

Meeting Title	Council of Governors		
Date	16.07.20	Agenda item	CGo7.20.16a

EXECUTIVE AND NON-EXECUTIVE REGULATION COMMITTEE (ENERC): OVERSIGHT AND ASSURANCE DURING THE COVID19 RESPONSE

Presented by	Non-executive committee chairs		
Author	Tanya Claridge, director of governance and corporate affairs		
Lead Director	Dr Maxwell Mclean, chairman		
Purpose of the paper	This paper provides an overview of the terms of reference and focus of the ENERC implemented in the Trust during its response to COVID19.		
Key control	This paper is a key control for the operation of the Board Assurance Framework and the Annual Governance Statement		
Action required	To note		
Previously discussed at/ informed by			
Previously approved at:	Committee/Group	Date	
Key Options, Issues and Risks			
The trust revised its governance infrastructure to ensure good, streamlined assurance and governance during its response to COVID19.			
The ENERC was implemented to enable committee level assurance discussions in relation to key issues escalated by exception, or derived from the workplans of previous board committees.			
The ENERC also received and considered the strategic risk register and the board assurance framework.			
Analysis			
This paper provides a;			
- A summary of the management of our statutory reporting through the ENERC/Board of Directors (Appendix 1),			
- The terms of reference of the ENERC (Appendix 2),			
- Details of the quality management systems adapted during the response to COVID19 (appendix 3),			
- Details of the quality oversight systems adapted during the response to COVID19 (appendix 4)			
The Minutes of the ENERC are available to governors through the papers of the Board of Directors.			
Recommendation			
The council of governors should note the sustained work within corporate governance to ensure the effective discharge of our statutory duties and to ensure effective escalation and assurance processes were maintained.			

Forthcoming statutory reporting

Governance Infrastructure March 2020-July 2020

Bradford Teaching Hospitals NHS Foundation Trust

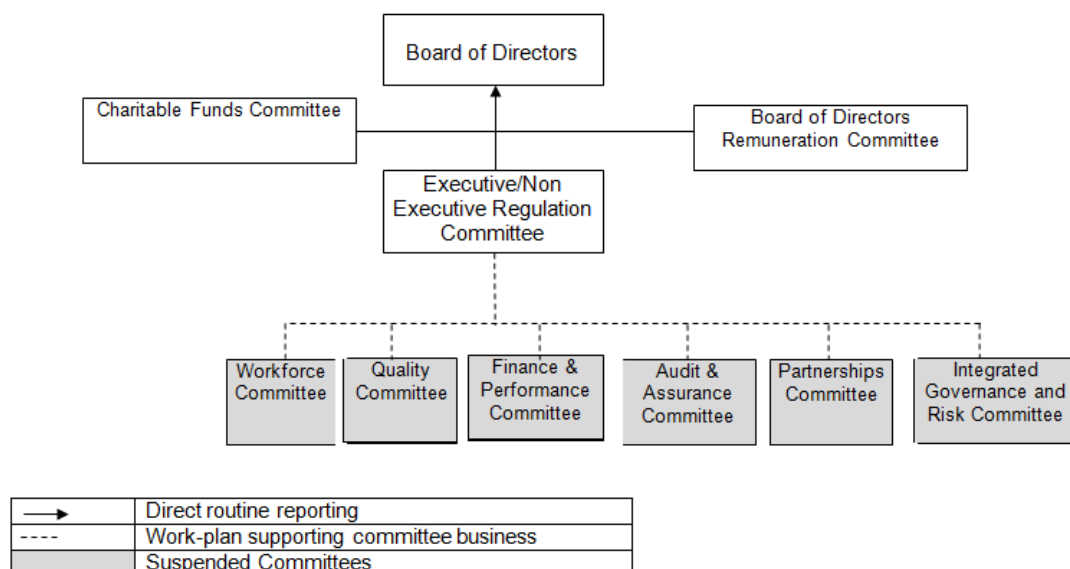
Governance Structure	March	April	May	June	July
Council of Governors (Open)	-	23/4/2020 Suspended	-	-	16/7/2020 Planned
Council of Governors (Closed)	-	23/4/2020 Planned	-	-	16/7/2020 Planned
Council of Governors N&R	10/3/2020 Held	-	-	2/6/2020 Planned	-
Open Board	12/3/2020 Held	-	27/5/2020 Reinstated From 14/5/2020	18/6/2020 New date Planned	09/7/2020 Planned
Closed Board	12/3/2020 Held	-	27/5/2020 Reinstated from 14/5/2020	18/6/2020 Sign off of Annual report and accounts	09/7/2020 Planned
Board development	-	8/4/2020 Suspended	-	18/6/2020 Suspended	-
Board Committees:					
Quality Committee	25/3/2020 suspended	29/4/2020 suspended	27/5/2020 Suspended	24/6/2020 Suspended	29/7/2020 Planned
F&P Committee	25/3/2020 suspended	29/4/2020 suspended	27/5/2020 Suspended	24/6/2020 Suspended	29/7/2020 Planned
Workforce	25/3/2020 suspended	29/4/2020 suspended	27/5/2020 Suspended	24/6/2020 Suspended	29/7/2020 Planned
Partnerships Committee	17/3/2020 Cancelled	-	19/5/2020 Suspended	-	21/7/2020 Planned
Remuneration Committee	-	-	27/5/2020 Planned	-	-
Charitables Committee	12/3/2020 Held	24/4/2020 Extraordinary	-	-	9/7/2020 Planned
IGRC	19/3/2020 Cancelled	15/4/2020 Suspended	20/5/2020 Suspended	17/6/2020 Suspended	15/7/2020 Planned
Audit and Assurance	-	7/4/2020 Suspended	19 and 20/5/2020 Stood down	10/6/2020 and 16/6/2020 To approve Annual report and accounts	28/7/2020 Planned
Exec/Non-exec regulation committee	25/3/2020 Held	29/4/2020	27/5/2020 Suspended	24/6/2020 Suspended	-

Key statutory reporting milestones

Governance requirement		May	June	July
FT Code of Governance		Review: 27/5/2020	Approval: 18/6/2020 Board of Directors	
FT Provider Licence		Review 27/5/2020	Approval: Board of Directors 18/6/2020	
Annual Governance Statement			Approval AAC: 10/6/2020 and 16/6/2020 Approval Board of Directors 18/6/2020	
Annual report and Accounts			Approval AAC: 10/6/2020 and 16/6/2020 Sign off Board of Directors: 18/6/2020	
Quality Account			Deferred to December 2019	
Other items (general governance)				
BO	Annual Information Governance Toolkit Submission	Ratification Board of Directors 27/5/2020		
BO	Complaints annual report			scheduled
BO	IPC report	Approval Board of Directors		scheduled
BO	Workforce Race Equality Standard & Equality & Diversity Update (PC)			scheduled
BO	Risk management strategy	Due-defer (interim strategy in place)		scheduled
BO	SIRO	Due		scheduled
Q/W	FTSU quarterly		Due (missed in March)	scheduled
Q	Health and Safety Annual report		Review: Virtual 30/6/2020	Approval 9/7/2020 Board of Directors
Q	SI Monthly reports (March/April/May)		Review Virtual 30/6//2020	
Q/W	Nurse staffing data publications	Due	Due	Due
W	Guardian of safe working hours	Due (quarterly)	Due (annual/HEE return)	scheduled
W	7 day services working biannual report	Due		scheduled
W	Annual organisational audit	Due		scheduled
FP	JV Pathology Annual report	Due		scheduled
FP	Digital strategy Annual report	Due		scheduled
FP	Treasury Management Annual review	Due		scheduled

Executive/Non-Executive Regulation Committee

TERMS OF REFERENCE



The purpose of the Committee is to provide the Foundation Trust Board with an objective and independent review (including relevant strategic risks and associated assurance) of the controls associated with the delivery of the Trust's Strategic Objectives

Trust Strategic Objectives		Committee Role
1	To provide outstanding care for patients	Assure
2	To deliver our financial plan and key performance targets	Assure
3	To be in the top 20% of employers	Assure
4	To be a continually learning organisation	Assure
5	To collaborate effectively with local and regional partners	Assure

Version	Issued to	Date	Comments	Review date
0.1	Chair, CEO, NED, NED		Approved through emergency powers delegated through the BOD Standing Orders	30/9/2020

1. Authority, Accountability and Responsibility

- 1.1 The Trust Board hereby resolves to establish a Committee of the Board to be known as the Executive/Non-Executive Regulation Committee (the Committee) as an emergency response to ensure appropriate governance during the COVID_19 pandemic
- 1.2 The Committee is a standing committee of the Trust's Board (the Board). Its constitution and terms of reference shall be as set out below, subject to amendment at future Board meetings.
- 1.3 The Committee is authorised by the Board to act and investigate any activity within its terms of reference. All members of staff are directed to co-operate with any request made by the Committee.
- 1.4 The Committee is authorised by the Board to instruct professional advisers and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the exercise of its functions.
- 1.5 The Committee shall embed the Foundation Trust's vision, standards, priorities and requirements, e.g. equality and human rights, through the conduct of its business.
- 1.6 The requirements for the conduct of business as set out in the Foundation Trust Board's Standing Orders are equally applicable to the operation of the Committee.

2. Purpose and objectives

- 2.1 The purpose of the Committee is to provide the Foundation Trust Board with an objective and independent review (including relevant strategic risks and associated assurance) of the of the controls associated with the delivery of the Trust's Strategic Objectives
- 2.2 The objective of the Committee is to enable the Foundation Trust Board to obtain assurance that all business of the Trust is managed to a high standard through consideration of items brought by exception for review or decision
- 2.3 The principal duties of the Committee are:
 - To receive and review the strategic objectives of the Foundation Trust and ensure decision making in relation to key controls brought by exception are proportionate and effective
 - To receive and review the Strategic Risks (with a risk score of 12 or more) or any other risks identified or being managed by the Trust allocated to it by the Board of Directors or escalated by Executive Directors

3. Operational Responsibilities

3.1 The Committee is responsible for providing the Board with assurance on all aspects of the business of the Trust brought by exception by the

3.2 The Committee will discharge this responsibility through:

- Maintaining a strategic oversight of key areas of risk associated with the delivery of the Trust's Strategic Objectives across the Foundation Trust; as escalated by the Executive Directors or as determined by the Board of Directors for inclusion.

4. Membership

4.1 The Chair of the Committee ("the Chair") will be a nominated Non-Executive Director. In their absence, the meeting will be chaired by the Deputy Chair, who will be a nominated identified Non-Executive Director.

4.2 The membership of the Committee shall comprise:

Title	Role
Non-Executive Director	Chair To ensure the Committee functions properly, that there is full participation during meetings, that all relevant matters are discussed and that effective decisions are made and carried out.
Non-Executive Director	Deputy Chair. To provide independent oversight and challenge to the Executive Directors
All other Non-Executive Director	To provide independent oversight and challenge to the Executive Directors
All Executive Directors	To support the purpose and aims of the Committee and to agree decisions, actions and provide input and feedback on management issues related to the agenda

4.3 The membership of the Committee will be reviewed on an bi-annual basis or as required.

4.4 The Director of Governance and Corporate Affairs (or deputy) will be in attendance at the meeting.

5. Quorum and attendance

5.1 A quorum shall consist of no less than two Non-Executive Directors and two Executive Directors (or their nominated Deputies) and must include as a minimum the Chair or Deputy Chair of the Committee.

5.2 The Non-Executive and Executive Director members should attend at least 75% of meetings within any calendar year. Attendance will be monitored and addressed by the Chair.

5.3 The Chairperson and the Chief Executive of the Foundation Trust Board reserves the right to attend any of the Committee's meetings as an ex-officio member.

- 5.4 Should any member be unavailable to attend, they may nominate a deputy, with full voting rights, to attend in their place subject to the agreement of the Chair.
- 5.5 The Committee may ask any of those who are in attendance but who are not members to withdraw to enable a full and frank discussion of particular matters.
- 5.6 Where the Committee is not quorate, the meeting should be rearranged within 2 weeks.

6. Frequency of meetings

- 6.1 The Committee will meet monthly and shall agree a schedule of meetings at least 12 months in advance. Additional meetings will be arranged as determined by the Chair of the Committee.
- 6.2 At the request of the Chair, the Committee may hold meetings by telephone, video link or by email exchange. Normal rules relating to quoracy will apply to the functioning of such a meeting. These meetings will be deemed as standard meetings of the Committee and shall be documented accordingly.

7. Standing Items

- 7.1 Strategic Risks relevant to the Committee
- 7.2 Exception reports from Executive Directors
- 7.3 Matters to share with Board Committees following return to business as usual governance
- 7.4 Matters to Escalate to the Strategic Risk Register
- 7.5 Matters to Escalate to the Board of Directors
- 7.6 Items for Corporate Communications

8. Agenda and papers

- 8.1 The Director of Governance and Corporate Affairs will hold an agenda setting meeting with the Chair and/or the Deputy Chair at least 2 weeks before the meeting date.
- 8.2 The agenda will be based around matters arising and requests from The Board of Directors or by exception at the request of Executive Directors. Following approval, the agenda and timetable for papers will be circulated to all Committee members.
- 8.3 Agenda items along with accompanying papers to be submitted to the Committee secretary one week prior to meeting dates.
- 8.4 The agenda and papers for meetings will be distributed five working days in advance of the meeting.
- 8.5 The minutes, highlight report and action log will be circulated to members within seven days of the meeting to check the accuracy.

8.6 Members must forward amendments to the Committee secretary within the next seven days.

9. Reporting

9.1 The Committee Chair and lead Executive Director(s) for the relevant agenda item shall report formally, regularly and on a timely basis to the Board of Directors on the Committee's activities by:

- 9.1.1 Providing a written update report (including detailed commentary on the assurance received and risks identified in relation to the key controls identified within the Board Assurance Framework) following each meeting
- 9.1.2 Bringing to the Board of Director's specific attention any significant matter under consideration by the Committee.
- 9.1.3 Ensuring appropriate escalation arrangements are in place to alert the Foundation Trust Board Chair, Chief Executive of any urgent/critical matters that may compromise the delivery of the Foundation Trust's Strategic Objectives.

9.2 If, through the course of Committee business an issue is raised which needs immediate escalation, or action taken, which is outside of the remit of the Committee this should be escalated to the appropriate Executive meeting, via the chair, for discussion and action.

10. Secretarial support

10.1 Secretarial support will be provided through the Office of Governance and Corporate Affairs.

11. Review Date

11.1 These terms of reference and operating arrangements shall be reviewed on at least an annual basis by the Committee for approval by the Board of Directors.

12. Links to other groups

12.1 The Committee, through its Chair and members, shall work to provide advice and assurance to the Board of Directors through the:

- 12.1.1 Joint planning and co-ordination of Board and Committee business.
- 12.1.2 Sharing of Information through consistent reporting to the Board of Directors and other Board Committees (once business as usual governance is in place), both by exception and in routine reports.

12.2 In doing so, the Committee shall contribute to the integration of governance across the organisation, enabling the incorporation of all sources of assurance into the Board's overall Board Assurance framework.

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Our Quality Management System: Quality Oversight during the COVID19 response

Presented by	Dr Bryan Gill, Chief Medical Officer	
Author	Tanya Claridge, Director of Governance and Corporate Affairs	
Lead Director	Dr Bryan Gill, Chief Medical Officer	
Purpose of the paper	This paper provides an overview of the specific Quality Oversight system in place in implemented in the Trust during its response to COVID19	
Key control	This paper is a key control for the operation of the Board Assurance Framework and the Annual Governance Statement	
Action required	To note	
Previously discussed at/ informed by		
Previously approved at:	Committee/Group	Date
Key Options, Issues and Risks		
<p>During 2016/17 the Trust developed and implemented a quality management system, with a central component being a knowledge management framework allowing creation, acquisition, dissemination and implementation of knowledge generated from the system across the organisation. The Quality Management System also provides a key infra-structure for quality governance and associated assurance processes</p> <p>The ‘organisational learning response system’, enables precursor incidents (which are identified from complaints, claims, incident reporting, inquests, mortality reviews, patient experience information, ProgRESS reviews, effectiveness data information from regulators and external partners, staff and patient conversations and a quarterly focus group of the learning and surveillance hub) to be used in a learning process to support Trust-wide change and improvement and contribute to the avoidance of future incidents.</p>		
Analysis		
<p>This paper provides a summary in to a specific element of the Quality Management System, the Trust-wide Quality Oversight which has been developed during the Trust’ response to the COVID 19. The Executive and Non-Executive Regulation Committee should be sighted on the system in place, this is usually a standing agenda item on the Quality Committee agenda.</p>		
Recommendation		
<p>The Executive and Non-Executive Regulation Committee should note the revised design of the QOS and the exception profiling tool that has been developed and implemented, and that this system is managed interdependently with the command and control infrastructure.</p>		

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Risk assessment						
Strategic Objective	Appetite (G)					
	Avoid	Minimal	Cautious	Open	Seek	Mature
To provide outstanding care for patients				g		
To deliver our financial plan and key performance targets			g	g		
To be in the top 20% of NHS employers					g	
To be a continually learning organisation				g		
To collaborate effectively with local and regional partners					g	
The level of risk against each objective should be indicated. Where more than one option is available the level of risk of each option against each element should be indicated by numbering each option and showing numbers in the boxes.	Low		Moderate	High	Significant	
	Risk (*)					
Explanation of variance from Board of Directors Agreed General risk appetite (G)						

Risk Implications	Yes	No
Corporate Risk register and/or Board Assurance Framework Amendments		*
Quality implications		*
Resource implications		*
Legal/regulatory implications		*
Diversity and Inclusion implications		*

Regulation, Legislation and Compliance relevance
NHS Improvement: Risk assessment framework, quality governance framework, code of governance , annual reporting manual
Care Quality Commission Domain: Safe, caring, effective, responsive, well led drop down
Care Quality Commission Fundamental Standard:
Other (please state):

Relevance to other Board of Director's Committee:					
Workforce	Quality	Finance & Performance	Partnerships	Major Projects	Other (please state)
*	*	*	*	*	Health and Safety

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1. Introduction

The Trust uses a Quality Management System to support the effective integration of the interdependent aspects of 'quality' into the Trust's Escalation and Assurance frameworks.

Figure 1: The Focus of our Quality Management System



The **Quality Oversight System** supports the 'surveillance', 'understanding', 'managing and escalating' and 'learning and improving' elements of the System. The Trust's **Organisational Learning and Response System** is embedded in the Quality Oversight System. The Trust's **Risk Management Strategy** provides a procedural infrastructure, alongside other key policies, for the managing and escalating elements of the system. The Trust's Board, Board Committees and their Sub-Committees provide a **Quality Governance** infrastructure for the assuring elements of the system.

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2. Our Quality Oversight System

The principles of the Quality Oversight System in use in the Trust are as follows:

- It is patient focussed – members are grounded in the fact that their purpose is to maintain good quality services for patients
- It is high trust – an environment which facilitates open and honest conversations about quality
- It is inclusive – all members feel able to contribute to discussion
- There is appropriate challenge – Members feel able to offer constructive challenge to colleagues to get to the bottom of the issues and identify suitable actions
- It is action orientated – all members come away from meetings with clarity as to the actions agreed and who is taking them forward
- It is well informed – members receive reports and data-packs which present information in a useful and distilled format to members which enable them to identify the potential quality risks
- It is comprehensive – the system has a planned and defined business cycle which enables them to consider potential risks in all areas within their remit, across Care Groups and Corporate Departments.

As well as specific incidents and events in the Trust the oversight system has developed the capability to consider

- care pathways including effectiveness data
- ward and service level intelligence, intelligence related to specific patient characteristics for example, patients with dementia, cancer patients, children, vulnerable adults etc.
- quality themes and trends for example within data relating to falls, pressure ulcers, serious incidents, complaints
- staffing issues including engagement, turn over, capacity and demand

The Quality Oversight Systems consists of a defined infrastructure and a range of processes to ensure that the organisation has early sight of any emergent risk to the quality of care that we provide. This includes risk to the health and safety of patients, visitors to the Trust and staff.

2.1 Our Quality Oversight System: Infrastructure

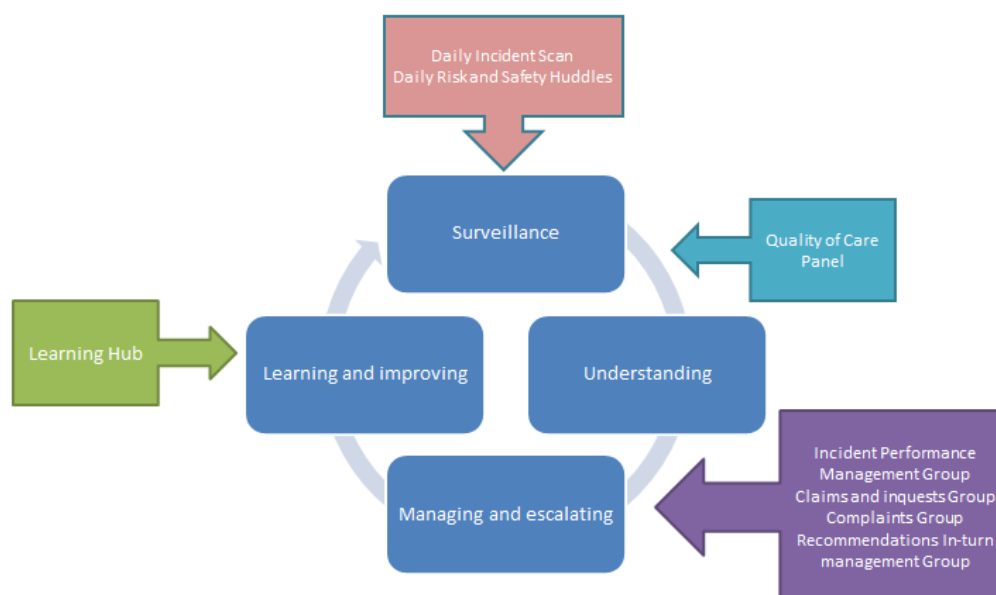
One of the key strengths of the Quality Oversight System is the infrastructure which has been designed to enable multi-disciplinary scans of our incident management system, and our daily service level risk and safety huddles across the Trust, culminating in a daily Trust Wide Risk Huddle, which takes place at 12pm every working day. The key questions that are posed daily are as follows:

- Were we safe yesterday?
- Are we going to be safe today?

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- What future risk could be on the horizon?

Figure 2: Our Quality Oversight System: Infrastructure



The **Quality of Care Panel** is designed to ensure executive leadership clear line of sight through the care provision and operational activities of the Trust, to ensure any past, present or future potential or actual unmitigated risk to the quality of our services has been captured, is understood and is being acted on and learnt from appropriately. The Panel meets every week and uses a range of intelligence including serious incident referral forms, serious incident exception reports, serious incident investigation reports, soft intelligence (internal/external), quality /Performance dashboard data, national alerts and relevant national intelligence to ensure that risks are understood, serious incidents are recognised and appropriate measures are taken to safeguard patients or improve the quality of care.

The **Management Groups** are all designed to support the identification of precursor incidents (which are identified from complaints, claims, incident reporting, inquests, mortality reviews, patient experience information, ProgRESS reviews, effectiveness data information from regulators and external partners, staff and patient conversations and a quarterly focus group of the learning and surveillance hub) from the information that they hold or receive, and ensure that they are being managed and escalated appropriately. All the management groups have care group representation as part of their membership.

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The **Learning Hub** acts as a virtual team across the Trust, bringing together all Care Groups and Corporate Departments and their respective information and intelligence, gathered through performance monitoring, and regulatory activities.

It is designed so that all members feel ownership and responsibility for the effective operation of the group. By collectively considering and triangulating information and intelligence, members work to safeguard the quality of care that people receive through learning and translation into practice activities (see section 3; our Knowledge Management System).

Members are a network of partners who work together and share information in the interests of patients and service users. This work is not confined to formal meetings. The Learning Hub can act as a virtual network in between meetings, with members interacting with each other in smaller groups where appropriate.

2.2 Processing, review and consideration

In order to generate meaningful and succinct intelligence from the vast amount of processing, review and consideration that occurs within the system, a standardised process across the oversight system is used, as reflected in table 1, to ensure that the organisation has oversight that gives assurance that the organisation is making real progress in relation to supporting a mature learning culture.

Table 1: Processing, review and consideration

		Mechanism	Output
Preparation	Assimilation of locally held data associated with complaints, litigation, incidents and coroner's inquests, mortality reviews, effectiveness data,	Daily Huddle Weekly QuOC Weekly IPMG Quarterly analysis Complaints Group Claims Group	Key Findings
Review	Analysis of type, causation, contributory factors and associated learning	Thematic review Quantitative analysis	Assessment
Evaluation	Escalation of areas of significant concern, initiation of thematic reviews to explore areas of potential concern, identification of opportunities for Trust-wide learning. Exploration of tacit experience and case studies	QuOC IPMG Divisional governance Learning and Surveillance Hub Sub-Committees	Risk and control identification (see table 2)
Report	Completion of outcome report of full review and recommended actions	Quality Committee	Assurance

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This processing of information is directly supported by the Office of Governance and Corporate Affairs, the Offices of the Chief Medical Officer and Chief Nurse and by key clinical and operational staff from the Care Groups through the various structures and mechanisms within the system.

A process of risk and control identification underpins the quality oversight system and is described in Table 2. The outcome of this also assessment directly influences the choice of 'learning categories', and subsequent learning modality and dissemination (see section 3).

Table 2: Risk and Control

Risk and Control		
Significant concern	Escalated for discussion and action at QuOC Reported to Integrated Governance and Risk Committee, Patient Safety Committee (and other relevant sub-committee of the Quality Committee) and through Care Group governance	Risk (see section 4)
Concern	Escalated for discussion and planning at Incident Performance Management Group/Complaints Group/Care Group governance. Referral for responsive ProgRESS review considered	Risk (see section 4)
Opportunities for Change and improvement	Referred for discussion and care group governance for action and support through the Learning Hub and relevant sub committees of the Quality Committee	Opportunities for change and improvement
Good practice	Referred for discussion and divisional action support through the Learning and Surveillance Hub and relevant sub committees of the Quality and Safety Committee	Opportunities for learning

The Quality Committee (see section 5) receives the following specific outputs from the Quality Management system:

- Monthly Quality Oversight System Summary
- Monthly Serious Incident Report, describing Serious Incidents declared and those where the investigation has been concluded
- Quarterly Incident Report
- Quarterly Effectiveness report
- Quarterly Patient Experience report

3. Organisational Learning and Response System

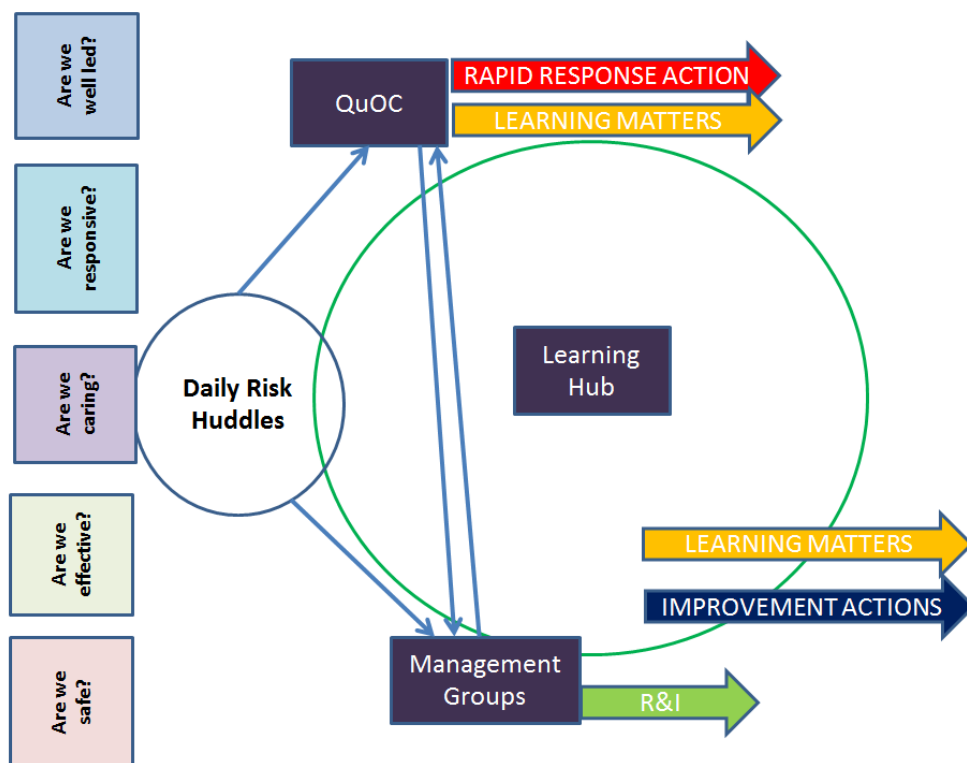
During 2016/17 the Trust developed and implemented a knowledge management framework allowing creation, acquisition, dissemination and implementation of this knowledge across the organisation. This system, the 'organisational learning response system', enables precursor incidents (which are identified from complaints, claims, incident reporting, inquests, mortality reviews, patient experience information, ProgRESS reviews, effectiveness data information from regulators and external partners, staff and patient conversations and a quarterly focus group of the learning and surveillance hub) to be used in

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a learning process to support Trust-wide change and improvement and contribute to the avoidance of future incidents and the mitigation of risk.

The organisational learning and response system is embedded in the organisations ‘Quality Oversight System’, which is represented in Figure 2. The key learning outputs from this system are represented in Figure 3 and described in more detail in Table 3. The term incident is used to refer to any sort of ‘precursor incident’ that can support the generation of learning.

Figure 3: Key learning outputs from the Organisational Learning and Response System



The Quality Committee receives a quarterly report from the organisational learning and response system, describing the precursor incident, the learning identified and how that learning was disseminated across the Trust.

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Table 3: Trust wide feedback mechanisms


Trust wide feedback mechanisms			
	Type	Content	Responsibility
Bounce-back	Contemporaneous feedback to reporter (part of incident management process)	Acknowledge report filed (eg automated response) • Debrief reporter (eg telephone debriefing) • Provide advice from safety experts (feedback on issue type) • Outline issue process (and decision to escalate)	Care Group Risk Management Complaints
Rapid response actions	Action within local work system	• Measures taken against immediate threats to safety or serious issues that have been marked for fast-tracking • Temporary fixes/workarounds until in-depth investigation process can complete (withdraw equipment; monitor procedure; alert staff)	QuOC Care Group
Risk awareness information	Information to all frontline personnel	• Safety awareness publications 'Learning matters' (posted/online bulletins and alerts on specific issues; periodic newsletters with example cases and summary statistics)	Learning hub Care Group
Publicising actions taken	Information to all personnel	• Report back to reporter on issue progress and actions resulting from their report • Widely publicise corrective actions taken to resolve safety issue to encourage reporting (e.g. using visible leadership support)	Care Group Risk Management Team/Assurance team
Improvement actions	Action within local work systems	• Specific actions and implementation plans for permanent improvements to work systems to address contributory factors evident within reported incidents • Changes to tools/equipment/working environment, standard working procedures, training programs, etc. • Evaluate/monitor effectiveness of solutions and iterate	Care Group Learning Hub ProgRESS team

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4. Risk Escalation Framework

The Trust's Risk Escalation Framework is clearly defined in the Trust's Risk Management Strategy (2019-2025). Our risk management strategy is designed to strengthen our ability to achieve our strategic objectives and business targets thus ensuring the continuation of the safe and effective delivery of our services. It does this by supporting our strategic and operational decision making and planning, helping us to comply with legal and regulatory requirements, improving our governance and controls and ensuring an open culture where people feel encouraged to take responsibility for minimising any negative effects of risk on our services and support improvements to the safety of the services

Table 4: Risk escalation framework



Risk identified and assessed	An initial discussion takes place with a line manager (and the Care Group/Specialty/Corporate Directorate Governance Lead for assistance if required) and then be assessed, graded and added to the risk register as appropriate
Ward/specialty/corporate service level	Monthly review of risks is undertaken at ward/specialty/corporate service level. Where the ward specialty or department feel unable to manage the risk this should be formally escalated to the Divisional Governance Lead for consideration at next meeting
Care Group/Corporate Department Level	Monthly review of risks escalated formally from ward/specialty/corporate service and all risk scored at 9 or greater to be reviewed at divisional level. Where the Division/Department feel unable to manage or address the risk themselves this should be escalated formally to the Corporate Risk Register. This is to be undertaken by checking the box escalate to corporate risk register on Datix and by informing the Director of Governance and Corporate Affairs in writing
Strategic level	<p>The Integrated Governance and Risk Committee reviews all risks newly escalated, considering whether to accept them onto the strategic risk register. Risks accepted are identified with an executive lead.</p> <p>All risk on the strategic risk register scoring greater than 12 are reviewed monthly at the Integrated Governance and Risk Committee., and managed within the principal risk structure of the register to enable alignment to the Board Assurance Framework (BAF)</p>
Committee Level	Board committees will review the principal risks and their component risks assigned to them and consider their impact on the Board Assurance Framework and how they should be reflected
Board Level	The Board reviews a high level register of Trust wide risks graded at 15 or greater at each meeting. The Board reviews its strategic risks (12 or above) via the BAF, receiving assurances from the Board Committees and undertaking a review of all BAF risks at each meeting.

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The strategy makes it clear that the Trust manages risks at a strategic, Care Group, Clinical Business Unit and service level.

Strategic risks are risks that have the potential to impact significantly on the Trust's strategic objectives or organisational risks that apply to the organisation as a whole and cannot be managed at Care Group level or are considered a risk to the delivery of the Trust's strategic objectives. These are reflected on the Strategic Risk Register Service level risks are risks that, having been assessed as active in relation to their likelihood and consequence, and following assessment, are considered appropriate to be managed and mitigated at Care Group, Clinical Business, Specialty or department level. Service level risks can also be managed through the Corporate infrastructure of the Trust, at Corporate Directorate or team level.

The risk escalation framework is presented in Table 4 and is supported by the governance infrastructure described in Section 5 and the roles and responsibilities of staff across the Trust described in the Risk Management Strategy.

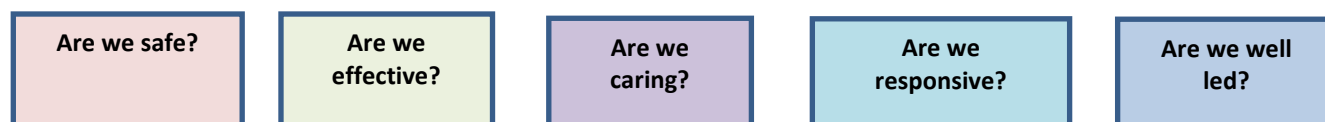
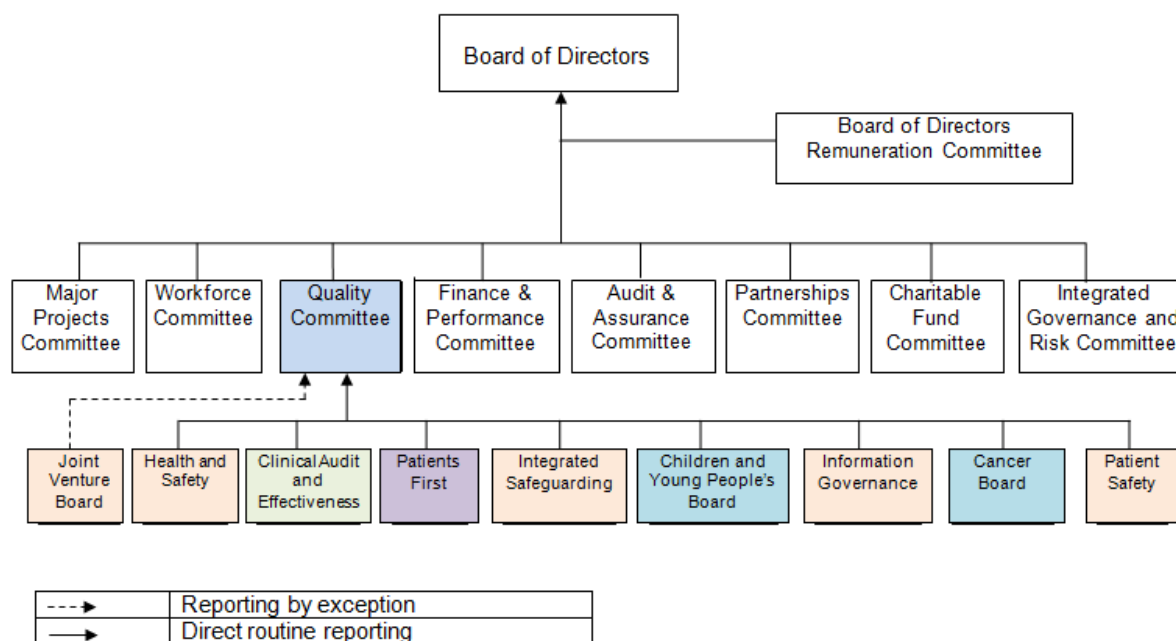
5. Quality Governance

The Board of Directors established a Quality Committee (see Figure 4) to provide it with an objective and independent review (including relevant strategic risks and associated assurance) of the quality of the care the Foundation Trust provides. This remit includes a focus on the Care Quality Commission (CQC) domains of safe, effective, caring, responsive and well led, and on also on the effectiveness of quality governance and risk management (including health and safety) systems.

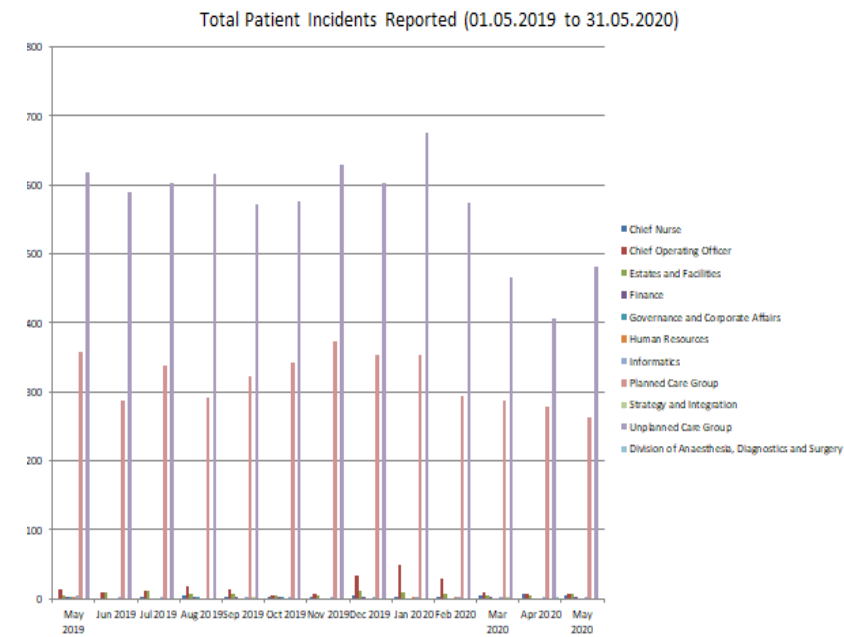
During the organisation's response to the COVID pandemic, assurance related to critical key controls usually subject to scrutiny at the Quality Committee have been managed through the work of the Executive and Non-Executive Regulation Committee as directed by the lead Executive Directors. The Terms of Reference of this Committee were approved by The Chairman, Chief Executive and two Non-Executive Directors.

Meeting Title	Executive and Non-Executive Regulation Committee		
Date	18.06.20	Agenda item	ERC.6.20.8

Figure 4: Quality Committee and its associated governance and infrastructure



Quality Oversight Exception Dashboard



CAS alerts

All patient safety alerts responded to within timeframe.
None received relevant to COVID.
One E&F alert in progress but outstanding-COO aware.
Low risk.

Inquests

Regulation 28 response submitted. No further correspondence from the Coroner.

Regulators

No additional requests/escalations from CQC.
Discussions ongoing in relation to HSE position with regards to RIDDOR reporting COVID infections in staff

Assurance

SJR re-start
Quality Governance restart

Daily risk huddle

The daily risk huddle occurred on every day.

Moderate and above harm incidents

All patient safety incidents where harm was moderate and above are under review through the risk huddle and IPMG/falls/pressure ulcer groups. A number of incidents have been escalated for QuOCs review.

Complaints

The Trust received complaints,low and moderate. These are currently under review.

Mortality

Weekly mortality collection form being maintained.
SJR process suspended except for COVID deaths. escalations made this week. Clear pattern associated with COVID pandemic.
HED data indicates alert pending for Sepsis.
HSMR (unadjusted) 90.23 (Jan19-Dec19)

Themes and trends

Alert

Advise

Assure

COVID specific incidents

Incidents where COVID is mentioned are routinely reviewed at the daily risk huddle and in the context of the silver conference call.

@55

A range of triggers are used to support horizon scanning of actual or latent risk and to support contextualisation of incidents, and the associated response framework

Quality data

The most up to date dashboard is available for review. BI are reviewing the agreed data points for production of a weekly dashboard

Ward Dynamic safety trigger tool

The current escalations from the ward dynamic safety tool is available for review.

National Patient Safety Collaboratives

The COVID-19 Response Safety Improvement Programme has identified three programmes:

- Managing deterioration in adults
- Managing deterioration of mothers with COVID-19 during pregnancy and of babies in neonatal units
- Safe tracheostomy care in adults for COVID-19 patients

Learning

The NHS national patient safety response team has issued a COVID update
There werelearning matters or rapid response alerts issued from the quality oversight system during this time period. The Learning Hub will be re-established from July 2020.