Bradford Teaching Hospitals
NHS Foundation Trust

EXECUTIVE & NON-EXECUTIVE REGULATION COMMITTEE MINUTES

Date:	Thursday 18 June 2020	**Time:**	08:30-10:30
Venue:	Via teleconference	**Chair:**	Dr Maxwell Mclean, Chairman
Present:	**Non-Executive Directors:** - Dr Maxwell Mclean (MM) - Ms Trudy Feaster-Gee (TFG) - Mr Barrie Senior (BAS) - Ms Selina Ullah (SU) was in attendance until the end of item 16. - Mr Mohammed Hussain (MHu) - Mr Jon Prashar (JP) - Mrs Julie Lawreniuk (JL) - Professor Laura Stroud (LS) **Executive Directors:** - Ms Mel Pickup, Chief Executive Officer (MP) - Ms Pat Campbell, Director of Human Resources (PC) - Ms Karen Dawber, Chief Nurse (KD) - Ms Sandra Shannon, Chief Operating Officer (SES) - Ms Cindy Fedell, Chief Digital and Information Officer (CF) - Mr John Holden, Director of Strategy and Integration (JH) - Mr Matthew Horner, Director of Finance (MH) - Mr Bryan Gill, Chief Medical Officer (BG)		
In Attendance:	- Dr Tanya Claridge, Director of Governance and Corporate Affairs (TC) - Mr Aubrey Sitch, Corporate Compliance Manager (taking minutes)		

No.	Agenda Item	Actions
ERC.6.20.1	**Apologies for Absence** There were no apologies to note.	
ERC.6.20.2	**Declarations of Interest** There were no interests declared.	
ERC.6.20.3	**Minutes of the previous meeting** The minutes of the previous meeting were agreed as an accurate record. The Committee noted that the following actions had been concluded and were now closed: • ERC.4.20.3 – Minutes of the previous meeting • ERC.4.20.8 – Maternity services update on actions • ERC.4.20.10 – Staff Wellbeing and Resilience • ERC.4.20.16 – Matters to escalate to the Strategic Risk Register The following item was discussed for progress and is on the agenda (ERC.6.20.7). The item was then closed. • ERC.4.20.5 – COVID-19 Response update MP will circulate the 29 April letter regarding the restart.	

	MH will circulate planning guidance for remainder of year when it is released (either end of June or start of July)	
ERC.6.20.4	**Matters escalated from Executive Directors** No matters to be escalated	
ERC.6.20.5	**Quality Dashboard** KD reported to the Committee on the following aspects of the Quality Dashboard: • Stillbirths rate is improving with downward trend. • Sepsis rates have remained stable. Lead staff are currently involved in managing PPE. • Falls with Harm shows a steep rise. This is a rate per 10,000 bed days and the Trust has less elective patients who would typically lower this figure. • Falls with severe harm has an error, the report should say 'head injury', not 'hand injury'. • Pressure Ulcers Cat 3+ has a spike in February that was a result of two patients with more than one pressure ulcer. The spike in May is attributed to some COVID-19 patients having to be nursed face down up to 23 hours a day. MP questioned the validity of 'per 10,000 bed days' following Ursula's review and asked if reporting absolute numbers may be more appropriate. BG explained the difficulties comparing pre and post COVID data and informed the Committee that he and CF were looking at this again and would feedback to the Committee. CF stated that indicators achieve their objective when they drive discussion whether they are the best fit or not. LS asked what the Trust is doing to learn from the particular challenges of treating COVID patients and how we are sharing with and learning from other trusts to prevent harm. KD highlighted the work of the Tissue Viability Team investigating the damage caused by PPE use and how that is being shared across the system and nationally. The Trust is an active member of the Primary Care Network. MP informed the Committee that she is representing WYAAT as the lead Chief Exec for critical care and trauma networks. MP can bring back helpful insights from their post-COVID comprehensive benchmarking exercise. BG reported to the Committee on the following aspects of the Quality Dashboard: • Crude Mortality showed a significant rise due to COVID-19 patients and highlighted the need to review how useful some indicators (including SHMI and HSMR) are going to be in the next 3 to 6 months. • Readmissions have dropped significantly due to the types of patients being looked after rather than solving a long standing problem. During the 'reset and restart' process, the bed base will be carefully managed and there is an opportunity to manage patient's return to hospital in a differently.	

	MHu asked at what point Meds reconciliation will be un-paused? BG stated that the national dashboard has been paused and no restart date provided, although he believes it will be around September time. The Trust is doing medicine reconciliation but the majority of patients have been purely COVID patients. The data is not currently required and is less relevant in this period. CF stated that the suspension of metrics is currently under review and guidance on which can be turned on and when will be available in the coming weeks.	
ERC.6.20.6	**Strategic Risks – Quality Committee** The Committee reviewed the Strategic Risks and Executive Directors highlighted the following: BG highlighted risk 3467 – Endoscopy Capacity. The majority of Endoscopy work has paused during the COVID response. The risk category needs to remain 'Extreme' as the additional delays to surveillance and screening may have detrimental impacts to patient outcomes in common with Trusts around the country. This needs to remain a high priority item with monitoring over the coming months until the true impact is known. LS asked how we are communicating with patients to help them feel safe and to maintain the partnership relationship between the Trust and its' patients. KD confirmed that the Trust is communicating with patients in general terms with letters regarding procedures, clinical communications about the nature of procedures and the specific area of restarting services again. KD highlighted Risk 3551 – Infection Control. This is a new risk added on the 19/5 relating to Maternity Theatres. Further detail will be provided within the maternity update (E.6.20.17).	
ERC.4.20.7	**COVID-19 Response update** SES presented a summary that a lot of 2 week wait work is being done and that where referrals prior to the pandemic had been around 365 per week, they initially dropped to an average of 136 although this has now increased to an average 280 per week. She highlighted endoscopy as being the biggest challenge in terms of unmet demand. In terms of managing patients on a cancer 62 day pathway, Daily processes are undertaken to ensure patients whose disease progression is time sensitive are being prioritised. BG stated that work to restart services will be influenced by the slower reduction COVID patient's being treated than is being seen elsewhere. As an illustration, 50% of all critical care activity for COVID patients in West Yorkshire is in Bradford. There have been positive conversations with acute and primary care partners to redesign services and around clinical prioritisations. The responsibility to communicate this to patients will be shared between the Trust and Primary and Community Services.	

	BG also said that as an organisation we have some key players in certain areas of research such as Dr Saralaya in Respiratory Care who has been instrumental in national research trials. BG described initiatives such as the recently launched Patient Recruitment Centre for vaccine trials alongside research partnerships with Bradford and Leeds Universities as well as the Wolfson Centre. Collectively, these put the Trust on the map regionally and nationally and lead to improvements in patient care. JH cited a recent conversation with a medic interested in a post at the Trust as an example of this sort of work aiding the Trust's ability to recruit and retain good people. BG requested that Dinesh and the respiratory team be applauded for their work which has been the majority of the Trust's frontline response to COVID. MP stated that there may be a time to particularly note the work of individuals but assured the Committee that daily 'Thank You' cards are being given to people and an awards evening has been planned. She noted the difficulty of drawing out individuals when collectively across the Trust so many had worked so hard.	
ERC.6.20.8	**Quality Oversight during COVID 19 response** BG thanked TC for the development of the Trust's Quality Oversight in general, not just during the COVID-19 response, as detailed in the report. The oversight systems enable the Trust to identify and reduce potential harm to patients. Appendix 2 of the report specifically describes the oversight during the COVID-19 response. One aspect is the weekly quality panel that identifies what factors need dealing with and whether additional support is needed or not. BG stated that the Trust is in a fairly unique situation compared with other trusts in having identified which parts of the quality governance to apply in the current environment and may serve as a template for streamlining the Trusts governance arrangements generally from Ward to Board. Despite the challenges faced, the Trust has had a strong oversight mechanism to provide reassurance, drive debate and celebrate what has been done well. The Committee noted the report and thanked Tanya for her work.	
ERC.6.20.9	**CQC Statement of Purpose** KD presented the Statement of Purpose which is a requirement of all organisations who register with the CQC. The Trust had to register the Yorkshire Clinic and Ophthalmology Services at Bradford University as separate sites. No previous Statement of Purpose could be identified by either CQC or the Trust. BAS said that the Statement of Purpose looked clear and appropriate. The Committee noted the Statement of Purpose.	

ERC.6.20.10	**Serious Incident Report – March to June 2020** BG presented a set of reports from the period of March to May while the Quality Committee had paused due to the COVID response. BG assured the Committee that, despite monthly reports not being reviewed by a Committee of the Board, the investigations and reporting required by the Trust's serious investigations process had continued (as detailed in the appendices). The Trust performs well at completing reports within the timescales defined by the national programme. A revised serious incident reporting and patient safety programme was due to be launched prior to the pandemic but will soon bring changes to the timing, depth and detail of the Trust's reports. There will continue to be a focus on identifying the immediate necessary actions early in a comprehensive investigation. There have only been a small number of incidents resulting in declarations, but not through lack of rigor. The escalation process and the DATIX reporting have continued and the Trust actively looks for potential serious harms through weekly panel meetings that discuss escalations with updates and clinical reviews. MM asked how the Trust's performance of 84% of investigations completed within the required timeframe compared with other trusts. BG explained that the Trust does compare well to other trusts and that the next phase is to build the learning culture across the Trust. TFG questioned the appropriateness of services that may be implicated in an investigation being involved in the investigation process and whether the Trust is following best practice in being sufficiently independent. BG assured the Committee that where an individual was implicated in an investigation that they would not have a role beyond providing a statement within the investigation. The Trust follows national guidance in providing expert opinion to understand the underlying issues in a given investigation. In some cases it is therefore likely, and appropriate, that a department such as the Infection Prevention Control is involved in investigating why an outbreak has occurred or another clinician from Anaesthetics provides an opinion on the actions of another anaesthetist. These investigations are often as a result of system rather than individual failings, in those cases the power of learning is enhanced when undertaken by the team as highlighted by the Royal College of Obstetrics and Gynaecology review of maternity services. Each investigation has an Executive lead, either BG or KD who will scrutinise and challenge where the team haven't got to the heart of the issue. TFG asked if was possible for the reports to be clearer and quicker in getting to the main findings with a summary earlier in the report. BG agreed that while the structure of the reports has improved, more can and will be done. TC stated that there are constraints applied to the current format of reporting as required by the	TC

	National Serious Incident Framework and that changes by the new National Patient Safety Strategy this Autumn are welcome but that some formatting changes may be possible to aid clarity. TFG asked what two incidents were referred to in the April SI report as there wasn't a clear link to any further information. BG stated that one was a previous investigation being concluded and the other related to the Endoscopy risk that had been identified and added to the Strategic Risk Register but that no incident had happened and therefore no investigation or report. TFG asked how the Trust was doing in procuring MRI safe equipment following the incident with a child on the wrong trolley. BG stated that the area has become a closed rather than open area to reduce the likelihood of a repeat but that purchasing of specific items has paused due to COVID but will continue soon. TFG asked how the Trust viewed the incidents across maternity and neonatal given the CQC concerns about maternity services. KD responded that the incidents were being viewed together as a result of their timing and the changes to reporting that occurred at that time. Another factor is that a small error in maternity can have a disproportionate amount of harm compared to other services with a similar rate of incidents, this leads to more serious incidents in maternity with very unfortunate outcomes such as still births. Maternity has a positive reporting culture and captures incidents. KD stated the benefit of having all Executive and Non-Executive Directors together giving a level of scrutiny and opportunity for discussion on issues that would have previously been looked at by the Quality Committee. MM agreed with the view and added that both he and MP were happy for NEDs to make direct enquiries with Executive colleagues. The Committee noted the reports and the required action to review the format of the report.	
ERC.4.20.11	**Patient Safety Incident and Health and Safety Management and Compliance Report Q4** BG presented the quarterly report that is to show the comprehensive approach taken to managing Health and Safety. Without going through the detail of every item listed in the appendices, BG highlighted the work undertaken around blood transfusions to demonstrate the attention of detail for safety and patient care. Future work will support the Transfusion team identify potential significant risks and share the learning. One example of this learning is the requirement of patients providing 2 samples of blood with a time period between them before a blood transfusion. Although this introduced operational challenge it was the safest way to proceed. BG invited follow up questions to himself, KD or TC either during or after the meeting. BAS commented on the graphs within the report and whether benchmarking data against other Trusts is available? TC advised	

	that all incidents are uploaded to the National Reporting and Learning System on a weekly basis. The system produces a twice a year report that benchmarks the Trust's ratio of 'low or no harm' incidents to 'serious' incidents. Although this benchmarking report wasn't available in time for this committee it is known that the Trust does benchmark well against others. BAS asked how the Trust can demonstrate that the benchmarking data has resulted in action rather than analysis. TC responded that the Trust tries, where possible, to triangulate data from other sources such as the staff survey and incident reporting to provide greater context. She provided an example of exploring the willingness of staff to report and understanding their actions when observing an incident that led to improvements in incident reporting. BG made the point that the best benchmark is yourself in order to consistently see that as an organisation you are improving. Quality departments across the WYAAT partnership are working together to improve the pace of learning through sharing information without fear of exposure. This helps each trust to learn from each other's mistakes and avoid repeating them. An example was one trust anxious about how to manage a deteriorating child but another trust had worked through this a few years earlier but was now able to share their learning. Where the NHS has historically been poor at sharing learning the Trust's system working is embedding learning more quickly. BAS asked if the peaks in number of incidents occurring during winter is expected and if so, why? BG responded that due to the increased number of patients being managed and the impact of staffing challenges over winter there is a winter peak that happens year on year. TFG asked for a view on the actions being taken with regard to the three 'most reported' incidents in table 1 of page 2 of the report; blood transfusion, patient falls and medication safety. BG described the challenge of providing an overarching view to the Regulation Committee but with sufficient detail to give the assurance required. KD had earlier discussed the patient falls and BG had discussed blood transfusion issues. The number of medication incidents indicates the level of strong scrutiny and reporting that takes place rather than a significant problem within the Trust as the majority of incidents were minor with no patient harm. The Medicine Safety Group reports to the Patient Safety Committee regularly on the improvement work being undertaken. The Committee noted the contents of the report and were assured of the controls in place to manage risk.	
ERC.6.20.12	**Organisation-wide procedural document, local guidelines and Trust wide clinical guideline compliance - 2019/20 Quarter 4** In response to TFG's question following the May Board meeting (Bo.5.20.35), TC presented a report with regard to the out of date policies being reported at 12%. The report is ordinarily seen by the	

	Patient Safety Committee then Quality Committee but is to provide assurance of the measures being taken to manage policies. TC informed the Committee that she receives fortnightly reports on policy compliance and that much work had been done since the report was produced. Compared with 3 years ago the Trust has much better compliance. JL asked if it would be possible to have a date by which the out of date policies would have been reviewed. TC stated that when a policy is out of date the Executive Director is required to either extend or review the policy as is appropriate but some policies have to be reviewed by unions etc. TC agreed that a date by when the policies would have been reviewed will be provided. TFG asked if there was a particular issue within the Finance team as the report showed 81% compliance. There were 3 Finance policies listed as out of date on the report and only 1 of those was still under review which was reliant upon Dr Saralaya who, for reasons mentioned in ERC.6.20.7 had limited availability at the moment. The Committee noted the report on compliance	TC
ERC.6.20.13	**Regulation 28: notification and response** BG informed the Committee about the actions taken following the receipt of a Regulation 28 received by the Trust. The Trust had already written to explain some of the factors involved in the case. Once the Regulation 28 was received a similar letter was sent in response. Learning has been made and can be seen in the development of a new tile for the Command Centre which will give real time data on managing patient deterioration. This is unique to the Trust and will help spot deteriorating patients sooner. The Committee noted the response and expressed thanks for a timely response to the Coroner.	
ERC.6.20.14	**Implementation of ReSPECT** KD summarised the presentation for ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) which she described as the 'Gold Standard' for initiating End Of Life Care (EOLC) discussions and has been developed by the Resuscitation Council. Some trusts in the region, including Leeds are already using this document to record patient's care preferences. The ReSPECT document would detail how people want to die with dignity, what levels of treatment they want and what escalations are wanted. The conversations help take away some the uncertainty and fear. Implementation is usually a 2 year process. The Trust started the process before Christmas with a planned completion date of September 2021 but want to fast track it for implementation by August 2020. The urgency is in part because of the number of	

	COVID patients who have come from other settings and died within 24 hours with insufficient clarity over what conversations clinicians have had with regard to EOLC for the patient. Work is underway across the system with weekly review meetings ensuring that the rapid progress is compliant with national guidance including the requirement of Board approval. Key partners include Airedale NHS FT, Bradford District Care Trust, Bradford and Craven CCG as well as the Yorkshire and Humber LMC. There is a risk around the sharing of data across different electronic information systems used across the partner organisations. Dr Paul Southern is investigating how this obstacle can be overcome and the Trust's EPR supplier is already working on this. MM asked what patient's relatives would notice. KD answered that they would have had the necessary conversations with an individual before the patient got to a place where they lacked the capacity for the conversations. They would also have identified what levels of treatment the patient wanted or did not want. These conversations would reduce the tension and create a better end of life experience for people. MHu asked if chaplains have been engaged in the process. KD explained that they haven't as yet but they will be instrumental in the roll out as will all staff across the Trust. Ways of engaging other staff beyond the small group of 6 involved at the moment are being developed. JL asked what the Trust does to respect patients' wishes who don't want to have these conversations. KD responded that the Trust would always respect the wishes of the individual. As clinicians and practitioners, it would be right to try and have those conversations as part of the process of caring for somebody. BG stated that during the COVID response, particularly in primary care, there was a lack of an ethical and moral framework to use when starting those conversations. The ICS has created an ethical framework for decision making whether at end of life decision making or restart decision making and clearly focuses heavily on advance care planning where there is an opportunity to get in earlier in a patients assessment. There is a lot of work to be done in training people how to use those frameworks and have those conversations. BAS asked how the Trust ensures, with relation to current and proposed procedures, that paper and EPR records are consistent with each other and reflect the patient's current expression of requirements. KD stated that there are risks associated with having more than one system and from having paper records but that there are processes in place currently to monitor the validity of data via algorithms running in the background on EPR. The Trust would always resuscitate unless proof of a DNA CPR was available. An example of the systems in practice arose with a Trust patient recently in the news with learning difficulties and Downs' Syndrome	

	on an end of life pathway who recovered and rescinded the DNA CPR, his record no longer shows DNA CPR. There is a current and continuing risk but no more so than by not implementing ReSPECT documentation. CF added that what is being highlighted is work still to be done and that analysis of workflows and risk assessment is part of the process. Whenever the Trust has a 'go live' event, a robust checklist is used to ensure that those scenarios have been worked through and that the Trust is comfortable that those risks are mitigated. Further discussion highlighted that the risk is current and that further planned action will reduce the risk. The current policy is to always resuscitate in the absence of a clear DNA CPR. It is rare for a patient to have an end of life agreement in place from outside of the Trust as this is usually brought up in the acute end of treatment. BAS confirmed that, in response to his question, he had heard this is a recognized live risk and that if and when the Trust moves to ReSPECT documentation it will be looked at again. BG stated the most common problem this documentation poses the Trust is when it becomes apparent that conversations have been had in the community that haven't been communicated with the hospital. As previously mentioned, the safest way forward is the current policy of 'if in doubt, resuscitate'. An audit was carried out early on in the response to COVID that assured staff that considerations were being made on a regular basis and that EPR showed a record of the recurring conversations unlike other trusts who rely on a piece of paper being moved about with the patient. System integration will be key in whatever solution is decided upon. JH said that there is a handling issue to be mindful of that a small part of the Bradford community may fundamentally misunderstand and create further suspicion as recently seen in COVID fake news. JH agreed that the ReSPECT documentation is the right thing to proceed with but that the narrative needs to be right. MP agreed that although unlinked to COVID, a minority of people will think it is. SU emphasised the need to engage communities with community advocates to prevent misunderstanding. KD responded that the ReSPECT tool cannot be adapted and there is therefore no plan for a 'consultation', but a communication plan and an implementation plan are being developed with the CCG. The Trust can use its strong links with the faith community, local MPs and others to communicate effectively that this is not to prevent treatment. GPs will start the conversations earlier in a patient's treatment. KD agreed to bring the implementation plan and the communications plan to the Quality Committee at the end of July. The committee noted the report and approved the proposal to fast track the ReSPECT initiative.	KD
ERC.6.20.15	**National Inpatient Survey**	

	KD presented the report to the Committee to highlight the progress made since the last Inpatient survey. The Trust had been one of the poorest performers with some complacent attitudes towards the survey. This year's results show that the Trust has implemented the 'Embracing Kindness' strategy and other specific initiatives such as 'Good Night, Sleep Tight'. The Trust was amongst the bottom 20% of trusts for 34 questions last year only 4 questions this year which is a significant improvement. Further improvement is expected in the coming year with targeted improvements on those four areas. MM asked if this could be a good news story to be shared. KD responded that after the 30 June embargo they could be. The Committee noted the report and the progress made since last year.	
ERC.6.20.16	**Health and Safety Annual Report** SES presented the report to the Committee and thanked TC and her team in particular for preparing a comprehensive and easy to read report. SES highlighted the following significant points: Overall, the Trust has made good progress in developing a positive Health and Safety culture. The report has examples of incident review and reporting throughout. Health and Safety training has also improved over the year as well as a strong emphasis on learning. The Trust has a comprehensive action plan which SES regularly tracks the progress of. There were 31 RIDDOR incidents investigated, reported and actioned with lessons learned being shared appropriately. Of particular concern is the number of physical assaults on staff. There have been 21 personal injury claims with two common themes in needle stick injuries and slips and falls. Needle stick injuries will be a focus for targeted improvement over the coming year. The Trust had three regulatory visits • The Ionising Radiation Medical Exposure Regulation (IRMER) improvement notice was lifted by the CQC and a positive follow up report was received. • The Environmental Agency visited in regard to waste management and gave a positive report. • A contractor was on site removing asbestos when they were inspected by the HSE. BAS asked what assurances are there that all inherent Health and Safety risks have been identified and that satisfactory management of those risks is in place. Before her connection was lost, SES confirmed that comprehensive processes are in place for identifying risks on a day to day basis through the use of the DATIX system and an audit process to conduct gap analysis in the longer term. JL confirmed that JP has a role as lead Non-Executive Director on	

	the Health and Safety Committee. JP added that he is more than happy for Non-Executive Directors to channel issues or concerns relating to Health and Safety through him as he regularly speaks to TC and attends the Health and Safety Committee as and when required. The Committee approved the report and were assured by the work undertaken to mitigate health and safety risks.	
ERC.6.20.17	**Maternity Services update – June 2020** MM thanked the Maternity Services team on the significant improvement achieving 97% one-to-one care in May (up from 83% in April) as a fantastic achievement. He also highlighted how helpful the two-year trend graphs were. KD repeated the praise as the majority of indicators are showing positive improvements and noted Michael Rooney's input from Informatics in producing the Maternity Dashboard. KD stated that in addition to the one-to-one care and the work to reduce still-births it was worth highlighting the following progress on Maternity Theatres: • The floor plan has been signed off • The final design is expected to go out to tender in July • Planning decision is expected in August/September • Contractors are to start on site in September The slippage from the original on site start of July is largely because of COVID. KD also highlighted the positive work in the detailed action plan. Maternity Theatres and Infection Control have implemented a national tool to review Caesarian Section and infection rates. KD wrote to the Chief Midwifery Officer on 5 May enquiring about maternity services improvement programs. After discussions between BG, MP and KD, the Trust joined a 'Maternity Safety Support Program' that provides an additional external view and assurance that is not CQC. As a result, the Trust will be having support from Prof Peebles (Consultant Obstetrician) and Sascha Wells-Munro (Deputy Chief Midwifery Officer). The Committee approved the report, noting the work and subsequent improvements that had been made.	
ERC.6.20.18	**Workforce Dashboard** PC presented her report to the Committee and highlighted key points. Engagement is still red on the dashboard; the 'Staff, Friends and Family Test' is still temporarily suspended nationally as is our local reporting on Appraisal Rates. The Trust will be piloting a national monthly survey from July to give additional engagement data. Further well-being data will be	

	gathered by a local survey to run in June. PC and SU agreed a majority of Workforce data indicators to be restarted in July and a detailed equality update for the July Board meeting. Monitoring of the use of agency staff has continued through the COVID response with an increase seen in May. Overall the picture is fairly static but there has been a steady return of bank HCAs returning to the workplace with fill rates increasing. Staff turnover has been very stable with less leavers than this time last year. The Trust's sickness rate is above the target of 5%. COVID sickness is reducing slowly. In addition, the percentage of staff either self-isolating or shielding is falling but currently at around 4%. In line with national guidance, formal sickness meetings have been suspended over the last 3 months with a focus on well-being discussions instead, particularly for those staff on long term sick. Discussions are being held with staff side re formal attendance management meetings restarting. A discussion will be had at ETM in the next few weeks to take a decision around the restart of mandatory training and what this looks like. These were the key issues PC wanted to pull out from the dashboard.	
ERC.6.20.19	**Strategic Risks - Workforce Committee** PC described two new risks added to the Strategic Risk Register. 3560 - 'Test and Trace' was added 9 June 2020. The national test and trace programme could result in the Trust having less staff to deliver its objectives when we consider staff absence rates already being higher than normal. Other trusts have seen entire departments shut down. There are mitigations in place and this risk is under weekly review. 3561 – The Trust not being able to provide staff with a safe working environment. Added 16 June 2020. JH and PC are leading a safe-working group looking at non-clinical workforce. A similar group is looking at the clinical workforce. It is registered as a risk because of the complexity in compliance with the government guidance at work. Risk Assessments and a COVID Secure checklist has been developed and put in place and a home or remote working policy to reduce the number of staff working on site is being developed. This risk is under weekly review.	
ERC.6.20.20	**Staff Well-being and resilience** PC presented the key points from her report as an update to last months detailed report. Virtually all BAME staff currently in work have completed an individual risk assessment. We are ensuring this is now part of the pre-employment health screening for all new employees and those returning from absences. Two virtual BAME network meetings have	

	taken place since May with a third planned for next week where Anna Trakoli (Consultant in Occupational Health) and PC will be focussing on risk assessments and well-being. MP, KD and Claire Chadwick (Nurse Consultant for Infection Control) answered questions about the use and availability of PPE from amongst the 50 members of staff at the second meeting. The way in which the BAME network is being engaged is receiving positive feedback. A new wellbeing survey has been launched to check the health and wellbeing offer to staff. The Psychology service has redirected its resource to outreach and one to one support work because of the low uptake of their helpline service and the availability locally and nationally of similar services. MHu asked what themes have arisen from the BAME risk assessments. PC confirmed that PPE and fit testing were key themes. KD explained how the Trust had responded to the concerns around PPE and fit testing. Sessions to provide feedback from the risk assessments heard Claire Chadwick explain the way the virus is transmitted and the appropriateness of different PPE types in different situations. The number of fit tests has been increased and staff are being tested for the most appropriate masks for them. PC agreed to produce a report on the outcomes and actions the Trust is taking to tackle the issues arising from the BAME risk assessments. JP commented that excellent work had taken place with regards to engaging with the concerns and perceptions within the BAME staff community and commended KD, MP and Claire Chadwick in particular on their approach to PPE. JP described a strong Health and Safety culture and mature conversations with Infection Control providing a robust way in which addressed staff concerns in the right way. The Committee agreed with JP that they were satisfied and assured by the Trust's robust approach to providing safe working conditions. He added the view that there will inevitably remain a residual risk of potential challenge from BAME staff should someone contract COVID that the Trust hasn't done enough even if it has. JP asked how the Trust's approach compared to other trusts with a similar ethnic mix in regard to PPE for BAME staff. KD said that COVID has encouraged trusts to work more closely together. The Trusts proactive and co-ordinated response, in her opinion, exceeds that of other similar trusts as demonstrated by having had no major concerns escalated outside of the Trust on PPE. The PPE hub has been than a place to collect PPE, it is a safe space for information assurance as well as equipment with strong leadership. MM thanked JP for his input and asked if anyone had an alternative opinion to that expressed by JP. There were no alternative opinions put forward. MP said that that, remarkably, staff-side concerns over PPE were no longer being raised through the JNC meeting which reinforced the view of how effective the work of those already mentioned had been.	PC

ERC.6.20.21	**Finance and Performance Dashboard** MM asked SES for a summary of Performance. SES described the principles underpinning the planned restart of services with regard to patient safety, staff safety and use of limited resources. Ahead of the longer term sustainable model for care delivery being implemented, a methodical process for testing and checking services will be used including the key tests of: • Is the service a priority? • Is restarting feasible? • In terms of staffing, PPE and safe environment, can the Trust safely restart? • What impact will it have on performance? A twice weekly process to clinically review category 1 and category 2 patients awaiting surgery has been taking place to ensure that, although waiting times are increasing, the patients who most urgently need surgery or treatment get it first. SES assured the Committee that robust planning to restart safely is taking place, patient priority and patient safety is foremost in all decisions and that a sustainable recovery is at the heart of the restart strategy. The Access to Health program is being started in partnership with the PCN leads to plan sustainable referral models for patients requiring outpatient assessments. SES noted a real appetite to work differently across the system There is an increased risk of harm for patients waiting for cancer treatments but not as high as initially thought due to treating patients in order of disease progression. The levels of risk identified in the strategic risk register are correct. In the coming weeks another risk around the impact of reduced capacity will be added to the Risk Register. MM asked MH for a summary of Finance. MH outlined the Trust's current financial position noting that the Month 1 report had gone to Board in May. The Trust is currently working within a breakeven framework until the end of July and was breakeven in May. Year to date, COVID related expenditure was £3.7m and the Trust is seeking to recover this cost. The Cash position is ahead of plan because of the pump-primed system allowing cash to flow more easily during the COVID response. The National Team are developing the planning guidance for the remainder of the year which is due early July. It is anticipated the Block arrangement (albeit amended) will continue for the remainder of the year. This will take into account a better understanding of the Trust's underlying run rates as the retrospective payment process is abandoned for an upfront payment process.	

	The three strategic risks around the financial position and the cash and liquidity position have been closed for 2019/20 and reinstated for 2020/21 with values that are aligned to the residual values given in the current financial framework. If this position changes and risks do start to materialise in the financial position, the ratings will be amended accordingly. The current risk being carried for the first four months of the year is, from a financial perspective, very low. JL suggested a future discussion be had at a Board development session as to how more detailed discussions on performance can take place, particularly around recovery trajectories as the opportunities for those discussions have been rightly paused. The Committee noted the reports and was assured by them.	
ERC.6.20.22	**Strategic risks - Finance and Performance Committee** This item was dealt with within ERC.6.20.22.	
ERC.6.20.23	**Partnerships Dashboard** JH advised that there hasn't been a formal Partnership meeting since January but assurance has taken place through reports to the Board and to the Regulation Committee, the CEO's and his own. JH outlined the four key points for attention: Stakeholder engagement will change as the post-COVID environment changes. It is likely that there may be a smaller number of key stakeholders identified and the maturity of those relationships reviewed and tracked more closely Vertical Integration has been discussed throughout this meeting which is in itself a good indicator of the Trust's approach to Partnership. MP has spoken of the work with the Health and Care Partnership. Bradford and Airedale Health and Care Partnerships are working together. Of the seven transformation programs that are underway across the patch, SES is leading on Access, KD is leading on Respiratory medicine, and JH is leading on Diabetes treatment. Coming out of COVID, partnerships will be fundamental to the way of working. The Trust is positioned well with good governance and able to support and influence. The Trust has been using its scale and professional leadership to help PCNs with first contact Physiotherapists which in turn helps the Trust's recruitment, retention and capacity. Horizontal Integration across the ICS and WYAAT continues but the Acute Collaboration Programme is likely to look different post-COVID positioned in support of the transformation programs. Partnership risks are very stable. There are five risks currently on the Strategic Risk Register. Some may require a refresh, e.g. now that the NHSE consultation on the West Yorkshire Vascular Service program is complete.	

	The Committee was given the opportunity to raise any concerns The report was noted and the Committee was assured.	
ERC.6.20.25	Board Assurance Framework (Q1 draft) and Strategic Risk Register Movement Log The Committee reminded themselves of the content of the Board Assurance Framework and reflected on whether they felt it was a true reflection of the position of the Trust. TC expressed the difficulty in applying a framework suitable for a world before COVID to the one now as so much has changed. The Trust's mechanisms for assurance have changed and this committee has been a way of bringing concerns back. The BAF is a fair reflection of where Executive Directors see the Trust. The Committee noted and approved the BAF to be submitted to the Board of Directors with an update	
ERC.4.20.14	**Any other business** No other items of business were	
ERC.4.20.15	**Matters to escalate to the Board of Directors** There were no matters to escalate.	
ERC.4.20.16	**Matters to escalate to the Strategic Risk Register**	
ERC.4.20.17	**Items for corporate communication** There were no items discussed.	
ERC.4.20.18	**Agenda items for meeting scheduled on x** There were no additional items arising from this meeting.	
ERC.4.20.19	**Date and time of next meeting** To be confirmed	

Bradford Teaching Hospitals
NHS Foundation Trust

ACTIONS FROM EXECUTIVE & NON EXECUTIVE REGULATION COMMITTEE - 18 June 2020

Date of Meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
18/6/20	**ERC.6.20.10**	**Serious Incident Report – March to June 2020** TFG asked if the presentation of SI reports could be improved such that key findings were visible earlier in the report.	Director of Governance and Corporate Affairs	July 2020	
18/6/20	**ERC.6.20.12**	**Organisation-wide procedural documents – Q4** JL asked for a date by when the policies passed their review date will have been reviewed	Director of Governance and Corporate Affairs	July 2020	
18/6/20	**ERC.6.20.14**	**Implementation of ReSPECT** KD agreed to bring the implementation plan and the communications plan to the Quality Committee at the end of July.	Chief Nurse	July 2020	
18/6/20	**ERC.6.20.20**	**Staff Well-being and resilience** PC agreed to produce a written report on the outcomes and actions the Trust is taking to tackle the issues arising from the BAME risk assessments.	Director of HR	July 2020	PC, 30/06; To be covered in the Equality report to Board on 09/07