| Group Integrated Governance and Risk Committee<br>Minutes | | | |
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| **Meeting date** | **Tuesday 26 April 2022** | **Meeting Time** | **14:00pm** |
| **Chair** | [redacted] **Acting Director of Clinical Governance and Patient Safety Specialist** | **Venue** | **Teams** |

| **Attendees** | |
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| **Name** | **Job Title** |
| [redacted] | Associate Direct of Clinical Governance and Patient Safety<br>AMD for Quality and Safety (RMCH MCS)<br>Interim Associate Director of Governance (NMGH)<br>Quality and Safety Lead (CSS)<br>Clinical Effectiveness Sister (MREH/UDHM)<br>Business Manager for Patient Safety and Risk (Minutes)<br>Group Head of Patient Safety<br>Assistant Chief Nurse for Patient Safety and Clinical Governance<br>Clinical Governance Manager<br>Associate Director of Quality Governance and Patient Safety Specialist (MLCO)<br>Assistance Director Quality Governance, Risk and Patient Safety (WTWA)<br>Acting Group Head of Compliance – Estates and Facilities<br>Clinical Effectiveness Matron (MREH/UDHM)<br>Clinical Governance Manager (MRI)<br>Medical Governance Lead (SM MCS)<br>Informatics Head of Governance<br>Deputy Chief Nurse – Patient Services<br>Director of Operations & Transformation<br>Acting Head of Legal Services (NMGH)<br>Assistant Human Resources Business Partner<br>Group Chief Nursing Informatics Officer<br>Group Estates and Facilities Assurance Manager<br>Group Head of Health and Safety |

| **1. Sub-Committee Opening Business** | |
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| **1.1** | **Welcome and purpose of the meeting** |
| | The Chair welcomed and thanked members for attending the Group Integrated Governance and Risk Committee and described the purpose of the meeting for the benefit of new members in attendance. The Committee supports the work of the Group Risk Oversight Committee by providing assurance in relation to the overall arrangements for governance, risk management and internal controls across the Trust. |
| **1.2** | **Apologies for Absence** |
| | [redacted] Group Head of Legal<br>[redacted] Clinical Effectiveness Manager (SMH)<br>[redacted] Group Associate Medical Director – Quality and Safety<br>[redacted] Quality and Safety Lead (CSS)<br>[redacted] Head of Business Office Informatics<br>[redacted] Assistant Director of Quality Governance and Patient Experience (RMCH/MCS) |
| **1.3** | **Declarations of interest** |
| | Following consideration of the agenda items there were no declarations of interest made. |
| **1.4** | **Minutes of last meeting** |
| | The minutes from the meeting held on 22/02/2022 were reviewed and approved by the Committee as an accurate record of the meeting and will be shared at GROC on 16/05/2022. |
| **1.5** | **Action log** |
| | The Committee reviewed the Action Log and noted the following updates:<br>**39 – Sites to review the approach to proactively assess the risk within services where there is a lack of substantive leadership** – Actioned through Oversight Panel. Action closed. |

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| | **44 – Update on Engaging Service users and patient representation at this Committee through the Patient and Public Involvement Sub-Group** – The Trust Policy, Process and Model for this has now been presented and approved at Group Quality and Safety Committee and that the deadline for implementation has in fact been extended to September 2022. Action Closed.<br><br>**50 – Review the Risk Management Framework and strategy and provide feedback** – The Committee were informed that this had been taken to GROC in March 2022 and had been approved. Action Closed.<br><br>**52 – Liaise with [redacted] regarding the decontamination risk emerging at UDHM** – It was reported to the Committee that [redacted] had been contacted and that this issue was now being managed through the Decontamination Team. Action Closed<br><br>**54 and 55 – Sites/MCS/LCO to review and escalate the Mental Health risks to establish the full extent of the limited mental health pathway and bed capacity and report this to the Group Mental health Safeguarding Sub-Committee** – There were several risks identified around patients attending ED who required onward referral which has now been escalated to the Group Mental Health Safeguarding sub-committee. However, there has not been an update on the outcome which is to be followed up. |
| | **Action:** Follow up the escalation of the limited Mental Health Pathway and bed capacity issues with the Group Mental Health Safeguarding Sub-Committee. |
| | **56 – Review Risks for [redacted] MCS associated with IT, Patient Records Migration and Cross-provider pathways to ensure that they are aligned across each site and any gaps in assurance are identified and mitigated as appropriate** – This risk was in relation to HIVE and staff being able to access data held within the system across site. A meeting has taken place to discuss this, and this is now being managed through the Transformation Team. Further assurance that this is being addressed and managed will be sought by obtaining the Risk Number from the HIVE Risk Register. |
| | **Action:** Confirm HIVE Risk Register number for the risks associated with [redacted] MCS in relation to IT, Patient Records Migration and Cross-Provider Pathways. |
| | **57 – Review the risks which are owned by each area which may impact other sites and ensure that these are linked and that there is no duplication** – [redacted] confirmed that this was being tracked and managed through Ulysses and work was ongoing to see how this information could be clearly presented and built into the Risk Management Strategy. Action ongoing.<br><br>**58 – WTWA ED Task and Finish Group to link in with NMGH and MRI to establish whether observation levels and absconding is an emerging risk and escalate this to the Mental Health Sub-Group** – An email update was provided on request from [redacted] who reported that whilst it had been the intention to establish an ED Task and finish Group it had now *"become a " Patient Safety and Quality Improvement monthly meeting between Emergency Care Village at WTWA and Mental Health Safeguarding and Mental Health Liaison teams to discuss issues in ED/AMU when looking after vulnerable patients" which will include absconders, but will also consider wider issues".* To date, there have been no escalations.<br><br>**60 – Discuss with DONs to see how information of Mixed Sex Accommodation Breaches can be escalated to Governance Leads for review and monitoring** – DONs currently receive notification of breaches, but it seems there is no formal process for this to be communicated to the Governance Leads. [redacted] will review this with the DONs to ensure that a process is firmly in place for Governance Leads to be notified of this as SCV data would suggest that this is not being reviewed and managed effectively. |
| **1.6** | **Matters arising from the Group Risk Oversight Committee** |
| | The Committee were informed that the Trust Risk Management Risk Strategy had been approved and will be presented to the Board of Directors in May 2022. Some of the processes within Ulysses need to be reviewed and updated to support the strategy. An additional module has been installed and a demonstration of this was provided by Ulysses with a further session to take place on 06/05/2022. The *Risk Appetite Statement* provided within the strategy is to be approved by the Trust Board of Directors when presented to them in May with a requirement for this to be reviewed and updated annually. |
| **1.7** | **Matters arising from Group Patient Safety Committee** |
| | There were no matters arising from PSC for escalation to this Committee |
| **1.8** | **Matters Arising from Clinical Effectiveness Committee** |
| | There were no matters arising from CEC for escalation to this Committee |

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| **1.9** | **Matters arising from other Sub-Committees/Groups not on the agenda** |
| | The Committee were informed of a paper which was presented to the Medical Devices Committee relating to high-risk consumables, including alarms. The Committee noted that the Medical Devices Committee will be responsible for the management and oversight of the devices highlighted in the paper.<br><br>The Committee were informed of some concerns which had been raised up through the Medicines Safety Committee with regards to the role of the Independent/Second Checker. There is still some misunderstanding in terms of the role definition which will be reviewed, and actions agreed at the Committee in June 2022. |
| **2. Integrated Risk: Oversight** | |
| **2.1** | **Risk Register Overview** |
| | The Committee received the Group Risk Profile designed to support discussions in relation to agenda items 2.1, 2.2 and 2.3. The Committee noted that it:<br><br>• Provided a summary of the risks being managed corporately: the *'Strategic Overview Risk Register'* (which included 24 risks)<br>• By exception identifies corporate risks with changes in risk score<br>• By exception provides details of corporate risks where target dates for mitigation had been exceeded<br>• Provides an overview of the risks being managed by each hospital/MCS/LCO: the *'local risks'*<br>• By exception provides details of local risks newly escalated to scoring 12 or above, and risks scored at 15 or above<br>• By exception provides details of local risks where the target date for mitigation has been exceeded<br>• Provides an overview of our proactive approach to assurance across the Trust relating to patient safety risks, themes, and trends |
| **2.2** | **Movement log (Corporate)** |
| | The Committee reviewed the Corporate Risk Register movement log, identifying 24 risks which are being actively mitigated to ensure that they do not threaten the Trust's ability to deliver its strategic objectives.<br><br>There are currently three risks which are scored at 20 meaning the potential negative outcomes of these risks are likely to occur. These risks are as follows:<br><br>• **MFT/004513** - Under delivery of activity/capacity which impacts the Trust's ability to meet national operational standards for urgent and elective care including cancer and diagnostics due to longstanding issues, demand pressures, capacity, workforce/estate constraints and the pandemic<br>• **MFT/004755** – Medicine Storage and Security<br>• **MFT/005182** – Understanding human-system interactions. If not achieved and utilised effectively to optimise care delivery, Never Events will continue to occur leading to potential serious physical or psychological harm for the patient, the teams caring for the patient and the public/Trust relationship.<br><br>All three risks are subject to significant controls and additional mitigation and are being monitored and managed appropriately.<br><br>The Committee noted that six risks had exceeded their deadline for mitigation of actions to be completed but had not reached their residual/target risk level. These risks are recorded below:<br><br>• **MFT/004513** – Under delivery of activity/capacity. This is having an impact on the Trust's ability to achieve the national standards for urgent and elective care, including cancer diagnostics and is caused by the longstanding issues; demand pressures, capacity, workforce, and estates restrictions and the ongoing COVID pandemic<br>• **MFT/005198** – NMGH Critical Building and Engineering Infrastructure. Failure to meet regulatory standards could have an impact on the health and safety of patients, carers, the public and staff<br>• **MFT/002842** – Effective Decontamination of Reusable Invasive Equipment/Devices across the Trust and NMGH. Failure to effectively decontaminate such equipment poses a risk to patient safety, regulatory compliance, performance, and the organisations reputation<br>• **MFT/000241** – Paediatric Dentistry Capacity. Failure to increase capacity in this area will mean longer waits treatment which will lead to poor or worsening dental health and pain |

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| | • **MFT/002263** – This relates to Cardiac Surgery performance and the risk this poses to patient with very limited access for P2<br>• **MFT/005092** – This risk relates to the financial regime for the final 6 months of the financial period 2020/2021 which has been extended to the first 6 months of 2021/2022. PbR contract arrangements remain suspended and have been superseded by a combination of a fixed block payments supplemented by a top up payment<br><br>There were no corporate risks where the likelihood of potential harm had increased despite the mitigation which was in place recorded in the risk profile received.<br><br>Three new risks had been escalated for consideration in relation to their impact on the Trust's strategic objectives where mitigation has reduced the likelihood of the potential outcome occurring:<br><br>• **MFT/05636** – HIVE Integration and Complex Care Pathways at NMGH<br>• **MFT/005637** – HIVE integration and Delay in Finalising Scope of LCO Services<br>• **MFT/005443** – LCO District Nursing Levels and their Ability to Deliver a Safe, Quality Care and Service<br><br>Of the Corporate Risks there were two risks where mitigation had reduced the likelihood of the potential outcome occurring:<br><br>• **MFT/004292** – Effective Prevention and control measures are not in place then COVID-19 acquisition will occur in staff and patients<br>• **MFT/005656** – Impact of Mandatory COVID Vaccination Programme for Staff |
| **2.3** | **Movement log (Local)** |
| | The committee reviewed the Site/MCS risk profiles and received the following updates:<br><br>**NMGH** – The Committee noted the significant number of risks which were equal to or greater than 15, 20 in total, seven of which are linked to risks on the Corporate Risk Register. One of the linked risks relating to Hospital Onset Covid Infections, **Corporate Risk Register No. MFT/004292**, has been reduced which mean NMGHs linked risk, **MFT/004747**, can be reduced and removed from the high-level risks currently recorded.<br><br>[redacted] highlighted concerns in relation to the following risks and the Committee noted the actions being taken to mitigate these risks:<br><br>• **MFT/005198 –** Critical Estate and Engineering Infrastructure linked to **MFT/00005406**<br>• **MFT/005254 –** Asbestos Containing Materials are not Adequately Managed in Accordance with the Control of Asbestos Regulations linked to **MFT/004430**<br>• **MFT/005816 –** NMGH Electrical Infrastructure: loss of electrical supply impact Clinical Services and business continuity<br><br>There were no risks for escalation to GROC, but the Committee were informed that NMGH were currently being supported with ongoing mitigations for:<br><br>• **MFT/00489** – Performance Against Breast 2WW<br>• **MFT/004864** – Medical and Clinical Nurse Specialist workforce for Urology, currently provided by NCA<br><br>NMGH continue to review its Risk Register to ensure that it is reflective of its current position and that risks are accurately scored and have the necessary risk structure in place to manage and escalate risks as required.<br><br>**UDHM** – There were no risks to report which had increased to 12 since the previous meeting in February 2022. Three risks, **MFT/000241, MFT/004756 and MFT/005397,** have been closed and merged to form **MFT/005850**, which relates to the lack of capacity for orthodontics, comprehensive care and paediatric GA Care. This has a score of 15 and is linked to **MFT/004478** recorded on the MRI risk register and will be escalated to GROC. The Clinical Effectiveness Team are currently assessing the emerging risks which primarily relate to HIVE and will be add these to the Risk Register over the coming week.<br><br>**MREH** – There were no risks on the Risk Register for MREH which were equal to or greater than 15 and no risks were reported to have increased to 12 since February 2022. However, there were several emerging risks which have the potential to significantly impact the Trust's ability to achieve its strategic objectives. These risks are listed as follows and are being appropriately monitored and managed at site level: |

- **MFT/005855** – Limited funding in the budget for B2 Support Worker positions
- **MFT/000205** – Retinal Lasers, currently scored at 4, but will shortly be increased to 12 due to lack capacity within the Laser Service
- **MFT/005764** – Macular Treatment Centre – The Injection Room Chairs used are now obsolete and the Anaesthetic Machines and Spacelabs used in MREH theatres will soon follow. Unfortunately, MEAM will shortly be withdrawing their support to provide repairs on this equipment which will impact the service provided to patients.

There is a need to increase the capacity and efficiency of the Macular Treatment Centre where current patient clinic waiting times are 4 hours or more, which is exacerbated by not having the necessary equipment to carry out certain tests. Patients are having to go to different areas where equipment is available which is impacting patient and staff flow as well as patient experience. Additional funding needs to be sourced to procure the additional equipment needed to help increase service capacity and efficiency.

It was noted that an OPTOS machine had been purchased for Withington hospital, but there were currently issues with the IT infrastructure which prevent the machine being added to the network. Work is ongoing to resolve this.

There are approximately 120 patients who are currently awaiting laser eye treatment whose treatment has been delayed due to the issues with Retinal Laser machines. Patients are currently being reviewed to ensure that they have not come to any harm. Additional capacity is being provided at weekends to reduce delays.

It was reported that in addition to these issues there was also a risk in relation to Glaucoma Surgery where increasing delays were being caused by limited anaesthetic cover. This risk is linked to CSS who will be provided with the details.

**MLCO** – Reported one risk equal to or greater than 15. This relates to **MFT/05443 - District Nurse staffing levels** which was taken to GROC in March 2022. This is still being actively monitored and will hopefully be reduced over the coming weeks as vacancies have been filled and staff will be commencing in these roles.

One risk has been increased to 12, **MFT/05663 – Children's Community Nursing Teams.** Teams across Manchester and Trafford have been under significant pressure to provide services. The Virtual Ward, which is substantially underfunded has had a huge impact on the services which CCNT normally provide. This risk continues to be regularly reviewed and managed through the MCS Risk structure.

The MLCO reported several emerging risks:

- **MFT/001607** – Increased risk in relation to District Nursing Central Locality. There is an increased demand which has led to a mismatch in capacity. A risk assessment is currently being completed and actions to mitigate this are under review
- **MFT/001469 and MFT/001487** – Estate availability for delivery of clinical services and provision of staff bases. This has been hampered by the need to provide Vaccination Clinic space and facilitation of staff moved from acute sites. These risks are both being reviewed by Operational Estates Group and where necessary will be escalated to Group Estates
- **MFT/001429** – Potential delays with Capital works due to the renewal of the lease by both MFT and GP. This is currently being reviewed and appropriately managed.

**MRI** – Since the Committee meeting in February 2022 the Associate Director of Strategic Planning has reviewed the Risk Register for the MRI to ensure that risks were mapped to the appropriate Hospital Committees. Plans are in place to go through these risks with the Committee Chair so that CSUs can review their risks and assess whether the scores and mitigations in place are still appropriate. Where necessary risks will be assessed to determine whether they need to be merged to a compound risk.

Having received and reviewed the report from the MRI the Committee noted there were six risk which were equal to or greater than 15. **MFT/000148** relating to inadequate cleaning has been increased to 16 due to outbreaks of MRSA and is linked to **MFT/000152,** relating to hospital acquired infections, including COVID.

The report also highlighted that there was a significant risk that if patient numbers continued to outstrip bed capacity, then the provision of safe care to patients will be compromised. **MFT/004475** relates to this risk and

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| | the MRI are in the process of screening all 12-hour breaches to ensure that the actions which are in place are appropriate to mitigate the risk and where necessary this will be further escalated.<br><br>The risk relating to the Project Red Capital scheme and associated service change recorded under **MFT/005206** was also being reviewed. There are concerns that should these not be delivered within the appropriate parameters this could have an impact on patient and staff safety, patient experience, clinical care, operational and financial performance and impinge the Trust's overall strategies and reputation.<br><br>There were two risks on the MRI Risk Register which needed to be raised with CSS to link them to their Risk Register. These are in relation to **MFT/005634 – Thoracic Radiology Provision** and **MFT/005777 – Provision of CT-Guided Biopsy Service**. Both have the potential to cause delays in the provision of cancer treatment pathways and are under review to see how these can be effectively managed and scores reduced.<br><br>The emerging risks for the MRI all relate to the implementation of HIVE. **MFT/004715** is the overarching Informatics risk which combines the two MRI HIVE risks recorded in their Risk Register, **MFT/005835 – HIVE Operational Readiness** and **MFT/005836 – Transformation of MRI Services resulting from HIVE**. Both risks are being managed accordingly through the risk structures which are in place.<br><br>**RMCH** – There were no risks recorded as being equal to or greater than 15 and there were no risks which had been increased to 12 during the reporting period. There were also no risks to be escalated to GROC. An achieving value risk had been developed which had initially been scored at 15 but had been reduced to 12.<br><br>RMCH reported that there were five emerging risks all scoring 12 which have been added to the register:<br><br>• **Theatre Lighting** – Lighting in Paediatric Theatres is reaching the end of its shelf-life and will need to be replaced. This has both cost and service provision implications<br>• **Theatre Equipment** – The lead time for the delivery of essential theatre equipment and issues with the new DSD service are likely to pose significant risks to the Trust in terms of service provision<br>• **VTE** – Compliance with risk assessments and lack of data available for patients under 18 increases the risk of these patients developing VTE<br>• **Complex Child Risk** – This risk relates to the complexities of caring for patients with multiple health needs both acutely and electively<br>• **Data Quality** – This risk has been developed and added to the Risk Register and relates to the transfer of patient level data to HIVE ensuring that no patients are lost in the process.<br><br>**St Mary's** – There were still risks scored 15 or greater on the register relating to the assessment and treatment pathways for patients referred to the Gynaecology Division, **MFT/002234, MFT/002530** and **MFT/004654**. These risks have been further impacted by the recruitment of staff recorded under risk **MFT/004452**.<br><br>Within the reporting period St Mary's reported two risks where the risk scores had been increased to 12 which are both being proactively managed through the Risk structure which is in place. Since the successful recruitment of two Band 6 Data Analysts the risk in relation to Informatics infrastructure and Business Intelligence, **MFT/002650**, initially scoring 16, has now reduced to 12. There were no risks which needed escalating to GROC.<br><br>There is a significant risk emerging in relation to the replacement of aging equipment and the lack of capital funding for this over the next 12 months. This risk is currently being assessed and will be presented at the Risk Management Committee on 09/05/2022 for review.<br><br>**WTWA** – There were three risks scoring 15 and above. These risks had initially been recorded as one risk under **MFT/002212**, but have been separated into the risks below:<br><br>• **MFT/001292 -** ED four-hour access, linked to **MFT/005092**<br>• **MFT/005559 -** Cardiac waiting lists/performance<br>• **MFT/004453** - Lack of safe and adequately ventilated space to provide lung function services, linked to **MFT/004513**<br><br>As some of the identified risks rely on input from CSS it will be important for WTWA to link in with them to ensure that their high-level risks are linked on their risk register. |

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| | WTWA recorded two risks whose scores had been increased to 12. One relates to Telemetry equipment, **MFT/002230** and the other relates to the accessibility of Clinical Data and the integration of HIVE, **MFT/005547**.<br><br>There were no risks to escalate to GROC.<br><br>Four emerging risks scoring 12 were awaiting review by the Hospital Board. These relate to the length of stay, greater than 12 hours, and the impact on patient experience for patients attending ED; intrahospital transfer to the Ortho-Plastics Service and limited capacity impacting on the timely management of patients; CATS system and limited capacity to accompany urgent referrals; and the implementation of HIVE and the impact on patient safety and services, including the non-integration of Allscripts EPR. These risks once reviewed by the Hospital Board will be assessed and the actions to mitigate them updated as required.<br><br>From the report the Committee noted that 19 risks were due for review or had exceeded their review dates, these have been escalated to the relevant Clinical Teams. The timely review of risks had been further impacted by annual leave over the Easter Bank Holiday, ownership of risks and the ongoing pandemic. Oversight of overdue risk is continually monitored by the Risk Committee monthly and supported by the Governance Team as required.<br><br>**Estates and Facilities** – The Committee reviewed the risks which were presented in the Groupwide Estates and Facilities report to see where these linked in with the risks identified within divisions. It was reported that there were currently 300 risks on the register which are being reviewed and linked as required.<br><br>**CSS** – The report provided by CSS detailed 10 risks which scored 15 or above. A number of these risks relate to diagnostics which link to the cancer risks. **MFT/001253 – Adult Histopathology**, has been increased to 20 and is currently under review by DLM and **MFT/004672 – RMCH MR Scanner** has been increased to 16 as the machine is breaking down daily. Both risks will be escalated to GROC on 26/04/2022.<br><br>CSS informed the Committee that all high-level risks were being escalated and managed appropriately through their current risk structure and governance framework.<br><br>The Chair wished to draw the Committees attention to the separate report which was provided listing the Cancer risks. Due to the large number of risks identified, it will be important to ensure that these are integrated across the Trust.<br><br>The Chair also noted the large number of high-level risks highlighted within the NMGH profile which were equal to or greater than 15 and wished to know whether there was any significant reason for this, i.e., a difference in scoring method or perhaps a need for training. The high number of risks may be because of the transition but will be explored further with support from Group Governance to see if it is possible to reduce some of these scores. |
| | **Action:** Group Governance to liaise with NMGH to understand the high number of high-level risk recorded on the risk register to determine if there is a requirement for additional support or training. |
| **2.4** | **New and emergent risks (Trust wide)** |
| **2.4c** | **Inequalities in Patient Safety** |
| | The Committee received a paper for information on healthcare inequalities in patient safety. This is an area of risk that we are aware of but which we do not fully understand. A better understanding of this risk will enable the Trust to establish appropriate actions to mitigate the risk.<br><br>At present there are measures in place to govern health inequalities which is aligned to Schedule 2N of the NHS Standard Contract and there is a Trust wide approach to equality impact assessment, quality assurance and registration including recovery of services and service changes, but the Committee were asked whether these measures alone were enough to manage this risk.<br><br>Members of the Committee agreed that it would be useful to review this risk collectively and suggested a small group be established to work on raising awareness of inequalities in healthcare and promote the importance of Equality Impact Assessments. |
| | **Action:** Establish a group to work on raising awareness of healthcare inequalities and the importance of completing Equality Impact Assessments. |

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| | [redacted], Director of Operations & Transformation, who joined the meeting today informed the Committee that she had attended a meeting this morning where health inequalities were discussed, and a Health Inequality Dashboard was provided to guide discussions. This might be something for the Trust to consider and could assist with moving things forward in relation to this risk. The Committee agreed it would be useful to have sight of any Inequality Dashboard which the Trust has to enable the Committee to review the risks so that these can be escalated as required. |
| | **Action:** Obtain a copy of the Health Inequality Dashboard for the Trust to determine the risks so that these can be escalated as required. |
| **2.4d** | **Staff Allegation Management** |
| | The Committee heard that several incidents in relation to staff allegations had recently been discussed at Group Safety Panel as they had not followed process. This issue has, since, been escalated for the attention of the Safeguarding Team who are now in the process of reviewing the policies and controls which are currently in place to manage allegations. No further action is required by this Committee. |
| **2.4e** | **Results Acknowledgement** |
| | The acknowledgement of results was another area of concern raised at Group Safety Panel which the Chair brought to the Committee for discussion today. From discussions it appeared that sites were not always receiving results or there were difficulties in accessing the information which resulted in failure to acknowledge results on the system. Due to inconsistencies across site for processing and acknowledging results a more robust system needs to be developed and put into place to capture and manage those results which fail to be acknowledged and appropriately communicated.<br><br>RG explained the governance process which was in place at WTWA to manage results acknowledgement. Although there is a process in place at the MRI, [redacted] reported that it was not as comprehensive as the process described by [redacted]. The Chair stressed the importance of results acknowledgement and has requested Governance Leads to ensure that this is effectively reported and managed through their governance infrastructure and will be seeking assurance from sites/MCS/LCO that this has been appropriately addressed. Oversight of this has been delegated to [redacted] who will review the structures and will provide feedback to the Committee in June 2022. |
| | **Action:** Group Governance to work with Governance Leads to review governance structures in place for the management of Results Acknowledgement and for this to be reported back to the Committee for assurance. |
| | It is important for the Trust to act now to identify where the current problems are and how this risk is going to be managed as results will need to be managed appropriately within HIVE once fully integrated. [redacted] is happy for colleagues to contact her directly if they would like further information on the governance process in place at WTWA.<br><br>A separate agenda item for this will be included at the Committee in June 2022 where the incident log will also be provided and reviewed. |
| | **Action:** Incident log in relation to results acknowledgements to be provided to the Committee for review. |
| **2.5** | **New and Emergent Integrated Risks (Site/MCS/LCO)** |
| | The MRI reported their concerns about lack of emergency theatre capacity which is an emerging risk. This is currently having an impact Renal Transplant Services.<br><br>WTWA wished to highlight their concerns around ED and the unknown risks in the waiting room which are being exacerbated by longer than normal waiting times. WTWA will work with the MRI and NMGH to review and determine what additional controls are needed to mitigate this emergent risk. |
| **2.6** | **Risk updates by exception (Group)** |
| **2.6a** | **HIVE** |
| | The Committee received an update on the HIVE Risk profile. There have been four escalations to GROC and as the HIVE Team progress through the log from Ulysses, included in the papers today, there may be more to escalate.<br><br>As we move forward with the implementation of HIVE, it is important to ensure that the necessary governance structure is agreed and in place to manage HIVE post implementation. [redacted] will be working closely with Governance Leads across the Trust and the HIVE Team to discuss this. |

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| | Consideration will also need to be given to the future management of risk and what this will look like in a digital hospital. |
| **2.6b** | **Never Events** |
| | [redacted]<br><br>The Committee were informed of the response from the Non-Executive Director following a presentation provided by St Mary's at a recent Patient Safety Scrutiny and Learning Committee meeting. St Mary's delivered a presentation on the learning outcomes of their never events. The presentation highlighted the importance of a systems approach for Never Events which the NED stated showed a good understanding of human interactions with systems and how things can go wrong.<br><br>The implementation of HIVE should assist in reducing the number of never events occurring as various processes are being written into the system, i.e., LoCIPPs, which will require users to input and confirm information at every stage of a procedure. |
| **2.6c** | **Cancer** |
| | The Committee received a full list of the risks associated with Cancer diagnostics and treatment pathways of which over 60 risks were recorded. The Committee are currently looking at how this information can be best communicated to the Cancer Committee. At present incidents and risk are not discussed at the Committee, but from the number of risks presented today, there is a need for this to be acknowledged and managed appropriately. Moving forward this Committee will ensure that a regular report is provided to the Cancer Committee for review and discussion which will include patient safety information and recommendations.<br><br>As Cancer Pathways rely on provision of services from CSS the Cancer Committee Terms or Reference explicitly states that CSS should have an agenda item to discuss Cancer Pathways and Risk at their Quality and Safety Committee. Failure to comply with this requirement means that there is no direct link for cancer risks to be escalated and managed. CSS are asked to review their governance structure to ensure that there is appropriate provision for the escalation of risks associated with cancer diagnostics and pathways to the Cancer Committee. In the meantime, the Cancer Committee will review the information received by the Committee today, to ensure that the risks identified are being appropriate managed. |
| | **Action:** CSS to review current governance structure to ensure there is sufficient provision for cancer risks to be escalated to the Cancer Committee as described in the Cancer Committees Terms of Reference. |
| **2.7** | **Risk updates by Exception** |
| **2.7a** | **Impact of Staff Psychological Wellbeing on Risk Registers, Site/MCS/LCO** |
| | The policy in relation to staff psychological well-being is now available through the Policy Hub on the MFT Intranet and implementation has been supported by [redacted]. [redacted] has been offered membership to the Human Factors Academy and will be working closely with colleagues who are currently involved with Project 2V to ensure that work is not being duplicated. |
| **2.8** | **External Visits and Accreditation** |
| | The Committee were provided with a report on External Regulatory and Accreditation Visits and were asked to note the contents of the report. Appendix 1 provides information on the regulatory and accreditation visits which took place between 01/02/2022 and 31/03/2022, whilst Appendix 2 provides information on the visits which are expected to take place between 01/04/2022 and 30/06/2022. |
| **3. Integrated Assurance: Oversight** | |
| **3.1a** | **Regulatory Compliance: Proactive assurance** |
| | The Committee received an update in relation to the risks from the safety oversight system. The profile captures the emergent and existing risks and allows the Trust to see where they sit within the framework and determine the levels of assurance that are required to achieve compliance with the regulations. The themes and trends provided within the profile follow the same process and allows the Committee to identify areas where additional assurance is required. This part of the profile is regularly reviewed an updated to keep abreast of new and emerging themes, trends and risks.<br><br>The Compliance Team continually monitor progress against the regulations to ensure that the correct level of assurance is achieved and maintained. Any risk highlighted in pink within the profile indicates that plans are |

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| | being developed, but that there are still gaps preventing full assurance. Those which are highlighted in green indicate that plans are in place to achieve the levels of assurance required and that once fully implemented assurance will be agreed. |
| **3.1b** | **Regulatory Compliance: External Queries** |
| | The Committee received a paper on External Enquiries for the period 01/04/2021 – 31/01/2022. The Committee were asked to note the information and the recommendations from the paper, which requires Sites/MCS/MLCO to note the themes at their Quality and Safety Committees and to record any decision on any action in response within their Quality and Safety Committee minutes.<br><br>Regulatory compliance is a continual assessment process which the Trust is now beginning to feel given the number of enquires which were received during the reporting period. For the Trust to change its CQC rating they will need to ensure that they provide detailed and quality returns. It is therefore essential that we capture and record all assurance and compliance along with the quality of practice so that this can be provide as evidence to support our responses. |
| **3.2** | **Internal Control: Policies and Guidance** |
| | The Committee were provided with an update of the Trust's current position in relation to policies. The new Policy Hub is now up and running, providing the Trust with a single repository for all policies and guidance. The Committee were assured that the actions which were outstanding from the previous meeting in February 2022 were on track with regular touch point meetings were being held with individual site leads.<br><br>The Policy Task and Finish Group met on 19/04/2022 and discussed the issues which users had encountered following the launch of the Policy Hub on 01/04/2022. Overall, the feedback from this meeting was positive. There are a few minor issues which have been raised which are being addressed internally with support from the external provider.<br><br>The Policy Task and Finish Group are now focussing on the Document Control Policy which is to be reviewed and re-written to ensure that it is aligned to the new system. The new policy will provide guidance on how policies should be written, the naming conventions and formats which should be used and how they should be categorised. GRH will be leading a small group to review and re-write the policy. Any members wishing to have an input with this can contact [redacted] direct.<br><br>A paper updating the Committee of the proposed changes to the Document Control Policy and progress towards the final draft has been requested to be shared with the Committee in June 2022. |
| | **Action:** Paper to be provided detailing the proposed changes to the Document Control Policy and progress toward the final draft. |
| **3.3** | **Policy: Management of Digital Clinical Photography and Video Recording** |
| | The Committee received the Management of Digital Clinical Photography and Video Recording Policy for ratification of the minor changes made to Appendix E and wording in Section 3.5. Due to several outstanding discussions between Medical Illustration and [redacted] in relation to the provision and access of cameras for use within the community, and no reference to NMGH within the policy the Committee were unable to ratify the policy. The Committee have requested that the Community are reference within the policy and that NMGH is consulted to ensure that the policy is aligned to their practices and that they too are referenced in the policy. |
| | **Action:** Further review of the Management of Digital Clinical Photography and Video Recording Policy required to ensure the Community and NMGH are referenced. |
| **3.4** | **Consent to Examination and Treatment** |
| | The Committee were expecting a draft copy of the Consent to Examination and Treatment Policy but were asked for a further extension. The policy has recently come up for review and there is currently some work in relation to consent which is being completed in collaboration with NMGH. It was reported that there were no legal changes to be made to the policy, but that it was important to ensure that the policy was aligned with NMGH. The Committee agreed to a further extension and request the draft policy to be available for review in June 2022. |
| **3.5** | **Internal Audit (by exception)** |
| | The Committee received a copy of the Internal Risk Management Audit Report, completed to assess the effectiveness of the risk management processes which are in place at Hospital/MCS/LCO level and Group Level. Following the audit, the Trust have been given an assurance rating of *"significant assurance with minor* |

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| | *improvement opportunities".* The actions set out in the report have all been agreed on the Committees behalf and have been provided to the Committee for information. |
| **3.6** | **Assurance Framework and map (routine reports) (From February 2022)** |
| | The Committee were provided with a paper providing a detailed response to the changes the CQC have made to the way in which they will be regulating providers from February 2022. Rather than following a multi-assessment framework a single assessment framework will be followed. This framework has been designed to provide more flexibility, moving away from scheduled inspections, and allowing the management of risk and uncertainty in a more proportionate and sophisticated way.<br><br>To support these changes a new module has been installed on Ulysses designed to manage risk and map assurance and compliance. We will be completing a pilot at NMGH to assess the effectiveness of this new technology and [redacted] is currently testing out a map for Safeguarding.<br><br>Full details of the Trust's approach are provided within the paper. Committee members have been advised to review the paper to familiarise themselves with the new process. |
| **3.7** | **Board Assurance Framework** |
| | The Committee were informed that the Board of Assurance Framework was currently under review and will include new strategic objectives. We will need to ensure that the assurance framework and map along with Risk Registers are aligned with the Board Assurance Framework. Further information on this will be provided to the Committee in June 2022.<br><br>For assurance that the Trust are compliant with CQC domain *"Well-Led"* a check and challenge session will be arranged with support from the external auditors. |
| **3.8** | **Annual Governance Statement** |
| | A draft copy of the Annual Governance Statement was provided for information. This provides details of the structures which are in place to maintain a robust system of internal control that supports the achievement of the Trust's policies, aims and objectives whilst safeguarding public funds and departmental assets. |
| **4.** | **Reporting committees: routine reports and escalations** |
| **4.1** | **Patient Safety Committee** |
| | There were no risks, not already covered on the agenda, escalated for consideration at the meeting. |
| **4.2** | **Clinical Effectiveness Committee** |
| | Risks in relation to cancer diagnostics and pathways of care discussed in agenda item 2.6c will be escalated |
| **5.** | **Committee closing business** |
| **5.1** | **Any other business** |
| | GROC wish to develop a Risk Management Handbook to support the Trust's Risk Management Strategy. The Chair has requested a small group be established to manage this and review the risk management training. |
| | **Action:** Establish Risk Strategy Management Group to develop a Risk Management Handbook and review training. |
| **5.2** | **Matters to escalate to the Group Risk Oversight Committee** |
| | With the integration of risks, it is the intention of this Committee to start building a profile for these which will be shared with GROC. |
| **5.3** | **Matters to escalate to other Committees** |
| | Matters will be raised as required. |
| **5.4** | **Items for Corporate Communication** |
| | Nothing to raise |