## MORECAMBE BAY INVESTIGATION SUB-COMMITTEE MEETING

To be held from 10:30 on Friday 6 May 2016 in the Boardrooms, Westmorland General Hospital

### AGENDA

<table>
<thead>
<tr>
<th>Item 2015/16</th>
<th>Lead</th>
<th>Action</th>
<th>Paper</th>
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<tbody>
<tr>
<td><strong>STANDING ITEMS</strong></td>
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</table>
| 187 | Apologies for Absence:  
Tony Falconer, Angela Herdman, George Butler | Chair | To receive & note | Verbal |
| 188 | Welcome & Introductions | Chair | To receive & note | Verbal |
| 189 | Minutes of the meeting held on 08 April 2016 | Chair | To receive & note | Attached |
| 190 | Action Tracker & Matters Arising | Chair | To receive & note | Attached |
| 191 | Minutes of the meeting of the KRIG held on: Tuesday 05th April 2016 & Tuesday 19th April 2016 | David Walker | To receive & note | Attached |
| 192 | Feedback:  
• QSG | David Walker and Margaret Williams | To receive & note | Verbal |
| **PERFORMANCE AND DELIVERY** |      |        |       |
| 193 | Kirkup Project Lead Presentations – One Year On  
   a)  
   i. Governance  
   ii. Education, Learning & Development  
   iii. Estates  
   iv. Partnership  
   v. Clinical Quality  
   vi. Workforce  
   b) “One Year On” Report/ MIAA final report | Project Leads  
   Mary Aubrey  
   David Wilkinson  
   Andy Waddington  
   Halcyon Edwards  
   Sasha Wells  
   Gertie NicPhillib  
   Halcyon Edwards  
   Martin Kinley | To receive & note | Presentations |
| 194 | Formal agreement of closure of project & transfer of action’s to existing governance structure. | Chair | To discuss & note | Verbal |
| 195 | Any Other Business | All | To receive & note | Verbal |
Minutes of the Morecambe Bay Investigation Sub-Committee on Friday 08 April 2016
in the Boardrooms, Westmorland General Hospital

PRESENT:
Melanie Weeks  Non-Executive Director
David Walker  Medical Director
Sue Smith  Executive Chief Nurse
Tony Falconer  Consultant Obstetrician
George Butler  Public Governor
Fiona Wise  Improvement Director (Monitor)
Margaret Williams  Lancashire CCG
Mike Flanagan  Lancashire CCG
Eleanor Hodgson  Cumbria CCG

IN ATTENDANCE:
Lindsay Lewis  Quality and Service Improvement Lead
Louise Jones  Communications
Cath Broderick  WE Consultant
Martin Kinley  Project Management Office
Christine Morris  Associate Director of Clinical Governance
Halcyon Edwards  Project Manager, Clinical Strategy
Lesley Bennett  Family representative
Angela Herdman  Family representative
Alison Nelson  Minute Secretary

16/172 APOLOGIES FOR ABSENCE
Anne Garden  Non-Executive Director (Chair)
Phillip Woodford  Associate Director of Corporate Affairs
Geoff Jolliffe  Cumbria CCG
Sasha Wells  Deputy Director & Head of Midwifery
Andy Waddington  Project Lead, Estates

16/173 WELCOME AND INTRODUCTIONS
Melanie Weeks welcomed everybody to the meeting, with a special welcome to
Angela Herdman & Lesley Bennett.

16/174 MINUTES OF THE MEETING HELD ON FRIDAY 04 MARCH 2016

16/161 MINUTES OF THE MEETING OF THE KRIG HELD ON TUESDAY 09 & 3
February 2016
David Walker asked that this be amended to read that the draft closure report would
go to QSG on 13 April 2016 and that the MIAA report would come to the Sub-
Committee in May.

16/162 FEEDBACK FROM THE QSG AND BOARD MEETINGS
Margaret Williams noted that she had reported that the CCG’s felt that the work of
the Strategic Partnership was of great importance and asked that this be added to
the minutes.

AGREED: That with the amendments discussed the minutes be approved as an
accurate record.
16/175 ACTION TRACKER & MATTERS ARISING

Melanie Weeks noted that all actions were on track or scheduled for discussion at the meeting.

16/176 MINUTES OF THE MEETING OF THE KRIK HELD ON TUESDAY 08 MARCH & TUESDAY 22 MARCH 2016.

The committee were asked to note the attached minutes.

David Walker reported that there were 2 major pieces of work on-going, the maternity strategic partnership work and the estates project. The other main focus of these meeting’s had been around the transition to the end of the project and the closure report.

George Butler asked about slippage in Mandatory training and David responded that actions were in place to address this and further detail was noted in the highlight report later on the agenda.

16/177 FEEDBACK FROM THE QSG MEETING

David Walker noted that there was no feedback from QSG as the next meeting was on the 13 April 2016.

David reported that at the Trust Board meeting the estates development at Furness had been a major item with a presentation from Andy Waddington. The programme was approved by the Board and there had been considerable media interest which had been supportive.

16/178 UPDATE ON WORK RELATING TO BETTER CARE TOGETHER AND THE REPORT OF THE RCOG

Eleanor Hodgson reported that there had been another steering group meeting since the last Sub-Committee where the Trust had put forward a more detailed response to option 1. This was well received and there was also some evaluation at that meeting. Sustainability of staffing was an area still outstanding; in the short term there was a general feeling of assurance but medium term everything was more of a concern. The Trust were now doing more work around this.

Eleanor went on to report on the Better Care Together work and the development of the maternity strategic. Lindsay Lewis noted that there had so far been 9 workshops over 9 months to develop the pathway, these workshops had included front line staff from all backgrounds, service users & public health. The current service had been looked at and gaps identified, the pathway had now been put together in draft and would be circulated to sub-committee members.

The emphasis on post-natal care was welcomed and pre-conception care was felt to be a priority. There was a concern raised around home birth and it was acknowledged that there is more work to be done on this particular area. Another area of concern was around mental health care and whether other agencies were on board with what was being done. Lindsay Lewis responded that there were two mental health midwives specifically looking at this and Sue Smith added that this was a bigger commissioning issue but is identified as an area which needs more work.
The pathway was well received by the sub-committee and it was felt that key messages to staff as the work continues to progress and change would be beneficial in keeping everybody updated.

16/179 ENGAGEMENT UPDATE

Sue Smith reported that the Trust was 1 of 3 to have access to the Maternity Experience Challenge Fund of £65k which would be used to help promote and develop communication across maternity services. The Trust had also been granted £9000 from NHS England to develop a film allowing the Trust to share its learning.

Lindsay Lewis added that the Trust would be using patient experiences & stories about the negative impact of poor communication.

Service Users would be invited to tell their stories both positive & negative around the communication they have received from the Trust and some of the Maternity Services Liaison Committee would also be involved. Following this a communication toolkit would be developed.

16/180 COMMUNICATION UPDATE

Louise Jones reported that all the monthly actions were complete. The main focus had been around the maternity unit announcement, the video for which has now been shared. Louise added that there were also further drop in sessions around maternity planned with 1 next week at FGH. The focus from now would be on looking at how the trust communicates updates with the maternity unit and changes in maternity along with preparing for the maternity matters event in Kendal.

16/181 MONTHLY PROGRESS & HIGHLIGHT REPORTS

a) Highlight Reports

i) Programme
Lindsay Lewis noted that KRIG meetings would continue with a further 2 more scheduled highlight reports received for projects with on-going actions. The attached reports would be the last monthly programme highlight reports though as next month’s meeting would see the presentation of the individual closure reports.

The MIAA work continues and the “One Year On” report is progressing well.

ii) Governance
Christine Morris reported that the project was now largely developed. There were 5 actions outstanding which would move to the Trust’s everyday governance structure.

Christine added that the CQC had taken the Trust’s learning to improve bulletin as an example of exemplar and further auditing would continue in the PALS department and would report through the Quality Committee.

iii) Education Learning & Development
David Walker reported that there had been lots of work completed on this project and that the work had also been extended beyond the Kirkup recommendations.
David noted there had been a few problems such as delays in inputting data on to TMS and the cancellation of the LIA event on how the organisation deals with training however TMS was now back on track and the LIA event had happened and was moving forward according to plan.

There was particular concern raised around slip[page with mandatory training and David did acknowledge this slippage which was largely due to service pressures but gave complete assurance that there were mitigating actions in place which were noted in the attached report. Sue Smith added that all staff now under-go revalidation which was an excellent measure for assessing learning rather than just have members of staff completed the training.

iv) Partnership
Halcyon Edwards noted that the trust had been held back on organising placements due to a delay at Central Manchester in getting the memorandum of Understanding through their board, however despite this they had confirmed they wanted to move forward with the placements which was a great step forward. Halcyon added that the trust would now need to look at similar placements with Lancashire teaching Hospitals and develop the element of the midwifery part of the recommendation.

Attendance at the ACE days is an open invite in future from Central Manchester though the next one does coincide with a Junior Dr's stroke and members of staff will also be sent to the Human Factor’s training.

Tony Falconer noted the importance of joint appointments as well as these placements and David Walker gave assurance that the Trust continues to look at this.

v) Communication
There was no further update on this project. However Angela Herdman asked for an update on a concern she had raised previously regarding communication with patient’s relatives other than their next of kin and Melanie Weeks confirmed that this had been raised with Mary Aubrey and a response would be provided in due course.

vi) Estates
Andy Waddington & Luke Irlam attended to present on the proposed FGH Maternity development, the presentation would be shared with sub-committee members.

b) Action Plan & Risk Register
Lindsay Lewis asked the committee to note the attached action plan for reference. All remaining actions had been transferred to the appropriate project executives and would be monitored through their respective committees. It was noted that the Action plan needed to be amended slightly so that the “expected risk” column actually read “current risk”.

AGREED: Lindsay Lewis would update the Action Plan to show the current risk ratings.

16/182 CLOSURE & SUSTAINABILITY REPORT

Halcyon Edwards asked the committee to note the tabled report which was an updated version to that which went out with the papers.
This version of the report would go to QSG on 13 April 2016 but This report would not be signed off by the Trust Board until the end of May and input from Sub-Committee members would be welcomed prior to this.

The deadline for feedback was Friday 22 April 2016 with the next version being presented at the Sub-Committee on the 06 May 2016 for final sign off by members prior to the Trust board meeting on 25 May 2016. Once the Trust Board has signed off the document it becomes a public document.

16/183 PMO: PROJECT POSITION REPORT

Martin Kinley reported that the PMO office was on track to deliver the draft MIAA report for the 22 April 2016. This would then be an appendix of the One Year On report.

16/184 PROGRAMME SINGLE VERSION REPORT

AGREEED: That the single version report be approved to go to Trust Board once the discussed amendment had been made.

16/185 ANY OTHER BUSINESS

There was no other business raised.

16/186 DATE AND TIME OF NEXT MEETING

Friday 06 May 2016, WGH Boardrooms 10:30am.
<table>
<thead>
<tr>
<th>Action No.</th>
<th>Date of Meeting</th>
<th>Minute Ref.</th>
<th>Agenda Item</th>
<th>Action Agreed</th>
<th>Exec Resp</th>
<th>Agreed Due Date</th>
<th>Revised Due Date</th>
<th>Comments/Outcome</th>
<th>RAG Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>58</td>
<td>04/12/2015</td>
<td>15/111</td>
<td>111</td>
<td>The merge of action 54 &amp; 55. To continue to carefully monitoring the work of NHS England Maternity Review and RCOG Safer Womens Healthcare review and take action as required.</td>
<td>David Walker to transfer to Eleanor Hodgson</td>
<td>Ongoing</td>
<td></td>
<td>This will now be picked up as part of the BCT work. There is a workshop on the 24th May with commissioners and all organisations involved in maternity to do a full gap analysis and the NHS England maternity review will be reviewed here. The action will be transferred to Eleanor Hodgson who is the SRO for the WACS BCT workstream.</td>
<td>(SBM)</td>
</tr>
<tr>
<td>61</td>
<td>04/12/2015</td>
<td>15/118</td>
<td>118</td>
<td>Assurance of ensuring work is continued and embedded into the Trust to be discussed in more details at the next meeting 8th January 2015.</td>
<td>All</td>
<td>08/01/2016</td>
<td>05/02/2016 04/03/2016 08/04/2016</td>
<td>This was discussed at the meeting on the 08 January 2016 with agreement that a more formal report of how this will look would go to the Sub-committee on the 05/02/16</td>
<td>(SFM)</td>
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### UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST

**AGENDA ITEM 190 2016/17**

**Morecambe Bay Investigation Sub-Committee 06 May 2016**

**MATTERS ARISING / ACTIONS TRACKER 2015/16 08 April 2016**

<table>
<thead>
<tr>
<th>Action No.</th>
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<tbody>
<tr>
<td>64.</td>
<td>08/01/2016</td>
<td>16/130</td>
<td>130.</td>
<td>Sue Smith agreed to provide a report summarizing the work of the Clinical Quality Project Group and the next steps for the next Sub-Committee meeting.</td>
<td>Sue Smith</td>
<td>05/02/2016</td>
<td>08/04/2016</td>
<td>This was deferred due to Sue Smith’s apologies having been noted for Feb &amp; March. This formed part of the One Year On report which was tabled on 08 April 2016.</td>
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RAG Rating Key:
- **Completion Status**
  - Overdue (O)
  - Scheduled for this meeting (SFM)
  - Scheduled beyond date of this meeting (SBM)
  - Action Completed (ACP)
  - Action Closed (ACD)

04/03/2016 – The one year on report to be tabled at this meeting
This was deferred and is on the Agenda for 08/04/2016
The One Year On Report was discussed on the 08/04/2016 and will be discussed in further detail on 06 May 2016.
## Matters Arising / Actions Tracker 2015/16 08 April 2016

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<th>Action No.</th>
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<tbody>
<tr>
<td>67.</td>
<td>08/01/2016</td>
<td>16/135</td>
<td>135.</td>
<td>That a report would go to the Quality Committee on the option's appraisal, specifically looking at any risks and mitigations needed.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(C)</td>
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<tr>
<td>71.</td>
<td>05/02/2016</td>
<td>16/149</td>
<td>149.</td>
<td>It was agreed that the options for engaging with the families around the work of the sub-committee be discussed with Jackie Daniel and then Sasha and Cath would report back and explore the options.</td>
<td>Sascha Wells &amp; Cath Broderick</td>
<td>04/03/2016</td>
<td>08/04/2016</td>
<td>Lesley Bennet &amp; Angela Herdman both attended the meeting on the 08 April 2016.</td>
<td>(C)</td>
</tr>
<tr>
<td>72.</td>
<td>05/02/2016</td>
<td>16/151</td>
<td>151.</td>
<td>That the Kirkup Project Leads would be invited to attend the meeting on the 4th March 2016 to feedback on how their individual workstreams will be reflected in the closure report.</td>
<td>David Walker</td>
<td>04/03/2016</td>
<td>08/04/2016</td>
<td>This has been revised due to annual leave and a number of apologies. The project leads are due to attend on 06 May 2016.</td>
<td>(SFM)</td>
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</tbody>
</table>

RAG Rating Key:
- **Completion Status**
  - Completion (C)
  - Overdue (O)
  - Scheduled for this meeting (SFM)
  - Scheduled beyond date of this meeting (SBM)
  - Action Completed (ACP)
  - Action Closed (ACD)
## MINUTES

### Present:

David Walker - Medical Director, UHMB (Chair)  
Lindsay Lewis – Quality & Service Improvement Lead, UHMB  
Halcyon Edwards – Partnership Project Lead, UHMB  
Andy Waddington - Estates and Facilities Manager, UHMB  
Louise Jones – Communications Manager, UHMB (WebEx)  
Heather Midgley – Business Support Unit Co-Ordinator, UHMB

### Item 1. Apologies for Absence

- Tina Turner – Divisional General Manager  
- Gill O’Connell – Associate Medical Director  
- Sascha Wells – Deputy Director and Head of Midwifery, Gynaecology & Obstetrics, UHMB  
- Owen Galt – Divisional Clinical Director, UHMB  
- David Burch – Clinical Lead O&G, UHMB  
- Val Wilson - Interim Deputy Director of Governance, UHMB  
- Lindsey Roome – L&D project Manager, UHMB  
- Gertie Nicphilib – Deputy Director of Workforce (WebEx)  
- Martin Kinley - Programme Manager, PMO, UHMB

### Item 2. a) Minutes of the meeting held on 22nd March 2016

The Minutes from the meeting held on 22nd March 2016 were agreed as a true and accurate record.

#### b) Matters Arising Tracker

The action tracker was reviewed.

**Complete**

No complete actions were noted.

**Outstanding Actions**

No outstanding actions were noted.

### Item 3. Feedback provided by DW:

**MBI Sub-Committee:** Next meeting is on Friday 8th April.  
**Board:** The usual report was presented in addition there was an FGH Maternity Estates paper which got a lot of coverage. A good presentation was given by Sascha Wells, Andy Waddington & Lesley Bennett, along with the display boards and the media involvement. The paper & presentation was extremely well received. This has been approved by the Board for the £11million funding requested for the FGH Maternity new build.  
**QSG:** No meeting.
4. **One Year On**

HE sent through to the Report publisher on Friday and today has received their very early amended version to ensure professional finish. HE presented this to the group. The amended version shows the gist of how the final report will look with a two column layout; the group agree this looks good and are happy with the colours used. The only area that HE isn’t happy with is the layout of the appendices; initially HE sent through a landscape version but the designers returned in portrait which meant there are a lot of areas without any text, it looks clumsy, so all agreed that HE will get them to return to landscape. Additional pictures are required, preferably of the artist impression of the new build exterior which LJ can provide these JPEG images. HE has some additional text to send to the designers as soon as possible (today/tomorrow morning) so that he can work on this to ensure we have this amended version in time for Sub-Committee on Friday.

The summary table has been updated in view of all progress has been updated. In the main, most actions have completed, with the exception of two sections of Education Learning & Development and one Estates which will be ongoing/on track (blue). Gap Analysis & Clinical Rotation will need some summary wording to show current position adding to say that it’s linked to the Maternity Strategic Partnership work and the Recruitment & Retention Strategy and they will remain blue to continue to be reviewed. This table will be updated ready for the Sub-Committee on Friday and will be incorporated into the final One Year On to show final progress. HE confirms that this will match the MIAA Report, HE will double check but feels all evidence with the exception of one Workforce item has been submitted).

HE will draft the Jackie Daniels area on the report today. The designers have missed information out of the Executive Summary page. HE will proof read the report. For the Sub-Committee and QSG the Executive Summary needs to be complete, the summary table needs updating with colours changing and they will be told that the report is a work in progress and the MIAA Report will be added when complete.

Future Sub-Committees to take on responsibility of remaining actions will be highlighted on the One Year On. These remaining actions will be transferred to the project executive sponsors for ongoing completion and monitored through the appropriate committees already established in the organisation. Report showing lessons learned and what could have gone better, what went well and what is yet to be completed (this is to be cross referenced with the appendices) and how they’ll be monitored going forward at which committee. Estates will be monitored through the Capital Expenditure Group & Finance Committee. The recurrent theme of the report is change in culture, what we have done is what we set out to do, commitment, compassion.

HE is away until 25th April and is hoping to have had comments from the Sub-Committee on 8th April. The final report is due for the 6th May for the Sub-Committee (papers required a week before), ready for the Board on the 25th May.

DWa thanks Hal for continued hard work.

5. **PMO Update**

MK on A/L. LL to get an update from MIAA to ensure that all required support is given in evidence collection.

6. **Maternity Partnership Update**

HE to complete a Maternity Strategic Partnership 2 page paper for QSG on Friday and to provide a proposed roster.

HE tried to speak to Director at St Mary’s at CMT to ascertain when the Memorandum of Understanding will be going to their Trust Board. They won’t accept any placement until it has been to the Board. We, including Mr Burch, are very keen to get these placement started. HE believes that Karen Connolly has to get the Director of Nursing
to accept for it to go on the Trust Board, she has been on leave. The next Trust Board is 9th May. The Clinicians have seen it in December, but this is now up to management. Karen is to provide a list of charges. DWa suggests involving Jackie Daniel to try and assist in getting this on the Board. Marie, Business Manager, & HE have been working on a operational plan. We need to get it tested by sending somebody so we know how long it takes to get the honorary contract. CMT are keen to have a recognised extract from a PDP – so they can see what the requirement is. Additional work needs to be done with Preston, we have had midwives that have required extra development that have gone to Preston. DWa to speak to Jackie Daniel

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<th>7. Governance Highlight Update</th>
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<tr>
<td>There are actions remaining because their dates were past the report timescale. The plan is when we close on the Kirkup report this will be ongoing work. The outstanding actions are to be picked up by Quality Committee. LL is in communication with Mary Aubrey, Executive Project Sponsor, regarding the remaining actions. We require assurance from Governance that remaining / ongoing actions will be mainstreamed in the work of the Governance directorate and then a handover of the plan with Exec sign off. LL to draft email from DWa.</td>
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<thead>
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<th>8. Workforce Highlight Update</th>
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<td>There is outstanding evidence required for the Workforce / Recruitment &amp; Retention Strategy has been updated, which it has, but requires the minute to confirm. We require assurance from Workforce that remaining / ongoing actions will be mainstreamed in the work of the Workforce directorate and then a handover of the plan with Exec sign off. LL to draft email from DWa. The action plan is completed, GN worked with MIAA and there hasn’t been any known problems with the evidence so far. Action Plan is all green.</td>
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<tr>
<th>9. Education, Learning &amp; Development Update</th>
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<tr>
<td>LL has questioned where the LiA Project is being monitored and remaining actions from KRIG action plan. We require assurance from Education Learning &amp; Development that remaining / ongoing actions will be mainstreamed in the work of the Education Learning &amp; Development directorate and then a handover of the plan with Exec sign off. LL to draft email from DWa. DWi will pick these up.</td>
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<th>10. Estates Update</th>
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<td>Board: As the Estates Board paper has been approved, the team will now work through the Procurement process now to get a start on site in September 2016. This is now classed as business as usual. Board Presentation: AW provided the presentation, with additional information for Sub-Committee. AW will introduce then the architect will talk them through the process. This presentation shows the bereavement suite layout with outdoor space. It also shows the elevation options, corrugated steel sheet or contemporary ideas. Operational Policy: Operational Policy is required; the design team need questions answering and AW feels that rather than do these as individual questions an Operational Policy would be much better suited. ACTION: AW will speak to SW CJR &amp; SS. Maternity Matters: The next event is in Kendal on 20th May 2016. AW will attend but will be late. The boards will be brought to this event. There is an open day on 14th April too. We require assurance from Estates that remaining / ongoing actions will be mainstreamed in the work of the Estates directorate and then a handover of the plan with Exec sign off. LL to draft email from DWa.</td>
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<th>11. Communication Update</th>
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<td>We require assurance from Communications that outstanding / ongoing actions will be mainstreamed in the work of the Communications directorate and then a handover of the plan with Exec sign off. LL to draft email from DWa. This will feed into the wider comm plan, followed up through EDG or Nursing &amp; Midwifery Group via Phil</td>
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KRING Minutes 05/04/2016
University Hospitals of Morecambe Bay NHS Foundation Trust
MBI Sub-Committee (06/05/2016)
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<tr>
<td><strong>12. KRIG Programme Update</strong></td>
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<td>This is ready to close and transfer. Continues to follow the process that we have established throughout. At Sub-Committee we can advise that at the next meeting can report on the close down arrangements for each area.</td>
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| 13. KPI’s Baseline Data as of February 2016 |
| Education Learning & Development – Discussion regarding any further data and information that can be added took place, GN or LH could assist with this. This is information regarding ALL staff not just WACS. |
| Clinical Quality – SW has data and LL will catch up with her. |
| Workforce - GN changed her KPI’s as the others weren’t truly measurable and didn’t reflect. Workforce already had their KPI’s in place to achieve residual vacancy factors by 31/03/17 and are currently exceeding Trust wide. There is a detailed plan that sits behind it too. Joint Working cross-bay is managed via Quality Committee is complete & ongoing. Clinical leadership is complete for the triumvirate review and 94% complete for the 8a+ appraisals. Escalation of risk & quality is via mandatory training, LL has information from Mary to show this is at 91%. |
| Governance – VW has used the KPI’s which were used in the Quality Improvement Plan. Procedural Document in place and in date, 51 out of 1167 documents out of date on library. To rank in the top 25% of Trusts on National Reporting, we were compliant 2014/15, 93.37% year to date. Sharing learning is produced via a monthly bulletin from March 2015 and on track for the 6 themed bulletins. 5% reduction in complaints. Positive review undertaken showing compliance with Monitor framework. Estates - Higher than average IWGC score from services users is at 4.84 out of 5. The reduction is number of decision to delivery interval breaches for emergency c-sections can’t be measured until the new theatre is in place. |
| Partnership – Awaiting data. |

| Decision was made to remove the following KPIs as it was felt that they were more process than KPIs: |
| Partnership – Memorandum of Understanding |
| Partnership – Development of a maternity Strategic Partnership within TNS record |

| Reminder from DWa to ensure there aren’t any gaps if there is information available we need to ensure it is input. |

| Reminder to please let DWa know if there are any resources required post 31st March. DWa has actioned the requests he has received. |

| 15. Any Other Business |
| 15.1 – Paediatric Input – Agreement that OG is to continue to be involved for the remaining meetings. |
| 15.2 – Future KRIG Meeting Requirements - After Sub-Committee on Friday 8th April All the Projects should be closed down and we should know where all their work is going and we should also have the emails from their Exec Directors saying they have picked up the work. We should write to the Committee and advise them of the actions which they are to receive. Highlight reports aren’t required anymore for KRIG. HE has all closure reports bar Workforce, DWa asks for GN to complete and this will be the last action required of her. It was agreed that the agenda for the next KRIG will consist of only: |
| -Final version of One Year On |
| -KPI Data |
| -Closedown actions sign off by Exec |
| -Maternity Strategic Partnership Update |

| No Estates update is required. |

| For the Sub-Committee agenda in 6th May should consist of each Project Lead coming in and giving a short presentation on their project start to finish, what we set |

| LL to find out more data for the next meeting |

| LL to ask GN to complete the closure report. |
out to do, what we have done, to discuss the closedown report. Request to Mary Aubrey or a Deputy, David Wilkinson or a Deputy for Education Learning & Development, Andy Waddington for Estates, Sascha Wells for Clinical Quality, Gertie Nic Philib for Workforce to attend to provide this presentation.

### 16. Date & Time of Next Meeting

**Tuesday 19th April 2016 - 14:00 – 16:00**

**Tuesday 3rd May 2016 – 14:00 – 16:00 this will be the final KRIG**

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**Quorum**

| Name                | Title                                                                 | 16/06/15 | 30/08/15 | 28/07/15 | 26/08/15 | 25/08/15 | 06/09/15 | 22/09/15 | 13/10/15 | 10/11/15 | 24/11/15 | 22/12/15 | 12/01/16 | 26/01/16 | 08/02/16 | 23/02/16 | 08/03/16 | 22/03/16 | 05/04/16 | 19/04/16 |
|---------------------|----------------------------------------------------------------------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|
| David Walker (Chair)| Medical Director UHMB                                               | ✓        | X        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        |
| Tina Turner         | Women and Children’s Divisional General Manager UHMB                | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        |
| Judith Griffin      | Senior Programme Advisor Kirkup Report                              | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        |
| Lindsay Lewis       | Quality & Services Improvement Lead/Kirkup Programme Manager, UHMB  | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        |
| Sasha Wells         | Deputy Director and Head of Midwifery, Gynaecology and Obstetrics, UHMB | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        |
| Louise Jones        | Communications Manager UHMB                                         | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        |
| Owen Galt           | Clinical Director Women’s and Children’s Services                    | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        |
| Gill O’Connell      | Associate Medical Director FGH UHMB                                 | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        |
| Martin Kinley       | Programme Manager, PMO UHMB                                         | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        |
| Fiona Wise          | Improvement Director for Monitor                                    |           |          |          |          |          |          |          |          |          |          |          |          |          |          |          |          |          |          |          |          |          |
| David Burch         | Clinical Lead O & G UHMB                                            |          |          |          |          |          |          |          |          |          |          |          |          |          |          |          |          |          |          |          |          |
| David Wilkinson     | Director of Workforce and OD UHMB                                   | X        | X        | X        | X        | X        | X        | X        | X        | X        | X        | X        | X        | X        | X        | X        | X        | X        | X        | X        | X        |
| Margaret Williams   | Lancashire North CCG                                                |           |          |          |          |          |          |          |          |          |          |          |          |          |          |          |          |          |          |          |          |

**Project Leads**

| Name                  | Title                                                                 | 16/06/15 | 30/08/15 | 28/07/15 | 26/08/15 | 25/08/15 | 06/09/15 | 22/09/15 | 13/10/15 | 10/11/15 | 24/11/15 | 22/12/15 | 12/01/16 | 26/01/16 | 08/02/16 | 23/02/16 | 08/03/16 | 22/03/16 | 05/04/16 | 19/04/16 |
|-----------------------|----------------------------------------------------------------------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|
| Val Wilson            | Interim Deputy Director of Governance UHMB                            | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        |
| Kathy Duffy           | Assistant Director of Organisational Development UHMB                | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        | ✓        |
| Lindsay Roome         | L&OD Project Manager                                                 | ✓        | ✓        | ✓        |          |          |          |          |          |          |          |          |          |          |          |          |          |          |          |          |          |          |
| John Bannister        | Deputy Chief Operating Officer UHMB (left Trust 28th August 2015)    | ✓        | ✓        |          |          |          |          |          |          |          |          |          |          |          |          |          |          |          |          |          |          |          |
| Rupert Wainwright     | Deputy Chief Operating Officer UHMB                                  |          |          |          |          |          |          |          |          |          |          |          |          |          |          |          |          |          |          |          |          |

**KRI G Minutes 05/04/2016**

University Hospitals of Morecambe Bay NHS Foundation Trust

MBI Sub-Committee (06/05/2016)
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KIRKUP REPORT IMPLEMENTATION GROUP (KRIG) – MEETING

Tuesday 19th April 2016 / 14:30 – 16:30
Room 3 Education Centre, WGH

MINUTES

Present:

David Walker - Medical Director, UHMB (Chair) (WebEx)
Sascha Wells – Deputy Director and Head of Midwifery, Gynaecology & Obstetrics, UHMB
Owen Galt – Consultant Paediatrician, UHMB
Lindsay Lewis – Quality & Service Improvement Lead, UHMB
Andy Waddington - Estates and Facilities Manager, UHMB
Louise Jones – Communications Manager, UHMB (WebEx)
Martin Kinley - Programme Manager, PMO, UHMB
Christine Morris - Heather Midgley – Business Support Unit Co-Ordinator, UHMB

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| 1. Apologies for Absence | Margaret Williams  
David Burch – Clinical Lead O&G, UHMB  
Halcyon Edwards – Partnership Project Lead, UHMB  
David Wilkinson, Director of Workforce |
| 2. a) Minutes of the meeting held on 5th April 2016 | The Minutes from the meeting held on 5th April 2016 were agreed as a true and accurate record.  
b) Matters Arising Tracker | The action tracker was reviewed.  
The following have been completed: 8, 13, 16,  |
| Outstanding Actions | 22 – MK wanted to bring this to everyone’s attention today to ensure that all evidence is in the correct folders and is in the action plan. MK & LL to meet and go through this. |
| 3. Feedback provided by DW: | MBI Sub-Committee: At the last meeting there were a lot of positive comments about the process throughout the year, particularly about the engagement process. The final report is expected at the May Sub-Committee.  
Board: No Board to report on.  
QSG: A very positive response was given regarding the draft report of ‘One Year on’. There will be another meeting in June where they will wish to sign off the final report, which will be the close down. There were a lot of positive comments about the work that everybody has done and the approach that has been taken. |
4. **One Year On**

The latest version of the One Year On report was presented by DW in HE’s absence due to annual leave. Request was made for any last minute comments to be raised or emailed to LL & HE.

SW has returned from leave and will read through in more detail but commented:
- Clinical Quality Project isn’t drawn out enough in the main narrative of the report with no real reference to recommendations 5, 6 & 7 in the main body. To be able to demonstrate that we have moved things on clinically it is important that this is in the main body of the report.
- In the Appendices it has been referred to as Clinical Strategy Project, this needs to read Clinical Quality Project.
- Acknowledgment Page – to the families that have been involved and all the work that they have done. The staff should be acknowledged formally too.

ACTION: LL to co-ordinate a list of staff (cross divisional/organisational/stakeholders) and families that have been involved.

- Review some of the pictures as some aren’t relevant or related – increase the number of Women’s and Children’s related pictures for insertion. LJ will get pictures to LL to collate for HE.
- SW will make further comments to HE.

LL highlights there isn’t much reference to the assurance process, or sequence of governance process, in the report. It is referred to but more detail is required. The MIAA Report will be an appendices within the report. LL will pick this up with MK.

SW to provide a paragraph on the Clinical Quality project.

Final report is due at Sub-Committee on the 6th May, papers required by 27th April to be sent 29th April. MK adds that the MIAA report, as a complete item, won’t be ready until the 29th April.

5. **PMO Update**

MK sent the timeline to the team with regards to the MIAA Report:

- 18th - 22nd April – The MIAA Report is going through the quality assurance process internally within their organisation
- 22nd April – we expect the report to be with us
- 22nd April – we will have a week to quality assure and look at the factual accuracy of the report
- 29th April – Report published

Plea for people to put time aside on 27th & 28th April to check the factual accuracy of their components. As soon as MK receives on 22nd he will distribute it around to Project Leads & Execs.

Expectation from MK is that the report will be green throughout with the exception of:
- Amber – MDT Attendance – due to lack of attendance / cancelled meetings
- Amber – Leadership & Development Attendance – poor attendance
- Blue – Estates – as the deadline is December 2017
- Blue – Audit Revisits – which are due June/July 2016

DW thanks all for continued effort and work being put in. LL reiterates thanks to MK for the hard work he has put in to co-ordinate.

6. **Maternity Partnership Update**

DW updates in HE’s absence. Memorandum of Understanding has been to Lancashire Teaching Hospital Board, but has not yet been to Central Manchester Foundation Trust. Initially we though that this would implicate on not allowing clinician placements to be booked. Central
Manchester Foundation Trust are now happy to go ahead with the organising of placements, before the MOU goes through the Board. DWa hopes to have had the first placements take place prior to the Board meeting in May 2016.

DWa confirms our staff aren’t being seconded to work there clinically, as this isn’t what has been agreed by UHMB. The honorary contract terms confirm that should they come across an emergency situation they wouldn’t be put at risk. From a midwife perspective it was agreed that 2 yearly they would undertake their PROMPT Day training in one of these organisations.

7. Communications
Maternity Matters Engagement Event Kendal

LL was concerned that there has been little communication about the event. The date it is taking place is Friday 20th May. Barry Rigg is co-ordinating the event. There was a discussion around the boards and whether they will need updating with end of project information, DWa wants to demonstrate what we’ve done as well as asking their views. LL suggests the closure presentations for the boards. SW highlights the need to share with Kendal the ongoing work that is continuing. The MLSC in this area is very well informed and very well attended. A stall specifically about Helme Chase will be required, and we should make more of the midwifery lead care – this could be used as a way to recruit more women to use it. The FGH presentation boards, possibly the birthing pool pictures on boards too, will be used as it will be an opportunity for those women wanting a consultant led birth to use FGH. Alternative meeting to be arranged to ensure all information has been gathered for the event.

ACTION: HM to circulate the flyer to the whole Division

ACTION: LJ to print on A4 presentations for the boards if appropriate

8. KPI’s Baseline Data as of February 2016

LL has checked all queries and wants Project Leads to check their data as this will be going into the One Year On report. LL highlighted the thing that stuck out for her was:
- number of appraisals that have been completed (87%)
- some of the Education Learning & Development stating national average figures

ACTION: LL is to separate out the monthly & annually for Consultants appraisals.

Future output is to separate Committees, agreed that LL doesn’t need to send this document to any other area. The letter to transfer responsibility to the Executive Leads (and returned in agreement).

9. Sub-Committee – 6th May

Project Leads presentation to be presented on 3rd May KRIG.

For the next Sub-Committee meeting we will require:
- final One Year On report, including MIAA report by MK
- Project Lead Closure Presentations (including real life examples)
  - Request if all happy for formal closure

AW has completed his Closure Presentation and will be present, Mary Aubrey will attend the beginning of the meeting, SW is to attend.

15. Any Other Business

At the last KRIG, 3rd May, the final version of the One Year On report will be presented and the project leads presentations will be viewed.
16. **Date & Time of Next Meeting**
**Tuesday 3rd May 2016 – 14:00 – 16:00 this will be the final KRIG**

### Quorum

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### Project Leads

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| Val Wilson | Interim Deputy Director of Governance UHMB | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Kathy Duffy | Assistant Director of Organisational Development UHMB | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Lindsay Roome | L&OD Project Manager | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| John Bannister | Deputy Chief Operating Officer UHMB (left Trust 26th August 2015) | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Rupert Wainwright | Deputy Chief Operating Officer UHMB | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Andy Waddington | Estates and Facilities Manager | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Tristram Reynolds | Associate Director of Estates and Facilities | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Kate Casey | Deputy Director KELD | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
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CANCELLED
| Quorate (Y/N) (members 5 inc. Chair/vice chair) | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | N | Y |
‘One Year On’
How we implemented the Kirkup Report

University Hospitals of Morecambe Bay NHS Foundation Trust’s implementation of the recommendations in the Morecambe Bay Investigation Report [Kirkup Report] published in March 2015
One Year On – how we implemented the Kirkup Report

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The publication of the Kirkup Report was a watershed moment, not just for the Trust but for those families and communities that had been so tragically let down by past failures.

It was important that we didn’t just accept the report and then treat the recommendations as a ‘check list’ of actions – we owed it to everyone involved to demonstrate we would truly learn from it.

This report contains many instances of changed and improved practice, examples of innovative approaches to the problems of our particular geography, and describes how we viewed the Morecambe Bay Investigation recommendations as the starting point for change not the end point.

Underpinning the achievement of the challenging tasks and deadlines that were set for us has been a commitment to change, and an understanding that when we listen to the views and experiences of our patients and their families we can provide services that people need in the ways that they want. Many of the families involved in the Morecambe Bay Investigation have joined us on that journey and continue to contribute in the co-design of services for the future. I would like to take this opportunity to say thank you for their continued support and involvement. I can only imagine how difficult and at times painful it must have been for them.

I would also like to acknowledge and praise the energy and commitment shown by our staff and partners to work together to make constructive and meaningful improvements for everyone who uses our hospitals.

There is still work to do. It would be wrong of us to think that by completing each of the recommendations that everything is now ok – that really would be complacent. Our strategy is one of continual improvement, creating the right environment for our staff to be able to implement best practice and to have the confidence to raise concerns when standards are not being met.

We live and work amongst the people who use our services and we want to be their hospital of choice, providing safe services in a compassionate way.

This is only the end of the beginning in terms of addressing the findings of Dr Kirkup. I look forward to sharing updates on further progress throughout the year.

Jackie Daniel
Chief Executive
3 Executive Summary

3.1 The here and now

We will never forget that we are telling our ‘improvement story’ because we let people down; and our heartfelt apologies and determination to improve will not erase the harm that was done in the past. We believe, as a result of that history, we have an obligation to ensure the services we are providing now and in the future are as safe as can be; so that our patients and their families will, appropriately, have confidence in them.

3.2 What this report wants to achieve

In addition to the many necessary and practical changes that have taken place in the University Hospitals of Morecambe Bay NHS Foundation Trust [UHMBFT] since the publication of the Morecambe Bay Investigation [also known as the Kirrup Report] in March 2015 there have also been significant changes in culture, demonstrated through a willingness to learn, and improvements in team-working and empathy. It is those changes that we hope will be evident to everyone who reads this report, our patients and their families, and to everyone who works in our hospitals, so they will have confidence in the services we provide and the value we place on them.

This report is intended to provide sufficient information on the implementation of the Morecambe Bay Investigation [MBI] recommendations to ensure that our patients, service users and the wider NHS can have confidence that we have achieved what was requested of us. In some cases we will provide information which shows that we have been able to achieve more than was asked of us.

The UHMBFT Trust Board, Governors, Foundation Trust members, and employees have worked purposefully, with assistance from members of the public to public that clinical standards have been raised and governance arrangements strengthened in line with the Morecambe Bay Investigation recommendations. This report is a story of that journey.

This report provides the following:

- A summary of the work undertaken, including the cultural changes and learning opportunities associated with each of the recommendations;
- For each of the recommendations provides details of the activities undertaken and milestones achieved through to completion;
- For each of the recommendations identifies work that will continue as part of day-to-day activity and the means by which this will be monitored within UHMBFT;
- Identifies factors which have proved critical in helping to implement the necessary improvements;
- Identifies learning that is being taken forward throughout the organisation;

4 Background and Context

4.1 Why the Morecambe Bay Investigation was necessary

The Morecambe Bay Investigation [MBI] was established by the Secretary of State for Health to examine concerns raised by the occurrence of serious incidents in maternity services provided by UHMBFT, including the deaths of mothers and babies, in the period from 1 January 2004 to 30 June 2013. These concerns covered three maternal deaths and the deaths of 16 babies at or shortly after birth. Relatives of those harmed, and others, had expressed their concerns, sometimes repeatedly, over the incidents themselves and inadequate responses to them by the Trust, the wider NHS, and regulatory bodies.
4.2 Findings of the Morecambe Bay Investigation

It was found that there was “suboptimal care in which different management would reasonably have been expected to make a difference to the outcome”, in one maternal death, five stillbirths and six neonatal deaths.

4.3 University Hospitals of Morecambe Bay NHS FT failures

The MBI found that the origin of the problems described above lay in “the seriously dysfunctional nature of the maternity service at Furness General Hospital [FGH]. Clinical competence was viewed as substandard with deficient skills and knowledge; working relationships were extremely poor, particularly between different staff groups such as obstetricians, paediatricians, and midwives; there were failure in risk assessment and care planning which resulted in inappropriate and unsafe care; and the response to adverse incidents was grossly deficient with repeated failures to investigate properly and learn lessons.

Whilst it is true that serious incidents happen in every health system it is also true that in the period from the beginning of January 2004 to the end of June 2013 the UHMBFT internal investigations missed numerous opportunities to identify the root causes of incidents; were not sufficiently rigorous; were over-protective of staff, and failed to respond properly with clear findings to patients and their relatives.

It was also true that clinical governance systems throughout the Trust at that time were inadequate, information did not flow properly or efficiently through the professional and managerial reporting lines, and critical links between incidents were not spotted or acted upon.”

5 The Recommendations

The MBI Report contained 44 recommendations. Eighteen of these related to UHMBFT and the remaining 26 related to the wider NHS.

Detailed information on the implementation of each of the 18 UHMBFT Recommendations can be found in the Appendices. That information includes a full transcript of the Recommendation, the overall project goals to meet the requirements of the Recommendation, what outcomes have been achieved, what outcome measures are being used [Key Performance Indicators – KPIs], how we are ensuring that the outcomes and actions have been incorporated into the day-to-day business of the Trust, how we are planning to sustain and monitor the improvements, whether there are any actions yet to be completed, how we will monitor these incomplete actions, and the ‘lessons learned’, i.e. both the good things and the things that could be improved on.

6 Recommendations 1 and 18

Recommendations 1 and 18 underpin the approach that we have taken to the implementation of the Kirkup requirements and as such have been expanded on in the following section.

6.1 Recommendation 1

Recommendation 1 stated: 'UHMBFT should formally admit the extent and nature of the problems that have previously occurred, and should apologise to those patients and relatives affected, not only for the avoidable damages caused but also for the length of time it has taken to bring them to light and the previous failures to act.'

In response the UHMBFT Chair of the Trust Board, Pearse Butler, said the following:

‘This Trust made some very serious mistakes in the way it cared for mothers and their babies. More than that, the same mistakes were repeated. And after making those mistakes there was a lack of openness from the Trust in acknowledging to families what had happened. This report vindicates those families.'
For these reasons, on behalf of the Trust, I apologise unreservedly to the families concerned. I am deeply sorry that so many people have suffered as a result of these mistakes. As the Chair of the Trust Board it is my duty to ensure that lessons are learned and nothing like this happens again.’

‘The Trust welcomes the publication of the Morecambe Bay Investigation report, accepts and acknowledges the criticisms and accepts the recommendations without reservation.

Towards the end of the period covered by the Morecambe Bay Investigation report – as a consequence of the problems in maternity and neonatal services – the whole Trust Board changed and the Secretary of State commissioned the Morecambe Bay Investigation.

The new Board recognised the need for improvement in our maternity and neonatal services and the Trust made a number of service improvements including the following:

- We’ve made a significant investment in staffing with over 50 additional midwives and doctors;
- We’ve improved culture and team-working at the Trust introducing, for example, multi-disciplinary ward rounds that take place four times a day on our maternity units;
- And we’ve improved patient safety by ensuring best practice and learning are shared consistently across all of our hospitals.

The Morecambe Bay Investigation report notes that concerns over clinical practice were confined to Furness General Hospital and concludes that significant progress is being made at this maternity unit.’

Jackie Daniel, the Trust Chief Executive, said:

‘We welcome these comments but we must not be complacent. We will address all the recommendations in the report to ensure that we further improve the services we offer to women and families across our hospitals.’

These apologies were broadcast on television on 3 March 2015 and a video of each apology is available on the Trust website – https://www.uhmb.nhs.uk/morecambebay-investigation/background-our-response/

On 19 March 2015 individual letters of apology were sent to each of the families involved with the investigation.

6.2 Recommendation 18

Recommendation 18 stated that “All of the [previous] recommendations should be implemented with the involvement of Clinical Commissioning Groups, and where necessary, the Care Quality Commission1 and Monitor2. In the particular circumstances surrounding the University Hospitals of Morecambe Bay NHS Foundation Trust, NHS England should oversee the process, provide the necessary support, and ensure that all parties remain committed to the outcome, through an agreed plan with the Care Quality Commission, Monitor and the Clinical Commissioning Groups.”

In order to meet Recommendation 18 a Sub-Committee of the Trust Board was established. The Morecambe Bay Investigation Sub-Committee was established to provide overview and scrutiny, and provide assurance that the action plan to meet the recommendations was monitored and implemented in full.

The Sub-Committee is chaired by a Non-Executive director, with membership
including service user representation, a public governor and a patient and public involvement (PPI) external expert. Cumbria CCG and Lancashire CCG each have statutory responsibilities as commissioners and have two places on the sub-committee. Their representatives provide a key line of communication between the Trust and the CCGs’ own governance arrangements. This enabled the CCGs to provide NHS England with necessary reports and assurance. The UHMB Improvement Director appointed by Monitor is an invited member of the Sub-Committee as well as representation from the Royal College of Obstetricians and Gynaecologists to provide external clinical expertise and guidance.

6.3 The role of the Clinical Commissioning Groups, NHS England\(^3\), the Care Quality Commission [CQC] and Monitor

We are happy to confirm that throughout the past 12 months we have obtained support from, and worked closely with, Cumbria CCG, Lancashire North CCG, NHS England, the CQC and Monitor, providing evidence and assurance to them through regular meetings and through their involvement in Project Groups and Committees. We have benefitted from the involvement of an Improvement Director, and more recently an Obstetric Improvement Director, and a Maternity Improvement Director, appointed through Monitor, and whose external viewpoints, knowledge, and support have been invaluable to us.

6.4 NHS England and the Quality Surveillance Group [QSG]

To support UHMBFT in its implementation of the MBI recommendations NHS England established a single organisation Quality Surveillance Group [QSG]. The group meets monthly and membership of the Group comprises:

- NHS England Area Director (Chair), Nursing Director and Medical Director
- CCG Accountable Officers
- Local Healthwatch representative(s)
- CQC Compliance Manager
- Monitor Compliance Manager
- Local Authority representative(s)
- Public Health England Centre Director
- Local Education and Training Board Director of Education Quality
- UHMBFT Chief Executive, Medical Director, Director of Nursing, Director of Governance

The purpose of the QSG is to systematically bring together the different parts of the system to share information. The QSG is a proactive forum for collaboration and its purpose is to provide:

- a shared view of risks to quality by sharing information;
- an early warning mechanism of risk about poor quality; and
- opportunities to co-ordinate actions to drive improvement, respecting statutory responsibilities of and on-going operational liaison between organisations.

The QSG collectively considers and triangulates information and intelligence to safeguard the quality of care. In particular, the QSG considers:

- what the data and soft intelligence is indicating about where there might be concerns regarding the quality of services
- where the QSG is most worried about the quality of services
- whether further action is required to address concerns, or collect further information, and where is there a lack of information and so a need for further consideration and/or information gathering

The QSG has ensured that all local, regional, and national organisations with an interest in the achievement of the MBI recommendations have been able to meet regularly to review progress and offer direction and support.

6.5 Recommendations for the wider NHS

It was acknowledged through the MBI that failures within the monitoring function of the North West Strategic Health Authority, poor communications of available information from UHMBFT to Monitor\(^1\), and the Care Quality Commission\(^2\) [CQC] all contributed to the many missed
opportunities to identify poor practice, links between incidents and poor working relationships.

It was also acknowledged that the whole of the NHS could learn lessons from the issues highlighted in the MBI report and for this reason the 26 recommendations, additional to the 18 for UHMBFT, were included in the report. These relate to the wider NHS including: all Trusts, the Department of Health, NHS England, all the Royal Colleges, the Care Quality Commission, Monitor, the General Medical Council, the Nursing and Midwifery Council, and the Parliamentary and Health Service Ombudsman.

On the one year anniversary of the publication of the MBI Report Dr Bill Kirkup observed that there had been progress on only 10 of the 26 national recommendations the report had made and ‘given we are a year on it is a disappointing position overall.’

Key recommendations yet to be fully implemented include:

- The introduction of medical examiners. This is in line with pre-existing recommendations in the Mid Staffordshire NHS FT Public Inquiry Report 2013 [Sir Robert Francis] and The Shipman Inquiry 2005 [Dame Janet Smith]
- Investigations by professional regulators, national reviews into rural isolated services
- A review of the NHS complaints system, and
- New standards for how Trusts should approach coroner’s inquests.

These delays have a detrimental impact on our ability to make further improvements which would contribute to safer services; and provide assurance to our patients, their families, and the families involved in the Morecambe Bay Investigation, that there are nationally agreed processes in place to support safe delivery of services.

7 Service Provision

7.1 Maternity Services

Maternity Services are provided at three locations within the Trust. These are:

Royal Lancaster Infirmary – Consultant Led Maternity Unit [CDU]

Furness General Hospital [Barrow-in-Furness] – CDU

Helme Chase [Westmorland General Hospital, Kendal] – stand-alone Midwife Led Unit [MLU]

7.2 Neonatal Services

Neonatal services are provided at both RLI and FGH:

- FGH is a designated Special Care Unit [SCU]. This provides special care and some limited high dependency services
- RLI is a designated Local Neonatal Unit [LNU]. This provides special
care, high dependency care, and a restricted volume of intensive care
- Neonatal Intensive Care Units [NICUs] are provided on a regional basis at Preston [Lancashire Teaching Hospitals NHS FT] and Burnley [East Lancashire Hospitals NHS Trust].

The transport of neonates is provided by the Lancashire and South Cumbria Neonatal Network STaRs team [Safe Transfer and Retrieval service].

8 The Transformation Journey

8.1 Within UHMBFT

Our continuing improvement journey started in advance of the publication of the MBI report in March 2015, and was noted in that report\(^4\). By 3 March 2015 UHMBFT was able to report that there was a new Trust Board in place, with new senior clinical managers in maternity services, and they had already commenced work to improve the quality and safety of maternity services on the FGH site. Nonetheless, the Kirkup Report observation that significant progress remained to be made and that change needed to be sustained, together with the specific recommendations, ensured that there was motivation and commitment to make improvements. Our hospitals are part of vibrant communities and our employees live in those communities; and we want to provide safe, high-quality services so that our colleagues and neighbours will have confidence in us. We have made many improvements since March 2015 and we intend to maintain these and build on them. Although the MBI focused on maternity services we have, wherever possible, used the recommendations in that report throughout the organisation and across all staff groups as we recognise the benefits this will bring.

8.2 The Care Quality Commission\(^1\) [CQC] and Monitor\(^2\)

Following CQC inspection visits in February 2014 UHMBFT was given an overall rating of ‘inadequate’ by the CQC in June 2014. This resulted in UHMBFT being placed in Special Measures by our regulator Monitor in June 2014. In response the Trust developed a CQC Improvement Plan which covered all the identified areas of concern, including those recommended by Monitor and which was regularly monitored through a Quality Surveillance Group.

Following a re-inspection by the CQC in July 2015 Jackie Daniel, UHMBFT Chief Executive, was able to report in December 2015 that the Trust’s rating had improved to ‘requires improvement’ with no areas rated as inadequate. Also, Professor Sir Mike Richards, CQC’s Chief Inspector of Hospitals, recommended to health sector regulator Monitor that the Trust be taken out of special measures.

9 Morecambe Bay Investigation Programme Governance

To implement the recommendations identified within the MBI Report, a robust MBI programme has been designed and implemented, with the Medical Director as the Project Executive Lead, the Women’s and Children’s Services [WACS] Divisional General Manager as Programme Lead, and a dedicated MBI Programme Manager.

Recommendations were themed into the six following project workflows:
1. Workforce
2. Estates
3. Governance
4. Education, Learning and development
5. Clinical Quality
6. Strategic partnership

Project leads and Executive Leads were identified for each workflow and each workflow was
responsible for the implementation of a number of recommendations from the MBI Report across the Trust (where applicable).

In addition to the above main workstreams a communication and engagement plan was developed to ensure there was good communication and engagement with all stakeholders.

Robust governance arrangements are in place to ensure the recommendations are monitored and implemented in full. These include the following:

A Kirkup Recommendation Implementation Group (KIRIG) meeting takes place twice a month; with an MBI Sub-Committee [sub-committee of the UHMBFT Trust Board] meeting monthly with representatives from all governing organisations. This includes patient representation. A monthly report consisting of a narrative report and a highlight report from each project group is produced for the Sub-Committee, UHMBFT Trust Board, and Quality Committee. There is a fully developed action plan which is updated monthly. All documents and progress reports are available via a dedicated page on the internet. A great deal of work has taken place on patient and public engagement to ensure service users’ opinions and views are represented and acted on as appropriate.

Project Key Performance Indicators [KPIs] and outcomes have been agreed, as well as a staged assurance process to ensure the recommendations have been fully addressed by the trust. A Programme Risk Register in place which is reviewed monthly and red risks escalated to the Sub-Committee.

Evidence and Assurance

To ensure effective and efficient delivery of the recommendations, each project within the MBI programme, has a detailed action plan. The action plans were devised to capture the actions required by the Trust to meet the requirements of each recommendation. To ensure the actions were completed to the appropriate standard a staged evidence and assurance process was put into place, as shown in the four stage process below:

Stage 1: Project Lead and Project Sponsor to:
- Collect evidence against the completed actions and sign off to indicate compliance
- Ensure the content is clinically appropriate and meets adequate assurance to meet the completed action as identified in the Action Plan.

Stage 2: Programme Management Office to:
- Receive submitted evidence against each completed action
- Undertake basic review to ensure evidence is sufficient and meets the minimum quality standards, i.e. accepted/approved copy, branded, identifiable, version control, dated, expiry date etc where applicable, and matches Action Plan
- Store evidence in electronic evidence folders
- Produce an evidence index which clearly cross references to the Action Plan

Stage 3: External Audit to:
- Review the electronic evidence folders and undertake deep dives into any areas of concern

Stage 4: Assurance Process
- Once evidence is internally and externally approved then that evidence is submitted to Stage 1 of the Assurance Process

10 Culture

10.1 Overarching view

Of all the necessary requirements for high-functioning organisations ‘culture’ must be the most elusive. It is easy to recognise when culture needs to change and yet can be hard to find effective means of changing it. Independent practitioners across a range of professional groups, clinical, scientific, management etc, with separate interests and skills may not necessarily make for an easy fit with each other. We recognise that improving the culture within UHMBFT has to be a continuous process which will never end. We recognise that at the heart of our approach to quality and safety improvement there needs to be awareness of the interactions between people, and between people and non-human elements involved in complex systems; in essence what is known as Human Factors. By having a holistic view of Human Factors and better understanding of the interaction between all the elements present in a system we are improving our organisational culture, including better communication and team
decision-making. We understand this is not a stand-alone solution, but rather a broad approach that ensures that people have a better understanding of how people are affected by the teams they work with, the systems they operate, and the environment they work within. It ensures people know that the combination of factors affects patient safety and well-being, so that with this awareness we can consistently provide safe and reliable care to patients.

We have appointed a Human Factors specialist to provide a focus for Human Factors across the Trust and have been developing a cadre of staff who have been trained in Insights Discovery, a powerful diagnostic tool designed to support staff to understand both themselves and others in the context of working better together.

‘Using Human Factors to understand and improve how we behave and interact with others and the world around us will help us to continually improve for the benefit of our patients and staff, and make our hospitals as safe as can be.’

Learning and Development Specialist

Our Behavioural Standards Framework was launched in October 2015. It was developed by staff members at all levels and disciplines in the Trust and it sets out the expectations for all staff to take responsibility for their professional behaviour, to work effectively with others and to challenge and be honest when they feel things are not right. This is a key element in establishing the Human Factors approach.

‘Having a Behavioural Standards Framework that was created for staff, by staff, gives us all a clear picture of what is expected of us so that we can deliver safe, high quality services, day in, day out, for our patients.’

Service Desk Team Leader

Other areas where the Human Factors approach has been incorporated is in supporting Root Cause Analysis (RCA)§ and review of clinical incidents through the weekly Patient Safety Summit, clinical skills training and simulation exercises, and the adoption of Schwartz rounds (identification of team decision-making issues, feelings, and targeted support to make improvements).

We will be able to measure some things, which can be seen as proxies for changed culture. These could include: reduction in sickness and absence rates; attendance at multi-disciplinary meetings [all possible staff groups, medical specialties, nursing, midwifery, professions allied to medicine, scientific, etc]; improved communication [across specialties and up and down the organisation]; willingness to speak up [new ideas, queries about clinical or managerial practice]; and willingness to listen [new ideas, queries about clinical or managerial practice].

‘We take the safety of our patients very seriously, and reviewing risks and issues at the four times a day, seven days a week, patient flow and safety meetings, means that we have started to change the culture to one where the patient is at the heart of everything we do’

Clinical Service Manager
10.2 Better Care Together

‘Better Care Together’ [BCT] is a clinically led, health economy-wide programme and is the main route through which the Trust’s long term future will be delivered. Throughout all of our plans our priority remains that of delivering high quality, safe services that meet the needs and expectations of our patients and the requirements of our regulators. At the heart of our proposals is a new model of ‘out of hospital’ care in which local GP practices will become the gateway for people to access all care, including hospital services. There will be a much more proactive approach to care, and people will be empowered to make lifestyle choices that will keep them healthy for longer. There will be opportunities for many hospital staff to provide their expertise within a community setting, taking care to the patient rather than bringing the patient to the hospital. For maternity and obstetric services this will see the continuation of the community midwifery model, where appropriate the provision of consultant obstetric clinics in community settings, and a pilot of case-load midwifery in the Furness area. The development of a multi-agency fully integrated maternity pathway is also been taken forward through BCT as described below.

With our partners in BCT we believe we have an opportunity to develop a pathway which describes and supports the continuous cycle from birth, early years, pre-conception, pregnancy and the post-natal period. Thus we will not simply focus on the needs of the pregnant woman and her family during her pregnancy but will take a whole-life approach so that it encompasses public health, the health of school age children and young people, mental health, together with pre-conception and conception advice and post-natal care. It will, over time, enable pregnancy and birth to be well understood and well supported life-events, and maximise the health of mothers and babies through knowledge shared at all stages.

We are aware that with increasing levels of complex births nationally, it is essential to improve health outcomes for mothers, babies and families by improving health prior to conception, throughout the school years, during pregnancy, birth, postnatal, and early years’ services.

To date a series of nine workshops have been carried out with representatives from the organisations involved in BCT, frontline staff, commissioners and service users. Each workshop has had 30-40 representatives to ensure good involvement of all key stakeholders. Through these workshops the current service has been reviewed, any gaps identified, and a Morecambe Bay Integrated Pathway has been designed. Through these workshops a number of key projects have been identified to ensure the pathway is implemented. These projects have been aligned with the National Maternity Review (2016)

11 Governance within UHMBFT

11.1 Our definition of Quality

Our definition of quality encompasses three equally important elements:

- Care that is safe
  - As evidenced through working with patients and their families to reduce avoidable harm and improve outcomes
- Care that is clinically effective
  - Not just in the eyes of clinicians but in the eyes of patients and their families
- Care that provides a positive experience for patients, their families and our staff
  - As evidenced by ‘I Want Great Care’; the Staff Survey; Listening into Action; and Big Conversations

11.2 Quality Governance

Quality Governance is the output from a combination of structures and processes at and below Trust Board level and this is undertaken through:
11.3 Our Quality Goal

A positive patient and family experience is of great importance to us. We understand that many of our patients often experience life changing diagnoses and treatments, and it is our ambition to make their experience of our care the best that it can possibly be. In order to do this we also recognise the need for our staff to feel valued and supported.

‘My role is to help staff understand how their behaviour and attitudes can impact not only themselves but their colleagues and even the care they give to our patients.’

Learning and Development Specialist

One focus for our improvement work is the views expressed through the I Want Great Care initiative. This will drive quality through a cycle of continuous improvement at ward level, with local actions taken in a timely way by Matrons and Ward Leaders to address concerns and issues raised through patient feedback. The I Want Great Care data is systematically monitored and displayed on all wards and departments involved. During 2014/15 we rolled out I Want Great Care to all wards and departments in the Trust; we have reduced complaints by 5%; we have ensured that 100% of complaints are acknowledged within three days, and ensured that 95% of complaints are responded to within 35 days. During 2016/17 we will be monitoring to ensure that all in-patient areas maintain I Want Great Care; that there is a further reduction in complaints of 3%, and we maintain the acknowledgement and response times for complaints at the 2014/5 goals.

11.4 Patient Safety Summit & the Patient Safety Unit

The weekly Patient Safety Summit reviews any incidents initially assessed by staff to have caused moderate patient harm [or near miss with a high risk rating] which have occurred in the previous week. This review is undertaken by senior doctors, nurses and Allied Health Professionals [AHPs]. The story relating to the incident is discussed along with any immediate actions taken and confirmation of individual learning. The Patient Safety Summit considers and promotes wider learning that can be applied across the organisation and confirms the need to follow Duty of Candour arrangements [monitored by the SIRI (Serious Incident Requiring Investigation) panel]. This learning is communicated in a number of ways within the organisation and with key stakeholder organisations. Responsibility for sharing learning, outcomes, and delivery of recommendations from incidents discussed at the Patient Safety Summit is through the Patient Safety Unit.

The development of a Patient Safety Unit [PSU] has commenced and its role is to ensure that the quality strategy and plans are clinically led and that resources are deployed to the areas of improvement that will most benefit patients and staff. The PSU will consist of senior clinical and support staff who will be under the leadership of the Medical Director and the Executive Chief Nurse. The Unit will provide clinical support and development in response to clinical concerns or themes that are identified through the Patient Safety Summit, internal or external reviews, or through concerns raised by staff or patients. The PSU will be responsible for setting the overall quality strategy and ensuring that resources are aligned to supporting delivery and embedding quality improvement across all services.

The output from this work will be contained in ‘lessons learned bulletins’ which will be issued monthly and available to all staff. In
addition, there will be themed lessons learned bulletins six times a year.

11.5 Incident Reporting

The Trust has supported staff to undertake the reporting and management of incidents through a range of training programmes. E-Learning packages are available for:

- how to report incidents [mandatory for all staff]
- how to manage incidents [mandatory for all managers]
- how to investigate incidents

There are also face-to-face training sessions on how to improve incident reporting, management and investigation.

All training is monitored by the Divisions and key training targets are included in performance reviews.

11.6 Learning with and from other organisations

Key to the development of a ‘learning organisation’ is developing sustainable long-term partnerships with academic and NHS partners so that we learn with, and from, other Trusts and international organisations to bring about measurable improvement. This was a specific recommendation made for all NHS organisations in the MBI Report.

Specifically we are developing strategic partnerships with:

- Strategic Partners for maternity services; these are formal arrangements that include shared learning, governance, benchmarking and academic networking
- Salford Royal NHS Foundation Trust on the Quality Assurance & Accreditation Scheme (QAAS)
- Listening into Action to accelerate employee engagement and involvement
- Advancing Quality Alliance (AQuA)\(^1\)\(^0\) to build on our membership by accessing training and train the trainer resources to enable key Improvement Champions across the organisation to be skilled in improvement science and methodologies
- Lancaster University to commission flexible and bespoke input to leadership development, improvement activities, and Action Learning sets
- Peer Reviews across like-minded organisations in order to provide independent assurance of quality standards

11.7 Quality Assurance and Accreditation Scheme [QAAS]

In order to support and promote consistent delivery of high standards of care within wards and departments a ward-based monitoring and accreditation scheme [see above] has been introduced that allows measurement and assessment of the wards and departments against a core framework of standards. This is designed to ensure that quality and safety are delivered and that patients and their families are at the heart of care delivery. QAAS will be overseen by the Patient Safety Unit.

12 Clinical Quality Project

Clinical Quality is about improving the standards of clinical care provided by all health professionals as a team which works together to ensure that women, children and patients receive the best care in the right place at the right time by the right professionals.

High standard clinical quality in maternity services helps to improve outcomes for women, babies and their families. It also helps to meet women's individual needs and wishes whilst ensuring that they and their baby are safe. It helps to ensure that women and their families have a positive experience throughout their pregnancy, birth and aftercare.

In maternity care, the multidisciplinary team of health professionals must take all possible steps to identify and effectively manage risk with a view to minimising potential harm. Continuous risk assessment, management and appropriate referral should therefore be core functions of care in pregnancy, labour, birth and throughout the postnatal period.

There is updated clinical guidance that reflects latest NICE (National Institute of Clinical Excellence) Guidance. This consists of antenatal risk assessment, intrapartum risk assessment, and when it is appropriate to transfer mothers to other units that will ensure the safe birth of their baby in a unit equipped and skilled to look after their specific care needs. This guidance has been refreshed and since 2012 has been standardised across all three maternity units at UHMBT [Royal Lancaster Infirmary, Furness General...
Hospital, and Helme Chase stand-alone midwifery led unit at Westmorland General Hospital, Kendal].

For example for women booked to delivery at Furness General Hospital if there is suspicion of premature labour prior to 32 weeks gestation these women will be transferred to the Royal Lancaster Infirmary or another appropriate unit which can provide a higher level of neonatal care and support for the baby.

Since 2012, all maternity staff (including Midwives, Obstetricians and Anaesthetists) receive PRactical Obstetric Multi-Professional Training (PROMPT) training. PROMPT is an evidence based multi-professional training package for obstetric emergencies. It is associated with direct improvements in perinatal outcome and has been proven to improve knowledge, clinical skills and team working. This training is mandatory along with other training requirements identified in the comprehensive maternity training needs analysis. It now also mandates attendance at a series of meetings that provided valuable learning and feedback as part of the multidisciplinary team for all midwives as part of their annual training plan. This is also articulated in all job descriptions across the organisation in respect of individual professionals taking responsibility for familiarising themselves with the trust mandatory training and their job essential role-specific training.

With robust audit programmes in place to audit the quality and delivery of services the maternity services at UHMBT can triangulate information and clinical outcomes across all three sites and make changes and improvements based on numerous sources which include: audit outcomes, clinical incidents, and the clinical governance performance dashboard as well as service user feedback.

All of this has seen improved outcomes for mothers and babies both from a clinical and patient experience perspective. Throughout the Clinical Quality project, clinical guidance and procedures as well as training and education plans for Women’s and Children’s services that are already in place have been reviewed, refreshed and where required updated.

Opportunities have been taken to improve further on developments and changes that had already been made prior to the Kirkup Report in March 2015. These are designed to provide high quality safe maternity services so that women receive the best care for themselves and their babies in ways that meet their wishes and needs. These changes and developments have been made with service user involvement and input as well as the views of a wide spectrum of professional groups. The principle of user involvements has underpinned everything the project has undertaken.

13 Workforce

13.1 Our Workforce Strategy

Our intention is that working at UHMBFT will be an experience that attracts high performing compassionate employees who are as drawn to our culture of achieving excellence as they are to the beauty and variety of our landscape.

Working in collaboration with private and third sector health and care organisations has enabled the Trust to develop a proactive and innovative recruitment strategy. The Trust was finding it challenging to recruit hard-to-fill specialist roles in an increasingly competitive employment market and had difficulties resourcing existing staff across its services and locations. Working on retention and attracting new talent to the area was pivotal if we were to meet the high volume demands of our services. The Trust recognised that attracting talent to South Cumbria was important, not just for the organisation but for other employers in the area as well. The Trust took the opportunity to build relationships with some major employers in the area, including BAE Systems, GlaxoSmithKline, Kimberley Clark, Siemens, and Furness College. We invested heavily in recruitment activities in partnership with these other employers. We developed a web portal - http://freshstart.uhmb.nhs.uk and collaborated in an initiative called ‘Choose South Cumbria’ which included hosting a week-long virtual careers fair in May 2015. Working across organisational boundaries with private and third sector organisations
has been an excellent learning opportunity. It has enabled the Trust to develop locally related solutions to improve recruitment and retention. We used a values based approach and developed an apprenticeship programme with three local colleges and the University. Once students have successfully completed the programme they can apply to us for a nursing discipline degree or other suitable roles. This new approach resulted in UHMBFT winning the collaborative working category in the Allocate Awards 2015. These awards are made by Allocate Software who provide workforce software solutions, such as rota management, for the NHS.

All this work led to a significant increase in recruitment over previous years. We have had 719 new starters since 2014/15, including 159 registered nurses and midwives, and 37 consultants [across all services and all three sites] were recruited in the same period.

As described above we want to actively support staff through the necessary change processes by having a culture of continuous improvement. Our workforce strategy focuses on building and embedding an organisational culture that will deliver a great place to work and a great place to be cared for. Recognising that consistently excellent patient services will only be delivered where there is a clearly articulated framework of our vision, values, and behaviours, we have set out what we stand for as a Trust and identified the behaviours and attitudes that our patients should expect from all our staff. We know from experience that we are judged on how we act, and our reputation is defined by how we deliver against our vision and put into practice our core values.

“Our team makes sure we get the right people, who live and breathe our values, working in our hospitals”

Workforce Business Partner

As part of our on-going work to improve the working life of our staff we have been one of the first Trusts in the country to appoint a Freedom to Speak-Up Guardian, and have started to improve inclusion for all staff by holding our first ever ‘Towards Inclusion’ event where we formed a ground breaking partnership with the British Association of Physicians of Indian Origin to help create a culture in our hospitals that recognises, respects, and values diversity.

We know that it takes time to achieve the cultural change we require, time to change the way people think, act and behave in an organisation. One of the means we use to measure our progress is through the NHS annual staff survey. The 2015 National NHS staff survey was published in February 2016 and when we compare this to 2014 we found that across two measures 3.95 out of 5 staff feel motivated at work [compared with 3.81 in 2014] and 3.72 out of 5 staff would recommend the organisation as a place to work or receive treatment, compared with 3.47 in 2014.

Other improvements since 2014 included:

- More staff felt they received support from their immediate line manager
- More staff feeling the Trust made effective use of patient and service user feedback
- There was an increase in staff witnessing and reporting potential harmful errors, near misses or incidents in the last month

“We are really pleased that we have seen improvements in motivation in our staff survey results as it is showing a slow but steady improvement in the morale of our staff and how proud they feel to work in our hospitals. Staff have worked really hard to make some significant improvements in the care we offer our patients, and they should feel proud of what they have achieved. It is also great news that there has been an increase in the number of staff receiving appraisals.”

Jackie Daniel – Chief Executive

This survey also reflected where as a Trust we are below average and we will be working through the leadership teams to understand how we can make improvements in these areas, which include things like the quality of appraisals, and the percentage of staff able to contribute towards improvements at work.
13.2 Cross Bay Working

There are a number of ways in which cross-Bay [and multi-disciplinary] working is achieved. They include:

- All job descriptions have been reviewed and revised to include the requirement for all clinical staff to be flexible regarding service provision, and they can, and do, work on sites other than their primary base when required.
- Job descriptions are also clear in respect of the Trust’s commitment to multi-disciplinary working and the need to develop strong cross-specialty relationships.
- UHMBFT has appointed specialist midwives to take a lead in important areas such as Governance, Risk, Practice Development, Audit, Quality & Safety, Bereavement, and Clinical Education. These posts are cross-Bay.
- All obstetric and midwifery Guidelines [as required by CNST\(^1\)] have been reviewed against NICE guidelines [where these are available] to ensure compliance, are available electronically through Heritage, and are in use throughout UHMBFT.

This work was undertaken as part of the implementation of Recommendations 8 and 14.

All our hospital sites have high quality video-conferencing facilities. These are used extensively to facilitate cross-Bay working without the need to travel. The tables below illustrate the range and variety of work undertaken in this way.
**RLI = Royal Lancaster Infirmary**  
**FGH = Furness General Hospital**  
**WGH = Westmorland General Hospital [Helme Chase stand-alone Midwifery Led Unit]**

### MATERNITY

<table>
<thead>
<tr>
<th>Meeting or activity</th>
<th>Cross Bay</th>
<th>External collaboration with</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participation in PROMPT multi-disciplinary training</td>
<td>with RLI, FGH and WGH</td>
<td>RLI and FGH [using VC facilities]</td>
</tr>
<tr>
<td>Monthly half-day Audit meetings</td>
<td>RLI and FGH [using VC facilities]</td>
<td>RLI and FGH</td>
</tr>
<tr>
<td>6-monthly full-day Audit meetings</td>
<td>RLI and FGH [using VC facilities]</td>
<td>RLI and FGH</td>
</tr>
<tr>
<td>weekly MDT [cancer]</td>
<td>RLI and FGH</td>
<td>Royal Preston Hospital</td>
</tr>
<tr>
<td>Monthly MDT [Colposcopy]</td>
<td>RLI and FGH</td>
<td>Central Manchester FT</td>
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### MATERNITY

<table>
<thead>
<tr>
<th>Current service provision</th>
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</tr>
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<tbody>
<tr>
<td>Integrated hospital and community working</td>
<td>RLI, FGH and WGH</td>
</tr>
<tr>
<td>Skills passport for all staff</td>
<td>RLI, FGH and WGH</td>
</tr>
<tr>
<td>Development programme for all grades of midwives</td>
<td>RLI, FGH and WGH</td>
</tr>
<tr>
<td>Succession planning</td>
<td>RLI, FGH and WGH</td>
</tr>
<tr>
<td>Mandated attendance at key meetings</td>
<td>RLI, FGH and WGH</td>
</tr>
<tr>
<td>3 days of mandated training for all midwives and clinical support workers to include PROMPT which is an MDT, in addition to important public health and midwifery updates</td>
<td>RLI, FGH and WGH</td>
</tr>
<tr>
<td>CTG package to include 'fresh eyes'. Will soon be competency based</td>
<td>RLI, FGH and WGH</td>
</tr>
<tr>
<td>Training matrix for professional essential training [band related]</td>
<td>RLI, FGH and WGH</td>
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### PAEDIATRICS

<table>
<thead>
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<th>External collaboration with</th>
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<tr>
<td><strong>Quarterly</strong> Perinatal meetings</td>
<td>RLI and FGH</td>
<td>Royal Preston Hospital Burnley General Hospital</td>
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<tr>
<td><strong>Monthly</strong> half-day Audit meetings including management, nurses, neonatology and community paediatrics,</td>
<td>RLI and FGH [using VC facilities]</td>
<td></td>
</tr>
<tr>
<td><strong>6-monthly</strong> full-day Audit meetings including management, community paediatrics, nurses, obstetrics and neonatology</td>
<td>RLI and FGH [using VC facilities]</td>
<td></td>
</tr>
<tr>
<td>Cystic Fibrosis - shared care, visiting clinics, and <strong>6 monthly reviews</strong></td>
<td></td>
<td>Central Manchester University Hospitals NHS FT</td>
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<tr>
<td>Visiting clinics for: Neurology, Cardiology [both monthly] urology and nephrology [quarterly]</td>
<td></td>
<td>Central Manchester University Hospitals NHS FT</td>
</tr>
<tr>
<td>Neonatal nursing <strong>daily</strong> liaison with Maternity</td>
<td>RLI and FGH</td>
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### ANAESTHETICS

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<th>Cross Bay</th>
<th>External collaboration with</th>
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<tr>
<td>Combined Audit meeting <strong>monthly</strong></td>
<td>with RLI and FGH</td>
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<tr>
<td>Anaesthetic scenario training</td>
<td>with RLI and FGH</td>
<td></td>
</tr>
<tr>
<td>Participation in PROMPT multi-disciplinary training</td>
<td>with RLI and FGH</td>
<td></td>
</tr>
<tr>
<td>Common clinical practice, guidelines &amp; protocols</td>
<td>across RLI and FGH</td>
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13.3 Integrated Teams

As noted above, and as part of the strategic intentions of UHMBFT, multi-disciplinary working with truly integrated teams is a high priority for UHMBFT. The work achieved through the Human Factors approach emphasizes that all staff members should value the contribution that their colleagues, across all working groups, can bring to the care we provide. This not only contributes to safer services, but also contributes to a better working environment.

13.4 Leadership development and integrated teams

In response to MBI Recommendations 14 and 16, and an 'inadequate' rating for the domain of 'well-led' in the CQC review of 2014, the Trust had decided by 2015 to review and improve leadership, teamwork, and communication across the organisation. There have been a number of improvements made to strengthen leadership at all levels of the organisation and these include the development of site-based leadership teams and leadership development programmes.

It had been found that job descriptions did not have consistently clear purposes or expectations in respect of management and leadership. The accountability arrangements varied between divisions and departments and functions and responsibilities were often not specified. It was difficult for post-holders to be clear about their roles and how they would be held to account, and it was difficult to recognise and celebrate achievements. Through a Trust wide design process and consultation a new management and leadership structure was developed, supported by new job descriptions. The structure, based on a triumvirate of clinical, managerial, and nursing roles, is replicated at every level throughout the Trust, so that there is integration of all those functions at every level. Each divisional management team typically consists of three leaders, the divisional triumvirate team who work as partners in the delivery of high quality, effective and efficient services for patients and staff. The team comprises a Divisional Clinical Director, an Assistant Chief Nurse, and the Divisional General Manager. They are required to communicate effectively as a team and as part of the Corporate Trust Management Team.

Reinforcing triumvirate working at all levels in the organisation is designed to promote succession planning and the facilitation of embedded expected behaviours and values. This will promote effective multi-disciplinary team working and communication.

In addition, both RLI and FGH have site based leadership triumvirates comprising a Deputy Chief Operating Officer, a Deputy Chief Nurse, and a Deputy Medical Director. These teams do not have line management responsibility in relation to divisional teams, but will be required to use their influence and professional credibility to support delivery of best practice across all services. The Deputy Chief Nurse/Head of Midwifery has a statutory role in relation to oversight of midwifery services and will be included in this team to provide leadership advice and support in relation to midwifery care, practice and performance.

14 Maternity Services

14.1 The improvements that were made before Kirkup was published

A new Trust Board was in place with a new Chief Executive appointed in August 2012, new Directors of Governance, Nursing and
Workforce appointed in 2013, a new Director of Finance [and Deputy Chief Executive] from the beginning of 2014, together with a new Medical Director in January 2015 and a new Chief Operating Officer in April 2015. This newly-configured team was focused on the need for change in an open and transparent culture.

Specifically in maternity services the following had begun:

Multi-Disciplinary Team training and development days were introduced in Maternity services in 2012 and there are currently three mandatory study days a year. These cover the following:

- **Day 1:** PROMPT [Practical Obstetric Multi-Professional Training]— All maternity, obstetric staff and anaesthetic staff
- **Day 2:** All maternity and obstetric staff.
- **Day 3:** All midwives and support staff.

Trainers have attended the multi-professional PROMPT facilitator training led by the RCOG in London. This then facilitates the use of ‘in house’ multi-professional obstetric emergency drills using our own guidelines and policies. Multi-professional training has allowed staff to deliver training on their own specialty and contribute to scenarios reflecting their job role.

There were major improvements in staffing levels within the service, with the appointment of an additional 27 whole time equivalent midwives to work across the Trust, and a further 16 community midwifery posts. The Trust also appointed specialist midwives to take a lead for important areas, including a Governance Lead, a Risk Manager, a Practise Development Midwife, an Audit Midwife, Clinical Educators, a Quality and Safety Midwife, and two Bereavement Midwives.

In early 2014, the Trust approved additional investment for its Children’s and Young People’s services with the recruitment of the equivalent of 21.48 full time staff. This campaign was aimed at recruiting both registered and children’s nurses and support workers. In May 2014, recruitment days were held for Clinical Leaders, Children’s Nurses, Clinical Support Workers and Play Specialists, and appointments were made.

Preceptorship scheme that was put in place across the Trust, together with the rotation of newly recruited midwives across the service so that they gain experience in all of the units across the Bay. That has helped to encourage people who have worked at the Trust a long time to want to rotate around the sites. Ward Managers and Matrons now meet face to face every week and the Labour Suite Coordinators have regular time out days to discuss progress, issues, etc.

Multi-disciplinary team [MDT] ward rounds to review women on the Labour Ward were increased to two or three times per 12 hour period and these consist of a Consultant, Registrar and Labour Suite Coordinator. The Maternity Ward, Labour Ward and SCBU speak on a daily basis to discuss activity on the wards, any transfers needed and any other issues. Other improvements include: the cross bay audit day that takes place every six months, the regular MDT perinatal and caesarean section audit meetings, and the monthly patient safety review meetings at each site. All root-cause analyses are now multi-disciplinary and cross-bay so the person carrying out the analysis is more often than not, based at another site, guaranteeing impartiality.

The relocation of the SCBU into the footprint of the Maternity Ward at FGH also helped the relationships between midwives, neonatal nurses and Paediatricians, enabling them to communicate more regularly and have any professional debate face to face.

The Trust launched the 15 Steps audit in its maternity units. This involves staff from outside the service, service users, governors and volunteers walking into each unit and feeding back on what they think of the environment and anything else based only on what they see in the first 15 steps onto the unit. This gives the Trust a good idea of the first impressions women get as they walk through the door and allow for positive changes to be made to improve the environment.
14.2 What improvements we have made since Kirkup was published

A number of Cross bay/ cross professional meetings are now in place in the Women and Children’s Division. These include:

- Divisional Governance Meeting (DGAG),
- Divisional Management Team and Board,
- Site based Multi-professional morbidity and mortality meetings,
- Cross Bay multi-disciplinary audit Meeting,
- Obstetrics and Gynaecological Guideline meeting,
- Obstetrics and Gynaecological Senior Meeting,
- Children and Young People multi-disciplinary - Knowledge, Information, Decision and Sharing days (KIDS)
- Training and development days,
- Children and Young People Seniors meetings,
- Multi-disciplinary team ward rounds in Obstetrics and Gynaecology
- Multi-disciplinary team ward rounds in Children’s and Young People’s services

There is now mandated attendance at:

- Prenatal mortality meetings;
- Caesarean section meetings;
- SIRI panel,
- Patient safety summit,
- Cross bay audit,
- Labour ward forums and
- Divisional Governance meetings

a) We have undertaken a review of all cross bay meetings to ensure that attendance is from the appropriate people and that there is a clear framework for cascading key clinical information, including learning from incidents, changes to protocols etcetera.

b) Attendance at mortality and morbidity debrief meetings for those staff involved in an incident is included as an explicit requirement in the Training Needs Assessment and job description/job plan of every registered professional.

c) All current risk assessment and transfer policies have been reviewed, updated and made available through Heritage.

d) Perinatal Institute Maternity Health Records are in place for all women and their use is subject to continuous audit.

e) There is updated clinical guidance that reflects latest NICE Guidance in respect of antenatal risk assessment, Intrapartum risk assessment, and transfer of mothers to other units that ensures the safe birth of their baby in a unit equipped and skilled to look after their specific care needs. This guidance has been refreshed and since 2012 has been standardised across all three maternity units at MBHT.

f) With robust audit programmes in place that audit the quality and delivery of services the maternity services at MBHT can triangulate information and clinical outcomes across all three sites and make changes and improvements based on audit outcomes, clinical incidents as well as service user feedback through numerous means and forums.

All of this has seen improved outcomes for mothers and babies both from a clinical perspective and also a patient experience perspective.

14.3 Video Conferencing links for real time learning

We have video conferencing equipment at all our sites, and in addition to these facilities
within meeting rooms we also now have them on our Labour Wards. This V-C equipment is used extensively to enable discussion between sites without the need for travel. Multi-disciplinary team meetings are also multi-site using this equipment. The MDT ward rounds on the Labour Ward are shared with, and have contributions from, staff across the Bay using these links.

15 Maternity Strategic Partnership

‘Partnering with other Trusts will give the organisations opportunities for learning, mentoring, staff development, sharing approaches and best practice in terms of governance and risk management. Having partners like this will help us to ensure that we can continue to learn and improve the services we offer to women and their families.’

David Walker – Medical Director

The MBI Report noted the team had consistently heard that since 2012 steps had been taken to improve the knowledge and skills of clinicians and the ways that they worked together. New medical staff had been appointed in both paediatrics and obstetrics; new midwifery staff had been appointed with experience and training in other units, not just one unit within the Trust; regular multidisciplinary meetings take place to discuss incidents, practice and management; and a more systematic approach has been put in place to investigate incidents, identify root causes and disseminate lessons learnt. There is enthusiastic and committed leadership for midwives across the Trust and particularly at FGH. Prior to the publication of the MBI Report UHMBFT and its partners in the BCT programme had determined that it would be appropriate to commence a search for a Maternity Stability Partner to provide the benefits that were subsequently specified through the Kirkup Investigation. This work has been continued through the Maternity Strategic Partnership.

UHMBFT believes that the Maternity Strategic Partnership fits within its determination to provide consistently high quality care. There is an appetite for change and a commitment to new ways of working and new teams. The aim is to have a partnership with organisations which value quality and innovation, which in turn assists us in ensuring safety and service enhancement.
In late 2015 a Royal College of Obstetricians and Gynaecologists [RCOG] Review of maternity services in Cumbria was commissioned by NHS Cumbria Clinical Commissioning Group and NHS Lancashire North Clinical Commissioning Group, and the timing of that review and report is broadly similar to that of the Morecambe Bay Investigation. There are many points of commonality in respect of observations and recommendations between the two reports; not least the requirement in the RCOG report that:

‘Arrangements must be in place for secondment of consultants providing maternity care on a regular basis as part of revalidation for in-service training at a large tertiary centre in order to maintain appropriate clinical skills.’

We felt that the two objectives that Recommendation 10 and the RCOG requirement above were seeking to address were:

a) To reduce the impact of potential clinical isolation of senior medical and nursing staff working in the Maternity and Paediatric services at UHMBFT. We believe this could be mitigated through:

- The formation of a ‘community of practice’ with one or more tertiary providers so that UHMBFT staff take part in training opportunities, learn about best practice, leadership traits and the actions that support a culture devoted to patient safety. This will, in turn, be a major determinant to ensure that local maternity services are safe and sustainable;
- The development of shared training in skills laboratories – supported by IT to enable multi-site, multi-organisational input to virtual ‘situational awareness’ training and creating conditions that foster team effectiveness and purpose.
- Opportunities for obstetric and midwifery staff to attend tertiary units for additional experience, which could include sub-specialisms particular to tertiary units.

b) To provide guidance and advice so that policies, protocols, and risk management are optimal; and so that rigorous governance processes support the delivery of high quality care in Morecambe Bay Hospitals. This could be achieved through:

- Peer review of policies and protocols between organisations with the aim of facilitating true understanding of the application and implication of these policies in safe clinical practice;
- Visiting expert review of ward rounds and MDTs to provide constructive challenge;
- Real time collaboration on risk management of complex cases
- Mentoring and support for all clinical staff, initially focussing on those in leadership roles.
- Mentoring and support for senior and middle management, including leadership coaching, so that a supportive culture of motivation can develop to support safety and change.
- Peer review of clinical incidents, investigations and complex cases which will inform the UHMBFT Board Assurance Sub Committee

15.1 Partnership with CMFT and LTH

Following publication of the MBI Report and in pursuit of Recommendation 10 the Board of UHMBFT made initial approaches to Central Manchester University Hospitals NHS FT, and responded to an approach from Lancashire Teaching Hospitals NHS FT. During these discussions between Chief Executives both organisations expressed interest in becoming Maternity Strategic Partners. The parties to Recommendation 10 are therefore:

- University Hospitals of Morecambe Bay NHS FT [UHMBFT]
- Central Manchester University Hospitals NHS FT [CMFT]
- Lancashire Teaching Hospitals NHS FT [LTH]
- With both NHS Cumbria CCG, and NHS Lancashire North CCG as Associate Partners
15.2 Memorandum of Understanding

The Memorandum of Understanding was approved by the UHMBFT Trust Board on the 25th November 2015. The Partnership is overseen by the Maternity Strategic Partnership Committee, with membership from the three partners and the two CCGs [Associate Partners]. It reports to the UHMBFT Trust Board as shown in the diagram following.

The first meeting of the Maternity Strategic Partnership Committee took place the 29th February 2016, with further meetings established on a quarterly basis [22nd June 2016, 14th September 2016, and 14th December 2016].

15.3 Who is taking part

In the first phase all non-training grade doctors in Obstetrics and Gynaecology at both FGH and RLI will take part in development placements at LTH and CMFT. Depending on each person’s special interests, and the CPD requirements identified in their Personal Development Plan we will undertake a matching process with LTH and CMFT to identify the best placement opportunities. It is possible for placements to include time at both trusts or one or the other. The clinical view is that 5 days would be the ideal length of time in total for each individual, although this is not fixed and can flex depending on individual requirements. Non-training grades will use their allocated study leave to undertake placements and the output from that placement will form part of their revalidation portfolio. Feedback from each placement is captured on the UHMBFT Training Management System and summary reports can be provided from this when required.

There are 26 non-training grades in O&G at UHMBFT and the intention is for one placement a month which will ensure that each doctor has undertaken a placement within their three-year validation period.

Midwifery development opportunities will be undertaken using a different model. To gain maximum utility from the scheme, and to fit in with midwifery contractual arrangements which do not include CPD or study leave as the norm, midwives will normally train in groups. These groups could be in skills labs, or via the V-C links on both sites. Topics will be determined and a programme established with our partners through the Maternity Strategic Partnership Committee. In addition to this, senior midwives will be given the opportunity to develop their specialty interests in the same ways as doctors on a one-to-one basis at our partner organisations.

Doctors and Midwives at both RLI and FGH are enthusiastic about the opportunities offered by the partnership, namely networking, experiencing the way another trust organises and delivers its work, and having the opportunity to learn and reflect on practice outside their own organisation.

A schedule of ‘virtual MDTs’ is in place within UHMBFT and undertaken cross-Bay using video links; and the use of video links in the planned skills labs at UHMBFT will be taken forward with our partners when they have the requisite equipment in place. UHMBFT already have shared rounds between the labour suites using video links, and our partners will also be able to take part in these once the appropriate links have been set up.

Since 2014 protocols and guidelines have been shared with both CMFT and LTH and this will continue

Currently Neonatology is included with the O&G opportunities, and once the processes and procedures have been established to facilitate the smooth working of placements in our partner organisations we will be extending the partnership, through a second phase, to cover Paediatrics and Anaesthetics. We will be seeking the views
of the paediatric and anaesthetic staff to determine how they believe the strategic partnership will work best for their specialties so that any partnership work is tailored to their needs and preferences.

15.4 Collaborative working and Placements

Six members of the UHMBFT staff took part in the first piece of collaborative working under the Strategic Partnership banner when they attended a Clinical Audit and Effectiveness day at CMFT on the 19th January 2016. The three obstetric consultants [including the clinical leads from both RLI and FGH] reported that:

- There was excellent turn out from CMFT doctors, nurses and midwives and all were actively involved in the presentations. Rotas and workload had been adjusted to facilitate attendance.
- There was wide ranging discussion about the management of a difficult case with contributions from all staff groups.
- Examples of information for GPs on a new College guideline were made available for UHMBFT staff to take away.
- There was a presentation on a ‘never event’ which led one of the UHMBFT consultants to check policy within UHMBFT to ensure the problem was covered in our protocols.
- It was an excellent opportunity for networking and a tour of the labour ward was offered and accepted on the day.
- Contact information was freely exchanged and details of specialist clinics provided.
- One member of staff noted that the day had provided a number of ideas for quality improvement actions as part of revalidation which he would be implementing on his return to UHMBFT.

The first clinical placement is planned for summer 2016 and a schedule of placements for the following 12 months will be developed in conjunction with both strategic partners. Organisational arrangements such as honorary contracts and other indemnifying arrangements have also been agreed with our partners. The schedule of placements will be supplemented by attendance at ACE days and Human Factors training, and all attendees will be required to provide feedback from the placement or meeting so that their continuing professional development portfolio can be updated, as well as the UHMBFT Training Management System. Summary reports of the outputs will be created quarterly and submitted to the Maternity Strategic Partnership Committee.

15.5 What the offers from CMFT and LTH comprise

There will be a continuation of the existing arrangements with both CMFT and LTH whereby clinical advice is available for obstetrics, maternity services, neonatology and paediatrics. UHMBFT also collaborate with CMFT and LTH in respect of incident investigation. Other clinical links are described in the tables in section 10.2

The offer of clinical placements has been made for the following obstetric sub-specialties: haematology; cardiology; rheumatology; diabetes; monochorionic twins; perinatal mental health; HIV in pregnancy; neurology; obesity; and endocrinology. Whilst undertaking placements UHMBFT doctors will also be able to take part in routine meetings such as practice reviews, business meetings and obstetric HDU meetings.

CMFT have an obstetric High Dependency Unit in St Mary’s. This gives an exceptional opportunity for midwives and doctors to see intensive care for women provided jointly by midwives and intensive care nurses in a dedicated obstetric facility outside the traditional Intensive Care Unit.
Discussions have commenced regarding a CMFT and/or LTH clinician spending a day in Morecambe Bay on a regular basis [preferably once a month]. Any such arrangement could allow for observation of practice, attendance at MDTs and ward rounds etc.

In addition to clinical skills placements CMFT have a highly regarded Human Factors training programme which incorporates Root Cause Analysis. They have offered UHMBFT places on forthcoming training events. We are in the process of exploring how CMFT can provide this training at RLI and/or FGH to enable more people from the full range of disciplines to attend.

15.6 How we imagine this will work in the future

Our desire is to see the Strategic Partnership flourish and for it to be an enduring element of the UHMBFT approach to individual and team development. We believe that relationships built through this partnership will have a positive effect on patient safety and be beneficial for staff recruitment and retention.

16 User Involvement and Engagement

16.1 User Involvement

In line with our approach to involve our service users in the work we do and our plans for the future we have, whenever possible, included current and past users of our maternity services in a number of service areas. The table below gives details of this work.

16.2 Working with families previously adversely affected or involved with the MBI

Over the past year we have worked closely with some of the family members affected or involved in the MBI. They have contributed to the Clinical Quality project group and the Estates project group where they were involved in the co-design. Two family members were voting members of the MBI Sub Committee and have attended meetings. They reviewed guidelines, took part in 15 Step Walk-arounds, and the Always Events project. Using personal experience one
family member has been instrumental in the planning and delivery of a national Cardiomyopathy meeting being held in Kendal in April 2016

16.3 Maternity Service Liaison Committees [MSLCs]

The MSLC acts as a multi-disciplinary forum bringing together the different professions involved in maternity care together with parents and parent’s representatives. There is an overarching MSLC for the whole of the Morecambe Bay area. This is chaired by a service user and has representation from UHMBFT, Cumbria CCG, Lancashire North CCG, and service users. There are also three locality based sub-committees covering Kendal, north Lancashire, and Furness.

The MSLC will advise the CCGs and other commissioners on all aspects of maternity services provided for their residents, including:

- Strategy for service
- Progress on implementing the national standards and recommendations
- Lessons from investigations and reviews of maternity services by the Care Quality Commission
- Service specifications for maternity service contracts
- Public and Patient involvement
- Configuration of services
- Quality standards for maternity services and ways of monitoring standards
- Clinical governance, audit and guidelines for clinical care
- The consistency in the delivery of maternity services and clinical practice across the district, based on reliable research evidence.

The MSLC aims to ensure that maternity services commissioners and the provider units take account of the views of women and families using the service.

These committees are an essential part of our engagement strategy. Members of the MSLCs take part in meetings [both public and those internal to the Trust], provide a sounding board for documents developed by the Trust, and provide the ‘user perspective’ for strategic developments.

16.4 Engagement Events

The Trust has made a commitment to take on board the experiences and views of the public, and to translate those views and experiences, wherever possible, into improved services we provide for them. We do not want to take a top-down approach. We want to ensure that our patients and families describe the Trust as their provider of choice based on the quality of their experience. The work we focus on now, and in the future, will be based on the guiding principle that all care will be viewed through the eyes of our patients and their families. In pursuit of this principle we have undertaken a number of engagement events, and used a range of engagement methods to find out what people feel and want.
In the autumn of 2015 Healthwatch Cumbria [HWC] was commissioned by NHS Cumbria Clinical Commissioning Group [CCG] and NHS Lancashire North CCG to undertake a conversation with the public regarding their experiences of maternity services in Cumbria and north Lancashire. The aim of the conversation was to understand ‘what does a great service look like’ and focused on the views and experiences of [mainly] women of childbearing age and their significant others. HWC worked with the MSLCs, the North and South Cumbria Communications and Engagement Groups and a number of NHS workers to co-design an internet based survey which resulted in 1,234 responses. 70 Engagement sessions were held, with hundreds of facilitated conversations and the results were analysed for statistical significance and relevance. There were themes that emerged from the questions, including the free text. The most significant of these were:

- The importance of continuity of care throughout the pregnancy, the birth and postnatal period
- Consistency and quality of information and communication
- Postnatal support for breastfeeding
- Support and information for women to make informed decisions and choices
- Accessible services and choice, thinking about some specific issues such as young mums, women with specific needs, travel, and place of birth

The themes that emerged were powerful and have already led us to make changes. For example, many women wanted their partners to be able to stay with them on the ward after induction, and overnight if the birth took place late in the day. The plans for the new maternity unit at Furness General Hospital have taken this into account. We were reminded that pregnancy and birth can be frightening and isolating experiences and that we need to be compassionate at all times. Continuity of care and carer was valued highly and as mentioned elsewhere we will be undertaking a pilot in 2016 to determine whether case-load midwifery is a model that delivers this continuity and whether it can work for our populations. We have been pleased to note that the National Maternity Review[14] makes this recommendation and we hope to be amongst the first in England to take forward a pilot and produce an evaluation of the model which takes women's views into account.

‘We were able to go out into the community at a recent event to ask them what was important to them and how they want to see us change and improve in the future. Hearing their feedback, especially around the proposed designs for our new Women’s and Children’s unit at Furness General Hospital has made a real difference and we can now take their comments and suggestions on board as we move forward.’

Maternity Unit Manager
16.5 Maternity Matters Events

In addition to the survey mentioned above 'Maternity Matters' public events were held in Barrow and Lancaster, with a further one planned for Kendal. These were promoted via traditional and social media channels, users stories were filmed for use on the Trust website, and feedback was captured at the events. We used the more qualitative data gathered from these facilitated groups which had used the café style ‘tablecloths’ information. The tablecloths were analysed thematically by two separate and independent researchers. It was found there was much in common with the results of the electronic survey, so there is a good match with the survey headlines. The themes that emerged from the additional qualitative analysis provide a summary response to the question we asked at the beginning: ‘What would a great maternity service look like’?

It would have:
- Well trained midwives who are knowledgeable and pleasant
- Midwives who are properly supported in their role
- Eradicated the need for agency staff
- Continuity of midwife support throughout pregnancy and labour
- Holistically well trained health care staff,
- Health care staff being respectful to the women and families they serve
- Good communication being practised and fostered between staff and staff and between staff and women
- Sensitivity towards family wishes and needs
- To treat the women as autonomous adults

16.6 Always Events

An Always Event is a clear, action-oriented, practice or set of behaviours that:
- Provides a foundation for partnering with patients and their families;
- Ensures optimal patient experience and improved outcomes; and
- Serves as a unifying force for all that demonstrates an ongoing commitment to person- and family-centred care

Always Events are aspects of the patient experience that are so important to patients and family members that health care providers must aim to perform them consistently for every individual, every time. These can only be developed with the patient firmly being a partner in the development of the event, and this co-production is fundamental to ensuring organisations meet the patients’ needs and what matters to them.

An Always Event must meet four criteria: It must be important [have a meaningful impact]; be evidence-based [contribute to optimal care]; be measurable [for evaluation purposes]; and be affordable and sustainable.

UHMBFT is a Pilot site for NHS England for ALWAYS events in maternity services. This is a co-design project with service users and frontline staff, to identify area of improvement which really matter to service users. As part of this project we have worked with the Maternity Service Liaison Committee and service users; we have been to well-baby clinics and places where mothers and babies congregate, and we have asked questions with the intention of acting on what we hear. We heard that women and their families wanted their partners to be able to stay overnight during the laboring and immediate post-natal period. This view directly contributed to the co-design of the new maternity unit at FGH and the inclusion of facilities for partners in the accommodation and lay-out.

We will be continuing with this approach within Maternity Services. Overnight accommodation for partners in the new unit at FGH is a first step, and we have been using this co-production technique in the development of our Integrated Maternity Pathway. We can see many opportunities in the future where we will be able to work with our patients and their families to ensure consistent delivery of high quality care that fits with what people want.
16.7 Friends and Family Test and UHMBFT Maternity Patient Experience Questionnaire

In order to measure the patient and family experience and satisfaction with the Obstetrics and Gynaecology services we ask women to complete a Maternity Patient Experience Questionnaire. This is given to all women who give birth and provides the opportunity for women to tell us about their antenatal, birth and postnatal experiences. Analysis and monitoring of the comments has demonstrated that negative comments are predominantly in the following categories:

<table>
<thead>
<tr>
<th>F&amp;F themes [for negative comments]</th>
<th>You said</th>
<th>We did</th>
</tr>
</thead>
<tbody>
<tr>
<td>Induction to the ward</td>
<td>Did not see the same midwife</td>
<td>on-going recruitment drive to recruit an additional 16 community midwives which will enable more continuity in antenatal and postnatal care</td>
</tr>
<tr>
<td>Availability of information</td>
<td>Too few visits in the postnatal period</td>
<td>UHMB designing end to end integrated maternity care pathway</td>
</tr>
<tr>
<td>Food</td>
<td>Small food portions</td>
<td>Alterations made to meal provisions, increase in healthy choices, milk, yoghurts, fruit snacks</td>
</tr>
<tr>
<td>Staffing</td>
<td>Not enough healthy choice</td>
<td>Maternity wards able to pick multiple choices on menus</td>
</tr>
<tr>
<td>Waiting times</td>
<td></td>
<td>Vending machines at FGH with healthier choices</td>
</tr>
<tr>
<td>Staff attitudes</td>
<td></td>
<td>Nutrition link staff identified to attend Trust nutrition meetings to represent Maternity</td>
</tr>
<tr>
<td>Communication</td>
<td></td>
<td>New trolley system in place at RLI and FGH allowing greater choice and portion size</td>
</tr>
<tr>
<td>Inconsistent advice</td>
<td></td>
<td>UHMBFT Maternity website live on internet with detail regarding the service and links to various national webpages</td>
</tr>
<tr>
<td>Not being listened to</td>
<td></td>
<td>Booking packs and patient information reviewed and updated</td>
</tr>
<tr>
<td>Discharge process</td>
<td>Not Enough information</td>
<td>Full review of all patient information and process in place to update all leaflets + leaflets go through service users for comments</td>
</tr>
<tr>
<td>Cleanliness</td>
<td></td>
<td>Contact numbers are provided in case urgent access to a midwife is required.</td>
</tr>
</tbody>
</table>

We use these comments to improve our service. Results are analysed quarterly and the data collected [including the Friends and Family Test information] allows us to continually monitor our services and make improvements when required.

16.8 You said - We did

We use the feedback from the F&F test, and the Maternity Questionnaires to make continuous improvements throughout the year. We have also found that the feedback received through other engagement events, Maternity Matters events, and discussions with service users further validates the views expressed in the Questionnaires.
16.9 MatExp Challenge Fund

Across UHMBFT the feedback from service users regarding maternity services has been collected using a variety of different methods. These include using a granular level patient experience questionnaire which gathers feedback on antenatal, labour, birth and post-natal experiences; and the national maternity Friends and Family Test. These two survey style feedback methodologies have provided a wealth of service user data on maternity services and identifying areas for improvement. In addition to these surveys UHMBFT has also run a number of community engagement events and “conversation cafés”. We have a very active and passionate Maternity Service Liaison Committee [MSLC] which collects views from a wide range of service users including vulnerable groups. All of these methods provide invaluable feedback on services.

From analysis and triangulation of this vital data, as well as feedback contained in complaints, concerns and incidents, we have been able to identify and implement operational service improvements. These have covered areas such as nutrition, antenatal clinics, community and hospital environments and active birth equipment.

However, there continued to be regular feedback which indicated that communication issues have a negative effect on the patient experience. Therefore UHMBFT put forward a bid to the NHS Challenge Fund for financial support for a project to develop a more intense, innovative and radical approach to addressing the communications skills gap, which in turn would engender a cultural change across multi-disciplinary teams in our Maternity services.

We have been successful in our bid and we plan to use the feedback we receive from service users, and the real stories and experiences we hear from patients and their families [both positive and negative] to develop and produce a creative training video. This will illustrate parents’ emotions and feelings and describe the impact that a range of communication styles have upon service users’ experiences and outcomes. By including some of the family members involved in the MBI it is hoped that this will bring reality and authenticity to the project, provide a voice for those affected, and involvement in the cultural changes which we believe will result from the use of the video.

This powerful teaching tool will form the basis of an intense multi-disciplinary communication training plan aimed at current and new staff. It is intended to bring about reflection on current practice and improve understanding of the impact that good and bad communication styles can have on women and their families. The outcomes from this project will form the basis of a training workshop for clinical and practice educators so that they will continue to develop a positive communication skills culture as part of their personal training portfolios and mandatory core-skills training. We would also like to extend this training approach throughout the Trust, and to partners such as General Practitioners and Health Visitors.
17 New Build at Furness General Hospital

17.1 Recommendation 17

‘The University Hospitals of Morecambe Bay NHS Foundation Trust should identify options, with a view to implementation as soon as practicable, to improve the physical environment of the delivery suite at Furness General Hospital, including particularly access to operating theatres, an improved ability to observe and respond to all women in labour and en-suite facilities; arrangements for post-operative care of women also need to be reviewed. Plans should be in place by December 2015 and completed by December 2017’.

17.2 Current position

The existing Labour Ward at FGH is situated on Level 4 [ground level], together with the Antenatal/postnatal maternity ward and consists of:

- A delivery suite comprising 6 delivery rooms [including a high risk room with en-suite, and an active birth pool room with en-suite], a 4 bedded bay and two triage rooms
- Post-natal ward with 19 Beds: 3 x 4 bed units plus 7 single rooms (including 2 en-suites).

Obstetric theatres are located some distance from the delivery room in a main theatre suite at FGH. This theatre is shared with gynaecology. The transfer involves access to theatres via a locked door and transfer through the medical assessment Unit (MAU). The process involves delivery suite contacting the MAU staff for patients and equipment from the MAU to be cleared prior to transfer. From the MAU the transfer route includes crossing the main corridor. To maintain privacy and dignity the public are stopped and curtains pulled across the width of the public corridor until the transfer has taken place. This is obviously far from satisfactory.

17.3 Care Quality Commission Report 3 December 2015

The CQC stated ‘The transfer of women to theatre could be improved. However, the trust had provided written assurance after the inspection that risks of transferring women were evaluated and action had been taken to mitigate the risk of any delays, and plans were also in place for a major refurbishment of the estate by December 2017, which included a dedicated obstetric theatre next to the labour ward.’

17.4 The new build

An external healthcare planner provided the capacity requirements for the new unit using projected future activity and demand levels. The information from the healthcare planner and the requirements of Health Building Notes [HBN] determined the number of rooms required.
Considerable attention was given to the design process with input from obstetric and maternity staff, estates, staff from anaesthesia and theatres, and patient representatives. A number of layout options were considered to ensure the most appropriate design in which to accommodate the required number of rooms in accordance to HBN09-02 standards, the recommendations from the MBI report, plus a bereavement suite. All rooms will be labour/delivery/recovery and postnatal rooms (LDRP) where women will be admitted and discharged from the same room. All rooms will be en-suite as recommended by the MBI report. Rooms will have facilities where birth supporters can stay with the service users if requested. The new unit provides accommodation over two floors, plus a plant room, specifically:

**Lower Ground Floor** (Level 3) approximate area = 620 m²
- Reception, triage room, Quiet rooms, Office, WC
- Maternity Assessment and triage rooms
- Seminar room and clinical skills

**Ground Floor** (Level 4) approximate area = 1450 m²
- Maternity: 14 Birthing rooms with en-suites, 2 bed transitional care rooms, offices, utility, Nurse Stations and WCs.
- SCBU: 3 x Cot bay, 1 x Single cot bay, Utility rooms, Parents’ overnight stay, Stabilisation room, office and WCs.
- Theatres: 2 x Theatres, 2 x Resuscitation rooms, 2 x Preparation rooms, utility rooms, nurse base, scrub room, recovery bays, theatre changes and WCs
- Bereavement suite: Viewing room, Bereavement birthing room, Bereavement sitting room, emergency corridor, Store, WC

As can be seen from the above, the obstetric theatres will be dedicated theatres on the same floor as the obstetric and maternity units

**17.5 Timeline**

Following sign-off by the UHMBFT Trust Board on 30 March 2016 there will be a series of design team meetings between April and the end of July 2016. These meetings will involve the architects, the preferred provider, the Trust and a full range of stakeholders as required. Work will commence on site in September 2016 with handover on completion in November 2017.

**18 Communications**

The aim of the Communications workstream was to ensure that staff, stakeholders, service users, and the public were aware of and understood:

- UHMBFT’s response and approach to implementing the recommendations contained in the MBI Report;
- Progress on implementing the recommendations;
- The difference the recommendations and UHMBFT’s actions have made to patients and staff

The Communications workstream worked to ensure that staff, stakeholders and the general public were aware of the Investigation, the outcomes, the progress to date, the next steps, and where they could find further information. At the beginning of the project, the Communications team held a session for project leads to focus on communications and engagement to assist them in producing their own communication and engagement plans and activities. The Communications team has also responded to various press enquiries relating to the Morecambe Bay Investigation, past cases where families sadly lost loved ones, and other maternity related issues.
18.1 Expectation Management

Two core tenets formed the basis of our communications with Trust staff, patients and members of the public. These were to be open and honest in all our dealings, and to maintain open communication channels with regular updates available to all our stakeholders. Work included the following:

- The Communications workstream ensured that staff, stakeholders and the general public were aware of the Investigation, the outcomes, the progress to date, the next steps, and sign-posted where to find additional information.
- At the beginning of the project, the Communications team held a session for project leads to focus on communications and engagement to assist them in producing their own communication and engagement plans and activities.
- After each Sub Committee meeting, the Communications Manager would share the agreed key messages to everyone who attended the meeting. All Sub Committee papers were then uploaded to the Trust website by the Communications Officer in order to ensure the Trust was as open and honest as possible with the public about what was being discussed and progress made.
- Each month, after the Trust Board meeting, the Communications team would send an update of the progress in implementing the recommendations. This would be sent to staff, stakeholders, the Trust Board, Governors, media, other NHS organisations with an interest in the Investigation, local MPs, local CCGs, and other local health organisations. The update was in form of a stakeholder letter, press release and a one page review. A series of social media updates were used to direct people to further on-line information. This information was also included in the Trust’s weekly staff newsletter and newsletter for Foundation Trust Members.

- Staff had the opportunity to hear more at the Trust’s monthly manager briefings, along with the opportunity to attend a monthly staff drop in session to find out more, or ask any questions they have. These drop-in sessions were arranged by the Communications team, and hosted by a Project Lead who received the appropriate briefing pack beforehand. Staff were also briefed via the weekly Friday Message from Jackie Daniel, Chief Executive, and via Weekly News which is a newsletter to all staff which the Communications team write and distribute.
- Maternity Matters events were held in Barrow and Lancaster, with a further one planned for Kendal. These were promoted via traditional and social media channels, users stories were filmed for use on the Trust website, and feedback was captured at the events.
- Working with each of the project leads, the Communications team wrote a series of focused stories, promoting the improvements and their impact on the services offered to women and families. Once completed, these focused stories were sent to the press and uploaded to a dedicated designed page on the Trust website.
- The Morecambe Bay Investigation page on the Trust website was redesigned, making it easier to read and understand in line with the Plain English standards and we are approved users of the Crystal Mark on our documents.

18.2 What Communications work went well

1) The regular updates each month worked well, as they provided clear, open and honest information about the improvements that were being implemented. These updates were shared widely so it gave everyone the opportunity to access information in a variety of different ways.
2) The redesigned Investigation page on the internet was beneficial as it was much more attractive and easy to follow. The use of the Plain English Campaign gave us the assurance that the information was clear and easy to understand.
3) The Maternity Matters events were very successful in terms of engaging with the public and receiving valuable feedback and ideas.
4) The relationships formed between the communications team and the project leads and wider Kirkup programme were effective and beneficial in supporting achievement of the actions.
18.3 What Communications work could have gone better

- Attendance at the staff information drop in sessions was low.
- Roles and responsibilities could have been clarified sooner for the first Maternity Matters event. This meant that a lot of the work was last minute and pressured for teams to achieve on top of their normal day to day jobs.
- Press coverage of our monthly updates could have been stronger - rather than updates, we could have offered features, interviews, more in-depth pieces perhaps to give a journalist more of an angle.
- Gaining information for the focused stories was difficult at times as project leads and their colleagues were busy working to meet the recommendations in the timescales given.

19 Lessons Learned – Whole Programme

19.1 What could have gone better

- We grouped the recommendations into ‘themes’ which overall worked well – however, some of the recommendations were pertinent to two project workstreams, e.g. Education, Learning and Development [ELD] had some cross-over with Workforce and also with Partnership; Governance had a recommendation which linked to Workforce; and communication between themed areas had to be monitored closely to see things were not overlooked. This was mitigated by the regular project team meetings and Kirkup Recommendation Implementation Group meetings [KRIG]
- The volume of work required to implement the ELD workstream recommendations was considerable and the timeframe for implementing the recommendations was short.
- Multi-disciplinary meetings, professional meetings, and the Leadership programme within the Women’s and Children’s Division have had variable attendance. New appointments to the management team and new clinical leadership will be addressing this as a high priority to identify the reasons and facilitate remedies. Monitoring will be undertaken through the Workforce Assurance Committee and the Quality Committee.

19.2 What went well

- Managing the projects within an overarching Programme of work with dedicated programme management and administration support
- Grouping recommendations together on a themed basis
- The allocation dedicated project managers to work on specific recommendations
- Trust Board member representation and guidance provided through the membership of the MBI Sub-Committee
- Good project governance with regular project leads’ meetings facilitated ‘visibility’ across the various workstreams
- The Trust wide engagement and commitment to change made a major contribution to the achievement of the recommendations. There was, and continues to be, a determination to demonstrate that we can meet the standards set for us.
- The support from our patients and their families
- Project teams which included front-line staff and service users in some projects to ensure change was integrated at all levels throughout the organisation
- Dedicated communication team to support the programme
- Using the Procure21 process to identify partners for the new build maternity unit at FGH

20 Post Project Tasks

- The new Maternity unit at FGH has to be completed in 2017. This allows 18 months to obtain the necessary planning permissions and build the unit. This project will be monitored through the Finance Committee and the Trust Board
- Due to the flooding in Cumbria in the winter of 2015 there was a delayed start of the Listening into Action work which forms Phase 2 of the Education, Learning and Development project. This meant that the project did not start until the 1st February with a focused ‘Big Conversation’. The aim of the event was to bring people from all areas of the organisation together to listen, discuss and agree actions on creating a learning organisation. 44 staff and a number of governors attended. From this event 5 workstreams have been developed with the overarching aim of
“Creating a culture of learning and development to improve the way we provide mandatory and role based training”. This is a 20 week programme and it is expected to complete at the end of June.

- The Maternity Strategic Partnership has commenced for obstetric and maternity staff and will be fully implemented through the inclusion of paediatric and anaesthetic staff over the coming months. All on-going work on the placements and feedback will be monitored and overseen through the Strategic Partnership Committee, the Quality Committee and the Trust Board.

We have received formal confirmation from each of the Executive Leads for the respective workstreams that any outstanding actions will be taken forward through the relevant committees and be reported to the Trust Board.

21 Formal Project Closure Approvals

21.1 Role of the Mersey Internal Audit Agency

As part of the UHMBFT 2015/2016 audit plan, Mersey Internal Audit Agency [MIAA] undertook a review of the Trust's response to the Kirkup Report. That review focused specifically upon recommendations 5 and 7 as agreed with the Trust's Executive Chief Nurse prior to the work commencing. The subsequent audit report was issued in September 2015 concluding that ‘the Trust had established an effective structure for oversight of the implementation of the Kirkup Report recommendations’.

In November 2015, the Trust commissioned a further piece of work to focus upon the remaining 16 Kirkup recommendations; this review was undertaken between December 2015 and the end of March 2016.

The focus of this review was the Trust’s ‘Kirkup Action Plan’, which is overseen by the Programme Management Office (PMO) and senior UHMBFT officers. MIAA have assessed the Trust’s response to each of the 16 recommendations and evaluated the robustness of the evidence to ensure it demonstrates delivery of the actions and provides assurance.

The review also followed up on the findings of the Kirkup Part I review in respect of recommendations 5 and 7.

The Trust expected a small number of recommendations to be completed during December 2015, the majority to be completed in January 2016 and the remainder in February 2016. As such, MIAA liaised with the Trust regarding the scheduling of the reviews to ensure the focus is upon assessing actions completed by the Trust.

The following were felt to be the overall system risks:

- The Trust Board is not provided with correct information in order for it to effectively govern the organisation;
- Risk to patient safety if the Trust fails to adequately respond to the Kirkup recommendations;
- A lack of progress in implementing recommendations may risk regulatory enforcement action; and
- Potential reputational damage if the Trust is not seen to be responding to the action plan.

The overall objective of the review has been to evaluate the robustness of the evidence for actions assessed by the Trust as complete, to ensure it demonstrates delivery of the actions and provides assurance.

Within this review the following sub-objectives will be considered:

- The Trust can evidence that actions which are recorded as ‘complete’ – within the Kirkup Action Plan – have been completed;
- The ‘completed’ status of each recommendation is reliable and supported by a robust audit trail of supporting documentation and evidence; and
- Any residual risk(s) is recorded and administered appropriately, in accordance with an approved management plan and/or risk tolerance limit.

The MIAA report is attached as Appendix 24.11 to this report.
22 Acknowledgements

There are a number of individuals and groups we wish to personally thank for their contribution in undertaking the work required to implement the recommendations and changes identified in ‘The Report of the Morecambe Bay Investigation’ (Dr B Kirkup, March 2015).

Firstly, we would like to acknowledge the families who have been affected by the events in the Morecambe Bay Investigation and the bravery they have demonstrated in the investigation process. We wish to thank personally Liza Brady, Lesley Bennett, Angela Herdman, and Margaret Hutchinson who despite being personally involved and affected by previous mistakes made within the organisation found the courage and determination to work with UHMBT to help improve the safety and quality of maternity services now and for the future.

We would like to express our sincere gratitude to a number of individuals, for providing the leadership and direction required to implement the recommendations from the MBI Report. We wish to thank and recognise the dedication of the individual project leads and acknowledge: Sascha Wells (Deputy Director and Head of Midwifery, Gynaecology and Obstetrics) for the leading the MBI Clinical Quality project, Val Wilson (Interim Deputy Director Of Governance ) for leading on the MBI Governance Project, John Bannister, (Deputy Chief Operating Officer), Rupert Wainwright (Interim Deputy Chief Operating Officer) and Gertie Nicphilib (Deputy Director of Workforce) for providing project leadership at various stages for the MBI Workforce Project, David Wilkinson (Director of Workforce and OD), Kathy Duffy, (Assistant Director of Learning & Organisational Development), and Lindsey Roome (Learning and Development Project Manager) for leading at various stages on the MBI Education, Learning and Development project. Andy Waddington, (Estates Corporate Services Manager) and Tristram Reynolds (Associate Director of Estates & Facilities) for project leadership on the MBI Estates project, and Halcyon Edwards for leading and project managing the Maternity Strategic Partnership project. For each of these projects the teams have comprised a range of individuals such as Executive Directors, clinicians [doctors, nurses, midwives and members of the professions allied to medicine], managers, frontline and support staff, and service users. We thank each and every one of them for their commitment and valuable contributions.

We also wish to give credit to the dedicated MBI Programme team who have effectively and efficiently directed, supported the delivery and reported on the progress of the MBI programme. We express thanks to David Walker (UHMBT Medical Director and MBI Programme Executive Sponsor), Lindsay Lewis, (UHMBT Quality & Service Improvement Lead and MBI Programme Manager), Tina Turner (UHMBT Divisional General Manager for Women’s & Children’s Services and MBI Programme Lead), Judith Griffiths (MBI Senior Programme Advisor), Hazel Donegan, Heather Midgley, and Clare Pearson for providing programme administration and support at various stages throughout the MBI programme, and Alison Nelson for MBI Sub-Committee administration and minuting. We would also like to acknowledge and thank Martin Kinley (UHMBT Programme Management Office, Programme Manager) and the Mersey Internal Audit Agency for the robust quality assurance process supporting the programme.

Good communication within the organisation, for the public and other stakeholders has been a key component of the work which has been undertaken over the past year. We thank Louise Jones (UHMB Communications
Engaging with the families involved, service users and wider public engagement has been a high priority throughout the past year. We wish to show our appreciation to Cath Broderick (We Consult & Chair of the RCOG Equality & Diversity Committee) for helping to direct and develop our engagement processes within maternity services at UHMBT, and to Barry Rigg (Engagement Manager, UHMB) for helping co-ordinate events. We would also like to thank the many service users who have participated in workshops and events over the past year and who have, by sharing their experiences, helped reshape the services we provide.

We would also like to thank the dedicated members of the Morecambe Bay Investigation Sub-Committee who have provided oversight, support and direction over the past year. This committee has been chaired by Anne Garden (Non-Executive Director UHMB); with representation from a number of organisations, service users and public representation including Melanie Weeks (Non-Executive Director, UHMB); Liza Brady (service user), Lesley Bennett (Service User), Angela Herdman (service user), Fiona Wise (Improvement Director, Monitor), Tony Falconer (Obstetrician and advisor for RCOG), Margaret Williams (Chief Nurse, Integrated Governance & Quality Improvement, Lancashire North Clinical Commissioning Group), Geoff Jolliffe (GP commissioning lead Furness) Dr Mike Flanagan (Secondary Care Doctor for the Governing Body), Eleanor Hodgson (Director for Children and Families, Cumbria CCG), George Butler, (Public Governor for UHMBT), Sue Smith (Executive Chief Nurse, UHMB), Cath Broderick (Independent PPI representative - We Consult and Chair of the RCOG Equality & Diversity Committee) and David Walker (UHMBT Medical Director & MBI Programme Executive Sponsor).

Throughout this programme of work we have benefitted from the support and contributions made by NHS Cumbria Clinical Commissioning Group and NHS Lancashire North Clinical Commissioning Group.
References

1. The Care Quality Commission is responsible for monitoring, inspecting and regulating health and social care services. They publish their findings, including ratings to help people choose care. http://www.cqc.org.uk

2. Monitor is an executive non-departmental public body of the Department of Health, which within England is responsible for making sure that: independent NHS Foundation Trusts are well-led so they can provide quality care on a sustainable basis; essential services are maintained; the NHS payment system promotes quality and efficiency; and procurement, choice and competition operate in the best interests of patients. https://www.gov.uk/government/organisations/monitor

3. NHS England leads the NHS in England. It sets the priorities and direction of the NHS and encourages and informs the national debate to improve health and care. NHS England shares out more than £100 billion in funds and holds organisations to account for spending this money effectively for patients and efficiently for the tax-payer.

4. Page 11: ‘we found welcome signs of significant recent improvements in the Trust, including its maternity services and governance’ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/408480/47487_MBI_Accessible_v0.1pdf


7. ‘I Want Great Care’ allows patients to leave meaningful feedback on their care, say thank you, and help the next patient: www.iwantgreatcare.org/information/about

8. ‘Listening into Action’ is a comprehensive outcome-oriented approach that engages staff in improving patient safety and experience, as well as staff experience. The approach is supported through training in improvement skills and techniques

9. ‘Big Conversations’ are led by the Chief Executive and the Executive Directors and give the staff the opportunity to discuss what frustrates them and gets in their way when making changes.


11. CNST: Clinical Negligence Scheme for Trusts


13. Options Appraisal: Reconfiguration of Obstetric and Maternity Services in Cumbria, Royal College of Obstetricians and Gynaecologists


## 24 Appendices and Evidence

### 24.1 Achievement of Recommendations

<table>
<thead>
<tr>
<th>Recommendations: UHMBFT should do the following:</th>
<th>Kirkup Date</th>
<th>Milestones</th>
<th>RAG</th>
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<tbody>
<tr>
<td>2 Review the skills, knowledge, competencies and professional duties of care of all obstetric, paediatric, midwifery and neonatal nursing staff, and other staff caring for critically ill patients in anaesthetics and intensive and high dependency care, against all relevant guidance from professional and regulatory bodies</td>
<td>This review should be completed by June 2015</td>
<td></td>
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<tr>
<td></td>
<td>Mandatory professional training and skills need analysis for each staff group that meets national standards and requirements</td>
<td>30-Jun-15</td>
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<tr>
<td></td>
<td>Undertake a gap analysis of training and development for all identified staff groups</td>
<td>30-Jun-15</td>
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<tr>
<td>3</td>
<td>Draw up plans to deliver the training and development of staff identified as a result of the review of maternity, neonatal and other staff, and should identify opportunities to broaden staff experience at other units, including by secondment and supernumerary practice</td>
<td>This should be in place in time for June 2015</td>
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<tr>
<td></td>
<td>Develop annual training plan for all staff groups</td>
<td>commenced June 2015</td>
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<td></td>
<td>Refine approach based on outcomes of gap analysis-Develop a fundamentally different approach to the sustainable delivery of mandatory training via a Listening into Action scheme</td>
<td>30-Jun-16</td>
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<tr>
<td></td>
<td>Identify opportunities for placements in strategic partner organisations for non-training grade medical staff in Maternity Services, midwives, neonatal nurses and paediatricians, and anaesthetic staff working in WACS</td>
<td>31-Dec-15</td>
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</table>
### Recommendations: UHMBFT should do the following:

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Kirkup Date</th>
<th>Milestones</th>
<th>RAG</th>
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<tbody>
<tr>
<td>4. Following completion of additional training or experience where necessary, UHMBFT should identify requirements for continuing professional development [CPD] of staff and link this explicitly with professional requirements including revalidation</td>
<td>this should be completed by September 2015</td>
<td>Scope CPD requirement of staff groups</td>
<td>30-Sep-15</td>
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<td></td>
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<td>Develop band-specific CPD plans, including revalidation requirements, for all staff groups</td>
<td>30-Sep-15</td>
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<td></td>
<td>Review CPD portfolio and documentation for all staff groups</td>
<td>30-Sep-15</td>
</tr>
<tr>
<td>5. Should identify and develop measures that will promote effective multi-disciplinary team working, in particular between paediatricians, obstetricians, midwives and neonatal staff</td>
<td>Identified by April 2015 and begun by June 2015</td>
<td>Multi-disciplinary and multi-professional meetings to be in place within the Division</td>
<td>complete</td>
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<td></td>
<td></td>
<td>Multi-disciplinary and multi-professional specific training and development days introduced in Maternity</td>
<td>complete</td>
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<td></td>
<td></td>
<td>Identify additional measures to promote multi-disciplinary working</td>
<td>complete</td>
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<tr>
<td>6. Draw up a protocol for risk assessment in maternity services, setting out clearly: who should be offered the option of delivery at Furness General Hospital and who should not; who will carry out this assessment against which criteria; and how this will be discussed with pregnant women and their families</td>
<td>to be completed by June 2015</td>
<td>Review and update all current risk assessment and transfer policies</td>
<td>complete</td>
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<td></td>
<td></td>
<td>Perinatal Institute Maternity Health Record in place for all women within the Trust</td>
<td>complete</td>
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<td>Recording of transfers through a Patient Safety Incident</td>
<td>complete</td>
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</table>
Some text from the image is not visible due to cropping or obstruction. However, the readable content is as follows:

### Recommendations: UHMBFT should do the following:

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Kirkup Date</th>
<th>Milestones</th>
<th>RAG</th>
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<tbody>
<tr>
<td>7</td>
<td>Should audit the operation of maternity and paediatric services to ensure that they follow risk assessment protocols on place of delivery, transfers and management of care and that effective multi-disciplinary care operates without inflexible demarcation between professional groups</td>
<td>in place by September 2015</td>
<td>All audits undertaken and scheduled in forward audit plan on on-going basis</td>
</tr>
<tr>
<td>8</td>
<td>Identify a recruitment and retention strategy aimed at achieving a balanced and sustainable workforce with the requisite skills and experience</td>
<td>completed by January 2016</td>
<td>Recruitment and retention strategy approved</td>
</tr>
<tr>
<td>9</td>
<td>Identify an approach to develop a better joint working between the main hospital sites, including the development and operation of common policies, systems and standards</td>
<td>begun by September 2015</td>
<td>All obstetric and midwifery guidelines as required by CNST are available on Heritage [now Sharepoint]. Guidelines have been reviewed against NICE guidelines [where available] to ensure compliance. Ensure a robust process is in place to review and amend the Trust-wide HR policies. Development and implementation of standard Divisional process for development, ratification, and implementation of Divisional procedural documents</td>
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</tbody>
</table>

### RAG RATING
## One Year On – how we implemented the Kirkup Report

<table>
<thead>
<tr>
<th>Recommendations: UHMBFT should do the following:</th>
<th>Kirkup Date</th>
<th>Milestones</th>
<th>RAG</th>
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<tbody>
<tr>
<td>Seek to forge links with a partner Trust so that both can benefit from opportunities for learning, mentoring, secondments, staff development and sharing approaches to problems</td>
<td>to begin September 2015</td>
<td>Joint planning meetings with partner organisations to scope and agree process</td>
<td>01-Sep-15</td>
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<td></td>
<td>Discussion with Senior Clinicians and Project Leads to further scope and develop an outline specification</td>
<td></td>
<td>30-Sep-15</td>
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<td></td>
<td>Develop more detailed specification and outline case for approval, supported by Capsticks Solicitors.</td>
<td></td>
<td>31-Oct-15</td>
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<td></td>
<td>Incident training provided as part of Mandatory (midwives/Obstetrics) training days.</td>
<td></td>
<td>complete</td>
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<td></td>
<td>TRUST Ulysses safeguard RCA and incident reporting and investigation training in place</td>
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<td>complete</td>
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<td></td>
<td>Implement additional training in an electronic format for all staff to continue to improve the reporting of safety incidents and promote a learning culture and reduction of harms. Also to include further information in relation to open and honest and duty of candour</td>
<td></td>
<td>31-Oct-15</td>
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<tr>
<td></td>
<td>Duty of Candour included within Being Open Policy, ratified and available on Heritage</td>
<td></td>
<td>complete</td>
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</tbody>
</table>
The University Hospitals of Morecambe Bay NHS Foundation Trust should review the structures, processes and staff involved in investigating incidents, carrying out root cause analyses, reporting results and disseminating learning from incidents, identifying any residual conflicts of interest and requirements for additional training. The Trust should ensure that robust documentation is used, based on a recognised system, and that Board reports include details of how services have been improved in response. The review should include the provision of appropriate arrangements for staff debriefing and support following a serious incident. This should be begun with maternity staff by April 2015 and rolled out to other staff by April 2016.

<table>
<thead>
<tr>
<th>Recommendations: UHMBFT should do the following:</th>
<th>Kirkup Date</th>
<th>Milestones</th>
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<tr>
<td>12. The University Hospitals of Morecambe Bay NHS Foundation Trust should review the structures, processes and staff involved in investigating incidents, carrying out root cause analyses, reporting results and disseminating learning from incidents, identifying any residual conflicts of interest and requirements for additional training. The Trust should ensure that robust documentation is used, based on a recognised system, and that Board reports include details of how services have been improved in response. The review should include the provision of appropriate arrangements for staff debriefing and support following a serious incident.</td>
<td></td>
<td>Current UHMB Risk management Policy available on Heritage</td>
<td>Apr-15</td>
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<td></td>
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<td>Human factors training to increase awareness</td>
<td>initial training June 2015 - on-going thereafter</td>
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<td>Trust standardised investigation templates and action plans in use for RCA/ rapid review based on NPSA tools</td>
<td>31-Aug-15</td>
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<td></td>
<td></td>
<td>Ensure identified practice (positive and negative) from RCA is communicated to Learning to Improve Group to ensure Trust wide learning</td>
<td>31-Oct-15</td>
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<td></td>
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<td>Trust weekly patient safety summit in place to review all near misses and moderate and above incidents-led by Executive Chief Nurse and Medical Director with senior representation from all Divisions</td>
<td>complete</td>
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</table>
### Recommendations: UHMBFT should do the following:

<table>
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<tr>
<td><strong>13</strong></td>
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<tr>
<td>The University Hospitals of Morecambe Bay NHS Foundation Trust should review the structures, processes, and staff involved in responding to complaints, and introduce measures to promote the use of complaints as a source of improvement and reduce defensive 'closed' responses to complainants. The Trust should increase public and patient involvement in resolving complaints, in the case of maternity services through the Maternity Services Liaison Committee.</td>
<td>This should be completed and the improvements demonstrated at an open Board meeting by December 2015</td>
<td>Review of complaints procedures to ensure compliance with national ombudsman recommendations and other national standards</td>
<td><strong>30-Jun-15</strong></td>
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<td></td>
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<td>Develop Management Procedure for the Investigation and Resolution of Complaints</td>
<td><strong>31-Aug-15</strong></td>
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<td>Roll out of existing awareness training from Patient relations Team and develop to include 'best practice' advice in relation to consistent and supportive management of complainants to include quality in terms of content</td>
<td><strong>July 2015 - on-going thereafter</strong></td>
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<td><strong>14</strong></td>
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<tr>
<td>The University Hospitals of Morecambe Bay NHS Foundation Trust should review arrangements for clinical leadership in obstetrics, paediatrics and midwifery, to ensure that the right people are in place with appropriate skills and support. The Trust has implemented change at executive level, but this needs to be carried through to the levels below. All staff with defined responsibilities for clinical leadership should show evidence of attendance at appropriate training and development events</td>
<td>commenced April 2015</td>
<td>Further review of Women's and Children's Services [WACS] leadership structure</td>
<td><strong>commenced April 2015</strong></td>
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<td></td>
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<td>Review and revise job descriptions including roles and responsibilities</td>
<td><strong>31-Dec-15</strong></td>
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<td>Link internal leadership training to Training Management System</td>
<td><strong>30-Sep-15</strong></td>
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<td>Review CPD portfolio/documentation for all staff groups</td>
<td><strong>30-Sep-15</strong></td>
</tr>
<tr>
<td>Recommendation</td>
<td>Kirkup Date</td>
<td>Milestones</td>
<td>RAG</td>
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<tr>
<td>The University Hospitals of Morecambe Bay NHS Foundation Trust should continue to prioritise the work commenced in response to the review of governance systems already carried out, including clinical governance, so that the Board has adequate assurance of the quality of care provided by the Trust’s services. This work is already underway with the facilitation of Monitor,</td>
<td>already underway by March 2015</td>
<td>Undertake external &quot;Well led&quot; review and partial review of Divisional Governance</td>
<td>Dec-15</td>
</tr>
<tr>
<td>Ensure that middle manager, seniors manager and non-executives have the appropriate clarity over roles and responsibilities in relation to quality and it should provide appropriate guidance and where necessary training.</td>
<td>to be completed by December 2015</td>
<td>Clinical Service Managers/ DGM included within Membership of key Divisional Governance Meetings</td>
<td>complete</td>
</tr>
<tr>
<td>Identify options, with a view to implementation as soon as practicable, to improve the physical environment of the delivery suite at Furness General Hospital, including particularly access to operating theatres, an improved ability to observe and respond to all women in labour and en suite facilities; arrangements for post-operative care of women also need to be reviewed</td>
<td>Plans should be in place by December 2015 and completed by December 2017</td>
<td>WACS team agree what rooms required in each area of remodelled Dept.</td>
<td>30-Jun-15</td>
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<td>Detailed layout agreed in conjunction with WACS team, including external teams such as Infection Prevention and patients/families. A series of meetings involving different people within WACS</td>
<td>30-Nov-15</td>
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<td>Board appoints P21 development partner</td>
<td>31-Dec-15</td>
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<td>Confirm finance</td>
<td>31-Mar-16</td>
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## 24.2 Recommendations

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Detail</th>
<th>Timeframe</th>
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<tbody>
<tr>
<td>1</td>
<td>The University Hospitals of Morecambe Bay NHS Foundation Trust should formally admit the extent and nature of the problems that have previously occurred, and should apologise to those patients and relatives affected, not only for the avoidable damage caused but also for the length of time it has taken to bring them to light and the previous failures to act.</td>
<td>This to be undertaken immediately on publication of the report</td>
</tr>
<tr>
<td>2</td>
<td>The University Hospitals of Morecambe Bay NHS Foundation Trust should review the skills, knowledge, competencies and professional duties of care of all obstetric, paediatric, midwifery and neonatal nursing staff, and other staff caring for critically ill patients in anaesthetics and intensive and high dependency care, against all relevant guidance from professional and regulatory bodies.</td>
<td>This review should be completed by June 2015, and identify requirements for additional training, development and, where necessary, a period of experience elsewhere.</td>
</tr>
<tr>
<td>3</td>
<td>The University Hospitals of Morecambe Bay NHS Foundation Trust should draw up plans to deliver the training and development of staff identified as a result of the review of maternity, neonatal and other staff, and should identify opportunities to broaden staff experience in other units, including by secondment and by supernumerary practice.</td>
<td>These should be in place in time for June 2015.</td>
</tr>
<tr>
<td>4</td>
<td>Following completion of additional training or experience where necessary, the University Hospitals of Morecambe Bay NHS Foundation Trust should identify requirements for continuing professional development of staff and link this explicitly with professional requirements including revalidation.</td>
<td>This should be completed by September 2015</td>
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<td>5</td>
<td>The University Hospitals of Morecambe Bay NHS Foundation Trust should identify and develop measures that will promote effective multidisciplinary team-working, in particular between paediatricians, obstetricians, midwives and neonatal staff. These measures should include, but not be limited to, joint training sessions, clinical, policy and management meetings and staff development activities. Attendance at designated events must be compulsory within terms of employment.</td>
<td>These measures should be identified by April 2015 and begun by June 2015.</td>
</tr>
<tr>
<td>6</td>
<td>The University Hospitals of Morecambe Bay NHS Foundation Trust should draw up a protocol for risk assessment in maternity services, setting out clearly who should be offered the option of delivery at Furness General Hospital and who should not; who will carry out this assessment against which criteria, and how this will be discussed with pregnant women and families. The protocol should involve all relevant staff groups, including midwives, paediatricians, obstetricians and those in the receiving units within the region. The trust should ensure that individual decisions on delivery are clearly recorded as part of the plan of care, including what risk factors may trigger escalation of care, and that all trust staff are aware that they should not vary decisions without a documented risk assessment.</td>
<td>This should be completed by June 2015.</td>
</tr>
<tr>
<td>7</td>
<td>The University Hospitals of Morecambe Bay NHS Foundation Trust should audit the operation of maternity and paediatric services to ensure that they follow risk assessment protocols on place of delivery, transfers and management of care, and that effective multidisciplinary care operates without inflexible demarcations between professional groups.</td>
<td>This should be in place by September 2015.</td>
</tr>
<tr>
<td>8</td>
<td>The University Hospitals of Morecambe Bay NHS Foundation Trust should identify a recruitment and retention strategy aimed at achieving a balanced and sustainable workforce with the requisite skills and experience. This should include, but not be limited to, seeking links with one or more other centre(s) to encourage development of specialist and/or academic practice whilst offering opportunities in generalist practice in the Trust; in addition, opportunities for flexible working to maximise the advantages of close proximity to South Lakeland should be sought.</td>
<td>Development of the strategy should be completed by January 2016.</td>
</tr>
<tr>
<td>9</td>
<td>The University Hospitals of Morecambe Bay NHS Foundation Trust should identify an approach to developing better joint working between its main hospital sites, including the development and operation of common policies, systems and standards. Whilst we do not believe that the introduction of extensive split-site responsibilities for clinical staff will do much other than lead to time wasted in travelling, we do consider that, as part of this approach, flexibility should be built into working responsibilities to provide temporary solutions to short-term staffing problems.</td>
<td>This approach should be begun by September 2015.</td>
</tr>
<tr>
<td>10</td>
<td>The University Hospitals of Morecambe Bay NHS Foundation Trust should seek to forge links with a partner Trust, so that both can benefit from opportunities for learning, mentoring, secondment, staff development and sharing approaches to problems. This arrangement is promoted and sometimes facilitated by Monitor as ‘buddying’ and we endorse the approach under these circumstances. This could involve the same centre identified as part of the recruitment and retention strategy.</td>
<td>If a suitable partner is forthcoming, this arrangement should be begun by September 2015.</td>
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<tr>
<td>11</td>
<td>The University Hospitals of Morecambe Bay NHS Foundation Trust should identify and implement a programme to raise awareness of incident reporting, including requirements, benefits and processes. The Trust should also review its policy of openness and honesty in line with the duty of candour of professional staff, and incorporate into the programme compliance with the refreshed policy.</td>
<td>This should be begun with maternity staff by April 2015 and rolled out to other staff by April 2016.</td>
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<td>12</td>
<td>The University Hospitals of Morecambe Bay NHS Foundation Trust should review the structures, processes and staff involved in investigating incidents, carrying out root cause analyses, reporting results and disseminating learning from incidents, identifying any residual conflicts of interest and requirements for additional training. The Trust should ensure that robust documentation is used, based on a recognised system, and that Board reports include details of how services have been improved in response. The review should include the provision of appropriate arrangements for staff debriefing and support following a serious incident.</td>
<td>This should be begun with maternity units by April 2015 and rolled out across the Trust by April 2016.</td>
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<td>13</td>
<td>The University Hospitals of Morecambe Bay NHS Foundation Trust should review the structures, processes and staff involved in responding to complaints, and introduces measures to promote the use of complaints as a source of improvement and reduce defensive ‘closed’ responses to complainants. The Trust should increase public and patient involvement in resolving complaints, in the case of maternity services through the Maternity Services Liaison Committee.</td>
<td>This should be completed, and the improvements demonstrated at an open Board meeting, by December 2015.</td>
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<td>14</td>
<td>The University Hospitals of Morecambe Bay NHS Foundation Trust should review arrangements for clinical leadership in obstetrics, paediatrics and midwifery, to ensure that the right people are in place with appropriate skills and support. The Trust has implemented change at executive level, but this needs to be carried through to the levels below. All staff with defined responsibilities for clinical leadership should show evidence of attendance at appropriate training and development events.</td>
<td>This review should be commenced by April 2015.</td>
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<td>No.</td>
<td>Recommendation</td>
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<td>15</td>
<td>The University Hospitals of Morecambe Bay NHS Foundation Trust should continue</td>
<td>This work is already underway with the facilitation of Monitor, and we</td>
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<td>to prioritise the work commenced in response to the review of governance</td>
<td>would not seek to vary or add to it, which would serve only to detract</td>
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<td>systems already carried out, including clinical governance, so that the Board</td>
<td>from implementation. We do, however, recommend that a full audit of</td>
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<td>has adequate assurance of the quality of care provided by the Trust’s services.</td>
<td>implementation be undertaken before this is signed off as completed.</td>
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<td>16</td>
<td>As part of the governance systems work, we consider that the University</td>
<td>This should be completed by December 2015.</td>
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<td>Hospitals of Morecambe Bay NHS Foundation Trust should ensure that middle</td>
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<td>managers, senior managers and non-executives have the requisite clarity over</td>
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<td>roles and responsibilities in relation to quality, and it should provide</td>
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<td>appropriate guidance and where necessary training.</td>
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<td>17</td>
<td>The University Hospitals of Morecambe Bay NHS Foundation Trust should identify</td>
<td>Plans should be in place by December 2015 and completed by December</td>
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<td>options, with a view to implementation as soon as practicable, to improve</td>
<td>2017.</td>
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<td>the physical environment of the delivery suite at Furness General Hospital,</td>
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<td>including particularly access to operating theatres, an improved ability to</td>
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<td>observe and respond to all women in labour and en-suite facilities;</td>
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<td>arrangements for post-operative care of women also need to be reviewed.</td>
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<td>18</td>
<td>All of the previous recommendations should be implemented with the</td>
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<td>involvement of Clinical Commissioning Groups, and where necessary, the</td>
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<td>Care Quality Commission and Monitor. In the particular circumstances</td>
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<td>surrounding the University Hospitals of Morecambe Bay NHS Foundation Trust,</td>
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<td></td>
<td>NHS England should oversee the process, provide the necessary support, and</td>
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<td>ensure that all parties remain committed to the outcome, through an agreed</td>
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<td>plan with the Care Quality Commission, Monitor and the Clinical</td>
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<td></td>
<td>Commissioning Groups.</td>
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</tbody>
</table>
### MORECAMBE BAY INVESTIGATION RECOMMENDATIONS

<table>
<thead>
<tr>
<th>Grouping</th>
<th>Recommendation #</th>
<th>Recommendations included</th>
<th>Timeline</th>
<th>Responsible Director</th>
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<tbody>
<tr>
<td></td>
<td>2</td>
<td>The University Hospitals of Morecambe Bay NHS Foundation Trust should review the skills, knowledge, competencies and professional duties of care of all obstetric, paediatric, midwifery and neonatal nursing staff, and other staff caring for critically ill patients in anaesthetics and intensive and high dependency care, against all relevant guidance from professional and regulatory bodies.</td>
<td>This review should be completed by June 2015, and identify requirements for additional training, development and, where necessary, a period of experience elsewhere.</td>
<td>Director of Workforce and Organisational Development</td>
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<tr>
<td>EDUCATION, LEARNING AND DEVELOPMENT</td>
<td>3</td>
<td>The University Hospitals of Morecambe Bay NHS Foundation Trust should draw up plans to deliver the training and development of staff identified as a result of the review of maternity, neonatal and other staff, and should identify opportunities to broaden staff experience in other units, including by secondment and by supernumerary practice.</td>
<td>These should be in place in time for June 2015.</td>
<td>Director of Workforce and Organisational Development</td>
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<td>4</td>
<td>Following completion of additional training or experience where necessary, the University Hospitals of Morecambe Bay NHS Foundation Trust should identify requirements for continuing professional development of staff and link this explicitly with professional requirements including revalidation.</td>
<td>This should be completed by September 2015</td>
<td>Director of Workforce and Organisational Development</td>
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<td>5</td>
<td>The University Hospitals of Morecambe Bay NHS Foundation Trust should identify and develop measures that will promote effective multidisciplinary team-working, in particular between paediatricians, obstetricians, midwives and neonatal staff. These measures should include, but not be limited to, joint training sessions, clinical, policy and management meetings and staff development activities. Attendance at designated events must be compulsory within terms of employment.</td>
<td>These measures should be identified by April 2015 and begun by June 2015.</td>
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<td>6</td>
<td>The University Hospitals of Morecambe Bay NHS Foundation Trust should draw up a protocol for risk assessment in maternity services, setting out clearly who should be offered the option of delivery at Furness General Hospital and who should not; who will carry out this assessment against which criteria, and how this will be discussed with pregnant women and families. The protocol should involve all relevant staff groups, including midwives, paediatricians, obstetricians and those in the receiving units within the region. The trust should ensure that individual decisions on delivery are clearly recorded as part of the plan of care, including what risk factors may trigger escalation of care, and that all trust staff are aware that they should not vary decisions without a documented risk assessment.</td>
<td>This should be completed by June 2015.</td>
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<td>7</td>
<td>The University Hospitals of Morecambe Bay NHS Foundation Trust should audit the operation of maternity and paediatric services to ensure that they follow risk assessment protocols on place of delivery, transfers and management of care, and that effective multidisciplinary care operates without inflexible demarcations between professional groups.</td>
<td>This should be in place by September 2015.</td>
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### WORKFORCE

| 8 | The University Hospitals of Morecambe Bay NHS Foundation Trust should identify a recruitment and retention strategy aimed at achieving a balanced and sustainable workforce with the requisite skills and experience. This should include, but not be limited to, seeking links with one or more other centre(s) to encourage development of specialist and/or academic practice whilst offering opportunities in generalist practice in the Trust; in addition, opportunities for flexible working to maximise the advantages of close proximity to South Lakeland should be sought. | Development of the strategy should be completed by January 2016. | CHIEF OPERATING OFFICER |

| 9.2 | The University Hospitals of Morecambe Bay NHS Foundation Trust should identify an approach to developing better joint working between its main hospital sites, including the development and operation of common policies, systems and standards. Whilst we do not believe that the introduction of extensive split-site responsibilities for clinical staff will do much other than lead to time wasted in travelling, we do consider that, as part of this approach, flexibility should be built into working responsibilities to provide temporary solutions to short-term staffing problems. | This approach should be begun by September 2015. |  |

### PARTNERSHIP

| 10 | The University Hospitals of Morecambe Bay NHS Foundation Trust should seek to forge links with a partner Trust, so that both can benefit from opportunities for learning, mentoring, secondments, staff development, and sharing approaches to problems. This arrangement is promoted and sometimes facilitated by Monitor as ‘buddying’ and we endorse the approach under these circumstances. This could involve the same centre identified as part of the recruitment and retention strategy. | If a suitable partner is forthcoming, this arrangement should be begun by September 2015. | MEDICAL DIRECTOR |
| 14 | The University Hospitals of Morecambe Bay NHS Foundation Trust should review arrangements for clinical leadership in obstetrics, paediatrics and midwifery, to ensure that the right people are in place with appropriate skills and support. The Trust has implemented change at executive level, but this needs to be carried through to the levels below. All staff with defined responsibilities for clinical leadership should show evidence of attendance at appropriate training and development events. This review should be commenced by April 2015. |
| 16 | As part of the governance systems work, we consider that the University Hospitals of Morecambe Bay NHS Foundation Trust should ensure that middle managers, senior managers and non-executives have the requisite clarity over roles and responsibilities in relation to quality, and it should provide appropriate guidance and where necessary training. This should be completed by December 2015. |
Project Title: Kirkup Education Learning and Development Project

<table>
<thead>
<tr>
<th>Prepared by</th>
<th>Date</th>
<th>Executive Sponsor</th>
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<tr>
<td>Project Manager</td>
<td>31st March 2016</td>
<td>Director of Workforce and Organisational Development</td>
</tr>
</tbody>
</table>

Project Recommendation (Project Summary)

- Review the skills, knowledge, competencies and professional duties of care of all obstetric, paediatric, midwifery and neonatal nursing staff, and other staff caring for critically ill patients in anaesthetics and intensive and high dependency care, against all relevant guidance from professional and regulatory bodies. This review should be completed by June 2015, and identify requirements for additional training, development and, where necessary, a period of experience elsewhere.
- Draw up plans to deliver the training and development of staff identified as a result of the review of maternity, neonatal and other staff, and should identify opportunities to broaden staff experience in other units, including by secondment and by supernumerary practice. These should be in place in time for June 2015.
- Following completion of additional training or experience where necessary, the University Hospitals of Morecambe Bay NHS Foundation Trust should: Identify requirements for continuing professional development of staff and link this explicitly with professional requirements including revalidation. This should be completed by September 2015.
- All staff with defined responsibilities for clinical leadership should show evidence of attendance at appropriate training and development events. This review should be commenced by April 2015

Project Information

Findings /failures which led to the recommendation

The Morecambe Bay Investigation Report described concerns relating to the skills, knowledge and competence of staff. They highlighted areas of concern around the funding, time to be released and support for training. There was no joined up approach to training in particular mandatory training, lack of clarity in relation to national standards for training or an adequate provision for continuous professional development.

“it is vital to learn all of the lessons so as to improve every layer of the system and eliminate the defects” (para 8.10)
### Overall Project Goal/ Outcomes

The outcomes for the project are to ensure staff are adequately trained and competent to undertake their roles. The Kirkup recommendations were an opportunity to really make a difference:

- to ensure a review takes place across all professional groups not just those identified in the report
- to become a learning organisation with a robust and forward thinking education governance structure
- to align education strategy with the future education and development needs of all staff across the organisation and to align with the BCT strategy

To improve patient safety and experience a three-phased approach was drawn up:

**Phase 1** Review of skills framework; knowledge; competencies; professional duties of care; role specific training; annual appraisal; personal specification and skills for the June deadline.

**Phase 2** Review of skills, knowledge, competencies and professional duties of care of all Obstetrics, Paediatrics, Midwifery, Neonatal nursing staff, staff caring for critical care patients, anaesthetics, Intensive Care and High Dependency unit staff.

**Phase 3** to be rolled out to all other staff groups in the Trust (additional to those mentioned in the MBI Report recommendations).

### Provide a narrative describing what has been achieved through your project

The project has led to:

- the agreement of clear and explicit training expectations, split into mandatory and essential role-specific training, for each of the professional staff groups in the Women’s & Children’s services [WACS] and in Critical Care; with clear performance monitoring to ensure that active management trajectories were in place to ensure compliance.
- the development of the Training Management System (TMS) to support the ongoing monitoring and management of all aspects of mandatory and role specific training on a real-time basis, with all training data captured in a single central resource
- Preceptorships and Leadership development programmes being implemented within the WACS Division.
What specific outcomes have you achieved?

What KPI or measurements have you used to demonstrate these outcomes?

KPI targets are:

- 95% of all staff completed each element of mandatory (Core Skills framework) training - reported monthly via the Workforce Assurance Committee
- 95% of staff completed each element of their Role-Specific training - reported quarterly via the Workforce Assurance Committee
- 95% of staff have an annual appraisal which includes a PDP - reported monthly via the Workforce Assurance Committee
- Divisional trajectories in place to deliver 100% compliance
- NHS Staff Survey results return above-average key finding results against NHS Constitutional Staff Pledges 2 and 4 - monitored through annual Board Report and quarterly Pulse Survey reports to the Workforce Assurance Committee

  - The first three elements looked specifically at the performance for the specific staff groups identified in the Kirkup Report (Women’s & Children’s Division and Critical Care)

How can you demonstrate these actions have been integrated into ‘business as usual’

- All elements of mandatory (core skills) training compliance are reported monthly to the Divisional Performance Review Meetings and to the Workforce Assurance Committee.
- Divisional monthly meetings have mandatory training compliance as a standing item
- An Educational Governance group reporting to the Workforce Assurance Committee has been established to have oversight of all training and development activities across the organisation
How will these changes be sustained and monitored?

- The Education Governance group will have responsibility for leading on embedding and sustaining the work achieved to date
- Mandatory training monitoring via the monthly Workforce Assurance Committee & Divisional Performance Review Meetings
- Essential Role Specific Training via the monthly Divisional Governance Assurance Group (DGAG) Meetings - any major concerns or compliance issues escalated to the Workforce Assurance Committee
- Personal and Career Development needs monitored via the Appraisal process
- Appraisal completion rates via the monthly Workforce Assurance Committee
- Staff survey results
- Pulse check survey results
- Practice Educator Group
- Staff engagement via the Listening into Action scheme

What objectives have yet to be completed?

- The Listening into Action scheme timelines were deferred following the planned Big Conversation event being rescheduled due to impact of Storm Desmond. The Scheme will deliver on a 20-week LiA timetable.
- Clinical Leadership development – following the initial leadership triumvirate development programme being implemented in March 2015, scoping work has been undertaken for a bespoke Clinical Director and Clinical Lead programme and implementation will commence following appointment to the senior clinical leadership positions in spring 2016.
- Although not included in the specific recommendations, the Trust plans to roll out the approach to role-specific training to the rest of the organisation

Who will be responsible for these ongoing objectives?

Director of Workforce & OD
Which committee will monitor these ongoing actions/objectives?

The monitoring of training will be through mainstream groups and committees, specifically the:

- Workforce Assurance Committee
- Divisional Performance Review meetings
- Education Governance Group

How will these ongoing objectives/actions be monitored (process for monitoring i.e. highlight report to committee etc)

**Workforce Assurance Committee** received the following reports monthly

- Education Governance Group minutes
- Highlight report
- Exec summary
- Mandatory and role essential training figures by monthly reporting from TMS

**Education Governance Group minutes**

- Providing leadership and direction on all matters relating to education, development (including preceptorship), learning training and (research) within the Trust
- Meets monthly
- Reports to the WAC
- Monitor sub groups i.e. PEG, strategic TMS group
- Action plans following LiA – Feb-June 2016
- PEG – 1/4ly meetings

**Training Management System**

- Monthly reporting to the Education Governance Group and the Workforce Assurance Committee
- Phase 2 TMS development, reporting, revalidation, Mentoring and eAppraisal
- Bi-monthly strategic TMS group
- Appraisal – managed by divisions and monitored by TMS
- eAppraisal capture CPD records May 2016
- Revalidation for nursing
Revalidation and CPD
- Appraisal – managed by divisions and monitored by TMS
- eAppraisal capture CPD records from April 2016
- Revalidation for nursing

Listening in Action [LiA] - big conversation ‘Developing a culture of learning’
- Action plans following LiA – Feb- June 2016
- Strategic partnership opportunities
- PEG – 1/4ly meetings

When do you expect these ongoing actions/objectives to be completed by?

LIA:
- actions to be completed by June 2016

Clinical Leadership:
- commence April 2016

Roll-out of Role-Specific Training Identification & Monitoring
- 31st December 2016 all Divisional role-specific training agreed
- April 2017 – performance monitoring of all role essential training

Lessons Learned – what worked well?

Corporate Induction
UHMB used to have a three-day corporate induction programme. A significant proportion of new starters attended the programme months after they had started. The feedback from the programme was that it was uninspiring and relied too heavily on PowerPoint presentations.

- Following review and consultation a new, one-day corporate induction programme was introduced (May 2014). It was designed around the Trust’s Vision and Values, is Director-led and highly interactive. The programme runs twice per month and new starters attend on their first day in post wherever possible (90% compliance). Local workplace induction has also been reviewed and converted into an electronic process and recorded in the Trust's Training Management System (TMS).
Appraisal
A review of our appraisal process was completed by CETAD, Lancaster University in 2014. To follow up on the recommendations we used the Big Conversation event to gather views of employees on how we can make appraisal relevant and meaningful to everyone. Our 2014 Staff Survey results show 89% of employees have had an appraisal, however disappointingly only 39% indicated it was well structured (a small improvement). Everyone recognised that the ‘conversation’ is the most important aspect; however the documentation appeared to get in the way.

- There was agreement that Appraisal provides a framework to help staff develop and the opportunity for self-reflection on performance and identification of development needs.

Human Factors
The Trust has been developing human factors training over the last 3 years. However the growth has been organic and had not been mapped or coordinated. Early in 2015 a decision was made to appoint a Learning & Development Human Factors Specialist who would scope activity within the trust, explore external training and potential links and make recommendations as to the way forward for UHMB Human Factors Training. The person commenced in post on 15/6/15.

- Schwartz rounds
- NHS Values and behaviours and Organisational Cultural Transformation

The Director of Medical Education (Postgraduate) was successful in an application to Health Education Northwest for UHMB to be a pilot site for the NHS Values and behaviours and Organisational Cultural Transformation Programme.

Training Records
The Training Management System is the Trust's primary system for the management and monitoring of training and is a distributed system that is accessible to all Trust staff who have an active network log-on account. The TMS comprises the following key features:

1. Individual staff members have their own individual record within the system
2. Individual TMS records allow the staff member to see and manage:
   o What is on their "To Do" list (i.e. things they are required to do)
   o What is on their "Done" list (i.e. things they have done/completed)
   o Their training archive (i.e. things they have done/completed in the past)
   o Their personal profile (i.e. their personal details including job role, work area, etc.)
   a. Staff within a particular ward, department or group can be identified and managed collectively
   b. Training activities can be added, removed or updated (e.g. recorded as complete) by a recognised/approved TMS Coordinator. Each ward or department will have at least 1 recognised/approved TMS Coordinator

The data from TMS can be easily extracted to form completion and non-completion (i.e. compliance) reports.
Education Governance

In May 2014 a Workforce Assurance Committee was established. The key function of the Workforce Committee is to provide strategic direction and board assurance in relation to all workforce matters. Among its key duties is:

1. Monitor all educational, training, learning and research activities comply with required regulations e.g. Learning & Development Agreement, Education Outcomes Framework, Deanery, GMC Standards, CQC, Health Education North West, Lancaster University Medical School, and the Research Governance Framework. Receive regular reports from educational feeder groups.
   a. Learning Agreement: Since 2014 Learning Agreements have been piloted for applications for CPD funding. The agreement requires discussion prior to the education / training and on completion covering:
      o How the learning meets organisational, personal development needs?
      o How practice and service delivery improved as a result of this learning?
      o How the individual shares their learning with their colleagues?
      o If this learning highlighted further learning or development needs?

Mandatory Training

In October 2013 the Trust approved the adoption of the national Core Skills Framework which went live in April 2014.

A Mandatory Training Matrix is published annually which outlines in broad terms:

- The full list of mandatory training topics
- Which staff group(s) are required to undertake each of the mandatory training topics
- How each of the mandatory training topics will be delivered for:
  o New staff (e.g. via Corporate or Local Induction)
  o Existing staff (e.g. via the annual mandatory training workbook or eLearning)
- The time parameters for delivering each of the mandatory training topics
- If update training is required and, if so, the frequency of the update training
Improvement Activities

1. The Trust appointed a Listening into Action (LiA) Lead in October 2014 and an Improvement Lead in January 2015.
2. Listening into Action is a key element of the improvement approach the Trust is adopting and has proven models of change. Its aim is to engage, empower and enable front line staff to deliver first class patient care and has been adopted by over 50 NHS organisations. Our second wave of Pioneering and Enabling our People schemes will begin in July 2015 with 21 being taken forward.
3. We launched our Improvement Champion training in May 2015 and currently have over 40 members of staff involved in the first cohort. These staff will champion the quality improvement plan within the Trust and drive the ongoing development of an improvement and safety culture. The second cohort will begin their training in July with a third planned for September.

Lessons Learnt – what could have gone better?

The project has highlighted the inadequacy of the previous processes in identifying and managing mandatory training and role-specific training, with little central control over what was truly mandatory for all staff or a specific requirement for certain individuals or groups. This included a lack of understanding of the resources required to deliver the training which in turn led to a capacity/demand mismatch. The adoption of the national Core Skills Framework allowed the capacity gap to be reduced and the ongoing work through the LiA Scheme will bring these into balance by transforming delivery methods.
24.5 Estates

**Project Title: Kirkup Estates Project**

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<th>Date</th>
<th>Executive Sponsor</th>
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<tr>
<td>Project Manager</td>
<td>31st March 2016</td>
<td>Director of Finance and Deputy CE</td>
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</table>

**Project Recommendation (Project Summary)**

The University Hospitals of Morecambe Bay NHS Foundation Trust should identify options, with a view to implementation as soon as practicable, to improve the physical environment of the delivery suite at Furness General Hospital, including access to operating theatres, an improved ability to observe and respond to all women in labour and en-suite facilities; arrangements for post-operative care of women also need to be reviewed. Plans should be in place by December 2015 and completed by December 2017.

**Project Information**

**Findings /failures which led to the recommendation**

Recommendation 17 of the Morecambe Bay Investigation Report described concerns relating to privacy and dignity in relation to the layout of the unit and the route from labour ward to theatre. Improvements were required to privacy and dignity of women going to theatre, physical environment, observation of women in labour, and en-suite facilities.

**Overall Project Goal/ Outcomes**

The outcomes for the project are to ensure the Maternity Unit is a safe environment for women using the services, that theatres are co-located within the maternity unit and dedicated for maternity use. This will increase the safety of the service and improve the patient experience. The aim is to have labour/delivery/recovery and postnatal rooms (LDRP), which will all be single en-suite rooms. This will again improve the patient experience and improve privacy, dignity and respect for all who use the service.

A new unit will improve the staff experience and morale and help restore the confidence of the people of Barrow and surrounding areas.
Provide a narrative describing what has been achieved through your project

The development of the estates plan for the new maternity development at Furness General Hospital has gone through a robust, detailed and considered decision making process.

An external healthcare planner, commissioned by UHMB completed an assessment of the capacity requirements for the redevelopment of maternity services at Furness General Hospital. The report concluded that an obstetric and midwifery unit at FGH will require 14 birthing rooms and 2 transitional care rooms.

Considerable attention has been given to the design process and a number of layout options have been considered to ensure the most appropriate design which accommodates the required number of rooms in accordance to HBN09-02 standards, as well as the recommendations from the Kirkup report.

3 options have been reviewed
- Option 1 – Transfer of Delivery Unit to existing Paediatric ward including direct link to dedicated existing theatre. Enabling works to facilitate transfer will result in refurbishment works to all remaining WACS’ departments.
- Option 2 – Expansion of existing Maternity unit to incorporate existing Ward 1 to create new Delivery unit including 2 new dedicated Theatres
- Option 3 – New building to accommodate Delivery, SCBU, Bereavement suite and 2 new Theatres.

An options appraisal was undertaken in order to provide a robust process for identification of the best option. The template for the options appraisal was developed in conjunction with UHMB procurement team and took into consideration quality and safety as well as cost. This appraisal scoring was weighted quality and safety at 70% and finance 30%. The options appraisal was completed with a wide range of both clinical and non-clinical representatives from maternity, gynaecology, and children’s and young people’s services.

This comprehensive process identified Option 3 as the preferred option, and this was later agreed by the WACS Divisional Board. The new-build option has also received support from members of the Trust Executive team, and was formally agreed at the December meeting of the Kirkup Review Implementation Group [KRIG].

The outcome of the option appraisal was shared with the MBI Sub-Committee on the 8th January 2016. A detailed discussion occurred around the position of the theatres in relation to the labour ward, with the theatre being located on the floor below the labour ward in the plans shown to the group. Following discussion and an agreement to revisit the theatres’ position the committee members agreed to recommend Option 3 for consideration by the Trust Board. Subsequently, through discussion with staff and with the involvement of service users, the plans were altered and the final arrangement is that theatres are located on the same floor as the LDRP rooms. The Estates update was discussed at the public Board meeting on 27.1.16 with a view to final Board approval in March 16.

The Trust is progressing with the development of the new Maternity Unit through the NHS’s ProCure21+ Framework. Final interviews for selection of P21+ Contractor were conducted on 29.1.16 by a Trust panel consisting of members from Women and Children’s team, Estates, Supplies and an external assessor. All 3 shortlisted P21+ Contractors gave presentations for the proposed new build which were scored by panel members. Following this process, Integrated Healthcare Projects (IHP) was appointed as the preferred P21+ provider.

A further design period is in place to develop plans for option 3. This design process will include engagement of frontline clinical staff and service users.
Stakeholder engagement meetings took place at 4 workshops in March.
The Trust Board approved the plans at its meeting on the 30th March 2016

What specific outcomes have you achieved?

Full staff engagement for signed off outline plan by end Dec 2015 as Kirkup recommendation 17 requirement
Continued development of design and procurement of P21+ PSCP (contractor) to ensure project delivery by Dec 2017

What KPI or measurements have you used to demonstrate these outcomes?

1) Higher than average “I Want Great Care” score from service users.
2) Reduction in number of decision to delivery interval breaches for emergency caesarean sections
3) Increased staff confidence, better than average recruitment and retention rates
4) New maternity facility built by December 2017, compliant with HBN09-02 and Kirkup Recommendation 17

How can you demonstrate these actions have been integrated into ‘business as usual’

Responses following staff engagement and Maternity matters events with public have been incorporated in design to date.
Feedback from staff and prospect of a brand new fully compliant facility will increase confidence and appeal of working at FGH.

How will these changes be sustained and monitored?

Monthly maternity FFT results
Completion certificates issued at end of project for Building regulations, planning, fire and HBN / HTM compliance
What objectives have yet to be completed?

All is in place for compliance with Kirkup recommendation 17 by ensuring new build will be complete by December 2017

Who will be responsible for these ongoing objectives?

Project Director, Project manager and supporting team

Which committee will monitor these ongoing actions/objectives?

Capital Planning Group reporting every quarter to Finance Committee

How will these ongoing objectives/actions be monitored (Process for monitoring i.e. highlight report to committee etc.)

Various meetings as part of construction management process will quality, program and cost control e.g. Pre-start meeting, Weekly site meetings, Monthly project / design team meetings, Cost control meetings, Phased handovers / Final handover

When do you expect these ongoing actions/objectives to be completed by?

December 2017
24.6 Workforce Project

Project Title: Kirkup Workforce Project

<table>
<thead>
<tr>
<th>Prepared by</th>
<th>Date</th>
<th>Executive Sponsor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Manager – Deputy Director of Workforce</td>
<td>31st March 2016</td>
<td>Chief Operating Officer</td>
</tr>
</tbody>
</table>

Project Recommendation (Project Summary)

The workforce project was set up to address four of the recommendations in the Morecambe Bay Investigation Report [March 2015]. These recommendations were:

- **Recommendation 8**
  Identify a recruitment and retention strategy aimed at achieving a balanced and sustainable workforce with the requisite skills and experience. This should include, but not be limited to, seeking links with one or more other centre[s] to encourage development of specialist and/or academic practice whilst offering opportunities in generalist practice in the Trust; in addition, opportunities for flexible working to maximise the advantages of close proximity to South Lakeland should be sought. Development of the strategy should be completed by January 2016. [Cross reference with Recommendations 3 and 10]

- **Recommendation 9.2**
  Identify an approach to develop a better joint working between its main hospital sites, including the development and operation of common policies, systems and standards. Flexibility should be built into working responsibilities to provide temporary solutions to short term staffing problems. This should have begun by September 2015.

- **Recommendation 14.1**
  Should review arrangements for clinical leadership in obstetrics, paediatrics and midwifery to ensure that the right people are in place with appropriate skills and support. The Trust has implemented change at executive level, but this needs to be carried through to the levels below. This review should be commenced by April 2015. [Linked to Education, Learning and Development workbook 14.2]

- **Recommendation 16**
  Ensure that middle managers, senior managers, and non-executives have the appropriate clarity over roles and responsibilities in relation to quality and it should provide appropriate guidance and where necessary training. To be completed by December 2015.
There were a number of failings within the body of the report which lead to the recommendations:

**Recruitment and retention difficulties (Recommendation 8)**
The report described difficulties with recruitment and retention of midwives and nurses in the women and children’s division. In addition, obstetricians and paediatricians and the recruitment of experienced middle-grade medical staff to FGH was difficult. During the period covered by the review, the service was heavily dependent upon locum doctors and bank/agency midwives and neonatal nurses. The organisation identified that there was a need to strengthen recruitment and retention of permanent staff across all staff groups.

**Lack of common/consistent policies across maternity services (Recommendation 9.2) (shared with Governance Project)**
Differences were identified between FGH and RLI with regard to some system and processes, which resulted in an inability to have a flexible workforce between sites.

**Poor Leadership (Recommendation 14.1) (shared with Education, Learning & Development Project)**
The MBI Investigation identified concerns with both leadership and the Divisional structures. The Investigation described a service where there were no strong role models, those in place had with no clear responsibilities and no decisive leadership. The MBI investigation also described a lack of vision and strategic planning of the services and that the lack of visible support and leadership contributed to increasingly defiant behaviour by clinical colleagues.

**Managerial Responsibility of Quality (Recommendation 16)**
Lack of understanding regarding escalation of risk. Failure to appropriately identify and escalate concerns regarding quality and risk. Poor functioning and understanding of governance structures. The MBI investigation described a situation where middle managers stated that they were not involved in the governance process and the Divisional Manager had little to do with clinical quality. It further described a scenario where the structures in place meant it was difficult for concerns to be heard and where there was a lack of wider involvement in incident reviews.
Overall Project Goal/ Outcomes

The programme outcomes are linked directly to the UHMBFT Quality Improvement Strategy 2016 – 2019

Provide a narrative describing what has been achieved through your project

We have reviewed our divisional structure and leadership roles which has resulted in the creation of the Women’s and Children’s [WACS] Division as a division in its own right. In addition, the triumvirate leadership model has been developed to ensure that our leadership is integrated across all professional groups [clinical and managerial] with a primary focus on patient care and experience.

This has enabled us to focus on providing safe and sustainable services for women, children, and young people cared for by UHMBFT. By creating a well led WACS Division we have been able to improve our recruitment and retention of nursing, midwifery, and medical staff. Acknowledging that there are still improvements that can be made within the Division and with recruitment and retention it is clear that the patient and staff experience has improved significantly.

What specific outcomes have you achieved?

**Recommendation 8:**
- Development of a Trust Recruitment and Retention strategy and an overarching Better Care Together Recruitment and Retention strategy across our partner organisations
- Development of bespoke recruitment plans for medical, nursing/midwifery, and allied health professional staff groups
- Regular review of recruitment activity and progress via the Workforce Assurance Committee
- Contracts of Employment reviewed to ensure flexibility in location cross-Bay in line with service needs
One Year On – how we implemented the Kirkup Report

Recommendation 9.2
- Cross Bay Obstetric and Midwifery guidelines in place
- Development of Multi-Disciplinary and Speciality specific training and development
- Specialist leadership roles for nursing and midwifery roles – including, for example, the development of governance, educational, quality & safety, risk, bereavement roles
- Job descriptions and job plans reviewed to ensure flexibility regarding service provision
- Robust process is in place to review and amend Trust-wide HR policies in partnership with Joint Working Group and Joint Local Negotiating Committee

Recommendation 14.1
- Review of the Divisional structures which has created the Women and Children’s Division (WACS)
- Review of leadership structure in WACS to create a co-ordinated team across clinical and management roles working in collaboration (Divisional General Manager, Clinical Director and Assistant Chief Nurse for Children and Young People and Deputy Head of Midwifery, Gynaecology & Obstetrics
- Review of the role of Deputy Director of Midwifery and Head of Midwifery, Gynaecology & Obstetrics which now sits within the strategic Executive Chief Nurse team and has overall accountability for midwifery
- Review of clinical leadership structure – including re-defining the roles of the clinical leadership with clear job descriptions, roles and responsibilities
- Review of midwifery and CYP leadership structure – including the development of Head of Midwifery, Deputy Head of Midwifery and Assistant Chief Nurse for CYP
- Specialist leadership roles for nursing and midwifery roles – including, for example, the development of governance, educational, quality & safety, risk, bereavement roles
- Identify lead roles within the consultant team – including, for example, education, governance, labour ward lead, clinical supervision responsibilities
- Job descriptions reviewed to ensure flexibility regarding service provision

Recommendation 16
- Clinical Service Managers/ Divisional General Manager included within Membership of key Divisional Governance Meetings
- Non-Executive Directors chair sub-board assurance meetings including quality, finance and workforce committees
- Annual Mandatory training for Risk and Incident management training, which includes feedback of incidents (e-learning package)
- Job descriptions reviewed to include clarity about responsibilities in respect of risk and incident management
- Self-assessment undertaken with manager roles (8A+) to understand and highlight any shortfalls in understanding regarding roles and responsibilities in relation to quality which identified a good understanding of responsibilities
### What KPI or measurements have you used to demonstrate these outcomes?

<table>
<thead>
<tr>
<th>Project</th>
<th>Key Performance Indicator</th>
<th>Frequency of data</th>
<th>Baseline Data as of Feb 2016</th>
<th>Data Collection</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recruitment &amp; Retention</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To achieve residual vacancy factors</td>
<td></td>
<td>2 monthly</td>
<td>Workforce Information report detailing progress against vacancy</td>
<td>Workforce Assurance Committee</td>
</tr>
<tr>
<td>(by 31/3/17)</td>
<td></td>
<td>6.5%</td>
<td>Monthly Divisional Governance Assurance Group (DGAG)/Divisional Management Team meetings</td>
<td></td>
</tr>
<tr>
<td>Registered Nurses 3.25% – 5.00%</td>
<td></td>
<td>8.0%</td>
<td>Recruitment &amp; Retentions strategy in place April 2015</td>
<td>Workforce Assurance Committee</td>
</tr>
<tr>
<td>Registered Midwives 4.0% – 6.0%</td>
<td></td>
<td>10.1%</td>
<td>Revised draft of Recruitment &amp; Selection Strategy</td>
<td></td>
</tr>
<tr>
<td>Consultant 5.0% - 7.5%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recruitment &amp; Retention strategy</td>
<td></td>
<td>3-yearly</td>
<td>Workforce Information report detailing progress against vacancy</td>
<td>Workforce Assurance Committee</td>
</tr>
<tr>
<td><strong>Joint Working across Bay</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Guidelines managed via Quality</td>
<td></td>
<td>3-5 yearly</td>
<td>Completed action</td>
<td>JWG/JLNC</td>
</tr>
<tr>
<td>Committee (ref 9.1)</td>
<td></td>
<td>Complete and on-going</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trust wide Workforce Policies 100% in date,</td>
<td></td>
<td></td>
<td>Policy Development managed via the Joint Working Group and Joint Local Negotiating Committee</td>
<td></td>
</tr>
<tr>
<td>Cross Bay Joint Partnership policy development in central repository</td>
<td></td>
<td>Complete and on-going</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Leadership</td>
<td>One off</td>
<td>Complete</td>
<td>Job Descriptions reviewed and in place</td>
<td></td>
</tr>
<tr>
<td>---------------------</td>
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<td>----------</td>
<td>----------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Clinical Leadership Triumvirate Review undertaken to review DGM, ACN and CD roles</td>
<td>Annual</td>
<td>94%</td>
<td>Annual appraisal and PDP in place to monitor skills development</td>
<td></td>
</tr>
<tr>
<td>Appraisal for all Trust leaders 8A+ 100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist Leadership roles Job Descriptions</td>
<td>One off</td>
<td></td>
<td>Job descriptions in place</td>
<td></td>
</tr>
<tr>
<td>Escalation of Risk and Quality</td>
<td></td>
<td></td>
<td>Bi-Monthly review of appraisal compliance via Workforce Commitment</td>
<td></td>
</tr>
<tr>
<td>Mandatory training for the management of Risk and Incidents</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Ulysses Safeguard Incident Reporting E-learning</td>
<td></td>
<td></td>
<td>Risk Management Policy in place</td>
<td></td>
</tr>
<tr>
<td>• Ulysses Safeguard Incident Management Investigation E-learning</td>
<td>As per mandatory training guidance</td>
<td></td>
<td>Monthly TMS reporting managed via Divisional DGAG/DMT</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Reported via Quality Committee</td>
<td></td>
</tr>
</tbody>
</table>
How can you demonstrate these actions have been integrated into 'business as usual'?

- All revised Job Description form part of UHMB Job Description centralised database
- Appraisal/ mandatory training reviewed at divisional level and at Workforce Assurance Committee
- KPI/ All monitored and reviewed through Workforce Assurance Committee
- Recruitment & Retention strategy in place and reduction in residual vacancy factor as per KPI

How will these changes be sustained and monitored?

All mandatory training, appraisals are reported and monitored at both a divisional and corporate level through the formal governance processes. Recruitment and retention is monitored at both a divisional and corporate level, with plans in place to mitigate any vacancies

What objectives have yet to be completed?

All actions have been completed. There is an on-going recruitment drive across the Trust and WACs division to reduce the residual vacancy factors as described above. This is monitored through the WACS division and Workforce Assurance Committee

Who will be responsible for these ongoing objectives?

Each divisional triumvirate leadership team, through the Performance Reviews and Workforce Assurance Committee

Which committee will monitor these ongoing actions/objectives?

Workforce Assurance Committee
When do you expect these ongoing actions/objectives to be completed by?

On-going recruitment and retention drives until no vacancies

Lessons Learned – what worked well?

Clear action plans and named responsible office for individual actions

Lessons Learnt – what could have gone better?

The original project lead left the organisation midway through the project and an interim project lead was assigned and then also left. Evidence collection and KPI data and closure reports have therefore had to be provided by a third project lead at a late stage in the process.
24.7 Clinical Quality Project

Project Title: Clinical Quality Project

<table>
<thead>
<tr>
<th>Prepared by</th>
<th>Date</th>
<th>Executive Sponsor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Manager</td>
<td>31st March 2016</td>
<td>Executive Nurse Director</td>
</tr>
</tbody>
</table>

Project Recommendation (Project Summary)

**Recommendation 5**: Should identify and develop measures that will promote effective multidisciplinary team-working, in particular between paediatricians, obstetricians, midwives and neonatal staff. These measures should include, but not be limited to, joint training sessions, clinical, policy and management meetings and staff development activities. Attendance at designated events must be compulsory within terms of employment. These measures should be identified by April 2015 and begun by June 2015.

**Recommendation 6**: Draw up a protocol for risk assessment in maternity services, setting out clearly: who should be offered the option of delivery at Furness General Hospital and who should not; who will carry out this assessment against which criteria; and how this will be discussed with pregnant women and families. The protocol should involve all relevant staff groups, including midwives, paediatricians, obstetricians and those in the receiving units within the region. The Trust should ensure that individual decisions on delivery are clearly recorded as part of the plan of care, including what risk factors may trigger escalation of care, and that all Trust staff are aware that they should not vary decisions without a documented risk assessment. This should be completed by June 2015.

**Recommendation 7**: Should audit the operation of maternity and paediatric services, to ensure that they follow risk assessment protocols on place of delivery, transfers and management of care, and that effective multidisciplinary care operates without inflexible demarcations between professional groups. This should be in place by September 2015.

Project Information

Findings /failures which led to the recommendation

1. The relationships between different groups of staff were extremely poor…with repeated failures to communicate important clinical information about patients…poor relationships hampered the development of the unit…multi-disciplinary meetings whether to discuss clinical policies or to examine poor outcomes, were difficult to arrange, took place infrequently and were often poorly attended by one or more staff groups
2. Emergency transfers of sick babies which could have been prevented
3. Many reports were extremely brief, failed to identify failures of care, and showed evidence of adopting an inappropriately protective approach…defensive ‘blame-shifting’ behaviour predominated
4. Together, they constituted a lethal mix that we have no doubt led to the unnecessary deaths of mothers and babies
5. Obstetricians, midwives and paediatricians had allowed the breakdown of personal and interdisciplinary relationships to jeopardise care
6. Midwives took over the risk assessment process without in many cases discussing the intended outcomes with obstetricians, and there were repeated instances of women being inappropriately classified as being at low risk and managed incorrectly
7. Paediatricians often adopted a wait and see approach, as a result, this necessitated emergency transfers of sick babies which could have been prevented
8. The safety of maternity units depends on their level of vigilance to detect risk and deviation from the norm, and on their taking effective action when it is found
9. Clinical records were extremely poor and often written in retrospect, also jeopardising the necessary transfer of vital information

| Overall Project Goal/Outcomes | Reduced variation in clinical decisions and management leading to improved outcomes including:
1. lower than national average transfers of sick babies
2. lower than national average mortality and morbidity of babies and mothers
3. Higher than average ‘IWantGreatCare’ score from service users |

Provide a narrative describing what has been achieved through your project

Throughout the project clinical guidance and procedures as well as training and education plans for Women’s and Children’s Services [WACS] that were already in place have been reviewed, refreshed and where required updated. Opportunities have been taken to improve further on those developments and changes already made prior to Kirkup reporting in March 2015 to ensure high quality safe maternity services that are continuously ensuring women receive the best care for themselves and their babies that meets their wishes and needs. Service user involvement and input into this as well as a wide spectrum of professional groups represented has really enabled this principle to be underpinned in everything the project has undertaken.

What specific outcomes have you achieved?

1. There is updated clinical guidance that reflects latest NICE Guidance in respect of antenatal risk assessment, Intrapartum risk assessment, and transfer of mothers to other units that ensures the safe birth of their baby in a unit equipped and skilled to look after their specific care needs. This guidance has been refreshed and since 2012 has been standardised across all three maternity units at MBHT.
2. In addition all maternity staff receives PROMPT training and this has been in place again since 2012. This was mandated along with other training requirements in the maternity training needs analysis. It now also mandates attendance at a series of meetings that provided invaluable learning and feedback as part of the MDT for all midwives as part of their annual training plan.
3. With robust audit programmes in place that audit the quality and delivery of services the maternity services at MBHT can triangulate information and clinical outcomes across all three sites and make changes and improvements based on audit outcomes, clinical incidents as well as service user feedback through numerous means and forums.
All of this has seen improved outcomes for mothers and babies both from a clinical perspective but also a patient experience perspective.

What KPI or measurements have you used to demonstrate these outcomes?

- Better than average Friends and Family Test data
- Lower than national average of transfers of sick babies
- Lower than national average of perinatal mortality

How can you demonstrate these actions have been integrated into ‘business as usual’

The maternity dashboard, audit, clinical incident reporting, and patient experience are all standing items on the Divisional Governance Assurance meetings as well as regular agenda items at Joint Maternity Commission Group meetings, and part of the Divisional Management Board meetings.

This information and clinical outcomes are also reported to the Maternity Services Liaison Committee.

How will these changes be sustained and monitored?

As above

What objectives have yet to be completed?

None

Lessons Learned – what worked well?

Having a service user on the project group was fundamental in improving existing guidance and procedures to ensure it really met the needs of women and their families. It also gave a different perspective which meant that the often missed question and answer because it was normally just assumed didn’t go unasked or unanswered.

Lessons Learnt – what could have gone better?

Bringing all the evidence together in a way that external people to the project could and can follow it and know what it pertains to and means.
24.8 Governance

Project Title: Governance Recommendations

<table>
<thead>
<tr>
<th>Prepared by</th>
<th>Date</th>
<th>Executive Sponsor</th>
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<tbody>
<tr>
<td>Project Manager</td>
<td>31 March 2016</td>
<td>Director of Governance</td>
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</tbody>
</table>

Project Recommendation (Project Summary)

The University Hospitals of Morecambe Bay NHS Foundation Trust should continue to prioritise the work commenced in response to the review of governance systems already carried out, including clinical governance, so that the Board has adequate assurance of the quality of care provided by the Trust’s services. This work is already underway with the facilitation of Monitor, and we would not seek to vary or add to it, which would serve only to detract from implementation. We do, however, recommend that a full audit of implementation be undertaken before this is signed off as completed.

Project Information

Findings /failures which led to the recommendation

“There is evidence of poor interdisciplinary working relations and substandard care. Identified failure of clinicians to work as an effective clinical team. Local and national guidelines were followed inconsistently, and there were repeated instances of failure to apply basic principles of care. Midwives took the lead in developing guidelines, with limited input from consultants

There was an incident reporting system (Safeguard), but not all staff had received training. A key weakness in clinical governance systems exists if the members of the clinical team do not recognise a poor outcome as a clinical incident that could potentially have been avoided, or do not report it, so that such cases go unnoticed outside the immediate clinical team. There are a number of reasons why this might have been the case: clinicians knowingly wishing to obscure poor outcomes to avoid loss of reputation and blame; clinicians not having the knowledge and skills to recognise that problems could have been avoided; or poor engagement and awareness of incidents across the full range of multidisciplinary staff, and therefore less discussion and challenge about incidents and causes, which might have resulted in the development of greater insight and recognition of problems

There may have been Root Cause Analyses carried out, but these were generally not undertaken by a multidisciplinary team. They might have been reviewed by the clinical lead. The previous pattern of inadequate, defensive, internal investigations was replicated, treating each incident in isolation, but subsequent events should have made the problems clear. The investigation team were distressed to hear and see evidence that the investigation of maternal deaths was also sometimes superficial and rudimentary, and failed to identify clear examples of substandard care that this approach was significantly flawed. In some cases, this reflected an over-reliance on poorly completed records, when it would have been evident from a conversation with the relatives of the deceased that warning signs were missed some time in advance of the subsequent acute deterioration of the patient’s condition. We were also taken aback to find that none of the unit clinicians, clinical director or executive directors appeared to have considered that there may have been a pattern to the occurrence of these extremely rare events in a small unit

Patients, parents and families indicated that they had not received adequate – or in some cases any – explanations of why something went wrong, and had basic questions about aspects of the care received. Throughout the period under investigation, information was provided to
The governance committees and, through them, to the Board. The focus is not on the lessons learnt or the issues arising from the complaints, but predominantly on the time taken to process an investigation. Information of a valuable nature that might have identified trends, clinical issues or consistent service failures appears to be absent in any meaningful way. The investigation formed the view that complaints were seen as an administrative chore by the Trust, to be completed as quickly as possible before addressing the next case. Opportunities for learning were missed, and it was hard to see how complaints were being used by the Trust to improve the care it offered patients. The Trust needs to consider carefully how it interacts with patients and families through complaints. It cannot see them as administrative tasks, but rather as insights into the working of the organisation. Complaints can be an essential route to tackling systemic and individual failings within an organisation. The approach during the period of the Investigation does not demonstrate that anything changed as a result of the lessons learnt by the failures in service. The Board needs to be vigilant and to challenge its officers about the complaints it receives, and not be satisfied with number-based reports.

Although the content of the meetings appeared appropriate, the committee operated at a high level, and received little detailed information related to actual clinical risks and outcomes in a systematic way but focused on quality development and strategy, and on receiving minutes from other committees. Quality and governance had a low profile at the Board, with the predominant focus being on finance and performance targets. Although there was evidence of systematic failings in the FGH maternity unit prior to 2008, it is clear that none of it reached senior levels in the Trust, particularly executive directors and the Board itself. Partly, this was due to poorly developed systems of clinical governance within the Trust which meant that there was little formal oversight of safety or other quality matters in clinical services. Staff identified the fact that governance structures functioned less well at divisional level and Divisional middle managers were not involved in the clinical governance process.”

<table>
<thead>
<tr>
<th>Overall Project Goal/ Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>The outcome for the Governance project is to ensure that staff ‘from the ward to the Board’ receive information in a systematic way ensuring Quality and Governance has a high profile throughout the organisation. Specifically this will include a robust reporting and assurance process that starts with front line staff and flows through the corporate committees to the Board in a clear Assurance Framework. A standardised approach to risk management throughout the organisation, a strong forward audit programme, a strengthened process for identifying and investigating when care falls below expected standards, and a responsive and compassionate response when our patients complain. We will learn and improve from our mistakes through the ‘learning to Improve’ Group and Trust wide ‘Learning to Improve’ bulletins, and will underpin clinical care with robust procedural documents that have been developed by multidisciplinary divisional teams before being ratified by divisional governance and management processes prior to Trust sign off and implementation. We will submit to a Monitor Well-Led review to evidence the success of the project implementation.</td>
</tr>
</tbody>
</table>
One Year On – how we implemented the Kirkup Report

Provide a narrative describing what has been achieved through your project

The past 24 months have seen a significant review and development phase within both the structure and delivery of Clinical and Corporate Governance at the Trust. The lack of confidence in the Trusts’ governance systems identified by our regulators has been used as a framework to undertake a wholesale review of governance from ward to board. Using the Monitor Governance Framework and key national documents, the Governance Team have systematically reviewed, developed and implemented robust methodology to ensure going forward, we can have confidence in the monitoring of the standard and quality of all the care we provide, and in the responses we make when areas of concern are identified. The pace of change has been rapid, and significant assurance is now being reported by our external auditors. The Governance processes received very positive in the recent CQC inspection and the Monitor Well-Led review had no amber/amber red/red ratings. Monitor has also recently requested to share our learning to improve bulletins as examples of good practice.

We are now working in partnership with the Good Governance Institute to continue our journey towards excellence.

What specific outcomes have you achieved?

Recommendation 9.1
A multidisciplinary approach to the development, ratification and implementation of all procedural documents to ensure consistency of approach across the Bay, underpinning the delivery of safe high quality care by an engaged and knowledgeable workforce
Central repository to ensure safe storage, efficient retrieval for clinical staff and on-going management of procedural documents

Recommendation 11
- Training packages ensure staff are well informed in relation to incident reporting and safety culture to improve insight and responsiveness into incident recognition
- Training packages for Managers/leads ensures they have clear sight of roles and responsibilities in relation to reporting and managing incidents and investigations and will therefore contribute to continually improving safety
- Staff will receive feedback on every incident, promoting engagement and improvements to support the monitoring of safe care
- A Trust Learning to Improve Bulletin will support learning from mistakes, and from what is done well to ensure the potential for improved clinical care and patient experience is maximised
- Staff opinion will support the development of an improved reporting system and engaged staff to support monitoring of clinical care
Recommendation 12

- A programme of general RCA training has been completed for a cohort of clinicians and managers to provide capacity for RCA work to underpin robust investigation of serious incidents and to ensure learning from incidents to maintain public confidence and continually improve care.
- Regular meetings with local CCG’s ensures that going forward the Trust and partners maintain open and transparent learning cultures
- 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
- Introduction of ‘Patient Safety Summits’ 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 to 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.

‘Awareness of human factors’ training has underpinned a developing understanding of why healthcare staff make errors and in particular, which ‘systems factors’ threaten patient safety

Recommendation 13

a. Our complaints and PALS procedures align with the ombudsman guidelines and we have developed a high quality response process for complaints.
b. The Patient Relations team to support and facilitate the Divisional teams with any complaints received and provide staff training to ensure staff feel confident and able to respond with sensitivity and compassion when patient experience has caused concern.
c. Every complainant has an allocated case officer as a point of contact and liaison. The increase in patient customer contact has enabled the identification of all concerns at an early stage reducing dissatisfaction with responses.
d. Regular audit is undertaken to monitor performance and the Trust has a KPI in relation to the reduction in complaints.
e. High quality data is shared to support customer engagement, response performance and identification of themes arising and shared learning and there is a clear reporting framework through corporate committees and to the Trust Board. Engagement with other providers in the North West has enabled greater shared learning.
Recommendation 15

- The Governance Strategy and Quality Improvement Plan has identified quality goals that incorporate national requirements and locally identified measures. Quality goals have been selected to have the highest possible impact across the overall Trust. The majority of measures are specific, measurable and time-bound to ensure that an effect and transparent, patient-centred governance framework is maintained to prevent a re-occurrence of past mistakes. Our clinical and corporate governance function will ensure that we not only identify, action and remedy harms, but by continually monitoring and reporting we will ensure our Trust Board are able to outline the needs and experiences of our patients at the heart of all decision making.
- Robust Risk management will ensure recognition and effective management of all threats and opportunities that may have an impact on the Trust’s ability to deliver its statutory responsibilities and the achievement of its objectives and values.
- To drive improvement in patient safety, the Trust has developed reporting templates (and will shortly integrate them to the Trust dashboards) to ensure it receives the best quality information possible. These include information relating to the workforce, patient experience, safety, effectiveness and efficiency.
- Each Division has a Divisional Governance Framework in place. Meetings are established at local ward/department level and clinical leaders support the review of safety issues at all level. Standardised divisional reports support the multi-disciplinary Divisional Governance and Assurance meetings. Executive Director-led Divisional performance meetings are held on a monthly basis to review the standardised information and areas of concern are escalated to the Assurance Committees.
- The audit process has been standardised and an electronic audit module for the registering, monitoring and reporting of audit has been developed.
- High levels of compliance with Health and Safety standards to maintain safe practices for patients and staff have been established and underpinned by a series of staff engagement events.
- During 2014/15 Internal Audit undertook a programme of audit in relation to Trust Governance processes and the following areas were found to have significant assurance:
  - Corporate and Divisional Governance – Significant assurance
  - Risk Management – Significant Assurance
  - Health and Safety (NHS Protect Audit) – Significant assurance
  - Project Management Office – High (Full) Assurance
    - The Trust has recently had a favourable Monitor Well-Led review receiving green and green/amber ratings, not amber, red/amber or red ratings were received.
What KPI or measurements have you used to demonstrate these outcomes?

All procedural documents to be held in a central repository and have been developed for cross Bay use by multi-disciplinary teams

- 2014-15: All documents in central repository on Document Library
- 2015-16: 100% In date, Cross Bay, MDT document development

UHMBFT will rank in the top 25% of Trusts on the National Reporting and Learning system and will continue to demonstrate a reduction in harm

1) 2014-15: 92% of patients will receive harms free care
2) 2015-2017: 95% of patients will receive harms free care
3) 2017-2019: 98% of patients will receive harms free care

Responsibility for sharing learning, outcomes and delivery of recommendations from incidents will be underpinned by Trust lesson learnt bulletins

1) Lessons learnt bulletins developed
2) 2015-17: 12 general bulletins and 6 themed bulletins per year
3) 2017-2019: 12 general bulletins and 6 themed bulletins per year

A positive 'Well-Led' Review

How will these changes be sustained and monitored?

The corporate Governance Division has a robust business plan detailing the annual work programme
The Trust will continue to monitor risk, incidents and patient relations via the governance meeting structure
The Kirkup governance work stream has identified KPI's for on-going measurement
The Governance Division continue to work with the Good Governance Institute to ensure embedded processes and development opportunities

What objectives have yet to be completed?

The Sign up to Safety Campaign was transferred out of the Governance work stream and is now managed by the Deputy Chief Nurse and progress will be monitored at the Quality Committee

Who will be responsible for these ongoing objectives?

The Sign up to Safety Campaign was transferred out of the Governance work stream and is now managed by the Deputy Chief Nurse and progress will be monitored at the Quality Committee
Which committee will monitor these ongoing actions/objectives?

The Sign up to Safety Campaign was transferred out of the Governance work stream and is now managed by the Deputy Chief Nurse and progress will be monitored at the Quality Committee.

How will these ongoing objectives/actions be monitored (process for monitoring i.e. highlight report to committee etc)

TBC

When do you expect these ongoing actions/objectives to be completed by?

TBC

Lessons Learned – what worked well?

The Governance work stream continued a programme of work that the Kirkup report acknowledged and did not want to add to. This enabled a seamless flow of actions from previous reports to the Kirkup action plan.

Lessons Learnt – what could have gone better?

Earlier agreement of project outcome’s and KPI’s
24.9 Partnership

**Project Title: Kirkup Partnership Project**

<table>
<thead>
<tr>
<th>Prepared by</th>
<th>Date</th>
<th>Executive Sponsor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Manager</td>
<td>31st March 2016</td>
<td>Medical Director</td>
</tr>
</tbody>
</table>

**Project Recommendation 10**

The University Hospitals of Morecambe Bay NHS Foundation Trust should seek to forge links with a partner Trust, so that both can benefit from opportunities for learning, mentoring, secondment, staff development and sharing approaches to problems. This arrangement is promoted and sometimes facilitated by Monitor as ‘buddying’ and we endorse the approach under these circumstances. This could involve the same centre identified as part of the recruitment and retention strategy.

**Project Information**

The Morecambe Bay Investigation noted that: “Medical staff have proved hard to recruit and there has been little opportunity for joint working or shared experience with other sites. All of this has contributed to the isolation of the hospital and its clinical practice. In such settings, practice can ‘drift’ away from the standards and procedures found elsewhere, and this can remain undetected until it has deviated a long way and obvious problems develop. In the maternity services at Furness General Hospital, this ‘drift’ involved a particularly dangerous combination of declining clinical skills and knowledge, a drive to achieve normal childbirth ‘whatever the cost’ and a reckless approach to detecting and managing mothers and babies at higher risk.

The prime responsibility for ensuring the safety of clinical services rests with the clinicians who provide them, and those associated with the unit failed to discharge this duty over a prolonged period. The prime responsibility for ensuring that they provide safe services, and that the warning signs of departure from standards are picked up and acted upon, lies with the Trust, the body statutorily responsible for those services.”

**Overall Project Goal/Outcomes**

1. To reduce the impact of potential clinical isolation of senior medical and nursing staff working in the Maternity and Paediatric services at UHMBFT, and in time extend the project to include obstetric and paediatric anaesthetic services
2. To provide guidance and advice so that policies, protocols, and risk management are optimal; and so that rigorous governance processes support the delivery of high quality care in Morecambe Bay Hospitals
One Year On – how we implemented the Kirkup Report

Project Goal 1 could be delivered through:

- The formation of a ‘community of practice’ with one or more tertiary providers so that UHMBFT staff take part in training opportunities, learn about best practice, leadership traits and the actions that support a culture devoted to patient safety. This will, in turn, be a major determinant to ensure that local maternity services are safe and sustainable;
- The development of shared training in skills laboratories – supported by IT to enable multi-site, multi-organisational input to virtual ‘situational awareness’ training and creating conditions that foster team effectiveness and purpose.
- Opportunities for obstetric and midwifery staff to attend tertiary units for additional experience, which could include sub-specialisms particular to tertiary units.

Project Goal 2 could be delivered through:

- Peer review of policies and protocols between organisations with the aim of facilitating true understanding of the application and implication of these policies in safe clinical practice;
- Visiting expert review of ward rounds and MDTs to provide constructive challenge;
- Real time collaboration on risk management of complex cases
- Mentoring and support for all clinical staff, initially focussing on those in leadership roles.
- Mentoring and support for senior and middle management, including leadership coaching, so that a supportive culture of motivation can develop to support safety and change.
- Peer review of clinical incidents, investigations and complex cases which will inform the UHMBFT Board Assurance Sub Committee

Provide a narrative describing what has been achieved through your project

Following publication of the MBI Report and in pursuit of Recommendation 10 the Board of UHMBFT made initial approaches to Central Manchester University Hospitals NHS FT, and responded to an approach from Lancashire Teaching Hospitals NHS FT. During these discussions, between Chief Executives both organisations expressed interest in becoming Maternity Strategic Partners. The parties to Recommendation 10 are therefore:

- University Hospitals of Morecambe Bay NHS FT [UHMBFT]
- Central Manchester University Hospitals NHS FT [CMFT]
- Lancashire Teaching Hospitals NHS FT [LTH]
- With both NHS Cumbria CCG, and NHS Lancashire North CCG as Associate Partners

What specific outcomes have you achieved?

- Memorandum of Understanding developed and agreed with Strategic Partners and approved at the UHMBFT Trust Board on the 26th November 2015.
Information provided by both strategic partners in respect of range of obstetric sub-specialty clinics covered by the partnership, and additional services offered for partnership placements.

Maternity Strategic Partnership Committee established, quarterly meetings scheduled, and first meeting held on the 29th February 2016.

Agreement reached with LTH regarding the process to be followed in respect of clinical indemnity for staff undertaking placements at LTH. UHMBFT have signed an Addendum to the Memorandum of Understanding to cover this issue. UHMBFT staff undertaking placements at CMFT will be required to have an honorary contract.

Agreement reached with CMFT that UHMBFT maternity and paediatric staff are welcome to attend their Audit and Clinical Effectiveness [ACE] days, commencing with six UHMBFT attendees at the meeting on the 19th January 2016. Dates have been provided for 2016.

Agreement reached with CMFT that up to three UHMBFT staff are welcome to attend each of the Human Factors training events provided in-house for CMFT staff. Dates have been provided for 2016.

What KPI or measurements have you used to demonstrate these outcomes?

- Memorandum of Understanding developed and agreed with all strategic partners and associate partners [CMFT, LTH, UHMBFT, Lancashire North CCG, & Cumbria CCG.
- 33% annual achievement of total staff identified to undertake placements in strategic partner organisations [i.e. 100% completion in 3 year period.
- Development of a Maternity Strategic Partnership module within the Training Management System [TMS] to record and report on MSP activity and provide evidence for Continuing Professional Development [CPD], annual appraisal and revalidation.
- The Strategic Partnership Committee to meet four times a year and produce Minutes to be shared with all MSP members, and the Quality Committee.

How will these changes be sustained and monitored?

Through the [Maternity] Strategic Partnership Committee

What objectives have yet to be completed?

On-going project

Who will be responsible for these ongoing objectives?

Project Director and Project manager
Which committee will monitor these ongoing actions/objectives?

Maternity Strategic Partnership Committee, reporting to the Morecambe Bay Sub-Committee/Quality Committee, and through to the Trust Board

How will these ongoing objectives/actions be monitored
(Process for monitoring i.e. highlight report to committee etc.)

Monthly reports to the Quality Committee
Minutes of the Maternity Strategic Partnership Committee

When do you expect these ongoing actions/objectives to be completed by?

This is an on-going project. The partnership has initially been set up for a three-year period however we hope this will be an enduring relationship with the partnership renewed on an annual basis with both our strategic partners.

Lessons Learned – what worked well?

UHMBFT clinicians are very keen to undertake placements, establish working relationships with clinical colleagues in tertiary hospitals and benefit from the opportunities on offer.

Lessons Learnt – what could have gone better?

Lead time required for development of Memorandum of Understanding and establishing the process for placements was underestimated.
### 24.10 Key Performance Indicators Data

<table>
<thead>
<tr>
<th>Project</th>
<th>Key Performance Indicator</th>
<th>Frequency of data</th>
<th>Baseline Data as of Feb 2016</th>
<th>Data Collection</th>
<th>Sustainability Monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education, learning and development</td>
<td>95% of all staff completed each element of mandatory (Core Skills framework) training - reported monthly via the Workforce Assurance Committee</td>
<td>Monthly</td>
<td>Complete 95% of staff completed their mandatory training 30.9.15 and these figures are reported monthly through Training Management System</td>
<td>1) Monthly recording via TMS 2) Monthly Divisional Governance Assurance Group (DGAG) Education Governance Group  The monthly Education Governance Group will: 1. Have oversight of mandatory training needs analysis 2. Ensure the embedding of the lessons learned from Kirkup across all divisions. 3. Provide leadership and direction 4. Oversee the development and implementation of key performance indicators</td>
<td>3) Compliance will be monitored monthly by the Divisional Governance Assurance Group. 4) Monthly Workforce Assurance Committee Additionally the mandatory figures get reported into the Workforce Assurance Committee on a monthly basis.</td>
</tr>
<tr>
<td></td>
<td>95% of staff completed each element of their Role-Specific training - reported quarterly via the Workforce Assurance Committee</td>
<td>Monthly</td>
<td>Training Management System [TMS] will be ready for reporting from June 2016. Trajectory in place to deliver role specific training in a timely manner</td>
<td>5) The role essential training has been agreed and signed off by Workforce Assurance Committee and Critical Care and Woman’s and Children’s populated onto Talent Management System Monthly recording via TMS 6) Monthly Divisional Governance Assurance Group (DGAG)</td>
<td>The monthly Divisional Governance Assurance Group will report and monitor monthly. The monthly Education Governance Group monitors the development</td>
</tr>
</tbody>
</table>
Education Governance Group will:

7) Have responsibility for the approval of job essential training needs analysis, training delivery and compliance

b. Ensure the embedding of the lessons learned from Kirkup across all divisions.

c. Provide leadership and direction
d. Oversee the development and implementation of key performance indicators

In addition the monitoring will be overseen by the monthly Workforce Assurance Committee.

- 95% of staff have an annual appraisal which includes a PDP reported monthly via the Workforce Assurance Committee

<table>
<thead>
<tr>
<th>Monthly Divisional Governance Assurance Group (DGAG)</th>
<th>February 2016:</th>
</tr>
</thead>
<tbody>
<tr>
<td>UHMB compliance currently stands at 87%</td>
<td></td>
</tr>
<tr>
<td>Doctors revalidation figures at April 2016 show that 95% of doctors have completed their annual appraisal</td>
<td></td>
</tr>
<tr>
<td>TMS will be ready for reporting on senior managers from June 2016.</td>
<td></td>
</tr>
<tr>
<td>Nursing staff will use this repository for Nursing and Midwifery staff annual CPD record for Revalidation</td>
<td></td>
</tr>
</tbody>
</table>

- NHS Staff Survey results return above-average key finding results against NHS Constitutional Staff Pledges 2 and 4 - monitored through annual Board Report and quarterly Pulse Survey reports to the Workforce Assurance Committee

<table>
<thead>
<tr>
<th>Annual Staff Survey figures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support from immediate managers [out of 5] 3.67 [3.69 national]</td>
</tr>
<tr>
<td>Staff appraised in the last 12 months 90% [86% national]</td>
</tr>
<tr>
<td>Quality of appraisals [out of 5] 4.11 [4.0 national]</td>
</tr>
</tbody>
</table>

8) eAppraisal
9) Monthly Divisional Governance Assurance Group (DGAG)
10) Education Governance Group
11) Revalidation
12) Monthly and Annually for consultants Workforce Assurance Committee
13) Quarterly to the Workforce Assurance Committee
### Clinical Quality

<table>
<thead>
<tr>
<th>Description</th>
<th>Frequency</th>
<th>Data Source</th>
<th>Reporting Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduced variation in clinical decisions and management leading to improved outcomes including:</td>
<td>Annually</td>
<td>2014/2015 data</td>
<td>Data pulled through BADGER NET Maternity dashboard</td>
</tr>
<tr>
<td>1. lower than national average transfers of sick babies</td>
<td></td>
<td></td>
<td>DGAG Quality committee</td>
</tr>
<tr>
<td>2. lower than national average mortality and morbidity of babies and mothers</td>
<td>Annually</td>
<td>2014/2015 data</td>
<td>Maternity dashboard/ monthly reporting</td>
</tr>
<tr>
<td>3. Higher than average ‘IWantGreatCare’ score from service users</td>
<td>Monthly</td>
<td>February 2016</td>
<td>FFT accumulative score</td>
</tr>
</tbody>
</table>

#### Pledge 4 Key Finding [Trust 2015]

- Staff reporting good communication between senior management and staff [26% [32% national]
- Staff able to contribute to improvements at work 65% [69% national]

- 2.91 [3.05 national]
  - Quality of non-mandatory training, learning or development [out of 5] 3.97 [4.03 national]

#### Clinical Quality

- Reduced variation in clinical decisions and management leading to improved outcomes including:
  1. lower than national average transfers of sick babies
  2. lower than national average mortality and morbidity of babies and mothers
  3. Higher than average ‘IWantGreatCare’ score from service users

- Data pulled through BADGER NET Maternity dashboard
- Maternity dashboard/ monthly reporting
- FFT accumulative score

- Monthly data
- February 2016
- 97.5% [national average = 95.7%]
### Workforce

<table>
<thead>
<tr>
<th>Recruitment &amp; Retention</th>
<th>February 2016</th>
<th>Workforce Information report detailing progress against vacancy Monthly Divisional Governance Assurance Group (DGAG)/Divisional Management Team meetings Recruitment &amp; Retention strategy in place April 2015 Revised draft of Recruitment &amp; Selection Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>To achieve residual vacancy factors (by 31/3/17) Registered Nurses 3.25% – 5.00% Registered Midwives 4.0% – 6.0% Consultant 5.0% - 7.5%</td>
<td>2 monthly 6.5% Registered nurses 8.0% registered midwives 10.1% Consultants completed</td>
<td>Workforce Assurance Committee</td>
</tr>
<tr>
<td>Recruitment &amp; Retention strategy</td>
<td>3-yearly</td>
<td>Workforce Assurance Committee</td>
</tr>
<tr>
<td>Joint Working across Bay</td>
<td>3-5 yearly Complete and on-going</td>
<td>Workforce Assurance Committee</td>
</tr>
<tr>
<td>Clinical Guidelines managed via Quality Committee (ref 9.1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trust wide Workforce Policies 100% in date, Cross Bay Joint Partnership policy development in central repository</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Leadership</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Leadership Triumvirate Review undertaken to review DGM, ACN and CD roles</td>
<td>One off Complete 94%</td>
<td>Job Descriptions reviewed and in place</td>
</tr>
<tr>
<td>Appraisal for all Trust leaders 8A+ 100%</td>
<td>One off annual complete</td>
<td>Annual appraisal and PDP in place to monitor skills development</td>
</tr>
<tr>
<td>Specialist Leadership roles Job Descriptions</td>
<td></td>
<td>Job descriptions in place</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bi-Monthly review of appraisal compliance via Workforce Commitment</td>
</tr>
</tbody>
</table>
### Escalation of Risk and Quality

| Mandatory training for the management of Risk and Incidents | As per mandatory training guidance | March 2016  
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>14) Ulysses Safeguard Incident Reporting E-learning</td>
<td>91%</td>
<td>* Risk Management Policy in place * Monthly TMS reporting managed via Divisional DGAG/DMT</td>
</tr>
<tr>
<td>15) Ulysses Safeguard Incident Management Investigation E-learning</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Governance

<table>
<thead>
<tr>
<th>All procedural documents to be held in a central repository and have been developed for cross Bay use by multi-disciplinary teams</th>
<th>Quarterly</th>
<th>February 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. 2014-15- All documents in central repository on Document Library</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. 2015-16 - 100% In date, Cross Bay, MDT document development</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1. complete</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. 4.4% of total documents out of date</td>
</tr>
<tr>
<td></td>
<td></td>
<td>51 documents out of date</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total of 1167 documents on library</td>
</tr>
<tr>
<td></td>
<td></td>
<td>* Risk Management Policy in place * Monthly TMS reporting managed via Divisional DGAG/DMT</td>
</tr>
</tbody>
</table>

**UHMBFT will rank in the top 25% of Trusts on the National Reporting and Learning system and will continue to demonstrate a reduction in harm**

<table>
<thead>
<tr>
<th>Quarterly</th>
<th>February 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. 2014-15, 92% of patients will receive harms free care</td>
</tr>
<tr>
<td></td>
<td>2. 2015-2017, 95% of patients will receive harms free care</td>
</tr>
<tr>
<td></td>
<td>3. 2017-2019, 98% of patients</td>
</tr>
<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**NB: since the KPI was set the inclusion criteria for NHS Trust incident measuring has been changed to include more categories of NHS Trust in the monitoring.**

<table>
<thead>
<tr>
<th>Quarterly</th>
<th>February 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2) Monthly report by the Procedural Documents Group to the Director of Governance detailing % out of date documents</td>
</tr>
</tbody>
</table>

**Quarterly Procedural Documents report to the Quality Committee**

**Quarterly SIRI report to the Quality Committee**
<table>
<thead>
<tr>
<th>Responsibility for sharing learning, outcomes and delivery of recommendations from incidents will be underpinned by Trust lesson learnt bulletins</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Lessons learned bulletins developed</td>
</tr>
<tr>
<td>- 2015-17, 12 general bulletins and 6 themed bulletins per year</td>
</tr>
<tr>
<td>- 2017-2019, 12 general bulletins and 6 themed bulletins per year</td>
</tr>
<tr>
<td>Quarterly</td>
</tr>
<tr>
<td>- General bulletin implemented and produced monthly from March 2015</td>
</tr>
<tr>
<td>- 12 Monthly general bulletins since March 2015. 6 themed bulletins a year</td>
</tr>
<tr>
<td>Monthly Learning to Improve Bulletin implemented</td>
</tr>
<tr>
<td>Quarterly CLIP report to the Quality Committee</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Governance</th>
</tr>
</thead>
<tbody>
<tr>
<td>UHMBFT will reduce complaints by a further 5%</td>
</tr>
<tr>
<td>1) 2014/15-reduce complaints by 5%</td>
</tr>
<tr>
<td>2) 2015/16-reduce complaints by 3%</td>
</tr>
<tr>
<td>3) 2016/17-reduce complaints by 2%</td>
</tr>
<tr>
<td>4) 2018/19-reduce complaints by 1%</td>
</tr>
<tr>
<td>Monthly WESEE report to DGAG</td>
</tr>
<tr>
<td>Quarterly complaints</td>
</tr>
<tr>
<td>1) 5% reduction achieved 2014/15</td>
</tr>
<tr>
<td>2) Reduction within trajectory year to date 2015/16</td>
</tr>
<tr>
<td>Quarterly complaints report from Patient Relations to the Quality Committee</td>
</tr>
<tr>
<td>Monthly divisional WESEE reports outlining divisional complaints rates</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>UHMBFT will receive a positive Well-Led Review showing compliance with Monitor Governance Framework</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarterly</td>
</tr>
<tr>
<td>Positive review undertaken showing compliance with Monitor framework. Action plan developed to address continuing improvement measure and the Trust is working with the Good Governance Institute to support on-going improvement towards</td>
</tr>
<tr>
<td>Triannual ‘Well Led’ review</td>
</tr>
<tr>
<td>Quarterly ‘Well Led’ Governance progress report to the Board</td>
</tr>
<tr>
<td>Monthly WESEE report to DGAG</td>
</tr>
<tr>
<td>Quarterly complaints report to the Quality Committee</td>
</tr>
<tr>
<td>Quarterly Report to the Board of Directors</td>
</tr>
</tbody>
</table>
### Estates

<table>
<thead>
<tr>
<th>Estates</th>
<th>Objective</th>
<th>February 2016</th>
<th>Monthly Maternity FFT Results</th>
<th>Quality Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Higher than average &quot;I Want Great Care&quot; score from service users.</td>
<td></td>
<td>97.5% [national average 95.7%]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduction in number of decision to delivery interval breaches for emergency caesarean sections</td>
<td>n/a until unit built</td>
<td>Continuous C-section audit</td>
<td>WACS Audit Group WACS DGAG</td>
<td></td>
</tr>
<tr>
<td>Increased staff confidence, better than average recruitment and retention rates</td>
<td>Monitored as part of work force – To achieve residual vacancy factors (by 31/3/17)</td>
<td>Recruitment and retention rates</td>
<td>Workforce Committee</td>
<td></td>
</tr>
<tr>
<td>New maternity facility built by December 2017, compliant with HBN09-02/ Kirkup recommendations</td>
<td>Will only be able to monitor when new build finished in 2017</td>
<td></td>
<td>Finance Committee</td>
<td></td>
</tr>
</tbody>
</table>

### Partnership

<table>
<thead>
<tr>
<th>Partnership</th>
<th>Objective</th>
<th>Frequency</th>
<th>Monitor and report to</th>
<th>Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Memorandum of Understanding developed and agreed with all strategic partners and associate partners [CMFT, LTH, UHMBFT, Lancashire North CCG, Cumbria CCG].</td>
<td></td>
<td>Quarterly</td>
<td>Collected and reported through TMS to produce Quarterly partnership report to the Strategic Partnership Committee</td>
<td></td>
</tr>
<tr>
<td>33% annual achievement of total staff identified to undertake placements in strategic partner organisations [i.e. 100% completion in 3 year period]</td>
<td></td>
<td></td>
<td>Quarterly partnership report to DGAG</td>
<td></td>
</tr>
</tbody>
</table>
The Strategic Partnership Committee to meet 4 times per year and produce Minutes to be shared with all MSP members.

| Quarterly | March 2016
25% [1 meeting held out of 4 scheduled annually] |
|-----------|---------------------------------------------|

Quarterly partnership report to the Strategic Partnership Committee
Contents

1. Introduction, Background and Objectives
2. Findings
Appendix A: Terms of Reference
1. Introduction, Background and Objective

Following the publication of the Kirkup Report on 3/3/15, which made 18 direct recommendations to the University Hospitals of Morecambe Bay NHS Foundation Trust (UHMB), the Morecambe Bay Investigation Report Committee (MBI), was established (as a sub-committee of the Trust Board) to ensure that the organisation fully responded to, and implemented, the Kirkup recommendations.

Six project teams were set up, each with a Project Sponsor, Project Lead and appropriate representation, to develop a suitable course of action designed to address the recommendations:

1) Clinical Quality
2) Education, Learning and Development
3) Estates
4) Governance
5) Workforce
6) Strategic Partnership

In addition project teams were established for Kirkup Programme (delivery and monitoring of the project) and Communications and Engagement.

The resultant ‘action plans’ defined the findings in the Kirkup Report which in turn linked to the recommendations and the timescale/deadline for implementation of corrective action on the part of UHMB; each was presented in a standard format and monitored through the Kirkup Report Implementation Group (KRIG). The action plans were devised to capture the actions required (in order to satisfy each recommendation) and in respect of each action, capture also, the responsible lead, progress made, completion date, expected outcomes/benefits, KPI/measure and evidence/output.

The sub-committee received the current version of the action plan on a monthly basis and each work-stream (Project Team) was required to provide a monthly progress and highlight report to the same. These formed the single monthly highlight report, received by the Trust Board.

As part of the UHMB 2015/2016 Internal Audit Plan, MIAA undertook a review of the Trust’s response to the Kirkup Report. That review, (Kirkup Part I), focussed specifically upon two recommendations, as agreed with the Trust’s Executive Chief Nurse. The subsequent audit report was issued in September 2015, concluding that ‘the Trust had established an effective structure for oversight of the implementation of the Kirkup Report recommendations’.
At its meeting on 6/11/15, the MBI approved the evidence and assurance processes in respect of the Kirkup Programme. The evidence collection process was defined in three stages:

**Stage 1 – Project Sponsor and Project Lead:**
Evidence to be collected against completed actions and signed off by the Project Sponsor and Project Lead, with the end output required only as evidence. Project Lead to ensure the content is clinically appropriate and provides adequate assurance to meet the completed action as identified in the action plan.

**Stage 2 – Programme Management Office (PMO):**
Basic review of the evidence submitted by each Project Lead to ensure it is sufficient to meet the sub-actions and meets at least the basic quality standards (i.e. accepted/approved copy, branded, identifiable, version control, dated, expiry date etc.) before storage of evidence and matches to action plan. Evidence for all Kirkup projects will be stored in central electronic evidence folders. An evidence index will be produced which clearly cross references to the action plan.

**Stage 3 – External Audit:**
External assurers to review the electronic evidence folders and deep dive into areas of concern.

UHMB commissioned MIAA to provide the Stage 3 external assurance.

The overall objective of the review was to evaluate the robustness of the evidence for actions assessed by the Trust as complete, to ensure it demonstrated delivery of the actions and provided assurance, with the following sub-objectives considered:

- the Trust can evidence that actions which are recorded as ‘complete’ – within the Kirkup Action Plan – have been completed;
- the ‘completed’ status of each recommendation is reliable and supported by a robust audit trail of supporting documentation and evidence; and
- any residual risk(s) is recorded and administered appropriately, in accordance with an approved management plan and/or risk tolerance limit.

The review was undertaken by identifying the evidence listed in respect of each of the actions on the action plan and comparing to the evidence stored on SharePoint, as and when the Project Management Office (PMO) notified that evidence in respect of recommendations had reached Stage 3 of the process as described above.
The documents held on SharePoint were then considered to confirm whether they were sufficient to demonstrate that the action had been achieved. Meetings were held with the Project Leads to discuss evidence and obtain clarification, where necessary.

Our review of Kirkup (Part II) covers the following work-streams and recommendations:

- Recommendation 1 (apology).
- Recommendation 18 (involvement of CCGs and external regulators).
- Education, Learning and Development – Recommendations 2, 3, 4 and 14.2.
- Clinical Quality – Recommendations 5, 6 and 7.
- Governance – Recommendations 9.1, 11, 12, 13 and 15.
- Estates – Recommendation 17.

Recommendation 15 within the Kirkup Report (the Governance work-stream) stated that:

‘the Trust should continue to prioritise the work commenced in response to the review of governance systems already carried out, including clinical governance, so that the Board has adequate assurance of the quality of care provided by the Trust’s services. This work is already underway with the facilitation of Monitor, and we (Kirkup) would not seek to vary or add to it, which would serve only to detract from implementation. We (Kirkup) do, however, recommend that a full audit of implementation be undertaken before this is signed off as completed.’

In 2015/2016 a Well-Led Framework Governance Review was carried out by an independent assessor (Grant Thornton), as recommended for NHS Foundation Trusts at least every three years, under Monitor’s Risk Assessment Framework. We agreed with the Interim Deputy Director of Governance that this Well–Led review would evidence the completion of Recommendation 15.

We have been provided with the report to the Trust Board 25/11/15 on the outcomes of the Well-Led (Grant Thornton) review which included a summary of the key findings and the 12 recommendations made, with the Trust’s response to those in respect of current and planned actions. We noted that a folder of evidence has been provided in respect of this recommendation on SharePoint, but we have not undertaken a detailed assessment of the same.
2. Findings

For each of the recommendations we initially assessed whether:

- Appropriate evidence had been provided in respect of the completed action; and
- The evidence was robust in order to provide assurance that the action had been completed.

We provided a RAG rating in respect of each of these assessments.

The initial review of appropriateness of evidence for the Clinical Quality, Education, Learning and Development and Workforce work-streams highlighted insufficient evidence had been submitted in respect of a significant number of actions.

Mid-audit red and amber ratings (applied by MIAA) in respect of appropriateness of evidence for the Clinical Quality and Education, Learning and Development work-streams were presented by MIAA at KRIG on 22/3/16. At this meeting the following was agreed:

- Project Leads would be notified of the outstanding evidence identified from the initial MIAA assessment and a deadline of 31/3/16 would be set for all Project Leads to submit the full evidence required; and
- Evidence would be considered for the project as a whole and therefore omissions in respect of a specific action would be acceptable if the evidence had been provided in respect of another action/recommendation, irrespective of whether this link was referenced in the action plan.

The final assessment of the action plan therefore is rated only on whether the evidence was robust in order to provide assurance that the action has been completed. For the final assessment MIAA used version 1.34 of the action plan, dated 30/3/16.

The agreed evidence process states ‘end output required only as evidence’. Separate actions within some of the plans refer to scoping of the actions or a breakdown of processes required to achieve an action, resulting in the same end output. In these examples we noted some actions as not applicable with regard to evidence, or considered a group of actions when assessing the evidence.

Where an amber rating has been provided, we have commented against the action point. We have also commented against actions where the evidence upon which we have based our assessment does not match the list of evidence as recorded in the action plan, as we found that some evidence stored in SharePoint had not been listed on the action plan. We have not provided a comment against green ratings which are fully evidenced by the documents listed in the action plan.
At the initial assessment of evidence, some actions were still ongoing, these were shown as blue in our evidence table. These were discussed at the KRIG meeting on 22/3/16 and Project Leads notified to prioritise the completion of these actions, where possible. A number of these actions have been completed and therefore we have been able to assess the evidence provided. There are now only three outstanding actions within the evidence table.
**MIAA Assessment**

**Tables - Key**

Column 1: Actions required as per the Kirkup Action Plan (referenced to recommendation number).

Column 2: Evidence available/output generated as recorded in version 1.34 of the action plan. NB: some evidence stored in SharePoint had not been listed in the action plan and in some cases the action plan did not list any evidence in respect of an action.


Column 4: MIAA comment/conclusion (where required, due to amber rating or due to evidence on which assessment is based not matching the evidence listed in the action plan).

**Kirkup - Recommendation 1**

The Trust should formally admit the extent and nature of the problems that have previously occurred, and should apologise to those patients and relatives affected, not only for the avoidable damage caused but also for the length of time it has taken to bring them to light and the previous failures to act. This should begin immediately with the response to this Report.

<table>
<thead>
<tr>
<th>Action</th>
<th>Evidence</th>
<th>R-A-G</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Receive and accept the Morecambe Bay Investigation <em>(Ref. 1 Programme Plan)</em>.</td>
<td>Report and apology</td>
<td></td>
<td>Video of the public apology made by the Chairman and Chief Executive on 3/3/15 and letter of apology to families dated 19/3/15 evidence requirements of recommendation.</td>
</tr>
</tbody>
</table>

**Kirkup - Recommendation 18**

All of the recommendations should be implemented with the involvement of Clinical Commissioning Groups, and where necessary, the Care Quality Commission and Monitor. In the particular circumstances surrounding the Trust, NHS England should oversee the process, provide the necessary support, and ensure that all parties remain committed to the outcome, through an agreed plan with the Care Quality Commission, Monitor and the Clinical Commissioning Groups.
Establish Kirkup Recommendation Sub-Committee: Identify appropriate membership including representation to meet recommendation 18 *(Ref. 4 Programme Plan).*

<table>
<thead>
<tr>
<th>Action</th>
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<tbody>
<tr>
<td>ToR Sub Committee and minutes</td>
<td></td>
<td></td>
<td>MBI Sub-Committee ToR ratified at Trust Board 29/4/15 includes membership from Monitor, NHS Lancashire North CCG and NHS Cumbria CCG. Minutes evidence attendance by representatives of both CCGs at 75% of meetings and Monitor representation at 50% of meetings. ToR purpose of the committee at points b. and d. reference the commissioner representation and provision of assurance to CCGs and regulators through their representation. Reporting requirements in the ToR include at points e. and g. the availability of reports to be included in the governance and reporting systems of each CCG through commissioner representatives and ensuring that reports are available to regulators and are included in the business of the Quality Surveillance Group. Paper on Kirkup Governance and Management arrangements presented to MBI Sub Committee 17/4/15 references CCGs, Monitor, Care Quality Committee (CQC) and NHS England. The ToR of the UHMB Single Organisation Quality Surveillance Group (QSG) – (core membership includes representation from NHS England, CQC, Monitor and CCGs) were amended in April 2015 to include responsibility for monitoring and gaining assurance in relation to Kirkup recommendations delivery. Kirkup report response governance arrangements map defines lines of reporting. Single monthly progress and highlight report presented to the QSG by UHMB Medical Director. NHS England present an assurance report on Kirkup recommendations 1-18 based on Trust evidence and information held by NHS England.</td>
</tr>
</tbody>
</table>
Education, Learning and Development

The evidence provided demonstrates the three areas of focus for the review of skills, knowledge and competencies (mandatory training, role specific essential training and CPD). The Trust had previously adopted the national Core Skills Framework for mandatory training, which meets the requirements of the recommendation in respect of identifying mandatory training requirements of the staff groups. The actions undertaken have been extended to include the identification of role essential training above the mandatory training requirements and this has been assessed for each staff group within Women and Children’s Services (WACS) and Critical Care (CC). The Project Team researched the recommended knowledge, skills and competency requirements from the Medical Royal Colleges and Nursing and Midwifery Council and liaised with other Trusts to identify whether a similar exercise had been undertaken. No specifications for particular job roles were identified and other Trusts had not considered this level of detail. Hence the essential role training specifications have been developed entirely within the divisions, with leads identified for each professional group. Whilst the review completion deadline of June 2015 was achieved in respect of mandatory training, this was not an achievable target for sign off of the essential role specific training element. An explanation briefing regarding the approach to the Education, Learning and Development recommendations has been submitted as evidence and concluded that ‘the action plan was innovative and aspirational and it exceeded the Kirkup recommendations, but it is clear that for this work to be fully completed for all three areas, an extension to the timescale for delivery was required’.

Action 3.3 in respect of Listening into Action (LiA) is ongoing with a completion date of 30/6/16. Formal agreement has been given to the ongoing monitoring of the action plan through the Workforce Assurance Committee, as part of the Kirkup programme close down process.

Kirkup - Recommendation 2

The Trust should review the skills, knowledge, competencies and professional duties of care of all obstetric, paediatric, midwifery and neonatal nursing staff, and other staff caring for critically ill patients in anaesthetics and intensive and high dependency care, against all relevant guidance from professional and regulatory bodies. This review should be completed by June 2015, and identify requirements for additional training, development and, where necessary, a period of experience elsewhere.
<table>
<thead>
<tr>
<th>Action</th>
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</thead>
<tbody>
<tr>
<td>Identify staff groups and key people within each group to scope relevant professional guidance and regulatory bodies <em>(Ref. 2.3).</em></td>
<td>Staff in post list held by L&amp;OD dept. reflects information in ESR accurately for the identified staff groups.</td>
<td></td>
<td>Evidenced by list of cost centres for WACS and Critical Care, ESR staff in post list, TMS Active Delegates List and reconciliation of ESR to TMS for staff in post.</td>
</tr>
<tr>
<td>Mandatory Professional Training and Skills Needs Analysis for each staff group that meet national standards and requirements <em>(Ref. 2.4).</em></td>
<td>Mandatory and role essential training matrix produced.</td>
<td></td>
<td>Mandatory training matrix in place for all WACS and Critical Care nursing and medical staff. For each training topic the rationale, delivery mechanism (new starters and existing staff), validity period, recording mechanism, monitoring/reporting mechanism are defined. Corporate induction programme document confirms inclusion of mandatory training for new starters, as assigned on the matrix.</td>
</tr>
<tr>
<td>Devise training matrix and skills passport for all staff groups <em>(Ref. 2.5).</em></td>
<td>Role specific training matrices produced.</td>
<td></td>
<td>Evidenced by essential role specific training matrices in the set format (rationale/ delivery mechanism/ validity period/ reporting and monitoring mechanism) for neonatal nursing, theatre nursing, ITU nursing, paediatric nursing, midwifery, O&amp;G medical, paediatric medical and anaesthetics/ ITU medical.</td>
</tr>
<tr>
<td>Ensure TMS reflects requirements <em>(Ref. 2.6).</em></td>
<td>Accurate monthly workforce training reports produced.</td>
<td></td>
<td>Mandatory training requirements reflected on TMS accounts and non-compliance reports evidenced. Aligning essential role specific training requirements with TMS has been part of the TMS development work. Version 1.34 of the Kirkup action plan confirms that the input of role essential training on TMS is on track and assigns a completion date of 31/3/16. MIAA has received confirmation on 31/3/16 from the Learning &amp; Development Specialist that this has been completed.</td>
</tr>
<tr>
<td>Action</td>
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<td>R-A-G</td>
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</tr>
<tr>
<td>Collate training and development records for all identified staff groups (Ref. 2.7).</td>
<td>Collated training and development records available.</td>
<td></td>
<td>Mandatory training gap analysis robust: Report of non-compliance figures for mandatory training and appraisal for all WACS and Critical Care staff groups as at July 2015 and subsequent reports to October 2015 to demonstrate improvements in compliance, monitored at the Education Governance Kirkup Task and Finish Group up to 30/11/15. Gap analysis of skills and knowledge in mandatory and role essential skills is an agenda item at the task and finish group (agendas and minutes evidenced). Mandatory training compliance is monitored outside of the Kirkup project by the Workforce Assurance Group. Specific report on Critical Care mandatory training compliance presented to October Workforce Committee. Essential role specific skills gap analysis evidenced for all staff groups in the form of TMS compliance reports/compliance figures against the training matrix. Compliance reports for Critical Care (Workforce Committee March 2016) and Maternity (Education and Development Report March 2016) have also been evidenced.</td>
</tr>
<tr>
<td>Undertake a gap analysis of training and development for all identified staff groups (Ref. 2.8).</td>
<td>Production of a list of all staff within the identified staff group who fall within the agreed parameters as requiring additional training, development or other experience.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Actions 2.1 and 2.2 have not been included in this evidence table as these refer to scoping the requirements of the recommendation and establishing governance structures to deliver the actions.

**Kirkup - Recommendation 3**

*The Trust should draw up plans to deliver the training and development of staff identified as a result of the review of maternity, neonatal and other staff, and should identify opportunities to broaden staff experience in other units, including by secondment and by supernumerary practice. These should be in place in time for June 2015.*
<table>
<thead>
<tr>
<th>UHMB Action Plan V1.34 30/3/16</th>
<th>MIAA Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Action</strong></td>
<td><strong>Evidence</strong></td>
</tr>
<tr>
<td>Develop annual training plan for staff groups <em>(Ref. 3.2).</em></td>
<td>Annual training plans.</td>
</tr>
<tr>
<td>Refine approach based on outcomes of gap analysis <em>(Ref. 3.3).</em></td>
<td></td>
</tr>
<tr>
<td>Scope current training programmes in professional groups to identify gaps in delivery, and implement training to deliver against these <em>(Ref. 3.4).</em></td>
<td>Training plan and trajectory.</td>
</tr>
<tr>
<td>Action</td>
<td>Evidence</td>
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</tr>
<tr>
<td>Identify Clinical rotation requirements for all staff groups within the Annual Work Roster to other units <em>(Ref. 3.5)</em></td>
<td>Experience needs analysis for identified staff.</td>
</tr>
</tbody>
</table>

Action 3.1 has not been included in this evidence table as this refers to scoping the requirements of the recommendation.

**Kirkup - Recommendation 4**

*Following completion of additional training or experience where necessary, the Trust should identify requirements for continuing professional development of staff and link this explicitly with professional requirements including revalidation. This should be completed by September 2015.*

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<tr>
<th>Action</th>
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<tbody>
<tr>
<td>Scope CPD requirements of staff groups <em>(Ref. 4.2).</em></td>
<td>CPD requirements described for all professional roles.</td>
<td></td>
<td>Regulatory bodies have confirmed that CPD requirements are based on the individual’s need. These are identified as part of the annual appraisal process. Appraisal and Development Review Framework and Guidance, and standard documentation in place. Compliance figures for appraisal evidenced for WACS, Critical Care and for medical staff.</td>
</tr>
<tr>
<td>Develop band specific Continuing Professional Development plans for all staff groups including revalidation <em>(Ref. 4.3).</em></td>
<td>Clear professional development pathways for all staff groups.</td>
<td></td>
<td>In 2015/16 revalidation only applies to medical staff. Revalidation and appraisal process for medical staff and link to GMC guidance provided as evidence.</td>
</tr>
</tbody>
</table>
### Kirkup (Part II)

**Kirkup - Recommendation 14.2**

All staff with defined responsibilities for clinical leadership should show evidence of attendance at appropriate training and development events.

<table>
<thead>
<tr>
<th>Action</th>
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</thead>
<tbody>
<tr>
<td><strong>Link internal leadership training to TMS</strong> <em>(Ref. 14.2.2).</em></td>
<td>Collated training information.</td>
<td></td>
<td>Internal leadership training which is included in essential role specific training e.g. mentoring is on TMS (as recommendation 2). Also evidenced is the Leadership Development Strategy (which details the training and development initiatives for senior leaders, middle managers, clinical leaders, ward and clinical team leaders), the Medical Leadership Development Stocktake (regarding organisation and delivery of leadership development for medical staff) and updates to the Trust Board and TMB on Clinical Leadership development.</td>
</tr>
<tr>
<td><strong>Review CPD portfolio/documentation for all staff groups</strong> <em>(Ref. 14.2.3).</em></td>
<td>Robust CPD records of all professional staff.</td>
<td></td>
<td>As recommendation 4 for e-appraisal.</td>
</tr>
</tbody>
</table>

Action 14.2.1 has not been included in this evidence table as this refers to scoping the requirements of the recommendation.
Clinical Quality

Kirkup - Recommendation 5

The Trust should identify and develop measures that will promote effective multidisciplinary team-working, in particular between paediatricians, obstetricians, midwives and neonatal staff. These measures should include, but not be limited to, joint training sessions, clinical, policy and management meetings and staff development activities. Attendance at designated events must be compulsory within terms of employment. These measures should be identified by April 2015 and begun by June 2015.
<table>
<thead>
<tr>
<th>Action</th>
<th>Evidence</th>
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</thead>
<tbody>
<tr>
<td>Multi-disciplinary and profession meetings in place within the Division <em>(Ref. 5.1).</em></td>
<td>Attendance records/TNA.</td>
<td></td>
<td>Terms of reference documents evidenced for Divisional Management Board (DMB), Divisional Governance and Assurance Group (DGAG), Divisional Management Team (DMT), specialty clinical audit meeting, labour ward forum, maternity and gynaecology ward managers meeting, maternity and gynaecology risk management group, perinatal meetings, CYP seniors meeting, CYP leaders group, obstetric and gynaecology seniors meeting, perinatal mortality review meetings. Terms of reference evidence multi-disciplinary membership and state attendance requirements of members, and for some meetings, method for monitoring attendance. Evidence provided of 2015/2016 attendance schedules for DMT, DMB, DGAG, CYP Leaders, CYP Seniors and O&amp;G Seniors. These records evidenced meetings taking place with poor attendance, leading to the meeting no longer being multi-disciplinary, with examples of some members who had not attended any meetings in the year. There were also examples of cancelled meetings, some of which were attributed to poor attendance. The Executive Chief Nurse has agreed that multi-disciplinary team attendance at meetings will now be monitored through either the Workforce Assurance Committee, Quality Committee or both and this will be linked to the work on multi-disciplinary team training attendance.</td>
</tr>
<tr>
<td>Action</td>
<td>Evidence</td>
<td>R-A-G</td>
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</tr>
<tr>
<td>Multi-disciplinary and professional specific training and development days introduced in maternity (Ref. 5.2).</td>
<td>Annual training schedules and attendance records.</td>
<td></td>
<td>Evidenced by training schedules and timetable/ agenda for the training listed in the progress column of the action plan. Other appropriate evidence submitted is Maternity Skills and Drills TNA confirming multidisciplinary approach to training, training matrix for nursing staff specifying staff grades for whom attendance is compulsory, and extract from TMS which confirms monitoring of attendance.</td>
</tr>
<tr>
<td>Professional specific training and development days introduced in Children and Young Peoples Services (Ref. 5.3).</td>
<td></td>
<td></td>
<td>Evidenced by schedule of training dates, the study programme and attendance sheets which demonstrate attendance at each session across a mix of grades and units/site bases. Training matrix specifies staff from whom attendance is compulsory.</td>
</tr>
<tr>
<td>Skills passports have been developed (Ref. 5.4).</td>
<td></td>
<td></td>
<td>Skills Passport provided as evidence. TMS extract shows compliance as at 13/1/16 in respect of essential role training.</td>
</tr>
<tr>
<td>Preceptorship programme introduced (Ref. 5.5).</td>
<td>Preceptorship programme.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Action</td>
<td>Evidence</td>
<td>R-A-G</td>
<td>Comment</td>
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</tr>
<tr>
<td>WACS MDT Leadership programme in place <em>(Ref. 5.6).</em></td>
<td>Programme and attendance records.</td>
<td></td>
<td>The Leadership Development Sessions timetable demonstrates that a fortnightly programme is in place. However the attendance records for 2015/2016 confirm 5 cancelled sessions and poor levels of attendance, with some staff having attended no sessions. A new Divisional General Manager and Clinical Director have been appointed within the leadership triumvirate structure and recognise that the programme to date has not been as successful as intended and as such will review the programme to consider what improvement can be made to ensure training is appropriate and relevant. The DMT will review the purpose of the existing programme to clarify and confirm requirements and forward plan. Attendance at the revised programme will be monitored via the DMT and DGAG.</td>
</tr>
<tr>
<td>Identify additional measures to promote multidisciplinary working: <em>(Ref. 5.7)</em></td>
<td>TNA.</td>
<td>As below:</td>
<td></td>
</tr>
<tr>
<td><strong>Ref 5.7.2:</strong> Attendance at the key meetings and at MDT joint training sessions, and staff development opportunities to be explicit in the job description of every registered professional.</td>
<td>Standardised JD’s.</td>
<td>As at 14/3/16 generic templates for bands 1-7 and bands 8-9 (also to be used for medical staff), V03032016 had been approved and distributed to staff and include under ‘Training and Development’ the phrase ‘maintain your professional standards in respect of education and training and ensure that you are aware of your specific area specialty training and needs analysis’. A live job description for a band 7 post within WACS was verified as using this template.</td>
<td></td>
</tr>
<tr>
<td>Ref. 5.7.3:</td>
<td>Review of all cross bay meetings to ensure that attendance is from the appropriate people and that there is a clear framework for cascading key clinical information including learning from incidents, changes to protocols etc.</td>
<td>Newsletters and briefings.</td>
<td>Evidence only required in respect of framework for cascading key clinical information as the review of cross bay meetings is a scoping exercise in respect of action 5.1. The WACS Weekly Safety Briefing has been provided as evidence. This is e-mailed to all staff, printed off and displayed in office areas and referred to in handovers. Specific evidence with regard to learning from incidents and the newsletters in respect of this has been submitted against recommendation 12.</td>
</tr>
<tr>
<td>Ref. 5.7.4:</td>
<td>Policy to be developed that specifies the requirement of debrief for all staff involved to include clinical supervision in a critical incident (align to recommendation 12; governance).</td>
<td>Updated policy.</td>
<td>The policy for ‘Supporting Staff Through Traumatic or Stressful Incidents v1.2’ has been submitted as evidence but linked to recommendation 6 on SharePoint. The policy refers to the requirement for debrief and hence currently meets the requirement of the action, but is to be updated and expanded as part of the implementation of clinical supervision.</td>
</tr>
<tr>
<td>Ref. 5.7.5:</td>
<td>Attendance at mortality and morbidity debrief meetings for those staff involved in an incident to be included as an explicit requirement in the TNA and job description/job plan of every registered professional.</td>
<td>Attendance records/TNA</td>
<td>As part of the maternity essential role specific training matrix these meetings have now been listed for midwifery staff (final matrix evidenced at recommendation 2). As at 5.7.2 the signed off job description, states ‘maintain your professional standards in respect of education and training and ensure that you are aware of your specific area specialty training and needs analysis’. Version 2 of the TNA/Skills &amp; Drills - Maternity, ratified 12/3/16 includes mortality and morbidity debriefs, as one of the meetings which must be attended at least once annually by all clinicians.</td>
</tr>
</tbody>
</table>

Action 5.7.1 has not been included in this evidence table as it refers to scoping key meetings to attend (part of 5.1).
Kirkup - Recommendation 6

The Trust should draw up a protocol for risk assessment in maternity services, setting out clearly: who should be offered the option of delivery at Furness General Hospital and who should not; who will carry out this assessment against which criteria; and how this will be discussed with pregnant women and families. The protocol should involve all relevant staff groups, including midwives, paediatricians, obstetricians and those in the receiving units within the region. The Trust should ensure that individual decisions on delivery are clearly recorded as part of the plan of care, including what risk factors may trigger escalation of care, and that all Trust staff are aware that they should not vary decisions without a documented risk assessment. This should be completed by June 2015.

<table>
<thead>
<tr>
<th>UHMB Action Plan V1.34 30/3/16</th>
<th>MIAA Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Action</strong></td>
<td><strong>Evidence</strong></td>
</tr>
<tr>
<td>Review and update all current risk assessment and transfer policies (Ref. 6.1).</td>
<td>Antenatal clinical risk assessment policy, transfer policy, clinical risk assessment of suspected labour.</td>
</tr>
<tr>
<td>Perinatal Institute Maternity Health Record in place for all women within the Trust (Ref. 6.2).</td>
<td>Perinatal Institute Maternity Health Record.</td>
</tr>
<tr>
<td>Recording of transfer through a Patient Safety Incident (Ref. 6.4).</td>
<td>Transfer PSI report.</td>
</tr>
<tr>
<td>Letter of apology for transfer due to capacity (Ref. 6.5).</td>
<td>Copy of template letter.</td>
</tr>
</tbody>
</table>
Action 6.6 has not been included in this evidence table as this refers to benchmarking Trust policy against another similar unit (part of 6.1).

**Kirkup - Recommendation 7**

The Trust should audit the operation of maternity and paediatric services, to ensure that they follow risk assessment protocols on place of delivery, transfers and management of care, and that effective multidisciplinary care operates without inflexible demarcations between professional groups. This should be in place by September 2015.

<table>
<thead>
<tr>
<th>UHMB Action Plan V1.34 30/3/16</th>
<th>MIAA Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Action</strong></td>
<td><strong>Evidence</strong></td>
</tr>
<tr>
<td>Ensure annual forward audit plan in place <em>(Ref. 7.0).</em></td>
<td>Annual forward audit plan.</td>
</tr>
<tr>
<td>Monthly record keeping/documentation audits in place <em>(Ref. 7.1).</em></td>
<td>Documentation audits/results with action plans.</td>
</tr>
<tr>
<td>Audits of transfers of neonates to external units to be completed <em>(Ref. 7.2).</em></td>
<td>Results of neonatal audits and action plans</td>
</tr>
<tr>
<td>Bi-annual audits of antenatal risk assessment <em>(Ref. 7.3).</em></td>
<td>Results of risk assessment and action plans</td>
</tr>
</tbody>
</table>
**Workforce**

**Kirkup - Recommendation 8**

The Trust should identify a recruitment and retention strategy aimed at achieving a balanced and sustainable workforce with the requisite skills and experience. This should include, but not be limited to, seeking links with one or more other centre(s) to encourage development of specialist and/or academic practice whilst offering opportunities in generalist practice in the Trust; in addition, opportunities for flexible working to maximise the advantages of close proximity to South Lakeland should be sought. Development of the strategy should be completed by January 2016.

<table>
<thead>
<tr>
<th>Action</th>
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<th>R-A-G</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Draft recruitment and retention strategy <em>(Ref. 8.1)</em>:</td>
<td>UHMB Recruitment and Retention Strategy Better Care Together Recruitment and retention strategy HENW Workforce Planning Submission Minutes WAC approving</td>
<td>As below:</td>
<td></td>
</tr>
<tr>
<td><strong>Ref 8.1.1</strong> Present recruitment and retention strategy to Workforce Committee.</td>
<td>Recruitment and Retention Strategy (20.04.15 &amp; 21.03.16) Recruitment Plans WAC Updates identifying progress with R&amp;R</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Ref 8.1.2</strong> Approval of recruitment and retention strategy.</td>
<td>Recruitment and Retention Strategy presented to the Workforce Assurance Committee 20/4/15.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Ref 8.1.3</strong> Develop divisional plans to support delivery of R&amp;R Strategy.</td>
<td>Minutes of Workforce Assurance Committee minutes 20/4/15 do not evidence formal approval of the strategy. However the strategy was updated, to meet the full requirements of the recommendation and presented to the Committee 21/3/16. Approval of the updated strategy was minuted.</td>
<td></td>
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</tr>
<tr>
<td><strong>Ref 8.1.4</strong> Set up process and monitor through Workforce Assurance Committee.</td>
<td></td>
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</tbody>
</table>
Kirkup - Recommendation 9.2

The Trust should identify an approach to developing better joint working between its main hospital sites, including the development and operation of common policies, systems and standards. Whilst we do not believe that the introduction of extensive split-site responsibilities for clinical staff will do much other than lead to time wasted in travelling, we do consider that, as part of this approach, flexibility should be built into working responsibilities to provide temporary solutions to short-term staffing problems. This approach should be begun by September 2015.
### UHMB Action Plan V1.34 30/3/16

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</thead>
</table>
| Cross Bay Obstetric and Midwifery guidelines in place, available on Heritage (electronic repository) (Ref. 9.2.1). | Guidelines on Heritage CNST report  
CYP Guideline Group Agendas  
CYP Guideline Group Minutes  
CYP Guideline Group Monitoring  
DGAG Agenda  
| Multi-Disciplinary and professional specific training and development days introduced in maternity (Ref. 9.2.2). | Maternity Training programme and attendance records  
Essential Role specific training summary  
Maternity Skills and Drills TNA. | R-A-G |                                                                                                                                                |
| Preceptorship programme introduced (Ref. 9.2.3).                      | Preceptorship Job description  
Newly Qualified Midwives Development package. | R-A-G |                                                                                                                                                |
| A number of cross bay speciality roles in place within WACS (Ref. 9.2.4). | Specialist roles Job descriptions. | R-A-G |                                                                                                                                                |
| Escalation policy in place in WACS (Ref. 9.2.5).                      | CYP Escalation & de-escalation policy  
Maternity Escalation policy. | R-A-G |                                                                                                                                                |
| Review job descriptions for clinical staff to ensure flexibility regarding service provision. (Ref. 9.2.6). | Leadership Job Descriptions  
Triumvirate leadership consultation  
Minutes Kirkup CQ project group RE development of nursing and midwifery JDs. | R-A-G | The generic job descriptions have been approved. These state that the post will be subject to the terms and conditions of UHMB FT (flexibility regarding service provision in contract evidenced at recommendation 8.2). Job descriptions specific to nursing and midwifery staff were reviewed at the Kirkup Clinical Quality Project Group 9/7/15. The draft template evidences the requirement for flexibility regarding service provision. |
### Kirkup (Part II)

#### UHMB Action Plan V1.34 30/3/16

<table>
<thead>
<tr>
<th>Action</th>
<th>Evidence</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Ensure a robust process is in place to review and amend Trust wide HR policies <em>(Ref. 9.2.7).</em></td>
<td>Development and Management of Procedural Documents Policy Minutes Joint Working Group RE Trust-wide workforce policy development Workforce policy Development timetable (agreed &amp; reviewed via JWG)</td>
<td>R-A-G</td>
</tr>
</tbody>
</table>

| Commence a review of policies to ensure consistency and review/amend where required *(Ref. 9.2.8).* | Minutes Joint Working Group RE Trust-wide workforce policy development Workforce policy Development timetable (agreed and reviewed via JWG). | R-A-G           |

#### Kirkup - Recommendation 14.1

The Trust should review arrangements for clinical leadership in obstetrics, paediatrics and midwifery to ensure that the right people are in place with appropriate skills and support. The Trust has implemented change at executive level, but this needs to be carried through to the levels below. This review should be commenced by April 2015.

<table>
<thead>
<tr>
<th>Action</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Review of leadership structure in Women’s and Children Division <em>(Ref. 14.1.1).</em></td>
<td>Leadership Tree showing WACS as separate division Structure charts Job Descriptions Consultation on changes to Triumvirate Leadership</td>
<td>R-A-G</td>
</tr>
<tr>
<td>Action</td>
<td>Evidence</td>
<td>R-A-G</td>
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<tr>
<td>Review of clinical leadership structure</td>
<td>Announcement regarding new leadership appointments (2012, 2014)</td>
<td></td>
</tr>
<tr>
<td>(Ref. 14.1.2).</td>
<td>Consultation paper RE midwifery management structure (2012)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Consultation on changes to Triumvirate Leadership</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Job Descriptions</td>
<td></td>
</tr>
<tr>
<td>Review of midwifery leadership structure</td>
<td>Organisational Charts</td>
<td></td>
</tr>
<tr>
<td>(Ref. 14.1.3).</td>
<td>Maternity Structure</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maternity Specialist roles Job Descriptions</td>
<td></td>
</tr>
<tr>
<td>Review of Children and Young Peoples Nursing Structure</td>
<td>Organisational Charts</td>
<td></td>
</tr>
<tr>
<td>(Ref. 14.1.4).</td>
<td>CYP</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CYP Specialist roles Job Descriptions</td>
<td></td>
</tr>
<tr>
<td>Identify lead roles within the consultant team</td>
<td>Job Plan summaries</td>
<td></td>
</tr>
<tr>
<td>(Ref. 14.1.5).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>WACS MDT Leadership programme in place</td>
<td>Leadership Development</td>
<td></td>
</tr>
<tr>
<td>(Ref. 14.1.6).</td>
<td>- set up and purpose</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- timetable</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Attendance Monitoring records</td>
<td></td>
</tr>
</tbody>
</table>

Action 14.1.7 (further review of WACS leadership structure) has not been included in this evidence table as the action does not include any additional outputs to those already evidenced in 14.1.1, 14.1.2, 14.1.3 and 14.1.5.

**Kirkup - Recommendation 16**

*As part of the governance systems work, we consider that the Trust should ensure that middle managers, senior managers and non-executives have the requisite clarity over roles and responsibilities in relation to quality, and it should provide appropriate guidance and where necessary training. This should be completed by December 2015.*
<table>
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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Clinical Service Managers/DGM included within Membership of key Divisional Governance Meetings <em>(Ref. 16.1).</em></td>
<td>Trust-wide ToR for Divisional Governance and Assurance Meetings Trust-wide ToR for Divisional Management Board Divisional DGAG attendance registers Divisional DMB registers.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Mandatory training for risk and Incident management training <em>(Ref. 16.2).</em></td>
<td>Mandatory training workbook.</td>
<td></td>
<td>These are not evidenced within the mandatory training workbook for 2014/2015. Incident management and incident reporting are e-learning packages on TMS and the validity period has been amended from 36 months to 12 months to meet the requirement of the action. Confirmation of the amendment has been received from the Learning and Development Specialist.</td>
</tr>
<tr>
<td>Incident training and feedback of incidents <em>(Ref. 16.3).</em></td>
<td>Incident Reporting System training (e-learning).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information governance <em>(Ref. 16.4).</em></td>
<td>Corporate Induction slides Information Governance. Mandatory training Workbook (ref unit 3).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NEDS chair meetings <em>(Ref. 16.5).</em></td>
<td>Minutes - Quality Committee - Finance Committee - Workforce Assurance Committee showing NEDS chairing.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### UHMB Action Plan V1.34 30/3/16

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<tbody>
<tr>
<td>Review and revise job descriptions including roles and responsibilities and if required create plan to consult and agree new job descriptions (reference action 14.1.3) <em>(Ref. 16.6).</em></td>
<td>Leadership Job Descriptions Triumvirate consultation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Undertake self-assessment exercise to highlight any shortfalls in understanding regarding roles and responsibilities in relation to quality <em>(Ref. 16.7).</em></td>
<td>Self-assessment of responsibility in relation to quality survey results.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gap analysis from self-assessment passed to operational divisions for review and implementation if required <em>(Ref. 16.8).</em></td>
<td>Email sharing the outcome of the self-assessment quality survey with divisional management teams requesting discussion and action at divisional level.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Partnership Development

**Kirkup - Recommendation 10**

The Trust should seek to forge links with a partner Trust, so that both can benefit from opportunities for learning, mentoring, secondment, staff development and sharing approaches to problems. This arrangement is promoted and sometimes facilitated by Monitor as ‘buddying’ and we endorse the approach under these circumstances. This could involve the same centre identified as part of the recruitment and retention strategy. If a suitable partner is forthcoming, this arrangement should be begun by September 2015.
## UHMB Action Plan V1.34 30/3/16

<table>
<thead>
<tr>
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<th>Evidence</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Establishment of project structure to lead development of partnership (Ref. 8).</td>
<td>Structure in place.</td>
<td></td>
<td>Maternity Strategic Partnership Committee draft terms of reference document in place (discussed at first meeting of the committee), with membership of UHMB, the two partner Trusts and CCGs.</td>
</tr>
<tr>
<td>Development of detailed project plan to implement MOU (Ref. 9).</td>
<td>Completed.</td>
<td></td>
<td>Development of comprehensive and detailed action plan is responsibility of MSP Committee as per terms of reference. Minutes of the first meeting on 29/2/16 evidence discussion of the aims, purpose and responsibilities of the committee. Proposed work programme, revisions required and administrative process to support were discussed at the meeting. Terms of reference define reporting arrangements of the MSP Committee and require a quarterly report to the UHMB Quality Committee and the CCGs on the delivery of the action plan. Documents in respect of the initial arrangements for placements of non-training grade doctors in obstetrics and gynaecology at Central Manchester University Hospitals NHS FT and also the outcomes of attendance of 6 UHMB staff at the CMFT Audit and Clinical Effectiveness day evidenced.</td>
</tr>
<tr>
<td>Implementation of MOU (Ref. 10).</td>
<td>MoU approved by UHMB Board on 25/11/15. Lancashire Teaching Hospitals NHS FT have evidenced approval by their Board 2/3/16. Awaiting approval by CMFT.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Actions 1-7 have not been included in this evidence table as these refer to outlining proposals for a partnership agreement, identifying potential partners and developing the MoU.
Governance

The evidence/output column of the action plan has been partially completed. The Project Lead has provided a full list of evidence within an evidence index filed within the evidence folder.

Kirkup - Recommendation 9.1

The Trust should identify an approach to developing better joint working between its main hospital sites, including the development and operation of common policies, systems and standards. Whilst we do not believe that the introduction of extensive split-site responsibilities for clinical staff will do much other than lead to time wasted in travelling, we do consider that, as part of this approach, flexibility should be built into working responsibilities to provide temporary solutions to short-term staffing problems. This approach should be begun by September 2015.

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<tbody>
<tr>
<td><strong>Action</strong></td>
<td><strong>Evidence</strong></td>
</tr>
<tr>
<td>Multi-disciplinary review of 50 CNST guidelines <em>(Ref. 9.1.3).</em></td>
<td>CNST Report.</td>
</tr>
<tr>
<td>Development of consistent approach to procedural document (guideline/policy/protocol/sop) review and ratification across divisions/Trust <em>(Ref. 9.1.5).</em></td>
<td>Trust Procedural Document for management of procedural documents, Maternity Policy.</td>
</tr>
<tr>
<td>Action</td>
<td>Evidence</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Development and implementation of standard divisional process for development, ratification and implementation of divisional procedural documents <em>(Ref. 9.1.6).</em></td>
<td>ToR Trust procedural documents meeting, Dec minutes, ToR for divisional meetings, minutes of divisional meetings, report to the Quality Committee re procedural documents.</td>
</tr>
<tr>
<td>Transfer of all document to SharePoint documents management system <em>(Ref. 9.1.7).</em></td>
<td>SharePoint access.</td>
</tr>
<tr>
<td>All documents to be reviewed, in date and of a high quality <em>(Ref. 9.1.8).</em></td>
<td>Divisional spreadsheets/action plan, ToR for divisional and Trust meeting, Minutes from Divisional/Trust meeting.</td>
</tr>
</tbody>
</table>

Actions 9.1.1, 9.1.2 and 9.1.4 have not been included in this evidence table as these refer to the historical systems in place within Maternity prior to the development of Trust guidance.  

**Kirkup - Recommendation 11**

The Trust should identify and implement a programme to raise awareness of incident reporting, including requirements, benefits and processes. The Trust should also review its policy of openness and honesty in line with the duty of candour of professional staff, and incorporate into the programme compliance with the refreshed policy. This should be begun with maternity staff by April 2015 and rolled out to other staff by April 2016.
<table>
<thead>
<tr>
<th>Action</th>
<th>Evidence</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Incident training provided as part of Mandatory (midwives/Obstetrics) training days (Ref. 11.1).</td>
<td>Training package Attendance Compliance 2015.</td>
<td>Included in mandatory training day 2. Monitoring of compliance in place (March 2016 Education and Development Maternity Report).</td>
<td></td>
</tr>
<tr>
<td>TRUST Ulysses safeguard RCA and incident reporting and investigation training in place (Ref. 11.2).</td>
<td>RCA training package, Incident reporting training package, Incident management training package.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duty of Candour included within Being Open Policy, ratified and available on Heritage (Ref. 11.3).</td>
<td>Policy.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Management procedure in place for the investigation and resolution of complaints (Ref. 11.4).</td>
<td>Trust procedure for the management of complaints, Q3 report to the Quality Committee with WACS data.</td>
<td>Also covered in recommendation 13.</td>
<td></td>
</tr>
<tr>
<td>Introduction of weekly Patient Safety Summits, led by clinical executives and attended by senior clinical medical and nursing staff to review all clinical incidents (Ref. 11.5).</td>
<td>ToR, agenda, minutes.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Action</td>
<td>Evidence</td>
<td>R-A-G</td>
<td>Comment</td>
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<tr>
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</tr>
<tr>
<td>Implement additional training in an electronic format for all staff</td>
<td>Training package on TMS, training compliance rates (ongoing work).</td>
<td></td>
<td>Incident reporting training is mandatory for all staff. New starters undertake the e-learning package and the backlog of non-compliance regarding existing staff is being addressed. It is acknowledged that there are limitations with regard to TMS and some data cleansing requirements to ensure compliance data is accurate, therefore this data has not been provided as evidence in respect of this action and has been noted as ongoing work. The action refers to the inclusion of further information in respect of duty of candour. However, this is not a requirement for the member of staff reporting the incident and therefore has not been included within the package, (refer to incident management training action 11.7 for inclusion of duty of candour).</td>
</tr>
<tr>
<td>to continue to improve the reporting of safety incidents and promote</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>a learning culture and reduction of harms. Also to include further</td>
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<tr>
<td>information in relation to open and honest and duty of candour (Ref.</td>
<td></td>
<td></td>
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<tr>
<td>11.6).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review current training programme for managers to ensure that roles</td>
<td>Training package on TMS, training attendance data (ongoing work).</td>
<td></td>
<td>Incident investigation training package includes training on completion of the duty of candour field. This is a mandated field within Ulysses for incidents reported as moderate or above level of harm and is still required to be completed if the level of harm is subsequently downgraded. Latest training attendance data has not been provided as evidence, as the accuracy of compliance data is ongoing work.</td>
</tr>
<tr>
<td>and responsibilities are understood and that appropriate investigations</td>
<td></td>
<td></td>
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<tr>
<td>are undertaken. Also to cover expanded duty of candour requirement in</td>
<td></td>
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<tr>
<td>Ulysses (Ref. 11.7).</td>
<td></td>
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<tr>
<td>Ensure robust feedback to staff (Ref 11.8).</td>
<td></td>
<td>As</td>
<td>As below:</td>
</tr>
<tr>
<td>Ref. 11.8.1 Implement electronic feedback to reporter via Ulysses.</td>
<td>Ulysses system live - examples of feedback, Pulse survey showing staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>improved experience of incident reporting feedback.</td>
<td></td>
<td></td>
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<tr>
<td>Action</td>
<td>Evidence</td>
<td>R-A-G</td>
<td>Comment</td>
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</tr>
<tr>
<td>Ref. 11.8.2 Thematic report to be developed for learning to improve group and Trust lessons learnt monthly bulletin.</td>
<td>Thematic report.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ref. 11.8.3 Standardised reporting of incidents to divisions to be initiated to support WESEE reporting.</td>
<td>Divisional reports.</td>
<td></td>
<td>Evidenced by data extracted from Ulysses (Jan 2016)</td>
</tr>
<tr>
<td>Ref. 11.8.4 Review potential for 'impact assessment' for lessons learnt</td>
<td>Minutes detailing discussions regarding impact assessment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Develop collaborative learning group for learning from complaints, litigation, incidents and patient experience (Learning to Improve group) to include Trust wide learning to improve bulletin (Ref. 11.9).</td>
<td>Live access to SharePoint site, ToR, minutes, examples of bulletins and deep dive publications.</td>
<td></td>
<td>Monthly Trust wide Learning to Improve bulletins are held centrally on SharePoint and also special bulletins which cover a specific theme.</td>
</tr>
<tr>
<td>To monitor staff perceptions of incident reporting and feedback through the quarterly Pulse surveys to help the Board measure staff perceptions reported to the Workforce Committee, about their workplace (Ref. 11.10).</td>
<td>Report to workforce committee detailing pulse survey, Pulse survey, feedback from survey monkey.</td>
<td></td>
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</tbody>
</table>
Kirkup - Recommendation 12

The Trust should review the structures, processes and staff involved in investigating incidents, carrying out root cause analyses, reporting results and disseminating learning from incidents, identifying any residual conflicts of interest and requirements for additional training. The Trust should ensure that robust documentation is used, based on a recognised system, and that Board reports include details of how services have been improved in response. The review should include the provision of appropriate arrangements for staff debriefing and support following a serious incident. This should be begun with maternity units by April 2015 and rolled out across the Trust by April 2016.

The action plan does not specifically refer to Board reports including details of how services have been improved or the provision of appropriate arrangements for staff debriefing and support following a serious incident. We discussed these with the Director of Governance who confirmed that both requirements were in place, and provided evidence to support, which has been added to the SharePoint evidence folder. In respect of Board reporting of service improvements, patient stories presented at Board and examples the Executive Chief Nurse report to the Board, where these are demonstrated, have been incorporated in the evidence folder and referenced in the evidence index at action 12.16.

In respect of appropriate arrangements for staff debriefing and support following a serious incident we noted that this is referenced in the Draft Risk Management Strategy Maternity Services version 5 (section 10) and also that the Policy for Supporting Staff following Traumatic or Stressful Incidents is referenced at action 5.7.4 and included within the evidence folder for recommendation 6. Additional evidence in the form of communications to staff regarding opportunities for support and debrief, including multi-disciplinary debrief, has been provided to demonstrate the process is in place.

Hence the requirements of the recommendation with regard to Board reporting of service improvements and arrangements for staff debriefing and support following a serious incident have been met.

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<tbody>
<tr>
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<tr>
<td>Action</td>
<td>Evidence</td>
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<tr>
<td>-----------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Safeguard (Ulysses) incident reporting system used for reporting and managing patient safety incidents (Ref. 12.3).</td>
<td>Trust incident management policy, Maternity Incident Policy.</td>
</tr>
<tr>
<td>WACS Governance lead and risk management team in maternity and CYP with processes in place aligned to Divisional and Trust Risk Management Policy (Ref. 12.4).</td>
<td>ToR/agenda/minutes for CYP and maternity/gynaecology Risk management group, guideline groups, audit meetings, DGAG, DMT/DMB, meeting structure, governance team structure, maternity incident policy.</td>
</tr>
<tr>
<td>Trust standardised investigation templates and action plans in use for RCA/ rapid review based on NPSA tools (Ref. 12.5).</td>
<td>Rapid review template maternity, Rapid review/ action plan template Trust, Ulysses RCA module.</td>
</tr>
<tr>
<td>All WACS incident themes monitored with lessons learnt and linked to audit and education programme (Ref. 12.6).</td>
<td>DGAG reports, Learning to Improve Bulletins/lessons learned, audit programme, educational programme.</td>
</tr>
<tr>
<td>Issues with clinical component of care of midwives results in referral to Supervision of midwives for further investigation (Ref. 12.7).</td>
<td>Evidence of referral, investigation and improvement/action plan.</td>
</tr>
<tr>
<td>Action</td>
<td>Evidence</td>
</tr>
<tr>
<td>--------</td>
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</tr>
<tr>
<td>WACS monthly lessons learned newsletter <em>(Ref. 12.8).</em></td>
<td>Newsletters/Learning to Improve bulletins.</td>
</tr>
<tr>
<td>All divisions now completing monthly lessons learnt <em>(Ref. 12.9).</em></td>
<td>Learning to Improve Bulletins.</td>
</tr>
<tr>
<td>WACS bi monthly Bulletin including lessons learnt <em>(Ref. 12.10).</em></td>
<td>Bi-monthly divisional bulletins.</td>
</tr>
<tr>
<td>Trust weekly patient safety summit in place to review all near misses and moderate and above incidents-led by Executive Chief Nurse and Medical Director with senior representation from all Divisions <em>(Ref. 12.12).</em></td>
<td>ToR, Minutes.</td>
</tr>
<tr>
<td>SIRI panel in place with NED chair <em>(Ref. 12.13).</em></td>
<td>ToR, Process, Minutes.</td>
</tr>
<tr>
<td>Human factors training to increase awareness <em>(Ref. 12.14).</em></td>
<td>Flyer, Course content, course feedback, training programmes, HF report.</td>
</tr>
<tr>
<td>Action</td>
<td>Evidence</td>
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<td>----------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Trust standardised investigation templates and action plans in use for RCA/ rapid review based on NPSA tools <em>(Ref. 12.15).</em></td>
<td>Ulysses RCA Module, RCA training package, Previous RCA paperwork (prior to electronic module).</td>
</tr>
<tr>
<td>Ensure identified practice (positive and negative) from RCA is communicated to Learning to Improve Group to ensure Trust wide learning <em>(Ref. 12.16).</em></td>
<td>Learning to Improve data from incidents/RCA, Learning to Improve Bulletins, SIRI flowchart, Minutes showing issues arising from SIRI for inclusion in bulletins, Board papers showing learning from patient stories, complaints, incidents and investigation (reporting is also via the SIRI panel and Quality Committee, but this recommendation specifically mentions the Board).</td>
</tr>
<tr>
<td>Development of internal RCA scrutiny panel (pre SIRI) to provide cross service, multi-disciplinary ‘fresh eyes’ and to include management and completion of actions arising from RCA. To support identification of themes and trends and identification of residual conflicts and training requirements <em>(Ref. 12.17).</em></td>
<td>Process Flowchart, Draft ToR, template for QA/scrutiny, RCA benchmark of questions, RCA QA, SUI process. RCA commissioner checklist, SIRI ToRs.</td>
</tr>
</tbody>
</table>
Kirkup - Recommendation 13

The Trust should review the structures, processes and staff involved in responding to complaints, and introduce measures to promote the use of complaints as a source of improvement and reduce defensive ‘closed’ responses to complainants. The Trust should increase public and patient involvement in resolving complaints, in the case of maternity services through the Maternity Services Liaison Committee. This should be completed, and the improvements demonstrated at an open Board meeting, by December 2015.

The action plan does not refer to the requirements to increase public and patient involvement in resolving complaints or demonstrate the improvements at an open Board meeting. It was noted that the Management Procedure for the Investigation and Resolution of Complaints includes at section 4.6.1, public and patient involvement in resolving complaints. Evidence in respect of involvement of the Maternity Services Liaison Committee (meeting minutes January 2016) has been added to the evidence folder in respect of action 13.1.

The Director of Governance report to the Trust Board, September 2015, demonstrates improvements delivered by the Patient Relations Team in respect of complaints with comparative data from quarter 1 2014/15 and quarter 1 2015/16. The Director of Governance report to the Trust Board January 2016 demonstrates the improvements through comparative data from Q2 and Q3 2015/16 to Q2 and Q3 2014/15. A summary of the improvements in the way complaints are handled is also included. The quarterly Complaints, PALS and Compliments report to the Quality Committee also provides comparative data to the same period in the previous year. Minutes of the Quality Committee are received by the Trust Board.

Hence the requirements of the recommendation have been met with regard to public and patient involvement in resolving complaints and demonstration of improvements at Board.
<table>
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<tr>
<th>Action</th>
<th>Evidence</th>
<th>MIAA Assessment</th>
<th>Comment</th>
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</thead>
<tbody>
<tr>
<td>Streamline reporting to divisions/quality committee in line with national KPI’s <em>(Ref. 13.2).</em></td>
<td>Divisional and Board Report, Annual Report.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Roll out of existing awareness training from Patient relations Team and develop to include ‘best practice’ advice in relation to consistent and supportive management of complainants to include quality in terms of content <em>(Ref. 13.5).</em></td>
<td>Customer care Training (now on Trust Mandatory Induction Programme), Patient Relations Team planned face to face sessions booked by any staff via TMS, Divisional specific identified training i.e. Mandatory Training for Nurses (based on planned training package), Service request – bespoke training (based on planned training package), Electronic package available to all staff via TMS.</td>
<td></td>
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<tr>
<td>Action</td>
<td>Evidence</td>
<td>R-A-G</td>
<td>Comment</td>
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</tr>
<tr>
<td>Review/Audit of complaints management to include all ‘re-visits’</td>
<td>Audit tool, Learning to Improve Bulletins, Report to Quality Committee, Customer Feedback Questionnaire template.</td>
<td></td>
<td>Audit tool developed and reporting commenced in Patients Relations Q3 2015/16 report to the Quality Committee, in respect of a sample of 12% of complaints received in Q2. The Interim Deputy Director of Governance has confirmed that the audit of all revisits will commence from April 2016 and therefore there is no evidence in respect of the audit yet. However, all re-visits are reviewed by the Patient Experience Manager and managed separately. The audit will consider whether re-visits are specific to certain types of complaints and any improvements which can be made to prevent re-submission of complaints after closure.</td>
</tr>
<tr>
<td>Develop managers ‘meet and greet’ customer contact process</td>
<td>Report from pilot site.</td>
<td></td>
<td></td>
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<tr>
<td>Develop North West Experience Hub</td>
<td>Minutes of meetings.</td>
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</table>
Estates

Kirkup - Recommendation 17

The Trust should identify options, with a view to implementation as soon as practicable, to improve the physical environment of the delivery suite at Furness General Hospital, including particularly access to operating theatres, an improved ability to observe and respond to all women in labour and en suite facilities; arrangements for post-operative care of women also need to be reviewed. Plans should be in place by December 2015 and completed by December 2017.

Evidence provided confirms that plans for the scheme were in place by December 2015. The P21+ development partner, Integrated Healthcare Projects stage 3 and 4 programme document dated 25/1/16 timetables project completion for 27/10/17, with the building becoming operational on 24/11/17. The project is to be monitored by the Capital Planning Group which reports to the Finance Committee, and the terms of reference document for this Group has been provided as evidence. Formal agreement has been given to the ongoing monitoring of the action plan through the Finance Committee, as part of the Kirkup programme close down process.
<table>
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<tr>
<th>Action</th>
<th>Evidence</th>
<th>MIAA Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Detailed layout for re-modelled department agreed in conjunction with the WACS teams such as Infection Prevention and patients/families. A series of meetings involving different people within WACS (Ref. 4).</td>
<td>Detailed scheme completed.</td>
<td>Strategic Healthcare Planning Report specifies capacity requirements. Minutes of Estates Project Group FGH Estates Plan Meeting evidence discussion of option appraisal with significant WACS representation. Evaluation matrix confirms requirements of Kirkup recommendation assessed for each option. Sketch plans produced for scheme. The January monthly progress and highlight report presented to the Board 27/1/16 stated that option 3 had been agreed by WACS Divisional Board and formally agreed at the December KRIG meeting. The MBI sub-committee 8/1/16 recommended option 3 for consideration of the Trust Board, subject to a report detailing the risks and mitigating actions of option 3 being considered at UHMB Quality Committee.</td>
</tr>
<tr>
<td>Board appoints P21 development partner (Ref. 5).</td>
<td>Appointment.</td>
<td>The appointment of the contractor was made 29/1/16, letter of appointment signed off by the Deputy Chief Executive/Director of Finance. The Trust Board of 30/3/16 received a paper regarding the process undertaken to progress the development of the FGH maternity and SCBU in respect of the approval of the final plans and capital investment. Formal minutes are not yet available but approval has been confirmed to MIAA.</td>
</tr>
<tr>
<td>Stages after finance confirmed (Ref. 6 - 13).</td>
<td>Completed.</td>
<td>Ongoing monitoring through the Capital Planning Group and Finance Committee.</td>
</tr>
</tbody>
</table>

Actions 1 -3 have not been included in this evidence table as these refer to processes required to achieve detailed layout of re-modelled department.
Conclusion:

The Trust has provided robust evidence to support completion of the actions in response to the recommendations, with the exception of the following:

- **Action 5.1** - Multi-disciplinary and profession meetings in place within WACS, for which attendance records demonstrated poor attendance, which in some cases resulted in the meeting being cancelled. Due to the low levels of attendance some meetings were no longer multi-disciplinary, as intended within the membership defined in the terms of reference.

- **Action 5.6/ action 14.1.6** – WACS MDT Leadership Programme in place. Attendance records evidence cancelled sessions and poor attendance, with some staff having attended no sessions.

The Trust will address these findings as follows:

- **Action 5.1** - Multi-disciplinary team attendance at meetings will be monitored through either the Workforce Assurance Committee, Quality Committee or both and this will be linked to the work on multi-disciplinary team training attendance.

- **Action 5.6/ action 14.1.6** – A new Divisional General Manager and Clinical Director have been appointed within the leadership triumvirate structure and recognise that the programme to date has not been as successful as intended and as such will review the programme to consider what improvement can be made to ensure training is appropriate and relevant. The Divisional Management Team will review the purpose of the existing programme to clarify and confirm requirements and forward plan. Attendance at the revised programme will be monitored via the DMT and Divisional Governance and Assurance Group.

The Trust has adequate arrangements in place to monitor the outstanding actions which have a completion date beyond 31/3/16, in respect of the Listening into Action programme (recommendation 3) and the ongoing FGH capital scheme (recommendation 17). The other incomplete action, 13 includes audit of complaints re-visits. This audit is scheduled to be commenced in April 2016 and audit results are included in the quarterly Patients Relations report to the Quality Committee.
Appendix A: Terms of Reference

Introduction Background

As part of the University Hospitals of Morecambe Bay NHS Foundation Trust (UHMB) 2015/2016 audit plan, we have undertaken a review of the Trust’s response to the Kirkup Report. That review focussed specifically upon recommendation numbers 5 and 7, as agreed with the Trust’s Executive Chief Nurse prior to the work commencing. The subsequent audit report was issued in September 2015 concluding that ‘the Trust had established an effective structure for oversight of the implementation of the Kirkup Report recommendations’.

In November 2015, the Trust commissioned a further piece of work to focus upon the remaining 16 Kirkup recommendations; this review will be undertaken between December 2015 and February 2016.

The focus of this review will be the Trust’s ‘Kirkup Action Plan’, which is overseen by the Programme Management Office (PMO) and senior UHMB officers. MIAA will assess the Trust’s response to each of the 16 recommendations and evaluate the robustness of the evidence to ensure it demonstrates delivery of the actions and provides assurance.

The review will also follow up on the findings of the Kirkup Part I review in respect of recommendations 5 and 7.

The Trust is expecting a small number of recommendations to be completed during December 2015, the majority to be completed in January 2016 and the remainder in February 2016. As such, MIAA will liaise with the Trust regarding the scheduling of our reviews, to ensure the focus is upon assessing actions completed by the Trust.

Overall System Risks

- The Trust Board is not provided with correct information in order for it to effectively govern the organisation;
- Risk to patient safety if the Trust fails to adequately respond to the Kirkup recommendations;
- A lack of progress in implementing recommendations may risk regulatory enforcement action; and
- Potential reputational damage if the Trust is not seen to be responding to the action plan.
Objectives

The overall objective of the review is to evaluate the robustness of the evidence for actions assessed by the Trust as complete, to ensure it demonstrates delivery of the actions and provides assurance.

Within this review the following sub objectives will be considered:

- The Trust can evidence that actions which are recorded as ‘complete’ – within the Kirkup Action Plan – have been completed;
- The ‘completed’ status of each recommendation is reliable and supported by a robust audit trail of supporting documentation and evidence; and
- Any residual risk(s) is recorded and administered appropriately, in accordance with an approved management plan and/or risk tolerance limit.

Scope of Work

We will review the objectives and risks identified through:

- Discussions with officers responsible for completion of the action plan and review of documentation; and
- Review of evidence to support the completion of actions recorded in the ‘actions taken’ column.

The review will focus only upon actions considered as complete by UHMB/ PMO.

Limitations inherent to the internal auditor’s work

We have undertaken the review of the process, subject to the following limitations.

Internal control

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding achievement of an organisation’s objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems. These include the possibility of poor judgement in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

Future periods

The assessment of controls relating to the Kirkup evidence process is that at April 2016. Historic evaluation of effectiveness is not always relevant to future periods due to the risk that:
• The design of controls may become inadequate because of changes in the operating environment, law, regulation or other; or

• The degree of compliance with policies and procedures may deteriorate.

**Responsibilities of management and internal auditors**

It is management’s responsibility to develop and maintain sound systems of risk management, internal control and governance and for the prevention and detection of irregularities and fraud. Internal audit work should not be seen as a substitute for management’s responsibilities for the design and operation of these systems.

We shall endeavour to plan our work so that we have a reasonable expectation of detecting significant control weaknesses and, if detected, we shall carry out additional work directed towards identification of consequent fraud or other irregularities. However, internal audit procedures alone, even when carried out with due professional care, do not guarantee that fraud will be detected. The organisation’s Local Counter Fraud Officer should provide support for these processes.

**Data Protection and Freedom of Information**

All documents acquired or created by us during the course of this assignment remain the property of the client.

MIAA are, thus, considered as a data processor rather than a data controller and are not, therefore, directly subject to the requirements of the Data Protection Act. No information relating to this, or any other, assignment will be directly disclosed to a third party by MIAA in response to a subject access request. Any requestor will be advised that they should approach the client.

These principles will also be applied in respect of any request for information relating to this, or any other, assignment under the Freedom of Information Act.
Report Distribution

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
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<tr>
<td>David Walker</td>
<td>Medical Director</td>
<td>Draft and Final</td>
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<tr>
<td>Sue Smith</td>
<td>Executive Chief Nurse</td>
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<tr>
<td>Sascha Wells</td>
<td>Deputy Director and Head of Midwifery</td>
<td>Draft and Final</td>
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<tr>
<td>Martin Kinley</td>
<td>PMO Programme Manager</td>
<td>Draft and Final</td>
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</table>

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