# The Governance Project group

- **Morecambe Bay Investigation Report Committee**
- **Kirkup Recommendation Implementation Group (KRIG)**

## Project Groups

<table>
<thead>
<tr>
<th>Education, Learning and Development</th>
<th>Clinical Quality</th>
<th>Workforce</th>
<th>Governance</th>
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<tbody>
<tr>
<td><strong>Project Sponsor</strong>: David Wilkinson</td>
<td><strong>Project Sponsor</strong>: Sue Smith</td>
<td><strong>Project Sponsor</strong>: Foluke Ajayi</td>
<td><strong>Project Sponsor</strong>: Mary Aubrey</td>
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<td><strong>Project lead</strong>: Kathy Duffy</td>
<td><strong>Project lead</strong>: Sascha Wells</td>
<td><strong>Project lead</strong>: John Bannister</td>
<td><strong>Project Lead</strong>: Val Wilson</td>
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- **Governance**
  - **Project Sponsor**: Mary Aubrey
  - **Project Lead**: Val Wilson
  
  - 9.1: Cross Bay Policy/guidelines
  - 11/12: Incidents management and investigation
  - 13: Complaints process
  - 15: Review of governance

- **Strategic Partnership (10)**
  - **Project Sponsor**: Jackie Daniel
  - **Project lead**: TBA

- **Communication and Engagement**
  - **Project Sponsor**: Phil Woodford
  - **Project lead**: Louise Jones

- **Estate**
  - **Project Sponsor**: Aaron Cummins
  - **Project lead**: Tristram Reynolds

- **Estate**
  - Review and implementation of estates plan (17)
The Governance Project group
Communication plan

**PLANNING PHASE**
- Meetings held with the Heads of the governance departments and supported to identify proposed responses and detailed actions
- Divisional Governance Leads to be invited to share proposals through the divisions
- User group to be identified

**IMPLEMENTATION PHASE**
- **Kirkup Project Meetings**
  - Kirkup sub-committee – monthly presentation/formal paper as requested
  - Kirkup Implementation Group – fortnightly update on project progress
  - Kirkup Project Leads Group – fortnightly review and support
- **Kirkup Governance Project Team meetings**
  - Weekly Project Lead briefing to Exec Sponsor
  - Monthly 1-1 with team leads
  - Monthly newsletter
  - Briefing at monthly Governance Division Leads meeting
- **Divisional engagement**
  - Governance work stream update for Divisional Governance and Assurance Groups (monthly newsletter)
  - Project Lead to give verbal update and take feedback at Divisional Governance Leads Group

Once the project has been agreed, a schedule will be developed for the governance team to attend clinical areas to share governance process’s and initiatives, identify challenges and gain insights from the front line.

- **User Involvement**
  - User to be identified to support the development of a cross divisional user group to enhance the planned improvements in experience, complaints and investigations
Scoping the report

The report has been reviewed to identify the comments relating to governance, quality and safety to ensure that all related issues have been captured. The comments were then themed and framed within the parameters of the recommendations. Leads for each theme have identified overarching responses and a detailed action plan is in development. The action plan will be reviewed by other stakeholders such as users and commissioning colleagues. In relation to Governance, the themes identified are detailed in the table below:

<table>
<thead>
<tr>
<th>Theme</th>
<th>Recommendation No</th>
<th>Detail</th>
<th>Kirkup Outcome</th>
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</table>
| Patient experience     | 13                | • Benchmarking against national recommendations  
  • Divisional Complaints training – management process and improving quality of responses  
  • Reporting against national KPI  
  • Proactive user engagement in clinical areas                                                                 | Improved customer engagement from the point of care when we don’t meet expectations, with robust and compassionate responses                                                                            |
| Incident reporting     | 11                | • Widely cascade existing training programme to improve the reporting of safety incidents and promote a learning culture and reduction of harms.  
  • Implement a training programme for managers to ensure that roles and responsibilities are understood and that appropriate investigations are undertaken  
  • Ensure robust feedback to staff  
  • Develop collaborative learning for learning from complaints, litigation, incidents and patient experience (Learning to Improve group) to include Trust wide learning to improve bulletin  
  • To monitor staff perceptions of incident reporting and feedback through surveys to help the Board measure staff perceptions reported to the Workforce Committee about their workplace. | A robust incident reporting system with robust feedback mechanisms.  
  An engaged workforce who report frequently and are supported within a culture of continual improvement |
## Governance Themes

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<tr>
<td>RCA</td>
<td>12</td>
<td>• Human factors training to increase awareness</td>
<td>A robust framework for identifying investigations, undertaking them sensitively, openly and honestly whilst identifying areas for change and improvement that are shared throughout the organisation and externally, with a view to prevent recurrence</td>
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<td></td>
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<td>• Implement a training programme in staff participating in RCA</td>
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<td></td>
<td></td>
<td>- General awareness</td>
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<td></td>
<td></td>
<td>- Undertaking robust investigations</td>
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<td></td>
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<td>- Managing RCA investigation on safeguard</td>
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<td></td>
<td></td>
<td>• Ensure identified practice (positive and negative) is communicated</td>
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<td>to the Learning to Improve Group to ensure Trust wide learning</td>
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<td></td>
<td></td>
<td>• Development of internal RCA scrutiny panel (Pre SIRI) to provide</td>
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<td>cross service, multi-disciplinary ‘fresh eyes’</td>
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<td>Risk management (including health and safety)</td>
<td>15</td>
<td>• Standardised process for the management of divisional risk registers</td>
<td>A wide ranging and comprehensive register underpinned by consistent review to support internal control and decision making</td>
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<td></td>
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<td>• Standardised reporting in relation to divisional risk register</td>
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<td>• Training packages for the management of risks on the risk register</td>
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<td>Policies/guidelines</td>
<td>9.1</td>
<td>• Development of consistent approach to procedural document (guideline/policy/protocol/SoP) review and ratification across divisions/Trust</td>
<td>A multi-disciplinary approach to the development and use of high quality procedural documents</td>
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<td></td>
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<td>• Transfer of all document to SharePoint documents management system</td>
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<td>• Risk assessment for out of date procedural documents</td>
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| Policies/guidelines           | 9.1               | • Development of consistent approach to procedural document (guideline/policy/protocol/sop) review and ratification across divisions/Trust  
                            |                   | • Transfer of all document to SharePoint documents management system  
                            |                   | • Risk assessment of out of date guidelines  | A multi-disciplinary approach to the development and use of high quality procedural documents |
| Governance process – Including reporting ward to board | 15                | • Development of standardised divisional report templates for Workforce, Experience,  
                                                   |                   | • Safety, Effectiveness, Efficiency, to link with identified Trust KPI’s within corporate/trust committees/dashboard  
                                                   |                   | • Review of commons aims and objective in meeting structures, management and TORs  
                                                   |                   | • Ward level meetings, Service/area/matron level meetings, Divisional, Corporate, Sub committee, Executive, Board  
                                                   |                   | • Development of Governance Strategy to include assurance and escalation process  
                                                   |                   | • Further engagement with Good Governance Institute for support, review and guidance  | Robust governance arrangements giving clinical quality and fiscal efficacy at least equal value. Transparent and effective reporting and investigative process’s with clear frameworks for learning, escalation and assurance with trust board and sub committees having clear sight of comprehensive, relevant and reliable data. |
| Learning to improve           | All               | • On-going development of Learning to Improve Group  
                                                   |                   | • Development of learning to improve SharePoint workspace to improve staff access and engagement  
                                                   |                   | • On-going development of monthly trust wide learning to improve bulletin  
                                                   |                   | • Rationalisation and on-going development of monthly divisional learning to improve bulletins  
                                                   |                   | • Development of framework for sharing learning to improve with all staff  
                                                   |                   | • Development of impact assessment against action arising from incidents/complaints to ensure lessons learnt  | Embed a culture of on-going trust wide sharing of lessons learnt and improvement measures inclusive all professionals groups |
## Governance Themes

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<tr>
<th>Theme</th>
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<th>High Level Actions</th>
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| Audit       | 9.1 15             | • Annual clinical audit plans to be developed using Healthcare Quality Improvement Partnership (HQIP) Guidance to prioritise audits.  
• Maintain quality standard of all audits will have an action plan developed in line with Healthcare Quality Improvement Partnership (HQIP) Guidance. Maintained quality standard of 100% of audits will have an action plan implemented within the allocated timescales  
• Develop a clinical audit module on the Ulysses safeguard system to follow up and monitor the timely implementation of clinical audit and action plans arising  
• To ensure the objectives of the clinical audit and effectiveness committee are embedded at divisional level and are expressed in local audit meeting structures and reporting | A transparent system of audit to ensure clinical care is of a high standard and in line with national standards. Ensuring findings from audit are widely shared and embedded within a culture of continuous improvement |
| Staff Engagement | All               | • Governance leads to maintain divisional presence  
• Develop programme of clinical staff engagement  
• Develop governance handbook (how to guide) for all staff  
• Develop user friendly governance strategy  
• Implement Governance newsletter | An enthusiastic and knowledgeable Governance division that is highly visible to support Trust wide engagement in safe and effective, high quality services. |
Demonstrate compliance of those recommendations that have an April deadline and identify associated evidence

Recommendations 11 and 12

The University Hospitals of Morecambe Bay NHS Foundation Trust has taken the following actions to improve the percentage of patient safety incidents resulting in harm, and so the quality of its services, by undertaking the following actions:

- The trust will continue to encourage and maintain a strong reporting culture
- Training has been increased for staff on reporting, managing and investigating patient safety incidents;
- Weekly senior manager review of all incidents causing moderate or greater harm have been maintained;
- Serious Incidents Requiring Investigation (SIRI) continue to be investigated and scrutinised at the SIRI Panel with the assistance of commissioners.
- Duty of candour is applied and monitored
- In January 2014 the Trust introduced ‘weekly meetings’ led by the Executive Chief Nurse and the Medical Director. These meetings are designed to ensure all incidents/complaints resulting in moderate harm are investigated promptly and identify any trends or themes arising from these investigations. They are cross divisional meetings attended by Clinical Directors, senior nurses, midwives and governance leads from across the Trust. These meetings have continued in the year and have improved clinical engagement in incident investigation.
- Staff Survey - Improving incident reporting: dealing with incidents & day to day issues is under review as part of a specific focus group that has been established to review the findings and agree the actions for the remainder of the year. Inclusive of this group are 2 DGM’s, 1 ACN, Lead AHP, staff side representatives, Respect at Work Lead, Head of Communications and a HRBP

The Trust continues to share information on patient safety incidents with commissioners and partner organisations where patient treatment or concerns cross the healthcare boundary. We receive details of incidents that our partner organisations have identified that relate to our care and we investigate them appropriately.

Learning from patient safety incidents is a key feature of the Trusts Risk Management Strategy and staff endeavour to use the knowledge gained from their investigation to improve care. The Trust has a good reporting culture and reported over 15,000 patient safety incidents in 2014/15 which has shown that the trust is in the highest 25% of reporters as shown from our reporting of incidents to the NPSA between 1 October 2013 to 31 March 2014. The National Reporting and Learning System (NRLS) helps the NHS to understand why, what and how patient safety incidents happen, learn from these experiences and take action to prevent future harm to patients. National data can be found at: www.nrls.npsa.nhs.uk/patient-safety-data/. Graph 7 below shows the total number of incidents reported and the number reported to the national patient safety agency.
Demonstrate compliance of those recommendations that have an April 2015 deadline and identify associated evidence

The difference between the two figures is in relation to incidents related to services provided outside the Trust

![Reported Patient Safety Incidents (PSI)](image)

A significant number of clinicians and managers have now received general RCA training to underpin robust investigation of serious incidents. The development of specific RCA advice and prompts to enable investigating staff to continue to improve the analysis of pressure ulcers to aid specific lines of enquiry has resulted in more effective learning from review of pressure ulcer incidents.

A review of ‘lessons learnt’ communications led to the development of the Trust Learning to Improve bulleting, a monthly organisation publication supported by the Learning to Improve Group (formally CLIP group) ensuring themes arising and improvements are widely shared electronically, in hard copy for display and via local governance meetings – staff feedback has been encouraging. Divisional bulletins reflect specific learning within divisions.
Demonstrate compliance of those recommendations that have an April deadline and identify associated evidence

INTERNAL AUDIT 2014/15

Corporate and Divisional Governance - Significant assurance
• A revitalised Board Assurance Framework now places greater emphasis on strategic risk and the framework the Trust has in place to deliver its objectives
• Work continues to plan in improving compliance with Monitors Governance Framework. Most actions are compliant with the rest being partially met of which all have on-going actions to ensure full compliance
• We developed a governance strategy as a baseline for the whole system review for governance processes.
• Our divisional terms of reference have also been reviewed to ensure process and accountabilities are clear and measurable. This work is on-going as our improvement journey continues
• Our reporting process have been reviewed to ensure good governance begins at ward level and is sighted, actioned and escalated through services, divisions and to appropriate corporate bodies.
• We have standardised reporting in the WESEE format
• All divisional now produce lessons learnt
• Corporate lessons learnt are now held centrally
• A new group to address organisational lesson learnt has had its inaugural meeting and the first Trust wide
• The Divisional Governance Leads Groups provides a monthly systematic compliance review in relation to attendance monitoring in the division and of divisional performance against agreed criteria

Risk Management – Significant Assurance
• The Corporate Risk Register has also been revised. The risk management processes of the Trust have been strengthened. These processes now have increased Assurances from Internal Audit
• A series of internal annual reports are being undertaken to provide a validation that the Trusts Risk Management systems have been defined in a way that allows the Trust to achieve its objectives
• Risks are now standing item agendas at the Board Sub-Committees and the Corporate Risk Register template has changed to give an overarching view as to how well risk is being managed
• Clinical Directors now present divisional risk registers quarterly to the Trust Management Board
Project resource requirements

- **Project Lead** required for 6 months who has the required skills and experience - 4 days per week (then subject to review)

- 1 WTE Band 3 for 6 months – Admin/IT person to support the implementation of SharePoint Trust wide to underpin a robust process for procedural documents and the management and reporting of divisional and corporate meetings, groups and sub-committee’s
Next steps

- Development of a detailed action plan for cross organisational consideration
- Review of ‘cross fertilisation’ with other project leads – where actions arising from recommendations may overlap one another
- Scan of other Trust initiatives to avoid layering and duplication