The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	30 July 2020						
Title	Consultant Appointments						
Report of	Andy Welch, Medical Director						
Prepared by	Colin Sakhe, HR Advisor (Medical & Dental)						
Status of Report	Public		Private		Internal		
	☒		☐		☐		
Purpose of Report	For Decision		For Assurance		For Information		
	☐		☐		☒		
Summary	The content of this report outlines recent Consultant Appointments.						
Recommendation	The Board of Directors is asked to review the decisions of the Appointments Committee.						
Links to Strategic Objectives	Patients – Putting patients at the heart of everything we do. Providing care of the highest standard focusing on safety and quality. People – Supported by Flourish, our cornerstone programme, we will ensure that each member of staff is able to liberate their potential.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☐	☐	☐	☒	☐	☐	☐
Impact detail	Ensuring the Trust is sufficiently staffed to meet the demands of the organisation.						
Reports previously considered by	Consultant Appointments are submitted for information in the month following the Appointments Panel.						

CONSULTANT APPOINTMENTS

1. APPOINTMENTS COMMMITTEE – CONSULTANT APPOINTMENTS

1.1 An Appointments Committee was held on 17 June 2020 and interviewed 3 candidates for 2 Consultant Physician in Diabetes & Endocrinology posts.

By unanimous resolution, the Committee was in favour of appointing Dr Earn Gan and Dr Anna Mitchell.

Dr Gan holds MBChB (University of Dundee) 2005, MRCP (UK) 2009 and PhD (Newcastle University) 2013. Dr Gan is currently employed as a Consultant Physician in Diabetes & Endocrinology at the South Tyneside and Sunderland NHS Foundation Trust.

Dr Mitchell holds MBBS (University of Newcastle) 2004, MRCP (UK) 2008 and PhD(Newcastle University) 2013. Dr Mitchell is currently employed as a Locum Consultant Endocrinologist based at the Royal Victoria Infirmary.

Dr Gan is expected to take up the post of Consultant Physician in Diabetes & Endocrinology on the 5 October 2020.

Dr Mitchell is expected to take up the post of Consultant Physician in Diabetes & Endocrinology in July 2020.

1.2 An Appointments Committee was held on 17 June 2020 and interviewed 1 candidate for 1 Consultant Rheumatologist post.

By unanimous resolution, the Committee was in favour of appointing Dr Ejaz Pathan

Dr Pathan holds MBBS (University of Mumbai) 1995 and MRCP (UK) 2005. Dr Pathan is currently employed as a Clinical Fellow based at the Toronto Western Hospital.

Dr Pathan is expected to take up the post of Consultant Rheumatologist in August 2020.

1.3 An Appointments Committee was held on 10 July 2020 and interviewed 1 candidate for 1 Consultant Obstetrician post.

By unanimous resolution, the Committee was in favour of appointing Dr Sophia Webster.

Dr Webster holds MBBS (University of Nottingham) 2003 and MRCOG (UK) 2014. Dr Webster is currently employed as a Locum Consultant Obstetrician based at the Royal Victoria Infirmary.

Dr Webster is expected to take up the post of Consultant Obstetrician in July 2020.

1.4 An Appointments Committee was held on 21 July 2020 and interviewed 1 candidate for 1 Consultant Medical Oncologist posts.

By unanimous resolution, the Committee was in favour of appointing Dr Lavanya Mariappan.

Dr Mariappan holds MBBS (Dr M G R Medical University) and MRCP (UK) 2012. Dr Mariappan is currently employed as a Specialty Trainee based at the Freeman hospital.

Dr Mariappan is expected to take up the post of Consultant Medical Oncologist in September 2020.

2. RECOMMENDATION

1.1 – 1.4 – For the Board to receive the above report.

Report of Andy Welch
Medical Director
21 July 2020

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Patient experience ambitions

"I want to be treated as person, not a condition."

We will develop systems and processes around you as a patient

"Co-ordination of my care is of utmost importance - I don't want to be passed to someone else unnecessarily."

We will only refer you on to others where they are specialists with more skills to solve a problem that the first person can't fix for you

"I want seamless access to care and support."

We will offer a 'today for you' for the routine patient contacts and organise our plans, workflow, systems to do this using the best technology available

"Proving clear information which I can understand will keep me safe."

We will ask you how you would like us to communicate with you. We will provide information to you in an accessible format to include patients who are deaf, unable to read and who do not speak English

"I don't want to stay in hospital if I don't have to."

We will use technology to avoid the need for you to come to hospital whenever we can

We will plan your discharge with you and your carer when it is safe to do so

NHS

The Newcastle upon Tyne Hospitals

NHS Foundation Trust

"I want professional staff to care fo me at the right time and in the right place."

We will recruit highly trained staff to care for you

"Being able to have a point of contact is important to me."

We will endeavour to offer a single contact service for you so that you 'journey only once' to us

"I want to be kept informed at all times during my care."

We will design our systems so that together we know where you are at any point in your care

"I don't want to have to wait."

We will aim to do today's work today and avoid having waiting lists wherever we can

"I want advice on how I can improve my health."

We will make every contact count, to help you make any changes that will enable you to live longer happier and healthier lives

Healthcare at its best
with people at our heart

NHS

The Newcastle upon Tyne Hospitals

NHS Foundation Trust

"Communicating in first language is important to me."

We will provide written and verbal information in your first language

"I want my carer to be involved and informed."

We will alert your medical records that you have a carer and involve them in your care

"I want professional staff to care for me at the right time and in the right place."

We will recruit highly trained staff to care for you

"Being able to have a point of contact is important to me."

We will endeavour to offer a single contact service for you so that you 'journey only once' to us

"I want to be asked about my experience."

We will ask, listen respond to your feedback at all times of your journey

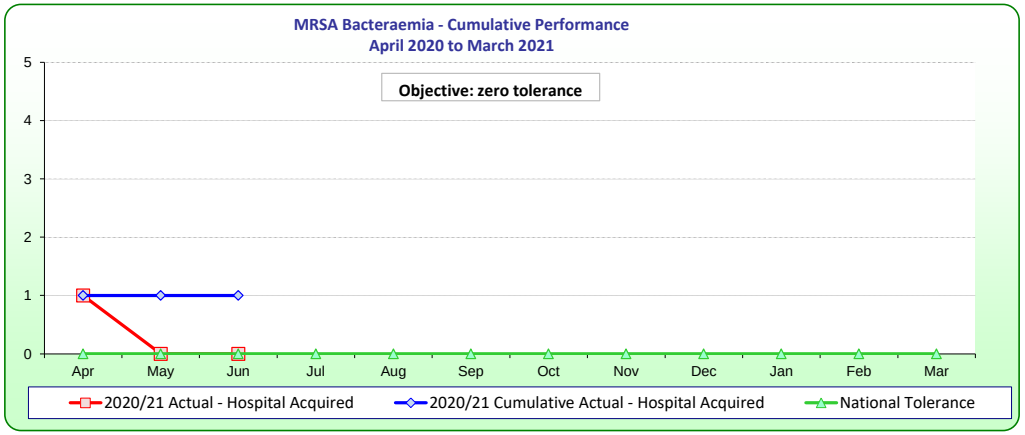
BRP - A6(iv)

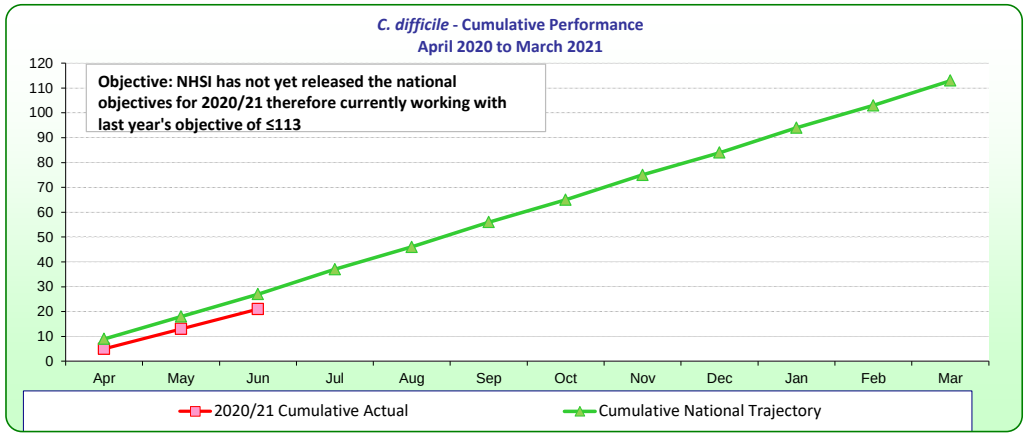
The Newcastle upon Tyne Hospitals
NHS Foundation Trust

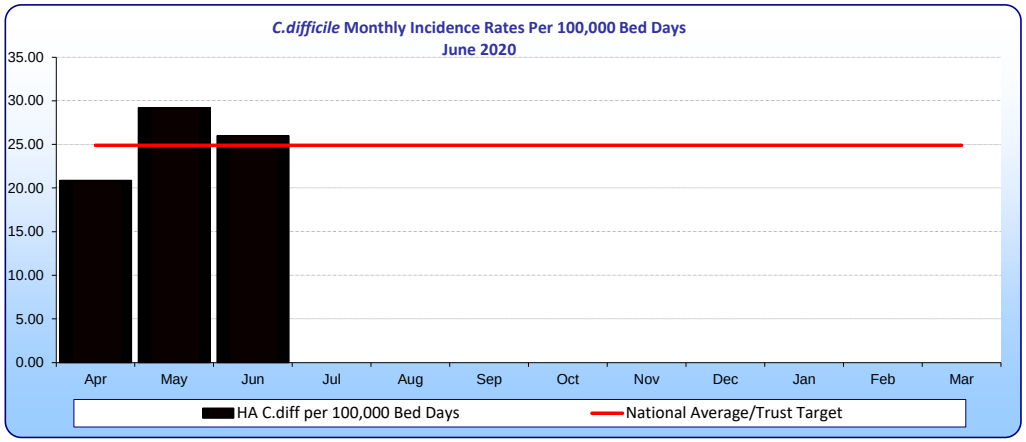
Healthcare-Associated Infections Report
June 2020

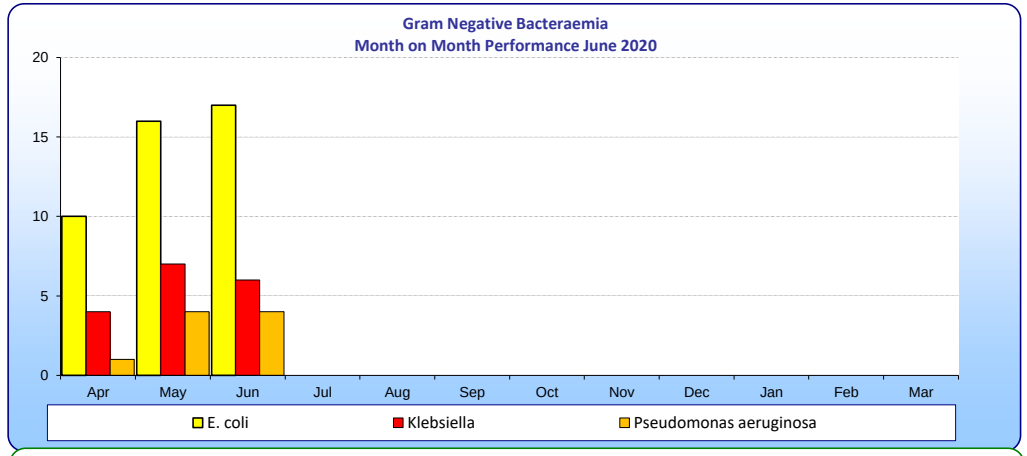
Healthcare-Associated Infection Report June 2020

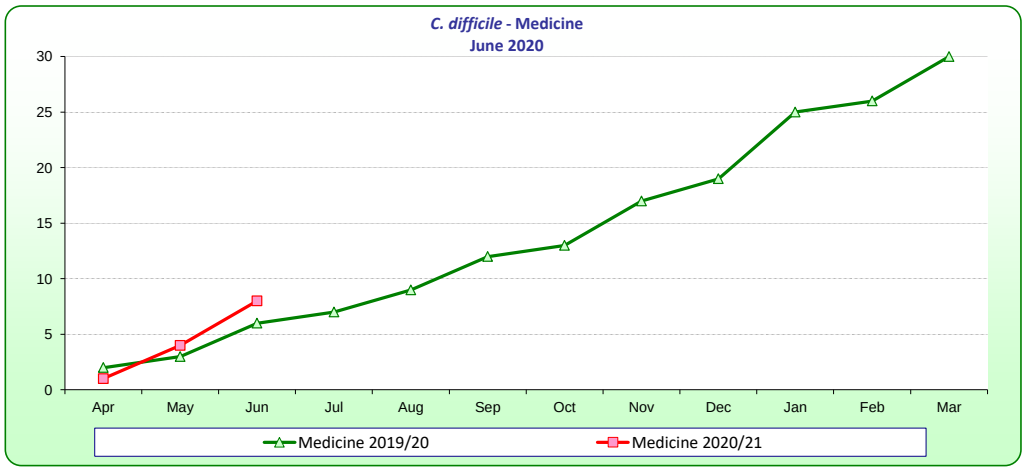
The Newcastle upon Tyne Hospitals NHS Foundation Trust

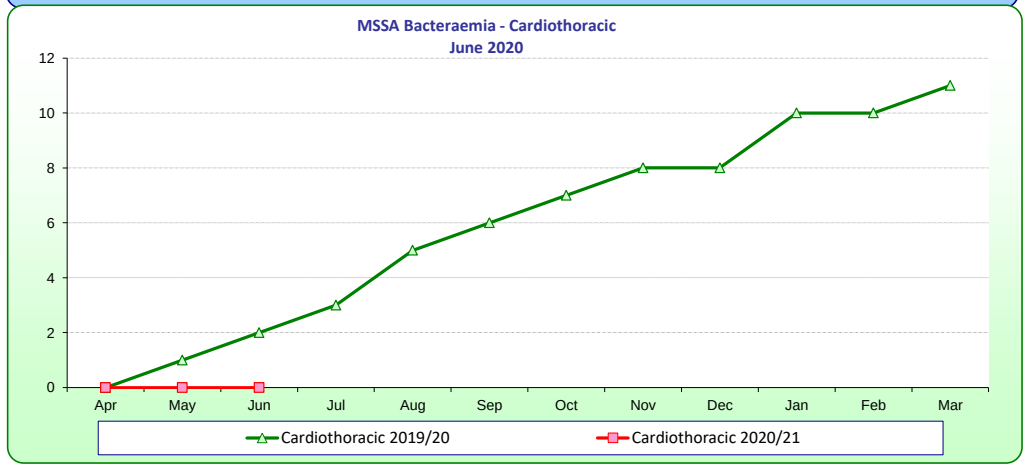






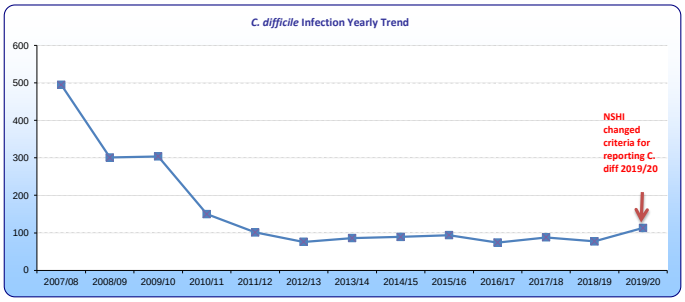


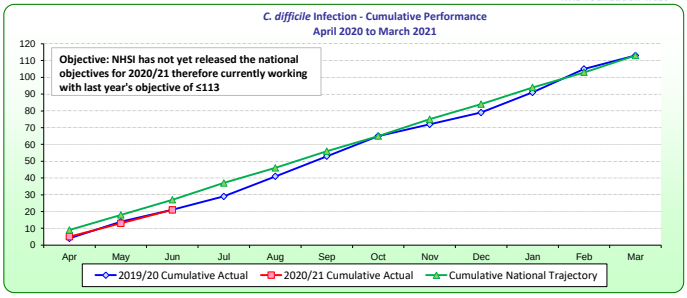


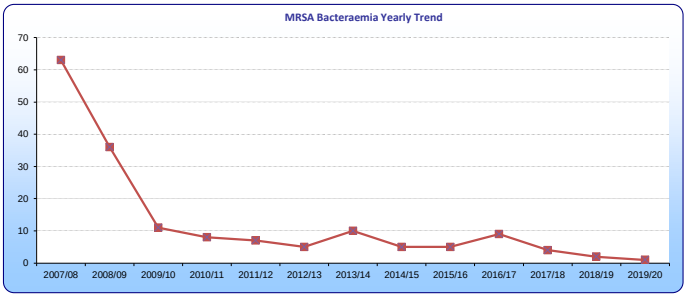


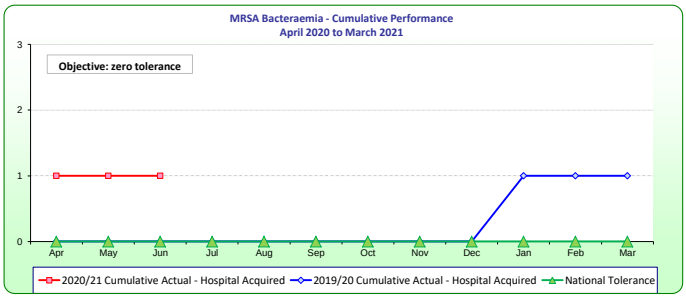
Healthcare-Associated Infection Report June 2020

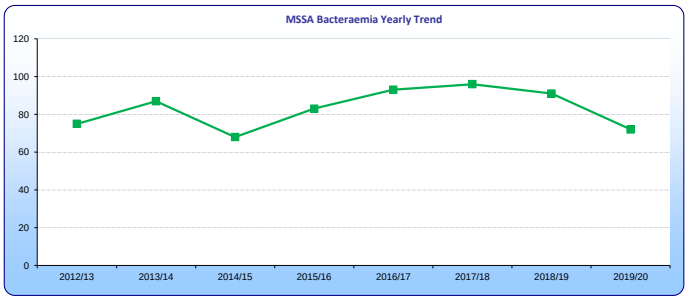
The Newcastle upon Tyne Hospitals NHS Foundation Trust

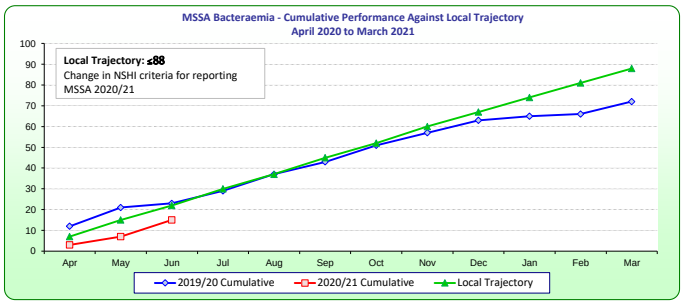


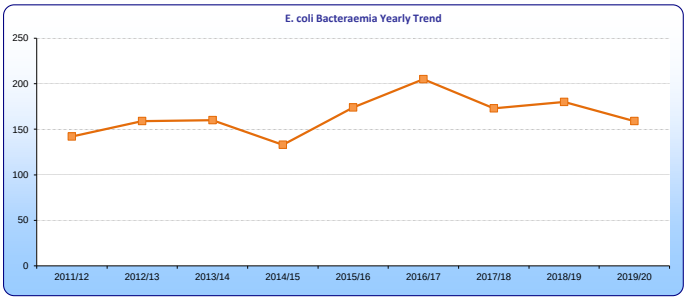


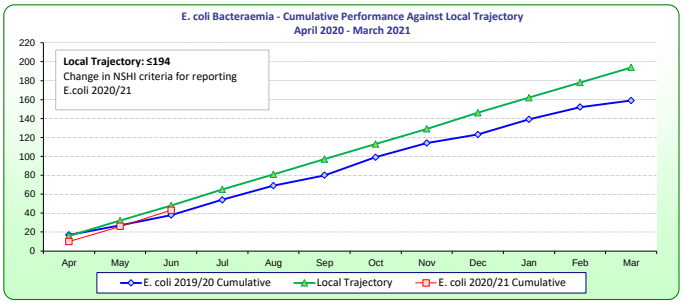


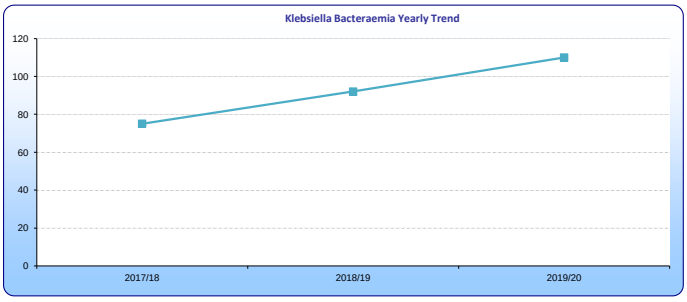


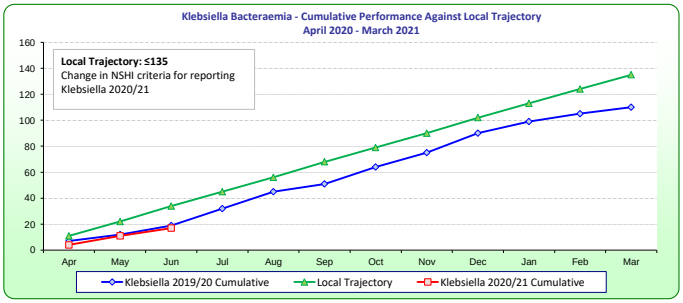


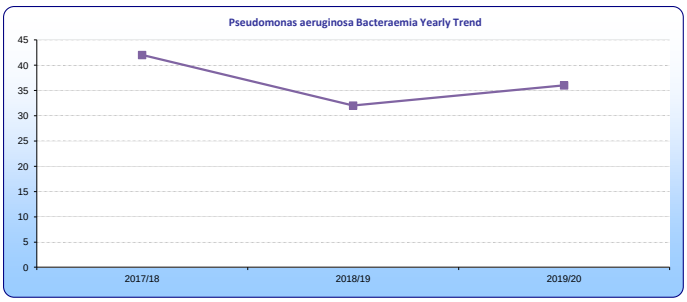


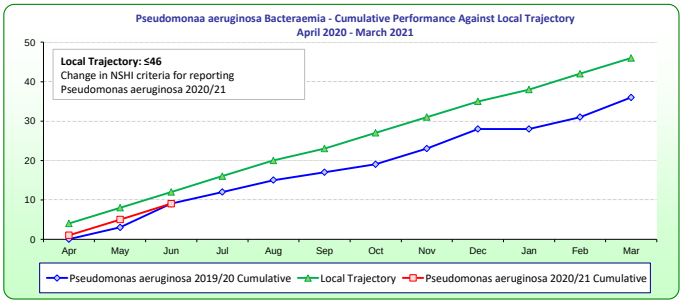












Healthcare-Associated Infection Report June 2020

The Newcastle upon Tyne Hospitals NHS Foundation Trust

IPC indicators (reported to DH)	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative
MRSA Bacteraemia - non-Trust	-	-	-										0
MRSA Bacteraemia - Trust-assigned (objective 0)	1	0	0										1
MRSA HA acquisitions	1	1	4										6
MSSA Bacteraemia - post-48 Hours Admission (local objective ≤65)	3	4	8										15
E coli Bacteraemia - post-48 Hours Admission (local objective ≤144)	10	16	17										43
Klebsiella Bacteraemia - post-48 Hours Admission (local objective ≤99)	4	7	6										17
Pseudomonas aeruginosa Bacteraemia - post-48 Hours Admission (local objective ≤33)	1	4	4										9
C.diff - Hospital Acquired (objective ≤113)	5	8	8										21
C.diff related death certificates	-	-	-										0
Part 1	-	-	-										0
Part 2	-	-											0

Periods of Increased Incidence (PIIs)	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative
MRSA HA acquisitions	-	-	-										0
Patients affected	-	-	-										0
C.diff - Hospital Acquired	-	-	-										0
Patients affected	-	-	-										0

Outbreaks	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative
Norovirus Outbreaks	-	-	-										0
Patients affected (total)	-	-	-										0
Staff affected (total)	-	-	-										0
Bed days losts (total)	-	-	-										0
Other Outbreaks	-	-	-										0
Patients affected (total)	-	-	-										0
Staff affected (total)	-	-	-										0
Bed days losts (total)	-	-	-										0

C.diff Transit and Testing Times Target <18hrs	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
Trust Specimen Transit Time	10:30	11:13	12:01										11:14
Laboratory Turnaround Time	02:27	02:08	03:18										02:37
Total to Result Availability	12:57	13:21	15:19										13:52

Hygiene Indicators/Audits (%)	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
CAT Trust Total	CAT suspended until September 2020 due to COVID-19 pandemic												
Hand Hygiene Opportunity													
Hand Hygiene Technique													
Environmental Cleanliness													

Infection Control Mandatory Training (%)	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
Infection Control	85%	85%	85%										85%

Aseptic Non Touch Technique Training (%)	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
ANTT (M&D staff only)	61%	61%	61%										61%

Agenda Item BRP A6(iv)a

COVID-19 BOARD ASSURACE FRAMEWORK Assurance Overview							
Goal no.	Organisational Goal	Executive Lead	Date Reviewed at Assuring Committee	Rag rate compliance			
				Q1	Q2	Q3	Q4
1	Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users	Director of Infection Prevention and Contol					
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections	Director of Infection Prevention and Contol					
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance	Director of Infection Prevention and Contol					
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion	Director of Infection Prevention and Contol					
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people	Director of Infection Prevention and Contol					
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection	Director of Infection Prevention and Contol					
7	Provide or secure adequate isolation facilities	Director of Infection Prevention and Contol					
8	Secure adequate access to laboratory support as appropriate	Director of Infection Prevention and Contol					
9	Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections	Director of Infection Prevention and Contol					
10	Have a system in place to manage the occupational health needs and obligations of staff in relation to infection	Director of Infection Prevention and Contol					

Goal 1: Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users										
Strategic Risk:			**Linked risk**:	**Date**:	Risk Score	Q1	Q2	Q3	Q4	
2142 - Acquistion of HCAI is a risk to patient safety					Initial	20				
				Reviewing Committee:	Current	16				
					Target	12				
3789 - Risk of patients and staff acquiring COVID HCAI			**Linked risk**:	**Date**:	Risk Score	Q1	Q2	Q3	Q4	
					Initial	20				
				Reviewing Committee:	Current	15				
					Target	5				
Key line of enquiry/ Systems and processes are in place to ensure:		Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Review Date	**Q1**	**Q2**	**Q3**	**Q4**
							Assurance RAG			
1.1	Infection risk is assessed at the front door and this is documented in patient notes	IPC risk assessments completed on admissions and pre-assessment documented within electronic patient record (EPR); established practice for all IPC risks. As of 13/05/2020 COVID assessment and shielding patients is included in the admission document for first patient encounter. If any risk identified, info added (shielding, contact, COVID-19 +/-) recorded on banner bar on EPR. If highlighted as a COVID-19 contact, flag added to EPR, automatically removed after 14 days.	Review of how compliance for this assessment will be audited.	Development of audit process in progress with PaperLite team (numbers of admissions vs. assessments in EPR).	30/06/2020	10/08/2020				

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Key line of enquiry/ Systems and processes are in place to ensure:		Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Review Date	**Q1**	**Q2**	**Q3**	**Q4**
							Assurance RAG			
1.2	Patients with possible or confirmed COVID-19 are not moved unless this is appropriate for their care or reduces the risk of transmission	Medicine clinical pathway for ED/AS. Clinical management of patients with known or suspected COVID-19 admission which is on the Trust Intranet site. Once triage/risk assessment completed and flag added to EPR, no patient transfer until there is an appropriate location to transfer the patient e.g. cubicle/cohort (based on likelihood of positivity). Limited patient transfer and only move based on clinical need and specialist care.	None currently.		30/06/2020	10/08/2020				

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1.3	Compliance with the PHE national guidance around discharge or transfer of COVID-19 positive patients	National guidance adopted into local guidelines and changed with guidance updates. Evidenced in PPE guidance on Trust intranet page. All non-elective patients tested on admission regardless of symptoms (serology and screening). Screening of elective admissions prior to admission. Patients transferred in-line with National PPE requirements for patients and staff with the exception of the use of gloves. Infection status communicated to receiving area COVID-19 status is part of transfer information. Patients discharged to nursing homes are screened in line with National guidance.	None currently.	The use of gloves during transfer of patients deviates from PHE guidance based upon risk of environmental spread from contamination gloves.	30/06/2020	10/08/2020				

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Key line of enquiry/	Systems and processes are in place to ensure:	Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Review Date	Q1	Q2	Q3	Q4
							Assurance RAG			
1.4	All staff (clinical and non-clinical) are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to the PPE that protects them for the appropriate setting and context as per national guidance	Training delivered by IPC Team and Clinical Educators, PPE buddies in place, multiple guidance posters and videos. Fit-tester training delivered by appropriate trainers (HSE guidance); list of fit testers available on Trust intranet site – on-going process. All staff wear PPE regardless of patients COVID status. The level of PPE is in line with the level of care deliver i.e. AGP or non-AGP. Evidenced on Trust PPE guidance. Contractors supplied with appropriate PPE and if required FFP3 fit testing is undertaken by contractor (i.e. asbestos removal). Robust PPE management with a dedicated team from Procurement overseeing supply and stock levels. All staff in non-clinical areas wear surgical face masks in non-COVID-19-secure areas from Monday 5th June All patients/visitors requested to wear face coverings from Monday 5th June.	None currently.	All staff wear respiratory PPE for patient contacts which will reduce transmission risk to patients. Perspex screens applied in the dialysis unit to reduce contact risk between patients attending for dialysis. Directorates to review how to manage patient flow for shielding patients through reset and recovery.	30/06/2020	10/08/2020				

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Key line of enquiry/ Systems and processes are in place to ensure:		Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Review Date	Q1	Q2	Q3	Q4
							Assurance RAG			
1.5	National IPC PHE guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	Trust guidance updated and communicated via COVID-19 briefs and in-line with national guidance. Trust has dedicated intranet page for COVID-19 with all clinical updates.	There is no correspondence sent from PHE to inform when guidance has been changed.	Government webpage checked on Friday and Monday morning by IPCT.	30/06/2020	10/08/2020				
1.6	Changes to PHE guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	Guidance changes communicate to the COVID-19 Hospital Control Team and when relevant, discussed at the executive meetings and escalated to Trust Board.	None currently.		30/06/2020	10/08/2020				
1.7	Risks are reflected in risk registers and the Board Assurance Framework where appropriate	COVID-19 risks have been incorporated into the Risk Register at directorate & corporate level. COVID-19 Risk Register entries included in Risk Register Report to Patient Safety Group; this group reports to Quality Committee. Weekly Datix incident report circulated to COVID-19 Hospital Control Team. Comprehensive range of risk assessments undertaken, examples include: shortages of PPE, asymptomatic staff, equipment.	None currently.		30/06/2020	10/08/2020				

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Key line of enquiry/ Systems and processes are in place to ensure:		Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Review Date	**Q1**	**Q2**	**Q3**	**Q4**
							Assurance RAG			
1.8	Robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	IPC risks assessment included in EPR. Risk assessment re priority for isolation rooms, guidance for staff available via 7-day IPCN cover and out of hours Microbiology support. IPC policies in place and surveillance for mandatory reporting organisms	None currently.		30/06/2020	10/08/2020				

Goal 2: Provide and maintain a clean and appropriate environmnet in managed premises that facilitates the prevention and control of infections										
Strategic Risk:			**Linked risk**:	**Date**:	Risk Score	Q1	Q2	Q3	Q4	
					Initial					
				Reviewing Committee:	Current					
					Target					
Key line of enquiry/ Systems and processes are in place to ensure:		Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Review Date	**Q1**	**Q2**	**Q3**	**Q4**
							Assurance RAG			
2.1	Designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas	PPE training delivered by Senior Nurse (Practice Development IPC), IPC nurses and clinical educators. Training records held by IPC admin team and updates provided to the Trust Board e.g. ECN report. Local PPE training at ward level by designated cascade staff and local records held. Volunteers had local induction as per Trust guidance.	None currently.		30/06/2020	10/08/2020				
2.2	Designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas	Hotel services supervisor trained in PPE by IPCT and then delivered training via cascade. Training records held by Hotel Services Manager. Domestic staff assigned to COVID-19 ward.	None currently.		30/06/2020	10/08/2020				
2.3	Decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE national guidance	Complies with national guidance and evidence in COVID-19 patient management documents on intranet. CapMan requests for AMBER COVID-19 cleans. COVID-19 cleans performed by Rapid Response, in line with all HCAI. Are monitored monthly by the Head of Facilities and reported to IPC Operational group.	None currently.		30/06/2020	10/08/2020				

Goal 2: Provide and maintain a clean and appropriate environmnet in managed premises that facilitates the prevention and control of infections										
Strategic Risk:			**Linked risk**:	**Date**:	Risk Score	Q1	Q2	Q3	Q4	
					Initial					
				Reviewing Committee:	Current					
					Target					
Key line of enquiry/	Systems and processes are in place to ensure:	Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Review Date	Q1	Q2	Q3	Q4
							Assurance RAG			
2.4	Increased frequency, at least twice daily, of cleaning in areas that have higher environmental contamination rates as set out in the PHE national guidance	As above, patient touch points or high touch points included as twice day.	None currently.		30/06/2020	10/08/2020				
2.5	Attention to the cleaning of toilets / bathrooms, as COVID-19 has frequently been found to contaminate surfaces in these areas	As above, touch points included as twice day.	None currently.		30/06/2020	10/08/2020				
2.6	Cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine, as per national guidance. If an alternative disinfectant is used, the local Infection Prevention and Control Team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses	Cleaning products used as per Trust policy. There was difficulty in obtaining usual cleaning products as this has now been added to Supplies push orders – other products were delivered which meet same standard. IPCT informed by Procurement prior to product shortage to enable planning and to assess effectiveness of alternative products.	None currently.		30/06/2020	10/08/2020				

Goal 2: Provide and maintain a clean and appropriate environmnet in managed premises that facilitates the prevention and control of infections										
Strategic Risk:			**Linked risk**:	**Date**:	Risk Score		Q1	Q2	Q3	Q4
					Initial					
				Reviewing Committee:	Current					
					Target					
Key line of enquiry/ Systems and processes are in place to ensure:		Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Review Date	Q1	Q2	Q3	Q4
							Assurance RAG			
2.7	Manufacturers' guidance and recommended product "contact time" must be followed for all cleaning / disinfectant solutions / products	As per Trust Decontamination of Patient Environment and Healthcare Equipment Policy.	None currently.		30/06/2020	10/08/2020				
2.8	As per national guidance: 'Frequently touched' surfaces, e.g. door/toilet handles, patient call bells, over-bed tables & bed rails, should be decontaminated at least twice daily & when known to be contaminated with secretions, excretions or body fluids. Electronic equipment, e.g. mobile phones, desk phones, tablets, desktops & keyboards should be cleaned at least twice daily. Rooms/areas where PPE is removed must be decontaminated, times to coincide with periods immediately after PPE removal by groups of staff (at least twice daily)	As previously noted. Twice day cleaning of staff electrical equipment in non-patient areas should be the responsibility of the user, guidance circulated and available on COVID-19 intranet page	All staff electronic equipment in clinical areas has not been routinely cleaned twice day.	Trust cleaning schedules are being reviewed to incorporate this requirement by the end of July. Changes will be available on COVID-19 intranet site and will be communicated via daily COVID-19 bulletin.	30/06/2020	10/08/2020				

Goal 2: Provide and maintain a clean and appropriate environmnet in managed premises that facilitates the prevention and control of infections										
Strategic Risk:			**Linked risk**:	**Date**:	Risk Score	Q1	Q2	Q3	Q4	
					Initial					
				Reviewing Committee:	Current					
					Target					
Key line of enquiry/ Systems and processes are in place to ensure:		Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Review Date	Q1	Q2	Q3	Q4
							Assurance RAG			
2.9	Linen from possible and confirmed COVID-19 patients is managed in line with PHE national guidance and the appropriate precautions are taken	Managed as per Trust Laundry Management Policy.	None currently.		30/06/2020	10/08/2020				
2.10	Single use items are used where possible and according to Single Use Policy	Follow appropriate guidance / policies. Reusing Single Use Equipment Policy during the COVID-19 Pandemic.	Deliver of supplies is not guaranteed where these are being issued centrally through the 'push' chain. Visors are being cleaned and reused to preserve stock. Possible shortages of NIV & CPAP devices.	Cleaning guidance included in PPE document on COVID-19 intranet page. Risk assessment and SOP in place regarding reprocessing of single use items in the event of extreme shortages (NIV and CPAP devices reprocessed via CSD); guidance prepared and in place prior to shortages experienced.	30/06/2020	10/08/2020				
2.11	Reusable equipment is appropriately decontaminated in line with local and PHE national policy	Complies with National guidance and evidence in COVID-19 patient management documents on intranet. Follows cleaning & decontamination of the patient environment & healthcare equipment policy.	None currently.		30/06/2020	10/08/2020				

Goal 2: Provide and maintain a clean and appropriate environmnet in managed premises that facilitates the prevention and control of infections										
Strategic Risk:			**Linked risk**:	**Date**:	Risk Score		Q1	Q2	Q3	Q4
					Initial					
				Reviewing Committee:	Current					
					Target					
Key line of enquiry/	Systems and processes are in place to ensure:	Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Review Date	**Q1**	**Q2**	**Q3**	**Q4**
							Assurance RAG			
2.12	Review and ensure good ventilation in admission and waiting areas to minimise opportunistic airborne transmission	Ventilation Safety Group monitors compliance of HTM requirements and planned programmed maintenance (PPM); established escalation process to DIPC where there are concerns.	Some isolation rooms are non-compliant with HTM standards for source isolation.	Refurbishing plan for existing cubicles on RV19; increasing the number of cubicle facilities with an ante room. Additional work for RV49 to create environment to ensure appropriate ventilation in COVID-19 ward (HDU).	30/06/2020	10/08/2020				

Goal 3: Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance										
Strategic Risk:			**Linked risk**:	**Date**:	Risk Score		Q1	Q2	Q3	Q4
					Initial					
				Reviewing Committee:	Current					
					Target					
Key line of enquiry/ Systems and processes are in place to ensure:		Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Review Date	**Q1**	**Q2**	**Q3**	**Q4**
							Assurance RAG			
3.1	Arrangements around antimicrobial stewardship(AMS) are maintained	Microbiologists document in patients' eRecord AMS decisions on individual patients.	Some business as usual work has been suspended to support COVID e.g. daily Micro ward rounds, Take 5 Audits, SIRM (including antibiotic reviews).	ABS rules applied at time of authorisation of results. Lab continue to test for antibiotic resistance which informs appropriate prescribing. AMS guidelines reviewed with National & local guidance.	30/06/2020	10/08/2020				
3.2	Mandatory reporting requirements are adhered to and boards continue to maintain oversight	Mandatory HCAI reporting continues. Bimonthly DIPC Reports to Board. Regular reports from DIPC to Quality Committee. Medical Director and Executive Chief Nurse in Gold COVID-19 Command Group.	None currently.		30/06/2020	10/08/2020				

Goal 4: Provide suitable a accurate information on infections to service users, their visitors and any person concerned with providing further support of nursing / medical care in a timely fashion										
Strategic Risk: 3790 - Personal Protective Equipment (PPE)			**Linked risk**:	**Date**:	Risk Score	Q1	Q2	Q3	Q4	
					Initial	20				
				Reviewing Committee:	Current	15				
					Target	10				
Key line of enquiry/ Systems and processes are in place to ensure:		Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Review Date	Q1	Q2	Q3	Q4
							Assurance RAG			
4.1	Implementation of national guidance on visiting patients in a care setting	Visitor information & guidance in line with National guidance; available on intranet. Patient information leaflets reviewed.	None currently.		30/06/2020	10/08/2020				
4.2	Areas in which suspected or confirmed COVID-19 patients are where possible being treated in areas marked with appropriate signage and where appropriate with restricted access	PPE signage at entrances. Clearly identified as restricted access and only accessible via swipe card. External company working with Trust Environment Group to enhance COVID-19 and non-COVID-19 signage.	None currently.		30/06/2020	10/08/2020				
4.3	Information and guidance on COVID-19 is available on all Trust websites with easy read versions	Dedicated COVID-19 page which is dated for evidence of last update. Daily email updates for all staff during pandemic, now reduced to three times a week as Trust continues restart work, unless required by exception.	None currently.		30/06/2020	10/08/2020				
4.4	Infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	COVID-19 positive status highlighted on EPR (banner bar). Status included in transfer information. Weekly Datix incident report sent to Hospital Control Team to help identify potential trends.	None currently.		30/06/2020	10/08/2020				

Goal 5: Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people

Strategic Risk: 3789 - Risk of patients and staff acquiring COVID HCAI	**Linked risk**:	**Date**:	Risk Score	Q1	Q2	Q3	Q4
			Initial	20			
		Reviewing Committee:	Current	15			
			Target	5			

	Key line of enquiry/ Systems and processes are in place to ensure:	Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Review Date	Q1	Q2	Q3	Q4
							Assurance RAG			
5.1	Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate them from non COVID-19 cases to minimise the risk of cross-infection, as per national guidelines	ED/AS clinical pathway – clear triage and screening pathway. Dedicated COVID-19 wards have now reverted to non-covid wards due to decreased number in COVID-19 cases. Plan to reconvert wards to COVID if Trust has a surge in cases. Reduce bed capacity in bays to reduce patients exposure risks improve social distancing.	None currently		30/06/2020	10/08/2020				
5.2	Mask usage is emphasised for suspected individuals	Suspected patients are isolated and surgical masks are used during any transfer. All outpatients and visitors are requested to wear face coverings when entering the sites.	None currently		30/06/2020	10/08/2020				
5.3	Ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff	Reception areas have been risk assessed and Perspex screening has been applied. Appropriate PPE is available and worn as per guidance.	None currently		30/06/2020	10/08/2020				

Goal 5: Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people

Strategic Risk: 3789 - Risk of patients and staff acquiring COVID HCAI	**Linked risk**:	**Date**:	Risk Score	Q1	Q2	Q3	Q4
			Initial	20			
		Reviewing Committee:	Current	15			
			Target	5			

	Key line of enquiry/ Systems and processes are in place to ensure:	Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Review Date	Q1	Q2	Q3	Q4
							Assurance RAG			
5.4	For patients with new-onset symptoms, it is important to achieve isolation and instigation of contract tracing as soon as possible	Isolation of symptomatic patients is priority over other organisms. Tracing and flagging of patient contacts via EPR for 14-day monitoring is completed with all COVID-19 cases which is supported by IPCNs, clinical teams flag EPR. Discharged patient contacts from w/c 22/06/2020 are contacted by IPCNs or clinical team to inform of contact & need to self-isolate. All HCAI COVID-19 cases positive from ≥3 days from admission are investigated from 30/05/2020 by IPCNs. (From 24/06/2020 this is now mandatory for all probable HCAI cases ≥ day 8 form admission).	None currently		30/06/2020	10/08/2020				

Goal 5: Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people

Strategic Risk: 3789 - Risk of patients and staff acquiring COVID HCAI	**Linked risk**:	**Date**:	Risk Score	Q1	Q2	Q3	Q4
			Initial	20			
		Reviewing Committee:	Current	15			
			Target	5			

	Key line of enquiry/ Systems and processes are in place to ensure:	Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Review Date	Q1	Q2	Q3	Q4
							Assurance RAG			
5.5	Patients with suspected COVID-19 are tested promptly	COVID-19 screen on admission or when suspected: • All patients at emergency admission, whether or not they have symptoms • those with symptoms of COVID-19 after admission • for those who test negative upon admission, a further single re-test conducted between 5-7 days after admission (there is a pop-up reminder on EPR to undertake a 7-day test; this can be audited) • test all positive patients on discharge to other care settings, including care homes and hospices • elective patient testing prior to admission	None currently		30/06/2020	10/08/2020				
5.6	Patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced	Lab monitors transition times of samples received for audit which is reported via lab quality assurance processes and in the quarterly IPC report. Tests are processed in batches and results are reported within 24 hours; CEPHID analyser available to perform tests with a 2-hour turnaround time for transplant patients.	None currently		30/06/2020	10/08/2020				

Goal 5: Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people

Strategic Risk: 3789 - Risk of patients and staff acquiring COVID HCAI			**Linked risk**:	**Date**:	Risk Score	Q1	Q2	Q3	Q4
					Initial	20			
				Reviewing Committee:	Current	15			
					Target	5			

Key line of enquiry/ Systems and processes are in place to ensure:		Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Review Date	Q1	Q2	Q3	Q4
							Assurance RAG			
5.7	Patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	Screening questions asked prior to appointment and on arrival. General IPC principles and isolation followed as per policy. Patient information describes symptoms and advises what actions to take by patients before coming to hospital if they are symptomatic or have been in contact with someone who is symptomatic (part of triage). Increased use of telephone consultations to replace face-to-face reviews.	None currently		30/06/2020	10/08/2020				

Goal 6: Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection										
Strategic Risk:			**Linked risk**:	**Date**:	Risk Score		Q1	Q2	Q3	Q4
					Initial					
				Reviewing Committee:	Current					
					Target					
Key line of enquiry/ Systems and processes are in place to ensure:		Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Review Date	**Q1**	**Q2**	**Q3**	**Q4**
							Assurance RAG			
6.1	All staff (clinical and non-clinical) have appropriate training, in line with latest PHE guidance, to ensure their personal safety and working environment is safe	Refer to Section 2. Fit-testing/checking on-going. Fit-testers available in all Directorates, with refresher sessions avialbale for all fit testers. List of fit tester is available centrally on the COVID intranet site. Reusable half and full face masks (FFP3 level) are being allocated to individual staff memebers where appropriate. Powered Air Purifying Respirators (PAPRs) have been purchased and are available in theatres, ICU areas and for other staff where appropriate.	Compliance with fit testing is challenging due to the inconsistent supply of specific types of FFP3 masks. All supplies are push rather than pull. From NHS Supply Chain.	Where staff cannot be fit tested to a disposable or reusable FFP3 mask will have access to a PAPRs, which do not require fit testing.	30/06/2020	10/08/2020				
6.2	All staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation, including correct donning and doffing procedeures	COVID-19 audit to confirm PPE compliance is performed during HCAI COVID-19 investigations. Training information is available on the COVID intranet site, including doffing vidoes and written protocols. Training has been delivered to all clinical areas with PPE cascade trainers encouraged. Clinical Educators, PPE advisors and IPCNs deliver local PPE advise and training.	None currently		30/06/2020	10/08/2020				

Goal 6: Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection										
Strategic Risk:			**Linked risk**:	**Date**:	Risk Score		Q1	Q2	Q3	Q4
					Initial					
				Reviewing Committee:	Current					
					Target					
Key line of enquiry/ Systems and processes are in place to ensure:		Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Review Date	Q1	Q2	Q3	Q4
							Assurance RAG			
6.3	A record of staff training is maintained	Refer to Section 2.	None currently		30/06/2020	10/08/2020				
6.4	Appropriate arrangements are in place that any reuse of PPE in line with the CAS alert is properly monitored and managed	Existing SOP for cleaning typhoon and 3M FFP3 reusable masks & powered hoods. Disposable items are not reused, risk assessment guides process for reusing items in circumstances for extreme PPE shortages. CAS Alerts co-ordinated via Hospital Control Team.	No audit trial for monitoring compliance of cleaning reusable items.		30/06/2020	10/08/2020				
6.5	Any incidents relating to the re-use of PPE are monitored and appropriate action taken	Users would report any incidences via Datix reporting and monitors.	None currently		30/06/2020	10/08/2020				
6.6	Adherence to PHE national guidance on the use of PPE is regularly audited	Strong peer support and challenge is encouraged to maintain staff safety. No formal audit evidence available. Audit of PPE compliance undertaken since 30/05/20 with any COVID-19 case positive from day ≥day 3 of hospital admission.	No evidence of regular audit program for COVID-19 PPE compliance at the present time.	IPCNs & PPE advisors visible presence across all clinical areas and provide education if identify any incorrect practices. Review of weekly COVID-19 Assurance checklist to include PPE compliance from 13/07/2020	30/06/2020	10/08/2020				

Goal 6: Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection										
Strategic Risk:			**Linked risk**:	**Date**:	Risk Score		Q1	Q2	Q3	Q4
					Initial					
				Reviewing Committee:	Current					
					Target					
Key line of enquiry/ Systems and processes are in place to ensure:		Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Review Date	Q1	Q2	Q3	Q4
							Assurance RAG			
6.7	Staff regularly undertake hand hygiene and observe standard infection control precautions	Hand hygeine performed in line with Trust Policy. Monthly Matron hand hygiene compliance monitored.	Some business as usual work has been suspended to support COVID-19. This includes program of hand hygiene validation audits undertaken by IPCNs.	Observations for compliance with hand hygiene opportunities has been incorporated into the COVID-19 audit tool which is undertaken as in section 6.6	30/06/2020	10/08/2020				
6.8	Hand dryers in toilets are associated with greater risk of droplet spread than paper towels. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination, as per national guidance	All clinical areas have paper towels for hand hygiene.	Hand dryers are in some Trust non-clinical areas e.g. public toilets.	Reviewed by Estates to and initial plan to electronically isolate hand dryers and replace with hand towels to minimise the environmental risks. Awaiting confirmed date of completion. Plan to review in September.	30/06/2020	10/08/2020				
6.9	Guidance on hand hygiene, including drying, should be clearly displayed in all public toilet areas as well as staff areas	Hand washing technique is displayed on the hand soap dispenser.	Display does not include guidance on drying.	Posters to be updated by end of July 2020.	30/06/2020	10/08/2020				
6.10	Staff understand the requirements for uniform laundering where this is not provided for on site	Dress and Appearance Policy and COVID-19 information with guidance on Trust intranet page.	Not all clinical staff wear uniforms.	Work in progress to ensure scrubs available for clinical staff where appropriate.	30/06/2020	10/08/2020				

Goal 6: Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection										
Strategic Risk:			**Linked risk**:	**Date**:	Risk Score		Q1	Q2	Q3	Q4
					Initial					
				Reviewing Committee:	Current					
					Target					
Key line of enquiry/ Systems and processes are in place to ensure:		Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Review Date	**Q1**	**Q2**	**Q3**	**Q4**
							Assurance RAG			
6.11	All staff understand the symptoms of COVID-19 and take appropriate action in line with PHE national guidance if they or a member of their household display any of the symptoms	Staff and family screening in-house POD – information on intranet on how to contact.	None currently		30/06/2020	10/08/2020				

Goal 7: Provide or secure adequate isolation facilities										
Strategic Risk:			**Linked risk**:	**Date**:	Risk Score		Q1	Q2	Q3	Q4
					Initial					
				Reviewing Committee:	Current					
					Target					
Key line of enquiry/ Systems and processes are in place to ensure:		Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Review Date	Q1	Q2	Q3	Q4
							Assurance RAG			
7.1	Patients with suspected or confirmed COVID-19 are where possible isolated in appropriate facilities or designated areas where appropriate	Designated COVID wards across both sites. If specialist care is required the patient is prioritised in cubicle for isolation. Agreed pathways for patient flow.	Limited cubicle capacity which could potentially become an issue.	IPCNs undertake daily cubicle review in medicine to support patient flow and prioritisation of cubicles. Daily morning meeting held with PSC to discuss potential cubicle availability. On-going refurbishment on RV19, RV48 and RV49.	30/06/2020	10/08/2020				
7.2	Areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance	In COVID-19 patient management guidance.	None currently.		30/06/2020	10/08/2020				
7.3	Patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	IPC policies MRSA/MSSA, C .diff, CPE, Isolation Policy.	None currently.	IPC Nurses with Patient Services Co-ordinator support prioritisation of patient placement.	30/06/2020	10/08/2020				

Goal 8: Secure adequate access to laboratory support as appropriate										
Strategic Risk:			**Linked risk**:	**Date**:	Risk Score		Q1	Q2	Q3	Q4
					Initial					
				Reviewing Committee:	Current					
					Target					
Key line of enquiry/ Systems and processes are in place to ensure:		Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Review Date	Q1	Q2	Q3	Q4
							Assurance RAG			
8.1	Testing is undertaken by competent and trained individuals	Training records held in the lab and in line with UKAS accreditation.	None currently.		30/06/2020	10/08/2020				
8.2	Patient and staff COVID-19 testing is undertaken promptly and in line with PHE national guidance	Staff in-house and household screening available and co-ordinated by OHS. Patient screening performed via relevant pathways.	None currently.		30/06/2020	10/08/2020				
8.3	Screening for other potential infections takes place	Mandatory HCAI reporting ongoing. SSI surveillance for hips / knees /spinal surgery ongoing.	Stopped MRSA screening on 31/03/2020 due to COVID-19 pressures to enable the laboratory to increase COVID screening capacity.	Usual MRSA screening programmes recommenced on 06/05/2020.	30/06/2020	10/08/2020				

Goal 9: Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections										
Strategic Risk:			**Linked risk**:	**Date**:	Risk Score	Q1	Q2	Q3	Q4	
					Initial					
				Reviewing Committee:	Current					
					Target					
Key line of enquiry/ Systems and processes are in place to ensure:		Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Review Date	Q1	Q2	Q3	Q4
							Assurance RAG			
9.1	Staff are supported in adhering to all IPC policies, including those for other alert organisms	Polices on intranet.	Policies are not be monitored for compliance due to suspended auditing to prioritise COVID additional work.	High visible presence of IPCNs, senior staff, clinical educators to support adherence to policies.	30/06/2020	10/08/2020				
9.2	Any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	Updated identified on daily COVID-19 briefings and intranet site. Good framework of meetings and management / communicate well.	None currently.		30/06/2020	10/08/2020				
9.3	All clinical waste related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current PHE national guidance	Waste guidance on intranet site for COVID-19.	None currently.		30/06/2020	10/08/2020				
9.4	PPE stock is appropriately stored and accessible to staff who require it	Stored in clinical areas clean utilities. Management of stock PPE oversight processes and systems; centralised ordering system in place.	National Supply channel issues.	Daily PPE stock position update for DIPC (including information on next delivery and PPE expected). Agreed minimal stock levels with trigger points of when to escalate to consider contingency measures.	30/06/2020	10/08/2020				

Goal 10: Have a system in place to manage the occupational health needs and obligations of staff in relation to infection										
Strategic Risk:			**Linked risk**:	**Date**:	Risk Score		Q1	Q2	Q3	Q4
					Initial					
				Reviewing Committee:	Current					
					Target					
Key line of enquiry/ Systems and processes are in place to ensure:		Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Review Date	**Q1**	**Q2**	**Q3**	**Q4**
							Assurance RAG			
10.1	Staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported	All healthcare workers included in communications and support offered by the occupational health service. Risk assessment for at risk/extremely vulnerable groups with bespoke advice sent by email to those with particular concerns: • Pregnant staff • Those with underlying health conditions including respiratory, gastroenterology, neurology, rheumatology, immunosuppression medications, cancer • Other high risk categories including ethnicity (appended information indicating volume and range of concerns and KPI for contact) Support telephone line established. Regular updates for staff and managers via email and COVID-19 intranet page. Enhanced flexible/agile working to support social distancing. Multi-disciplinary Staff Support Cell developed.	None currently.	30 redeployed Trust staff joined OHS to support during the peak of activity as main stream Trust activity declined.	30/06/2020	10/08/2020				
10.2	Staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained	Fit testing training delivered, records held by IPC admin team.	None currently but acknowledge work on-going.		30/06/2020	10/08/2020				

Goal 10: Have a system in place to manage the occupational health needs and obligations of staff in relation to infection										
Strategic Risk:			**Linked risk**:	**Date**:	Risk Score		Q1	Q2	Q3	Q4
					Initial					
				Reviewing Committee:	Current					
					Target					
Key line of enquiry/ Systems and processes are in place to ensure:		Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Review Date	**Q1**	**Q2**	**Q3**	**Q4**
							Assurance RAG			
10.3	Consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the cross-over of care pathways between planned and elective care pathways and urgent and emergency care pathways as per national guidance	Staffing templates/requirements are reviewed due to reduced bed capacity on wards. Staff Redeployment Cell developed to oversee appropriate staff placement/temporary redeployment. Staff movement limited.	None currently.		30/06/2020	10/08/2020				
10.4	All staff adhere to national guidance on social distancing (2 metres) wherever possible, particularly if not wearing a facemask and in non-clinical areas	Trust signage promoting social distancing and environmental risk assessments available.		Environmental working group devising staff handbooks to reinforce social distancing. Planned completion time is July 2020.	30/06/2020	10/08/2020				
10.5	Consideration is given to staggering staff breaks to limit the density of healthcare workers in specific areas	Workplace COVID-19 secure risk assessment tool on the COVID intranet page.	Local risk assessment and changes to directorate working.		30/06/2020	10/08/2020				

Goal 10: Have a system in place to manage the occupational health needs and obligations of staff in relation to infection										
Strategic Risk:			**Linked risk**:	**Date**:	Risk Score		Q1	Q2	Q3	Q4
					Initial					
				Reviewing Committee:	Current					
					Target					
Key line of enquiry/ Systems and processes are in place to ensure:		Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Review Date	**Q1**	**Q2**	**Q3**	**Q4**
							Assurance RAG			
10.6	Staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	Staff absence and well-being monitored using ESR and Allocate. HR, OHS and line managers in contact with staff. All staff with symptoms are tested (or the index case if a household member). Contact tracing of staff is undertaken by OHS when social distancing has not been maintained without appropriate PPE. Non-symptomatic staff working in situations where there is a declared COVID-19 outbreak or where a colleague they have been in contact with tests positive will be offered be testing	None currently.		30/06/2020	10/08/2020				
10.7	Staff that test positive have adequate information and support to aid their recovery and return to work.	Sit reps made to COVID-19 team daily and linked with laboratory reported data regarding staff requesting swabs and positive results. OHS control the information to staff re both negative and positive staff screening results. Initial results often resulted in further queries regarding self-isolation and management of household contacts.	None currently.		30/06/2020	10/08/2020				

BRP -
A6(vii)

Score	Impact/Consequence	Injuries	Financial Impact	Impact on Health objectives	Impact of programme
1	Insignificant	No obvious harm.	Costs 1K and under	No significant effect on quality of care	No Delay to Programme
2	Minor	No permanent damage. First aid injury. No lost time.	Costs up to 10K	Noticeable effect on quality of care	Minor delay to Programme (up to 1 week)
3	Moderate	Sprain, strain, burn. May require medical treatment. Lost time. Temporary incapacity.	Costs up to 50K	Significant effect on quality of care	Moderate delay to Programme (1 week to 1 month)
4	Major	Loss of limb, fracture, crushing. RIDDOR reportable. Exposure to toxins. Permanent incapacity. Major disruption to service.	Costs between 50K & 500K	Patient care significantly impaired	Major delay to Programme (1 month to 6 months)
5	Catastrophic	Fatality. Multiple casualties. Loss of service.	Costs over 500K	Patient care impossible	Delay to programme greater than 6 months

Impact / Consequence

Likelihood	**Insignificant 1**	**Minor 2**	**Moderate 3**	**Major 4**	**Catastrophic 5**
Almost certain 5	5	10	15	20	25
Likely 4	4	8	12	16	20
Possible 3	3	6	9	12	15
Unlikely 2	2	4	6	8	10
Rare 1	1	2	3	4	5

Northern Centre for Cancer Care Cumbria Project							Project Risk Register. Date 06/12/2019													Risk Register Northern Centre for Cancer Care Cumbria Project
			Rating Assessment					Post Control				Owner / Leader				Action By Date				
No	CATEGORY	RISK	LIKELIHOOD (1 -5)	COST IMPACT (1 -5)	PROGRAMME IMPACT (1 - 5)	OVERALL	MITIGATION AND CONTROL	LIKELIHOOD (1 -5)	COST IMPACT (1 -5)	PROGRAMME IMPACT (1 - 5)	OVERALL RATING	Stage 2	Stage 3	OBC	Post FBC		ITEM STATUS	Cost Impact (Cost £ Opportunity -£)	Risk assessed cost impact	Included Stage 3 Value	COMMENTS (Incl. notes on basis of quantification and valuation of risk provision)
1	Personnel	Inability to recruit Clinical Staff to substantive NCUH posts. Impact on clinical service quantity and quality	5	4	4	R	Recruitment and employment of clinical staff by NuTH being explored. Skill mix and staff role development for nurses and AHPs essential for a resilient long term service model. This requires resource for training and backfilling of posts during	4	4	4	R			NCIC	NCIC	Ongoing	Open				
2	Personnel	Sustainability of Dosimetry Service at Cumbria	5	4	2	R	NUTH providing remote support to carry out planning. Post out to advert as a joint post between NUTH & NCIC - Employer will be NUTH Post will be based at NCIC	4	4	2	A				NUTH/NCIC		Open				
3	Personnel	Tupe Process - Successful implemetation of the Tupe process	3	3	3	A	Full Planned consultation process with buy in from NCIC & NUTH. Process to be led by HR leads Christine Mann (NUTH) Christine Lightfoot (NCIC) Operational Lead Phil Powell. Tupe to be complete 6 months prior to agreed transfer of service	2	2	2	G				NUTH/NCIC		Open				
4	Personnel	Development of job plans and recruitment to newly identified posts	3	3	3	A	Job plans are currently being worked up for identified posts. Joint recruitment across NUTH & NCIC process has been agreed	2	2	3	G				NUTH/NCIC		Open				
5	Personnel	Changes to Key Personnel during the Project	4	2	2	A	Trust to ensure where possible key people are retained for the duration of the project. Ensure that information and knowledge is shared between the Project Team to mitigate any personnel changes. Where planned changes are known, ensure transition period and formal handover to new staff	3	2	2	A	CCC	CCC	NUTH/NCIC	NUTH/NCIC	N/A	Open				
6	Personnel	There may be a lack of appropriate resouce (funds, time or people) to complete the compliant business case stages effectively	3	3	3	A	Design to cost plan approach.	3	3	3	A			All			Open				
7	Personnel	Assimilation of Service Delivery to ensure quality of service is delivered to the same standards and guidelines	3	2	2	A	Honorary Contracts for essential staff at NUTH & NCIC - Cross site working in place	3	2	2	A				NUTH/NCIC	Ongoing	Open				
8	Personnel	Vacancies within HR Team - Potential to impact of capacity of HR (NCIC)	4	3	4	R	Identified HR Manager for NCIC & NUTH. Recruitment in progress	3	3	3	A				NCIC		Open				
9	Personnel	Clinical Staff Sickness - Current sickness of consultant resulting in no asssigned consultant based at NCIC for approx 2 months with return date not guaranteed	4	4	4	R	Working with NCIC to maintain/provide consultant cover	4	4	4	R				NUTH/NCIC	01/01/2020 - ongoing					

No	CATEGORY	RISK	Rating Assessment				MITIGATION AND CONTROL	Post Control				Owner / Leader				Action By Date	ITEM STATUS	Cost Impact (Cost £ Opportunity -£)	Risk assessed cost impact	Included Stage 3 Value	COMMENTS (Incl. notes on basis of quantification and valuation of risk provision)
			LIKELIHOOD (1 -5)	COST IMPACT (1 -5)	PROGRAMME IMPACT (1 - 5)	OVERALL		LIKELIHOOD (1 -5)	COST IMPACT (1 -5)	PROGRAMME IMPACT (1 - 5)	OVERALL RATING	Stage 2	Stage 3	OBC	Post FBC						
10	ICT	Robust IT Infrastructure delayed between NCIC & NUTH. Negative impact on access to clinical data. Infrastructure connection interfaces between NUTH & NCIC causes delay in service transfer or new facility becoming operational	3	2	2	A	Develop proposals and implement upon agreement of advance funding. Delay mitigated by early installation - manage through IT workstream	2	2	2	G			NUTH/NCIC	NUTH/NCIC		Open				ICT specification outstanding although dialogue into proposals has been occurring.
11	Equipment	Older linac fails and cannot be repaired. Clinical Service dependent on one linac for long term, impact on staff and clinical service	3	3	3	A	Spare parts retained from LA2 to ensure rapid repair where possible, failure of major component considered unlikely but possible. Service managed with one linac for 6 months, but staff were stressed.	3	3	3	A			NCIC	NCIC	Ongoing	Open				
12	Equipment	Late procurement of equipment leads to delay in operations	3	3	3	A	Manage equipment budget and procurement early in the process. Utilise existing equipment where appropriate. Include sensible 12 week commissioning/decant period	2	3	3	A			NCIC	NCIC		Open				
13	Equipment	Specifications of trust equipment not defined/change or procured on time	3	3	3	A	Trust to provide detailed requirements pre-GMP and procurement programme	2	3	3	A			NCIC	NCIC		Open				Specifications to be clear and provided within a reasonable timescale for review.
14	Equipment/Service	Additional MRI scanner is not operational in PFI building when the new cancer centre commences services	3	3	3	A	Opportunity to share assessment of equipment and bulk purchase with NuTH. Identified specifications of replacement to mirror NUTH equipment - water cooled	3	3	3	A			NCIC	NCIC	Ongoing	Open				
15	Service	Change of service specification impacts on design and cost of cancer centre	3	5	5	R	Design and likely service model compliant with the latest draft service specification for radiotherapy. No update to chemotherapy service specification anticipated. Changes to NICE recommendations may increase activity in	2	4	2	A			NCIC	NCIC	Ongoing	Open				
16	Service	Delay to agreeing and implementing service model to ensure an efficient and resilient service.	3	2	3	A	Requires engagement of all involved parties. Service model has been agreed and is currently being worked through within all clinical work groups	3	2	3	A			NCIC	NCIC	Ongoing	Open				
17	Service	Delay to agreeing and implementing finance and contractural service model to ensure a viable service long term.	3	2	3	A	Service model has been agreed and is being taken forward by the finance and contracting working sub group	3	2	3	A			NCIC	NCIC	Ongoing	Open				
18	SLA's	Changes in Service Specifications leads to delays and increased cost in finalising SLA's with NuTH	3	4	4	R	Develop SLA's early in accordance with programme. Change Control process to be managed by Project Team	3	3	3	A			NUTH/NCIC	NUTH/NCIC		Open				SLA's to be developed asap. Currently being managed / worked through within the teams/workstreams
19	Design	Changes in the clinical brief/scope leads to increased cost and delay	4	3	3	R	Further design development following FBC to be treated as reviewable design data and agreed/signed off by clinical user groups. Decisions for any changes will be taken forward by CCL - Lynsey Brown (lead)	2	2	3	A	CCC	CCC	Project Director	Project Director		Open				Change Control process to be followed
20	Design	Design does not meet Infection control and Fire Safety standards	2	2	2	G	Liaise with IC and Fire Officer at regular intervals during the design process. OBC signed off by both parties.	2	2	2	G	CCC	LOR	Project Director	Project Director		Open				Consultation ongoing.

No	CATEGORY	RISK	Rating Assessment				MITIGATION AND CONTROL	Post Control				Owner / Leader				Action By Date	ITEM STATUS	Cost Impact (Cost £ Opportunity -£)	Risk assessed cost impact	Included Stage 3 Value	COMMENTS (Incl. notes on basis of quantification and valuation of risk provision)
			LIKELIHOOD (1 -5)	COST IMPACT (1 -5)	PROGRAMME IMPACT (1 - 5)	OVERALL		LIKELIHOOD (1 -5)	COST IMPACT (1 -5)	PROGRAMME IMPACT (1 - 5)	OVERALL RATING	Stage 2	Stage 3	OBC	Post FBC						
21	Design	Ambiguities between trust and contractor works information	3	2	2	A	Trust to check and align proposals and work to remove ambiguity.	2	2	2	G			NCIC	NCIC		Open				
22	Design	Trust failure to review and approve design in accordance with programme	3	3	3	A	Detailed programme and review process, Trust to ensure key parties are made available. Info issued in accordance with Procedure.	2	3	3	A			NCIC	NCIC		Open				Review procedure to be agreed with Trust and other members, information release schedules to be issued and review dates set. See note above regarding programme baord between PFI/Trust
23	BREEAM	Not achieving BREEAM Excellent	1	3	2	G	Undertake Pre-assessment with reasonable margin of comfort. Achieve early credits where possible and review progress regularly during design and construction stage. Regular update on securing credits from advisor.	1	3	2	G	CCC	CCC	Scott Hughes	Scott Hughes		Open				BREEAM target is still tight but looks achievable. Contractor input required on their specific credits. Risk rating to be reviewed once pre-demolition audit is complete.
24	Construction	Impact on clinical services due to dust, noise and other nuisances during the works	4	2	2	A	Mitigation plan to be developed by Contractor. Acceptable levels to the Trust to be included in the contract. Supervisor to manage expectations and notify clinical staff of any impact on a weekly basis. Aspergillosis risk to be managed during demolition.	3	2	2	A	CCC	CCC	Contractor	Contractor		Open				Contractor method statement to be produced and agreed by the Trust. Works Information provides contractual protection to the Trust. Initial meeting held with Infection Control to discuss demolition, risk assessment being developed by Clive Grahams team.
25	Construction	D&B Contractor goes into liquidation or becomes insolvent during the project.	2	2	4	A	Appoint financially sound contractor and undertake rigorous financial checks. Graham appointed GMP agreed	1	1	1	G			Cost Advisor	Cost Advisor		Open				Graham appointed and Financially sound. Performance Bond not an option on Procure 22, only a PCG. Graham to provide company accounts for review.

No	CATEGORY	RISK	Rating Assessment				MITIGATION AND CONTROL	Post Control				Owner / Leader				Action By Date	ITEM STATUS	Cost Impact (Cost £ Opportunity -£)	Risk assessed cost impact	Included Stage 3 Value	COMMENTS (Incl. notes on basis of quantification and valuation of risk provision)
			LIKELIHOOD (1 -5)	COST IMPACT (1 -5)	PROGRAMME IMPACT (1 - 5)	OVERALL		LIKELIHOOD (1 -5)	COST IMPACT (1 -5)	PROGRAMME IMPACT (1 - 5)	OVERALL RATING	Stage 2	Stage 3	OBC	Post FBC						
26	Capital Cost	Increase in capital cost above budget during FBC stage, may include impact of VAT treatment.	3	4	3	R	Regular cost planning of budget against design as it develops by appointed cost advisor. Finance and Contracting group to continue to progress	3	3	3	A			Cost Advisor	Cost Advisor		Open				Cost Advisor appointed and capital cost plan being developed to review current design against the budget. Equipment budget may not fully cover 2nd LINAC. NCIC reviewing VAT implications and to report to Finance and Contracting sub group 11th June 2020 against capital budget. Clarification received re VAT no
27	Capital Cost	Impact of increased costs on FBC Contigency Sum - Sum reduced from £898k to £346k due to unexpected unavoidable costs relating to demolition and enabling works - little headroom left for further unexpected events	3	5	4	R	Chris Birtle (F&C sub group) to action through the finance and contracting group to proactively work up options that could provide mitigating savings should they be required to keep the project on budget	3	5	4	R			Cost Advisor	Cost Advisor		Open				
28	Financial	Additional insurance requirements.	2	3	1	A	Liaise with potential insurance provider to check insurance requirements.	1	3	1	G			NCIC	NCIC		Open				NCUHT to investigate if there are any additional insurance requirements. PFI, SPV and construction insurances (P22) be reviewed
29	Utilities	Strike of unforeseen/unknown live services and inaccuracy of GPR survey of existing below ground service locations	3	3	2	A	Ground radar scan and CAT scan around perimeter and site once cleared to ensure that no live services remain in the working area. Issue has been addressed	2	2	2	G			NCIC	NCIC		Open				Live services known to be coming up infirmary road however exact locations still remain unknown. Sub surface scan to be completed to fully inform.
30	Transport	Installation of Varian linac requires access routes	3	3	3	A	Track route and undertake maintenance strategy to ensure a suitable method of access prior to work commencing.	2	3	2	A			NCIC	NCIC		Open				NCUHT to report findings.
31	Programme	Handover is delayed due to construction or techinical commissioning issues	2	3	3	A	Early and effective planning and coordination with the PSCP & Technical commissioning manager.	2	3	3	A			NCIC/Graham	NCIC/Graham		Open				
32	Commissioning	Failure to plan and coordinate functional commissioning	4	3	3	R	Commissioning manager and equipment manager to be appointed? Soft landings?	2	3	3	A			NCIC/Graham	NCIC/Graham		Open				
33	Covid -19	Staffing levels due to high infection rates/sickness/childcare/self isolation	5	4	4	R	Currently unable to mitigate	3	2	2	A			NUTH/NCIC	NUTH/NCIC		Open				
34	Covid -19	Training across all areas - staff unable to travel between sites for training due to restrictions relating to Covid 19 - risk that staff will not receive adequate/appropriate training for the service to run to planned timetables	5	5	5	R	Non face to face/virtual training being utilised in as many instances as possible	3	2	2	A				NUTH/NCIC		Open				
35	Covid -19	Operationally work done during Covid 19 may not be covered by usual governance	4	2	2	A	Ongoing work between NCIC & NUTH to ensure governance is worked through. Planning for post Covid 19 is ongoing	3	1	2	A				NUTH/NCIC		Open				
		Ch														Total		-	-	-	

Northern Centre for Cancer Care Cumbria Project								Project Risk Register. Date 06/12/2019														isk Registe Northern Centre for
			Rating Assessment						Post Control				Owner / Leader				Action By Date					
No	CATEGORY	RISK	LIKELIHOOD (1 - 5)	COST IMPACT (1 - 5)	PROGRAMME IMPACT (1 - 5)	OVERALL	Trigger date	MITIGATION AND CONTROL	LIKELIHOOD (1 - 5)	COST IMPACT (1 - 5)	PROGRAMME IMPACT (1 - 5)	OVERALL RATING	Stage 2	Stage 3	OBC	Post FBC		ITEM STATUS	Cost Impact (Cost £ Opportunity -£)	Risk assessed cost impact	Included Stage 3 Value	COMMENTS (Incl. notes on basis of quantification and valuation of risk provision)
1	H&S	Accident/Incident as a result of Construction traffic and adjacencies to existing link corridor/VIE plant	3	4	4	R		Include in Pre-construction H&S plan. Segregate construction traffic where possible with a traffic management plan. Protect link corridor	2	4	4	A			Contractor /P&HS			Open				
2	Existing structure	Defects in the existing link structure.	3	1	2	A		Approval of connections to link corridor / bridge and avoid additional load to corridor. PFI related defects would be dealt with by the PFI	3	1	2	A			Graham			Open				Defects can't be identified prior to commencing work, Graham to
3	Planning	Planning application approval process leads to delay and additional cost	3	4	3	R		Liaise early with LPA and obtain comfort letter for OBC. Liaise regularly during design development to ensure expectations are	2	2	2	G	CCC	CCC	P&HS			Open				Reserved matter underway. Risk of delay mitigated.
4	Design	Incomplete design of bunker leading to design change.	3	4	3	R		Procure supplier ASAP to finalise design.	2	3	3	A			NCUHT / Graham			Open				Agreement to go with Veritas from all parties, risk level
5	Design	Change in legislation / technical guidance.	3	3	3	A		D+B contractor and design team to monitor potential change pre-GMP. The risk post GMP would then sit with the Trust.	3	3	3	A			NCUHT / Graham			Open				Change in legislation can't be predicted, compensation event to be
6	Design	Building overheating (especially in the atrium)	4	4	4	R		Create a thermal model, equipment and occupancy heat gain to be calculated, solar reflective glass to be implemented and mitigation strategy to be	2	4	4	A			P+HS			Open				P+HS are aware of this risk and are currently working towards
7	Design	It might be suggested to include a sprinkler system as an active fire protection method due to inclusion of this in the PFI hospital.	3	4	4	R		Ensure that the building meets HTM standards for fire protection.	2	4	4	A			P+HS			Open				The building is designed to comply with HTM standards and

8	Design	Late decision on IT connection - Clartiy needed as to whether there is a new data connection to the external supply or if the connection is back	3	2	2	A		Trust to be pushed for a clear direction in a timely manner	2	1	1	G			CCL			Open				
9	Construction	Re-route of HV cable between link corridor and building	5	3	2	R		Review options for diverting cable with the PFI/Trust, look at protection options if diversion not possible	5	3	2	R			CCL			Open				The diversion costs would need to sit with the PFI/Trust, protection
10	Construction	VIE protection during construction is inadequate and lead to damage to VIE, resulting in serious disruptions to operational hospital	2	4	4	A		Retain VIE protection from demolition phase which includes full encapsulation with crash deck. Trust o expedite installation of second VIE plant on	2	2	2	G			CCL			Open				Demolition contractor has been requested to provide cost for
11	Construction	Damage caused to insitu HV cable if diversion not possible	3	3	3	A		H&S review required to confirm works which are feasible adjacent to the cable	3	2	2	A			Graham			Open				
12	Construction	The level of build quality delivered by PSCP does not match the brief	2	4	4	A		Robust monitoring by Graham Construction Site Supervisor and NEC3 Supervisor team. PSCP has a full quality management system in place.	2	3	3	A			Graham			Open				
13	Construction	Material and labour shortages due to geographical location	4	4	3	R		Early market testing of key packages to secure resource Meet the buyer events to identify wider supply chain.	2	3	2	A			Graham			Open				
14	Construction	Vandalism disrupts build programme	3	3	3	A		Site Security to be incorporated into construction plan and prelims. High risk areas to be carefully reviewed around the front of the existing PFI and link	2	2	2	G			Graham			Open				
15	Construction	Damage or interference to or failure of site services during construction resulting in disruption to clinical service.	2	3	3	A		Risk/method statements to be provided for before works undertaken. Procedures for working with services detailed\agreed within	1	3	3	G			Graham			Open				
16	Construction	Procurement strategy, management of supply chain, lead time	3	3	3	A		Work in partnership with the PSCP and Joint Cost Advisor to ensure procurement strategy considers the management of lead in time issues ahead of	2	3	3	A			Graham / Gleeds			Open				

17	Construction	Systems tie-in to PFI not clear/not known or not possible to match existing systems architecture	3	3	2	A		PSCP to identify scope of works in conjunction with NHS	2	2	2	G			Graham			Open				
18	PFI interfaces	Unforeseen works on PFI hospital site cause delay.	3	3	3	A		Regular site liaison meetings.	2	3	2	A			Graham			Open				Meetings will be scheduled between the project team and The Trust
19	PFI interfaces	Disruption caused to the existing hospital.	3	3	3	A		Site management plan, regular liaison with PFI and continuous monitoring to ensure minimal disruption is caused.	2	3	2	A			Graham			Open				A clear line of communication is to be in place with the PFI
20	Funding	GMP not within affordability.	3	3	3	A		Robust cost planning; cost plan input into the design; early key packages to be market tested, prelims, risk etc.. Agreed early. Value engineering	2	3	3	A			NCUHT / Graham			Open				Graham to review Gleeds Cost Plan and to carry out market
21	Funding	Exchange rate to the USD for the Veritas bunker purchase - quoted in USD	3	4	3	R		Work with Vertias to understand the possibility and cost implications of fixed exchange rates and other financial remedies to reduce	3	3	3	A			Graham			Open				Veritas have some suggestions to offer to minimise
22	Funding	Economic uncertainty brought about via Brexit. Construction inflation calculations may be inadequate.	3	4	3	R		Impact of BREXIT to be monitored Possible early purchase of products to be investigated Early Market testing of key components to be	3	4	3	R			Graham			Open				
23	Funding	Assumptions in cost plans change from initial early budgets	3	4	3	R		Regular review of benchmark assumptions and updating of indices in cost plan. Refinement of cost plan in consultation with	3	3	3	A			Graham / Gleeds			Open				
24	Procurement	Adequacy of competent supply chain not up the required standard.	3	3	3	A		Meet the buyer with M&E partner capabilities statement, company checks to be carried out and existing supply chain to be utilised on key	2	3	3	A			Graham			Open				Graham agreed to meet the buyer event and checks to
25	Covid -19	Risk to supply chain - early warning relating to Veritas having difficulty securing shipping containers impacting on the movement of products worldwide	4	4	4	R		Graham in contact with Veritas	4	4	4	R			Graham			Open				
26	Covid-19	Risk to workforce due to illness	3	3	3	R		Workforce have low numbers currently in the 'at risk' category any absence should be short term	3	2	2	A			Graham			Open				

27	Covid -19	Delay and disruption to supply chain of materiels from outside of the UK due to restrictions of movement	4	4	4	R		Currently unable to mitigate	4	4	4	R			Graham			Open				

AUDIT COMMITTEE ANNUAL REPORT 2019-2020

1. PURPOSE

The purpose of this report is to provide assurance to the Trust Board that the Audit Committee has met its key responsibilities for 2019-20, in line with its terms of reference and the requirements of the Audit Committee Handbook.

The following sections outline overall achievements throughout the year. The report also outlines action points for continuing development during the coming year.

2. AUDIT COMMITTEE RESPONSIBILITIES

The key purpose of the Audit Committee is to provide the Board with:

- an independent and objective review of financial and organisational controls, the system of integrated governance and risk management systems and practice across the whole of the organisation's activities (both clinical and non-clinical);
- assurance of value for money;
- compliance with relevant and applicable law;
- compliance with all applicable guidance, regulation, codes of conduct and good practice; and
- advice as to the position of the Trust as a "going concern."

It does this through receipt of assurances from auditors, management and other sources.

3. AUDIT COMMITTEE MEMBERSHIP AND MEETINGS

The Committee is appointed by the Board from the Non-Executive Directors of the Trust and consists of four members with a quorum being two members.

Four ordinary meetings and one extraordinary meeting were held between 1 April 2019 and 31 March 2020 and attendance was as follows:

	Attendance at ordinary meetings	Attendance at extraordinary meeting
Mr D Stout, Non-Executive Director (Committee Chair)	4 of 4	1 of 1
Mr J Jowett, Non-Executive Director	4 of 4	0 of 1
Professor K McCourt, Non-Executive Director	3 of 4	1 of 1
Mr S Morgan, Non-Executive Director	4 of 4	1 of 1

The Committee met the minimum number of five meetings per year and other attendees at the meetings have included:

- External and Internal Audit at all meetings;
- The Trust Fraud Specialist Manager;
- Management, represented by the Finance Director, Assistant Chief Executive, Chief Operating Officer, Executive Chief Nurse, Medical Director and Director of Quality and Effectiveness;
- The Trust Secretary and Deputy Trust Secretary who also provide Secretariat Support to the Committee; and
- The Corporate Risk & Assurance Manager.

4. GOVERNANCE, INTERNAL CONTROL AND RISK MANGEMENT

The Committee is required to review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the Trust's activities, both clinical and non-clinical, that supports the achievement of the Trust's objectives, internal control and risk management.

The Audit Committee followed the Schedule of Business for 2019/20 and it uses a rolling programme and action log to track committee actions.

The Committee has reviewed:

- Its Terms of Reference and Schedule of Business.
- The Head of Internal Audit opinion (May 2019).
- The Board Assurance Framework; being the underlying assurance processes that indicate the achievement of corporate objectives and the effectiveness of management of principal risks.
- Risk management arrangements and reviewed and approved an updated Risk Management Policy.
- Other governance arrangements such as the Scheme of Delegation, Standing Financial Instructions and Standing Orders*.
- The Trust compliance with the changes to the UK Code of Governance.
- Audit Committee briefing note – ISA 240, 250, 501 & 570.

*A detailed review of the Scheme of Delegation, Standing Orders and Standing Financial Instructions was undertaken during the year to ensure they accurately reflected the changes to the Board Committees. This was following an exercise undertaken with DAC Beachcroft to update/refresh the Trust Constitution.

The Board Assurance Framework (BAF) focuses on the key risks against achievement of the strategic objectives. The BAF is a 'live' document which is continuously reviewed and updated by the Corporate Risk & Assurance Manager.

During 2019/2020, a new format for the Board Assurance Framework (BAF) and Executive Oversight Register was introduced. Each meeting of the Committee is updated on the BAF and Register.

Each Committee of the Board has a responsibility to review, assess and gain assurance on the effectiveness of mitigations and action plans as set out in the BAF specific to the Committee purpose and function. Quarterly each Committee of the Board receives a report detailing the:

i) Executive Lead review undertaken during the previous 3 month period and any recommendations for risks held on the Board Assurance Framework aligned to that Committee;
ii) assurances received and any areas requiring Committee consideration;
iii) number of risks held on the BAF, movements in risks and the risks categorised by risk type;
iv) risks added/removed to the Executive Oversight Register during the period; and
v) operational risk profile.

The Trust Board Risk Appetite Statement and tolerance levels were reviewed and refreshed during the year, with final approval provided at the Trust Board meeting held on 30 January 2020.

During the year the Trust Board also received a standing update on Corporate Governance matters, these reports regularly included a section to provide further assurance over risk management arrangements in addition to the quarterly BAF reports.

Regular reporting of updates from the Finance, Quality and People Committee Chairs was implemented during the year through the inclusion of a standing agenda item. These updates allowed the Audit Committee to receive assurance over the work of those Committees.

The Committee is satisfied that the system of risk management in the organisation is adequate in identifying risks and allows the Board of Directors' to understand the appropriate management of those risks. The Committee believes there are no areas of significant duplication or omission in the systems of governance (that have come to the Committee's attention) that have not been adequately resolved.

5. INTERNAL AUDIT

The Committee has ensured that there is an effective internal audit function established by management that meets mandatory Internal Audit Standards and provides appropriate independent assurance. The Trust receives its internal audit service from AuditOne.

This was achieved by:

- Reviewing and approving the Internal Audit Strategy and Annual Plan and the more detailed programme of work, including regular updates of performance against the Plan.
- Consideration of the major findings arising from internal audit work and management's responses.
- Receipt of the Internal Audit Annual Report and Head of Internal Audit Opinion.
- Monitoring progress with implementation of agreed audit recommendations.

The Committee received a report from the internal auditor at each of its committee meetings which summarised the audit reports issued since the previous meeting.

The internal audit plan for 2019-20 was based on a risk assessment approach centred on discussions with senior staff and Directors and was linked to the organisation's assurance framework. Assurances from Internal Audit reports are mapped to the BAF clearly in the BAF document itself.

6. EXTERNAL AUDIT

The Committee has reviewed the work and findings of external audit and considered the implications and management responses to their work.

This was achieved by:

- Discussing and agreeing with the external auditor the nature and scope of the audit as set out in the External Audit Annual Plan.
- Reviewing external audit reports, together with the appropriateness of management responses.
- Received the year-end Audit Opinion, ISA 260 report (Trust and Charity) and the report on the Quality Account.

The Council of Governors has the statutory responsibility for the appointment of the external auditors, and this process is led by a sub-group of public Governors supported by Trust officers and the Chair of the Audit Committee. During 2018, a robust procurement and evaluation process was undertaken regarding the external audit contract with Mazars LLP appointed as the Trust's external auditors with effect from 1st October 2018 for 3 years to 30th September 2021. The contract includes an option to extend for a further 1 year after the 3 years. The Mazars LLP external audit fees for 2019/20:

- Statutory Accounts £65,160 (inclusive of VAT)
- Quality Accounts/Report £11,160 (inclusive of VAT)*
- Charity Accounts £12,000 (inclusive of VAT) [An increase of £810 from the 2018/19 fee to reflect the agreed contracted amount]

*The fee for the work on the Quality Report for 2019/20 was reduced to £3,080 (plus VAT) to reflect the requirement issued in March 2020 to no longer include the Quality Report in the Annual Report in response to the COVID-19 pandemic, with auditors being advised to cease assurance work on the Quality Report at that time.

To ensure that the independence of the external auditors is not compromised where work outside the scope of the Audit Code has been procured from the external auditors, the Trust has a policy which requires that no member of the team conducting the external audit may be a member of the team carrying out any additional work and their lines of accountability must be separate.

During 2019/20 the Trust policy on Non-Audit Work was reviewed and updated for presentation at the April 2020 Committee meeting.

No additional services/non-audit work was carried out by Mazars LLP during 2019/20.

7. MANAGEMENT

The Committee has challenged the assurance process when appropriate and has requested and received assurance reports/verbal updates from Trust management throughout the year.

8. FINANCIAL AREAS OF REVIEW

The Committee has ensured that the systems for financial reporting to the Board are subject to review.

The Committee has achieved this primarily through review and approval of the Annual Accounts and TAC schedules, including those of the Newcastle upon Tyne Hospitals NHS Charity. The Committee also reviewed the External Audit Opinion and fed back relevant comments for consideration by the external auditors.

In the course of 2019-20, there were no significant issues that the Committee had to consider in relation to the financial statements. During the year, the Committee reviewed the following significant risks:

- Management over-ride of controls (Group and Trust);
- Property valuations (Trust); and
- Fraud in revenue recognition (Trust).

Other areas of management judgement discussed related to the appropriateness of the estimate for incomplete patient spells at the year-end and accounting for the Trust PFI scheme.

These have been considered through the presentation of the external audit plan and discussions with the Trust's external auditors, Mazars LLP.

9. OTHER AREAS OF ACTION AND REVIEW

The Committee has:

- Reviewed details of all Losses and Compensation Payments.
- Received reports on approved single tender actions where applicable.
- Reviewed regular debtors and creditors reports.
- Received regular reviews of the Counter Fraud Work plan, the Fraud response log, associated progress reports and the Annual Report on counter fraud.

- Reviewed the minutes of associated Committees and Groups.
- Reviewed the content of the statutory Annual Report (including the Quality Report and Annual Governance Statement).
- Reviewed and endorsed changes to the Trust Scheme of Delegation/Standing Orders and Standing Financial Instructions.
- Received the Annual Accounts preparation timetable and subsequently the Annual Accounts and Going Concern Review.
- Received a report on special severance payments.
- Received the Trusts Modern Slavery Act Statement.
- Received a report on a Genomes Project Write off.
- Received updates on Standards of Business Conduct, including declarations of interest, fit and proper persons and the annual register of gifts and hospitality.
- Received a report on waivers and breaches of the Trust SFIs.
- Received an action log to follow up previous Committee meeting actions.
- Received an Annual Review of the Clinical Audit Process.
- Received regular updates from the Chairs of the Quality, People and Finance Committees.

In addition a significant amount of work was undertaken during the year to improve the Trust position regarding the completion of internal audit recommendations. This included the regular follow up reports from AuditOne being circulated regularly to the Executive Team members by the Trust Secretary, and individual Directors providing feedback on the status of recommendations pertinent to their portfolio of work. This has resulted in a reduction in the number of overdue actions, particularly those where 'no update was received' as to the status of the action.

10. PROGRESS FOR 2020-2021

The self-assessment checklist from the HFMA Audit Committee Handbook has been completed and attached in Appendix 1.

Recommendation: The Audit Committee is asked to review the self-assessment; provide any further feedback/commentary, particularly on the areas highlighted in bold, and agree the self-assessment as an accurate reflection of Committee effectiveness.

There are three key areas where the Committee will be revisiting during 2020/21 which are:

1. Continuing from the work performed during 2019/20, the need to monitor the process and implementation of outstanding internal audit and external audit recommendations in order to ensure that old recommendations are followed up timely and robustly.

2. A significant amount of work has been undertaken on reviewing and refining the Trusts Governance Structure and Risk Management arrangements. The Trust Risk Management Policy was reviewed and significantly updated during the year. Further work is required on terms of:

a. Roll-out and delivery of revised Risk Management Policy.
b. Further development of a fully integrated Board Assurance Framework and Risk Appetite following on from the issue of the revised Policy.
c. Reviewing the Trust Policy Approval process.

The Committee will need to seek assurance over the implementation of the policy and the changes in processes which require establishing during the year.

3. The Standards of Business Conduct Policy has been reviewed and updated which will require consideration and approval by the Audit Committee in 2020/21. The policy review builds upon the work undertaken during 2019/20 to consolidate the Trust declarations process through the utilisation of MES Declare portal which went live on 13th January 2020. Once the policy has been approved, the Committee will need to seek assurance over the implementation of the policy and the changes in processes which require establishing during the year.

The Committee will need to receive assurances regarding the activities outlined above and further in light of the above, there is a need to further refine the content of this Annual Report in the future to include for example:

- the comprehensiveness of assurances in meeting the Board and Accounting Officer's needs;
- the reliability and integrity of these assurances;
- whether the assurance available is sufficient to support the Board and Accounting Officer in their decision taking and their accountability obligations;
- the implications of these assurances for the overall management of risk;
- financial reporting for the year.

Report of Kelly Jupp
Trust Secretary
27 March 2020

Agenda Item / Issue	Jan	Apr	May/ June [EO]	Jul	Oct
Assurance and Risk Management					
Receive governance documents: - Scheme of Delegation/SFIs/SOs (Annual Review) – min annually - Modern Slavery Act Statement – min annually - New guidance or mandatory documents - as and when required	x x	 x		 x x	 x
Review of the full Assurance Framework for the completed year and the year ahead	x	x		x	x
Monitor the Board Assurance Framework (BAF) to ensure identified gaps in controls or assurances are addressed (min twice a year)		x		x	
Review findings of other significant assurance functions (outwith internal and external audit), for example the CQC, NHSI and NHS Resolution– as and when required	x	x		x	x
Undertake a Self-Assessment of the Committee's Effectiveness and produce an Audit Committee Report for the main Board setting out how the Committee has met its Terms of Reference. This should support the Annual Governance Statement.		x		x	
Review the Risk Register Report	x	x		x	x
Review the Committee's Terms of Reference		x			
Review the Draft and Final Annual Governance Statement		X (D)	X (F)		
Note the business of other governance committees	x	x		x	x
Review Clinical Audit Process	x				x
Receive assurance over systems for financial reporting to the Trust Board		X			
Review arrangements by which staff may raise concerns and receive an annual report on the application of the Trust policy on raising concerns		X			X
Financial Governance					
Agree the Financial Statements timetable and plans	x				
Review Accounting issues raised as part of the Financial Statements audit		x	x		
Approve draft and final Trust Annual Financial Statements, prior to Board approval and TACs		X (D)	X (F)		
Approve draft and final Charity Annual Financial Statements, prior to Board approval				X (D)	X (F)
Approve the draft and final Annual Report (inc Quality Account) text, prior to Board approval		X (D)	X (F)		
Review and recommended to the Board, changes to the Corporate Governance Manual – as and when required	x	x		x	x
Review the Schedule of Losses and Compensation	x	x		x	x
Annual Review of the Register of Gifts and Hospitality	x				
Annual Review of Register of Directors' Interests				X	
Annual Review of Special Severance Payments / Settlement Agreements		x			
Review the report of Debtors and Creditors balances	x	x		x	x
Review the Schedule of Approval of Single Tender Action	x	x		x	x
Receive the External/Internal Audit Protocol	x				
Consider Financial Statements Accounting Policies, Estimates and Judgements			X		
Review of Going Concern Position		X			
Internal Audit					
Review the draft and approve the final Annual Plan	X (D)	X(F)			
Receive the Outcome of Audit Work / Progress Update	x	x	x	x	x
Receive the draft and final Head of Internal Audit Opinion		X (D)	X (F)		
Receive the Annual Report and IA Charter				x	
External Audit					
Approve the Annual Plan and 3 year Strategic Plan	x				
Receive the Outcome of Audit Work – as and when required	x	x	x	x	x
Receive the Management Letter / ISA260 report to the Trust			x		
Receive the Management Letter / ISA260 report to the Charity					x
Receive the Annual Audit Letter				x	

Agenda Item / Issue	Jan	Apr	May/ June [EO]	Jul	Oct
Receive the Limited Assurance Report on the Quality Report			x		
<u>Counter Fraud</u>					
Approve the Annual Plan and Annual Fraud Self Review Tool		x			
Receive the Fraud Response Log /Fraud register	x	x		x	x
Receive the Activity Report	x	x		x	x
Receive the Annual Report				x	
Additional Assurance areas for Committee consideration annually:					
Policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements (5.3.6) *Policies for managing and investigating complaints and legal claims against the Trust, including referrals to NHS Resolution (5.3.7)* *Oversee the maintenance of the policy framework of the Trust and review any significant breaches of the procedures (5.6.1)*					

NB – Receive at every meeting the minutes (for approval) from the previous meeting and action log.
NB – At every meeting, receive minutes of Quality, People, Private Practice Committee, Payroll Consortia and Finance Committee.

EO = Extraordinary Committee meeting for approval of the Annual Report and Accounts

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TERMS OF REFERENCE – AUDIT COMMITTEE

1. CONSTITUTION OF THE COMMITTEE

The Audit Committee is a statutory Committee established by the Board of Directors to monitor, review and report to the Board on the suitability and efficacy of the Trust's provisions for governance, risk management and internal control.

2. PURPOSE AND FUNCTION

The purpose and function of the Committee is to:

2.1 monitor the integrity of the financial statements of the Trust and Group, any formal announcements relating to the Trust's financial performance, and review significant financial reporting judgements contained in them;

2.2 monitor, review and report to the Board of Directors on the adequacy of the processes for governance, assurance, and risk management, and facilitate and support the attainment of effective processes through its independence;

2.3 review the effectiveness of the Trust's internal audit function, counter fraud services and external audit function;

2.4 provide assurance to the Board of Directors that an appropriate system of internal control is in place to ensure that Trust business is conducted in accordance with legal and regulatory standards, and affairs are managed to secure economic, efficient and effective use of resources with particular regard to value for money;

2.5 report to the Board of Directors on the discharge of its responsibilities as a Committee; and

2.6 provide assurance to the Board of Directors that the Trust has policies and procedures in place to protect the organisation from/related to, fraud and corruption.

3. AUTHORITY

The Committee is:

3.1 a statutory Non-Executive Committee of the Trust Board of Directors, reporting directly to the Board of Directors, and has no executive powers, other than those specifically delegated in these Terms of Reference;

3.2 authorised by the Board to investigate any activity within its Terms of Reference, to seek any information it requires from any officer of the Trust, and to invite any employee to provide information by request at a meeting of the Committee to support its work, as and when required; and

3.3 authorised by the Board of Directors to secure the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for the exercise of its functions, including whatever professional advice it requires (as advised by the Executive Lead of the Committee and / or the Trust Secretary).

4. MEMBERSHIP AND QUORUM

MEMBERSHIP

4.01 Members of the Committee will be appointed by the Trust Board of Directors and the Committee will be made up of at least four members.

4.02 All members of the Committee will be independent Non-Executive Directors. One of the members will be appointed by the Trust Board of Directors as the Chair of the Committee and a second member will be appointed as Vice-Chair by the Trust Board of Directors.

4.03 The Committee Chair will be a financially experienced professional/executive possessing relevant postgraduate, Chief Financial Officer, or accountancy credentials, assessed as being appropriate to the role by the Nominations Committee, on behalf of the Board of Directors. It is expected that at least one member will have a formally recognised professional accountancy qualification.

4.04 The membership will include:

- a Non-Executive member of the Finance Committee;
- a Non-Executive member of the Quality Committee; and
- a ~~one or more~~ Non-Executive member~~s~~ of the People Committee ~~Board of Directors~~.

4.05 The Chair of the Board of Directors will not be a member of the Committee but may be in attendance.

4.06 The Senior Independent Director of the Board of Directors will not be Chair of the Audit Committee.

4.07 Only members of the Committee have the right to attend Committee meetings. Alternate, or substitute, members may be agreed in advance with the Chair of the Committee for a specific meeting but not for more than one and will not count towards the quorum. Other non-Committee members may be invited to attend and assist the Committee from time to time, according to particular items being considered and discussed.

4.08 In the absence of the Committee Chair, the Vice-Chair will chair the meeting.

4.09 Members are able to attend Committee meetings in person, by telephone, or by other electronic means. Members in attendance by electronic means will count towards the quorum.

4.10 The Director of Finance will act as the Executive lead for the Committee and will attend all ~~–~~meetings. ~~At least one further Executive team member will be in attendance at each meeting.~~

4.11 The Chief Executive and other members of the Executive team should be invited to attend as appropriate with an expectation that if invited they should attend in person. In addition, the Chief Executive should be required to attend, at least annually, to discuss the process for assurance that supports the Annual Governance Statement.

4.12 External Audit and Internal Audit representatives, and the Trust Fraud Specialist Manager will be invited to attend meetings of the Committee at the discretion of the Chair. In addition, they will ~~on occasion~~ be invited to meet Committee members prior to the formal conduct of the business of the meeting without members of the Executive present.

4.13 The Council of Governors may nominate up to two governors to attend one meeting of the Committee annually to observe proceedings. The observation of Board assurance committees by governors will be subject to conditions agreed by the Board of Directors. The Chair of the Committee may in exceptional circumstances exclude governors from being present for specific items.

4.14 The Trust Secretary, or their designated deputy, will act as the Committee Secretary. The Trust Secretary, or a suitable alternative agreed in advance with the Chair of the Committee, will attend all meetings of the Committee.

4.15 All members of the Committee will receive training and development support before joining the Committee and on a continuing basis, as required, to ensure their effectiveness as members, supported by the process of annual appraisal, as agreed by the Board of Directors.

4.16 An attendance record will be held for each meeting and an annual register of attendance will be included in the annual report of the Committee to the Board of Directors.

QUORUM

4.17 The quorum necessary for the transaction of business will be two members, both of whom will therefore be Non-Executive Directors, as specified in 4.02 and 4.04 of these Terms of Reference.

4.18 Members unable to attend a meeting of the Committee may nominate a deputy to attend on their behalf, agreed with the Chair of the Committee. ~~Nominated deputies shall not count towards the quorum.~~

4.19 A duly convened meeting of the Committee at which a quorum is present will be competent to exercise all or any of the authorities, powers and discretions delegated to the Committee.

5. DUTIES

5.1 The Committee will undertake the duties detailed in the NHS Audit Committee Handbook (HFMA latest edition) and will have regard to the Audit Code for NHS Foundation Trusts. The Committee will carry out the duties below for the Foundation Trust and major subsidiary undertakings as a whole, as appropriate. The Committee will set an annual plan for its work to form part of the Board's Annual Cycle of Business, and report to the Board on its progress. The duties of the Committee will include:

6. FINANCIAL REPORTING

The Committee will:

6.1 ensure that the systems for financial reporting to the Board of Directors, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided;

6.2 ensure the integrity of the Annual Report and Financial Statements of the Trust and Group before submission to the Board of Directors, and any other formal announcements relating to its financial performance, reviewing significant reporting issues and judgements that they contain, and including the meaning and significance of the figures, notes and significant changes; accounting policies and practices followed, and significant changes; explanation of estimates or provisions having

material effect; the schedule of losses and special payments and any reservations and disagreements between internal and external auditors, and the executive directors, which are not resolved;

6.3 review summary financial statements, Trust Accounts Consolidation (TAC) data, the Annual Report and Accounts~~significant financial returns to regulators and any financial information contained in other official documents~~, including the Annual Governance Statement;

6.4 review the consistency of, and changes to, accounting policies across the Trust and its subsidiary undertakings including the operation of, and proposed changes to, the Corporate Governance Manual, Standing Orders, Standing Financial Instructions, Scheme of Delegation and Reservation of Powers, Matters Reserved to the Board and Standards of Business Conduct, including maintenance of registers and the Fraud Response Plan;

6.5 review the methods used to account for significant or unusual transactions where different approaches are possible (including unadjusted mis-statements in the financial statements);

6.6 receive and review an annual report on special severance payments made during the year via a settlement agreement;

6.7 review whether the Trust has followed appropriate accounting standards and made appropriate estimates and judgements, taking into account the views of the External Auditor; and

6.8 review the clarity of disclosure in the Trust's financial reports and the context in which statements are made.

7. GOVERNANCE, RISK MANAGEMENT AND INTERNAL CONTROL

The Committee will review:

7.1 the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives;

7.2 the risk environment of the Trust to ensure that the governance system is adequately addressing the full range of current, and potential future, risks;

7.3 the adequacy of risk and control related disclosure statements, in particular the Annual Governance Statement, together with the Head of Internal Audit Opinion,

External Audit Opinion or other appropriate independent assurances, prior to endorsement by the Board of Directors;

7.4 the effectiveness of systems and processes for risk management in the Trust, in accordance with the Risk Management Strategy and Policy approved by the Committee, including arrangements for the development and review of the Board Assurance Framework and the Corporate Risk Register;

7.5 the Board Assurance Framework and processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;

7.6 the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements, any related reporting and self-certifications, and work related to counter fraud and security, as required by the NHS Counter Fraud Authority;

7.7 the policies for managing and investigating complaints and legal claims against the Trust, including referrals to the NHS Resolution ~~Litigation Authority~~; and

7.8 the Register of Directors' Interests; and Register of Gifts and Hospitality on a regular basis, and not less than annually.

8. INTERNAL CONTROL AND COUNTER FRAUD

The Committee will:

8.01 ensure that there is an effective Internal Audit function that meets the *Public Sector Internal Audit Standards* and provides appropriate independent assurance to the Committee, Chief Executive, and Board of Directors;

8.02 consider and approve the Internal Audit Strategy and Annual Plan, and ensure it has adequate resources and access to information, including the Board Assurance Framework, to enable it to perform its function effectively and in accordance with the relevant professional standards. The Committee will also ensure the function has adequate standing and is free from management or other restrictions;

8.03 review all reports on the Trust from the Internal and External Auditors which identify "limited assurance" or "no assurance";

8.04 review and monitor, on a sample basis, the Executive Management's responsiveness to the findings and recommendations of audit reports, and ensure coordination between Internal and External Auditors to optimise use of audit resource;

8.05 meet the Head of Internal Audit on a formal basis, at least once a year, without Executive Directors or management, to consider issues arising from the internal audit programme and its scope and impact. The Head of Internal Audit will be given the right of direct access to the Chair of the Committee, Chief Executive, Board of Directors, and to the Committee;

8.06 assure itself that the Trust has policies and procedures for all work related to fraud and corruption as required by the NHS Standard Contract and NHS Counter Fraud Authority (NHS CFA). ;

8.07 consider the effectiveness of Counter Fraud services routinely, at least once every two years; and

8.08 monitor the implementation of the policy on standards of business conduct for directors and staff (i.e. Codes of Conduct and Accountability) in order to offer assurance to the Board of Directors on probity in the conduct of the Trust's business.

8.09 consider and approve the Annual Fraud Plan, and ensure that adequate resources and access to information enables the Fraud Team to perform its work effectively and in accordance with the relevant professional standards and the NHS Counter Fraud Manual;

8.10 approve the contents of the annual Fraud Self Review Tool prior to submission to the NHS CFA.

9. EXTERNAL AUDIT

The Committee will:

9.1 consider and make recommendations to the Council of Governors, in relation to the appointment, re-appointment and removal of the Trust's External Auditor;

9.2 work with the Council of Governors to manage the selection process for new auditors. If an auditor resigns, the Committee will investigate the reasons, and make any associated recommendations to the Council of Governors;

9.3 obtain assurance of External Auditor compliance with the Audit Code for NHS Foundation Trusts;

9.4 approve the External Auditor's remuneration and terms of engagement, including fees for audit or non-audit services and the appropriateness of fees, to enable an adequate audit to be conducted;

9.5 agree and review the policy regarding the supply of non-audit services by the External Auditor and monitor that service, taking into account relevant ethical guidance;

9.6 review and monitor the External Auditors' independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the External Auditors and consider the implications and management's responses to their work;

9.7 meet the External Auditor at least once a year, without management being present; to discuss their remit and any issues arising from the audit;

9.8 establish with the External Auditors, the nature and scope of the audit, as set out in the annual plan before the audit commences; and

9.9 review all External Audit reports for the Trust and Charity, including the reports to those charged with governance (before its submission to the Board of Directors), the limited assurance report on the Quality Report and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

10. OTHER BOARD ASSURANCE FUNCTIONS

The Committee will:

10.01 oversee the maintenance of the policy framework of the Trust, in particular the Policy for the Development of Procedural Documents and the Corporate Governance Manual, and review any significant breaches of the procedures;

10.02 review arrangements by which staff may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters, ensuring that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action. The Committee will receive an annual report on the application of the Trust policy on raising concerns;

10.03 monitor and receive assurance on compliance with the Trust's Speaking Out Policy and ensure that the policy allows for proportionate and independent investigation of such matters and appropriate follow-up action;

10.04 review the findings of other significant assurance functions, both internal and external to the Trust, and consider the implications for the governance of the Trust. These will include, but not be limited to, any reviews undertaken by the Department of Health Arms-Length Bodies, Regulators, and professional bodies with responsibility for the performance of staff or functions;

10.05 review the work, and receive the minutes, of other Committees within the organisation and its subsidiaries, whose work can provide relevant assurance to the Audit Committee's own scope of work and in relation to matters of quality affecting the Board Assurance Framework, including the Quality Committee, the Finance Committee, the People Committee, and the Payroll Consortium;

10.06 ensure there is no duplication of effort between the Committees, and that no area of assurance is missed as part of its responsibility for reviewing the Annual Governance Statement prior to submission to the Board of Directors;

10.07 review matters pertaining to clinical risk management and satisfy itself on the assurance that can be gained from the Clinical Audit function, including receiving the Clinical Audit Annual Plan and Annual Report and other updates on progress twice a ~~throughout the~~ year to maintain process oversight;

10.08 receive information on Single Tender Waivers, as approved by the Chief Executive, to gain assurance that such waivers were appropriate;

10.09 receive a schedule of losses and compensations and approve appropriate write-offs;

10.10 review registers relating to the Standards of Business Conduct Policy and consider any breaches and action taken; and

10.11 review every decision by the Council of Governors or the Board of Directors to suspend their respective Standing Orders.

10.12 In fulfilling its responsibilities, the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

11. REPORTING AND ACCOUNTABILITY

11.1 The Committee Chair will report formally to the Trust Board of Directors on its proceedings after each meeting on all matters within its duties and responsibilities, summarising areas where action or improvement is needed.

11.2 The Committee will report to the Trust Board annually on its work in support of the Annual Governance Statement. The Annual Report will:

- set out clearly how the committee is discharging its responsibilities;

- include a statement referring to any non-audit services provided by the external auditors, and if so, how auditor objectivity and independence is safeguarded;
- set out details of the full auditor appointment process, and where the Council of Governors decide not to accept the recommendations of the Committee, a statement setting out (a) an explanation of the Committee's recommendation in relation to the appointment, re-appointment or removal of the external auditor and (b) the reasons the Council of Governors has chosen not to accept those reasons;
- provide explanatory details, where during the year the External Auditor's contract is terminated in disputed circumstances, on the removal process and the underlying reasons for removal;
- be signed by the Chair of the Audit Committee; and
- be presented to the Annual General Meeting, with the Chair of the Audit Committee in attendance to respond to any stakeholder questions on the Committee's activities.

11.3 The Chair of the Committee will write to the Independent Regulator of NHS Foundation Trusts (NHS Improvement) in those instances where the services of the External Auditor are terminated in disputed circumstances.

11.4 Where exceptional, serious and improper activities have been revealed by the Committee, the Chair of the Committee will write to NHS Improvement, if insufficient action has been taken by the Board of Directors after being informed of the situation.

11.5 The Chair of the Committee shall provide, as a minimum ~~an~~ annually, an update to the Council of Governors on the work of the Committee.

11.6 The Terms of Reference shall be reviewed by the Committee and approved by the Board of Directors on a minimum basis of every two years.

12. COMMITTEE ADMINISTRATION

12.1 The Committee will meet a minimum of five times a year and at such other times as the Chair of the Committee, in consultation with the Trust Secretary, will require allowing the Committee to discharge all of its responsibilities.

12.2 The Chairman may at any time convene additional meetings of the Committee to consider business that requires urgent attention.

12.3 The agenda will be set in advance by the Chair, with the Trust Secretary and Executive Lead, reflecting an integrated cycle of meetings and business, which is

agreed each year for the Board and its Committees, to ensure it fulfils its duties and responsibilities in an open and transparent manner.

12.4 Notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, will be made available to each member of the Committee, no less than five working days before the date of the meeting in electronic form. Supporting papers will be made available no later than three working days before the date of the meeting.

12.5 Committee papers will include an outline of their purpose and key points in line with the Trust's committee protocol, and make clear what actions are expected of the Committee.

12.6 The Chair will establish, at the beginning of each meeting, the existence of any conflicts of interest and ensure these are recorded in the minutes accordingly.

12.7 The Committee Secretary will minute the proceedings of all Committee meetings, including recording the names of those present, in attendance and absent. Draft minutes of Committee meetings will be made available promptly to all members of the Committee, normally within ten working days of the meeting.

12.8 The Committee will, at least once a year, review its own performance, using a process agreed for all Board Committees by the Board of Directors.

Procedural control statement: 2nd April 2020
Date approved: 15th June 2020
Approved by: Audit Committee
Review date: May 2021

CHARITABLE FUNDS COMMITTEE ANNUAL REPORT 2019-2020

1. PURPOSE

The purpose of this report is to provide assurance to the Trust Board that the Charitable Funds Committee has met its key responsibilities for 2019-20, in line with its terms of reference and the requirements of the Audit Committee Handbook.

The following sections outline overall achievements throughout the year. The report also outlines action points for continuing development during the coming year.

2. COMMITTEE RESPONSIBILITIES

The Charitable Funds Committee is a statutory Committee established by the Board of Directors to manage, on behalf of the Board, all charitable funds under the control of the Trust, considering the requirements of the Department of Health and the Charity Commission for England and Wales.

The key purpose of the Charitable Funds Committee is to:

i) apply the Trust's charitable funds in accordance with their respective governing documents and ensure that funds are used in accordance with the charity's objectives – all with the budget, priorities and spending criteria determined by the Trust Board as trustees and consistent with the Charities Act 2011 and the Charities (Protection and Social Investment) Act 2016 (the 'PSI Act 2016');
ii) manage the Trust's charitable funds in accordance with statutory requirements of the Charity Commission, Department of Health & Social Care guidance and the Trust's Standing Orders, Reservation of Powers to the Board and Delegation of Powers, the Scheme of Delegation and Standing Financial Instructions; and
iii) make decisions, on behalf of the Corporate Trustee, involving the sound investment of charitable funds in a way that both preserves their capital value and produces a proper return consistent with prudent investment and ensures compliance with the Trustees Act 2000, the Charities Act 2011, the PSI Act 2016 and Charity Commission regulations.

It does this through receipt of assurances from management, investment managers and other sources.

3. COMMITTEE MEMBERSHIP AND MEETINGS

The Committee is appointed by the Board and consists of five members of the Board with a quorum being three members (with at least one Executive Director and one Non-Executive Director).

Four ordinary meetings and two extraordinary meetings were held between 1 April 2019 and 31 March 2020 and attendance was as follows:

	Attendance at ordinary meetings	Attendance at extraordinary meetings
Mr K Godfrey, Non-Executive Director (Committee Chair)	4 of 4	2 of 2
Mr J Jowett, Non-Executive Director	4 of 4	2 of 2
Ms J Baker, Non-Executive Director	3 of 3*	2 of 2
Dame Jackie Daniel, Chief Executive Officer (CEO)	0 of 4	0 of 2
Mr A Welch, Medical Director and Deputy CEO	1 of 4	2 of 2
Mrs A Dragone, Finance Director	4 of 4	2 of 2

* Ms Baker joined the Trust as a Non-Executive Director in July 2019.

The Committee met the minimum number of four meetings per year and other attendees at the meetings have included:

- The Assistant Chief Executive;
- Head of Charitable Funds
- The Trust Secretary and Deputy Trust Secretary who also provide Secretariat Support to the Committee; and
- The Deputy Finance Director.

The Committee members are asked to consider the membership of the Committee to ascertain whether any further changes are required.

4. FINANCIAL MANAGEMENT, CONTROL & REPORTING

The Committee has ensured that the systems for financial reporting to the Board are subject to review.

The Committee has achieved this primarily through review and approval of the Annual Report & Accounts.

In the course of 2019-20, there were no significant issues that the Committee had to consider in relation to the financial statements.

During the year, the Committee also:

i) Considered the Funds banking arrangements and agreed not to make any changes. The Committee also endorsed the increase in the Association of NHS Charities fee.

ii) Reviewed the Statement of Financial Activities, the Balance Sheet and the Debtors and Creditors report at every ordinary meeting. In addition grants in excess of the agreed threshold were reviewed and where appropriate, approved.

iii) Received and reviewed regular income and target spend reports.

5. FUNDRAISING AND INVESTMENT

During the year the services of Tarnside Consultancy were procured to review the Trust's Charity and help in realising the organisation's ambition. A workshop was held and a report produced which highlighted that the Charity was performing well and generated healthy returns, however further investment was required to heighten the Charity profile and increase fundraising income further.

The Committee:

i) Received regular updates on fundraising activities.
ii) Considered investment reports and reviewed the performance of the investment portfolios against a number of targets including the consumer price index. Returns on investments were debated.
iii) Supported the proposed transfer of the current Newton's portfolio into a Sustainability Fund.

6. GOVERNANCE, INTERNAL CONTROL AND RISK MANGEMENT

The Committee had a Schedule of Business for 2019/20 and uses a rolling programme and action log to track committee actions.

The Committee has reviewed:

- Its Terms of Reference and Schedule of Business.
- The Scheme of Delegation.

During the year an exercise was undertaken by the Head of the Charitable Funds to further improve the review process and enable more consistent and timely decision making. The Scheme of Delegation was reviewed and the thresholds updated. Further the Committee agreed to the formulation of a Grants Panel with a specific threshold of approval. As yet the Grants Panel has not been required to meet and therefore this position will be monitored during 2020/21.

The Committee considered a paper on Online Payments and agreed that further work was required before a decision be agreed.

There were no additional matters arising during the course of the year that required reporting to the Charity Commission.

7. INTERNAL & EXTERNAL AUDIT

The Audit Committee is responsible for ensuring that there is an effective internal audit function established by management that meets mandatory Internal Audit Standards and provides appropriate independent assurance. The Trust receives its internal audit service

from AuditOne and annually an Internal Audit is undertaken on the key controls in operation for the Charitable Funds.

The scope of the Charitable Funds internal audit is to review key aspects of fund management i.e. receipt of income (through legacies, donations and fundraising), fund and investment management, banking arrangements as well as the process of making (in accordance with donor's wishes where relevant) and approving payments. The 2019/20 audit commenced in March 2020 and the final report is awaited. The 2018/19 equivalent report received a 'substantial assurance' conclusion.

The Audit Committee has reviewed the work and findings of external audit and considered the implications and management responses to their work. The Audit Committee undertake this role as the Charity accounts are included within the overall Trust Group accounts. The detail is therefore included in the Annual Report of the Audit Committee for 2019/20.

Mazars LLP are the appointed Trust's external auditors and the fee for the Charity Accounts for 2019/20 was £12,000 (inclusive of VAT). This was an increase of £810 from the original 2018 agreed contract.

8. MANAGEMENT

The Committee has challenged the assurance process when appropriate and has requested and received assurance reports/verbal updates from Trust management throughout the year.

Following on from the Charity Review undertaken during the year it was agreed a new Charity Communications Officer and a Charity Director post be created and recruited into. During the year Ms Audrey Barton was appointed, and commenced in post as the Charity Communications Officer. Ms Terri Wishart was appointed as the Trust Charity Director.

9. OTHER AREAS OF ACTION AND REVIEW

The Committee considered how Charitable Funds could be utilised to support the Trust staff, and patients, in responding to the COVID-19 pandemic; and further authorised the use of such funds for related specific items.

In addition a significant amount of work was undertaken during the year to review the standing agenda items, streamline the Committee agenda and reformat Committee reports in accordance with the Trust standard Committee reporting format.

10. PROGRESS FOR 2020-2021 & REVIEW OF EFFECTIVENESS

There are three key areas where the Committee will be revisiting during 2020/21 which are:

1. A review of the Trust Charity overarching Strategy including its Objects. Further work is required to ensure that the Charity Objects are clear and that requests for funding are aligned to the Objects appropriately.
2. A review of Charity governance arrangements, including standardising key templates such as the grant application form and ensuring such forms are consistently signed appropriately with sufficient information to support the application. In addition the risk assessment will be revisited and presented to the Committee during 2020/21.
3. Development of a new Fundraising Strategy and making it easier for individuals to donate, including the implementation of an easy to use online payment mechanism.

The Committee will need to receive assurances regarding the activities outlined above.

The Committee will need to undertake a more detailed review of its effectiveness using an approach agreed by the Trust Board. This work will be undertaken during the Summer of 2020.

Report of Kelly Jupp
Trust Secretary
23 April 2020

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Newcastle upon Tyne Hospitals NHS Charity	Jun-19	Sep-19	Dec-19	Mar-20	May-20	Aug-20	Dec-20	Mar-21	Jun-21	Committee met in February instead of March for a standard meeting with Extraordinary meetings held in January, March and April.
Charitable Funds Committee Schedule of Business										
Regular items										
SoFA & Balance Sheet & Summary Report	x	x	x	x	x	x	x	x	x	
Grant Applications & Recommendations from Grants Panel	x	x	x	x	x	x	x	x	x	
Income Report	x	x	x	x	x	x	x	x	x	
Summary of Investment Performance/Investment Reports	x	x	x	x	x	x	x	x	x	
Summary of Grants agreed since last meeting	x	x	x	x	x	x	x	x	x	
Minutes & Action Log	x	x	x	x	x	x	x	x	x	
Fundraising & Communications Report	x	x	x	x	x	x	x	x	x	
Sub-Committee Minutes	x	x	x	x	x	x	x	x	x	
Target Spend Report	x	x	x	x	x	x	x	x	x	
Annual reports										
Annual Report & Accounts		x				x				Interim Accounts presented to May meeting
Investment Management Review		x		x	x		x			Deferred from February to May
JRE Scientific Committee -Recommendations		x					x			
Ad hoc										
Policies and procedures (including Donation of Money Policy, Grants Policy and Fundraising Policy)		x		x		x				
ToRs	x				x				x	

FINANCE COMMITTEE ANNUAL REPORT 2019-2020

1. PURPOSE

The purpose of this report is to provide assurance to the Trust Board that the Finance Committee has met its key responsibilities for 2019-20, in line with its Terms of Reference.

The following sections outline overall achievements throughout the year. The report also outlines action points for continuing development during the coming year.

2. COMMITTEE RESPONSIBILITIES

The Finance Committee is a non-statutory Committee established by the Trust Board of Directors to provide assurance to the Board on the delivery of the financial aspects of the Trust's annual Operational Plan, including financial strategy and planning, transformation and sustainability, the financial performance of the Trust, and on commercial and procurement activity, strategic investments and the development of the Trust's digital and estates infrastructure.

The purpose and function of the Committee is to gain assurance, on behalf of the Board of Directors, that:

- the strategic financial principles, priorities, risk and performance parameters are aligned and support the Trust's strategic objectives and its long-term sustainability;
- the Trust's degree of exposure to financial risk, and any potential to compromise the achievement of the strategic objectives is being effectively managed;
- reporting on the financial performance of the Trust is being triangulated against agreed plans, progress and performance measures, reporting on progress to the Trust Board;
- the Trust's resources and assets are being used and maintained effectively and efficiently;
- financial management and planning information is robust, credible and high quality, and that such information is reviewed and triangulated by the Committee;
- the Trust complies with current statutory and external reporting standards and requirements, including NHS and Treasury policies and procedures;
- the Trust's capital investment programme is fully developed, effectively managed and delivered, and that it is fit for purpose;
- mitigations and action plans as set out in the Board Assurance Framework specific to the Committee purpose and function are effective;
- procurement decision-making and documentation is robust; and
- Committee associated strategies are developed and delivered.

It does this through the receipt of assurances from management groups such as the Capital Management Group and Supplies and Services Procurement Group, the receipt of regular reports relating to areas which impact the financial position of the Trust and discussions and reports on the management of risks relating to the Committee's area of focus.

3. COMMITTEE MEMBERSHIP AND MEETINGS

The Committee is appointed by the Board of Directors and consists of 6 members (noting a minimum of 6 members is required as per the Terms of Reference), drawn from the Non-Executive Directors and members of the Executive Team.

The Committee's quorum is four members and include the Chair or Vice-Chair, and at least one other Non-Executive Director.

Six ordinary meetings and two extraordinary meetings were held between 1 April 2019 and 31 March 2020 and attendance was as follows:

	Attendance at ordinary meetings	Attendance at extraordinary meetings
Mr S Morgan, Non-Executive Director (Finance Committee Chair)	6 of 6	2 of 2
Mr D Stout, Non-Executive Director (Audit Committee Chair)	6 of 6	2 of 2
Mr E Weir, Non-Executive Director (until 30 September 2019)	2 of 3	N/a
Mrs A Dragone, Finance Director	5 of 6	2 of 2
Mr M Wilson, Chief Operating Officer	5 of 6	1 of 2
Mr G King, Chief Information Officer	5 of 6	1 of 2
Mr R Smith, Estates Director	2 of 6	1 of 2

The Committee met the minimum number of six meetings per year and other attendees at the meetings have included:

- The Director for Enterprise and Business Development;
- The Deputy Business and Development Director;
- The Deputy Finance Director;
- The Project Director, Financial Improvement;
- The Assistant Director of Finance;
- The Procurement and Supply Chain Director;
- The Senior Business Development Manager – Performance; and
- The Trust Secretary and Deputy Trust Secretary who also provide Secretariat Support to the Committee.

On 30 January 2020, the Trust Board agreed to change the Committee name from the Finance and Investment Committee to the Finance Committee. This reflected the change in the financial environment and the Trust focus on delivery of the Cost Improvement Programme.

4. REPORTING & AREAS OF REVIEW

During the year, the Committee:

- Received, and constructively challenged the content of the regular reports on the Trust financial position and progress on the Transformation and Financial Improvement Programme.
- Reviewed the Trust Intellectual Property Policy and approved an update to reflect alignment with the Newcastle University equivalent policy.
- Considered delegation arrangements for 'Interim' and 'Acting' staff members, as well as authority to commit expenditure on behalf of the Trust.
- Reviewed the closing Trust financial position for 2018/19 and considered the high level assumptions within the main income contracts for 2019/20.
- Received a presentation on the Corporate Nursing, Patient Services and Interpreting Services financial positions.
- Was fully briefed on the requirement to transition to a new financial ledger and considered the associated risks/benefits of progressing in order to ensure adequate assurance was received prior to the transfer.
- Approved the raising of a royalty-free licence agreement with Altered Eating Ltd, subject to certain conditions.
- Received a presentation on Waiting List Initiatives (WLIs), as well as assurances over the governance arrangements in place regarding WLIs.
- Considered the capital and revenue plans for future periods, seeking assurances over the validity of the assumptions and risks detailed within.
- Received updates on Directorate performance against plan and queried variances arising.
- Approved changes to the Overseas Visitors Policy, as well as approving in principle the granting of 20% equity in the proposed Jetstream TX spin out company to the Trust so that the legal arrangements for creating the company could commence.
- Received additional reports on surplus land, cyber essentials, capital projects and CQUIN; as well as minutes of associated management group meetings.
- Approved investments/business cases in accordance with the delegated authority of the Committee.
- Reviewed the content of the 2020/21 Financial Plan, Budget and CIP, and sought assurances over the associated risks.

5. GOVERNANCE, INTERNAL CONTROL AND RISK MANGEMENT

The Committee had a Schedule of Business for 2019/20 and utilises a rolling programme and action log to track committee actions.

The Committee receives regular updates on risks recorded on the Board Assurance Framework which relate to the Committee's area of focus. Discussions have included those pertaining to recurrent delivery of the Cost Improvement Programme, as well as cyber security requirements.

During the year the Committee has reviewed:

- Its Terms of Reference and Schedule of Business;
- The quarterly Board Assurance Framework (BAF) Assurance Reports; and
- The robustness of processes in place for investment decision making.

The Committee is satisfied that investments are prioritised appropriately, in accordance with the Trust Strategy.

6. MANAGEMENT

The Committee has challenged the assurance process when appropriate and has requested and received assurance reports/verbal updates from Trust management throughout the year.

7. PROGRESS FOR 2020-2021 & REVIEW OF EFFECTIVENESS

There are three key areas which require Committee consideration during 2020/21 which are:

1. Reporting format/content - Committee members have expressed the need to consider the assurances received/reporting of capital project management and the management of WLIs.
2. Terms of Reference (ToR) - linked to point 1 above, the Committee ToR make explicit reference to areas whereby the Committee will need to consider sufficient assurances have been received and whether additional reports should be incorporated into the Committee Schedule of Business going forwards, in particular:
    a. Commercial Unit activity and the associated Strategy: and
    b. Strategies e.g. IM&T, infrastructure etc.
3. Committee effectiveness - The Committee will need to undertake a more detailed review of its effectiveness using an approach agreed by the Trust Board. This work will be undertaken during the Summer of 2020.

The Committee will need to receive assurances regarding the activities outlined above.

Report of Kelly Jupp
Trust Secretary
14 May 2020

BRP A9(iv)

Finance Committee		May-20	Jul-20	Sep-20	Nov-20	Jan-21	Mar-21	May-21
Regular reports								
Management Group reports	x	x	x	x	x	x	x	
Finance performance indicator report [In main finance report]	x	x	x	x	x	x	x	
CQUINs [In main finance report]	x	x	x	x	x	x	x	
Finance risks (BAF)	x	x	x	x	x	x	x	
Finance risks (CT) [In main finance report]	x	x	x	x	x	x	x	
Estates perf v Capital Plan [In main finance report]	x	x	x	x	x	x	x	
Transformation programme [In main finance report]	x	x	x	x	x	x	x	
Trust balance sheet position [In main finance report]	x	x	x	x	x	x	x	
SSPC minutes [when available]		x	x	x	x	x	x	
CMG minutes [when available]		x	x	x	x	x	x	
SPCIG minutes [when available]		x	x	x	x	x	x	
Performance (against Finance and Operational Plans, contracts)		x	x	x	x	x	x	
Procurement Plan/Update [every other meeting from Sept]			X		X		X	
Capital Projects Update [Top 10 strategic projects] [every other meeting from July]		X		X				
Annual reports								
Annual Report & Accounts [May Annually]							X	
Reference Costs			X					
Terms of Reference	x						x	
Annual report / review of effectiveness	x						x	
Revenue and budget setting, CIP estimates								
Capital expenditure and strategy (longer term plan)	X						X	
Estates strategy, including PFI (and fire remedial works programme) update		X						
Ad-hoc reports to be considered								
COVID & Nightingale Update	X							
RRR Programme update [Twice a year]	X			X			X	
WLI [Twice a year]				X			X	
Charitable Funds Financial Update			X			X		
Maintenance deep dive					X			
Commercial strategy / Updates [twice a year]			X			X		

Policies and procedures e.g. Treasury management, Investment management
Business cases / investment proposals
GIRFT/Model Hospital
Business development / commercial activity
Transformation / Improvement initiatives e.g. GDE
Market Strategy/Intelligence
Digital Strategy
Finance strategy
Investment strategy - Trust and Charity
Infastructure strategy
KPI setting

Terms of Reference – Finance Committee

1. Constitution of the Committee

The Finance Committee is a non-statutory Committee established by the Trust Board of Directors to provide assurance to the Board on the delivery of the financial aspects of the Trust's annual Operational Plan, including financial strategy and planning, transformation and sustainability, the financial performance of the Trust, and on commercial and procurement activity, strategic investments and the development of the Trust's digital and estates infrastructure.

2. Purpose and function

The purpose and function of the Committee is to gain assurance, on behalf of the Board of Directors:

2.01 that the strategic financial principles, priorities, risk and performance parameters are aligned and support the Trust's strategic objectives and its long-term sustainability;

2.02 that the Trust's degree of exposure to financial risk, and any potential to compromise the achievement of the strategic objectives is being effectively managed;

2.03 that reporting on the financial performance of the Trust is being triangulated against agreed plans, progress and performance measures, reporting on progress to the Trust Board;

2.04 that the Trust's resources and assets are being used and maintained effectively and efficiently;

2.05 on the robustness, credibility and quality of financial management and planning information, which is reviewed and triangulated by the Committee;

2.06 on the Trust's compliance with current statutory and external reporting standards and requirements, including NHS and Treasury policies and procedures;

2.07 on the development, effective management, and delivery of the Trust's capital investment programme, and that this is fit for purpose;

2.08 to review, assess and gain assurance on the effectiveness of mitigations and action plans as set out in the Board Assurance Framework specific to the committee purpose and function; and

2.09 on the robustness of procurement decision-making and documentation.

2.10 The Committee will provide the Trust Board of Directors with advice and support on the development and delivery of the following strategies:

- capital strategy;
- investment strategy;
- estates strategy;
- infrastructure strategy;

- commercial strategy;
- procurement strategy
- information management and technology strategy; and
- any Trust strategies related to digital infrastructure, cyber and data security.

3. Authority

The Committee is:

3.1 a non-statutory Committee of the Trust Board of Directors, reporting directly to the Board of Directors, and has no executive powers, other than those specifically delegated in these Terms of Reference;

3.2 authorised by the Board of Directors to investigate any activity within its Terms of Reference, to seek any information it requires from any officer of the Trust, and to invite any employee to provide information by request at a meeting of the Committee to support its work, as and when required; and

3.3 authorised by the Board of Directors to secure the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for the exercise of its functions, including whatever professional advice it requires (as advised by the Executive Lead of the Committee and / or the Trust Secretary).

3.4 The Committee shall be able, in exceptional circumstances, to establish sub-committees and / or task and finish groups for the purpose of addressing specific tasks or areas of responsibility, if approved by the Trust Board. In accordance with the Trust's Standing Orders and Scheme of Delegation, the Committee may not delegate powers to a sub-committee or task and finish group unless expressly authorised by the Board of Directors.

3.5 The Terms of Reference, including the reporting procedures, of any sub-committees or task and finish group, must be approved by the Board of Directors and be reviewed on an annual basis.

4. Membership and quorum

Membership

4.01 Members of the Committee shall be appointed by the Trust Board of Directors and shall be made up of at least six members drawn from Non-Executive Directors (three members minimum) and members of the Executive Tteam (three members minimum).

4.02 One of the Non-Executive members will be appointed by the Trust Board of Directors as the Chair of the Committee.

4.03 A further Non-Executive member of the Committee will be appointed as Vice-Chair, likewise by the Trust Board of Directors.

4.04 The membership of the Committee shall include:

- a Non-Executive member of the Audit Committee

- the Director of Finance
- the Chief Operating Officer
- the Chief Information Officer
- the Director of Estates
- the Director for Enterprise and Business Development

4.05 The Chief Executive, as the Trust's Accountable Officer, shall have the right to attend the Committee at any time. Otherwise, only members of the Committee have the right to attend Committee meetings. Other non-committee members may be invited to attend and assist the Ccommittee from time to time, according to particular items being considered and discussed.

4.06 In the absence of the Committee Chair, the Vice-Chair shall chair the meeting. Members are expected to attend all meetings and will be required to provide an explanation to the Chair of the Committee if they fail to attend more than two meetings in a financial year.

4.07 The Director of Finance and the Chief Operating Officer shall act as joint Executive Leads for the Committee.

4.08 Members are able to attend Committee meetings in person, by telephone, or by other electronic means. Members in attendance by electronic means will count towards the quorum.

4.09 The Council of Governors may nominate up to two governors to attend one meeting of the Committee annually to observe proceedings. The observation of Board assurance committees by governors shall be subject to conditions agreed by the Board of Directors. The Chair of the Committee may, in exceptional circumstances, exclude governors from being present for specific items.

4.10 The Trust Secretary, or their designated deputy, shall act as the Committee Secretary. The Trust Secretary, or a suitable alternative agreed in advance with the Chair of the Committee, shall attend all meetings of the Committee.

4.11 All members of the Committee shall receive training and development support before joining the committee and on a continuing basis to ensure their effectiveness as members, supported by a performance assessment process, as agreed by the Board of Directors.

4.12 An attendance record shall be held for each meeting and an annual register of attendance will be included in the annual report of the Committee to the Board.

4.13 The Chair of the Board of Directors will not be a member of the Committee but may be in attendance.

Quorum

4.14 The quorum necessary for the transaction of business shall be four members as defined in 4.01 and 4.04 above, including the Chair or Vice Chair and at least one Non-Executive Director.

4.15 Members unable to attend a meeting of the Committee may nominate a deputy to attend on their behalf, agreed with the Chair of the Committee. Nominated deputies will not count towards the quorum.

4.16 A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers, and discretions delegated to the Committee.

5. Duties

5.1 Cycle of Business

The Committee will:

5.1.1 set an annual set of objectives and an annual plan for its work to form part of the Board's Annual Cycle of Business, informed by the Board Assurance Framework, and report to the Board on its progress.

5.2 Strategies and policies

The Committee will:

5.2.1 review the Trust's financial strategy, planning assumptions, and related delivery plans and transformation programmes, and provide informed advice to the Board of Directors on their robustness, comprehensiveness and relevance to the Trust's vision, values, strategic objectives and impact;

5.2.2 review guidance for the development and delivery of the financial aspects of annual operational, service, and financial planning, including assumptions on revenue, budgets, capital, working and associated targets, and parameters on efficient and effective use of resources;

5.2.3 review, and recommend to the Board of Directors, the Annual Financial Plan, including key financial performance indicators, following consultation and engagement with the People and Quality Committees;

5.2.4 provide advice and support on significant financial and commercial policies prior to their recommendation for Board approval. This will include policies relating to costing, revenue, capital, working capital, treasury management, investments, and benefits realisation;

5.2.5 seek assurance that financial policies and plans are aligned to the Trust's agreed approach to the development of place-based, systems and regional working, and align with the Trust's strategic approach to commissioners and stakeholders;

5.2.6 identify sources of economic, financial, and related intelligence and data, relevant to the Trust in the context of the "place" of Newcastle and the North East to inform the work of the Ccommittee and the Board of Directors; and

5.2.7 identify learning and development needs arising from the work of the Committee for consideration by the People Committee.

5.3 Annual Financial Plan

The Committee will:

5.3.1 review the Trust's Annual Financial Plan for recommendation and approval by the Board;

5.3.2 review progress and performance against the approved plan and any significant supporting plans and targets, and analyse the robustness of any corrective action required;

5.3.3 assess reports regarding future cost pressures and key financial risk areas;

5.3.4 review the Trust's Statement of Financial Position, with a particular focus on debtors, creditors, and asset valuations; and

5.3.5 receive and review an overview of financial and service delivery agreements and key contractual arrangements entered into by the Trust.

~~5.3.5~~5.3.6 receive and review expenditure on waiting list initiatives against the annual plan and seek assurance on the processes in place for waiting list initiatives management.

5.4 Risk

The Committee will:

5.4.1 Receive the risks held on the Board Assurance Framework pertaining to the Committees area of focus to review the suitability and robustness of risk mitigations and action plans with regard to their potential impact on the Trust Strategic Objectives. To provide the Audit Committee with assurance on the effectiveness of the management of principal risks relating to the Committees purpose and function.

5.4.2 To receive the Executive Oversight Report for information.

5.5 Performance and progress reporting

The Committee will:

5.5.1 monitor the effectiveness of the Trust's financial and operational performance reporting systems, ensuring that the Board is assured of continued compliance through its annual reporting processes, reporting by exception where required to the Board;

5.5.2 agree a succinct set of key performance and progress measures relating to the full assurance purpose and function of the Committee, including:

- the Trust's strategic financial priorities;
- national performance and statutory targets;
- consolidated financial performance summaries and related budgets;
- statement of financial position;
- working capital performance;

- cash flow status;
- progress on capital investment programme;
- use of resources ratings;
- charitable funds investment performance; and
- risk mitigation;

5.5.3 triangulate progress against these measures and seek assurance around any performance issues identified, including proposed corrective actions;

5.5.4 provide regular reports to the Board, including as part of the bi-monthly Integrated Quality and Performance Report, on assurance around key areas of Trust performance, risk, and corrective actions, both retrospectively and prospectively;

5.5.5 agree a programme of benchmarking activities and reference points to inform the understanding and effectiveness of the Committee and its work;

5.5.6 be assured of the credibility of sources of evidence and data used for planning and progress reporting to the Committee, and to the Board, in relation to the Committee's purpose and function;

5.5.7 ensure the alignment and consistency of Board assurances, use of data and intelligence, by working closely with the Audit Committee, Quality Committee and People Committee; and

5.5.8 review the following formal reports to the Board as part of the Annual Cycle of Business:

- Annual Financial Plan~~e Report~~;
- Finance Reports;
- Capital Investment Policy;
- ~~Scheme of Delegation;~~
~~Standing Orders;~~
- ~~Standing Financial Instructions;~~ and
- Annual Report and Accounts (Group, Trust and Charity).

5.6 Capital, investments, acquisitions and disposals

The Committee will:

5.6.1 review the Trust's capital and investment policies against appropriate benchmarks prior to recommendation for Board approval;

5.6.2 agree a consistent and robust methodology for the assessment of proposed capital expenditure, acquisitions, joint ventures, equity stakes, major property transactions, mergers, and formal or informal alliances with other Institutions;

~~5.6.3 review project initiation documents for capital schemes over an agreed de minimis amount;~~

~~5.6.4~~5.6.3 review business cases and proposals over the threshold specified within the Trust Scheme of Delegation ~~with a likely value of £500,000 or more~~, and provide advice to the Board accordingly;

5.6.~~4~~5 assure the Trust Board, on a regular basis, of the effectiveness of, and compliance with, the capital and investment strategies and related policies, including the effective prioritisation of investment decisions, the robustness of processes and rigour of investment decision-making, and report on this as part of the Committee's Annual Report to the Board;

5.6.5 monitor the performance of investments, and commission and review reports on the benefits realisation of infrastructure and service improvement investments made; and

5.6.6 exercise delegated responsibility on behalf of the Board in line with the Standing Financial Instructions for proposals for acquisition and disposal of assets in accordance with Trust policy.

5.7 Infrastructure, estates and digital

The Committee will:

5.7.1 review the following policies and plans, in order to provide informed and authoritative advice to the Board:

- estates;
- infrastructure;
- digital strategy, including digital, cyber, and data security.

5.8 Commercial strategy

The Committee will:

5.8.1 provide support and advice on the development and implementation of the commercial strategy for the Trust.

5.8.2 assure the Trust Board, on a regular basis, of the effectiveness of, and compliance with, the commercial strategy and related policies, including the effective prioritisation of commercial decisions, the robustness of processes and rigour of commercial decision-making, and report on this as part of the Committee's Annual Report to the Board;

5.9 Statutory compliance

The Committee will:

5.9.1 ensure, on behalf of the Board, that current statutory and regulatory compliance and reporting requirements are met, including compliance with treasury policies and procedures and the appropriate safeguards for security of the Trust's funds as an NHS Foundation Trust;

5.9.2 ensure the proper reporting of actions deemed "high-risk" by regulators, or actions with an equity component, which entail a potentially significant risk to reputation or to the stability of the business of the Trust, or which create material contingent liabilities;

5.9.3 ensure future legislative and regulatory and reporting requirements are identified and appropriate action taken; and

5.9.4 consider, and recommend for approval by the Board, any proposed changes to Trust Standing Financial Instructions, Standing Orders and Scheme of Delegation.

6. Reporting and accountability

6.1 The Committee Chair will report formally to the Trust Board of Directors on its proceedings after each meeting on all matters within its duties and responsibilities, summarising areas where action or improvement is needed.

6.2 The Committee will provide an Annual Report to the Board to inform and / or accompany the Trust's Annual Report. This shall include an assessment of compliance with the Committee's Terms of Reference and a review of the work and effectiveness of the Committee.

6.3 The Chair of the Committee shall provide an annual update to the Council of Governors on the work of the Committee.

6.4 The terms of reference shall be reviewed by the Committee and approved by the Board of Directors on an annual basis.

7. Committee Administration

7.1 The Committee will meet a minimum of six times a year and at such other times as the Chair of the Committee, in consultation with the Committee Secretary, shall require, allowing the Committee to discharge all of its responsibilities.

7.2 The Chair may at any time convene additional meetings of the Committee to consider business that requires urgent attention.

7.3 The agenda will be set in advance by the Chair, with the Trust Secretary and Executive Lead, reflecting an integrated cycle of meetings and business, which is agreed each year for the Board and its Committees, to ensure it fulfils its duties and responsibilities in an open and transparent manner.

7.4 Notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, shall be made available to each member of the Committee, no less than five working days before the date of the meeting in electronic form. Supporting papers shall be made available no later than three working days before the date of the meeting.

7.5 Committee papers shall include an outline of their purpose and key points in line with the Trust's Committee protocol, and make clear what actions are expected of the Committee.

7.6 The Chair shall establish, at the beginning of each meeting, the existence of any conflicts of interest and ensure that these are recorded in the minutes accordingly.

7.7 The Committee Secretary shall minute the proceedings of all Committee meetings, including recording the names of those present, in attendance and absent. Draft minutes of Committee meetings shall be made available promptly to all members of the Committee, normally within ten working days of the meeting.

7.8 The Committee shall, at least once a year, review its own performance, using a process agreed for all Board committees by the Board of Directors.

Procedural control statement: 04 February 2020
Date approved: 22 May 2020 [Finance Committee] and [TBA] [Board]
Approved by: [TBA]
Review date: May 2021

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BRP A9(iv)

People	Apr-20*	Jun-20	Aug-20	Oct-20	Dec-20	Notes
Regular items						
Management reports		x	x	x	x	
Dashboard		x	x	x	x	
Education and training report including medical education, LEG updates and Apprentices		x	x	x	x	
#Flourish at Work - Staff Experience		x	x	x	x	
Employment Relations		x	x	x	x	
Recruitment and retention			x	x	x	
Workforce planning			x	x	x	
Minutes		x	x	x	x	
Action log		x	x	x	x	
People dashboard		x	x	x	x	
People risks - BAF report	x		x			Feb-21
NHS Staff survey & engagement plans/updates			x		x	Feb-21
Annual reports						
Annual report of the Committee (including effectiveness consideration)		x				
Education and training strategy				x		
Workforce Plan 2020/21				x		
People Strategy and priorities				x		
GMC training survey				x		
Communication strategy			x			
Freedom to speak up Guardian				x		
Gender Pay Report						Feb-21
WRES & WDES			x			
Apprenticeship Update			x			
Guardian of Safe Working Hours Annual Report						Apr-21
Equality and Diversity - including action plans			x			
Workforce Age Profile & Demographics update				x		
NHSLA Annual Report					x	
Ad hoc						
Health and Wellbeing			x			
Policies and procedures						By exception
ToR & SOB		x				
Deep dives						By exception
Culture review						By exception
Pensions						By exception
Ethnic Pay Report						Feb-21
RRR and Nightingale		x				

*Cancelled due to COVID-19 Pandemic

Terms of Reference – People Committee

1. Constitution of the Committee

The People Committee is a non-statutory Committee established by the Board of Directors to monitor, review and report to the Board on the cultural and organisational development of the Trust, and on the strategic performance of people and workforce priorities, and impact of the Trust as a significant employer, educator and partner in health, care and research.

2. Purpose and function

The purpose and function of the Committee is to gain assurance, on behalf of the Board of Directors:

2.01 on the identification of strategic people and workforce priorities for the Trust as a significant employer in the North East and as a partner in training, education, and development of health and care capacity in the region and nationally;

2.02 in relation to the organisation's understanding of strategic workforce needs (including well-being, recruitment, retention, development of people, and organisational capacity) and the quality and effectiveness of plans to deliver them;

2.03 that the commitments of the NHS Constitution and the stated values of the Trust ~~and standards of behaviour, in accordance with the Standards of Business Conduct Policy~~ and Professional Leaderships Behaviours, are being practiced throughout the organisation, based on evidence;

2.04 that the approach to all aspects of employment and culture in the Trust are informed by relevant and up-to-date research on innovation and practice;

2.05 to review, assess and gain assurance on the effectiveness of mitigations and action plans as set out in the Board Assurance Framework specific to the C~~c~~ommittee purpose and function;

2.06 on the Trust's legislative and regulatory compliance as an employer, including anticipation of, and planning for, future requirements;

2.07 on the development of staff governance in the organisation, including staff engagement processes, with the Committee acting as the oversight Committee;

2.08 on the development of strategic communications and engagement, and reputation management with internal and external stakeholders, local communities and partners, with the People Committee acting as the oversight Committee;

2.09 on the impact on workforce of changing professional and organisational practices, including those involved in increased system-based and partnership working (in collaboration with the Quality Committee); and

2.10 that the Trust fulfils its leadership and influencing role on service quality standards and practice, as an organisation of national importance, as a significant service provider in the

North East, and as a partner in training, education and development of health and care capacity in the region (in collaboration with the Quality Committee).

2.11 The Committee will agree progress reporting and information requirements relating to its remit on behalf of the Board of Directors, and will oversee the resulting performance.

3. Authority

The Committee is:

3.1 a non-statutory Committee of the Trust Board of Directors, reporting directly to the Board of Directors, and has no executive powers, other than those specifically delegated in these Terms of Reference;

3.2 authorised by the Board of Directors to investigate any activity within its Terms of Reference, to seek any information it requires from any officer of the Trust, and to invite any employee to provide information by request at a meeting of the Committee to support its work, as and when required; and

3.3 authorised by the Board of Directors to secure the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for the exercise of its functions, including whatever professional advice it requires (as advised by the Executive Lead of the Committee and / or Trust Secretary).

3.4 The Committee shall have the power to establish, in exceptional circumstances, sub-committees and / or task and finish groups for the purpose of addressing specific tasks or areas of responsibility, if approved by the Trust Board. In accordance with the Trust's Standing Orders, the Committee may not delegate powers to a sub-committee or task and finish group unless expressly authorised by the Trust Board of Directors.

3.5 The Terms of Reference, including the reporting procedures of any sub-committees or task and finish groups, must be approved by the Trust Board of Directors and reviewed on an annual basis.

4. Membership and quorum

Membership

4.01 Members of the Committee shall be appointed by the Trust Board of Directors and shall be made up of at least six members drawn from Non-Executive Directors (three members minimum) and members of the Executive Tteam (three members minimum).

4.02 One of the Non-Executive members will be appointed by the Trust Board of Directors as the Chair of the Committee.

4.03 A further Non-Executive member of the committee shall be appointed as Vice-Chair, likewise by the Trust Board of Directors.

4.04 The membership shall be:

- the Director of Human Resources;
- the Chief Operating Officer; and
- the ~~Director of Communications and Engagement~~ Assistant Chief Executive.

4.05 The Chair of the Board of Directors shall not be a member of the Committee but may be in attendance.

4.06 Other than as specified above, only members of the Committee have the right to attend Committee meetings. Other non-Committee members may be invited to attend and assist the Committee from time to time, according to particular items being considered and discussed.

4.07 In the absence of the Committee Chair, the Vice-Chair shall chair the meeting. Members are expected to attend all meetings and will be required to provide an explanation to the Chair of the Committee if they fail to attend more than two meetings in a financial year.

4.08 The Director of Human Resources shall act to fulfil the role of Executive lead for the C~~c~~ommittee.

4.09 Members are able to attend Committee meetings in person, by telephone, or by other electronic means. Members in attendance by electronic means will count towards the quorum.

4.10 The Council of Governors may nominate up to two governors to attend one meeting of the Committee annually to observe proceedings. The observation of Board assurance committees by governors will be subject to conditions agreed by the Board of Directors. The Chair of the Committee may in exceptional circumstances exclude governors from being present for specific items.

4.11 The Trust Secretary, or their designated deputy, shall act as the Committee Secretary. The Trust Secretary, or a suitable alternative agreed in advance with the Chair of the Committee, shall attend all meetings of the Committee.

4.12 All members of the Committee shall receive training and development support as required ~~before joining the Committee and on a continuing basis~~ to ensure their effectiveness as members, supported by a performance assessment process, as agreed by the Board of Directors.

4.13 An attendance record shall be held for each meeting and an annual register of attendance will be included in the annual report of the Committee to the Board.

Quorum

4.14 The quorum necessary for the transaction of business shall be four members, as defined in 4.01 and 4.04 above, with at least one Non-Executive Director present.

4.15 Members unable to attend a meeting of the Committee may nominate a deputy to attend on their behalf, agreed with the Chair of the Committee. Nominated deputies shall not count towards the quorum.

4.16 A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions delegated to the Committee.

5. Duties

5.1. Cycle of Business

The Committee will:

5.1.1 set an annual plan for its work to form part of the Board's Annual Cycle of Business, informed by the Board Assurance Framework, and report to the Board on its progress.

5.2 People Strategy and policies

The Committee will:

5.2.1 assess the strategic priorities and investments needed to support the knowledge, skills and capacity of the people in the Trust (human capital), and advise the Board accordingly;

5.2.2 review the Trust's Leadership Development Strategy, Education and Workforce Development Strategy, Education Quality Strategy and Apprenticeship Strategy, and related delivery plans and programmes, providing informed advice to the Board of Directors on their robustness, comprehensiveness and relevance to the Trust's vision, values, strategic objectives and impact;

5.2.3 provide advice and support on the development of significant people-related policies [those which have a significant impact on staff e.g. health and wellbeing] prior to their adoption. It is expected that this will relate to a small number of policies by exception in any given year, which will be agreed in advance as part of the cycle of business for the Committee;

5.2.4 review by exception, people-related policies against benchmarks to ensure that they are comprehensive, up-to-date, and reflect best practice;

5.2.5 review strategic intelligence, research evidence on people and work, and distil their relevance to the Trust's strategic priorities (including, where necessary, commissioning research to inform its work) relating to:

- the impact of changing working practices;
- the potential and impact of technology on working lives;
- models of employment practice drawn from multiple sectors;
- organisational and work design;
- incentives and rewards;
- developments and best practice in delivery of education, training and development;
- national, regional and local workforce and population trends; and
- other dynamics affecting the future development of the health and care workforce;

5.2.6 review the development and effective use of shared intelligence and data with partners on local health and care skills to shape the growth of future capacity in the "place" of Newcastle and the North East.

5.2.7 be assured of the integrity of the Trust's processes and procedures relating to the introduction of new clinical roles.

5.3 Risk

The Committee will:

5.3.1 receive risks held on the Board Assurance Framework pertaining to the Committees area of focus to review the suitability and robustness of risk mitigations and action plans with regard to their potential impact on the Trust Strategic Objectives. To provide the Audit Committee with assurance on the effectiveness of the management of principal risks relating to the Committee's purpose and function.

5.3.2 to receive the Executive Oversight Report for information.

5.4 # Flourish At Work - Staff Experience and Engagement including organisational culture

The Committee will:

5.4.1 agree and oversee a credible process for assessing, measuring and reporting on the "culture of the organisation" on a consistent basis over time;

5.4.2 oversee the coherence and comprehensiveness of the ways in which the Trust engages with staff and with staff voices, including the staff survey, and report on the intelligence gathered, and its implications, to the Board of Directors;

5.4.3 act as the oversight Committee for the coherence and alignment of different codes of personal and professional behaviour and conduct, (considering, for example, Professional and Leadership Behaviours, the Standards of Business Conduct Policy, and The Nolan Principles), covering all permanent and temporary staff acting in the name of, or on the business of, the Trust;

5.4.4 take an oversight role on behalf of the Board of Directors in:

- securing positive progress on equality and diversity, including shaping and setting direction, monitoring progress and promoting understanding inside and outside the Trust;
- evaluating the impact of work to promote the values of the organisation and of the NHS Constitution;
- promoting staff engagement and partnership working; and
- developing a consistent working environment where people feel safe and able to raise concerns, and where bullying and harassment are visibly and effectively addressed.

5.5 Organisational capacity – sustainability and strategic transformation

The Committee will:

5.5.1 ensure the systems, processes and plans used by the Trust have integrity and are fit for purpose in the following areas:

- strategic approach to growing the knowledge, skills and capacity of the people (human capital) in the Trust;
- analysis and use of sound workforce, employment and demographic intelligence;
- the planning of current and future workforce capacity;
- effective recruitment and retention;
- new models of care and roles;
- flexible working;
- identification of urgent capacity problems and their resolution;
- continuous development of personal and professional skills; and
- talent management.~~;~~

5.5.2 review the productivity of permanent and temporary staff by exception, including the effectiveness and efficiency of their deployment, the best use of skills, and the flexibility and maturity of working practices in the Trust;

5.5.3 consider the coherence and pace of Trust plans to secure the benefits for the Trust and its staff from:

- transformational change, service redesign and pathways of care;
- new and innovative ways of working;
- use of tools and technology;
- environmental sustainability;
- opportunities for changing practices and skills across traditional professional boundaries;
- joint working with partners both in health and social care and other sectors; and
- the value of apprenticeships.~~;~~

5.5.4 review plans for ensuring the development of leadership and management capacity, including the Trust's approach to succession planning.

5.6 Education and training

The Committee will:

5.6.1 review the Trust's current and future educational and training needs to ensure they support the strategic objectives of the organisation in the context of the wider health and care system;

5.6.2 review the Trust's strategic contribution to the development of the health and care workforce;

5.6.3 secure the necessary assurances about the Trust's compliance with the practice requirements of professional and regulatory bodies for all staff;

5.6.4 ensure the development of an annual education and training programme to meet the education and workforce development priorities described within the Trust's Strategy.

5.7 Communications

The Committee will:

5.7.1 provide advice and support on the development of the Trust's engagement and communications strategies and related programmes of work, and review the effectiveness of internal communications and engagement;

5.7.2 ensure engagement and consultation processes with staff, stakeholders and communities both reflect the ambition and values of the Trust and also meet statutory requirements;

5.7.3 agree and oversee a credible process for assessing, measuring and reporting on the reputation of the organisation as an employer and workplace of choice;

5.7.4 review the appropriateness and effectiveness of stakeholder and partnership development in supporting strategic goals and programmes of work related to the purpose and function of the People Committee, and report to the Board of Directors accordingly.

5.8 Performance and progress reporting

The Committee will:

5.8.1 establish a succinct set of key performance and progress measures relating to the full purpose and function of the Committee, including:

- the Trust's strategic priorities on people;
- national performance targets;
- organisational culture;
- workforce utilisation;
- staff health and well-being; and
- strategic communications.

5.8.2 review progress against these measures, and their impact, and seek assurance around any performance issues identified, including proposed corrective actions;

5.8.3 agree a programme of benchmarking activities to inform the understanding of the Committee and its work;

5.8.4 ensure the credibility of sources of evidence and data used for planning and progress reporting to the Committee, and to the Board of Directors in relation to the Committee's purpose and function;

5.8.5 ensure alignment of the Board assurances and consistent use of data and intelligence, by working closely with the Audit Committee, Quality Committee and Finance Committee;

5.8.6 review and shape the people -related content of the bi-monthly Integrated ~~Quality & Performance~~ Board Report ~~to the Board~~;

5.8.7 review the following formal reports to the Board of Directors as part of the Annual Cycle of Business:

- Annual People report;

- Equality and Diversity Reports and Action Plans – e.g. Gender Pay, WRES, WDES and Ethnic Pay -etc.;
- NHS Staff Survey Results;
- Fit and Proper Persons Test;
- Trade Union Faculty Time report; and
- Modern Slavery Act.

5.9 Statutory compliance

The Committee will:

5.9.1 ensure, on behalf of the Board of Directors, that current statutory and regulatory compliance and reporting requirements are met:

- standards of professional conduct and practice (including consideration of Professional and Leadership Behaviours, the Standards of Business Conduct Policy, and The Nolan Principles);
- Freedom to Speak Up Guardian;
- Guardian of Safe Working Hours;
- equality and diversity;
- health and safety; and
- consultation on service change;

5.9.2 ensure future legislative and regulatory requirements, which are to be placed on the Trust as an employer, are identified and appropriate action taken.

6. Reporting and accountability

6.1 The Committee Chair will report formally to the Trust Board of Directors on its proceedings after each meeting, on all matters within its duties and responsibilities, summarising areas where action or improvement is needed.

6.2 The Committee shall report to the Trust Board annually on its work in support of the Annual Report. The Annual People Report shall:

- set out clearly how the Committee is discharging its responsibilities; and
- be presented to the Annual General Meeting with the Chair of the Committee in attendance to respond to any stakeholder questions on the Committee's activities.

6.3 The Annual People Report shall include an assessment of compliance with the Committee's Terms of Reference and a review of the effectiveness of the committee.

6.4 The Chair of the Committee shall provide an annual update to the Council of Governors on the work of the Committee.

6.5 The Terms of Reference shall be reviewed by the Committee and approved by the Board of Directors on an annual basis.

7. Committee Administration

7.1 The Committee shall meet a minimum of four times a year and at such other times as the Chair of the Committee, in consultation with the Committee Secretary, shall require, allowing the Committee to discharge all of its responsibilities.

7.2 The Chair may at any time convene additional meetings of the Committee to consider business that requires urgent attention.

7.3 The agenda will be set in advance by the Chair, with the Trust Secretary and Executive Lead, reflecting an integrated cycle of meetings and business, which is agreed each year for the Board and its Committees to ensure it fulfils its duties and responsibilities in an open and transparent manner.

7.4 Notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, shall be made available to each member of the Committee, no less than five working days before the date of the meeting in electronic form. Supporting papers shall be made available no later than three working days before the date of the meeting.

7.5 Committee papers shall include an outline of their purpose and key points, in line with the Trust's Committee protocol, and make clear what actions are expected of the Committee.

7.6 The Chair shall establish, at the beginning of each meeting, the existence of any conflicts of interest and ensure that these are recorded in the minutes accordingly.

7.7 The Committee Secretary shall minute the proceedings of all Committee meetings, including recording the names of those present, in attendance and absent. Draft minutes of Committee meetings shall be made available promptly to all members of the Committee, normally within ten working days of the meeting.

7.8 The Committee shall, at least once a year, review its own performance, using a process agreed for all Board committees by the Board of Directors.

Procedural control statement: 3rd June 2020
Date approved: [TBA]
Approved by: [TBA]
Review date: May 2021

PEOPLE COMMITTEE ANNUAL REPORT 2019-2020

1. PURPOSE

The purpose of this report is to provide assurance to the Trust Board that the People Committee has met its key responsibilities for 2019-20, in line with its Terms of Reference.

The following sections outline overall achievements throughout the year. The report also outlines action points for continuing development during the coming year.

2. COMMITTEE RESPONSIBILITIES

The People Committee is a non-statutory Committee established by the Board of Directors to monitor, review and report to the Board on the cultural and organisational development of the Trust, and on the strategic performance of people and workforce priorities, and impact of the Trust as a significant employer, educator and partner in health, care and research.

The purpose and function of the Committee is to gain assurance, on behalf of the Board of Directors, that:

- the strategic people and workforce priorities for the Trust as a significant employer and as a partner in training, education, and development of health and care capacity in the region and nationally are identified;
- the organisation has a clear understanding of strategic workforce needs (including well-being, recruitment, retention, development of people, and organisational capacity) and the quality and effectiveness of plans to deliver them;
- the commitments of the NHS Constitution and the stated values of the Trust and standards of behaviour, are being practiced throughout the organisation, based on evidence;
- the approach to all aspects of employment and culture in the Trust are informed by relevant and up-to-date research on innovation and practice;
- the effectiveness of mitigations and action plans as set out in the Board Assurance Framework are reviewed, assessed and assurances obtained specific to the committee purpose and function;
- legislative and regulatory compliance is achieved as an employer, including anticipation of, and planning for, future requirements;
- staff governance in the organisation is fully developed, including staff engagement processes;
- strategic communications and engagement are developed, and reputation management is robust with internal and external stakeholders, local communities and partners;
- the impact on workforce of changing professional and organisational practices is considered, including those involved in increased system-based and partnership working (in collaboration with the Quality Committee); and
- the Trust fulfils its leadership and influencing role on service quality standards and practice, as an organisation of national importance, as a significant service provider in

the North East, and as a partner in training, education and development of health and care capacity in the region (in collaboration with the Quality Committee).

It does this through the receipt of assurances from management, the receipt of regular reports relating to areas which impact our people, as detailed in section 4 below, and discussions and reports on the management of risks relating to the committee's area of focus.

3. COMMITTEE MEMBERSHIP AND MEETINGS

The Committee is appointed by the Board of Directors and consists of six members (as specified in the Terms of Reference), drawn from the Non-Executive Directors and members of the Executive Team.

The Committee's quorum is four members, with at least one Non-Executive Director present.

Five ordinary meetings were held between 1 April 2019 and 31 March 2020 and attendance was as follows:

	Attendance at ordinary meetings
Mr Jonathan Jowett, Non-Executive Director (Committee Chair)	5 of 5
Professor Kath McCourt, Non-Executive Director	4 of 5
Mr Keith Godfrey, Non-Executive Director	2 of 5
Mrs Dee Fawcett, Director of Human Resources	5 of 5
Mrs Caroline Docking, Assistant Chief Executive	3 of 5
Mr Martin Wilson, Chief Operating Officer	5 of 5

The Committee met five times during the year, therefore complying with the minimum number of four meetings per year as specified in the terms of reference. Other attendees at the meetings have included:

- Head of Education and Workforce Development;
- Head of Human Resources;
- Head of Workforce Engagement & Information;
- Deputy Head of Education and Workforce Development;
- Workforce Development Manager; and
- The Trust Secretary and Deputy Trust Secretary who also provide Secretariat Support to the Committee.

4. REPORTING

i) Annual Reports

During the year, the following Annual Reports were received by the Committee:

- People Strategy Annual Report (2018/19)
- Workforce Plan 2019/20
- Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Targets & Action Plan
- GMC Training Survey Annual Report
- NHSLA Annual Report

ii) Regular Reports

Committee members have also received regular updates on:

- Education & Training, including Medical Education and specific updates from the Learning and Education Group (LEG).
- Employment Relations.
- Recruitment & Retention.
- Workforce Systems Development.
- People Dashboard.
- Board Assurance Framework (BAF) Committee Assurance Report.

iii) Ad-Hoc Reports

In addition to those reports listed above, a number of reports have been received by the Committee. These include:

- Flourish Programme Updates
- Significant legal cases such as the Flowers Case (re annual leave) and the Hallett vs Derby Hospitals case (re Junior Doctors in training)
- Workforce Age Profile & Demographics update
- Pensions Position Update
- SafeCare Demonstration/Update
- Impact of the ICS on NuTH
- NHS Staff Survey Results & Engagement Plans
- Flexible Working
- Clinical Director Succession Planning
- Health and Wellbeing Activity Update
- Mandatory Training & Appraisal Performance
- Ethnic Pay Report
- Gender Pay Report
- Education & Training Review Update

5. GOVERNANCE, INTERNAL CONTROL AND RISK MANGEMENT

The Committee had a Schedule of Business for 2019/20 and utilises a rolling programme and action log to track committee actions.

As highlighted in Section 4 ii, the Committee receives regular updates on risks recorded on the Board Assurance Framework which relate to the Committee's area of focus. Discussions have included a central focus on the risk of 'an inability to recruit and retain staff including qualified nurses, specialist staff and medics could result in the inability to provide safe, effective, high class services'.

6. PROGRESS FOR 2020-2021 & REVIEW OF EFFECTIVENESS

There are three key areas which require Committee consideration during 2020/21 which are:

1. Communication Strategy – the Committee Terms of Reference specify a number of duties regarding 'Communications' (section 5.7) and therefore Committee members will need to consider the assurances required in 2020/21 in relation to their duties.

2. Assurances received regarding how the Trust develops a consistent working environment where people feel safe and able to raise concerns, including reporting from the Trust:

- Freedom to Speak up Guardian, as well as concerns raised through the Speak in Confidence facility and concerns logged via Datix;
- Chair of the Junior Doctor Forum; and
- The Guardian of Safe Working.

Committee members are asked to consider the reporting arrangements in place regarding 'raising concerns'.

3. Committee membership and effectiveness – The Committee Chair highlighted during the year 2019/20 that its membership would need to be reviewed regularly to ensure it remained fit for purpose, with members having discussed previously whether clinical membership was required. Committee members are asked to revisit membership to ascertain whether any further changes are required.

The Committee will need to undertake a more detailed review of its effectiveness using an approach agreed by the Trust Board. This work will be undertaken during the Summer of 2020.

The Committee will need to receive assurances regarding the activities outlined above.

Report of Kelly Jupp
Trust Secretary
1 June 2020

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QUALITY COMMITTEE ANNUAL REPORT 2019-2020

1. PURPOSE

The purpose of this report is to provide assurance to the Trust Board that the Quality Committee has met its key responsibilities for 2019-20, in line with its Terms of Reference.

The following sections outline overall achievements throughout the year. The report also outlines action points for continuing development during the coming year.

2. COMMITTEE RESPONSIBILITIES

The Quality Committee is a non-statutory Committee established by the Trust Board of Directors to monitor, review and report to the Board on the quality of care to the Trust's patients, specifically in relation to patient safety, clinical effectiveness and patient experience.

The purpose and function of the Committee is to gain assurance, on behalf of the Board of Directors, that:

- The Trust has appropriate quality governance structures, systems, processes and controls in place and to meet Trust legal and regulatory requirements;
- The Trust delivers continuous quality improvements;
- Any shortcomings in the quality and safety of care are identified and addressed;
- The Trust's approach to continuous quality improvement processes for all Trust services, the Trust's research and development activities and its clinical practice, and assurances on robust mechanism of research governance which is subject to regular scrutiny and monitoring;
- The quality impact of changing professional and organisational practices;
- Ensuring the Trust fulfils its leadership and influencing role on service quality standards and practice; and
- Effective mechanisms were in place for the involvement of patients and the public, staff, partners and other stakeholders in improving quality assurance and patient safety.

It does this through the receipt of assurances from the management groups, the receipt of regular reports relating to areas which impact the quality of care provided to patients, such as Infection Prevention and Control, Safeguarding and End of Life Care, and discussions and reports on the management of risks relating to the committee's area of focus.

3. COMMITTEE MEMBERSHIP AND MEETINGS

The Committee is appointed by the Board of Directors and consists of nine members (noting a minimum of 7 members is required as per the Terms of Reference), drawn from the Non-Executive Directors, members of the Executive Team and other senior staff members.

The Committee's quorum is four members and include the Chair or Vice-Chair, and at least one other Non-Executive Director.

Six ordinary meetings were held between 1 April 2019 and 31 March 2020 and attendance was as follows:

	Attendance at ordinary meetings
Professor K McCourt, Non-Executive Director (Committee Chair)	6 of 6
Mr K Godfrey, Non-Executive Director	5 of 6
Professor D Burn, Non-Executive Director	0 of 6
Mr A Welch, Medical Director and Deputy CEO	5 of 6
Ms M Cushlow, Executive Chief Nurse	5 of 6
Mr M Wilson, Chief Operating Officer	3 of 6
Mrs A O'Brien, Director of Quality and Effectiveness	6 of 6
Mr A Vincent, Assistant Medical Director, Patient Safety & Quality	1 of 6
Mrs E Harris, Deputy Chief Nurse*	3 of 5

* Mrs Harris was invited to join the committee after the inaugural meeting.

The Committee met the minimum number of six meetings per year and other attendees at the meetings have included:

- The Deputy Medical Director;
- The Deputy Chief Operating Officer;
- The Deputy Director of Quality and Effectiveness;
- The Clinical Effectiveness Manager;
- The Associate Medical Director, Research; and
- The Trust Secretary and Deputy Trust Secretary who also provide Secretariat Support to the Committee.

4. MANAGEMENT GROUPS

To ensure that the Committee maintains adequate oversight of the management of quality related matters across the Trust, a series of Management Groups were established. The Management Groups established were as follows:

- Patient Safety;
- Patient Experience and Engagement;
- Clinical Outcomes and Effectiveness; and
- Compliance and Assurance.

The Committee receives a Chair's report detailing the activities of the Management Groups to each meeting. Additionally, the minutes of the Management Groups are received by the Committee at each meeting.

The Terms of Reference for each of the Management Groups, which clearly define the remit of each of the groups, were approved by the Committee.

Due to changes in leadership, the Research and Innovation Management Group has yet to hold its first meeting. Professor John Isaacs, Assistant Medical Director for Research and Development, attended the March 2020 meeting of the Committee to provide an update regarding Research and Development.

The financial year 2019/20 was the first year of operation of the Quality Committee as an assurance Committee within the new Trust governance structure. Acknowledging that 2019/20 was essentially the 'transition' year, Committee members have highlighted the need to review the content, frequency and scheduling of reports given the increased administrative burden/workload that has become apparent in servicing the Committee.

5. REPORTING

i. Annual Reports

During the year, the following Annual Reports were received by the Committee:

- Leadership Walkabouts;
- Safeguarding;
- Healthcare Associated Infections;
- Clinical Audit;
- Health and Safety;
- Patient Safety and Quality Review Panel; and
- Equality, Diversity and Human Rights.

ii. Regular Reports

Additional quarterly and biannual reports on the above areas of focus have also been received.

Committee members have also received regular updates on the CQC Action Plan, the Integrated Quality and Performance Report and the BAF Quality Committee Assurance Report.

iii. Ad-Hoc Reports

In addition to those reports listed above, a number of reports have been received by the Committee. These include:

- *Diagnostic Deep Dive:* Following a discussion at the July meeting of the Committee, Stephen Lowis, Senior Business and Development Manager, attended the September

meeting to provide an in-depth review of the Trust's diagnostic performance and highlighted any pressure points that could result in an adverse impact on patients due to a delay in receiving a diagnosis.

- *Trust Response to Winter Pressures:* At the January meeting of the Committee, Martin Wilson, the Chief Operating Officer, detailed the ways in which the Trust was managing additional pressure on the organisation as a result of the Winter season, in particular due to increases in attendance as a result of seasonal flu.
- *Coronavirus Update:* At the March meeting of the Committee, members discussed the early impact of the pandemic on the organisation and ongoing plans to respond.

6. GOVERNANCE, INTERNAL CONTROL AND RISK MANGEMENT

The Committee had a Schedule of Business for 2019/20 and utilises a rolling programme and action log to track committee actions.

As highlighted in Section 5 ii, the Committee receives regular updates on risks recorded on the Board Assurance Framework which relate to the Committee's area of focus. Discussions have included those pertaining to the Trust environment which could impact the quality of care provided to patients (including the accommodation in the Special Care Baby Unit and Maternity Assessment Unit), failure to achieve required CQC standards which could impact on the Trust's ability to remain "Outstanding" and the risks relating to Healthcare Associated Infections and Influenza.

7. PROGRESS FOR 2020-2021 & REVIEW OF EFFECTIVENESS

There are three key areas which require Committee consideration during 2020/21 which are:

1. Quality Governance Structure - A review of the Quality Governance Structure is required to ensure it continues to provide adequate assurance to the Committee, and subsequently the Board.
2. Committee schedule of business and membership – The Committee will need to consider whether the membership of the Committee is sufficient and whether the content and scheduling of standard reports received by the Committee is appropriate. The Committee may wish to explore transitioning to quarterly meetings which would fit in with the broader Governance cycle.
3. Committee effectiveness - The Committee will need to undertake a more detailed review of its effectiveness using an approach agreed by the Trust Board. This work will be undertaken during the Summer of 2020.

The Committee will need to receive assurances regarding the activities outlined above.

Report of Fay Darville
Deputy Trust Secretary
14 May 2020

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Quality	May-20	Jul-20	Sep-20	Nov-20	Jan-21	Mar-21	May-21	Jul-21
Regular reports								
Management Group reports, includes updates on:								
- New interventional procedures								
- IPC								
- NCEPOD		x	x	x	x	x	x	x	
Leadership walkabouts		x (Annual Report)	x	x	x	x	x	x	
Health and Safety		x (Annual Report)		x			x (Annual Report)		
External visits/CQC		x	x	x	x	x		x	
Minutes	x	x	x	x	x	x	x	x	
Action log	x	x	x	x	x	x	x	x	
Integrated Quality & Performance report	x	x	x	x	x	x	x	x	
Quarterly								
Safeguarding	x	x (Annual Report)	x	x			x	x (Annual Report)	
Mortality		x	x		x		x		
BAF Committee Assurance Report	x		x		x		x		
Learning from deaths		x		x		x		x	
Learning disability	x			x		x		x	
Patient Experience			x	x		x		x	
IPC (IPC BAF intro reportMay 20 then quarterly with main IPC report)	x	x		x		x		x	
Bi-annual								
Medicines Management				x			x		
End of Life and palliative care				x		x			
Research and Innovation			x			x			
Quality Account		x		x				x	
Quality Improvement			x			x			
Annual								
HCAI		x						x	
Serious Incidents					x				
Compliance/External accreditation		x						x	
Clinical Audit			x (Annual Report)					x	
NICE				x					
Review of effectiveness		x						x	
Annual report to Board (Annually in May from 2010)	x						x		
Terms of Ref and SoB	x						x		
Quality Strategy		x						x	
Patient Safety & Harm reduction report				x					
ED & Human Rights report				x					
Clinical Strategy		x						x	
PLACE assessment update report						x			
Ad-hoc								
Policies and procedures								
Minutes from SubGroups	x	x	x	x	x	x	x	x	
COVID-19 update	x								
Nightingale Update	x								

Matters for review by exception by the Committee:
Litigation report

Nursing and Midwifery strategy
New clinical pathways and roles
report
CQUIN/QI
GIRFT
CQC Fundamental Stds

Terms of Reference – Quality Committee

1. Constitution of the Committee

The Quality Committee is a non-statutory Committee established by the Trust Board of Directors to monitor, review and report to the Board on the quality of care to the Trust's patients, specifically in relation to patient safety, clinical effectiveness and patient experience.

2. Purpose and function

The purpose and function of the Committee is to gain assurance, on behalf of the Board of Directors:

2.1 that the Trust has appropriate quality governance structures, systems, processes and controls in place to achieve consistently safe high-quality care and to meet the Trust's legal and regulatory obligations;

2.2 that the delivery of continuous quality improvement is a hallmark of the way the Trust and its people work, recognised by stakeholders, including partners and the public;

2.3 that any shortcomings in the quality and safety of care against agreed standards are being identified and addressed in a systematic and effective manner;

2.4 on the Trust's approach to continuous quality improvement processes for all Trust services, the Trust's research and development activities and its clinical practice, acting as a guardian and advocate; and to seek assurance that the Trust has a robust mechanism of research governance which is subject to regular scrutiny and monitoring;

2.5 on the quality impact of changing professional and organisational practices, including those involved in increased system-based and partnership working (in collaboration with the People Committee);

2.6 that the Trust fulfils its leadership and influencing role on service quality, standards and practice, as an organisation of national importance, as a significant service provider and as a partner in training, education and development of health and care capacity in the region (in collaboration with the People Committee) and beyond;

2.7 around current and future statutory and mandatory quality and patient safety standards, such as Care Quality Commission (CQC) Fundamental Standards, and the actions needed to meet them;

2.8 on the effectiveness of mechanisms used for the involvement of patients and the public, staff, partners and other stakeholders in improving quality assurance and patient safety at the Trust, and report on their value and impact to the Board; and

2.9 to review, assess and gain assurance on the effectiveness of mitigations and action plans as set out in the Board Assurance Framework specific to the committee purpose and function.

3. Authority

The Committee is:

3.1. a non-statutory Committee of the Trust Board of Directors, reporting directly to the Board of Directors, and has no executive powers, other than those specifically delegated in these Terms of Reference;

3.2 authorised by the Board of Directors to investigate any activity within its Terms of Reference, to seek any information it requires from any officer of the Trust, and to invite any employee to provide information by request at a meeting of the Committee to support its work, as and when required; and

3.3 authorised by the Board of Directors to secure the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for the exercise of its functions, including whatever professional advice it requires (as advised by the Executive Leads of the Committee and / or the Trust Secretary).

3.4 The Committee shall have the power to establish sub-committees and / or task and finish groups for the purpose of addressing specific tasks or areas of responsibility, if approved by the Trust Board. In accordance with the Trust's Standing Orders, the Committee may not delegate powers to a sub-committee or task and finish group unless expressly authorised by the Trust Board of Directors.

3.5 The Terms of Reference, including the reporting procedures of any sub-committees or task and finish groups must be approved by the Trust Board of Directors and reviewed on an annual basis.

4. Membership

4.01 Members of the Committee shall be appointed by the Board of Directors and shall be made up of least seven members drawn from Non-Executive Directors (three members minimum) and members of the Executive team (four members).

4.02 One of the Non-Executive members will be appointed by the Trust Board of Directors as the Chair of the Committee.

4.03 A further Non-Executive member of the Committee shall be appointed as Vice-Chair, likewise by the Trust Board of Directors.

4.04 The membership shall include:

- the Medical Director
- the Executive Chief Nurse
- the Chief Operating Officer
- the Director of Quality and Effectiveness
- the Associate Medical Director, Patient Safety and Quality
- the Deputy Chief Nurse

4.05 The Chair of the Board of Directors and the Chief Executive shall not be members of the Committee, but may be in attendance.

4.06 Other than as specified above, only members of the Committee have the right to attend Committee meetings. Other non-Committee members may be invited to attend and assist the Committee from time to time, according to particular items being considered and discussed.
Additional (non-core) membership will be drawn from the senior clinical leadership teams within the Trust, including the Deputy Medical Director (Research lead), to provide the depth and breadth of experience required to inform the committee to complete its business effectively.

4.07 In the absence of the Committee Chair, the Vice-Chair shall chair the meeting. Members are expected to attend all meetings.

4.08 The Medical Director and the Executive Chief Nurse shall act jointly as the Executive Leads for the Committee.

4.09 Members are able to attend Committee meetings in person, by telephone, or by other electronic means. Members in attendance by electronic means will count towards the quorum.

4.10 The Council of Governors may nominate up to two governors to attend one meeting of the Committee annually to observe proceedings. The observation of Board assurance committees by governors shall be subject to conditions agreed by the Board of Directors. The Chair of the Committee may exclude governors from being present for specific items.

4.11 The Trust Secretary, or their designated deputy, shall act as the Committee Secretary. The Trust Secretary, or a suitable alternative agreed in advance with the Chair of the Committee, shall attend all meetings of the Committee.

4.12 All members of the Committee shall receive training and development support before joining the Committee and on a continuing basis to ensure their effectiveness as members, supported by a performance assessment process, as agreed by the Board of Directors.

4.13 An attendance record shall be held for each meeting and an annual register of attendance will be included in the annual report of the Committee to the Board.

Quorum

4.14 The quorum necessary for the transaction of business shall be four members, as defined in 4.01 and 4.04 above, including the Chair or Vice Chair, and at least one other Non-Executive Director.

4.15 Members unable to attend a meeting of the Committee may nominate a deputy to attend on their behalf, agreed with the Chair of the Committee. Nominated deputies will not count towards the quorum.

4.16 A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions delegated to the Committee.

5. Duties

5.1 Cycle of Business

The Committee will:

5.1.1 set an annual plan for its work to form part of the Board's Annual Cycle of Business, informed by the Board Assurance Framework, and report to the Board on its progress.

5.2 Strategy

The Committee will:

5.2.1 advise and contribute to the strategic quality priorities and investments needed to support high-quality clinical outcomes and improve clinical effectiveness in the Trust, and advise the Board accordingly;

5.2.2 review the Trust's Quality Strategy, Quality Account and related delivery plans and programmes, and provide informed advice to the Board on their robustness, comprehensiveness and relevance to the Trust's vision, values, strategic objectives and impact;

5.2.3 take note of international intelligence and research evidence on clinical safety and practice and distil their relevance to the Trust's strategic quality priorities (including where necessary commissioning research to inform its work);

5.2.4 be assured around the monitoring of the Trust's suite of quality-assurance policies against benchmarks to ensure they are comprehensive, up-to-date and reflect best practice; and

5.2.5 scrutinise and triangulate advice on the development of significant clinical and quality policies prior to their adoption.

5.3 Risk

The Committee will:

5.3.1 receive risks held on the Board Assurance Framework pertaining to the Committees area of focus to review the suitability and robustness of risk mitigations and action plans with regard to their potential impact on the Trust Strategic Objectives. To provide the Audit Committee with assurance on the effectiveness of the management of principal risks relating to the Committees purpose and function.

5.3.2 to receive the Executive Oversight Report for information.

5.4 Outcomes and processes

The Committee will:

5.4.1 review the Quality Account to be assured it reflects the integration of clinical quality and patient safety improvement processes;

5.4.2 be assured of the integrity of the Trust's control systems, processes and procedures relating to critical areas, to include:

- high quality care (through the Trust's quality review processes);
- compliance with fundamental standards of quality and safety;
- patient safety and harm reduction;
- ~~S~~safeguarding – adults and children
- infection prevention and control;
- clinical audit;
- introduction of new clinical pathways and procedures;
- introduction of new clinical roles (in conjunction with the People Committee);
- dissemination and implementation of statutory guidance;
- escalation and resolution of quality concerns; and
- patient and carer involvement and engagement;

5.4.3 ensure the effective operation of processes relating to clinical practice and performance, including early detection of issues and problems, escalation, corrective action and learning.

5.5 Learning and communication

The Committee will:

5.5.1 be assured of the effectiveness of systems and processes used for continuous learning, innovation and quality improvement, establishing ways of gaining assurance that appropriate action is being taken;

5.5.2 be assured that the robustness of procedures ensure that adverse incidents and events are detected, openly investigated, with lessons learned being promptly applied and appropriately disseminated in the best interests of patients, of staff and of the Trust;

5.5.3 ~~-~~be assured that evidence-based practice, ideas, innovations and statutory and best practice guidance are identified, disseminated and applied within the Trust;

5.5.4 develop and oversee a programme of activities to engage Board members directly in quality assurance processes and to ensure that such processes include the establishment of a procedure to review, distil and implement the learning from these activities, including 'walk-abouts', reviews, focus groups and deep-dives; and

5.5.5 be assured of the effectiveness of communication, engagement and development activities designed to support patient safety and improve clinical governance.

5.6 Patient and public engagement

The Committee will:

5.6.1 be assured of the effectiveness of a credible process for assessing, measuring and reporting on the 'patient experience' in a consistent way over time, including the appropriateness and effectiveness of processes for patient engagement in support of the Trust's strategic goals and programmes of work.

5.7 Research

The Committee will:

5.7.1 triangulate through assurance the robustness of quality-assurance processes relating to all research undertaken in the name of the Trust and / or by its staff, in terms of compliance with standards and ethics, and clinical and patient safety improvement processes.

5.8 Progress and performance reporting

The Committee will:

5.8.1 review a range of evidence and data from multiple sources, including management and executive committees and groups, on which to arrive at informed opinions on:

- the standards of clinical, service quality and patient safety in the Trust;
- compliance with agreed standards of care and national targets and indicators; and
- organisational quality performance measured against specified standards and targets;

5.8.2 review a succinct set of key performance and progress measures relating to the full purpose and function of the Committee;

5.8.3 review progress against these measures on a regular basis and seek assurance around any performance issues identified, including proposed corrective actions and reporting any significant issues and trends to the Board of Directors;

5.8.4 review and shape the quality-related content of the bi-monthly Integrated Quality, Performance, People & Finance Report to the Board of Directors;

5.8.5 agree the programme of benchmarking activities to inform the understanding of the Committee and its work;

5.8.6 be assured of the credibility of sources of evidence and data used for planning and progress reporting to the Committee and to the Board in relation to the Committee's purpose and function;

5.8.7 ensure alignment of the Board assurances and consistent use of data and intelligence, by working closely with the Audit Committee, People Committee and the Finance Committee;

5.8.8 review the following formal reports prior to submission to the Board of Directors as part of the Annual Cycle of Business:

- an Annual Quality Report to inform and / or accompany the Trust's Annual Report;
- Infection Prevention and Control Annual Report;
- Safeguarding Annual Report;
- NICE Compliance Annual Report; and
- the process for management review of specific service reports.

5.9 Statutory and regulatory compliance

The Committee will:

5.9.1 be assured of the arrangements for ensuring maintenance of the Trust's compliance standards specified by the Secretary of State, the CQC, NHS England, and statutory regulators of health care professionals.

6. Reporting and Accountability

6.1 The Committee Chair will report formally to the Trust Board of Directors on its proceedings after each meeting on all matters within its duties and responsibilities, summarising areas where action or improvement is needed.

6.2 The Committee shall report to the Trust Board annually on its work in support of the Annual Report. The Annual Report of the Quality Committee shall:

- set out clearly how the Committee is discharging its responsibilities; and
- be presented to the Annual Members Meeting / Annual General Meeting, with the Chair of the Committee in attendance to respond to any stakeholder questions on the Committee's activities.

6.3 The Annual Report of the Quality Committee shall include an assessment of compliance with the Committee's Terms of Reference and a review of the effectiveness of the committee.

6.4 The Chair of the Committee shall provide an annual update to the Council of Governors on the work of the Committee.

6.5 The Terms of Reference shall be reviewed by the Committee and approved by the Board of Directors on an annual basis.

7. Committee Administration

7.1 The Committee shall meet a minimum of six times a year and at such other times as the Chair of the Committee, in consultation with the Committee Secretary, shall require, allowing the Committee to discharge all of its responsibilities.

7.2 The Chair may at any time convene additional meetings of the Committee to consider business that requires urgent attention.

7.3 The agenda will be set in advance by the Chair, with the Trust Secretary and Executive Leads, reflecting an integrated cycle of meetings and business, which is agreed each year for the

Board and its Committees, to ensure it fulfils its duties and responsibilities in an open and transparent manner.

7.4 Notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, shall be made available to each member of the Committee, no less than five working days before the date of the meeting in electronic form. Supporting papers shall be made available no later than three working days before the date of the meeting.

7.5 Committee papers shall include an outline of their purpose and key points in line with the Trust's Committee protocol, and make clear what actions are expected of the Committee.

7.6 The Chair shall establish, at the beginning of each meeting, the existence of any conflicts of interest and ensure these are recorded in the minutes accordingly.

7.7 -The Committee Secretary shall minute the proceedings of all Committee meetings, including recording the names of those present, in attendance and absent. Draft minutes of Committee meetings shall be made available promptly to all members of the Committee, normally within ten days of the meeting.

7.8 The Committee shall, at least once a year, review its own performance, using a process agreed for all Board committees by the Board of Directors.

Procedural control statement: 14 May 2020
Date approved: [TBA]
Approved by: [TBA]
Review date: May 2021

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Remuneration	May-20	Oct-20	Dec-20	Mar-21
Minutes	X	X	X	X
Action Log	X	X	X	X
Review of VSM Remuneration Policy				X
Review of VSM Pay	X			
Fit and proper persons review		X		
Clinical Excellence rewards programme	X		X [planning for next round]	
Annual Report of the Committee/Review of Committee effectiveness	X			
Appointments	X [as required]	X [as required]	X [as required]	X [as required]
Sucession planning	X		X	
VSM performance review	X			
Terms of reference review	X			
Pensions Update/Policy Review	X	X		

TERMS OF REFERENCE – APPOINTMENTS AND REMUNERATION COMMITTEE

1. Constitution of the Committee

1.1 The Appointments and Remuneration Committee is a statutory Committee established by the Board of Directors to oversee, on behalf of the Trust Board, the appointment and remuneration of the Chief Executive, Executive Directors, and other Very Senior Managers at the Trust.

1.2 The Committee is constituted in line with the requirements of the NHS Codes of Conduct and Accountability and the Higgs report. The Higgs report recommends the Committee be comprised exclusively of Non-Executive Directors, a minimum of three, who are independent of management.

1.3 The Board of Directors approved the establishment of the Appointment and Remuneration Committee, formerly the 'Terms of Service and Remuneration Committee' (known as "the Committee" in these Terms of Reference) for the purpose of:

a) the nomination of the Chief Executive and other Executive Directors for the Trust;
b) the determination of the remuneration, contracts and terms of service and allowances for the Chief Executive and other Executive Directors and Very Senior Managers for the Trust; and
c) overseeing the process for allocation of the Local Clinical Excellence Awards.

1.4 The Committee is a formal sub-committee of the Board of Directors. It is appointed and authorised by the Board of Directors to act within its Terms of Reference. All members of staff are directed to co-operate with any request made by the Committee.

1.5 The Committee is authorised by the Board of Directors to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for, or expedient to, the exercise of its functions.

2. Purpose and function

2.1 The purpose of the Committee will be to determine the appropriate remuneration and terms of service for the Chief Executive, other Executive Directors and Very Senior Managers, including:

a) all aspects of salary (including any performance-related elements / bonuses);
b) provisions for other benefits for senior staff, including pensions and annual leave allocations at variance with standard NHS terms and conditions;
c) arrangements for the recruitment of the Chief Executive, other Executive Directors and Very Senior Managers; and
d) arrangements for termination of employment and other contractual terms.

2.2 The Committee may call such Trust officers as it sees fit to be in attendance, in order to provide advice and guidance, including the Chief Executive (except where the pay and

conditions of the Chief Executive are under consideration) and the Director of Human Resources.

2.3 In all deliberations pertaining to the Chief Executive and all other Executive Directors, the Committee shall take into account the Fit and Proper Persons requirements, required by the Care Quality Commission (CQC).

2.4 The Committee shall consider the recommendations arising from the Clinical Excellence Awards Programme before making recommendation(s) to the Trust Board on such awards.

3. Authority

The Committee is:

3.1 a statutory Non-Eexecutive Committee of the Trust Board of Directors, reporting directly to the Board of Directors, and has no executive powers, other than those specifically delegated in these Terms of Reference;

3.2 authorised by the Board of Directors to investigate any activity within its Terms of Reference, to seek any information it requires from any officer of the Trust, and to invite any employee to provide information by request at a meeting of the Committee to support its work, as and when required;

3.3 authorised by the Board of Directors to secure the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for the exercise of its functions, including whatever professional advice it requires (as advised by the Executive Lead of the Committee and / or the Trust Secretary).

4. Membership and quorum

Membership

4.1 Members of the Committee will be appointed by the Board of Directors and will be made up of at least four members.

4.2 The Committee's membership will comprise the Chairman of the Board and a minimum of two ~~four~~ other Non-Executive Directors.

4.3 The Chief Executive, Director of Human Resources and Trust Secretary will attend the Committee. Other non-Committee members may be invited to attend and assist the Committee from time to time, according to particular items being considered and discussed.

4.4 The Chairman of the Board will chair the Committee. A further member of the Committee will be appointed as Vice-Chair by the Trust Chairman as required. In the absence of the Chairman of the Board, the Vice-Chair will chair the meeting. Members are expected to attend all meetings of the Committee.

4.5 The Trust Secretary, or their designated deputy, will act as the Committee Secretary. The Trust Secretary, or a suitable alternative agreed in advance with the Chair of the Committee, will attend all meetings of the Committee.

4.6 All members of the Committee will receive training and development support as required before joining the Committee and on a continuing basis to ensure their effectiveness as members, supported by the process of annual appraisal, as agreed by the Board of Directors.

4.7 An attendance record will be held for each meeting and an annual register of attendance will be included in the annual report of the Committee to the Board.

Quorum

4.8 The quorum necessary for the transaction of business will be three ~~Non-Executive Director~~ members.

4.9 A duly convened meeting of the Committee at which a quorum is present will be competent to exercise all or any of the authorities, powers and discretions delegated to the Committee.

5. Duties

5.1 Appointment of the Chief Executive Officer

The Committee will:

5.1.1 evaluate the existing skills, knowledge and experience of the Board of Directors and prepare a description of the role and capabilities required for the appointment of a Chief Executive;

5.1.2 identify suitable candidates to fill the Chief Executive vacancy as it arises, making recommendations to the Chairman and Committee members in respect of a Chief Executive appointment;

5.1.3 ensure that the Chief Executive Officer meets the fit and proper persons tests in line with the statutory fitness requirements set out in the NHS Improvement provider licence for directors of NHS foundation trusts;

5.1.4 make a recommendation to the Non-Executive Directors who are not members of the Committee on the appointment of the Chief Executive Officer;

5.1.5 make a recommendation to the Council of Governors, for approval by them, on the appointment of the Chief Executive Officer;

5.1.6 upon appointment, confirm the individual's remuneration within the range agreed by the Committee for the Chief Executive Officer; and

5.1.7 give full consideration to succession planning, taking into account the challenges and opportunities facing the organisation and the skills and expertise required upon the Board of Directors.

5.2 Appointment of Executive Directors

The Committee will:

5.2.1 when considering the appointment of an Executive Director, evaluate the existing skills, knowledge and experience of the Board of Directors and prepare a description of the role and capabilities required for the appointment of an Executive Director;

5.2.2 be assured that a robust recruitment process is established to identify suitable candidates to fill Executive Director vacancies as they arise, making recommendations to the Chairman, Chief Executive and Committee members in respect of Executive Director appointments;

5.2.3 ensure that the Executive Director meets the fit and proper persons tests of the general conditions of the NHS Improvement provider licence;

5.2.4 be assured that an appropriate Interview Panel is convened with responsibility for determining whether the Executive Director should be appointed;

5.2.5 prior to appointment, endorse the remuneration range for an Executive Director and confirm on appointment that the remuneration level is within the specified range; and

5.2.6 give full consideration to succession planning, taking into account the challenges and opportunities facing the organisation and the skills and expertise required upon the Board of Directors.

5.3 Remuneration

The Committee will:

5.3.1 taking account of ensuring value for money for the organisation, determine the range of remuneration and allowances for the appointment and retention of the Chief Executive and / or Executive Directors and VSM's. No Director or the Chief Executive Officer shall be involved in any decisions relating to his or her own remuneration;

5.3.2 subject to receipt of a report on the annual performance of the Chief Executive (from the Chairman of the Board of Directors), and taking account of such national pay determinants, comparative data, performance against objectives and other matters considered appropriate by the Committee, review the remuneration of the Chief Executive on an annual basis;

5.3.3 subject to receipt of a report on the annual performance of individual Executive Directors (from the Chief Executive), and taking account of such national pay determinants, comparative data, performance against objectives and other matters considered appropriate by the Committee, review the remuneration of individual Executive Directors/VSM's an annual basis;

5.3.4 taking account of value for money requirements for the organisation, ensure that remuneration is sufficient to recruit retain and motivate the Chief Executive / Executive Directors with the level of skills appropriate for the proper and robust management of the organisation;

5.3.5 oversee the approval of any termination or severance payments that are proposed for the Chief Executive or other Executive Directors, for other Very Senior Managers (VSMs) and others as may be required by NHSI/E and the Department of Health; and

5.3.6 monitor levels of remuneration across the organisation, particularly in relation to those 'high earning' members of staff. Responsibility for the determination of the salaries of VSMs, other than Executive Directors, is delegated to the Chief Executive and advised by the Director of Human Resources. The Committee Chair will review annually the earnings of the VSMs including senior clinicians with corporate responsibilities.

5.4 Succession Planning

The Committee will:

5.4.1 ensure that the Trust has a detailed succession plan in place for all Executive Team members, other Trust Directors and 'mission critical' posts.

5.5 Performance Review

The Committee will:

5.5.1 oversee the annual performance review process for the Chief Executive Officer, Executive Team members, Assistant Medical Directors and very senior managers across the Trust. In addition to ensure that the outcome of the process being to result in the generation of a single performance rating from measuring the achievement of objectives and alignment to the Trust behaviours framework;

5.5.2 ensure that the performance appraisals of the Chief Executive Officer, Executive Team members, Assistant Medical Directors and very senior managers are undertaken in accordance with the Trusts performance review policy; and

5.5.3 review and approve the Chief Executive Officer and each Executive Directors objectives annually.

5.5.4 The Committee has authority to commit financial resources in respect of matters identified in these Terms of Reference. The Director of Finance must be informed of any decision requiring the use of resources and the Director of Human Resources informed to ensure the appropriate changes are made to the Chief Executive's / Executive Director's contract of employment and remuneration.

5.5.5 In carrying out this role the Committee may form sub committees for the performance of roles within any Trust processes as it thinks fit. Further, it may authorise the Chairman or Deputy Chairman to liaise with such Trust officers or others as circumstances dictate to ensure that Trust processes are adhered to including delegating functions under such processes so that any formal determinations can be made by the Committee in a reasonable way.

6. Reporting and Accountability

6.1 The Committee Chair will report formally to the Trust Board of Directors on its proceedings after each meeting on all matters within its duties and responsibilities, summarising areas where action or improvement is needed.

6.2 The Terms of Reference will be reviewed by the Committee and approved by the Board of Directors on a minimum basis of every two years.

6.3 The Committee will review its effectiveness and compliance with these Terms of Reference each year, and report the outcomes of this review to the Board.

7. Committee Administration

7.1 The Committee shall meet as frequently as it may determine to meet its purpose, but not less than once per calendar year. A meeting shall be called by the Trust Secretary at the request of any member.

7.2 The Chairman may at any time convene additional meetings of the Committee to consider business that requires urgent attention.

7.3 The agenda will be set in advance by the Chair, with the Trust Secretary.

7.4 Notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, will be made available to each member of the Committee, no less than five working days before the date of the meeting in electronic form. Supporting papers will be made available no later than three working days before the date of the meeting.

7.5 Committee papers will include an outline of their purpose and key points in line with the Trust's Committee protocol, and make clear what actions are expected of the Committee.

7.6 The Chair will establish, at the beginning of each meeting, the existence of any conflicts of interest and ensure these are recorded in the minutes accordingly.

7.7 -The Committee secretary will minute the proceedings of all Committee meetings, including recording the names of those present, in attendance and absent. Draft minutes of Committee meetings will be made available promptly to all members of the Committee, normally within ten working days of the meeting.

Procedural control statement: 21 May 2020
Date approved: [TBA]
Approved by: Board of Directors **[TBA]**
Review date: May 2021

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CHARITABLE FUNDS COMMITTEE

DRAFT MINUTES OF THE MEETING HELD ON FRIDAY 28 FEBRUARY 2020

Present:	Mr K Godfrey [KG] *[Chair]*	Non-Executive Director
	Ms J Baker [JB]	Non-Executive Director
	Mr J Jowett [JJ]	Non-Executive Director
	Mrs A Dragone [AD]	Finance Director

In attendance:
Mrs C Docking [CD], Assistant Chief Executive
Mr D Reynolds [DR], Deputy Director of Finance
Mr M Love [ML], Head of Charitable Funds
Mrs A Barton [AB], Communications Development Officer

Observing:
Sir John Burn, Chairman
Mrs T Adegbie, Insight Programme Participant

Secretary: Mrs K Jupp [KJ] Trust Secretary *[Minutes]*

Note: The minutes of the meeting were written as per the order in which items were discussed.

20/02 BUSINESS ITEMS

i) Apologies for Absence and Declarations of Interest

Apologies for absence were received from Mr A Welch (AW), Medical Director/Deputy Chief Executive.

No additional declarations of interest were noted.

ii) Minutes of the previous meeting held 20 December 2019, the Extraordinary Meeting on 30 January and Matters Arising

The minutes of the meeting held on 20 December 2019 were agreed to be an accurate record of the meeting.

Matter arising – nursing issue.

The minutes of the extraordinary meeting held on 30th January were agreed as an accurate record subject to the amendment:

Any additional internal funds take away from £50k.
External organisations additional to the £50k.

Come back in May.

Amend mins - agreed to support £50k and stop sentence there.

[ML joined the meeting at 10.45am].

c. Quality Improvement for Faculty/Quality Committee consideration

CD - AOB and KM meeting.

Execs looking at re-profiling the bid - working up for a future date.

KG - need to tighten figures and phasing.

JJ - remind that core business.

CD - separating out core business and discretionary/one off.

JJ - looked at Charity website wording re aims etc.

CD - need to revisit core objects of the charity and the charity strategy.

a. Ratification of Donation of Money Policy

ML - not really changed - up for review and endorsement.

JB - pg 21 of 177 - administration re Ward as intended beneficiary, do we have to specify 'Ward'?

ML - under Charity Commission law - obliged to follow donor wishes.

JB - shouldn't encourage specification of a Ward.

KG - amend to General Fund.

CD - need to link to NY work re overlap with declarations of interest - need to link NY and ML **[ACTION01]**.

Add in some wording re general fund **[ACTION02]**.

Approved but accept needs to come back following link to declaration of interest work

SJB - opportunity to follow up donations?

AB - forms e.g. payroll giving form - we separate out a lot - need to review funds.

b. Online Payments for Trust and Charity

JJ reference to PCI audit requirement.
CD - Charlie Bear can take credit card payments.

ML - new ledger - would be phase 2 - earliest would be June.

CD - can we consider from a fundraising perspective and check with other charities. Revisit in May **[ACTION03]**.

JB - have provided/have not provided - contradiction - have they or have they not? Should be 'have not'.

JB - any analysis re flow of payments and associated costs?

KG - says comparison v current fees.

CD - will look at the demand.

iii) Action Log

The action log was received and discussed.

KG - query re item 3.

Rachael Whitton leading the project - nearly at contract now and working out costs, good deal, trying to calculate recovery of costs from NHSE

Action 13 - ML - DM put on hold as want to redecihm?

KG - Grants policy needs adding in to AdminControl.

ML - was considered at September meeting.

KJ to pick up with Fay **[ACTION04]**.

Action 16 - CD - Need some examples.

20/03 ITEMS TO CONSIDER

i) SoFA and Balance Sheet, including Summary Report, as at 31 January 2020

ML presented the report to the end of January 2020.

ML - opening balance £35.2m, brought in £3.5m, expen £3.6m - next expenditure is £95k.

Unrealised gains now £3.1m.

Current balance of £38m.

AD - investments hit in the last week – coronavirus.
ML - income higher due to £827k increase in legacy income. Brought in more legacies in January than whole of last year.

ML - modest increase in investments.

AD - when are investment managers next in?

ML to arrange for investment managers to come to next meeting **[ACTION05]**.

ii) Grant Applications, including:

7289
JB - don't have an understanding of research/medical.

General request that when people write applications need to make them easy to read.

Agreed.

7321
KG - query re Bobby Robson bit?

ML - split into 2 applications - £72k BR and £32k (or £36k) Charlie Bear.

JB - started funding from 2004?

ML – yes.

JB - NICE guidelines - why don't we fund as a hospital.

KG - guidelines are not mandatory - we can choose which ones prioritise.

JB - papers for the smaller applications - lots which link to complementary services and year of nursing - concerned that people deliberately keeping under the radar e.g. 10 bids at £9k for £90k.

CD - governance prevents this.

JJ - who funded before Bobby Robson as they didn't start until 2008.

AD - general charity supported first.

Agreed

7333
AD - concerns re governance of this one - how do we know if they have spent 5 hours with that person or 3 hours with that one etc?

KG - did say we would take procurement opinion previously on e.g. Citizens Advice - is the hourly rate appropriate?

CD - seems a fair rate, thinks is a good value for money.

ML to compare with CAB - ask procurement to compare and bring back for information **[ACTION06]**.

Agreed.

7343
JB - why is it a different form? But form is better.

KG - likely that GNCH Committee form - went there first.

CD - need one form in future.

JB - how do we know these are transformational?

KG - need to devise an evaluation re impact and outcomes **[ACTION07]**.

JB - lot of money and what do kids get who don't like sport/football.

ML to ask the question re is there an alternative e.g. arts/crafts etc. **[ACTION08]**.

CD - good joint funding.

Agreed.

7345
ML - one post has been in before and one new.

JB - poor application re what they do and their impact.

ML - comes routinely - detailed bid at start.

Need a user friendly summary on every application **[ACTION09]**.

Agreed.

7349
KG - not enough in fund.

ML - general fund balance to be used to top up.

AD - grant came in few years ago to do, not enough in estates budget to do.

JB - doesn't include furniture and how will equip the lounge? Will they come back with another bid?

ML to clarify no further bid - if yes agreed **[ACTION10]**.

7351
KG - came previously and we sent back - thought patient accommodation was being considered as part of estates strategy.

CD - feels like better value for money.

AD - daft as a brush office conversion closed down.

Agreed.

7357 - not on the summary.
AD - don't think Directorate would take money out of budget - wouldn't come through revenue.

JB - need to demonstrate invest to save.

Agreed for one year but need outcomes to come back to the Committee in one year time.

CD - why wasn't 3 years requested?

JB - initial for 1 year and will then consider.

CD - who will fund whilst evaluation.

JJ AdminControl - scanned documents cant highlight but can scribble**

JB - not properly signed e.g. by DM, refers to emails which aren't there.

DR, CD and ML to discuss **[ACTION11]**.

Agreed need to be properly signed.

iii) Grants Panel/Committee Update

20/04 ITEMS TO RECEIVE

i) Charity Review – Update

CD provided an update, noting the following:

ii) Summary of Grants agreed since the last Meeting of the Committee

ML - 5 approved over £5k - totally £49k. 1 of which - query with retrieval centre - resolved - all 5 agreed.

KG - how does this bid link to the earlier application.
ML - same but different.

61 applications approved totally £60k.

Applications pending - Ewen Shepherd?

ML - is the one on the top of the action log - procuring piece of kit.

JB - Pg 101 - complementary therapy ones?

ML - not actually approved.

CD - need to add in another column re either additional or part of an existing bid.

JJ - what happens at away days?

KG - tend to be strategy.

CD - will be updates.

JJ - surgeons when to Jesmond Dene House?

CD - need to say what is acceptable **[ACTION12]**.

ML - funds available.

ML to get copy of Jesmond Dene invoice **[ACTION13]**.

SJB - should get a deal with hotels/meeting venues.

JB - should invest in community premises.

CD - Wallace and Gromit charity - something specific for children's hospital.

ML - bid came in after closed off papers for this committee - has been approved.

KG - will come in as an income item and flow out as a grant.

iii) <u>Target Spend Report to January 2020</u>

ML presented the report.

ML - 3 above - ophthalmology, general medicine and general Cancer - virtually on target.

Cardio, Peri op etc. below what would anticipate.

Will do a review at the end of the year.

Target spend is a notional figure.
JB - query why some are so low?

KG - frequency of report.

CD - could ask funds for their strategy for the 12 months.

KG - request annually.

iv) Income Report to January 2020

ML - income up by £700k - recent legacies.

Largest recipients - cancer, cardio and children's.

v) Summary of Investments

a. Newton's Quarterly Investment Report to 31 December 2019
b. CCLA Quarterly Investment Report to 31 December 2019
c. Summary Investment Report

The investment reports were received.

vi) Fundraising & Communications Report

CD presented the report, noting the contents.

CD - appointed a Charity Director - JB involved - appointed Terri Wishart - Director of Advancement at Newcastle University.

Will start 1 June.

AB here to develop fundraising approach. In a couple of weeks Terri will give some time.

AB - 4 weeks in post.

Looking at the 'brand' for the charity - to refresh and improve.

Website - want to be clear, easy to use and be a platform for opportunities.

Reviewing leaflets and materials.

Mapping stakeholders.

Induction - didn't mention charity.

Campaigns - GNCH 10th anniversary this year - find good stories to share and encourage donations, link to 5P's.

GNR - 117 out of 290 places filled.

Donor journey.

Discussed the tents for GNR.

CD - will have a Newcastle Hospitals Charity tent and a Bobby Robson tent.

CD - NEDs on induction **[ACTION14]**.

[SJB left the meeting at 12.04].

vii) Minutes of Associated Meetings:

a. Charlie Bear Committee – 23 October 2019 and 22 January 2020

b. Great North Children's Hospital Foundation – 21 November 2019 and 16 January 2020

c. Sir Bobby Robson Foundation – 24 January 2020

JJ - SBR Institute - quoting £15m - expectation that the Trust will fund most of it and 'support' from the CEO.

Beachwood house at Freeman - knock down and build new clinical trials unit with a patient hotel on the top.

DR - paper for Execs, unlikely Trust will have capital, patient status - residents? Other considerations re income if move out.

CD - could do an appeal campaign - initially 2 separate appeals proposed - one charity not 2 appeals.

JJ - different stakeholders.

JJ - Great Ormond Street - Morgan Stanley Clinical Building.

AD - RVI more appealing than Freeman.

JJ - April 24th is next Bobby Robson meeting so need to have a communication prior to this.

20/05 ANY OTHER BUSINESS

i) Meeting De-Brief

ii) Date and Time of the Next Meeting

The next scheduled meeting of the Committee is Friday 1 May 2020, Board Room, Freeman Hospital, 10:30am

iii) Other Business

CD - caring for doctors caring for patients document - supporting wellbeing of teams that supports patient care.

Outline proposal from Sarah Platt who is keen to support intensive care team - could we test out the thinking.

Enough money in ICU fund.

CD to draft a form up/template and test out with Committee members - will link in with key stakeholders and get advice from Association of Charities **[ACTION15]**.

The meeting closed at 12.14.

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COUNCIL OF GOVERNORS

DRAFT MINUTES OF MEETING HELD ON 20 FEBRUARY 2020

Present:
Professor Sir J Burn, Chairman
Dame J Daniel, Chief Executive
Public Governors (Constituency 1 – see below)
Public Governors (Constituency 2 – see below)
Public Governors (Constituency 3 – see below)
Staff Governors (see below)
Appointed Governors (see below)

In Attendance:
Professor K McCourt, Non-Executive Director
Ms J Baker, Non-Executive Director
Mr J Jowett, Non-Executive Director
Mr A Welch, Medical Director/Deputy Chief Executive
Mrs A Dragone, Finance Director
Mr M Wilson, Chief Operating Officer *[from 14:24pm]*
Mr P Towns, Assistant Director of Nursing
Mrs K Jupp, Trust Secretary
Ms L Hall, Deputy Director of Quality & Effectiveness [for agenda item 20/02 i only]
Ms AM Troy-Smith, Quality Development Manager [for agenda item 20/02 i only]
Mrs R Carter, Head of Quality Assurance & Clinical Effectiveness [for agenda item 20/02 I only]
Mr Y Hunter-Blair, Assistant Director of Production & Preparation [for agenda item 20/02 ii only]

Secretary: Mrs F Darville, Deputy Trust Secretary (Minutes)

Minutes of this meeting are written as per the order in which items were discussed, not as per the agenda, to reflect quoracy.

20/01 BUSINESS ITEMS

i) Apologies for Absence and Declarations of Interest

Apologies were **received** from Governors Mr P Briggs, Mrs J Carrick, Miss R Draper, Professor A Fisher, Dr V Hammond, Mr J Hill, Mrs R Hudson, Ms F Hurrell, Mrs S Nelson, Dr M Saunders, Councillor A Schofield, Mr M Warner and Professor A Wathey.

Further apologies were **received** from Ms M Cushlow, Executive Chief Nurse, Mrs A O'Brien, Director of Quality and Effectiveness, Mrs C Docking, Assistant Chief Executive,

Dr V McFarlane Reid, Director of Enterprise & Business Development and Non-Executive Directors Mr S Morgan, Professor D Burn and Mr K Godfrey.

There were no additional declarations of interest made at this time.

It was resolved: (i) to **note** the apologies and (ii) that no further interests had been **declared**.

ii) Minutes of the Meeting held on 21 November 2019 and Matters Arising

The minutes of the meeting were **agreed** as an accurate record.

It was resolved: to **accept** the minutes of the previous meeting.

iii) Meeting Action Log

The action log was **received,** with one action in progress.

It was resolved: to (i) **receive** the action log and **note** the progress and (ii) **note** the ongoing action.

iv) Chairman's Report

The Chairman presented the report, **noting** that it was presented at the public session of the Board of Directors on 30 January 2020.

It was resolved: to **receive** the report.

v) Chief Executive's Report

The Chief Executive **provided** a verbal update, with the following salient points **noted**:

- The Trust, along with the wider NHS, was in a time of transition following the election of a new Government. The Trust continued to collaborate on health policy.
- Work to refresh the Long Term Plan continued, with the People Plan to be published in the near future. Some uncertainty remained around requirements for organisations to agree priorities going forward.
- An NHS wide comprehensive spending review was underway. Health would feature prominently within this spending review, however it was unlikely that funding would be sufficient enough to significant reduce waiting times.
- The Trust has submitted a bid to become a part of the Academic Health Science Network (AHSN), with interviews to take place next Tuesday. If successful, this would be beneficial for the organisation's reputation and finances.
- The Trust continued to operate within challenging circumstances. It was the only Trust of its size currently achieving the Accident and Emergency performance target. The teams continued to work effectively under an increase in attendances and in increased patient acuity. The Trust also continues to assist other organisations were possible.

- The Trust anticipated delivering its financial obligations for the current financial year and was working on its financial plan for 2020/21.
- The Trust continued to demonstrate its strengths in Research and Innovation (R&I). If successful in the AHSN bid, this would result in badge recognition and could encourage substantial research grants and allocations into the organisation.
- The Trust strengthened its own internal R&I structures, with Professor John Isaacs appointed as Assistant Medical Director for R&I. Further developments were underway to improve the Trust's infrastructure for research and to improve relationships with both Newcastle University and Northumbria University.
- The results of the Staff Survey were released following completion in the autumn. The majority of Trust staff responded to say that Newcastle Hospitals was their first preference for them and family/friends to receive care and received the highest score in the country on this question.
- It was acknowledged that further work was required to improve areas around bullying and harassment and recognition of Black Asian and Minority Ethnic (BAME) staff. An event was scheduled for staff to collaborate, consider the results and to draft action plans to maintain the Trust's strong position.
- Trust staff, and in particular the Chief Executive, continued to collaborate with other NHS providers in national roles to ensure that the region continues to be well represented. The Trust became an NHS authority on matters pertaining to climate change and has been invited to join the national group. The Chief Executive noted that she continued to sit on the NHS Assembly and as Chair of the Shelford Group.

The Medical Director/Deputy Chief Executive provided an update on Coronavirus, with the following points noted:

- Coronavirus is a family of viruses which include the common cold, MERS and SARS. The latest strain that has presented appeared to have originated in China over the last few months. It was noted that to date, there appeared to be circa 80k cases which have resulted in circa 2k deaths. This represents a mortality rate of around 0.25%.
- It was reported that the majority of those infected with Coronavirus suffered from mild flu-like symptoms and that most of those who had died from the virus had significant co-morbidities.
- Prof Chris Witty, Chief Medical Officer for England, recently visited the Trust to tour the Trust's High Consequence Infectious Disease (HCID) unit which admitted the first two patients in England with confirmed Coronavirus.
- The Trust remains well prepared for Coronavirus however, the vast majority of the Trust continues to operate as usual.

It was resolved: to **receive** the report.

vi) <u>Governor Elections Results</u>

The Deputy Trust Secretary presented the report.

The agreement of the Council was required to allow for the extension of the terms of office of the newly elected Governors to be in line with the standard Governor election cycle.

This was **agreed.**

It was resolved: to (i) **receive** the report and (ii) **note** the agreement to extend the terms of office of the newly elected Governors to be consistent with the standard Governor election cycle.

20/02 PRESENTATIONS

i) End of Year Quality Account Presentation

The Deputy Director of Quality & Effectiveness, Quality Development Manager, Head of Quality Assurance & Clinical Effectiveness and Assistant Director of Nursing **delivered** the presentation detailing the Quality Account for 2019/20.

The following key points were **noted** from the presentation:

- While the quality priorities of the organisation do change, the overall quality of care provided to patients within the Trust remained an absolute commitment for all staff.
- A brief overview of progress to date for the 2019/20 priorities was provided:
    - Priority 1: Healthcare Associated Infections (HCAIs) – significant progress had been achieved. Across the year, a 10% year on year reduction of instances of MSSA bacteraemias had been observed.
    - Priority 2: Pressure Ulcers (PU) – targeted work continued to reduce across the organisation. A brief spike in instances was observed in October, which has since been recovered. The Trust continues to consider Quality Improvement (QI) work in this area and seeks to embed the methodology amongst wider staff to increase Trust knowledge.
    - Priority 3: Management of Abnormal Results: a task and finish group was convened to manage the Trust response to any results which were either missed or there was a delay in response. Work remained in progress to 'close the loop' by creating an electronic flag to identify abnormal results at a glance. It was anticipated that further refinement of the process was required and would result in testing of a revised system.
    - Priority 4: System for Action Management and Monitoring (SAMM) – it was advised that the Trust aspired to create or procure a system that would allow for more robust management of actions resulting from internal and external inspections carried out within clinical directorates. A multidisciplinary group within the Trust had been convened to consider however it advised that no 'off the shelf' item would be available to be procured at present however some companies noted their intention to develop something suitable in future. It was further advised that there was limited in-house IT development capacity at present due to organisational focus on the paperlite programme.

- Priority 5: Enhancing capability in Quality Improvement (QI) – The Trust remains focussed on the Trust wide benefits of embedding QI methodologies across the organisation due to the proven improvements in outcomes for both patients and staff.
- Priority 6: Deciding Right – work continues within this area to ensure that end of life and palliative care decisions were made in good time to ensure patient's wishes were recorded. Further collaboration with local councils continue.
- Priority 7: Treat as One – the invaluable collaboration between the Trust and the Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust was noted and would continue in the coming year.
- Priority 8: Reasonable adjustments for patients with suspected or known learning disability – work continued to ensure that those patients had the best possible experience as a patient with the Trust.

The Committee queried the approximate percentage of patients that had a suspected or known learning disability. The Assistant Director of Nursing agreed to provide the figure outwith the meeting **[ACTION01].**

Presenters went on to highlight the proposed quality priorities for 20/21 which included:

- Patient Safety
  - Reducing Infection
  - Pressure Ulcer Reduction
  - Management of Abnormal Results
- Clinical Effectiveness
  - Enhancing capability in QI
  - Shared Decision Making (SDM)/Consent
- Patient Experience
  - Treat as One
  - Ensure reasonable adjustments are made for patients with suspected or know Learning Disability
  - Establish a Patient Experience Volunteer Network

It was noted that the priorities for the coming year remained broadly consistent with those for 2019/20 with a couple of amendments. Those under Patient Safety would remain the same as further improvement was required to embed into every day standard practice.

It had been agreed to step down the SAMM priority due to limitations to system capabilities and this priority was replaced by Shared Decision Making and Consent. This was to ensure that there was a consistent approach to fully informing patients about treatment options across the Trust.

It had also been agreed to step down the 'Deciding Right' priority due to work undertaken thus far to replace with the establishment of a patient experience volunteer network.

Regarding the Pressure Ulcer priority, Dr Murthy queried the focus on reduction rather than prevention. It was noted that pressure damage would be difficult to eradicate completely within a hospital setting.

Mr Cranston queried whether infection prevention and control (IPC) and hand hygiene remained a Trust priority. The Deputy Director of Quality and Effectiveness advised that while it was not captured within this exercise, IPC remained a cornerstone of the Trust's standard practice and continued as part of the organisation's business as usual.

[The Chief Operating Officer and Assistant Director of Production and Preparation joined the meeting 14:24pm]

[The Chief Executive left the meeting at 14:25.]

The Quality Development Manager went on to note that Governor consideration and agreement was required in relation to the selection of a local quality indicator alongside the mandated 18 week wait and 4hr A&E target performance measures. It was suggested that the Trust use Healthcare Associated Infection with a focus on Staphlococcus Aureus.

Mrs Errington suggested that the matter be considered by the Quality of Patient Experience Working Group. The Quality Development Manager agreed to collaborate on the matter with Mrs Errington, with the result of discussions to be feedback to the wider Council in advance of the next meeting **[ACTION02].**

[The Quality Development Manager, Head of Quality & Assurance & Effectiveness and Deputy Director of Quality & Effectiveness left the meeting at 14:32pm]

It was resolved: to (i) **receive** the presentation and (ii) **note** the requirement for the Quality Development Manager to liaise with Mrs Errington regarding the selection of a local performance measure.

ii) Newcastle Specials Presentation

The Assistant Director of Production and Preparation provided the presentation with the following points to note:

- The Trust was in possession of a wholesale dealers license and produced a range of products to exacting patient requirements for both inpatients and a number of external customers.
- There were five specialised production zones for a range of different products including those developed for children, those for patients with difficulty swallowing and cytotoxic chemotherapy. All production was subject to a rigorous quality control process.
- The presentation highlighted the top twelve pharmacy products made at ward level equated to 39.9m dose units in 2018. By producing these away from the ward setting, it would release nursing time back to direct patient care.
- The potential for further commercial opportunities was noted and the aspirations for further future growth were highlighted.

It was resolved: to **receive** the presentation.

[The Assistant Director of Production and Preparation out 14:55pm]

20/03 REPORTS FROM GOVERNOR WORKING GROUPS

i) Nominations Committee Report

The Chairman presented the report and **noted** the following points:

- Mrs Pat Ritchie, Chief Executive of the Newcastle City Council, joined the Trust's Board of Directors as an Appointed Non-Executive Director.
- The Trust commenced the recruitment process for two Non-Executive Directors. One of the positions would replace Mr Godfrey who would stand down from the Board of Directors in the summer and the other was as a result of the provision to increase the number of Non-executive Directors on the Board. The focus would be to enrich the Board with knowledge on the digital agenda. The interviews would be scheduled for the coming months.

It was resolved: to **receive** the report.

ii) Quality of Patient Experience (QPE) Working Group Report

Mrs Errington presented the report, **noting** that group members had undertaken a number of visits as detailed in the report.

Regarding the report pertaining to Ward 18 (FH), Miss Colvin-Laws queried whether the walkers had been cleared in the day room as this had been an issue when a relative had been an inpatient. Mr Forrester confirmed that it was now clear.

It was resolved: to **receive** the report.

iii) Business Development (BD) Working Group Report

Dr Valentine presented the report with the following points to **note**:

- The recent meeting discussed the ongoing proposal for Governors to attend Board Committee meetings, agreeing that this continue.
- The group received a presentation from Healthwatch Newcastle.
- Members of the group attended the Quality Account consultation.
- Newly elected Governors were invited to attend meetings as members or on an ad-hoc basis.

It was resolved: to **receive** the report

iii) Community Engagement and Membership (CEM) Working Group Report

Mr Cranston provided a verbal report with the following points to **note:**

- Going forward, the working group would be the 'People, Engagement and Membership Working Group' to highlight the alignment to the People Committee.
- Meetings of the working group had been altered to take place bimonthly, opposite to the formal meeting. All Governors were welcomed to attend.
- The first Members Event of the year took place on 6 February 2020 on the subject of Transplantation. The feedback received on the presentations by Professor Schueler and Professor White was overwhelmingly positive, along with the inclusion of the Governor Surgery section. It has been agreed that this format continue going forward with suggestions for further improvement of the format welcomed.
- The two remaining Members Events for 2020 have been scheduled for Thursday 11 June 2020 on the History of the RVI and on Thursday 22 October on Sustainability and the Declaration of the Climate Emergency.

It was resolved: to **receive** the report.

20/04 QUALITY AND PATIENT SAFETY/PERFORMANCE & DELIVERY

i) Integrated Report – Quality, Performance, People & Finance – January 2020

The Chief Operating Officer tabled a paper which highlighted the requirements for the Trust as a result of the NHS Operational Planning and Contracting Guidance for 2020/21. Detailed within the paper were the 16 requirements along with their current statuses and the assessed risk in achieving compliance.

A number of areas were rated green as either the Trust already met the requirement or was working to achieve the requirement in the near future. These included the requirements around the commencement of reablement care within two days of referral, the avoidance of ambulance handover delay and 'corridor care' and the acceleration of outpatient transformation plans.

Areas of challenge in achievement were noted as the reduction of bed occupancy to a maximum of 92%, lowering the Trust's waiting list by 31 January 2021 and the elimination of waits of over 52 weeks for treatment.

The Integrated Report was received for information.

Mr Stewart-David queried the Trust's performance in relation to cancer when compared to other providers. The Medical Director/Deputy Chief Executive advised that while patient outcomes continue to be good, the Trust was currently not achieving the 62 day pathway target. The Chief Operating Officer added that the Trust cares for patients with a range of cancers, including those that were rare and particularly complex.

Regarding the Trust's financial performance, the Finance Director advised that the Trust planned to spend £50m on capital programmes in 2020/21 however noted that the next two years would be challenging financially for the organisation and the NHS as a whole.

Regarding the Executive summary provided within the report, Dr Murthy queried the measure the Trust has put in place to recover the performance position. The Chief Operating Officer advised that although the Trust was not able to meet a number of the performance standards, it continued to perform well when compared to its peers.

It was further advised that a review of the wider clinical standards was currently underway and it was anticipated that they would be published in the coming weeks. An update would be provided to Governors in due course.

Mrs Yanez queried the drivers to non-compliance of the 2 week Breast symptomatic performance standard. The Chief Operating Officer advised that this was due to limitations within radiology staffing and to the prioritisation of those patients who were most likely to have a positive diagnosis.

Dr Murthy went on to query the financial penalty for not meeting targets to which the Finance Director advised was under constant review due to factors such as value based commissioning and contract negotiations with Commissioners.

It was resolved: to **receive** the report.

20/05 ITEMS TO APPROVE

i) Council of Governors Working Group Terms of Reference

The Trust Secretary advised that the Terms of Reference for the Council of Governor Working Groups were refreshed to better align them to the Board Committees within the Trust's governance structure. Minor amendments to the names of two of the committees – 'Business Development Working Group' to 'Business and Development Working Group' and 'Community Engagement and Membership Working Group' to 'People, Engagement and Membership Working Group' – were made. In addition, the content of the Terms of Reference were amended to be consistent with each other.

The Trust Secretary also advised that the appointment and reappointment timeline for the Chairs of the Working Groups was included

The Council agreed to the content of the Terms of Reference however requested that further amendment be made to section 4.1.5 to remove the word 'only' to allow for attendance at Working Group meetings of the wider Council.

The Council **approved** the content on this basis.

It was resolved: to (i) **receive** the report and to (ii) **approve** the revised content of the Terms of Reference following amendment to section 4.1.5.

ii) Lead Governor Arrangements

The Trust Secretary presented the paper noting that the role description had been updated following discussion at the Governor workshop in January 2020.

The Council **approved** the arrangements for Lead Governor as set out in the report.

It was resolved: to (i) **receive** the report and (ii) **approve** the arrangements for Lead Governor therein.

20/06 ITEMS TO RECEIVE AND ANY OTHER BUSINESS

i) Update from Committee Chairs and Any Other Business

People Committee

Mr Jowett provided the update **noting:**

- Two meeting of the Committee had taken place since the last meeting of the Council.
- The meeting held in February considered the initial findings following the release of the Staff Survey results. The Trust continued to score well on themes such as staff feeling trusted to do their job, that their role made a difference within the organisation and that positive action had been undertaken in relation to health and wellbeing. Action plans to improve areas such as pressure to come to work when ill and senior management acting on feedback were in place and would be monitored by the committee going forward.
- The Committee received the Gender Pay Report and the Ethnic Pay Report, noting that both would be interesting topics for further discussion at future Governors meetings which the Deputy Trust Secretary agreed to facilitate **[ACTION03].**

Quality Committee

Professor McCourt provided the update, **noting:**

- The Committee had met on one occasion since the last meeting of the Council.
- Reports were received from the management groups which provide necessary assurance to the Committee that care provided to patients continued to be of the highest standard. These included specific detail around sepsis management, the adult inpatient survey and the maternity survey and the robust process for the approval of new interventional procedures.
- Estates challenges which had the potential to impact the quality of care provided were discussed and continue to be monitored, particularly those relating to space occupancy on the Maternity Assessment Unit.
- As a newly formed committee, a review of the activity undertaken in the inaugural year would be undertaken to ensure activity and output of the committee remained consistent with its terms of reference.

Audit Committee

Professor McCourt provided the update, **noting:**

- The Committee meets on a quarterly basis and last met on 28 January 2020.
- The agenda consisted of a number of updates relating to Corporate Governance and Compliance including the revised Risk Management Policy, the refreshed Standing Financial Instructions and Standing Orders and a progress report on the Trust's compliance in regard to the Standards of Business Conduct.
- Updates were received from both Internal and External Audit, along with a report relating to Counter Fraud activity and schedules of both Debtors and Creditors and Losses and Compensation.

Charitable Funds Committee

Ms Baker provided the update, **noting:**

- The committee met twice since the last meeting of the Council, in one formal meeting and one extraordinary meeting. The extraordinary meeting was called to consider two significant applications for funding which required a timely response.
- The Committee agreed to move its current Newton investment portfolio into a sustainable fund.
- A number of applications were received and approved, including those for a database for hip surveillance in children with cerebral palsy and a clinical cystic fibrosis fellowship.
- The review of the Trust's Charity continues which the Committee was contributing to consider ways in which the profile could be raised to generate further funding.

Finance Committee

The Finance Director provided the update, noting:

- The committee has met twice since the last meeting of the Council, in one formal meeting and one extraordinary meeting. The extraordinary meeting was called to consider the Trust's year end position.
- The impact of blended tariffs was discussed, along with the Trust's continuing strong cash balance.
- The Committee received updates on the Trust's Transformation programme and the plans relating to revenue and capital programmes.
- The Committee remained assured that the Trust would deliver its financial obligations at year end.

It was resolved: (i) to **receive** the updates and (ii) **note** the requirement for the Deputy Trust Secretary to facilitate the inclusion of the Gender Pay Report and Ethnic Pay Report presentations at a future meeting.

ii) <u>Matters arising from the Informal Governors Meeting</u>

Mr Cranston advised that the informal meeting of Governors immediately preceding the formal session discussed a variety of matters, including the recent Members Event on 6 February 2020, terminology included within the recently revised Terms of Reference for the Governor Working Groups and the potential for further Governor interaction with

Healthwatch following the recent presentation to the Business and Development Working Group.

It was resolved: to **receive** the update.

iii) Date and Time of Next Meeting

The next meeting of the Council of Governors would be held on **Thursday 23 April 2020** in Function Rooms 137 and 138, Education Centre, Freeman Hospital. [Meeting subsequently cancelled due to social distancing restrictions put in place as a response to COVID-19 pandemic].

The next meeting of the Council of Governors would be a private workshop on **Thursday 18 June 2020** in Function Rooms 137 and 138, Education Centre, Freeman Hospital.

There being no further business the meeting closed at 3:35pm.

GOVERNORS' ATTENDANCE 20 FEBRUARY 2020

A	Mr Derrick Bailey	Y
S	Mr Andrew Balmbra	N
S	Mrs Glenda Bestford	Y
2	Mr Graham Blacker	Y
3	Mr Paul Briggs	Apologies
1	Mrs Judy Carrick	Apologies
2	Mr Terrance Coleman	Y
S	Miss Dani Colvin-Laws	Y
S	Mr Steve Connolly	Y
2	Mr Steven Cranston	Y
1	Miss Ruth Draper	Apologies
2	Mrs Carole Errington	Y
A	Professor A Fisher [Newcastle University]	Apologies
1	Mr David Forrester	Y
1	Dr Vanessa Hammond	N
2	Ms Catherine Heslop	N
S	Mr John Hill	Apologies
S	Mrs Rachael Hudson	Apologies
S	Mrs Fiona Hurrell	Apologies
2	Dr Helen Lucraft	Y
2	Mr Matthew McCallum	N
1	Mrs Jean McCalman	Y
2	Mr John McDonald	Y
3	Dr Lakkur Murthy	Y
1	Mrs Susan Nelson	Apologies
2	Mrs Carole Perfitt	Y
3	Dr Michael Saunders	Apologies
A	Cllr Ann Schofield	Apologies
2	Miss Claire Sherwin	N
1	Mr David Stewart-David	Y
A	Mrs Norah Turnbull	Y
1	Dr Eric Valentine	Y
3	Mr Michael Warner	Apologies
A	Professor Andrew Wathey	Apologies
2	Mr Fred Wyres	N
1	Mrs Pam Yanez	Y

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FINANCE COMMITTEE

DRAFT MINUTES OF THE MEETING HELD ON 25 MARCH 2020

Present:	Mr S Morgan [SM] *[Chair] [via Starleaf]*	Non-Executive Director
	Mr D Stout [DS] *[via Starleaf]*	Non-Executive Director
	Mrs A Dragone [AD]	Finance Director

In Attendance:
Dr V McFarlane Reid [VMR], Director for Enterprise and Business Development
Mr D Reynolds [DR], Deputy Finance Director
Mr I Bestford [IB], Project Director, Financial Improvement
Mrs K Jupp [KJ], Trust Secretary

Secretary:	Mrs F Darville [FD] *[minutes][via Starleaf]*	Deputy Trust Secretary

Note: The minutes of the meeting were written as per the order in which items were discussed.

The meeting was not quorate.

20/09 BUSINESS ITEMS

(i) Apologies for Absence and Declarations of Interest

Apologies for absence were received from Mr G King [GK], Chief Information Officer, Martin Wilson[MW], Chief Operating Officer, Mr R Smith, Estates Director and Mrs K Simpson, Deputy Director of Business and Development.

There were no additional declarations of interest made.

(ii) Minutes of the Formal Meeting held on 27 January 2020 and Extraordinary Meeting held on 27 February 2020 and Matters Arising

The minutes of 27 January 2020 and 27 February 2020 meetings were agreed to be accurate representations, with no amendments required.

There were no matters arising.

(iii) Action Log

The action log was received, with the following updates noted:

- **Action 93** –IB raised the matter with Trust auditors who advised that there was no need for contingent liability. Mitie, the subsequent supplier for the service, removed the waste in question. The action was now closed.

- **Action 98** – AD advised that planning permission was required to increase the value of the Walkergate site. The matter would be revisited in July as the planning application would take 3 months to complete. A further update to be provided from RCS.

20/10 FINANCIAL POSITION

(i) Finance Report including Month 11, (ii) I&E Position and Directorate Performance & (iii) Forecast and Risks

DR presented the Month 11 report, with the following points highlighted. It was noted that the report was drafted prior to COVID-19 impacting the Tust:

- The Trust was currently on target to meet its Control Total (CT), with Income and Expenditure currently above plan. The impact of matched drugs and the payment of subcontractors in the community contract were noted.
- There was a current deficit position of £74k.
- A recovery in activity had been observed.
- Risks pertaining to COVID-19 in relation to the Trust's financial position have been observed, such as incurring extra expenditure and the loss of income.
- The Trust had been instructed to submit a bid to Government regarding this additional expenditure, both up to and after 15 March 2020. A bid of circa £750k was submitted which appeared consistent with those submitted by other organisations.
- A drop in activity had been observed in outpatients; however the Trust would be able to make a saving against the associated spend in relation to this activity.
- To mitigate an element of this risk, a year end deal with all CCGs (with the exception of Cumbria) had been negotiated to allow the Trust to gain additional income to meet the targets.
- NHS England (NHSE) were yet to agree their year-end deal with negotiations continuing.
- Additional costs associated with the Trust's response to COVID-19, such as increasing IT provision for home working, were noted however the Trust remained on target to meet its financial obligations come year end.

SM queried whether the Trust was experiencing an increase in debtors at this time. DR advised that there had been no noticeable increase in debtors. AD added that due to the ledger implementation, the Trust currently had a higher level of creditors.

It was further noted that extensions had been agreed to the annual report and accounts deadlines, with the Trust's external audits to be completed fully.

DS queried whether there would be a national mechanism in place to ensure costs associated with organisation's responses to COVID-19 are sufficiently recorded and would include the potential for reimbursement for lost contributions for non-elective activity. DR advised that a template document had been received by the Trust which was completed and submitted yesterday. It included all costs associated with the Trust's response to COVID-19, including those measures put into place to assist staff. AD noted that the Trust was currently providing both free car parking and a lunch for all staff.

(ii) Month 11 Directorate Activity Summary & Forecast Year-End Activity and Contract Position

The report was received.

SM queried the causes for the large variances in Ear, Nose and Throat, Plastics, Ophthalmology and Dermatology (EPOD) and Children's Services. AD advised that this was likely to be caused by staffing costs and VMR agreed to follow up and provide further detail prior to the next meeting **[ACTION01].**

20/11 PERFORMANCE & DELIVERY

(i) Month 11 Transformation and Financial Improvement Update

IB presented the report with the following key points noted:

- To date, the Trust had delivered £26.5m of the Trust's Cost Improvement Programme (CIP) target of £32m. Of that figure, £22.5m of those savings had been made on a recurrent basis with the remainder coming from non-recurrent sources.
- A further £2m would be actioned and delivered in Month 12. These relate to savings on clinical supplies and the roll out of the KidzMedz initiative in Children's Services.
- It was noted that there was a current reliance on savings from non-recurrent sources.
- It was anticipated that the Trust would carry forward approximately £7.5m into the 2020/21 financial year, in addition to the £25m stipulated in the revised requirements. It was noted that this would likely change given the current situation regarding COVID-19 and there would be a four month 'ceasefire' with the proposed block contract arrangements in place.
- As a result of this, the Transformation team would be redeployed to assist the Trust in other ways such as business continuity and considering areas of service level improvement across the Trust. The focus in this work would not be to reduce costs but rather prioritising service and quality improvement.
- It was advised that the Trust was looking to utilise the current situation to progress areas of transformation that would allow for both the continuity of some services during COVID-19 and to introduce innovative ways of working, such as virtual outpatient appointments, which would continue following the resumption of services in the future.

DS queried whether it would be possible for organisations to look to retrieve any of the cost slippage on CIP as a cost associated with recovering for COVID. AD advised that the four month standstill was intended to compensate for this.

(ii) New Ledger Implementation Update

It was advised that in the main, the system was implemented smoothly with some small issues to note:

- The Electronic Staff Record (ESR), to allow for the feed of staff data to be included in the ledger, would be integrated today.

- An issue with the conversion of creditor files within the ledger resulted in a delay in paying creditors.
- The former ledger supplier, Advanced, provided the Trust will access to the data they held however this was not in a readable format. It was advised that they were legally obligated to provide the data in a way that was easily accessible to the Trust to allow for a final close down of the contract. As such, the Trust has sought legal advice on the matter.

DS queried the likelihood of Advanced resolving to issue to which DR advised that it appeared that attempts to remedy the situation were genuine on their behalf.

AD advised that the final meeting of the project team would take place this Friday.

(iii) Top 10 Capital projects – Actual v Budget Position

The Committee considered the report.

SM queried the amount of projects that were likely to be deferred to next year and which projects were currently overrunning on costs. KJ agreed to ascertain this detail from RCS. Similarly, SM queried the situation with the Special Care Baby Unit (SCBU) project, noting that it appeared to be substantially under cost, and asked for an update regarding the Clinic H work which appeared to be overrunning. KJ agreed to follow up and query the position with RCS **[ACTION02].**

AD advised that in the relation to the Car Park project, it was currently overrun as it was spending ahead of schedule and the cost pressures were being negotiated with Newcastle Council.

Further information was requested from the Committee regarding the CAV schemes, which KJ agreed to follow up. It was further requested that future versions of the report contain more detail about project statuses **[ACTION03].**

20/14 FINANCIAL PLAN, BUDGET AND CONTRACTS 2020/21

(i) 2020/21 Financial Plan, Budget and CIP – Key Messages including NHSE/I Letter Regarding COVID – 19 & (ii) 2020/21 Budget Control Mechanisms

It was noted that in accordance with the Trust's SFIs, the proposed budget for 2020/21 required consideration by the Trust's Board of Directors following review by this committee. The following key points were noted:

- The budget would be considered collectively as an Integrated Care Partnership (ICP), rather than by individual organisations. This required further adoption at the Trust Board to which KJ agreed to include on AdminControl **[ACTION04].**
- As previously outlined, business as usual has been suspended as a result of COVID-19. This has included the provision of a block contract, rather that Payment by Results.

This would be based initially on the Trust's Month 9 income position with the addition of expenses that would be topped up. This was expected to be an extra 2%. AD advised that this 'top up' figure was negotiable.

- It was noted that the Trust should remain cautious regarding this additional figure as it would be non-recurrent. DR expressed concern regarding the Trust receiving a large amount of money come year end – likely circa £5m to include £1.4m for cancer MDTs.
- It was noted however that there was yet to be any guidance released regarding intra-Trust transfers relating in particular to maternity and laboratory testing.
- Regarding the block contract, DR advised that it would be based on an average of an organisation's income over months 1 to 9. In relation to specialised commissioning, AD advised that variances were not included.

SM queried the non-recurrent reserves and whether a reasonable contingency was in place. AD advised that cash balance and annual leave provision could be considered. DR noted that the Trust would not be able to claim on slippage of CIP as compensation. The centre was removing the 1.1% efficiency saving rate however the Trust's CIP ambition was bigger than the one set at a national level.

DS suggested whether the Trust could include any slippage in its CIP programme as an impact on the organisation of COVID-19. AD advised that this may not be possible as not all Directorates across the Trust were impacted by COVID-19 to the same extent. Some areas were able to operate some element of activity as usual.

IB advised that performance management would likely take place over the final six months of the 2020/21 financial year to ensure expenditure was sufficiently controlled.

SM queried whether there were any opportunities for revenue creation within the Commercial and Business Development plan. DR advised that there were no assumptions in the plan for 2020/21 regarding the Commercial Enterprise Unit (CEU). VMR added that the team that would be running the unit were due in post on 1 June however it was likely that they would be redeployed to assist the Trust in other ways in responding to COVID-19.

SM further queried whether there was any extra demand through PPU, which IB confirmed that there was not.

AD advised that funds for the creation of the CEU were sourced from within the Research and Development overhead. The process of ascertaining and agreeing a return to the Trust on the unit continued. It was agreed that the matter would be added to the agenda for the September meeting of the Committee. KJ agreed to facilitate **[ACTION05].**

DS noted that appropriate financial governance be applied when considering the impact of COVID-19.

The Committee discussed the significant transformation occurring within the Trust as a result of COVID-19, particularly in relation to outpatients and patient discharge. IB advised that Jo McCallum had been tasked with logging all of the changes that have happened or were discussed in this area.

Regarding the Trust's business continuity plans, SM queried whether it has been updated and considered by the Board. VMR advised that the Trust's existing pandemic plan was being updated in light of actions taken in relation to COVID-19. AD noted that new areas, such as the use of block contracting, would require inclusion.

The Committee agreed that the cost of COVID-19 and the reconfiguration of services offered and delivered would be a useful topic for a future Board workshop. KJ agreed to consider and schedule **[ACTION06].**

DS queried the ongoing profitability of service lines and management of this. AD advised that generally, PbR contracting would be useful in recovery however some elements of block contracting would be beneficial.

The Financial Plan and Budget for 2020/21 were agreed.

(iii) 2020/21 Contracts Update

VMR presented the report, noting that an updated paper would be provided for Board discussion on 26 March.

SM queried which operational standards were being utilised to which IB advised those set out via NHS Improvement, including Referral to Treatment times (RTT) and Accident and Emergency performance.

20/13 ITEMS TO RECEIVE

(i) BAF Finance Committee Assurance Report

The BAF report was presented with the following points to note:

- There were four risks contained within the report which related to the Finance Committee's area of focus. All of these risks have been reviewed by the Executive Director lead.
- In relation to SO1.6, the Committee discussed how reputational damage could be managed in this regard. IB noted that the Trust had currently undertaken the Patient Led Assessments for the Care Environment (PLACE) assessments and the forthcoming results would be utilised to improve organisational compliance. KJ added that the Trust's Council of Governors was engaged in the process.

AD queried whether Angela O'Brien could be approached to provide further assurance around these in relation to the work undertaken around the Quality Report. KJ advised that the Executive Leads have primary responsibility for reviewing their risks.

The Committee requested that the Executive Director leads provide further assurance that the risks outlined within the report were being sufficiently and consistently managed and

reviewed. It was further requested that the report be presented to the next meeting of the Committee to allow for further review of the BAF to take place. KJ agreed to facilitate **[ACTION07].**

The Committee queried whether risks relating to COVID-19 were being managed in the same way. KJ agreed to link in with Natalie Yeowart, Corporate Risk and Assurance Manager, for further detail **[ACTION08].**

(ii) Minutes of:

a) SSPC – 6 Dec 19 and 10 Jan 20

b) CMG – 20 Jan 20, 5 Feb and 3 Mar 20

The minutes were received.

In relation to the Supplies and Services Procurement Committee, AD advised that a swifter method of securing supplies within the Trust was required due to COVID-19. It was suggested that the Trust may have to make prepayments or pay faster. It was also anticipated that more waivers of the Trust's Standing Financial Instructions (SFIs) may be required.

SM queried whether there was an assumption that the Trust would be investing in its supply chain to maintain continuity of service going forward. DS advised whether there had been any approaches from the Trust's suppliers regarding potential retainers or advances. AD advised that this has not been the case thus far and advised that consideration around the potential for payment upon delivery of items.

SM noted that further consideration regarding the ongoing strength of the Trust's supply chain should be considered by the Board of Directors. AD agreed to consider and follow up with the Trust's Procurement department and feedback **[ACTION09].**

DS advised consideration be made of the Treasury's rules regarding prepayments. KJ agreed to consider these in relation to the Trust's plans for prepayments in relation to the SFIs **[ACTION10].**

It was noted that going forward, the SPPC minutes need to include a review of waivers and breaches, along with the numbers of waivers in place in relation to wider procurement.

20/14 ITEMS TO APPROVE

(i) Report on the Award of Contracts for the Supply of Gas and Electric

SM queried when the deal had been negotiated and whether a comparison had been made to the market more recently. It was suggested that if this has not been done, it would be prudent to do so following a recent fall in market prices. AD agreed to follow this up with RCS **[ACTION11].**

20/15 ANY OTHER BUSINESS

(i) Meeting De-Brief

SM advised that he would discuss the key outcomes of the meeting to ensure that there was sufficient Board oversight of these.

It was agreed that the meeting sufficiently discussed the pertinent issues being the impact of COVID-19, the BAF, funding issues and budget implications.

(ii) Date and Time of the Next Meeting

The next meeting of the Finance and Investment Committee is scheduled for Friday 22 May 2020 at 2pm in Meeting Room 2 Culture Centre RVI.

The meeting closed at **3.25pm.**

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DRAFT MINUTES OF THE PEOPLE COMMITTEE HELD ON 18 FEBRUARY 2020

Present:	Mr J Jowett (JJ) *[Chair]*	Non-Executive Director
	Professor K McCourt (KMc)	Non-Executive Director
	Mr K Godfrey (KG) *[via telephone]*	Non-Executive Director
	Mrs D Fawcett (DF)	Director of Human Resources (HR)
	Mr M Wilson (MW)	Chief Operating Officer

In attendance:
Mr P Turner (PT), Head of Human Resource Services
Ms J Raine (JR), Deputy Head of Workforce Development
Mr N Picton (NP), Head of Workforce, Engagement & Information
Mr S Surash (SS), Consultant Neurosurgeon
Ms K Pearce (KP), Head of Equality, Diversity and Inclusion

Secretary: Mrs K Jupp (KJ) Trust Secretary *[Minutes]*

Note: The minutes of the meeting were written as per the order in which items were discussed.

20/01 BUSINESS ITEMS

iv) Ethnic Pay Report

SS and KP presented the report with the following points to note:

- Following review of the Trust's Workplace Race Equality Standard (WRES) data, KP noted that the widening gap.
- The detail behind the Trust's staff survey results has now been released which would allow for further interrogation of data.
- The Trust performed well when compared to other organisations across the country as a whole.
- No significant difference had been observed between colleagues within the Medical and Dental staff groups however differences were observed at managerial level.
- It was noted that much of the data was subjective and when BME staff were consulted, it was felt that they did not have the same access to opportunities as their white colleagues.
- The biggest difference in metrics was observed in relation to bullying and harassment. Instances of this were being further explored
- SS noted that the snapshot of data utilised for the report as at 31 March 2019 made for uncomfortable reading.
- 8.52% of the workforce was BME, which rose to 23.9% of Medical staff, 19.7% of Consultants and 16.7% of Senior Managers.
- It was advised that the data demonstrated that white applicants were more likely to be shortlisted and successful within consultant positions than BME staff.
- Discrepancies in additional pay from programmed activity and Clinical Excellence Awards (CEA) were noted.

- A further lag in female staff was observed.
- It was noted that medical pay awards provided the theoretical trend and advised that a white consultant would earn three times more in pay than a BME female consultant.
- The glass ceiling for BME nurses appeared to be between bands 6 and 7.
- There were no senior BME non-clinical staff in the Trust.

The Committee discussed the Trust's aspirations to move forward while considering its reputation. SS advised that a number of striking comments had been made about the subjective experiences of those within the Trust. KP advised that representative leadership played a pivotal role in setting the tone for the organisation.

JJ queried how representative the Trust's BME population was when compared to the population it served. KP noted that the Trust hosted a BME recruitment event last year which was attended by over 400 people with a focus on engagement and highlighting the routes into NHS employment through NHSJobs.

The need for positive role models to be in place along with closing the gap regarding career progression were highlighted as key factors with SS further highlighting the need for a whole scale culture change over the next decade.

KG commended KP and SS on the work undertaken to complete the report.

JJ queried the next steps to which SS advised discussions had taken place with Yvonne Coghill regarding representation and the report had been endorsed by Simon Stephens. The need for a launch event was noted.

It was noted that the report would be presented to be approved at the Board of Directors meeting in March 2020. DF suggested that as the report had been finalised, a more timely agreement date would be required and therefore it was suggested that the matter be discussed at the Board Development Session scheduled for February. KJ agreed to facilitate **[ACTION01]**.

KP noted the aspiration for other Trusts to undertake a similar exercise.

MW queried whether the recommendations included within the report were robust enough to which SS advised that the WRES members were content with the recommendations as proposed. KP suggested that ownership at Directorate level for the implementation of the recommendations were required.

JJ confirmed the People Committee's recommendation of the report and requested that some key metrics to highlight the Trust's adherence to the recommendations be provided going forward. DF to assist in the facilitation of this **[ACTION02]**.

KM queried the practicalities of ensuring attendance of a Committee member at each appointment panel taking place across the Trust. SS advised that it has not yet gone out to advert for the steering committee.

KJ noted that the Trust would be taking positive action when recruiting for two new Non-Executive Directors and suggested that the report be discussed in greater deal at the April Trust Management Group meeting and agreed to schedule **[ACTION03]**.

[SS left the meeting at 13.50pm]

v) Gender Pay Report

KP presented the report, noting the following salient points:

- The headline data suggested that the Trust position had remained consistent over the past three years.
- A slight reduction has been observed in the main pay gap between male and female staff.
- No change had been observed in the median pay gap over the last 12 months however a small change had been seen in the median bonus gap.
- No significant change is quartiles were observed.
- Of the Trust's circa 11,000 female and circa 3,000 male employees, a third of male employees were in the higher quartile.

KMc noted that the senior staff cohort appeared relatively stable in terms of turnover.

The Committee discussed the key focus of CEAs, with DF advising that the criteria in awarding them had been revised and endorsed by the Remuneration Committee. This would be rolled out for this year's scheme.

The Committee were asked to approve the report for publication however JJ noted that it appeared that the Chief Executive's approval was required.

[KP left the meeting at 13.57pm].

KG recommended CEA panel consideration. JJ suggested that the recommendation be made to the Remuneration Committee meeting scheduled for 27 February. KJ agreed to facilitate **[ACTION04]**.

i) Apologies for Absence and Declarations of Interest

Apologies for absence were received from Mrs C Docking (CD) and Mr P Turner (PT). No additional declarations of interest were made.

ii) Minutes of the last meeting held on 17 December 2019 and Matters Arising

The minutes of the last meeting were agreed as an accurate record.

KG queried whether the 23% of staff who had received warnings for their sickness levels (as highlighted on page 8/130) were for long or short absences. DF agreed to investigate and feedback outwith the meeting **[ACTION05]**.

There were no matters arising.

iii) Action Log

The Committee action log was received. The following updates were noted:

- Action 21: The November 2020 timeline was queried, with MW noting that this was in line with the standard timetable for succession planning. DF advised that appraisals were due for completion by 30 September annually so there was scope to bring the deadline forward. MW advised that any themes that may arise through the process would be shared with the Committee on an ongoing basis. JJ requested that the Committee be advised whether the Directorates have plans in place for succession planning, to include the leadership for 17 clinical directorates, as a RAG rating. MW agreed to action for next meeting of the Committee.
- Action 22: DF advised that the Chief Information Officer has requested orders to be raised for the solutions required to improve provision and noted that this was anticipated by the end of May 2020.

In relation to succession planning, KMc queried the progress on resolving resilience in fragile services. MW advised that this related to a slightly different matter however MW and DF agreed to consider this and the potential consequences more broadly, highlighting in particular cardiac physiologists **[ACTION06]**.

20/02 STRATEGY

A. Excellence in Training

i) Workforce Development Update, including:

a. Learning and Education Group (LEG) Update and minutes from the last meeting

DF provided the update with the following points to note:

- There had been no meetings of the Learning and Education Group since the last meeting of the Committee.
- There had been lots of change in both the post graduate and undergraduate teams as both were currently without an admin manager.
- Dr Ifti Haq, Consultant Cardiologist, had been appointed as Director of Medical Education (DME) with a deputy DME being sought as well as reviewing the Newcastle University appointment.
- Gill Long has been appointed as Associate Director of Education and Nursing Development as a replacement for Emma Shipley and would join the Trust from 23 March 2020. This is on a one year fixed term contract and has been agreed as a secondment from Cumbria.

b. Medical Education Update

It was advised that there had been no meetings within Medical Education since the last meeting of the Committee.

c Education and Training Review Update

DF tabled slides which would be circulated to members via AdminControl following the meeting **[ACTION07]**. The following points were noted:

- Stephen Welfare concluded his review at end of September 2019. There had been a delay in reviewing the results with DF/AW and MC reviewing the recommendations prior to Executive Team discussion last week.
- The slide pack demonstrated the main themes from the outcome of the review.
- Process to include a range of engagement events with questionnaires, group and individual meetings and to include both internal and external stakeholders.
- Regarding themes, focus on ensuring that the Trust ensures that the basics were correct in terms of policies and procedures that are fit for purpose (such as regarding study leave), the voice of the learner was considered and value of educators was demonstrated.
- Medical, Nursing and HR colleagues continue to work together to consider recommendations.
- DF reiterated that a restructure would not be taking place and that communications would be shared across the Trust regarding the structure and Dr Haq's role.
- It was agreed that an update on the Education and Training review would be provided at the March Trust Management Group. KJ agreed to facilitate **[ACTION08]**.
- It was also agreed that more focussed work regarding workforce planning was required with 'deep dives' into three areas to be undertaken.

B ***#Flourish@Newcastle Hospitals***

ii) **#Flourish@Work – Staff Experience**

a. **The NHS Staff Survey**

NP provided the update, noting the following salient points and advising that the national embargo on results was lifted today:

- The results demonstrate that the Trust has maintained its position in relation to its staff engagement score.
- No significant change has been observed across the ten themes.
- A new theme relating to team working has been implemented this year.
- Within the themes, the Trust performed better in 70% of the themes when compared to its peers.
- When compared to the previous year, it was noted that there were more questions which demonstrated a decline rather than an improvement.
- Despite this, 79% of questions demonstrated no significant movement.
- In comparison to the Trust's Shelford colleagues, the Trust was sector leading in four of the ten themes. This is compared to six last year.
- The Trust performed best within its sector in relation to bullying and harassment and equality and diversity.
- It was noted however that the BME flourish event undertaken last week, it was advised that instances of bullying and harassment from colleagues had deteriorated from last year.
- The figures demonstrating the Directorate level breakdown would be available in mid March.
- The HSJ has reported that the Trust has scored the highest nationally for recommending the Trust as a place to receive care.

- It was noted that the Trust's response rate did not meet the target that had been set for itself.

NP apprised the committee of next steps noting that directorates and departments would receive their results to allow for the development of action plans. It was agreed that the matter would be included on the agenda for the next Board Development Session scheduled for February, along with the provision of a snapshot of the results for the March Board of Directors meeting, in addition to the WRES submission. KJ agreed to facilitate **[ACTION09]**.

A small improvement was observed in the response to questions relating to flexible working.

MW expressed disappointment at the outcome from the Flourish event regarding BME staff bullying results and noted that there was movement from one year to the next.

Referring to question 22b, KG noted the deteriorating position. It was also noted that morale amongst nursing and midwifery staff had reduced and queried whether the two were related. MW suggested that the drop may have been a consequence of the same level of prep work undertaken in advance of the CQC visit had not been repeated.

The Committee agreed that further insight was required from the Trust's directorates and departments, with focus required on any areas who have not embraced the process.

MW advised that last year, a grid was produced detailing directorate activity against their action plan. NP agreed to provide an updated version for the next meeting of the committee **[ACTION10]**.

b. Flourish Programme

DF noted that the Flourish initiative remained as a cornerstone programme within the Trust's strategy. It was advised that the Chief Executive recently chaired a round table discussion with key stakeholders to focus the next phase of the initiative on 'flourish at the frontline' and the translation from Board to Ward.

It was noted that the Assistant Chief Executive would lead on activity.

c. Communications Strategy

Item deferred.

20/03 PERFORMANCE AND DELIVERY

i) People Dashboard – January 2020

The People Dashboard was received with the following highlights to note:

- Compliance issues relating to mandatory training were noted.
- Regarding appraisal compliance, frustration with the process for managers have been noted when interacting with the system.

- The first virtual robotic processing would go live within the next two weeks within the revised HR portal. This would remove the need for 4,000 staff hours to be utilised in inputting data into ESR.
- It was advised that the admin associated with study leave would be automated from April. Work to improve local induction in this regard was also underway.

JJ highlighted that a drop in sickness rates was observed in January to which NP advised that no obvious matter had been identified as the cause. MW suggested the impact of an early flu season could positively reduce absences later in the season.

ii) Key People risks and mitigation, including:

a. Employment Relations

PT advised that a tribunal was ongoing and an update would be provided for information in due course.

No change regarding national cases had been observed.

b. Recruitment and Retention

NP advised that a good retention rate had been observed nationally, with planning currently underway in the Trust for the next BME and disability events in October 2020.

In relation to internal recruitment, 5 members started in January. The Trust has been included in the national toolkit as an exemplar.

DF advised that work had been recently completed and the impact of the BME event that took place in 2019 and the conversion in to employment. It was noted 23% of attendees went on to secure roles within the Trust, with further analysis underway within HR.

c. Workforce Systems Development

Matter discussed under agenda item 20/03 i.

iii) Pensions Update

JJ queried whether the rate of uptake had been as expected and whether this compared favourably to other organisations. DF agreed to consult with peer organisations and feedback to Committee members outwith the meeting **[ACTION11]**.

MW noted that an underwhelming uptake had been observed with the recycling scheme, with Committee members noting the potential impact of the Budget announcements in early March.

JJ queried whether there had been any increase in Trust capacity observed following pension changes to which MW advised that the number of sessions given up was lower than lost activity.

iv) Raising Concerns – triangulation report

DF advised that a paper had been drafted based on the previous staff survey results therefore will be updated to reflect the recent staff survey results. The revised paper would be submitted at the next meeting of this committee **[ACTION12]**.

20/04 ITEMS TO RECEIVE

i) Chair of the Junior Doctors Forum (JDF) Report

Due to time constraints, it was agreed that this item be deferred until the next meeting of the Committee **[ACTION13]**. JR advised that the last forum meeting discussed sleep and was well attended.

It was requested that the themes from recent meetings be considered at the next meeting of the Committee **[ACTION14]**.

20/03 PERFORMANCE AND DELIVERY

i) Key People risks and mitigation, including:

d. Mandatory Training & Appraisal Performance Update

JR advised that the compliance with statutory mandatory training to the end of January 2020 was 88.95%, which represented a 10% increase from November 2019. Whilst this was noted as an improvement, this was still below the required position.

Regarding compliance with Information Governance/Date Security and Protection training figures, the impact of paperlite was noted. It was advised that the training has captured circa 11,000 staff.

Work continues within individual directorates and teams were further effort to improve compliance was required. KJ advised that additional sessions would take place in March.

20/05 ANY OTHER BUSINESS

i) Date and Time of Next Meeting

The next meeting of the Committee was scheduled for Tuesday 21 April 2020 at 1pm in the Boardroom, Freeman Hospital.

There being no further business, the meeting closed at **2:57pm.**

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Agenda item A9(ii)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	30 July 2020						
Title	Annual Statement on behalf of The Newcastle upon Tyne Hospitals NHS Foundation Trust 2020/21 - Modern Slavery and Human Trafficking Act 2015						
Report of	Kelly Jupp, Trust Secretary						
Prepared by	Dan Shelley, Procurement and Supply Chain Director						
Status of Report	Public		Private		Internal		
	☒		☐		☐		
Purpose of Report	For Decision		For Assurance		For Information		
	☐		☒		☐		
Summary	The content of this report outlines the Trust's commitment prevent modern slavery and human trafficking in its supply chain. It demonstrates that the Trust have reviewed and met it's requirements in line with Section 54 of the Modern Slavery Act 2015. There have been no changes from the previous statement other than updating the financial year reference.						
Recommendation	The Board of Directors is asked to consider and approve this statement which demonstrates the Trust's continuing support of the requirements of the legislation, prior to final sign off by the Trust's Chief Executive.						
Links to Strategic Objectives	Performance – Being outstanding, now and in the future.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☐	☒	☐	☐	☐	☐	☐
Impact detail	Maintain compliance with all regulatory requirements.						
Reports previously considered by	Annual submission to the Board of Directors. Report approved by the Audit Committee held on 28 July 2020.						

ANNUAL STATEMENT ON BEHALF OF THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST 2020/21

MODERN SLAVERY AND HUMAN TRAFFICKING ACT 2015

1. INTRODUCTION

The Newcastle upon Tyne Hospitals NHS Foundation Trust offers the following statement regarding its efforts to prevent modern slavery and human trafficking in its supply chain. It demonstrates that the Trust have reviewed and met it's requirements in line with Section 54 of the Modern Slavery Act 2015.

2. THE ORGANISATION

The Newcastle upon Tyne Hospitals NHS Foundation Trust is one of the most successful NHS Teaching Trusts in the country. It offers the second highest number of specialist services of any group of hospitals in the UK. The Trust's hospitals have over 2,250 beds and it manages over 1.72 million patient 'contacts' every year. The Trust provides innovative, high quality healthcare, including community services and primary care, and was rated "Outstanding" by the Care Quality Commission in June 2016 and again in 2019. Services are provided locally, regionally, nationally and internationally.

The Trust employs around 13,500 members of staff making it one of the largest employers in the North East with an annual turnover of around £1billion. The core values of the organisation are:

- **We care and are kind -** We care for our patients and their families, and we care for each other as colleagues.
- **We have high standards -** We work hard to make sure that we deliver the very best standards of care in the NHS. We are constantly seeking to improve.
- **We are inclusive -** Everyone is welcome here. We value and celebrate diversity, challenge discrimination and support equality. We actively listen to different voices.
- **We are innovative -** We value research, we seek to learn and to create and apply new knowledge.
- **We are proud -** We take huge pride in working here and we all contribute to its ongoing success.

The Trust considers the potential social impact and effect of its supply chain prior to the commencement of a procurement. It is committed to ensuring its suppliers adhere to the highest standards of ethics and undertakes due diligence when considering new suppliers as well as regularly reviewing existing suppliers.

The Trust has implemented the Standard Selection Questionnaire (SQ), which includes the requirement for supplier disclosure of any offence under the Mandatory Exclusion Grounds

and also requires confirmation of compliance with reporting requirements under Section 54 of the Act 2015.

The Trust recognises that it has a responsibility to take a robust approach preventing and addressing any concerns to slavery and human trafficking.

The organisation is absolutely committed to preventing slavery and human trafficking in its corporate activities, and to ensuring that its supply chains are free from slavery and human trafficking.

3. TRAINING

A programme to deliver Modern slavery training to all Procurement and Supplies teams was completed in September 2018 and this will be refreshed as case law and best practice develops.

Members of the Procurement team who are Chartered Institute of Procurement and Supply (CIPS) qualified, or studying to become qualified, abide by the CIPS code of ethics and undertake an annually revised CIPS Ethics Test.

4. THE TRUST'S POLICY FRAMEWORK

The Trust has a number of policies in place which support this agenda including:-

i) Contractors – Guidance in the use of Contractors.

ii) Speak up We're Listening Policy – the Trust Whistleblowing Policy to enable staff to raise concerns.

iii) Safeguarding Policies
   a) Safeguarding Adults Policy and Guidelines
   b) Child Protection and Safeguarding Children: Policies and Procedures
   c) Responding to Patients, Carers, Public who are Victims of Domestic Abuse Policy

iv) Recruitment and Section Policies
   a) Non-Medical staff
   b) Senior Medical and Dental Staff
   c) Junior Medical and Dental Trust Doctors Posts
   d) Staff Bank
   e) Volunteer
   f) Prevention of Illegal Working
   g) Locum Appointments Procedure (Medical and Dental)

The Trust's policy on the Use of Contractors provides additional assurance, and clearly refers to the "Right to Work", stating that:

"Checks must be undertaken for all workers to confirm that a worker has the legal right to work in the UK, the contractor must see one of the documents or combinations of the documents specified in List A or List B (included in the policy) of the Employment Check Standard. The worker must only provide documents from List B if they cannot provide documents from List A.

The documents must show that the worker is entitled to do the type of work being offered.

If the worker shows one of the original documents, or combinations of documents contained in List B, it indicates that they only have limited leave to work in the UK. The contractor must evidence that checks have been repeated before the expiry date of the document/s, at which point the worker must produce evidence that they have applied for further right to work and/or leave to remain or cease working for the contractor".

5. APPROVAL FOR THIS STATEMENT

The Board of Directors is asked to consider and approve this statement which demonstrates the Trust's continuing support of the requirements of the legislation, prior to final sign off by the Trust's Chief Executive.

Report of Kelly Jupp
Trust Secretary
20 July 2020

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