NHS
Oxford University Hospitals
NHS Foundation Trust

Trust Board Meeting in Public: Wednesday 10 July 2019

TB2019.65

Title	**Quality Committee Chairman's Report**

Status	For information
History	The Quality Committee provides a regular report to the Board.

Board Lead(s)	Professor David Mant, Quality Committee Chairman			
Key purpose	Strategy	**Assurance**	Policy	**Performance**

Executive Summary

1. The Quality Committee is a sub-committee of the Trust Board, and as such provides a regular report to the Board on the main issues raised and discussed at its meetings.

2. Under its terms of reference, the Committee is responsible for providing the Trust Board with assurance on all aspects of quality including delivery, governance, clinical risk management, workforce and information governance, research & development; and the regulatory standards of quality and safety.

3. In line with best practice in other sectors, the Quality Committee also produces an Annual Report to the Board summarising its activities for the financial year 2018/19, setting out how it met its Terms of Reference. This is provided in Section 2.

4. The Quality Committee Terms of Reference and Membership are attached at Appendix 1.

Recommendations

5. The Board is asked to:

- **Note** the Quality Committee's regular report to the Board from its meeting held on 12 June 2019.
- **Review** and **approve** the Quality Committee Annual Report 2018/19 including the Terms of Reference (Section 2).

Introduction

Since the Board last met in public on 8 May 2019, the Quality Committee ["the Committee"] held its most recent meeting on 12 June 2019.

Under its terms of reference, the Committee is responsible for providing the Trust Board with assurance on all aspects of quality including delivery, governance, clinical risk management, workforce and information governance, research & development; and the regulatory standards of quality and safety. This report aims to contribute to the fulfilment of that purpose.

Quality issues reviewed by the Committee in June 2019

a) Overall workload and pressure on staff continues to increase, with unsustainable levels of bed occupancy, so that the Trust struggles to meet many national access and performance targets. However, the Hospital Standardised Mortality Ratio (HSMR) for the last data period (February 2018 to January 2019), the most basic indicator of care quality, remains 89 - significantly lower than the UK average.

b) The Committee received its regular report from the Clinical Governance Committee (covering its meetings in April and May 2019) and the following points were highlighted:

- Approximately 90% of the Trust uses the generic WHO checklist with 10% using adapted checklists which will require more work to ensure they are aligned to this updated generic checklist.
- The Pharmacy turnaround time for to take out (TTOs) drugs was 85%, which is not meeting the Key Performance Indicator (KPI) of 90%. An increase in workload on all sites and staff using their residual annual leave shortly before year end have impacted on turnaround, particularly on the JR site.
- Of the 634 harm reviews requested since the process started, 622 harm reviews have been completed (98%). The majority of reviews identified no harm or minor harm. The gynaecology services were responsible for 76% of the 52+ week delays necessitating harm reviews.
- 55 patients on a 62 day pathway were treated later than day 104 in Quarter 3. This is a significant rise, due mainly to increased referrals and treatment for prostate cancer.

c) The Committee's consideration of the revised Integrated Performance Report included discussion of the following:

- In April (month 1) OUH achieved 84.73% against a trajectory of 87.5% for the ED 4 hour wait target. Horton site achieved 91%, JR site achieved 83%.
- Both sites experienced a 7% increase in ED attendance demand, with bed occupancy levels at c100%.
- Very high bed occupancy throughout the Trust continues to be the predominant risk to delivering the ED 4 hour standard.

- At the end of April, the Trust reported 13 '52 week waits'; 10 were treated in May and 3 had treatment dates in June. Clinical harm reviews had been completed and protocols for minimising harm were being followed.
- Only 5 out of 8 cancer standards had been achieved in the last month reported.

d) In its consideration of the paper on Serious Incidents Requiring Investigation (SIRI) and Never Events, the Committee's attention was drawn to Never Events which related to treatment of skin lesions and to SIRIs arising from less than optimal management of VTE prophylaxis when surgery is cancelled at short notice. The Committee noted that immediate action had been taken to raise awareness of good practice and to disseminate lessons from these events.

e) The newly developed Maternity Dashboard was presented to the Committee. The Directorate was still in the process of benchmarking compliance with the recommended standards set out in the Safety Care Bundle (Version 2). A detailed action plan was being developed to address the current gaps and actions and identify resources required to achieve standards. It was agreed that the quantitative presentation of data needed to improve, with control charts reflecting outcome and performance targets.

f) The Committee received the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) and noted the improvements that had been made to the CRR.

g) The Committee received a progress update on the delivery of the Quality Priorities for 2019/20

h) The Committee received the annual Safeguarding report, which provided a summary of the key issues and activity in relation to Safeguarding of Children and Adults during 2018/19. Safeguarding children consultations had increased by 21%. Safeguarding Adult consultations had increased to 1516. The Committee sought assurance that we have capacity to deal with this increasing workload and asked again why the Annual Report could not include outcome data to provide quality assurance.

i) The Committee received the annual report of activity for 2018/19 in relation to Patient Experience, PALS, Complaints, public engagement. The report highlighted opportunities for learning and service change that had been identified throughout the year.

j) The Committee heard a patient story which detailed the experience of a patient who had put forward a complaint about the use of jargon by staff in the Emergency Department (ED).

k) The Committee received the Infection Prevention and Control report and heard that there were no cases of post-48 hour MRSA bacteraemia but 7 cases of post-48 hour MSSA bacteraemia reported during April 2019. An action plan to address the increase in MSSA had been provided.

l) The Health and Safety Annual Report was presented. During the reporting period the Health and Safety team had continued to broaden its influence to better support all areas of the organisation and especially to develop collaborations with clinical leads. The Committee agreed the need to ensure that Health and Safety risks were appropriately and accurately recorded on the Risk Register, including our statutory compliance with regulated risks.

Key Risks discussed included:

a) The ongoing risk that current operational pressure could have an adverse impact on patient safety and quality of care; to guard against which the Committee remained vigilant in its scrutiny of key quality indicators.

b) Bed occupancy levels are the predominant risk to delivery of the 4 hour ED standard

c) Risk management within the Health and Safety Department – A stocktake of compliance and a gap analysis is underway

d) Increasing demand on the Safeguarding team due to the increases seen.

Key Actions Agreed included:

a) An Executive review of the Risk Register to ensure that risk scores remain relevant and appropriate, so that risk is managed effectively at all levels of the Trust and the Register both informs management action and provides assurance to the QC and Board.

b) The Committee to be provided with a note on the external certification requirements for Health and Safety within areas across the Trust.

c) Medicines Reconciliation issues to be addressed with urgency and the approach to the WHO audit to be referred to the Trust Management Executive.

d) The content and presentation of quantitative data in the new Integrated Performance Report, Patients Experience Report, and Maternity Dashboard to continue to be improved to reflect the positive comments made by the Quality Committee and the requests for information from the Governors' PEMQ committee.

Recommendation

The Trust Board is asked to **note** the contents of this report.

Professor David Mant

Chairman, Quality Committee

July 2019

Section 2

Quality Committee Annual Report

1. Background

1.1. Good practice states that the Trust Board should review the performance of its Committees annually to determine if they have been effective, and whether further development work is required.

1.2. This Annual Report summarises the activities of the Trust Board's Quality Committee (the Committee) for the financial year 2018/19 setting out how it has met its Terms of Reference.

1.3. The purpose of the Committee is laid down in its Terms of Reference. In summary, it is responsible for providing the Trust Board with assurance on all aspects of quality including delivery, governance, clinical risk management, workforce, information governance, research and development; and the regulatory standards of quality and safety.

2. Scope of Review of Effectiveness

2.1. The review undertaken by the Director of Regulatory Compliance and Assurance focused on a review of the papers presented to the Quality Committee in comparison to the agreed Terms of Reference and the Cycle of Business. The review has been broken down into responsibilities, reporting arrangements, Cycle of business, membership and attendance record.

2.2. This review covers the financial year from 1 April 2018 to 31 March 2019, and as a result it will not take into account any changes made to the operation of meetings from April 2019 onwards.

Responsibilities

2.3. During 2018/19 the Committee has delivered the key responsibilities as set out in the Terms of Reference. Compliance with the key responsibilities was evidenced by the routine presentation and consideration of:

- Patient, Carer and Staff Story reports;
- Clinical Governance Committee reports and minutes;
- Quality reports, including updates and reflections from national reports, safe staffing and acuity metrics,
- Quality Account;
- SIRI and Never Events Reports including Annual Review Report;
- Board Assurance Framework and Corporate Risk Register review including the review of high scoring divisional risks associated with the Committee;
- Inpatient Survey results;
- Updates on the CQUIN Programme;
- Review of Winter Preparedness Plan;

- Update on Quality Priorities;
- Staff Survey results;
- Updates in relation to progress against completion of the CQC Inspection Action Plans.

2.4. The Committee also considered the following:

- Workforce and Organisational Development Performance Reports;
- Annual reports on: Complaints, Patient Experience and Patient Advocacy and Liaison Service [PALS], Safeguarding Adults and Children report and Tissue Viability.

2.5. The Board Assurance Framework and Corporate Risk Register were reviewed and discussed at the end of each meeting to ensure that identified controls were appropriate to mitigate the risks to a level within the Trust's risk appetite.

Reporting Requirements

2.6. The Committee reported to the Trust Board after each meeting during the year. Reports included a description of the business conducted, risks identified and key actions agreed. Key risks discussed by the Committee and reported to the Trust Board for information included:

- The potential risk that on-going operational and financial pressures could have an adverse impact on patient safety and the quality of care.
- A review of the summary of risks currently recorded on the divisional risk registers held by each of the five clinical divisions.
- Risks identified in the findings of the CQC's reports on Maternity Services at the John Radcliffe, Oxford Centre for Enablement on the Nuffield Orthopaedic Centre site, and the Well-Led review;
- Risks associated with the continuity in the temporary suspension of obstetric and neonatal services at the Horton General Hospital;
- Risks associated with poor hand hygiene, identified by audits during the year, which it was noted were continuing to be addressed in the divisions, supported by the Infection Prevention Control Team [IPC].
- Risks associated with the fragility of maintaining safe staffing levels. While assured that the safety of patients was secured through the efforts of staff, the Committee was less confident that there had been no negative impact on patient experience, and the importance of ensuring staff health and well-being was emphasised.

2.7. Specific issues arising from quality reports included

- Performance against quality metrics, highlighting points in relation to new cases of colonisation with Candida Auris, high numbers of influenza cases, Norovirus breakout and SIRI investigations submitted to OCCG;
- Staffing levels in Midwifery which remained a key constraint for the Trust, pressure ulcer category 2 and 3 increases, decreases in falls and key themes from complaints;

- Information on non-compliance against the WHO checklist in the Medicine Rehabilitation and Cardiac Division and in the Clinical Support Services Division;
- The reduction of external funding for non-medical education, particularly in relation to the challenges facing the Trust to develop on-going operational performance;
- Difficulties in understanding data relating to infection prevention in respect of cleaning scores.
- Mixed sex breeches and the implementation of the Patient Experience Delivery Plan to ensure Trust compliance to national reporting requirements.
- The Committee specifically considered the End of Life Care Quality Priority.
- The performance of cleaning scores and measures needed to put in place to improve the standard across the Trust.
- Concerns rose from the Trust-wide Cannula Audit and the placement of such by ambulance staff resulting in subsequent failures to remove, with the potential consideration to following the development of a related LocSSIP (Local Safety Standard for Invasive Procedures).
- The worsening standard of Outpatient letters sent to GPs within 7 days.

2.8. The reports from the Committee consistently identified areas to be raised to the Trust Board or referred to other sub-committees of the Trust Board from National and Trust Reports. There was specific reference made to: assessments and supporting evidence for submission to NHS Resolution in respect of the Self-Certification of Maternity Services; Winter Preparedness plan, the proposal to close the Churchill TSSU, Cleaning Assurance Standards Report, Updates on Gynaecology, CQC System Wide Review and CQC Well-led Review and more generally in Trust reports in relation to Never Events, serious incidents and workforce retention.

Cycle of Business

2.9. The items on the cycle of business were largely delivered as planned with some minor adjustments to the timing of delivery of some papers. A number of additional items were considered by the Committee during the year including papers on:

- Cleaning Assurance Standards
- Analysis of 12 hour breaches July 2017- April 2018
- Sterile Services Provision
- NHSI Undertakings and Action plans
- Updates on harm reviews and long waits
- Approach to Quality Impact of 2018/19 Capital Programme

3. Membership and Attendance Record

3.1. During 2018/19, the Committee met six times with attendance recorded in the table below. The Terms of Reference states that all members will attend at least four out of six committee meetings per financial year. One of the Committee members in post for the full year did not attend at least four meetings.

3.2. The Quorum is set as a minimum of six members (two Non Executives (NEDs) and two Executive Directors). At its meeting in October 2018, the Committee was not Quorate, for this meeting there were five attendees. This arose as there were two NED vacancies in October 2018. This position was corrected by the December 2018 meeting.

Committee Member		11-Apr-18	13-Jun-18	08-Aug-18	10-Oct-18	12-Dec-18	13-Feb-19
Committee Chairman, Non-Executive Director	Professor David Mant	✓	✓	✓	✓	✓	✓
Non-Executive Director	Dame Fiona Caldicott	✓	✓	✓	×	✓	✓
Chief Executive	Dr Bruno Holthof	✓	✓	✓	×	×	✓
Medical Director	Dr Tony Berendt (until Sep 2018) Dr Clare Dollery (From Sept 2018 - Jan 2019) Professor Meghana Pandit (from Jan 2019)	✓	✓	✓	✓	✓	✓
Director of Clinical Services	Mr Paul Brennan Ms Sara Randall (Acting from July 2018)	✓	✓	✓	✓	✓	✓
Deputy Medical Director	Dr Clare Dollery (Acting Medical Director as above)	✓	✓	✓	✓	✓	✓
Chief Nurse	Ms Sam Foster	✓	✓	✓	×	✓	✓
Non-Executive Director	Mr Christopher Goard	✓	✓	×	✓	✓	✓
Chief Information and Digital Officer	Mr Peter Knight (until Aug 2018)	×	×	✓			
Non-Executive Director	Mr Geoffrey Salt (until Sep 2018)	✓	✓	✓			
Director of Assurance	Ms Eileen Walsh	✓	✓	✓	✓	✓	✓

Key

✓ In attendance (or represented by deputy) × Not in attendance ■ Not in Post

3.3. The Committee has on occasion also welcomed visitors to observe some meetings.

4. Self-assessment

4.1. In 2017/18 the Committee acknowledged that the quality of the papers routinely presented to it had improved (particularly the Quality Report, Reports on Serious Incidents Requiring Investigation [SIRI] and Never Events, and report from the Clinical Governance Committee), allowing it to provide better assurance that these aspects of quality were being appropriately managed. This improvement was sustained during 2018/19, with further changes being made to ensure that the Quality Report is data-led and key quality indicators presented with sufficient granularity to allow problems to be identified at a clinical unit or ward level when appropriate, with commentary on the remedial action being taken.

4.2. In order to try to improve the utility of committee papers and reduce duplication, it was agreed with the Chief Medical Officer and Chief Nursing Officer that we should disaggregate the information traditionally included in the "Quality Report" into separate more focused reports (e.g. a Mortality Report, Clinical Operations Report etc.) and would try to achieve better integration of data on performance and quality. Initial experience of these changes has been encouraging but optimising the quality of data reported to the Committee will take time. We therefore anticipate further improvement to the structure and content of papers in 2019/20 as we learn from experience.

4.3. The Committee has also welcomed the recent introduction of an integrated report on patient experience. Although further work is needed to ensure the report is evidence-led, with improved data quality and exception reporting at an appropriately granular level, this development will improve our ability to offer quality assurance and facilitate triangulation of patient experience issues.

4.4. The development in 2018/19 of which the Committee is particularly proud is the improvement in the way it handled risk. Risk-related reports now have their own dedicated slot near the beginning of the agenda (rather than being the last agenda item with often limited time for discussion) to make it more likely that meetings are focused on the key risks facing the organisation. In order to better monitor whether risk is being appropriately handled (and if necessary escalated), high level risks are now being made explicit at divisional and clinical unit, with reporting of remedial action being taken.

4.5. A major challenge faced by the Committee in 2018/19 was the additional work involved in meeting the Board's request to monitor the implementation of the workload and governance aspects of the NHSI Undertakings, which not only took up a substantial amount of scarce committee time (at times seriously overloading the committee agendas) but also at times reduced the planned focus stated in the 2017/18 Annual Report on improving risk management and data quality. In conjunction with the necessary focus on ad-hoc issues identified by CQC, the Committee had to work hard to continue to pay due attention to care quality and safety issues which are not subject to regulation.

5. Terms of Reference

5.1. The Terms of Reference were last reviewed and revised in July 2018, with an annual review date set.

5.2. The updated Terms of Reference (ToR) are presented in Appendix 1, with minor changes from the previous year's ToR highlighted.

6. Conclusion and actions for 2019/20

6.1. The review has identified that the Committee has delivered the responsibilities as set out in the Terms of Reference. In particular it has continued to monitor the quality of the patient, public and staff experience during the course of the year, overseen the Quality Priorities as reflected in the Quality Account, and reviewed the results from the recent CQC visits during the year and monitored progress in relation to the completion of action plans and reviewed plans in relation to NHSI Undertakings and the CQCs Well-Led Review.

6.2. Attendance was not Quorate at the October 2018 meeting, reflecting the number of NEDs in post and available to attend, but the cycle of business has been completed and requirements of the Committee fulfilled.

6.3. The Cycle of Business has been reviewed recently by the Chair, Chief Medical Officer and Chief Nursing Officer, with a view to further improving the effectiveness of reporting to the Committee. This review highlighted the need to be clearer in relation to the purpose of the papers brought forward to the Committee. In broad terms it was agreed that:

- Where the purpose is to monitor quality KPIs directly, the Committee should aim to receive more concise data-driven papers, usually at two monthly intervals,

- Where the purpose is to assure the Committee that quality governance processes are being effectively implemented, a 12 month interval between papers will usually suffice.

6.4. It now seems likely that the Quality Committee and Finance and Performance Committee will merge in 2019/20. However, this will not change the importance of:

i) the continued development of data on care quality to improve the assurance information included in papers;
ii) ensuring risks impacting on care quality are being effectively identified and escalated, with the major quality risks driving the committee agenda;
iii) non-regulated care quality issues receiving due attention.

7. Recommendation

The Board is asked to:

- Review and approve the Annual Report 2018/19.
- Review the Quality Committee Terms of Reference, revised to incorporate minor amendments to reflect changes in membership.

Appendix 1

Quality Committee
Terms of Reference

1. Authority

1.1. The Quality Committee (the Committee) is constituted as a standing committee of the Trust Board. The Committee is a Non-Executive Committee and has no executive powers, other than those specifically delegated in these Terms of Reference. The Terms of Reference can only be amended with the approval of the Trust Board.

1.2. The Committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

1.3. The Committee is authorised by the Trust Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experiences and expertise if it considers this necessary.

2. Purpose of Committee

2.1. The Quality Committee is responsible for providing the Trust Board with assurance on all aspects of quality including delivery, governance, clinical risk management, workforce and information governance, research & development; and the regulatory standards of quality and safety.

3. Membership

3.1. The membership of the committee shall be composed of the following core members:

- ~~*5*~~ 4 Non-Executive Directors (one of whom will be the Chair of the Committee)
- Chief Executive
- Chief Medical Officer
- Chief Nursing Officer
- Chief Operating Officer
- Chief Assurance Officer
- *Chief People Officer*
- ~~*Chief Information and Digital Officer*~~
- ~~*Deputy Medical Director*~~

3.2. All Board members outside the core membership have an open invitation to attend any meeting if he/she wishes to do so.

4. Attendance and Quorum

4.1. The quorum for any meeting of the Committee shall be attendance of a minimum of ~~*six*~~ *five* members of which two will be Non-executive Directors and two Executive Directors.

4.2. It is expected that all members will attend at least 4 out of 6 committee meetings

per financial year. 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.

4.3. If Executive or Non-executive Directors are unable to attend a meeting, they should nominate a deputy subject to agreement with the Chief Executive and consultation with the Committee Chairman. Deputies will be counted for the purpose of the quorum.

4.4. The Chair may request attendance by relevant staff at any meeting.

5. Frequency of meetings

5.1. Meetings of the Quality Committee shall be held six times per year, scheduled to support the business cycle of the Trust and at such other times as the Chairman of the Committee shall identify, subject to agreement with the Chairman of the Trust and the Chief Executive.

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

5.3. Meetings of the Quality Committee shall be set at the start of the calendar year.

6. Specific Duties

6.1 The Quality Committee shall:

- Oversee the effectiveness of the clinical systems developed and implemented by the Clinical Governance Committee to ensure they maintain compliance with the Care Quality Commission' Fundamental Standards of quality & safety.
- Oversee an effective system for safety within the Trust, with particular focus on; patient safety, including a consideration *of the quality impacts of the financial improvement and EBITDA performance,* staff safety and wider health & safety requirements.
- Oversee an effective system for delivering a high quality experience for all its patients and service users, including carers, with particular focus on involvement and engagement for the purposes of learning and making improvement.
- Oversee an effective system for monitoring clinical outcomes and clinical effectiveness; with particular focus on ensuring patients receive the best possible outcomes of care across the full range of Trust activities.
- Assure the Trust's maintenance of compliance with the Care Quality Commission registration through assurance of the systems of control, with particular emphasis on the Fundamental Standards of quality and safety.
- Oversee and assure the Board on statutory and mandatory requirements, relating to quality of care.
- Oversee and assure on external assessment systems professional bodies' and regulatory bodies' requirements.
- Monitor and review the system for Quality Governance, Information Governance, Workforce Governance, Research & Development Governance,

ensuring that the Board is assured of continued compliance through its annual report, reporting by exception where required.

- Identify annual objectives of the Committee, produce an annual work plan in the agreed Trust format, measure performance at the end of the year and produce an annual report. This will also include an assessment of compliance with the Committee's terms of reference and a review of the effectiveness of the committee.
- Consider any relevant risks within the Board Assurance Framework and corporate level risk register as they relate to the remit of the Committee, as part of the reporting requirements, and to report any areas of significant concern to the Audit Committee.
- Undertake any other responsibilities as delegated by the Trust Board.

7. Sub-Committees

7.1 The Quality Committee has no formal sub-committees but it will receive regular reports from the Clinical Governance Committee.

8. Administrative Support

8.1 The Quality Committee will be supported by the Medical Director, as the nominated lead Executive Director. The Committee will be supported administratively by the Head of Corporate Governance, whose duties in this respect will include:

- Agreement of the agenda with the Chief Medical Officer and the Committee Chair, collation and distribution of papers at least five working days before each meeting.
- Taking the minutes and keeping a record of matters arising and issues to be carried forward.
- Providing support to the Chair and members as required.

9. Accountability and Reporting arrangements

9.1 The Committee shall be directly accountable to the Trust Board.

9.2 The Committee shall refer to the Board any issues of concern it has with regard to any lack of assurance in respect of any aspect of quality. The Chair of the Committee shall prepare a summary report to the Board detailing items discussed, actions agreed and issues to be referred to the Board. The Chairman will report any specific issues on the risk register to the Audit Committee.

9.3 The minutes of the Committee meetings shall be formally recorded and submitted to the next meeting of the Board following the production of the minutes.

10. Monitoring Effectiveness and Compliance with Terms of Reference

10.1 The Committee will carry out an annual review of its effectiveness and provide an annual report to the Board on its work in discharging its responsibilities, delivering its objectives and complying with its terms of reference, specifically commenting on relevant aspects of the Board Assurance Framework and relevant regulatory frameworks.

11. Review of Terms of Reference

11.1 The Terms of Reference of the Committee shall be reviewed at least annually by the Quality Committee and approved by the Trust Board.

Date approved: **Month Year**
Approved by: **[name of parent committee]**
Next review date: **Month Year**

Appendix 1

Quality Committee Membership 2019/20

Non-Executive Director (Chair)	Professor David Mant
Chief Executive	Dr Bruno Holthof
~~*Deputy Medical Director*~~	~~*Dr Clare Dollery*~~
~~*Chief Information and Digital Officer*~~	~~*Professor Peter Knight*~~
Chief Nursing Officer	Ms Sam Foster
Non-Executive Director	Mr Christopher Goard
Chief Medical Officer	*Professor Meghana Pandit*
Acting Chief Operating Officer	*Ms Sara Randall*
Chief Assurance Officer	Ms Eileen Walsh
Non-Executive Director (Vice Chair)	*TBC*
Non-Executive Director	*TBC*