted in discussion were cardiac surgery, cardiology (P2 patients) and respiratory/thoracic. Under the Philips/CPAP replacement programme there were delays with equipment supply to new CPAP patients due to lack of devices and this had adversely affected the respiratory waiting list. GR noted the good performance in cardiology in response to emergency cases but that this has limited elective work. What is the financial impact of that shift in activity? TG responded with an explanation of this year's block payment and ERF arrangements which would see no impact on income as result of the switch. What is unclear is how much of that protection will be in existence next year and this may need negotiation. National financial mechanisms are in general set up to incentivise elective work over emergency work. We need to keep up negotiations on the non-elective base and this forms a big part of discussions on financial planning. **Noted:** The Performance Committee noted the update on Activity Restoration.		
9.1	**FINANCIAL REPORT – Month 09 2021/22**		
22/16	The Committee received this report which gave an oversight of the Trust's in month and full year financial position. Key items covered: - Statement of Comprehensive Income (SOCI) position • Run rate trends • Activity • Statement of Financial Position • Statement of Cash Flow • Cash position and forecast • Cash Management • Capital • Spotlight on Homecare Pharmacy • Spotlight on BPPC The discussions under PIPR had covered this item. **Noted:** The Committee noted the financial update.		
9.2	**CIP REPORT- Month 09 2021/22**		
22/17	The Committee received the report which summarised the Trust's progress with the CIP plan to M09 2021/22, CIP achievement to date and the ongoing steps to ensure the CIP target is met.		

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	TG referred to CIP risk. Work is underway to look at next year's CIP and getting a clearer idea of what we want to achieve. The current risk rating reflects those targets we need to reach, and some further CIP identified. There is a gap and work needed to close these gaps. GR noted that CIP risk fluctuates throughout the year and wondered whether the risk rating reflected the time of the year and thus how far along the CIP delivery pipeline. TG stated that the reduction of risk over the year is a result of huge amount of work and not a given at the start of year. GR acknowledged this. SP noted it is helpful also to benchmark against others as not all Trusts are in a good CIP position. DL referred to the CIP 22/23 plan, recognising that it is still early in the process and there is a gap – the non-recurrent CIP shows 0 for target – is this realistic? TG advised there is a timing issue on this. EM and TG agreed with teams the need to get going on CIP targets but this was done without operating guidance yet issued. The CIP reporting had been updated in the Operational Planning report to show a recurrent and non-recurrent element, and this is how it will be reported in future CIP updates. Apologies that it did not quite align for this Committee. GR asked for clarity on whether income improvement can be included as CIP. TG explained that if there is an improvement in the bottom-line then it is classified as CIP. CC advised that this is how our Regulators determine CIP, via the bottom-line analogy. GR referred to the increase in private income at a time when NHS activity in the hospital is constrained and sought confirmation that this was due to the time lag for payment, and that increased income in December reflects increased private patient activity a few months earlier when capacity was less constrained. TG explained that there is a time lag of approx. two months on income received and the private patient procedure taking place. We would not therefore expect the run rate in private patient income between now and year end to show an increase given current constraints. **Noted:** The Performance Committee noted the approach to CIP and the progress to date.		
9.2.1	**CIP Benchmarking**		
	This report was deferred.		
10	**ACCESS & DATA QUALITY**		
	This bi-monthly report was deferred.		
FUTURE PLANNING			
11	**PERFUSION SERVICES CONTRACT UPDATE**		
22/18	TG gave a verbal update to the Committee. The draft contract had been sent to Cambridge Perfusion Services in mid-		

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	December with comments received back late last week. Work is now underway to review these comments, some of which will require further legal advice. TG advised that work would continue with the legal team along with engagement with GR and other committee members as it progresses. GR agreed with above course of action and asked TG to give assurance on the interim contractual/service position. TG updated that CPS engagement is good; there is an interim arrangement regarding some non-pay funding, which is deemed reasonable; currently there is no continuity of service risk. We continue to work to the old contract with a slight change on non-pay to reflect inflation. We await response from legal team and are looking to get the contract agreed by year-end **Noted:** The Performance Committee noted the update on Perfusion Services Contract.		
12	**INVESTMENT GROUP – Chair's Report**		
22/19	The report was taken as read. TG referred to the investment requests approved at the last Investment Group meeting: Anti-microbial Pharmacist: this will help reduce spend in that area; operating planning guidance highlights this as a continued focus in NHS and likely that CQUINS will be linked to this post. Bronchoscopy Cryotherapy Equipment : The team brought to Committee a plan of how to save to enable spend in this area. **Noted:** The Performance Committee noted the update from the Investment Group.		
13	**ANNUAL REPORTS**		
13.1	**2022/23 Planning**		
22/20	TG gave a summary to the Committee: The operating guidance was issued on 24 December but was not accompanied by the usual technical guidance, which came out two weeks ago. The finance team are working through this. Today's report to the Committee takes the information received to date, which has been used to translate to a financial position and highlight key risks for next year. TG referred the Committee to the waterfall diagram in the report and explained each step of this in detail. The plan is based on low Covid-19 prevalence. If this changes or other emergency growth continues which would affect elective flow and raise financial uncertainty, then at that point the team would need to work through those scenarios and assess the risks. The plan will be discussed with Commissioners over the next weeks and months It was noted that ICS continue to be a partner and their financial planning is looking bleaker with a prediction of a large deficit. As yet we do not know		

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	how much of this deficit RPH might be asked to absorb and this will form part of a robust negotiation. CC was concerned as to how we play our part in the system and referred to past discussion about roles by organisations within the ICS particularly of the potential role for RPH leading on diagnostics. Has this been developed and how will it affect the System target of 120% of pre-pandemic levels? TG advised that RPH is actively leading a piece of work on diagnostic capacity in ICS. This work has been difficult to conclude as running concurrently with the Omicron wave. There has been some useful benchmarking data which has been shared with ICS. There is also a review on a Community Diagnostic Hub business case which is being led by the CCG; this has been discussed with the ICS and Philips. The 120% will be very challenging for the system. CC asked whether RPH will be contributing to the system deficit? TG directed the Committee to the waterfall diagram which includes a share of the deficit. CC noted the funding envelope and share allocations and levelling up, was C&P a gainer or loser? TG advised that £2.8m was allocated to C&P system. SP gave some context by referring to an EoE CEO conversation yesterday on elective recovery. He added that Executive Directors have a good understanding of the planning position, but there are many risks especially with system and regional context. DL noted that this plan assumes no or very little pandemic. Is there any contingency for another wave? TG referred to the waterfall diagram and the section which covers risk, noting that a low Covid planning scenario would be a risk for this organisation. **Noted:** The Performance Committee noted the planning update and will receive further updates in due course.		
14	**ISSUES FOR ESCALATION**		
22/21	• Board of Directors • Audit Committee – No items flagged. • Quality & Risk Committee – No items flagged. • Strategic Projects Committee		
15.1	**COMMITTEE FORWARD PLANNER**		
22/22	The Chair noted several items had been deferred, including the divisional presentation which will re-start in March. AJ added that the Committee self-assessment is due for reporting next month and she will send out a link to all to complete the survey before the meeting. **Noted:** The Committee noted the Committee Forward Planner.	AJ ALL	Jan/Feb

Agenda Item		Action by Whom	Date
15.2	**REVIEW OF MEETING AGENDA AND OBJECTIVES**		
22/23	GR commended the Executive Directors for a detailed set of papers produced in such challenging circumstances.		
15.3	**BAF: END OF MEETING WRAP-UP**		
22/24	All risk items were covered in discussions, with no further items raised.		
15.4	**EMERGING RISK**		
22/25	No items raised.		
16	**ANY OTHER BUSINESS**		
	No items were raised.		
	FUTURE MEETING DATES		

2022	Time	Venue	Apols rec'd
27 January	0930-1100hrs	MS Teams	
24 February	0900-1100hrs	MS Teams	
31 March	0900-1100hrs	MS Teams	
28 April	0900-1100hrs	MS Teams	
26 May	0900-1100hrs	MS Teams	
30 June	0900-1100hrs	MS Teams	
28 July	0900-1100hrs	MS Teams	
25 August	0900-1100hrs	MS Teams	
29 September	0900-1100hrs	MS Teams	
27 October	0900-1100hrs	MS Teams	
24 November	0900-1100hrs	MS Teams	
15 December	0900-1100hrs	MS Teams	

The meeting finished at 1037 hrs

Date: 24.02.2022

Royal Papworth Hospital NHS Foundation Trust
Performance Committee
Meeting held on 27 January 2022

Appendix 1 DOI July 2021

Employee Name	Position Title	Interest Declared	Interest Category	Interest Situation	Interest Description	Col Date From
Ahluwalia, Dr Jagjit Singh	Non-Executive Director	Y	Financial interests	Outside employment	Associate at Deloitte	01/10/2018
Ahluwalia, Dr Jagjit Singh	Non-Executive Director	Y	Financial interests	Outside employment	Associate at the Moller Centre,Cambridge.	01/10/2018
Ahluwalia, Dr Jagjit Singh	Non-Executive Director	Y	Financial interests	Outside employment	Employee at CUH since 1996, seconded to Eastern Academic Health Science Network as Chief Clinical Officer since April 2019.	21/04/2019
Ahluwalia, Dr Jagjit Singh	Non-Executive Director	Y	Financial interests	Outside employment	Fellow at the Cambridge Judge Business School. This is an honorary position, I am not on faculty and not paid for this role. However I do deliver occasional lectures for CJBS, some of which are remunerated.	01/01/2018
Ahluwalia, Dr Jagjit Singh	Non-Executive Director	Y	Financial interests	Outside employment	Programme Co-Director for East of England Chief Resident Training programme, run through the postgraduate medical education department at CUH. This is a paid role.	01/09/2010
Ahluwalia, Dr Jagjit Singh	Non-Executive Director	Y	Financial interests	Shareholdings and other ownership interests	Co-director and shareholder in Ahluwalia Education and Consulting Limited. I undertake private work in the field of healthcare management, reviews and healthcare related education and training through this company for a range of clients including but not limited to the NHS, pharmaceuticals and charities.	01/10/2018
Ahluwalia, Dr Jagjit Singh	Non-Executive Director	Y	Non-financial professional interest	Outside employment	Member C & P Clinical Ethics Committee. Not remunerated so not employed.	01/05/2020
Ahluwalia, Dr Jagjit Singh	Non-Executive Director	Y	Non-financial professional interest	Outside employment	Member Eastern Region Clinical Senate (since March 2020 - this is within my role at Eastern AHSN. Not remunerated for this role specifically.	01/03/2020
Ahluwalia, Dr Jagjit Singh	Non-Executive Director	Y	Non-financial professional interest	Outside employment	Trustee on the main board of Macmillan Cancer Support	01/02/2017
Blastland, Mr. Michael Iain	Non-Executive Director	Y	Financial interests	Outside employment	Board member of the Winton Centre for Risk and Evidence Communication	01/04/2016
Blastland, Mr. Michael Iain	Non-Executive Director	Y	Financial interests	Outside employment	freelance writer and broadcaster	01/02/2017
Blastland, Mr. Michael Iain	Non-Executive Director	Y	Indirect interests	Outside employment	My partner is an adviser to Thrive, a games-based mental health app and support service.	11/05/2021
Blastland, Mr. Michael Iain	Non-Executive Director	Y	Non-financial professional interest	Outside employment	Advisor to the Behavioural Change by Design research project	01/08/2017
Blastland, Mr. Michael Iain	Non-Executive Director	Y	Non-financial professional interest	Outside employment	Member of advisory group for Bristol University's Centre for Academic Research Quality and Improvement.	01/08/2020
Blastland, Mr. Michael Iain	Non-Executive Director	Y	Non-financial professional interest	Outside employment	Member of the oversight Panel for the Cholesterol Treatment Trialist's Collaboration	01/08/2020
Conquest, Mrs. Cynthia Bernice	Non-Executive Director	Y	Non-financial professional interest	Loyalty interests	Member of the Seacole Group - Network for BAME NEDs in the NHS	25/02/2021
Fadero, Mrs. Amanda Therese	Non-Executive Director	Y	Indirect interests	Loyalty interests	Trustee of Nelson Trust Charity	01/10/2013
Fadero, Mrs. Amanda Therese	Non-Executive Director	Y	Indirect interests	Sponsored research	My brother Matthew Wakefield has recently been appointed as the Chairman of Oxford BioDynamics PLC- a biotechnology company developing personalised medicine tests based on 3D genomic biomarkers	14/12/2020
Fadero, Mrs. Amanda Therese	Non-Executive Director	Y	Non-financial professional interest	Loyalty interests	I am an Associate Non Executive Director at East Sussex Healthcare NHS Trust	01/07/2020
Glenn, Mr. Timothy John	Chief Finance Officer	Y	Non-financial professional interest	Loyalty interests	My wife is ICS development lead for the East of England.	31/03/2020
Hall, Dr Roger Michael Owen	Medical Director	Y	Financial interests	Shareholdings and other ownership interests	Director of a medical services company Cluroe & Hall Ltd	01/09/2016
Leacock, Ms. Diane Eleanor	Non-Executive Director	Y	Financial interests	Outside employment	Director, ADO Consulting Ltd	01/12/2020
Leacock, Ms. Diane Eleanor	Non-Executive Director	Y	Non-financial personal interests	Loyalty interests	Trustee, Benham-Seaman Trust	01/12/2020
Leacock, Ms. Diane Eleanor	Non-Executive Director	Y	Non-financial personal interests	Loyalty interests	Trustee. Firstsite	01/12/2020
Leacock, Ms. Diane Eleanor	Non-Executive Director	Y	Non-financial professional interest	Loyalty interests	Member of the Seacole Group, a network for BAME NEDs in the NHS	01/12/2020
Midlane, Mrs. Eilish Elizabeth Ann	Chief Operating Officer	Y	Indirect interests	Loyalty interests	Holds an unpaid Executive Reviewer role with CQC	03/08/2020
Monkhouse, Ms. Oonagh Jane	Director of Workforce and Organisational Development	N	I have no interests to declare			23/12/2020

Posey, Mr. Stephen James	Chief Executive	Y	Non-financial personal interests	Loyalty interests	Partner is CEO of the Royal College of Obstetrics and Gynaecologists	01/03/2019
Posey, Mr. Stephen James	Chief Executive	Y	Non-financial personal interests	Loyalty interests	Partner is a Trustee of Magpas, Registered Charity	25/02/2021
Posey, Mr. Stephen James	Chief Executive	Y	Non-financial personal interests	Outside employment	Director of Cambridge University Health Partners (CUHP) an Academic Health Science Centre	15/11/2016
Posey, Mr. Stephen James	Chief Executive	Y	Non-financial professional interest	Outside employment	Chair EOE Cardiac Network	01/10/2018
Posey, Mr. Stephen James	Chief Executive	Y	Non-financial professional interest	Outside employment	Chair NHSE East Operational Delivery Network Board	01/05/2017
Posey, Mr. Stephen James	Chief Executive	Y	Non-financial professional interest	Outside employment	Co-Chair EOE Strategic Programme Board - Critical Care	01/07/2020
Posey, Mr. Stephen James	Chief Executive	Y	Non-financial professional interest	Outside employment	Executive Reviewer for the Care Quality Commission (CQC)	01/06/2018
Posey, Mr. Stephen James	Chief Executive	Y	Non-financial professional interest	Outside employment	Hold an Honorary Contract with Cambridge University Hospitals NHSFT	01/02/2017
Posey, Mr. Stephen James	Chief Executive	Y	Non-financial professional interest	Outside employment	Trustee of the Intensive Care Society - Registered Charity	25/02/2021
Raynes, Mr. Andrew Duncan	Chief Information Officer	Y	Financial interests	Patents	CIS UCQ is a Trademark for health and care IT courses established under my consultancy ADR Health Care Consultancy Solutions Ltd	05/04/2021
Raynes, Mr. Andrew Duncan	Chief Information Officer	Y	Financial interests	Shareholdings and other ownership interests	Owner of ADR Health Care Consultancy Solutions Ltd	02/05/2017
Raynes, Mr. Andrew Duncan	Chief Information Officer	Y	Non-financial professional interest	Loyalty interests	Spouse works for Royal College of Nursing (I cant see a situation from the drop down pertinent to this declaration so have selected the most likely reflecting the circumstances)	01/06/2017
Robert, Mr. Gavin	Non-Executive Director	Y	Financial interests	Outside employment	Affiliated lecturer, Faculty of Law, University of Cambridge	30/09/2013
Robert, Mr. Gavin	Non-Executive Director	Y	Financial interests	Outside employment	Senior Consultant, Euclid Law (a specialist competition law firm)	01/07/2016
Robert, Mr. Gavin	Non-Executive Director	Y	Indirect interests	Loyalty interests	My spouse is Senior Bursar at St Catherine's College, University of Cambridge	01/06/2019
Robert, Mr. Gavin	Non-Executive Director	Y	Non-financial professional interest	Outside employment	Trustee and Vice Chair, REAch2 Multi-Academy Trust	01/09/2018
Rudman, Mrs. Josie	Chief Nurse	Y	Non-financial professional interest	Outside employment	CQC specialist advisor	29/04/2017
Rudman, Mrs. Josie	Chief Nurse	Y	Non-financial professional interest	Outside employment	Director of operations in contain, test and trace (secondment)	28/09/2020
Rudman, Mrs. Josie	Chief Nurse	Y	Non-financial professional interest	Outside employment	Director on National New Hospitals Program (secondment)	29/04/2021
Wallwork, Mr. John	Chairman	Y	Financial interests	Outside employment	Independent Medical Monitor for Transmedics clinical trials	21/04/2021
Wallwork, Mr. John	Chairman	Y	Non-financial professional interest	Shareholdings and other ownership interests	Director Cambridge university health partners CUHP	21/04/2021
Wilkinson, Dr Ian Boden	Non-Executive Director	Y	Indirect interests	Clinical private practice	Private health care at the University of Cambridge;	01/03/2021
Wilkinson, Dr Ian Boden	Non-Executive Director	Y	Indirect interests	Loyalty interests	Director of Cambridge Clinical Trials Unit; Member of Addenbrooke’s Charitable Trust Scientific Advisory Board; Senior academic for University of Cambridge Sunway Collaboration; University of Cambridge Member of Project Atria Board (HLRI).	01/03/2021
Wilkinson, Dr Ian Boden	Non-Executive Director	Y	Non-financial personal interests	Sponsored research	Grant support for research from Wellcome Trust, BHF, MRC, AZ, GSK, Addenbrooke's charitable Trust, Evelyn Trust	01/03/2021
Wilkinson, Dr Ian Boden	Non-Executive Director	Y	Non-financial professional interest	Outside employment	Hon Consultant CUHFT and employee of the University of Cambridge	01/03/2021