PUBLIC TRUST BOARD OF DIRECTORS' MEETING

Wednesday 31 August 2022 in the Board Room, Westmorland General Hospital, Burton Road, Kendal LA9 7RG

Please note the meeting will also take place via Microsoft Teams.

Commencing at 10am

Reference Document Pack			
Item		**Lead**	**Paper**
Matters for Consideration			
93	Patient Story Presentation	Chief Nursing Officer	Attached
Patients			
97	Recovery Support Programme Dashboard – August 2022	Deputy Chief Executive / Intensive Support Director	Attached
98	Care Quality Commission (CQC), Niche and Royal College of Surgeons (RCS) Improvement Plan Progress Report	Director of Governance	Attached
Performance			
100 ii	Assurance Committee Minutes	Chairs of the Assurance Committees	Attached
People			
101	Cultural Programme Board – Terms of Reference and Programme Update	Interim Chief People Officer	Attached
Governance and Assurance			
103	Quality Governance & Accountability Framework and Appendices	Director of Governance	Attached
104	Membership Strategy	Company Secretary	Attached

Contact: Paul Jones, Company Secretary
Tel: 01539 716684
Email: paul.jones4@mbht.nhs.uk

THIS PAGE IS INTENTIONALLY BLANK

Contact: Paul Jones, Company Secretary
Tel: 01539 716684
Email: paul.jones4@mbht.nhs.uk

We are UHMBT

Together, we are creating a great place to be cared for and a great place to work

NHS
University Hospitals of Morecambe Bay
NHS Foundation Trust

cda Cumbria Deaf Association
supporting deaf people since 1894

Patient Story
Accessible Information Standard
August 2022

We're here for *you*

From 1 August 2016 onwards, all organisations that provide NHS care and/or publicly-funded adult social care are legally required to follow the Accessible Information Standard.

The Standard is a key feature in the NHS contract.

Accessible Information Standard

NHS
University Hospitals of Morecambe Bay
NHS Foundation Trust

The Standard sets out five principles:

1. Identifying
2. Recording
3. Flagging
4. Sharing

5. Meeting the information and communication support needs of people with a:

- disability
- Impairment
- sensory loss

Success / Impacts

We are UHMBT

Together, we are creating a great place to be cared for and a great place to work

NHS
University Hospitals of Morecambe Bay
NHS Foundation Trust

UHMBT RSP Highlight Report

Improving Together

July 2022

Executive Summary - Improving Together

Our Improvement plan is subdivided into 3 categories:

- **Short term - Go live by 31/03/22**

19 short term projects in the plan

All programmes of work delivered within the agreed timescales (1 element outstanding, mitigations in place, solution to be delivered by Mid August)

- **Medium term - Go live by 31/03/23**

66 medium term projects in the plan

50 projects in Green status - on track

4 projects in Amber status

12 projects have been delivered

- **Long term - Go live post 01/04/23**

4 long term projects in the plan

4 projects in Green status - on track

Programme Dashboard – Short Term Projects

Recovery Support Programme Dashboard - W.C. 04th July 2022

PROGRAMME RAG STATUS: AMBER

Programme Commentary

19 Projects were tracked due for delivery before 31/03/2022.

18 Projects have been delivered as follows:

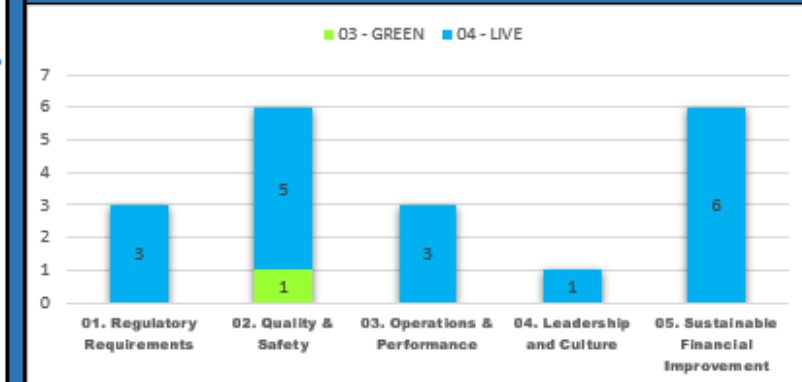
Regulatory:- Maternity - Badgernet Roll Out, Patient Safety Phase 1, Risk Management Phase 1
Quality and Safety:- Harm Free Care Panel Live, Consistent Auditing HCAI, Refined processes and tools for consistency in assessment in falls and pressure ulcers, Development of and evidence of Cross Group Learning and Spread
Ops and Performance:- ED - SDEC Commenced a 4 month trial period at RLI, Frailty Pathways RLI - Staffing Business Case Approvals, Phase1 - Criteria to reside linked to ward/board rounds.
Leadership and Culture:- Cultural Engagement platform launched
SFIP:- 21/22 - H1/H2 Roadmap, High Cost Agency, Business Case Process and System Reform, Scheme of Delegation, Plan for Success, System Reform.

Of the remaining projects, 1 has a Green RAG Status as follows
- 'Safe Staffing Governance - to meet with Suppliers Chief Technology Officer and team to discuss the option of replicated Data Access as temporary solution for the remainder of our contract (until May 2023). solution to be implemented by Mid August.

Delivery Performance Summary

Short Term Projects	19	Green	1
Red		Live	18
Amber		Status TBC	4
		Other Projects	66

Delivery Performance - Short Term Projects



Exception Reporting - Short Term Projects - Red RAG

Exception Reporting - Short Term Projects - Amber RAG

Programme Dashboard – Medium Term Projects

Medium Term - Commentary

66 Projects are tracked due for delivery before 31/03/2023.
50 have a Green RAG Status
4 have an Amber RAG Status as follows:

- ED, **5 Day 8-8 SDEC RLI/FGH - Perm** - Recruitment Ongoing,
- ED, **7 Day 8-8 SDEC RLI/FGH - Perm** - Recruitment Ongoing,
- ED, **P2 - Criteria to reside linked to ward/board rounds (all sites)** - Delay to Identification of key metric / measurement suite to demonstrate impact on organisational KPIs,
- **Stroke, Pre-Hospital.** FAST Training to be completed by Reception Staff by the end of August.

12 Projects have been delivered as follows:

- **Quality and Safety:-** Improve Consistency of Domestic Cover and standards.

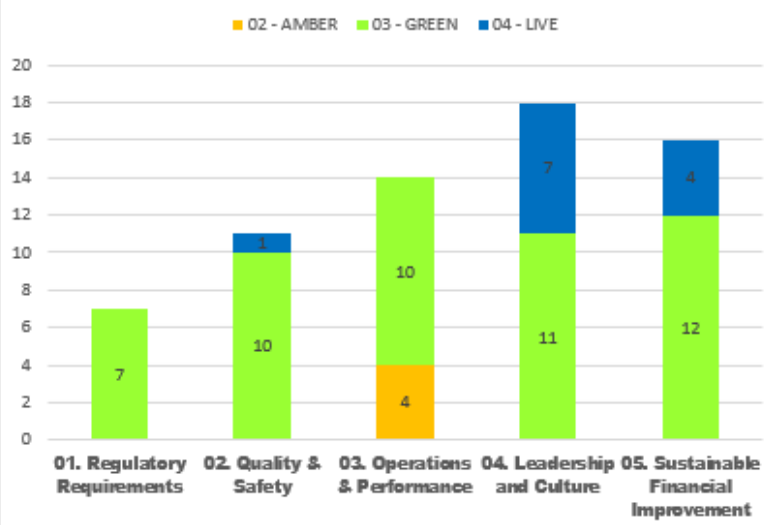
- **Leadership and Culture:-** Aligning Plans with People Plan, Trust Strategy, Equality and Diversity, Just and Learning, Culture Dashboard and Leadership for all, Board Programme Launched

- **SFIP:-** 21/22 - NHSI Checklist, Financial Skills - Non Finance, Financial Skills Training - Finance, Non Finance Training for Finance Staff.

Medium Term Delivery Performance Summary

Medium Term Projects	66	Red	
		Amber	4
		Green	50
		Live	12
Other Projects	4		

Delivery Performance - Medium Term Projects



Exception Reporting - Medium Term Projects - Amber RAG

Phase 2 - 5 day, 8am-8pm Medical SDEC RLI/FGH staffing - permanent	Recruitment Ongoing
Phase 2 - 7 day, 8am-8pm Medical SDEC RLI/FGH staffing - permanent	Recruitment Ongoing
P2 - Criteria to reside linked to ward/board rounds (all sites)	Delay to Identification of key metric / measurement suite to demonstrate impact on organisational KPIs to August
Stroke - Pre-Hospital	FAST training has now been added to the Reception staff TMS to be completed by end of August.

Programme Dashboard – Long Term & TBC Projects

Long Term - Commentary

4 Projects are tracked due for delivery after 31/03/2023.

Regulatory:- Patient Safety Investigations - Phase 2.
Quality and Safety:- Digital Solution for Contemporaneous Documentation
Ops and Performance:- ED - Frailty Pathways RLI - Recruitment Campaign Completed, Virtual Wards

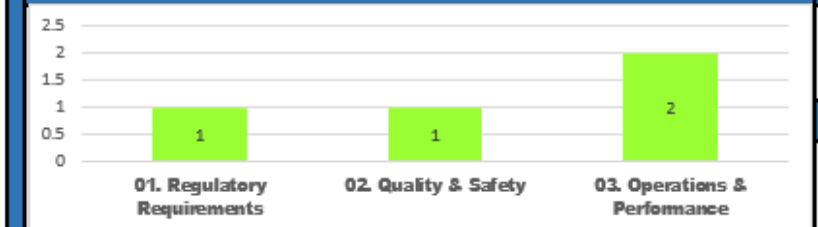
Long Term Delivery Performance Summary

Long Term Projects: 4

Red		Green	4
Amber		Live	

Other Projects:

Delivery Performance - Long Term Projects



Exception Reporting - Long Term Projects - Red RAG

Exception Reporting - Long Term Projects - Amber RAG

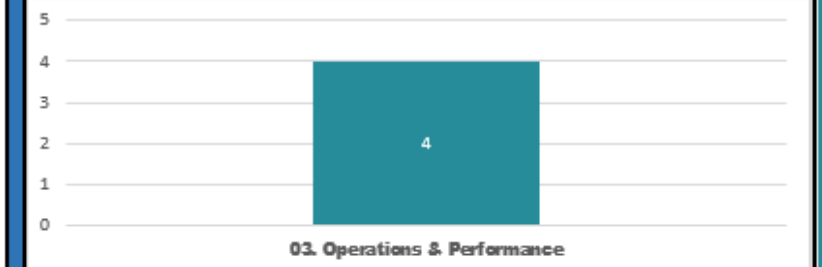
TBC

4 Projects have a delivery status to be confirmed (No Go-Live dates confirmed)

4 Projects are tracked due for delivery after 31/03/2023.

Ops and Performance:- ED - Full Medical SDEC (RLI & FGH), Frailty Pathways RLI - Med Unit 2 to Med Unit 1 transfer Completed, Frailty Pathways RLI - Estates Changes Implemented
Leadership & Culture:- Board Programme Launched.

Delivery Performance - TBC Projects



Exception Reporting - TBC Term Projects

ED - Decongestion	New Workstream being formed with scoping meeting planned
Frailty Pathways RLI - Estates changes implemented	To fit in with estates and capital plans, TBC
Frailty Pathways RLI - Medical Unit 2 to Medical Unit 1 transfer completed	Awaiting Stroke Therapy area move to make space and approved plans.
Phase 3 - Full Medical SDEC (RLI & FGH)	To fit in with estates and capital plans, TBC

Thank You
Any Questions

CQC/NICHE/RCS Improvement Plan Dashboards

Table1: Summary of Recommendation Allocation by Trust Care Group

Report	Trust Wide / Corporate	Medicine	Surgery	WACs	Community	Core Clinical Services	Total
NICHE	65	0	7	0	0	0	**72**
RCS	0	0	7	0	0	0	**7**
CQC Must Do	6	37	1	14	0	3	**61**
CQC Should Do	1	31	6	10	0	4	**52**
Total	**72**	**68**	**21**	**24**	**0**	**7**	**192**

Table2: Summary of Recommendation Allocation by Trust Tier 1 (Committee) Meeting

Report	Trust Management Group	Audit Committee	Finance Committee	People Committee	Quality Assurance Committee	Total
NICHE	12	15	0	10	35	**72**
RCS	2	0	0	2	3	**7**
CQC Must Do	14	2	0	10	35	**61**
CQC Should Do	13	0	0	11	27	**52**
Total	**41**	**17**	**0**	**33**	**100**	**192**

Table3: Summary of Recommendation Allocation by UHMBT Theme and Remits of Tier 1 Meetings

Tier 1 Meeting Remit	UHMBT Theme	NICHE	RCS	CQC Must Do	CQC Should Do	Total
Audit Committee	Corporate Governance	15		2		**17**
Finance Committee	N/A - No Recommendations	N/A	N/A	N/A	N/A	N/A
People Committee	Culture and Leadership	8		2	2	**12**
	Staffing: Appraisal and CSF Training	1	1		3	**5**
	Staffing: Health and Wellbeing	1			1	**2**
	Staffing: Non-CSF Training		1	3	1	**5**
	Staffing: Staffing Numbers			5	4	**9**
Quality Committee	Clinical Governance	20	2	11	3	**36**
	Clinical Strategy	1		1	1	**3**
	Consent	1	1			**2**
	EPR/Patient Records	5		1	1	**7**
	Fundamental Care Standards	3		6	4	**13**
	Infection Prevention			1	3	**4**
	Information Governance	1		1	3	**4**
	Medicines Management			5	7	**12**
	Mental Capacity/Mental Health	1		2	2	**5**
	Mortality & Morbidity	3				**3**
	Patient Dignity & Respect			3	1	**4**
	Safeguarding			3	2	**5**
	Sepsis			1		**1**
Trust Management Group	Estates			1	7	**8**
	Operational Performance			5	2	**7**
	Performance Monitoring & Reporting	3			1	**4**
	Service Design and Delivery	9	2		1	**12**
Cross Remit	Maternity Services			3	2	**5**
	Stroke Services			5		**5**
Total		**72**	**7**	**61**	**52**	**192**

Table 4: Recommendations by Tier 1 (Committee) Meeting - alphabetical order of meeting

Report	Ref.	Tier 1 Meeting	Recommendation
NICHE	SD50	Audit Committee	Recommendation 50 - Clarify role of governors and escalation mechanisms • Governor training and induction programmes should be revisited to confirm that methods for escalating concerns are clearly set out and understood. • Procedures for escalation should include processes for resolution where governors remain dissatisfied with responses to issues raised.
NICHE	SD51	Audit Committee	Recommendation 51 - Institutional memory Formal handover procedures should be in place for all incoming and outgoing Board members (including postholders with committee chair roles). These handovers should include employee relations issues and sub-specialty summaries.
NICHE	SD56	Audit Committee	Recommendation 56 (ICS/CCG) Terms of reference for all quality assurance forums should be explicit about specific areas of focus, reports to be considered and how issues should be monitored. Key Issues Reports should be used for escalation. An issues log should be maintained which identifies concerns with departments/specialties involved and this should be shared, populated and reviewed at key governance forums.
NICHE	SD57	Audit Committee	Recommendation 57 (ICS/CCG) - Internal audit should test the efficacy of CCG assurance at a Trust specialty level as part of its annual work programme.
NICHE	MD19	Finance & Performance Committee	Recommendation 19 - Lorenzo All scan and clinical results should be acknowledged by the requester. Clinicians should be trained on the use of Lorenzo to ensure that they are aware of how to complete this activity. It should be made clear to all staff in which part of Lorenzo key documentation should be filed to reduce the amount of time spent finding key clinical information. A record of stent register status should be clearly marked and visible.
NICHE	MD20	Finance & Performance Committee	Recommendation 20 - Recording of ethnicity • The sample provided does not include information on ethnicity other than White or Unknown/Mixed. The Trust should examine whether it is recording ethnicity in its records in line with expected practice.

NICHE	MD30	Finance & Performance Committee	Recommendation 30 (ICS/CCG) - Clinical records in the form of emails (Link to R34(E)) • The Trust should add all Consultant staff email accounts to their Very Important Persons (VIP) list for a period of seven years once employment is ended. • The Trust should revisit its record-keeping policy as regards the use of email communications between clinicians containing clinical information. This should include: - clarification of what is an acceptable use of email in sharing patient specific clinical information, both internally and externally, to the Trust (including in clinical networks); - ensuring that where patient specific clinical information is shared by email (if appropriate) that these communications are retained as part of the clinical record; - revisiting the Trust email archiving policy, in light of the above, to ensure that emails can be retrieved where necessary (for example for SAR purposes); and - that all professionals should record the fact that an onward communication has been made within the clinical record.
NICHE	MD59	Finance & Performance Committee	Recommendation 59 (National) - Protecting patient confidentiality Examine ways in which confidential patient information is appropriately anonymised for the purposes of employment tribunal hearings. Guidelines should include: • advice to healthcare professionals on the use of patient information in these proceedings in line with Good Medical Practice guidance and GMC guidance on the use of personal information; • advice on the relevant GDPR and Data Protection regulations and the right to protect private information for both patients, their families and other individuals; • information relating to circumstances where patients do consent to the use of their personal information being used; and • the application of how Duty of Candour applies in such circumstances.
NICHE	MD61	Finance & Performance Committee	Recommendation 61 (National) - Learning from Deaths Consider a revision to the Learning from Deaths guidance to ensure that patient records on death are suitably managed in original form by professionals to reduce the risk of posthumous amendment.
NICHE	SD34	Finance & Performance Committee	Recommendation 34 (National) - Clinical records and email communications NHS England and NHS Improvement should decide whether more guidance is needed in relation to the uses and retention of email correspondence (or other electronic communications) as part of health records and any regional or national implications of recommendation 9 above.
CQC Must Do	MD70	Finance & Performance Committee	The service must ensure appropriate systems are used for maintaining accurate, complete and contemporaneous records for service users (Regulation 17(2)(c))
CQC Should Do	SD23	Finance & Performance Committee	The trust should consider whether they can build a separate paediatric treatment area to meet best practice guidelines
CQC Should Do	SD56	Finance & Performance Committee	The trust should ensure senior leaders of the department have oversight of paediatric activity and performance in the ED.

CQC Should Do	SD65	Finance & Performance Committee	The trust should ensure patient records are stored securely.
CQC Should Do	SD80	Finance & Performance Committee	The service should implement effective use of the whiteboard communication system on the birth centre
CQC Should Do	SD83	Finance & Performance Committee	The Trust should ensure that privacy and confidentiality is maintained for patients when sharing personal information
CQC Should Do	SD103	Finance & Performance Committee	The trust should ensure that all records are securely stored
NICHE	MD11	People Committee	Recommendation 11 - Professional relationships: Intelligence from the InterBe meeting in August 2020 should be used to assess the severity of concerns associated with relationships between senior clinical staff to determine whether issues can be resolved or if other remedial action needs to be taken
NICHE	MD28	People Committee	Recommendation 28 - Consultant relationships (Link to R65(E)) • The Trust should pay particular attention to any grievance raised by a Consultant or senior medical member of staff about another peer. Prompt and diligent investigations should be undertaken to ensure that the basis of concerns is fully understood and properly actioned to resolve peer-to-peer difficulties and concerns in a transparent and effective manner. • The Board should be made aware at an early stage of any specialty where relationships may be failing as this is a key patient safety marker. The Board should monitor actions to achieve improvement. This should be undertaken via the Employee Relations Report. • The Medical Director should be informed of any concerns about Consultant relationships (as Responsible Officer).
NICHE	MD31	People Committee	Recommendation 31 - Clinical dispute resolution • The Trust should introduce a mechanism of escalation, separate to the existing grievance and Freedom to Speak Up processes, whereby clinical disputes (in MDTs, between individuals or within departments) are formally mediated and resolved. The responsibilities for professionals involved in the event to engage in this mechanism of escalation should be made clear. This should be supported by a formal policy and should detail timescales for reporting, arbitration, resolution, and the trigger for the involvement of independent clinical adjudicators. Processes to report into other forums (such as Clinical Governance, mortality review, Ethics Committee and Revalidation) should be made clear within this policy.
NICHE	SD45	People Committee	Recommendation 45 - Managing team dysfunction A uniform approach should be applied to team dysfunction. This should include: • Clear communication from the Trust re the service strategy, goals and objectives - particularly around behavioural standards • Holding to account against professional standards in Good Medical Practice • Sustained visible leadership and “sponsorship” from the Board • Intelligent review of patient outcomes and harms • Follow-up, monitoring and review to ensure that behavioural improvements are sustained.

NICHE	SD46	People Committee	Recommendation 46 - Duty to monitor staff wellbeing The Trust has a duty to monitor staff stress levels and wellbeing and to intervene to support and understand the underlying issues before burn out affects patient care. The Trust should develop a cultural dashboard to identify key metrics that can provide early warning of team stress e.g. Occupational Health referral, employee relations concerns, engagement scores.
NICHE	SD47	People Committee	Recommendation 47 - Appraisals for medical staff (Link to R40) • Appraisals may identify colleagues who are having difficulties and a protocol should be put in place to safeguard staff when concerns are apparent. • The Responsible Officer should explicitly monitor appraisals which may demonstrate team dysfunction as a means of early warning and to instigate remedial interventions. • Specialty interests with key outcome measures at unit level should be agreed. Individual Consultants should be given lead responsibility for specialist areas with outcomes linked to the clinical audit programme and fixed into appraisal processes.
NICHE	SD48	People Committee	Recommendation 48 - Engagement with Consultant body • Engagement by executive and non-executive members of the Board with the Consultant body should be examined and options provided to facilitate increased opportunities for interaction. • This should include a clear programme of engagement at sub-specialty level over a rolling programme. This should be in addition to existing Medical Advisory Committee meetings.
NICHE	SD64	People Committee	Recommendation 64 (National) - Regulation and oversight of team dysfunction (Link to R65(E)) • NHS England and NHS Improvement should discuss the lessons learned from this review with the Care Quality Commission and share them with the National Quality Board or similar regulatory oversight group, in respect of the failings to resolve the long standing dysfunction in this team. • NHS England and NHS Improvement should provide clear guidance about what external support might be available to Trusts from the regional medical directors' teams and the advisory options when there is team dysfunction emerging. • Regulatory activity should review the effective functioning of the Responsible Officer role in regard to managing concerns where team dysfunction may be apparent. • Guidance should include ensuring Trusts are encouraged to seek early support where team dysfunction may put patient safety at risk.
NICHE	SD66	People Committee	Recommendation 66 (National) - Whistleblowing Guidance on setting up appropriate governance processes should be developed to support intractable whistleblowing cases. It should aim to provide resolution to concerns and facilitate learning in relation to patient safety.
NICHE	SD68	People Committee	Recommendation 68 (National) - Role of the GMC in relation to team dysfunction The GMC should reflect on this investigation. They should: • seek to understand how and if team dysfunction issues impact on fitness to practice investigations. • whether the role of medical managers and their fitness to practice (in relation to their management function) have been sufficiently considered in this case. • ensure that GMC guidance in relation to the RO regulations is up to date and considers the 2013 amendments to the regulations and learning since the role was introduced. • indicate to Trusts that the GMC Connect dashboard can be made accessible to Medical Directors as well as the RO team.

CQC Must Do	MD5	People Committee	The trust must continue to make improvements in the culture of the organisation, especially within maternity and trauma and orthopaedics, to enable staff to be supported to perform their duties effectively. (Regulation 18 (2) (a))
CQC Must Do	MD20	People Committee	The trust must improve the multidisciplinary working and culture between the department and specialities and speciality teams to maximise patient care and outcomes. (Regulation 12 (2) (i); Regulation 17 (2) (a))
CQC Must Do	MD52	People Committee	The trust must ensure all relevant staff have completed Paediatric Advanced Life Support when supporting paediatric provision in the emergency department. (Regulation 12(1)(2)(i))
CQC Must Do	MD53	People Committee	The trust must review the service's paediatric staffing provision, including the environment they wait in and the paediatric nursing and medical cover in line with The Royal College of Paediatrics and Child Health (RCPCH) Standards for Children and Young People in Emergency settings (2012) (Regulation 18(1))
CQC Must Do	MD66	People Committee	The service must ensure there are sufficient maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. (Regulation 18 (1)(2)(a))
CQC Must Do	MD92	People Committee	The service must ensure they deploy sufficient suitably competent and experienced staff and ensure all staff receive appropriate skills and drills training and professional development to enable them to maintain competency given the low numbers of deliveries. (Regulation 18 (1) (2) (a))
CQC Must Do	MD98	People Committee	The service must ensure nurse staffing levels meet the minimum standards of the National Institute of Health and Care Excellence. Regulation 18 (1): Staffing.
CQC Must Do	MD99	People Committee	The service must ensure medical staffing levels meet the minimum standards of the Royal College of Physicians. Regulation 18 (1): Staffing
CQC Should Do	SD34	People Committee	The trust should take appropriate actions to improve staff mandatory training, including safeguarding training in line with trust compliance targets.
CQC Should Do	SD35	People Committee	The trust should take appropriate actions to improve staff appraisal completion in line with trust compliance targets
CQC Should Do	SD93	People Committee	The service should consider protected time to allow for the completion of mandatory training
CQC Should Do	SD95	People Committee	The service should work to engage the workforce and increase visibility of the executive team
RCS	MD1	People Committee	Actions the Trust Must take to ensure patient safety is protected: A review of redacted clinical activity in performing unicompartmental knee replacements is required given the review may indicate an insufficient number of these procedures being undertaken to maintain the appropriate skill set required for the techniques involved.

RCS	MD2	People Committee	Actions the Trust Must take to ensure patient safety is protected: Assure evidence of redacted training in anterior approach surgery before further anterior approach hip replacements are performed.
NICHE	MD2	Quality Assurance Committee	Recommendation 2 - Quality and safety data in the Integrated Performance Report: The quality and safety data in the Integrated Quality and Performance Report (IQPR) should be expanded to include trend and thematic analysis. Key quality and safety metrics should be included in a new upfront performance dashboard and hotspot reporting should include more detailed analysis on key risks
NICHE	MD4	Quality Assurance Committee	Recommendation 4 - Urology audit: The newly appointed Urology Audit Lead should have dedicated and experienced support to provide best practice guidance on conducting audit and governance meetings. The terms of reference and agendas for the audit meeting should be drawn from best practice in other Urology services
NICHE	MD5	Quality Assurance Committee	Recommendation 5 - Safe Today Report: The Safe Today Report should be received at department and care group level before presentation to UT&FG and UQOC33. It should also be developed further to provide more appropriate measures of assurance with: • inclusion of an overarching scorecard to enable the reader to understand performance 'at a glance'; • a reduction in the narrative analysis throughout the report; • greater emphasis on prospective performance through the use of early warning indicators and forecasting in order to allow timely identification of deteriorating performance; • more same causal factor analysis of complaints, litigation, incidents and Patient Advice and Liaison Service (PALS) feedback; • an expansion of the quantitative and qualitative data relating to patient and staff experience, including patient feedback in the form of real time and retrospective data collection, staff pulse surveys and a wider range of workforce metrics (e.g. turnover, appraisals, training, use of agency staff, staff sickness, as well as concerns raised by staff)
NICHE	MD8	Quality Assurance Committee	Recommendation 8 - Quality of investigations in Urology services: All reported incidents and complaints received in relation to Urology services should, for a period of at least 12 months, be investigated by a dedicated independent team outside the department which has access to independent Urology advice. This would remove pressure on the existing team to investigate each other and provide room to work on relationship development. It would also help to set a standard for future high-quality investigations. [This recommendation related to incidents and complaints requiring investigation not all cases]
NICHE	MD9	Quality Assurance Committee	Recommendation 9 - Thematic review: Quality performance reporting should include thematic and same causal factor analysis of complaints, litigation, incidents, and PALS information to ensure that lessons can be learned, and actions taken to prevent recurrence of the same. Themes should be discussed at departmental, care group, and committee level with a clear focus on actioning improvement
NICHE	MD10	Quality Assurance Committee	Recommendation 10 - Mortality review (Link to R15 and R26) Every inpatient Urology death must have a case review conducted by Consultant Urologists with external support in using structured judgement review (SJR) methodology (Royal College of Physicians) or other recognised case note review methodology and be subject to Trust level scrutiny (as per Trust Policy). Every death must then be presented without exception to a Urology mortality meeting. These should be separate from audit and multidisciplinary team (MDT) meetings until such time that mortality review becomes an accepted and business as usual activity

NICHE	MD14	Quality Assurance Committee	Recommendation 14 - Fluid balance monitoring Fluid balance practice should be audited and a programme of high-quality recording put in place for Urology patients.
NICHE	MD15	Quality Assurance Committee	Recommendation 15 - Mortality review (Link to R10 and R26) • Following on from our recommendation on mortality review in our Draft Current Controls Assessment Report, the Trust must develop a robust mechanism for identifying deaths by speciality using both admission and treatment function codes and other identifiers. This should include deaths up to 30 days post-discharge. • The HOGAN and National Confidential Enquiry into Patient Outcome and Death (NCEPOD) scoring arising from mortality reviews must be subject to audit and further scrutiny within the Trust. • All NCEPOD or HOGAN scores of 2 or above should give rise to further review by the Trust, investigation where appropriate and the potential need for Duty of Candour processes.
NICHE	MD16	Quality Assurance Committee	Recommendation 15 - Named Consultants • Named Consultants, for complex patients, should be introduced in Urology. This should include non-cancer patients. Complex cases without a diagnosis should be discussed at MDT or Radiology meetings. • Clinicians should be allocated clinical responsibility for the oversight of pathways including by cancer type to develop greater ownership and to drive improvements in services. (See R54(E)).
NICHE	MD17	Quality Assurance Committee	Recommendation 17 - Capacity and best interests: applying the Mental Capacity Act 2005 • Capacity assessment and best interest decision-making should be improved through audit, training, and best practice examples. • An enhanced focus should be given to people presenting with dementia or confusion and those with a learning disability. • A thematic review examining the pathway, management and replacement of suprapubic catheters should be undertaken.
NICHE	MD18	Quality Assurance Committee	Recommendation 18 - Consent Consent for operations must be completed on every occasion. Any consent not completed correctly must be reported and investigated to improve practice. Consenting practice should be subject to audit and should include whether the patient dated the consent and the practice of confirmation of consent where the operating surgeon is different from the consenting surgeon. Theatre staff should be alerted to our concerns regarding consenting practice and be authorised to report all incidents where consent is not compliant with expected practice.
NICHE	MD21	Quality Assurance Committee	Recommendation 21 - Case note review • There should be a repeat case note review (100 cases) in 12 months (Autumn 2022) to assess if improvements have been sustained and embedded.

NICHE	MD2 3	Quality Assurance Committee	Recommendation 23 - Clinical monitoring The Trust should continue to embed good practice and use of: • Venous thromboembolism (VTE) assessment. • Nutrition, hydration and associated food/fluid balance monitoring must be enforced as fundamental standards. Use of the Malnutrition Universal Screening Tool (MUST) should be audited at specified intervals to ensure scoring and onward actions are appropriate. Total Parenteral Nutrition (TPN) guidelines should be reviewed and monitored to ensure that this option is considered early for all patients who are at risk of malnutrition. • The Trust should monitor the recent implementation of the electronic NEWS2 charts to ensure that the new system is successful in identifying and responding to deteriorating patients. • Access to formal on call microbiology advice out-of-hours should be provided.
NICHE	MD2 4	Quality Assurance Committee	Recommendation 24 - Standard operating policies and procedures The Trust must ensure the following are up-to-date and subject to regular audit: • the identification and management of Urosepsis and obstructed kidneys; • the identification and management of sepsis and the deteriorating patient; • the management and registration of stents; • handover of patients between on call Consultants; • consenting guidelines, including actions to be taken when patients cannot consent and when emergency surgery is required; • interspecialty referral processes; and • recording decisions made when a patient is referred to Intensive Treatment Unit (ITU), the escalation of capacity issues and a clear protocol regarding options when ITU is full.

NICHE	MD26	Quality Assurance Committee	Recommendation 26 (National) - Mortality review (Link to R10 and R15) • Any post-operative death should be subject to rigorous and contemporaneous case review and monitored at Trust level. This would also help support accurate reports to the Coroner if required to be written some months post death. • Death summaries and sudden death reports to the Coroner should be audited for quality and accuracy. • Every inpatient death within the Surgical and Critical Care Group (S&CCG) should be reported and subject to case review, this review should be shared within the department and at Trust level. • Every inpatient death in Urology services and other surgical specialties should be discussed in departmental meetings. • Every inquest involving the Trust must include consideration of whether an incident might have occurred that requires investigation and to prepare statements and reports in an adequate timeframe. • Statements to Coroners written in relation to whole episodes of care involving a team or a Trust service should be subject to validation by legal or corporate services to ensure that all parties have a right of reply (where needed) and that statements made are accurate. This is distinct from an individual health care professional providing a witness statement solely in relation to their own input. • Failures in care identified as a result of producing a Coroner's statement must be reported as an incident and any named individuals given a right of reply. • The Trust's Providing Statements to the Coroner Standard Operating Procedure should be revised to include the above. • The Trust must assure themselves that the Providing Statements to the Coroner Standard Operating Procedure is being complied with. Statements should differentiate between fact and opinion. In addition, there should be a clear indication of how the statement has been compiled. • The Trust should ensure that records are retained post-death and copies made for the purposes of review and investigation to mitigate the risk of retrospective entry. [The Medical Examiner role was introduced in the Trust in April 2020; this function should be assessed against the above recommendations].
NICHE	MD27	Quality Assurance Committee	Recommendation 27 - Managing complaints and compound family questions • The Trust's Management Procedure for the Investigation and Resolution of Complaints should be reviewed to ensure advice is clear on the handling of persistent/compound complaints that are not vexatious. • Repeated approaches/compound questions from a family in relation to concerns in care, including the death of a loved one, should be formally logged as a complaint. These cases should be allocated an appropriate single point of contact or family liaison officer to manage the process and support the family. These cases should also be flagged and carefully monitored as they have potential for extended resolution timescales. • Any case involving an inquest or complaint from a family should also be reviewed to determine whether it should be recorded as an incident(s). Any subsequent investigation and complaints processes should be managed in a coordinated fashion. • Compound complaints often arise once medical records are provided as these may be incomplete (due to archiving and multiple patient record systems). The Trust should ensure that full sets of medical records are provided at the outset of the request in line with existing Freedom of Information Act (FOIA), Subject Access Requests (SAR) and Access to Health Records Policies. • Clear guidance on sharing the medical records of deceased patients with families should be set out to ensure that relatives are provided with requested information promptly and in line with the appropriate legislation. • When FOIA or SAR include requests for email-based information, all searches should be formally logged and centrally managed so that the Trust has a full record of searches available to them.

NICHE	MD29	Quality Assurance Committee	Recommendation 29 - Triggers for external investigations • Terms of reference for all externally commissioned investigations should be scoped individually and quality assured to ensure that patient/family questions are included and that specific Trust concerns are addressed. (This principle should be followed for all root cause analysis (RCA) and serious incident (SI) reports undertaken internally in line with good practice). The Trust should develop a set of triggers for external investigations to be undertaken including when departmental dysfunction is apparent. • The Trust should revisit its tolerance for requesting external support in investigations.
NICHE	MD60	Quality Assurance Committee	Recommendation 60 (National) - Never Event review Revisit the Never Events cases highlighted in this review and ensure that the Trust applies rigour to all possible Never Events reporting.
NICHE	SD32	Quality Assurance Committee	Recommendation 32 (National) - Coroner's statements NHS England and NHS Improvement should develop guidance for Trusts and NHS organisations more widely in relation to the following aspects of recommendation 5 (R26) above: • Statements to Coroners written in relation to whole episodes of care involving a team or a Trust service should be subject to validation and where a statement includes or implies failures in care all individuals named should be given a right of reply. This is distinct from an individual health care professional providing a witness statement solely in relation to their own input. • Where failures in care are identified as a result of the production of a statement and a new incident is reported, the Coroner should be informed to determine if an investigation report will be required for any further proceedings. • Trusts must assure themselves that their policies in relation to providing statements to the Coroner are being complied with. Statements should be based on fact rather than opinion and there should be a clear indication of how the statement has been compiled.
NICHE	SD33	Quality Assurance Committee	Recommendation 33 (National) - Clinical practice NHS England and NHS Improvement should consider what relevant guidance could be developed for Trusts and NHS organisations more widely in relation to recommendations 1–8 made in this report and how these lessons might be shared. The learning from this report would be of benefit to the wider NHS community through an anonymised case study which will be developed from this case.
NICHE	SD35	Quality Assurance Committee	Recommendation 35 - Review Niche patient case studies The Trust should review all Niche case studies in priority order to contact patients in respect of Duty of Candour or ensure appropriate investigations have been completed to a high standard and actions have been implemented.
NICHE	SD38	Quality Assurance Committee	Recommendation 38 - Revisit and align all reporting policies The Trust should revisit and recommunicate the following policies to ensure that the purpose is clear, that they are aligned to each other and that they are workable for staff to readily follow and apply when escalation is required. This should include a flow diagram so staff can see which policy to follow in which situation. • Incident reporting • Raising Concerns • Grievance management • Whistleblowing • Freedom to Speak Up

NICHE	SD39	Quality Assurance Committee	Recommendation 39 (ICS/CCG) - A specialty focus The Trust should identify key specialty metrics that enable focus on harms to be triangulated in subspecialties of the Surgical and Critical Care Group (S&CCG). This should include: • A single monthly report on claims, incidents, Parliamentary Health Service Ombudsman (PHSO), Never Events and complaints with a cumulative analysis of themes arising. • At least biannual thematic reviews (regardless of whether complaints or claims are upheld) to understand any concerns being raised at the earliest possible opportunity. • An annual reconciliation of claims and complaints and their conversion to incident reports should be undertaken to ensure all patient safety concerns are logged through the incident reporting process for learning. • Learning and sharing relevant patient safety issues arising from MHPS investigations (which should be logged as incidents where appropriate). • Use of the annual GMC National Trainee Survey results to ensure information on junior doctors' experience is considered as part of these metrics.
NICHE	SD40	Quality Assurance Committee	Recommendation 40 - Implement clinical audit programme (Link to R4, R9, R14, R18, R25, R41, R47) A standard should be set for each of the following against which a clinical audit programme should be implemented: • Handover quality • Emergency surgery including access to and use of theatres out of hours • Emergency transfers from FGH to RLI • Stent register compliance • Results review and acknowledgement • MDT referrals, implementation of actions, attendance and quality of behaviours • Out-of-hours support from junior doctors • Ward round management • Consenting practice • Continuity of care • Harms as a result of delayed follow ups and IRDs • Application of National Institute for Clinical Excellence (NICE) guidance
NICHE	SD42	Quality Assurance Committee	Recommendation 42 - 104 day cancer breach root cause analysis • Ensure all 104 day cancer waiting time breaches are subject to a root cause analysis (RCA) and thematic reviews are acted upon to ensure pathway problems are properly identified and improved. • The Trust should follow the newly released (October 2021) North West Guideline: Managing Long Waiting Cancer Patients
NICHE	SD44	Quality Assurance Committee	Recommendation 44 - Patient handover Handover of patients between Consultants should include: • a formal handover arrangement between Consultants for out of hours cover. • a handover for patients who are transferred between Consultants.

NICHE	SD49	Quality Assurance Committee	Recommendation 49 - Trust Management of Royal College reports • The Trust should inform regulators (CQC and NHS England and NHS Improvement) and commissioners of any plans for external reviews for quality and safety concerns, including Royal College Invited Service Reviews as soon as they are confirmed. This will ensure that regulators and commissioners can take this into account in their assurance activity in real time. • Advisory reports from the Royal Colleges should be shared, in full or in summary where appropriate, by the Trust with the Trust Board. • The Trust should formally inform the regional or local NHS England and NHS Improvement team, the Care Quality Commission and relevant fitness to practice investigations conducted by the GMC and commissioners of relevant Royal College reports and share these where appropriate. • Transparent action plans arising from all Royal College reports should be developed by the Trust, shared with the Trust Board and formally monitored through the Trust Quality Committee.
NICHE	SD58	Quality Assurance Committee	Recommendation 58 (ICS/CCG) - The CCG should ensure that its contractual requirements with the Trust relating to incident reporting, and as set out in the Quality Schedule to the latest contract (2021/22), are met.
NICHE	SD67	Quality Assurance Committee	Recommendation 67 (National) - Assurance review NHS England and NHS Improvement should commission a Phase 5 review (Autumn 2022) in line with the Terms of Reference to include assurance on key elements such as: • continuity of care; • named Consultant; • MDT management; • follow-up patient pathways; • the quality of incident reporting and investigations; • team development opportunities; and • mortality governance. to establish if implemented changes have become embedded and are sustainable.
NICHE	SD69	Quality Assurance Committee	Recommendation 69 (National) - Enforcement and follow up of actions from Royal College Invited Service Reviews Invited Service Reviews should include: • clear expectations for Royal College Invited Service Review reports to be shared, in full, by the Trust with the relevant Trust Board; • expectations for when Royal College Invited Service Review reports should be shared, in full, by the Trust with regulators; and • clarity about the implementation of action plans arising from Invited Service Reviews to enable the Royal College to be satisfied that recommendations have been fully addressed to end their active involvement.
NICHE	SD72	Quality Assurance Committee	Recommendation 72 (National) - Testicular Implant Recall NHS England and NHS Improvement should share the findings from the testicular implant recall exercise with relevant bodies and agree the next steps at a local or national level.
CQC Must Do	MD1	Quality Assurance Committee	The trust must ensure that governance processes are robust and effective (Regulation 17 (1))

CQC Must Do	MD3	Quality Assurance Committee	The trust must ensure that incidents are identified, graded appropriately to reflect the level of harm and that they are acted upon and investigated in a timely way. (Regulation 12 (2) (b))
CQC Must Do	MD4	Quality Assurance Committee	The trust must improve on the timeliness of responses to complaints. (Regulation 16 (2))
CQC Must Do	MD6	Quality Assurance Committee	The trust must ensure that further development and investment in pharmacy resources should be prioritised to make sure medicines reconciliation rates and antimicrobial stewardship are improved across the trust. (Regulation 12 (2) (g))
CQC Must Do	MD10	Quality Assurance Committee	The trust must ensure that stroke patients receive treatment in line with best practice guidance and in line with the trust's stroke pathway so there are no delays to treatment. (Regulation 12 (2) (i))
CQC Must Do	MD12	Quality Assurance Committee	The trust must ensure that risk assessments and mental capacity assessments are carried out for mental health patients in line with trust policy. (Regulation 12 (2) (a))
CQC Must Do	MD13	Quality Assurance Committee	The service must ensure that there is enough staff with the right qualifications, skills, training and experience to provide care and treatment, specifically in relation to medical staffing including taking into account national guidance for the care of children and specifically paediatric emergency medicine consultant cover – This in line with the Royal College of Paediatrics and Child Health "Facing the Future – standards for children and young people in emergency care settings". (Regulation 18 (1))
CQC Must Do	MD14	Quality Assurance Committee	The service must ensure that audit information (including national audits) is submitted, up to date, accurate and properly analysed and reviewed by people with the appropriate skills and competence to understand its significance. When required, results should be escalated, and appropriate actions taken to improve. (Regulation 17 (2) (a))
CQC Must Do	MD15	Quality Assurance Committee	The trust must ensure that controlled drugs are safely prescribed, administered, recorded and stored and that registers are correctly and fully completed. The trust must ensure there is a system in place to assess and monitor formal competencies for nursing staff to administer medicines under patient group directions. (Regulation 12 (2) (g))
CQC Must Do	MD16	Quality Assurance Committee	The trust must ensure that robust action plans to improve and manage the flow of patients through the emergency department are put in place, taking into account known factors contributing to the hindrance of flow through the department and mitigating the ongoing risks and issues identified in the department. (Regulation 17 (2) (b))
CQC Must Do	MD17	Quality Assurance Committee	The department must ensure that the corridor escalation plan is adhered to and that incidents are appropriately recorded when the plan dictates. (Regulation 12 (2) (a) (b) (d))
CQC Must Do	MD18	Quality Assurance Committee	The service must ensure that privacy and dignity of patients is maintained, particularly when patients are in non-designated cubicle areas. (Regulation 10 (2) (a)

CQC Must Do	MD19	Quality Assurance Committee	The trust must ensure that patients' pain is effectively managed including that pain scores are re-assessed within 60 minutes as per trust policy. (Regulation 12 (2) (a) (b))
CQC Must Do	MD29	Quality Assurance Committee	The trust must implement an effective risk and governance system for the whole stroke pathway. (Regulation 17 (1) & (2) (a) & (b))
CQC Must Do	MD36	Quality Assurance Committee	The service must ensure staff have access to up-to-date and evidence-based guidelines and policies. (Regulation 12 (1))
CQC Must Do	MD37	Quality Assurance Committee	The service must ensure all women assessed as at risk of having sepsis receive care and treatment in line with national guidance and requirements. (Regulation 12 (1))
CQC Must Do	MD38	Quality Assurance Committee	The service must continue to develop a vision and strategy through engagement with staff, focused on sustainability and aligned to local plans within the wider health economy. (Regulation 17 (1) (2) (a) (e))
CQC Must Do	MD39	Quality Assurance Committee	The trust must ensure they establish and operate effective governance processes and systems, with robust action plans to monitor and improve the safety and quality of services and mitigate risks to women and families using the service. (Regulation 17 (1) (2) (a) (b))
CQC Must Do	MD46	Quality Assurance Committee	The trust must ensure that staff in the service adhere to trust infection prevention and control policy in the use of personal protective equipment and maintain patient and staff safety through social distancing at all times and in all areas. (Regulation 12(1)(2)(h))
CQC Must Do	MD47	Quality Assurance Committee	The service must ensure they participate in clinical audit to demonstrate the effectiveness of care and treatment. (Regulation 17(1))
CQC Must Do	MD49	Quality Assurance Committee	The trust must ensure that, patients with mental health concerns are seen in a timely way (Regulation 12(1)(2)(i))
CQC Must Do	MD50	Quality Assurance Committee	The trust must ensure pain is assessed in line with clinical standards, administered in a timely way and recorded in patient notes. (Regulation 12(1)(2)(i))
CQC Must Do	MD51	Quality Assurance Committee	The trust must ensure all patients are clinically assessed and National Early Warning Scores are documented for all patients. (Regulation 12(1)(2)(i))
CQC Must Do	MD58	Quality Assurance Committee	The trust must operate an effective clinical escalation system to ensure stroke care and treatment is assessed and implemented in a timely way. (Regulation 12 (1) & (2) (a) & (b))

CQC Must Do	MD59	Quality Assurance Committee	The trust must implement an effective system to ensure that all clinical staff have the knowledge, competence, skills and experience to care for and provide treatment to patients presenting with symptoms of stroke. (Regulation 18 (2) (a))
CQC Must Do	MD68	Quality Assurance Committee	The service must ensure risk assessments are completed and are actions taken to minimise any risks identified (Regulation 12(1)(2)(a) (b))
CQC Must Do	MD84	Quality Assurance Committee	service must ensure staff assess the risks to women during and after birth in order to identify women at risk of deterioration. (Regulation 12 (1) (2) (a))
CQC Must Do	MD85	Quality Assurance Committee	The service must ensure that women presenting in labour have immediate access to suitable qualified and skilled midwifery staff. (Regulation 18 (1))
CQC Must Do	MD86	Quality Assurance Committee	The service must ensure staff assess and mitigate the risks to women's health and safety in an emergency situation either during home birth or at the unit. They must ensure appropriate escalation and transfer takes place. (Regulation 12 (1) (2) (a) (b))
CQC Must Do	MD88	Quality Assurance Committee	The service must ensure all equipment is properly maintained and that staff do not use equipment that is not safe nor used for its intended purpose. Specifically, they should not use a domestic bath to support water birth. All staff should be aware of the birthing pool emergency evacuation process and have access to the required equipment at all times. (Regulation 12 (1) (d) & (e))
CQC Must Do	MD91	Quality Assurance Committee	The trust must ensure they establish and operate effective governance processes and systems, with robust action plans to monitor and improve the safety and quality of services and mitigate risks to women and families using the service. (Regulation 17 (1) (2) (a) & (b))
CQC Must Do	MD96	Quality Assurance Committee	The service must ensure effective systems are in place to assess and mitigate individual patient safety risks. Regulation 12 (1)(2)(a) and (b): Safe care and treatment
CQC Must Do	MD97	Quality Assurance Committee	The service must ensure people are kept free from harm. Regulation 13(5) Safeguarding service users from abuse and improper treatment
CQC Must Do	MD100	Quality Assurance Committee	The trust must ensure there is full oversight of services offered by the care group through robust governance processes. Regulation 17(2)(a): Good Governance
CQC Must Do	MD101	Quality Assurance Committee	The service must ensure effective systems are in place to monitor discharges to prevent patients from becoming deconditioned. Regulation 17 (1)(2)(b): Good governance
CQC Must Do	MD102	Quality Assurance Committee	The service must ensure there are effective systems are in place to consistently assess, monitor and improve patient safety and the quality of care. Regulation 17 (1)(2)(a) and (b): Good governance

CQC Should Do	SD7	Quality Assurance Committee	The trust should ensure that Patient Group Directions oversight should be strengthened to ensure sure appropriate and timely review and implementation
CQC Should Do	SD8	Quality Assurance Committee	The trust should ensure that the uptake of medicines management e-learning be prioritised to help improve medicines safety
CQC Should Do	SD9	Quality Assurance Committee	The trust should ensure that Electronic Prescribing and Medicines Administration (EPMA) auditing be strengthened to proactively identify prescribing and administration errors
CQC Should Do	SD22	Quality Assurance Committee	The trust should ensure that all staff follow infection control principles, including the use of personal protective equipment (PPE) at all times and receive refresher training in this where deemed necessary
CQC Should Do	SD24	Quality Assurance Committee	The trust should consider whether the triage service in the walk-in waiting area can be improved so that the triage nurse can observe patients in the waiting area more easily
CQC Should Do	SD25	Quality Assurance Committee	The trust should consider ensuring that there is a doctor or consultant at all safety huddles so that clinical information is not omitted from being shared with nursing staff.
CQC Should Do	SD26	Quality Assurance Committee	The trust should ensure that a more robust system of assessing skin integrity and pressure sores is put in place rather than the “safe and seen” assessment used presently.
CQC Should Do	SD27	Quality Assurance Committee	The trust should consider giving emergency department managers access to view incidents that are graded no harm or low harm, in order that there is complete oversight of incidents in the department to ensure that they have been graded correctly or may meet the criteria for a serious incident
CQC Should Do	SD28	Quality Assurance Committee	The trust should consider completing the urgent and emergency care plans that have been delayed so that these can feed into the medicine care group strategy
CQC Should Do	SD42	Quality Assurance Committee	The service should ensure the policy for cleaning of the birthing pool is ratified and implemented to control the risk of spread of infection.
CQC Should Do	SD43	Quality Assurance Committee	The service should ensure that recommendations from external incident investigations are fully considered and appropriate, robust action plans put in place
CQC Should Do	SD44	Quality Assurance Committee	The service should act to improve the assessment of women’s pain in light of their clinical condition and ensure all women receive pain relief in a timely manner

CQC Should Do	SD55	Quality Assurance Committee	The trust should consider what actions the service can take to improve safeguarding adults and safeguarding children level three training rates for doctors and nurses.
CQC Should Do	SD64	Quality Assurance Committee	The trust should ensure that systems and processes are established and operated effectively to identify, assess, monitor, escalate and take mitigating actions, particularly in relation to the safe storage of medicine and the checking of emergency resuscitation equipment.
CQC Should Do	SD76	Quality Assurance Committee	The service should act to improve the quality of safety information shared in SBAR handover.
CQC Should Do	SD81	Quality Assurance Committee	The trust should ensure that visible information about requesting a chaperone is available to patients attending the centre.
CQC Should Do	SD104	Quality Assurance Committee	The service should ensure they complete MUST documentation
RCS	MD3	Quality Assurance Committee	Actions the Trust Must take to ensure patient safety is protected: In respect of more complex cases, more effective utilisation of MDT to: (i) Improve governance in respect of clear decision making, transfer/handover of care documentation. (ii) Ensure appropriate consultant surgeon involvement.
RCS	MD4	Quality Assurance Committee	Actions the Trust Must take to ensure patient safety is protected: The consent pro-forma should ensure that the potential risks of the planned surgery are clearly documented for the patient to assimilate and space to record that these have been explained to the patient.
RCS	MD5	Quality Assurance Committee	Actions the Trust Must take to ensure the Trauma and Orthopaedic Service is improved: redacted may benefit as part of learning to reflect upon and discuss with colleagues case AXX in particular, possible reasons for the femoral notch (which was not documented in the operation note) occurring.
RCS	MD6	Quality Assurance Committee	Actions the Trust Must take to ensure the Trauma and Orthopaedic Service is improved: The Trust should take steps to improve the continuity of care for patients through their pre-operative, intra-operative and post-operative care pathway. This may include, but is not limited to, listing patients, wherever possible, on the operating surgeon clinic list.
RCS	SD7	Quality Assurance Committee	Actions the Trust Should consider as part of its development of the Trauma and Orthopaedic service: If the Trust identifies primary concerns about an individual surgeon, then a formal review of their clinical practice is recommended. If the Trust identifies concerns associated with the surgical service then a review of the service is recommended.
NICHE	MD1	Trust Management Group	Recommendation 1 - Oversight of Urology through Trust governance structures: Reporting lines need to be clearly articulated in the terms of reference for each of the groups and committees which have been established for oversight of the Urology service and depicted in an organogram. Links to the Urology department, care group, committee and Board governance structure should also be confirmed

NICHE	MD3	Trust Management Group	Recommendation 3 - Performance framework for Urology: Introduce a performance and accountability framework which clearly sets out the approach to corporate and care group scrutiny of Urology and, where necessary, support from the Enhanced Support Programme (ESP)
NICHE	MD6	Trust Management Group	Recommendation 6 - Meeting administration: Meeting administration must be improved. This should include: • a review of the ToR for all meetings at departmental and care group level to ensure they are in date, aligned to the objectives required of the meeting, and also other key meetings, with agendas planned to reflect these; • the introduction of standardised templates for agendas, minutes, and action logs; and • the provision of training for individuals with minute-writing responsibilities and all minutes should be reviewed by the relevant Chair before distribution
NICHE	MD7	Trust Management Group	Recommendation 7 - Risk registers at service, care group and Trust level: The challenges currently being faced by the Urology service should be reviewed to determine whether the risks are sufficient to warrant inclusion on the service, care group or Corporate Risk Register (CRR) or the Board Assurance Framework (BAF); this includes the difficulties with on call cover at Furness General Hospital (FGH) and continuing fractured relationships as a patient safety risk. Departmental and care group meetings should include risk as a standing agenda item and the risk profile of the service should be reviewed at least quarterly
NICHE	MD12	Trust Management Group	Recommendation 12 - Pooled model of patient care • There is an urgent need to review the pooling of patient referrals and the way in which patients are allocated to, and reviewed by, clinicians in Urology to ensure that continuity of care is optimised. • There should be clear procedures for allocating patients against specific pathways (including in line with Cancer MDT guidance). Any subsequent changes to management plans should be agreed with the named Consultant/an appropriate clinician especially if there are clinic cancellations or delays to treatment.
NICHE	MD13	Trust Management Group	Recommendation 13 - Monitoring of additional activity sessions (AASs) Introduce a robust policy and controls to retrospectively and prospectively review AAS activity in the Urology department, including a quarterly analysis of the number, value, and justification for AASs undertaken on a clinician-by-clinician basis.
NICHE	MD22	Trust Management Group	Recommendation 22 (Cancer Alliance) - Improving the pathway for bladder cancer diagnosis • Where appropriate, conducting a flexible cystoscopy on the day of attending the One Stop Clinic would make this a truly one-stop service. • Patients meeting the two-week wait criteria with visible haematuria and normal estimated glomerular filtration rate (eGFR) should be triaged to have a CT Urogram prior to attending clinic to streamline the service. • Patients requiring ongoing monitoring following chemotherapy/radiotherapy should be referred back via the MDT to a named Consultant at the Trust, on completing their therapy, who is then responsible for co-ordinating on-going care (e.g. in this case, being clear about the rationale for examination under anaesthetic (EUA), biopsy, cystoscopy and stenting). The MDT will need to ensure there is a clear management plan and processes put in place to ensure Urology actions are implemented. This will also allow time to plan dates for surgery to meet required timescales. • Lancashire and South Cumbria Cancer Alliance follow up protocols should be agreed and followed. • All patients should be listed on the stent register. If they are transferred to another Trust with the expectation that the stent is removed, this should be explicitly stated; if patients are transferred into the Trust with a stent in situ, they should be added to the Trust's stent register.

NICHE	MD25	Trust Management Group	Recommendation 25 (ICS &CCG) - Nephrostomy service • The Trust and Clinical Commissioning Groups (CCGs) should review arrangements for out-of-hours nephrostomy provision, including over bank holidays and emergency cover. • The arrangements that have been put in place should be assessed to ensure that standards for accessing nephrostomy provision out of hours and for returning patients to the Trust are appropriate, agreed, and form part of a standard operating procedure that is audited to confirm compliance.
NICHE	SD36	Trust Management Group	Recommendation 36 - Urology pathway priority management • There is a need to redesign follow-up pathways for Urology patients to match capacity and demand to prevent backlogs and balance this with the faster response for new referrals. Clear protocols for long-term active surveillance which ensures cases are appropriately seen at the right intervals are required. • Advance booking for long-term surveillance procedures should be introduced (including stent replacement and cystoscopy) and audited to ensure delays are minimised.
NICHE	SD37	Trust Management Group	Recommendation 37 - Capacity and demand modelling in Urology The Trust should undertake a capacity and demand modelling exercise (including the use of PLICS information) to provide an up to date baseline for the service and to support job planning. This should include: • Medical staffing levels • Junior staffing resources • Administrative resource • Nursing skills and a clinical nurse specialist role review
NICHE	SD41	Trust Management Group	Recommendation 41 (Cancer Alliance) - Cancer MDT management The Trust, with the Cancer Alliance, should: • Agree and implement new Standards of Care (SoC) in line with the advice of the Streamlining MDT Meetings guidance. • Clarify the expectations of core members at both local and network MDTs and the expectation for named Consultant Urologists to present their cases. A deputy role for the chair of the local MDT should be put in place. • Ensure that all core members attend the MDT as agreed above. • Audit the new processes to ensure alignment with the introduction of the named Consultant. • Ensure responsibility for actioning decisions made at the local MDT is maintained within the Trust. • Ensure there is clarity for responsibility for actioning decisions made at the network MDT. • Ensure that professional behaviours are demonstrated at both local and network MDTs and confirmed through observation and transparent feedback on a regular basis for all attendees.
NICHE	SD43	Trust Management Group	Recommendation 43 - Emergency theatre access • The Trust should monitor the use of emergency theatres out of hours in Urology (building on the analysis provided in this report) to establish whether the existing Standard Operating Procedure (Theatre Access) is effective in changing the pattern of practice highlighted by this report. • This should be examined in the context of whether some emergency theatre demand could be reduced through the provision of ward based facilities.
NICHE	SD52	Trust Management Group	Recommendation 52 - Media articles Revise advice and guidance on dealing with media articles that name individuals and provide support to ensure an appropriate right of reply is sought (also in line with GMC guidance on responding to criticism in the media).

NICHE	SD53	Trust Management Group	Recommendation 53 (ICS/CCG) - As part of the work underway to establish system governance, commissioners should agree shared mechanisms to enable proactive commissioning and visibility of the Trust's services at specialty/sub-specialty level.
NICHE	SD54	Trust Management Group	Recommendation 54 (ICS/CCG) - Alternative mechanisms for specialty/sub-specialty level scrutiny as part of routine assurance processes should be examined, for example cyclical deep dives as part of an annual work plan led by commissioning managers for scrutiny by quality assurance forums. The heat map approach (as in Appendix 10) developed by the CCG provides a useful model for this purpose. The CCG should add an analysis of complaints/concerns/incidents from GP practices at a specialty level on at least an annual basis as part of this scrutiny.
NICHE	SD55	Trust Management Group	Recommendation 55 (ICS/CCG) - A reporting template should be developed which brings together quality, activity, and performance information at a specialty level. A programme of reporting at this level should be agreed with the Trust, with frequency of reporting for each specialty to reflect jointly agreed priorities. This should provide a single source of reporting to all relevant governance groups. The Safe Today report provides a sound basis for development.
NICHE	SD62	Trust Management Group	Recommendation 62 (National/ICS/CCG) - Networked support for team development NHS England and NHS Improvement and the CCG should seek stronger working relationships between the Trust and tertiary centres to support Consultants in facilitating the provision of sub-specialty services at the Trust.
NICHE	SD63	Trust Management Group	Recommendation 63 - Development of safe services and specialist interests A Urology strategy should be developed involving all key Urology medical staff and other relevant healthcare professionals to set the context for the following actions: • The Trust should undertake an equipment stocktake for Urology and plan into the capital replacement programme the need for cystoscopes, bipolar diathermy and suction equipment both in the short term and over the medium term or consider lease options. • Examine, with the Trust and CCG, the development of Urology sub-specialisms building on Andrology and stone services, the management of superficial bladder cancer, local anaesthetic transperineal biopsy work and paediatrics. • Examine, through the provider collaborative network, the viability of Urology provision across two sites and its associated support services in the long term should be examined in respect of future provision at Furness General Hospital. Formal consideration of centralising inpatient and emergency Urology services on one site should be revisited. This should include options for dedicated ward based facilities.

NICHE	SD65	Trust Management Group	Recommendation 65 (National) - Guidance and support to Responsible Officers from NHS England and NHS Improvement Regional Medical Directors • NHS England and NHS Improvement should ensure that guidance to ROs is up to date and a final version is in force to include the 2013 RO regulation amendments and learning since the role was introduced. Regional Medical Directors should use this investigation as a case study to reinforce escalation processes for Responsible Officers who may be facing conduct difficulties within their medical workforce. • The North West Regional Medical Director should share this case study with other Regional Medical Directors to reinforce the importance of the RO role, appointment processes and the lessons learned from this investigation. • Good practice should be shared between Trusts to provide clarity on the best approaches for dealing with and escalating behavioural and conduct issues that are impacting on patient safety in line with Good Medical Practice. • The Trust Board should revisit its understanding of the role of the RO and assure itself that there is clarity of duties between the Medical Director (now as RO) and the wider team in exercising duties to meet the RO regulations.
NICHE	SD70	Trust Management Group	Recommendation 70 (National) - Sharing of information between regulatory bodies The effectiveness and intention of the Emerging Concerns Protocol https://www.cqc.org.uk/what-we-do/how-we-work-people/emerging-concerns-protocol should be revisited in the context of the findings of this case. The inclusion of additional signatories (e.g. Royal Colleges, NHS England and NHS Improvement) should be considered. This may be the most appropriate process to improve information sharing.
NICHE	SD71	Trust Management Group	Recommendation 71 (National) - Assessing the effective role of the Responsible Officer in Well-Led assessments The role of the RO and its development since the introduction of this function in 2010 should form a regular and consistent part of examination as part of internal and external Well-Led and governance reviews.
CQC Must Do	MD2	Trust Management Group	The trust must ensure that risks in the organisation are correctly identified and appropriate mitigations put in place in a timely way (Regulation 17 (2) (b))
CQC Must Do	MD2 1	Trust Management Group	The department must ensure that all known risks are singularly identified on the risk register and that risks are supported by robust action plans that can reduce or mitigate the risks. They must also ensure that these action plans are regularly reviewed to ensure effectiveness and action plans amended where progress cannot be achieved. (Regulation 17 (2) (b))
CQC Must Do	MD3 0	Trust Management Group	The trust must operate an effective clinical escalation system to ensure stroke care and treatment is assessed and implemented in a timely way. (Regulation 12 (1) & (2) (a) & (b))
CQC Must Do	MD3 1	Trust Management Group	The trust must implement an effective system to ensure that all clinical staff have the knowledge, competence, skills and experience to care for and provide treatment to patients presenting with symptoms of stroke. (Regulation 18 (2) (a))
CQC Must Do	MD3 2	Trust Management Group	The trust must continue to monitor and take appropriate actions to improve average length of patient stay for patients having trauma and orthopaedics surgery. (Regulation 12 (1))

CQC Must Do	MD33	Trust Management Group	The trust must continue to monitor and take actions to improve referral to treatment waiting time performance in line with national standards. (Regulation 12 (1))
CQC Must Do	MD48	Trust Management Group	The service must ensure that care is provided in line with national performance standards for waiting times from referral to treatment and arrangements to admit, treat and discharge patients. (Regulation 12(1)(2)(i))
CQC Must Do	MD54	Trust Management Group	The trust must take action to improve safeguarding adults and safeguarding children level three training rates for doctors and nurses. (Regulation 18(1))
CQC Must Do	MD67	Trust Management Group	The service must ensure medical staff complete all required safeguarding level 3 training. (Regulation 18 (1)(2)(a))
CQC Should Do	SD41	Trust Management Group	The service should consider implementing a policy and schedule for changing the keypad code at ward entrances to maintain security
CQC Should Do	SD45	Trust Management Group	The service should continue to act to ensure women received continuity of care in line with national recommendations and targets
CQC Should Do	SD62	Trust Management Group	The trust should ensure that wards are secured to maintain patient safety
CQC Should Do	SD63	Trust Management Group	The trust should ensure that fire doors are maintained and used correctly
CQC Should Do	SD79	Trust Management Group	The service should progress actions to enable improved access within the birth centre, in context of the physical environment.

Table 5: Overview of CQC Recommendation & Actions Status and Progress

Key:

Not Applicable
Unable to Complete
Not Started
In Progress (Behind Schedule
In Progress (New Action)
In Progress (On Schedule)
Fully Completed **(awaiting approval)**
Fully Completed / Approved

Type	Recommendation	Ref	Lead Manager	Service	Action	Progress Status
Must Do	The trust must ensure that governance processes are robust and effective (Regulation 17 (1))	MD1 /1	Mr Richard Sachs	TRUSTWIDE	The Trust will complete the recommendations from the Good Governance Institute (GGI) to deliver improved governance and assurance structures and processes from ward to board	Partially complete (Overdue)
Must Do	The trust must ensure that governance processes are robust and effective (Regulation 17 (1))	MD1 /2	Mr Stuart Bates	TRUSTWIDE	The Trust has completed an Initial Section 26 / Notice of Proposal evidence submission detailing the actions taken to address governance processes and ensure they are robust and will be sustained	Fully complete (Awaiting approval)
Must Do	The trust must ensure that governance processes are robust and effective (Regulation 17 (1))	MD1 /3	Mr Richard Sachs	TRUSTWIDE	The Trust (CEO and Director of Governance) will work with NHSE/I (Becky Southall) to review outcomes of GGI work completed in 2021/22 to identify how to refine the GGI Governance structure and to improve implementation and embeddedness of this refined governance structure within the Trust.	Fully complete (Awaiting approval)
Must Do	The trust must ensure that governance processes are robust and effective (Regulation 17 (1))	MD1 /4	Mr Paul Jones	TRUSTWIDE	Company Secretary to review and introduce a process to ensure statutory Responsibilities of Execs in highlighting issues of concern to the Trust Board	Fully complete (Approved)

Must Do	The trust must ensure that risks in the organisation are correctly identified and appropriate mitigations put in place in a timely way (Regulation 17 (2) (b))	MD2 /1	Mr Richard Sachs	TRUSTWIDE	The Trust will implement and embed a new Risk Management Strategy, new Trust Wide Risk Management Group to oversee Risk and review, update the associated Risk Management Processes and deliver Risk Management Training, to ensure this is embedded throughout the organisation. The operational elements are in place. The resource with regards to Risk Practitioner in place until December 2021.	Fully complete (Approved)
Must Do	The trust must ensure that incidents are identified, graded appropriately to reflect the level of harm and that they are acted upon and investigated in a timely way. (Regulation 12 (2) (b))	MD3 /1	Mr Richard Sachs	TRUSTWIDE	The Trust will implement a review of the existing Trust Wide Incident Reporting, Investigation and Management Policy, Procedures and Systems, in line with the new National Patient Safety Strategy and Framework, and then deliver and embed the required improvements. The infrastructure, revised Policy and systems in place by end of Q2. The embedding / reviewing by the end of Q3. Review the position by end of Q4.	Partially complete (Overdue)
Must Do	The trust must improve on the timeliness of responses to complaints. (Regulation 16 (2))	MD4 /1	Mr Richard Sachs	TRUSTWIDE	The Trust will implement an action plan to improve Complaints responses time with a target to meet regulatory standards by end of October 2021, with a stretch target of meeting Trust standards by the end of March 2022.	Partially complete (Overdue)
Must Do	The trust must continue to make improvements in the culture of the organisation, especially within maternity and trauma and orthopaedics, to enable staff to be supported to perform their duties effectively. (Regulation 18 (2) (a))	MD5 /1	Ms Claire Alexander	TRUSTWIDE	The Trust will continue to deliver its ESP Programme within the wider Trust Culture and Transformation Group workstream to make the required improvements in the WACS Care Group to enhance a positive culture and support the delivery of effective care and treatment	Partially complete (Overdue)
Must Do	The trust must continue to make improvements in the culture of the organisation, especially within maternity and trauma and orthopaedics, to enable staff to be supported to perform their duties effectively. (Regulation 18 (2) (a))	MD5 /2	Ms Claire Alexander	TRUSTWIDE	The Trust will continue to deliver its ESP Programme within the wider Trust Culture and Transformation Group workstream to make the required improvements in the T&O Speciality to enhance a positive culture and support the delivery of effective care and treatment	Partially complete (Overdue)

Must Do	The trust must continue to make improvements in the culture of the organisation, especially within maternity and trauma and orthopaedics, to enable staff to be supported to perform their duties effectively. (Regulation 18 (2) (a))	MD5 /3	Ms Beverley Edgar	TRUSTWIDE	The Trust has developed and implemented a Trust Wide Cultural Transformation Workstream which is overseen by the Director of People and Organisational Development and is monitored/reported at Workforce Assurance Committee and Trust Management Group, the Work Stream include programmes on: Just and Learning Culture, Magnet 4 Europe, Freedom to Speak Up, Medical engagement/leadership, Talent Management & Leadership Development, Workforce Transformation	Partially complete (Overdue)
Must Do	The trust must continue to make improvements in the culture of the organisation, especially within maternity and trauma and orthopaedics, to enable staff to be supported to perform their duties effectively. (Regulation 18 (2) (a))	MD5 /4	Ms Beverley Edgar	TRUSTWIDE	Within the Culture and Transformation Work Stream, the Trust has a specific programme of work to develop and implement a Cultural & Leadership Diagnostic & Dashboard , with target outcomes of; Build of UHMB Cultural Dashboard in Model Hospital , Completion of all diagnostic tools across the 6 elements of the programme , Outcomes presented to Cultural Transformation Board, Trust Management Group and Board of Directors	Partially complete (Overdue)
Must Do	The trust must continue to make improvements in the culture of the organisation, especially within maternity and trauma and orthopaedics, to enable staff to be supported to perform their duties effectively. (Regulation 18 (2) (a))	MD5 /5	Ms Beverley Edgar	TRUSTWIDE	The Trust (Led by People and Organisational Development) will work with NHSE/I to implement a cultural engagement tool to help improve staff engagement.	Partially complete (Overdue)
Must Do	The trust must continue to make improvements in the culture of the organisation, especially within maternity and trauma and orthopaedics, to enable staff to be supported to perform their duties effectively. (Regulation 18 (2) (a))	MD5 /6	Ms Beverley Edgar	TRUSTWIDE	Trust to implement an online conversation platform to enable staff to provide anonymous feedback on: - The Trust's; Vision, Values, Culture and Leadership - What changes are needed? - Our Fundamental purpose as an NHS Trust? - Acceptable behaviours to colleagues, patients, partners and the public - What is required to make these changes? The Trust will then publish the results form the conversation , then develop and implement an action plan to address the issues raised.	Fully complete (Approved)

Must Do	The trust must ensure that further development and investment in pharmacy resources should be prioritised to make sure medicines reconciliation rates and antimicrobial stewardship are improved across the trust. (Regulation 12 (2) (g))	MD6 /1	Mrs Kam Mom	Pharmacy	The Pharmacy Service will develop and submit a Business Case for the recruitment of substantive pharmacy staff to undertake medicines reconciliation in the Trust. Once approved this will be implemented and the additional capacity deployed to ensure this recommendation is met and sustained through regular monitoring.	Partially complete
Must Do	The trust must ensure that further development and investment in pharmacy resources should be prioritised to make sure medicines reconciliation rates and antimicrobial stewardship are improved across the trust. (Regulation 12 (2) (g))	MD6 /2	Mrs Kam Mom	Pharmacy	The Pharmacy Service will develop and submit a Business Case for the recruitment of substantive pharmacy staff to undertake antimicrobial stewardship in the Trust. Once approved this will be implemented and the additional capacity deployed to ensure this recommendation is met and sustained through regular monitoring.	Partially complete
Must Do	The trust must ensure that further development and investment in pharmacy resources should be prioritised to make sure medicines reconciliation rates and antimicrobial stewardship are improved across the trust. (Regulation 12 (2) (g))	MD6 /4	Mrs Kam Mom	Pharmacy	Recommendation MD115 to be reviewed with Chief Pharmacist, Medication Safety Officer and ADOp of CCS to determine; a) is the is the same recommendation as MD6 b) if it is the same recommendation, are there any new actions required? c) if no no new actions are required this new recommendation will be managed through MD6	Fully complete (Awaiting approval)
Must Do	The trust must ensure that stroke patients receive treatment in line with best practice guidance and in line with the trust's stroke pathway so there are no delays to treatment. (Regulation 12 (2) (i))	MD10/1	Mrs Melanie Woolfall	Accident and Emergency	The Trust has developed and implemented a detailed improvement plan to address the issues identified in the Section 31 Notice, the plan includes; To meet the immediate safety concerns by 20/05/2021. To deliver the agreed improvement plan against the 8 domains by the 8 week deadline (July 2021) and to ensure improvements are sustained September 2021. This action will also be used to manage and complete any requirements of Recommendations MD29, MD30, MD31, MD 58 and MD59 (all of which relate to the provision of Stroke Care and Treatment) that fall within the scope of the 8 week plan.	Fully complete (Awaiting approval)
Must Do	The trust must ensure that stroke patients receive treatment in line with best practice guidance and in line with the trust's stroke pathway so there are no delays to treatment. (Regulation 12 (2) (i))	MD10/2	Mrs Melanie Woolfall	Accident and Emergency	The Medicine Care Group will work with partner organisations to deliver and submit the ICS business case for stroke services. This will ensure sufficient capacity and resources to meet best practice guidance.	Partially complete (Overdue)

Must Do	The trust must ensure that stroke patients receive treatment in line with best practice guidance and in line with the trust's stroke pathway so there are no delays to treatment. (Regulation 12 (2) (i))	MD1 0/3	Ms Jane McNicholas	Accident and Emergency	The Trust will establish and embed a Stroke Task and Finish Group to oversee the required performance improvement in Stroke Medicine to achieve the standard required to enable the successful exit from the CQC Section 31 notification. This action will also be used to manage and complete the requirements of Recommendations MD29, MD30, MD31, MD 58 and MD59, all of which relate to the provision of Stroke Care and Treatment.	Partially complete
Must Do	The trust must ensure that risk assessments and mental capacity assessments are carried out for mental health patients in line with trust policy. (Regulation 12 (2) (a))	MD1 2/1	Mrs Melanie Woolfall	Accident and Emergency	Trust Safeguarding Policy already includes MCA Risk Assessments. The Care Group will work with Safeguarding Team to ensure that assessments are carried out as part of everyday practice in line with Trust Policy and all staff understand their role and responsibilities. This will be monitored through; Quarterly DOLS/MCA Audits undertaken by Trust Safeguarding Team, reported at Safeguarding Operational Performance Group and local Spot Checks undertaken by Matrons and Unit Managers. Best Practice and learning from Monitoring to be shared from these. Maintain high quality risk / MCA assessments in line with Trust policy.	Partially complete
Must Do	The service must ensure that there is enough staff with the right qualifications, skills, training and experience to provide care and treatment, specifically in relation to medical staffing including taking into account national guidance for the care of children and specifically paediatric emergency medicine consultant cover – This in line with the Royal College of Paediatrics and Child Health "Facing the Future – standards for children and young people in emergency care settings". (Regulation 18 (1))	MD1 3/1	Mr Neil Smith	Accident and Emergency	The Trust has a programme of work for reviewing compliance with the 'Facing The Future' requirements and to deliver improvements, which is reported through to the MGAG. This includes meeting national guidance for staffing requirements, including paediatrics.	Partially complete (Overdue)

Must Do	The service must ensure that there is enough staff with the right qualifications, skills, training and experience to provide care and treatment, specifically in relation to medical staffing including taking into account national guidance for the care of children and specifically paediatric emergency medicine consultant cover – This in line with the Royal College of Paediatrics and Child Health “Facing the Future – standards for children and young people in emergency care settings”. (Regulation 18 (1))	MD1 3/2	Mrs Melanie Woolfall	Accident and Emergency	The Medicine Care Group has confirmed that existing arrangements for the RLI Paediatric Ward to provide overnight Paediatric Nursing Cover/Support to RLI ED on an 'as required' basis remain in place.	Partially complete (Overdue)
Must Do	The service must ensure that audit information (including national audits) is submitted, up to date, accurate and properly analysed and reviewed by people with the appropriate skills and competence to understand its significance. When required, results should be escalated, and appropriate actions taken to improve. (Regulation 17 (2) (a))	MD1 4/1	Mr Paul Smith	Accident and Emergency	The Medicine Care Group will strengthen and assure the local Audit processes and leadership to ensure audits are completed and submitted as required in line with RCEM requirements and any remedial actions are implemented.	Partially complete
Must Do	The service must ensure that audit information (including national audits) is submitted, up to date, accurate and properly analysed and reviewed by people with the appropriate skills and competence to understand its significance. When required, results should be escalated, and appropriate actions taken to improve. (Regulation 17 (2) (a))	MD1 4/2	Mr Paul Smith	Accident and Emergency	The Medicine Care Group RCEM Audit will be a standing agenda item at MGAG from January 2022 for regular monitoring.	Partially complete (Overdue)
Must Do	The service must ensure that audit information (including national audits) is submitted, up to date, accurate and properly analysed and reviewed by people with the appropriate skills and competence to understand its significance. When required, results should be escalated, and appropriate actions taken to improve. (Regulation 17 (2) (a))	MD1 4/3	Mrs Heather Pratt	Accident and Emergency	The Trust Clinical Audit team will review and update Trust Wide Clinical Audit processes, to include; Implement and Embed new Clinical Audit Governance structure as required from the Trust Wide GGI Governance Review, to ensure consistent Ward To Board processes and escalation and to appoint a National Audit Co-ordinator within the Trust Clinical Audit Team.	Fully complete (Approved)

Must Do	The service must ensure that audit information (including national audits) is submitted, up to date, accurate and properly analysed and reviewed by people with the appropriate skills and competence to understand its significance. When required, results should be escalated, and appropriate actions taken to improve. (Regulation 17 (2) (a))	MD1 4/4	Mr Paul Smith	Accident and Emergency	Clinical Director and DADOp for Urgent Care to undertake a review to ascertain if Medicine Clinical Audits are "properly analysed and reviewed by people with the appropriate skills and competence to understand its significance". The findings of the review will then be used determine if an action plane is required and if so, will be used to develop an action plan. The results of this review and any action plan will be reported to the Medicine Clinical Audit Meeting(s) and the Trust Clinical Audit Standards Group.	In progress
Must Do	The trust must ensure that controlled drugs are safely prescribed, administered, recorded and stored and that registers are correctly and fully completed. The trust must ensure there is a system in place to assess and monitor formal competencies for nursing staff to administer medicines under patient group directions. (Regulation 12 (2) (g))	MD1 5/1	Mrs Kam Mom	Accident and Emergency	The Medicine Care Group will increase vigilance/oversight of remedial actions following Controlled Drug and Enhanced control safe and secure storage audit actions as captured on the new AMaT System. Any findings or recommendations from these audits will be implemented and monitored through future regular audits.	Partially complete (Overdue)
Must Do	The trust must ensure that controlled drugs are safely prescribed, administered, recorded and stored and that registers are correctly and fully completed. The trust must ensure there is a system in place to assess and monitor formal competencies for nursing staff to administer medicines under patient group directions. (Regulation 12 (2) (g))	MD1 5/2	Mrs Kam Mom	Accident and Emergency	The Pharmacy Service will strengthen Patient Group Direction oversight. To include refresh of the policy, implementation of audit, increasing staff awareness and delivery of any required staff training.	Partially complete (Overdue)
Must Do	The trust must ensure that robust action plans to improve and manage the flow of patients through the emergency department are put in place, taking into account known factors contributing to the hindrance of flow through the department and mitigating the ongoing risks and issues identified in the department. (Regulation 17 (2) (b))	MD1 6/1	Miss Leanne Cooper	Accident and Emergency	Plans have been developed as part of the BHACP UEC Programme, it has been signed off by A&E Delivery Board and now has additional PMO support to help its delivery. A robust improvement programme that facilitates patient flow corporately is in place and delivered in line with the Urgent Care action plan.	Fully complete (Approved)
Must Do	The department must ensure that the corridor escalation plan is adhered to and that incidents are appropriately recorded when the plan dictates. (Regulation 12 (2) (a) (b) (d))	MD1 7/1	Mrs Melanie Woolfall	Accident and Emergency	The Medicine care Group ensure that the RLI ED corridor escalation plan is adhered to by staff and that incidents are recorded and escalated to the Patient Flow Team. Investigate scope for automated monitoring/recording of corridor waits.	Partially complete

Must Do	The service must ensure that privacy and dignity of patients is maintained, particularly when patients are in non-designated cubicle areas. (Regulation 10 (2) (a)	MD1 8/1	Mrs Melanie Woolfall	Accident and Emergency	The Medicine Care Group will review Processes for maintaining the privacy and dignity of (non-Cubicle) patients in RLI ED, to identify and implement improvements, to include; Staff Awareness, Matron Review/Spot Checks, Seen and Safe Process/documentation, collaborative projects with NHSE/I and NWAS colleagues	Partially complete
Must Do	The trust must ensure that patients' pain is effectively managed including that pain scores are re-assessed within 60 minutes as per trust policy. (Regulation 12 (2) (a) (b))	MD1 9/1	Mrs Melanie Woolfall	Accident and Emergency	To be managed through the fundamentals work on managing a deteriorating patient and medicines management. To be reviewed as part of RCEM audit to determine required actions Pain scores to be monitored as part of safety checks	Partially complete (Overdue)
Must Do	The trust must improve the multidisciplinary working and culture between the department and specialities and speciality teams to maximise patient care and outcomes. (Regulation 12 (2) (i); Regulation 17 (2) (a))	MD2 0/1	Ms Bongi Gbadebo	Accident and Emergency	The Medicine Care Group will review current MDT working arrangements in the RLI ED to identify and implement improvements, including the design and development of a new priority admissions unit (PAU).	Partially complete
Must Do	The department must ensure that all known risks are singularly identified on the risk register and that risks are supported by robust action plans that can reduce or mitigate the risks. They must also ensure that these action plans are regularly reviewed to ensure effectiveness and action plans amended where progress cannot be achieved. (Regulation 17 (2) (b))	MD2 1/1	Mrs Diane Smith	Accident and Emergency	The Medicine Care Group will review all risks in line with the business plan to ensure risk have been identified and properly captured on the risk registers with appropriate mitigation in place	Fully complete (Approved)
Must Do	The department must ensure that all known risks are singularly identified on the risk register and that risks are supported by robust action plans that can reduce or mitigate the risks. They must also ensure that these action plans are regularly reviewed to ensure effectiveness and action plans amended where progress cannot be achieved. (Regulation 17 (2) (b))	MD2 1/2	Ms Bongi Gbadebo	Accident and Emergency	The Medicine Care Group will ensure a regular review of risk registers is built in with the Health and Safety & Risk team to provide review and challenge, ensure a process with the Clinical Governance Team for identifying and agreeing new risks.	Partially complete (Overdue)
Must Do	The department must ensure that all known risks are singularly identified on the risk register and that risks are supported by robust action plans that can reduce or mitigate the risks. They must also ensure that these action plans are regularly reviewed to ensure effectiveness and action plans amended where progress cannot be achieved. (Regulation 17 (2) (b))	MD2 1/3	Mrs Diane Smith	Accident and Emergency	The Medicine Care Group will explore possibility of risk register workshops with the Good Governance Institute (GGI) to improve the medicine risk register and associated management	Unable to complete

Must Do	The department must ensure that all known risks are singularly identified on the risk register and that risks are supported by robust action plans that can reduce or mitigate the risks. They must also ensure that these action plans are regularly reviewed to ensure effectiveness and action plans amended where progress cannot be achieved. (Regulation 17 (2) (b))	MD2 1/4	Mr Stuart Bates	Accident and Emergency	The Trust will implement and embed new Trust Wide Risk Management Strategy, New Risk Management Group and associated Risk Management Process, to ensure this is embedded throughout the organisation.	Fully complete (Approved)
Must Do	The trust must implement an effective risk and governance system for the whole stroke pathway. (Regulation 17 (1) & (2) (a) & (b))	MD2 9/1	Mrs Melanie Woolfall	Medicine	All recommendations related to the stroke treatment pathway are being managed under the Action Plan that Trust has developed to address the section 31 improvement work, this action plan is overseen by the Chief Operation Officer and its progress is monitored at / reported to Trust Management Group and Partner Organisations.	Partially complete
Must Do	The trust must operate an effective clinical escalation system to ensure stroke care and treatment is assessed and implemented in a timely way. (Regulation 12 (1) & (2) (a) & (b))	MD3 0/1	Mrs Melanie Woolfall	Medicine	All recommendations related to the stroke treatment pathway are being managed under the Action Plan that Trust has developed to address the section 31 improvement work, this action plan is overseen by the Chief Operation Officer and its progress is monitored at / reported to Trust Management Group and Partner Organisations	Partially complete
Must Do	The trust must implement an effective system to ensure that all clinical staff have the knowledge, competence, skills and experience to care for and provide treatment to patients presenting with symptoms of stroke. (Regulation 18 (2) (a))	MD3 1/1	Mrs Melanie Woolfall	Medicine	All recommendations related to the stroke treatment pathway are being managed under the Action Plan that Trust has developed to address the section 31 improvement work, this action plan is overseen by the Chief Operation Officer and its progress is monitored at / reported to Trust Management Group.	Partially complete
Must Do	The trust must continue to monitor and take appropriate actions to improve average length of patient stay for patients having trauma and orthopaedics surgery. (Regulation 12 (1))	MD3 2/2	Mr Daniel Bakey	Surgery and Critical Care Services	The Trust has established a number of Work streams in the Accelerator/ Restore and Recovery Programme to help improve (reduce) the average length of stay of patients (including T&O Patients), the Work Streams are; Cancer services, Outpatients, Diagnostics and Elective Inpatients	Partially complete (Overdue)
Must Do	The trust must continue to monitor and take actions to improve referral to treatment waiting time performance in line with national standards. (Regulation 12 (1))	MD3 3/1	Mr Scott McLean	TRUSTWIDE	The Trust has established a number of workstreams within the Covid Recovery Programme which will help improve RTT performance, these include; Cancer services , Outpatients , Diagnostics and Elective Inpatients	Fully complete (Approved)

Must Do	The trust must continue to monitor and take actions to improve referral to treatment waiting time performance in line with national standards. (Regulation 12 (1))	MD3 3/2	Miss Leanne Cooper	TRUSTWIDE	Trust RTT performance is monitored via the Trust IPR (Integrated Performance Report), Care Groups also report on their RTT performance at monthly Care Group Performance Reviews Overall Trust RTT performance (18 week wait) at March/April 2022 was ~70% Trust will be involved in NHS Wide '2022-23 Delivery Plan for COVID-19 Elective Backlog'. Key Targets for 2022-23 are; Elimination of 104 Week Waits, Elimination of 78 Week Waits	Fully complete (Approved)
Must Do	The trust must continue to monitor and take actions to improve referral to treatment waiting time performance in line with national standards. (Regulation 12 (1))	MD3 3/3	Miss Leanne Cooper	TRUSTWIDE	Trust RTT performance is monitored via the Trust IPR (Integrated Performance Report), Care Groups also report on their RTT performance at monthly Care Group Performance Reviews Trust will be involved in NHS Wide 'Delivery Plan for COVID-19 Elective Backlog'. Key Target: Elimination of 52 Week Waits by March 2025	In progress
Must Do	The service must ensure staff have access to up-to-date and evidence-based guidelines and policies. (Regulation 12 (1))	MD3 6/1	Mrs Tracey Roberts Cuffin	Maternity Service	The Maternity Service will work with the Trust Policy Co-ordinator to Implement and deliver a review and update of the service's Procedural Documents to ensure all guidelines are up to date (outcome measures: to achieve 95% target). Priority will be given to any 'High Risk' Guidelines that are overdue for review.	Partially complete
Must Do	The service must ensure staff have access to up-to-date and evidence-based guidelines and policies. (Regulation 12 (1))	MD3 6/3	Dr Owen Galt	Maternity Service	The Maternity Service will work with Trust NICE Lead to Implement and deliver a review and update of the service's Procedural Documents to ensure they are aligned with prevailing NICE Guidance Documents	Partially complete
Must Do	The service must ensure staff have access to up-to-date and evidence-based guidelines and policies. (Regulation 12 (1))	MD3 6/4	Ms Heather Gallagher	Maternity Service	To review and update any out of date, high-risk, emergency guidelines.	Partially complete
Must Do	The service must ensure all women assessed as at risk of having sepsis receive care and treatment in line with national guidance and requirements. (Regulation 12 (1))	MD3 7/1	Mr Mark Davies	Maternity Service	The Maternity Service will work with the Trust Acute Care Team and the Trust Clinical Audit Team to undertake a Re-audit of the sepsis management of all expectant mothers against national standards, a post audit action plan will be developed and implemented to address any performance issues.	Partially complete (Overdue)

Must Do	The service must ensure all women assessed as at risk of having sepsis receive care and treatment in line with national guidance and requirements. (Regulation 12 (1))	MD3 7/3	Mr Mark Davies	Women and Children's Services	The Service appointed Consultant Obstetrician will work with the Trust NICE Lead to review the sepsis guidance to ensure it is aligned with national NICE guidance.	Partially complete
Must Do	The service must continue to develop a vision and strategy through engagement with staff, focused on sustainability and aligned to local plans within the wider health economy. (Regulation 17 (1) (2) (a) (e))	MD3 8/1	Mrs Linda Womack	Maternity Service	The Maternity Service will work with patients, staff and partner organisations to undertake a sustainability focussed review and update of the Maternity Vision and Strategy. To link in local plans to ensure we are fitting with the wider health economy and any recommendations as a result of Ockenden	Partially complete
Must Do	The service must continue to develop a vision and strategy through engagement with staff, focused on sustainability and aligned to local plans within the wider health economy. (Regulation 17 (1) (2) (a) (e))	MD3 8/3	Mrs Tamsin Cripps	Women and Children's Services	OS Action - The Trust and the WACS Care Group will work in conjunction with the Maternity Safety Support Programme (MSSP) to develop and implement improvements in the Trusts Maternity Services, to include; Improvement in Maternity Dashboard Metrics, Safe escalation and transfer ,Sepsis care and identification of the deteriorating patient and Implementation of CQC Must Do's Recommendations	Unable to complete
Must Do	The trust must ensure they establish and operate effective governance processes and systems, with robust action plans to monitor and improve the safety and quality of services and mitigate risks to women and families using the service. (Regulation 17 (1) (2) (a) (b))	MD3 9/1	Ms Heather Gallagher	Maternity Service	The Maternity Service will work with the Corporate Governance Team and Good Governance institute (GGI) to deliver and embed the new Trust Wide governance processes and systems within the Care Group (See also 91/1)	Unable to complete
Must Do	The trust must ensure they establish and operate effective governance processes and systems, with robust action plans to monitor and improve the safety and quality of services and mitigate risks to women and families using the service. (Regulation 17 (1) (2) (a) (b))	MD3 9/3	Ms Heather Gallagher	Maternity Service	To develop and implement a governance Maternity Risk Strategy which aligns to the wider Trust Risk Strategy	Partially complete (Overdue)
Must Do	The trust must ensure they establish and operate effective governance processes and systems, with robust action plans to monitor and improve the safety and quality of services and mitigate risks to women and families using the service. (Regulation 17 (1) (2) (a) (b))	MD3 9/4	Mrs Tamsin Cripps	Maternity Service	OS Action - The Trust and the WACS Care Group will work in conjunction with the Maternity Safety Support Programme (MSSP) to develop and implement improvements in the Trusts Maternity Services, to include; Improvement in Maternity Dashboard Metrics, Continuity of care, Safe escalation and transfer ,Sepsis care and identification of the deteriorating patient and Implementation of CQC Must Do's Recommendations	In progress

Must Do	The trust must ensure that staff in the service adhere to trust infection prevention and control policy in the use of personal protective equipment and maintain patient and staff safety through social distancing at all times and in all areas. (Regulation 12(1)(2)(h))	MD4 6/1	Mrs Melanie Woolfall	Accident and Emergency	Prevailing and COVID specific IPC/PPE Policies already in place, monitoring through Spot Checks and Audits already in place. The service will re-communicate requirements to increase staff awareness and to encourage staff to actively challenge and/or report non-compliance, reported or identified incidents of non-compliance to be investigated and resolved.	Partially complete (Overdue)
Must Do	The service must ensure they participate in clinical audit to demonstrate the effectiveness of care and treatment. (Regulation 17(1))	MD4 7/1	Mr Paul Smith	Accident and Emergency	The Care Group will participate in Clinical Audit as required and the Medicine Care Group will ensure that Clinical audit is tracked through the Care Group MGAG Meeting to ensure participation, timely data submission and implementation of post Audit Action Plans. Audit Progress will also be shared with and/or reported at Trust Clinical Audit Meeting. In particular; RCEM, SSNAP and TARN Audits	Partially complete (Overdue)
Must Do	The service must ensure they participate in clinical audit to demonstrate the effectiveness of care and treatment. (Regulation 17(1))	MD4 7/2	Mrs Heather Pratt	Accident and Emergency	The Trust Clinical Audit Team will review and update Trust Wide Clinical Audit processes, to include; Implement and Embed new Clinical Audit Governance structure as required from the Trust Wide GGI Governance Review, to ensure consistent Ward To Board processes and escalation and to appoint a National Audit Co-ordinator within the Trust Clinical Audit Team.	Fully complete (Approved)
Must Do	The service must ensure that care is provided in line with national performance standards for waiting times from referral to treatment and arrangements to admit, treat and discharge patients. (Regulation 12(1)(2)(i))	MD4 8/1	Miss Leanne Cooper	Accident and Emergency	Plans has been developed as part of the BHACP UEC Programme, it has been signed off by A&E Delivery Board and now has additional PMO support to help its delivery. A robust improvement programme that facilitates patient flow corporately is in place and delivered in line with the Urgent Care action plan. (See MD16/1 also)	Fully complete (Approved)
Must Do	The trust must ensure that, patients with mental health concerns are seen in a timely way (Regulation 12(1)(2)(i))	MD4 9/1	Miss Leanne Cooper	Accident and Emergency	The Service Mental Health improvement projects are being managed within the Bay Health and Care Partners (BHACP) Urgent and Emergency Care (UEC) Improvement Programme under the Pre Hospital/A&E avoidance programme. The BHACP UEC Improvement Plan includes input from local MH Trust (Lancashire and South Cumbria Trust) and local Police Forces.	Fully complete (Approved)

Must Do	The trust must ensure that, patients with mental health concerns are seen in a timely way (Regulation 12(1)(2)(i))	MD4 9/2	Ms Emma Fitton	Accident and Emergency	The BHACP UEC Improvement Programme includes implementation of MHUAC services, actions specific to FGH ED include: Implementation of an additional mental health post at FGH ED to support frequent attender service, introduction of Street triage service with Cumbria police in October 2021. This service will run Tues to Fri (twilight) as this is when the majority of 136s occur. This service will hopefully have a positive impact on the number of patients with mental health problems presenting at ED.	Fully complete (Approved)
Must Do	The trust must ensure pain is assessed in line with clinical standards, administered in a timely way and recorded in patient notes. (Regulation 12(1)(2)(i))	MD5 0/1	Mrs Melanie Woolfall	Accident and Emergency	The Medicine Care Group will manage this recommendation through the fundamentals work on managing a deteriorating patient and medicines management. To be reviewed as part of RCEM audit to determine required actions Pain scores to be monitored as part of safety checks	Fully complete (Awaiting approval)
Must Do	The trust must ensure all patients are clinically assessed and National Early Warning Scores are documented for all patients. (Regulation 12(1)(2)(i))	MD5 1/1	Mrs Melanie Woolfall	Accident and Emergency	The Medicine Care Group will manage this recommendation through the fundamentals work on managing a deteriorating patient and medicines management	Fully complete (Awaiting approval)
Must Do	The trust must ensure all relevant staff have completed Paediatric Advanced Life Support when supporting paediatric provision in the emergency department. (Regulation 12(1)(2)(i))	MD5 2/1	Mrs Melanie Woolfall	Accident and Emergency	The Medicine Care Group will review resuscitation training requirements / standards in relation to paediatric training and develop a plan for compliance where necessary	Partially complete (Overdue)
Must Do	The trust must review the service's paediatric staffing provision, including the environment they wait in and the paediatric nursing and medical cover in line with The Royal College of Paediatrics and Child Health (RCPCH) Standards for Children and Young People in Emergency settings (2012) (Regulation 18(1))	MD5 3/1	Ms Bongi Gbadebo	Accident and Emergency	The Trust has a programme of work for reviewing compliance with the 'Facing The Future' requirements and to deliver improvements, which is reported through to MGAG. This will include Medical and Nursing staffing levels and paediatric environment at FGH ED. This Action is for Medical Staffing Levels.	Partially complete (Overdue)
Must Do	The trust must review the service's paediatric staffing provision, including the environment they wait in and the paediatric nursing and medical cover in line with The Royal College of Paediatrics and Child Health (RCPCH) Standards for Children and Young People in Emergency settings (2012) (Regulation 18(1))	MD5 3/2	Mrs Melanie Woolfall	Accident and Emergency	The Trust has a programme of work for reviewing compliance with the 'Facing The Future' requirements and to deliver improvements, which is reported through to MGAG. This will include Medical and Nursing staffing levels and paediatric environment at FGH ED. This Action is for Nursing Staffing Levels.	Partially complete (Overdue)

Must Do	The trust must review the service's paediatric staffing provision, including the environment they wait in and the paediatric nursing and medical cover in line with The Royal College of Paediatrics and Child Health (RCPCH) Standards for Children and Young People in Emergency settings (2012) (Regulation 18(1))	MD5 3/3	Ms Bongi Gbadebo	Accident and Emergency	The Trust has a programme of work for reviewing compliance with the 'Facing The Future' requirements and to deliver improvements, which is reported through to the A&E delivery Board. This will include Medical and Nursing staffing levels and paediatric environment at FGH ED. This Action is for paediatric environment.	Partially complete (Overdue)
Must Do	The trust must take action to improve safeguarding adults and safeguarding children level three training rates for doctors and nurses. (Regulation 18(1))	MD5 4/1	Mrs Melanie Woolfall	Accident and Emergency	The Medicine Care Group will review Safeguarding guidance / training requirements against current compliance and ensure robust plan in place in conjunction with the Safeguarding Team	Partially complete (Overdue)
Must Do	The trust must operate an effective clinical escalation system to ensure stroke care and treatment is assessed and implemented in a timely way. (Regulation 12 (1) & (2) (a) & (b))	MD5 8/1	Mrs Melanie Woolfall	Medicine	All recommendations related to the stroke treatment pathway are being managed under the Action Plan that Trust has developed to address the section 31 improvement work, this action plan overseen by the Chief Operation Officer and its progress is monitored at / reported to Trust Management Group.	Partially complete
Must Do	The trust must implement an effective system to ensure that all clinical staff have the knowledge, competence, skills and experience to care for and provide treatment to patients presenting with symptoms of stroke. (Regulation 18 (2) (a))	MD5 9/1	Mrs Melanie Woolfall	Medicine	All recommendations related to the stroke treatment pathway are being managed under the Action Plan that Trust has developed to address the section 31 improvement work, this action plan is overseen by the Chief Operations Officer and its progress is monitored at / reported to Trust Management Group.	Partially complete
Must Do	The service must ensure there are sufficient maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. (Regulation 18 (1)(2)(a))	MD6 6/1	Mrs Tamsin Cripps	Maternity Service	To complete a robust workforce plan agreed by Trust Board based on the outcomes of the Birth Rate Plus Review.	Partially complete
Must Do	The service must ensure there are sufficient maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. (Regulation 18 (1)(2)(a))	MD6 6/2	Ms Heather Gallagher	Maternity Service	Review and complete a maternity training plan to include Core Skills Framework, job essential training and core competency training	Partially complete (Overdue)
Must Do	The service must ensure medical staff complete all required safeguarding level 3 training. (Regulation 18 (1)(2)(a))	MD6 7/1	Mr Mark Davies	Maternity Service	The Maternity Service will ensure medical staff complete safeguarding level 3 training in a timely manner and in line with Trust targets	Partially complete (Overdue)

Must Do	The service must ensure risk assessments are completed and are actions taken to minimise any risks identified (Regulation 12(1)(2)(a) (b))	MD6 8/1	Mrs Tamsin Cripps	Maternity Service	The Maternity Service will complete its existing work programme to move all risk assessments into the Local ICS 'BadgerNet' Maternity System and to establish; an auditing process for the Risk assessments held in BadgerNet and to review and update existing escalation processes in light of the introduction of BadgerNet	Partially complete (Overdue)
Must Do	The service must ensure risk assessments are completed and are actions taken to minimise any risks identified (Regulation 12(1)(2)(a) (b))	MD6 8/2	Ms Heather Gallagher	Maternity Service	To develop a process to ensure appropriate risk assessments are carried out throughout the pregnancy journey	Partially complete (Overdue)
Must Do	The service must ensure appropriate systems are used for maintaining accurate, complete and contemporaneous records for service users (Regulation 17(2)(c))	MD7 0/1	Mrs Tamsin Cripps	Maternity Service	The Maternity Service will implement the Local ICS 'BadgerNet' Maternity System	Fully complete (Approved)
Must Do	The service must ensure appropriate systems are used for maintaining accurate, complete and contemporaneous records for service users (Regulation 17(2)(c))	MD7 0/2	Ms Heather Gallagher	Maternity Service	The Maternity Service will further strengthen existing processes for record keeping, undertake appropriate audit and external checks of these processes.	Partially complete (Overdue)
Must Do	service must ensure staff assess the risks to women during and after birth in order to identify women at risk of deterioration. (Regulation 12 (1) (2) (a))	MD8 4/1	Mrs Linda Womack	Maternity Service	The Maternity Service will undertake an Audit of MOEWS at HHCMU to confirm compliance levels with this recommendation and, if required, will then review and the relevant guidance documents for HCMU and undertake staff awareness and training that is required.	Fully complete (Approved)
Must Do	The service must ensure that women presenting in labour have immediate access to suitable qualified and skilled midwifery staff. (Regulation 18 (1))	MD8 5/1	Mrs Linda Womack	Maternity Service	Recommendation relates to the Helme Chase Maternity Unit (HCMU), which is is a Mid Wife Led Unit. WACs Care Group will review the service provision at HCMU and confirm whether it is concordant with the prevailing national standards/requirements for a Mid Wife Led Maternity Unit.	Partially complete (Overdue)
Must Do	The service must ensure that women presenting in labour have immediate access to suitable qualified and skilled midwifery staff. (Regulation 18 (1))	MD8 5/2	Mrs Linda Womack	Maternity Service	The Maternity Service will look at recruitment and retention strategy for Helme Chase Maternity Unit and deliver an improved trajectory for education and training for Helme Chase Maternity Unit, as part of wider Maternity Service strategy	Partially complete (Overdue)

Must Do	The service must ensure staff assess and mitigate the risks to women's health and safety in an emergency situation either during home birth or at the unit. They must ensure appropriate escalation and transfer takes place. (Regulation 12 (1) (2) (a) (b))	MD8 6/1	Mrs Linda Womack	Maternity Service	The Maternity Service will review and update the Operational Policy Document(s) for the Helme Chase Maternity Unit and ensure the documents are aligned with relevant standards.	Partially complete (Overdue)
Must Do	The service must ensure staff assess and mitigate the risks to women's health and safety in an emergency situation either during home birth or at the unit. They must ensure appropriate escalation and transfer takes place. (Regulation 12 (1) (2) (a) (b))	MD8 6/2	Mrs Linda Womack	Maternity Service	The Maternity Service will meet with North West Ambulance Service (NWAS) to discuss and agree dates for skills drills/training to take place.	Partially complete (Overdue)
Must Do	The service must ensure all equipment is properly maintained and that staff do not use equipment that is not safe nor used for its intended purpose. Specifically, they should not use a domestic bath to support water birth. All staff should be aware of the birthing pool emergency evacuation process and have access to the required equipment at all times. (Regulation 12 (1) (d) & (e))	MD8 8/1	Mrs Linda Womack	Maternity Service	The Maternity Service have confirmed that; the domestic bath has not been used since 2014, it has been very clearly identified as being 'out of order' and will now be de-commissioned, an SOP for the evacuation of the Birthing Pool is in place, staff awareness and training took place in August 2021 - Action Completed	Fully complete (Awaiting approval)
Must Do	The trust must ensure they establish and operate effective governance processes and systems, with robust action plans to monitor and improve the safety and quality of services and mitigate risks to women and families using the service. (Regulation 17 (1) (2) (a) & (b))	MD9 1/1	Ms Heather Gallagher	Maternity Service	The Maternity Service will further strengthen local governance and assurance processes in line with the Trust's internal Governance Review and established Maternity best practice and work with the national maternity and safety improvement team to review and develop any additional improvements identified (see also 39/1)	Partially complete (Overdue)
Must Do	The service must ensure they deploy sufficient suitably competent and experienced staff and ensure all staff receive appropriate skills and drills training and professional development to enable them to maintain competency given the low numbers of deliveries. (Regulation 18 (1) (2) (a))	MD9 2/1	Mrs Tamsin Cripps	Maternity Service	The Maternity Service will implement a training plan to ensure that staff at the Helme Chase Maternity Unit have the appropriate skills and competency to provide care and treatment to the low risk births / expectant mothers treated at the Helme Chase Maternity Unit.	Partially complete (Overdue)
Must Do	The service must ensure effective systems are in place to assess and mitigate individual patient safety risks. Regulation 12 (1)(2)(a) and (b): Safe care and treatment	MD9 6/1	Ms Bongi Gbadebo	Medicine	The Service will investigate moving one ward from Medical Unit 2 to a new purpose built frailty unit in Medical Unit 1 (action under review in reference to the recommendation)	Partially complete
Must Do	The service must ensure effective systems are in place to assess and mitigate individual patient safety risks. Regulation 12 (1)(2)(a) and (b): Safe care and treatment	MD9 6/2	Mrs Emily Henry-Farncombe	Medicine	The Service will undertake additional building work on the existing wards in Medical Unit 2 to enhance the accommodation	Partially complete (Overdue)

Must Do	The service must ensure people are kept free from harm. Regulation 13(5) Safeguarding service users from abuse and improper treatment	MD9 7/1	Mrs Melanie Woolfall	Medicine	The Medicine Care Group will review Safeguarding guidance / training requirements against current compliance and ensure robust plan in place in conjunction with the Safeguarding Team to ensure service users are kept free from harm	Partially complete (Overdue)
Must Do	The service must ensure nurse staffing levels meet the minimum standards of the National Institute of Health and Care Excellence. Regulation 18 (1): Staffing.	MD9 8/1	Mrs Melanie Woolfall	Medicine	The Service will recruit a new Advanced Nurse Practitioner to improve the care offered to patients. This will form part of a wider staffing review to ensure there is adequate nursing staffing within the service.	Partially complete (Overdue)
Must Do	The service must ensure nurse staffing levels meet the minimum standards of the National Institute of Health and Care Excellence. Regulation 18 (1): Staffing.	MD9 8/2	Mr Tony Crick	Medicine	Improving the care offered to patients by employing two new physiotherapists, to support Medical Wards in Medical Unit 2	Fully complete (Approved)
Must Do	The service must ensure medical staffing levels meet the minimum standards of the Royal College of Physicians. Regulation 18 (1): Staffing	MD9 9/1	Mr Scott Bremner	Medicine	To service will undertake a medical staffing review to ensure staffing levels are meeting RCP minimum standards. Findings to be reported via MGAG with actions put in place to recruit to roles where necessary.	Fully complete (Approved)
Must Do	The trust must ensure there is full oversight of services offered by the care group through robust governance processes. Regulation 17(2)(a): Good Governance	MD1 00/1	Mr Richard Sachs	Medicine	The Trust will complete the GGI review of Governance Meeting Structures, Reporting and Escalation	Fully complete (Awaiting approval)
Must Do	The trust must ensure there is full oversight of services offered by the care group through robust governance processes. Regulation 17(2)(a): Good Governance	MD1 00/2	Mr Stuart Bates	Medicine	The Trust has completed an Initial Section 26 / Notice of Proposal evidence submission detailing the actions taken to address governance processes and ensure they are robust and will be sustained	Fully complete (Approved)
Must Do	The service must ensure effective systems are in place to monitor discharges to prevent patients from becoming deconditioned. Regulation 17 (1)(2)(b): Good governance	MD1 01/1	Ms Bongi Gbadebo	Medicine	The service will review current systems in place for patient discharges and seek to improve the monitoring and escalation processes to help prevent patients from becoming deconditioned.	Partially complete (Overdue)

Must Do	The service must ensure effective systems are in place to monitor discharges to prevent patients from becoming deconditioned. Regulation 17 (1)(2)(b): Good governance	MD1 01/2	Mr Paul Smith	Medicine	Clinical Director and/or Director Nursing of Medicine Care Group to issue a communication to Medicine Care Group staff who work in Medical Unit 2, to instruct that non Trust system (e.g. Whats App) cannot be used as tools for communication about patients or for the escalation of concerns regarding patients. Any practical issues with the communication about patients or for the escalation of concerns regarding patients located in Med Unit 2 at the RLI should be escalated to the Trust's Chief Information Officer and Chief Clinical Information Officer and alerted to the Trust Management Group for immediate action and resolution.	In progress
Must Do	The service must ensure there are effective systems are in place to consistently assess, monitor and improve patient safety and the quality of care. Regulation 17 (1)(2)(a) and (b): Good governance	MD1 02/1	Mrs Diane Smith	Medicine	Review the systems and processes that are in place to assess and monitor safety and quality of care	Partially complete
Must Do	The service must ensure there are effective systems are in place to consistently assess, monitor and improve patient safety and the quality of care. Regulation 17 (1)(2)(a) and (b): Good governance	MD1 02/2	Mrs Melanie Woolfall	Medicine	Medical Care Group to ensure that there are improvements in the completion and review of monitoring assessments and risk assessments for individual patients on the Medical Wards in Med Unit 2 from August 2021 to December 2022.	In progress
Must Do	The service must ensure there are effective systems are in place to consistently assess, monitor and improve patient safety and the quality of care. Regulation 17 (1)(2)(a) and (b): Good governance	MD1 02/3	Mrs Melanie Woolfall	Medicine	Medicine Care to ensure that the escalation of concerns on the Medical Wards in Med Unit 2 can be appropriately integrated into and reported through the Care Group and Trust Governance structures.	In progress
Must Do	The service must ensure there are effective systems are in place to consistently assess, monitor and improve patient safety and the quality of care. Regulation 17 (1)(2)(a) and (b): Good governance	MD1 02/4	Ms Debbie Crawford	Medicine	Medicine Care Group to work with Radiology to improve the performance in achieving the 1 Hour Target for Stroke CT's for patients located in the Medical Wards in Medical Unit 2 at the RLI.	In progress
Must Do	The trust must ensure continued development and investment in pharmacy resources to make sure medicines reconciliation rates and antimicrobial stewardship are improved across the trust. (Regulation 12 (2) (g))	MD1 14/1	Mrs Kam Mom	Pharmacy	Recommendation to be reviewed with Chief Pharmacist, Medication Safety Officer and ADOp of CCS to determine; a) is the is the same recommendation as MD6 b) if it is the same recommendation, are there any new actions required?	Partially complete

					c) if no no new actions are required this new recommendation will be managed through MD6	
Must Do	The trust must ensure that antimicrobial prescribing guidelines are consistently followed. (Regulation 12 (2) (g))	MD1 15/1	Mrs Kam Mom	Pharmacy	Recommendation reviewed with Chief Pharmacist, Medication Safety Officer and ADOp of CCS, to consider whether this recommendation is already being addressed through Recommendation MD6 and/or MD114 (The trust must ensure continued development and investment in pharmacy resources to make sure medicines reconciliation rates and antimicrobial stewardship are improved across the trust.)	Partially complete
Must Do	The trust must ensure that antimicrobial prescribing guidelines are consistently followed. (Regulation 12 (2) (g))	MD1 15/2	Mrs Kam Mom	Pharmacy	Anti-Microbial Stewardship Pharmacists and Pharmacy Technicians to undertake a review of the Trust Antimicrobial prescribing Guidelines to ascertain if the documents are up to date and fit for purpose, if the review identifies any changes that are required the Anti-Microbial Stewardship Pharmacists and Pharmacy Technicians will then liaise with the Document Authors and the Procedural Document Team to ensure the documents are promptly updated and re-issued. PHARM/GUID/003 - Antimicrobial Paediatrics Guideline CORP/GUID/060 - Antibiotic Prescribing in Surgery CORP/GUID/061 - Antibiotic Prescribing for Medicine	In progress
Must Do	The trust must ensure that antimicrobial prescribing guidelines are consistently followed. (Regulation 12 (2) (g))	MD1 15/3	Mrs Kam Mom	Pharmacy	Pharmacy to complete Audit 2763 Audit of Agreed Antimicrobial Use, results of Audit to reported at Medication Safety Group and shared with Care Groups, Audit results will confirm if antimicrobial prescribing guidelines are being followed. Pharmacy to investigate if data collected for 2022/23 Qtr1 could be used to provide a preliminary assessment to identify any high risk issues or high risk areas, so that interim remedial actions can be undertaken.	Partially complete

Must Do	The trust must ensure that antimicrobial prescribing guidelines are consistently followed. (Regulation 12 (2) (g))	MD1 15/4	Ms Jane McNicholas	Pharmacy	Chief Pharmacist, in conjunction with Chief Medical Officer and the Director of Infection Prevention and Control, will issue an immediate communication to all prescribers to inform them that the CQC Inspection Report contains a Must Do Recommendation on 'Ensuring that antimicrobial prescribing guidelines are consistently followed' and that as prescribers they should ensure they are aware of the the Trust's antimicrobial prescribing guidelines and ensure they followed, with any clinical concerns and issues with the guidelines being appropriately escalated.	In progress
Must Do	The trust must ensure that patient's privacy is upheld. Regulation 10(1)(2)(a)	MD1 21/1	Ms Bongi Gbadebo	Accident and Emergency	Compliance and Assurance Team and Medicine Care Group Triumvirate to undertake review Recommendation MD121 to determine if this recommendation is a 'duplicate' of the existing Recommendation MD18 from the August 2021 Inspection report. If it is determined that recommendation MD121, it will then be decided if the existing action plan to address Recommendation MD18 is sufficient to address both Recommendations, or if Recommendation MD121 requires an independent action plan.	Partially complete
Must Do	The trust must ensure that patient records are stored in a secure manner and can be accessed by staff. Regulation 17(1)(2)(c)	MD1 22/1	Mrs Melanie Woolfall	Accident and Emergency	Medicine Care Group Action Plan to improve IG compliance at FGH ED Issue Immediate communication to FGH ED staff to inform them that the CQC have issued a Must Do Recommendation to improve Information Governance in the Department.	Partially complete
Must Do	The trust must ensure that patient records are stored in a secure manner and can be accessed by staff. Regulation 17(1)(2)(c)	MD1 22/2	Mrs Melanie Woolfall	Accident and Emergency	Medicine Care Group Action Plan to improve IG compliance at FGH ED Continue with ongoing communication to maintain staff awareness of Information Governance and Patient Confidentiality.	In progress
Must Do	The trust must ensure that patient records are stored in a secure manner and can be accessed by staff. Regulation 17(1)(2)(c)	MD1 22/3	Mrs Melanie Woolfall	Accident and Emergency	Medicine Care Group Action Plan to improve IG compliance at FGH ED Continue with spot checks of IG compliance through Matron Audits and Service Reviews.	In progress

Must Do	The trust must ensure that patient records are stored in a secure manner and can be accessed by staff. Regulation 17(1)(2)(c)	MD1 22/4	Mrs Melanie Woolfall	Accident and Emergency	Medicine Care Group Action Plan to improve IG compliance at FGH ED Undertake an Audit of IG compliance at FGH ED, by end of August 2022, with results to reported by to Care Group Governance meeting and Care Group Management meeting In September 2022 Any Items of significant concern will also be escalated to the Information Governance & Data Quality Group.	Partially complete
Must Do	The trust must ensure that patient records are stored in a secure manner and can be accessed by staff. Regulation 17(1)(2)(c)	MD1 22/5	Mrs Melanie Woolfall	Accident and Emergency	Medicine Care Group Action Plan to improve IG compliance at FGH ED Schedule a Re-Audit of IG Compliance in the FGH ED, to take place in 2023, to monitor for improvements. Audit specification to state that; results to be reported by to the Care Group Governance meeting and Care Group Management meeting, and any Items of significant concern will also be escalated to the Information Governance & Data Quality Group.	In progress
Must Do	The service must ensure that care and treatment is provided in a safe way by the proper and safe management of medicines. Regulation 12 (1) (2) (g)	MD1 26/1	Mrs Kam Mom	Accident and Emergency	To Recruit and deploy Pharmacists and Pharmacy Technicians dedicated to support and to improve Medicine Management within the Emergency Departments at FGH and RL 2 FTE Pharmacist(s) at FGH ED 2 FTE Pharmacy Technicians at FGH ED 1 FTE Pharmacist(s) at RLI ED 2 FTE Pharmacy Technicians at RLI ED	Partially complete
Must Do	The service must ensure that care and treatment is provided in a safe way by the proper and safe management of medicines. Regulation 12 (1) (2) (g)	MD1 26/2	Mrs Kam Mom	Accident and Emergency	Medicine Care Group and Pharmacy to work together to develop and implement a business case to replace the Mediwell Drug storage systems used in the Emergency Departments at FGH and RLI.	Partially complete
Must Do	The service must ensure that patients are treated with dignity and respect. Including ensuring their privacy and having due regard to any relevant protected characteristics. Regulation 10 (1) (2) (a) (c)	MD1 27/1	Ms Bongi Gbadebo	Accident and Emergency	Compliance and Assurance Team to review this recommendation with with members of the Medicine Care Group Triumvirate to determine if it is a 'duplicate' of Recommendation MD121, and if it is a duplicate whether a separate action is required or not.	Partially complete

Must Do	The service must ensure that all premises and equipment used by the service provider are secure and suitable for the purpose for which they are being used. Regulation 15 (1) (b)(c)	MD1 28/1	Ms Bongi Gbadebo	Accident and Emergency	In light of the prevailing Capital situation and the physical constraints on the RLI site, Medicine Care Group to liaise with CEO, COO and CFO to identify any practical options and associated timescales for 'ensuring that RLI ED Premises are suitable for the purpose for which they are being used', these will then be reported back to Trust Board and the CQC Engagement Meeting. Non-Estates solutions to improvement Patient Safety Adult and Paediatric Waiting Areas and the Paediatric Treatment Areas are being investigated under Actions MD128/2 and MD128/3.	In progress
Must Do	The service must ensure that all premises and equipment used by the service provider are secure and suitable for the purpose for which they are being used. Regulation 15 (1) (b)(c)	MD1 28/2	Mrs Melanie Woolfall	Accident and Emergency	Medicine Care Group will investigate alternative solutions (not Estates Works) to improve clinical observation of Adult Patients and clinical oversight of Paediatric Patients in the waiting areas. Consideration to be given to some form of regular intentional rounding of the ED Waiting Areas by clinical staff. Risks to be updated on the risk register	In progress
Must Do	The service must ensure that all premises and equipment used by the service provider are secure and suitable for the purpose for which they are being used. Regulation 15 (1) (b)(c)	MD1 28/3	Mrs Melanie Woolfall	Accident and Emergency	Medicine Care Group will investigate alternative solutions (not Estates Works) to improve the safety of Patients in the Paediatric Treatment Area.	In progress
Should Do	The trust should ensure that Patient Group Directions oversight should be strengthened to ensure sure appropriate and timely review and implementation	SD7/ 1	Mrs Kam Mom	TRUSTWIDE	Chief Pharmacist, Trust Procedural Document Team and Chair of Drugs, Therapeutics and Medicines Management Group to continue and complete existing programme of work to review and improve the processes for the review, approval and implementation of Patient Group Directives (PGDs)	Fully complete (Approved)
Should Do	The trust should ensure that the uptake of medicines management e-learning be prioritised to help improve medicines safety	SD8/ 1	Mrs Kam Mom	TRUSTWIDE	The Pharmacy Service will implement proactive scrutiny of medicines management e-learning compliance via the Medication Safety Group and plan improvements with the Care Groups	Partially complete (Overdue)

Should Do	The trust should ensure that Electronic Prescribing and Medicines Administration (EPMA) auditing be strengthened to proactively identify prescribing and administration errors	SD9/1	Mrs Kam Mom	TRUSTWIDE	As part of GGI Governance review, confirm that Electronic Prescribing and Medicines Administration (EPMA) auditing will be part of remit of EPMA Steering Group and complete review of EPMA Steering Group Terms of Reference to including Auditing of EPMA. Chair of EPMA Steering Group to work with Trust Clinical Audit Team to establish programme of Audits with results reported back to EPMA Steering Group for post audit action plans to be developed in conjunction with Care Groups.	Fully complete (Approved)
Should Do	The trust should ensure that all staff follow infection control principles, including the use of personal protective equipment (PPE) at all times and receive refresher training in this where deemed necessary	SD2 2/1	Mrs Amy Mbuli	Accident and Emergency	Prevailing and COVID specific IPC/PPE Policies already in place, monitoring through Spot Checks and Audits already in place. The service will re-communicate requirements to increase staff awareness and to encourage staff to actively challenge and/or report non-compliance, reported or identified incidents of non-compliance to be investigated and resolved.	Partially complete (Overdue)
Should Do	The trust should consider whether they can build a separate paediatric treatment area to meet best practice guidelines	SD2 3/1	Ms Bongi Gbadebo	Accident and Emergency	The Trust has a programme of work for reviewing compliance with the 'Facing The Future' requirements and to deliver improvements, which is reported through to the A&E delivery Board. This will include a review provision of paediatric services at RLI ED to determine most appropriate service design	Partially complete (Overdue)
Should Do	The trust should consider whether the triage service in the walk-in waiting area can be improved so that the triage nurse can observe patients in the waiting area more easily	SD2 4/1	Mr Richard Vallely	Accident and Emergency	The Medicine Care Group will, in conjunction with the RLI Estates Team, undertake a review of the RLI ED triage area and develop improvement plan	Fully complete (Awaiting approval)
Should Do	The trust should consider ensuring that there is a doctor or consultant at all safety huddles so that clinical information is not omitted from being shared with nursing staff.	SD2 5/1	Ms Bongi Gbadebo	Accident and Emergency	The Medicine Care Group will review records of Medical attendance at Safety huddles and consider the feasibility of requiring Medical attendance at all safety huddles at RLI ED. The Service will then undertake a review of the safety huddle process and will review and update the Safety Huddle SOP if required.	Partially complete (Overdue)
Should Do	The trust should ensure that a more robust system of assessing skin integrity and pressure sores is put in place rather than the “safe and seen” assessment used presently.	SD2 6/1	Mrs Melanie Woolfall	Accident and Emergency	The Medicine Care Group will undertake comparative Audits of the 'Waterlow' risk assessments against the 'Seen & Safe' risk assessments to identify the most appropriate documentation method. The more robust method for assessing Tissue Viability will then be	Partially complete (Overdue)

					implemented, with procedural documents to updated accordingly	
Should Do	The trust should consider giving emergency department managers access to view incidents that are graded no harm or low harm, in order that there is complete oversight of incidents in the department to ensure that they have been graded correctly or may meet the criteria for a serious incident	SD27/1	Mrs Melanie Woolfall	Accident and Emergency	Incident Management Policy already in place which contains detailed guidance on the grading of the harm level of incidents. Review of Incident Management System has confirmed that; ED managers already have access rights to all incidents in the ED, have access rights to re-grade the harm level of these incidents and have access rights to flag these incidents as a 'Serious Incident'. ED Managers have been offered further training in the Incident Management System and grading the harm level of incidents. All Incidents graded with a Harm level of Moderate or above are also independently reviewed at the Trust Wide Weekly Patient Safety Summit.	Fully complete (Approved)
Should Do	The trust should consider giving emergency department managers access to view incidents that are graded no harm or low harm, in order that there is complete oversight of incidents in the department to ensure that they have been graded correctly or may meet the criteria for a serious incident	SD27/2	Mrs Melanie Woolfall	Accident and Emergency	RLI ED Matron to work Medicine Care Group Patient Safety Team and Trust Patient Safety Team to produce a summary of the various Patient Safety systems, processes and meetings that are in place in Medicine Care Group and the Trust which help to ensure that there is "complete oversight of incidents in the department".	In progress
Should Do	The trust should consider completing the urgent and emergency care plans that have been delayed so that these can feed into the medicine care group strategy	SD28/1	Miss Leanne Cooper	Accident and Emergency	Plans have been developed as part of the BHACP UEC Programme and signed off by A&E Delivery Board. Additional PMO support allocated to help delivery. A robust improvement programme that facilitates patient flow corporately is in place and delivered in line with the Urgent Care action plan.	Fully complete (Approved)
Should Do	The trust should consider completing the urgent and emergency care plans that have been delayed so that these can feed into the medicine care group strategy	SD28/2	Mrs Diane Smith	Accident and Emergency	Bay/Trust Wide elements being managed through Action SD28/1 by Leanne Cooper Medicine Care group are responsible for implementing two elements of the Urgent and emergency care plans; 'Front Door' and 'ED'.	Fully complete (Approved)

Should Do	The trust should take appropriate actions to improve staff mandatory training, including safeguarding training in line with trust compliance targets.	SD34/1	Mrs Carol Park	Surgery and Critical Care Services	The Surgery Care Group has improved Mandatory training compliance and is currently meeting Trust targets, the Surgery Care Group will review compliance again in 3 months time and if compliance remains high, action can be closed.	Fully complete (Approved)
Should Do	The trust should take appropriate actions to improve staff appraisal completion in line with trust compliance targets	SD35/1	Mr Daniel Bakey	Surgery and Critical Care Services	The Surgery Care Group will take steps to improve appraisal compliance through: weekly monitoring of performance at SMG, monthly monitoring at Governance Meeting, red flagging of Hot Spots, discussion in 1-to-1's with Clinical Leads and Dept/Ward Managers.	Partially complete (Overdue)
Should Do	The service should consider implementing a policy and schedule for changing the keypad code at ward entrances to maintain security	SD41/1	Mrs Linda Womack	Maternity Service	The Maternity Service at RLI will work with the Estates Team and the Security to undertake a review of the security systems, to establish the practical feasibility and implementation of Swipe Card Access, or the continuation of Key Pad Access, if Key Pad access continues a schedule of code changes will then be established and implemented.	Fully complete (Approved)
Should Do	The service should ensure the policy for cleaning of the birthing pool is ratified and implemented to control the risk of spread of infection.	SD42/1	Mrs Linda Womack	Maternity Service	The Maternity Service will review and update the organisational policy for the cleaning of the birthing pools and ensure the document complies with relevant standards	Fully complete (Approved)
Should Do	The service should ensure that recommendations from external incident investigations are fully considered and appropriate, robust action plans put in place	SD43/1	Ms Heather Gallagher	Maternity Service	The WACS Care Group Triumvirate will review recommendations from external incident investigations (including the Ockenden Report) and will then ensure that remedial action plans are robust, are monitored at Triumvirate meetings and that evidence is provided against each action.	Partially complete
Should Do	The service should act to improve the assessment of women's pain in light of their clinical condition and ensure all women receive pain relief in a timely manner	SD44/1	Mrs Claire Bowman	Maternity Service	The Maternity Service will carry out a Pain Management Audit and will develop an improvement plan once audit results are available	Partially complete
Should Do	The service should continue to act to ensure women received continuity of care in line with national recommendations and targets	SD45/1	Mrs Ruth Deery	Maternity Service	The Maternity Service will develop a continuity of care model by locality, the care model will be aligned with national recommendations and targets.	Partially complete
Should Do	The trust should consider what actions the service can take to improve safeguarding adults and safeguarding children level three training rates for doctors and nurses.	SD55/1	Ms Bongi Gbadebo	Accident and Emergency	The Medicine Care Group will review guidance / training requirements against current compliance and ensure robust plan in place in conjunction with the Safeguarding Team (action links to MD54)	Partially complete (Overdue)

Should Do	The trust should ensure senior leaders of the department have oversight of paediatric activity and performance in the ED.	SD5 6/1	Mr Neil Smith	Accident and Emergency	The Medicine Care Group will work with the Business Intelligence Team to include data on the ED paediatric activity within the Trusts command and control centre platform, and will undertake a review of the ED Safety Huddle SOP to ensure that includes ED paediatric activity.	Partially complete (Overdue)
Should Do	The trust should ensure that wards are secured to maintain patient safety	SD6 2/1	Ms Sarah Maguire	Surgery and Critical Care Services	The Surgery Care Group will obtain quote(s) to improve security on Surgery Wards at FGH. Quote obtained on day of Inspection, funding in place, need to confirm progress of Works.	Partially complete (Overdue)
Should Do	The trust should ensure that fire doors are maintained and used correctly	SD6 3/1	Mrs Carol Park	Surgery and Critical Care Services	Met with staff and ward managers. Responsibilities and accountabilities made clear and staff will be held to account re standards for their ward/ department. Daily matron checks in place Action completed	Fully complete (Approved)
Should Do	The trust should ensure that systems and processes are established and operated effectively to identify, assess, monitor, escalate and take mitigating actions, particularly in relation to the safe storage of medicine and the checking of emergency resuscitation equipment.	SD6 4/1	Ms Sarah Maguire	Surgery and Critical Care Services	The Surgery Care Group has existing processes to ensure that Resuscitation equipment is checked daily and monitored via the AMaT system. Action complete	Partially complete (Overdue)
Should Do	The trust should ensure that systems and processes are established and operated effectively to identify, assess, monitor, escalate and take mitigating actions, particularly in relation to the safe storage of medicine and the checking of emergency resuscitation equipment.	SD6 4/2	Ms Sarah Maguire	Surgery and Critical Care Services	Trust Wide Safe and secure storage of medicine (SSSM) policies and procedures already in place, annual SSSM audit undertaken by Pharmacy and reported to Medication Safety Group. Spot checks on SSSM undertaken by Matrons and Ward Managers. SSSM data collection/audit to be moved to AMAT system to enable more rigorous monitoring by Matrons and Ward Managers. The Service will communicate to staff to reiterate the importance of the SSSM and will continue with monitoring and escalation.	Partially complete (Overdue)
Should Do	The trust should ensure patient records are stored securely.	SD6 5/1	Ms Sarah Maguire	Surgery and Critical Care Services	Briefings held with staff to staff to reinforce IG and privacy requirements Daily matron checks in place, Information Governance included in Service Reviews. The majority of patient records are now electronic, Minimal paper notes remaining within locked trollies for security.	Fully complete (Approved)

Should Do	The service should act to improve the quality of safety information shared in SBAR handover.	SD7 6/1	Mrs Holly Parkinson	Maternity Service	The Maternity Service will undertake a review and update of the SOP / Guideline for SBAR Handover and ensure it is aligned with National Standards.	Partially complete
Should Do	The service should act to improve the quality of safety information shared in SBAR handover.	SD7 6/2	Mrs Linda Womack	Maternity Service	The Maternity Service will undertake a review practice of current SBAR Handover processes and identify if/how these can be re-implemented / re-energised	Partially complete
Should Do	The service should act to improve the quality of safety information shared in SBAR handover.	SD7 6/3	Mrs Linda Womack	Maternity Service	The Maternity Service will work with the Trust Clinical Audit team to undertake an annual Audit to measure compliance with SBAR guideline/ SOP and will develop remedial action plans if required undertake a yearly audit to provide assurance	Partially complete
Should Do	The service should progress actions to enable improved access within the birth centre, in context of the physical environment.	SD7 9/1	Mrs Linda Womack	Maternity Service	There are two lifts for access to the South Lakes Birth Centre; one for emergency access for trolley patients, one for ambulatory patient/family access. The Maternity Service will ensure the induction training of all new staff includes information on how to enable access the delivery suites in an emergency.	Partially complete (Overdue)
Should Do	The service should implement effective use of the whiteboard communication system on the birth centre	SD8 0/1	Mrs Tamsin Cripps	Maternity Service	The Maternity Service, in conjunction with I3 Service, will undertake a post Badger Net implementation review of the whiteboards at the South Lakes Birth Centre	Partially complete
Should Do	The trust should ensure that visible information about requesting a chaperone is available to patients attending the centre.	SD8 1/1	Mrs Diane Smith	Accident and Emergency	The Medicine Care Group will develop and implement posters/signage so patients attending the Kendal Urgent Treatment Centre are made aware that they can request a chaperone to be present during their treatment	Fully complete (Approved)
Should Do	The Trust should ensure that privacy and confidentiality is maintained for patients when sharing personal information	SD8 3/1	Mrs Melanie Woolfall	Accident and Emergency	The Medicine Care Group will brief staff at the Kendal Urgent Treatment Centre to re-iterate the importance of maintaining patient confidentiality and will then undertake a review as part of the regular matron audit to confirm compliance with patient privacy / confidentiality requirements, ensure staff are up to date with IG training. Regular monitoring at MCGAG to be established.	Partially complete (Overdue)
Should Do	The service should consider protected time to allow for the completion of mandatory training	SD9 3/1	Mrs Linda Womack	Maternity Service	The Maternity Service already schedule 4 compulsory mandatory training days per annum for all staff in Maternity Services, to help ensure ongoing compliance with mandatory training. Additional protected time for the completion of mandatory training is available to	Partially complete (Overdue)

					staff at the discretion of Department/Unit/Ward Managers.	
Should Do	The service should work to engage the workforce and increase visibility of the executive team	SD95/1	Mr Paul Jones	Maternity Service	The Trust will maintain and enhance Executive Directors presence on all sites, through a schedule of planned Executive visits/presence.	Fully complete (Approved)
Should Do	The trust should ensure that all records are securely stored	SD103/1	Mrs Melanie Woolfall	Medicine	The Medicine Care Group will brief staff at RLI Medical Unit 2 to re-iterate the importance of maintaining patient confidentiality and will then undertake a review as part of the regular matron audit to confirm compliance compliance with patient privacy / confidentiality requirements. Also check compliance with IG core skills training on Medical Unit 2 Wards	Fully complete (Approved)
Should Do	The service should ensure they complete MUST documentation	SD104/1	Mrs Melanie Woolfall	Medicine	The Medicine Care Group will manage this recommendation through the fundamentals work on managing a deteriorating patient and medicines management. Matrons will maintain regular oversight through assurance checks.	Fully complete (Awaiting approval)
Should Do	The service should ensure that cleaning schedules are completed appropriately. (Regulation 12	SD116/1	Mrs Melanie Woolfall	Medicine	Medicine Care Group, with support from Infection Prevention and Facilities, will, issue an immediate communication to FGH Ward/Unit Managers and FGH Matrons informing that the CQC have issued a Should Recommendation to improve the completion Cleaning Schedule and that the immediate action should be taken to ensure Cleaning Schedules are completed.	In progress
Should Do	The service should ensure that cleaning schedules are completed appropriately. (Regulation 12	SD116/2	Mrs Melanie Woolfall	Medicine	Medicine Care Group, with support from Infection Prevention and Facilities, will, review and update the cleaning schedules on the Medical Wards at FGH, progress will be monitored by regular audit and re-audit of compliance with the revised cleaning schedules. Progress will be reported at the Care Group Governance meeting and the Trust Infection Prevention Control Group.	In progress
Should Do	The trust should ensure that their updated policy for the management of violence and aggression should include clearer guidance about the use of medicines in line with National Institute for Health and Care Excellence (NICE) guidelines. (Regulation 17	SD117/1	Mrs Kam Mom	Medicine	Recommendation reviewed with Chief Pharmacist, Medication Safety Officer and ADOp of CCS. Confirmed that Pharmacy are already leading on the review of the rapid tranquilisation policy.	Fully complete (Awaiting approval)

Should Do	The trust should ensure that their updated policy for the management of violence and aggression should include clearer guidance about the use of medicines in line with National Institute for Health and Care Excellence (NICE) guidelines. (Regulation 17	SD1 17/2	Mrs Kam Mom	Medicine	Trust NICE Lead to facilitate a re-baseline assessment of NG10, with input from Medicine Care Group, Pharmacy, Security and Safeguarding to be completed by end of October 2022. Progress and completion of re-baseline assessment will be reported to Trust Clinical Audit & Standards Group. Outcomes from re-baseline assessment to be used in subsequent review and update of Procedural Documents CORP/POL/016, CORP/POL/044 and CORP/PROT/011- see action SD117/3, SD117/4 and SD117/5	Partially complete
Should Do	The trust should ensure that their updated policy for the management of violence and aggression should include clearer guidance about the use of medicines in line with National Institute for Health and Care Excellence (NICE) guidelines. (Regulation 17	SD1 17/3	Mr Mark Lippett	Medicine	Following completion of re-Baseline Assessment of NICE Guideline NG10 lead by Trust NICE Lead (target date October 2022), the author of Trust Procedural Document CORP/POL/044 (Behaviour Management and Supportive Intervention), will use outcomes from the re-Baseline Assessment of NICE Guideline NG10 to inform a review and update of Trust Procedural Document CORP/POL/044 with support from Pharmacy, Safeguarding and Care Groups. Progress will be monitored/reported at Trust Procedural Documents and Patient Information Leaflet Meeting	In progress
Should Do	The trust should ensure that their updated policy for the management of violence and aggression should include clearer guidance about the use of medicines in line with National Institute for Health and Care Excellence (NICE) guidelines. (Regulation 17	SD1 17/4	Mr Dan Willis	Medicine	Following completion of re-Baseline Assessment of NICE Guideline NG10 lead by Trust NICE Lead (target date October 2022), the author of Trust Procedural Document CORP/POL/016 (Violence & Aggression), will use outcomes from the re-Baseline Assessment of NICE Guideline NG10 to inform a review and update of Trust Procedural Document CORP/POL/016 with support from Pharmacy, Safeguarding and Care Groups. Progress will be monitored/reported at Trust Procedural Documents and Patient Information Leaflet Meeting	In progress

Should Do	The trust should ensure that their updated policy for the management of violence and aggression should include clearer guidance about the use of medicines in line with National Institute for Health and Care Excellence (NICE) guidelines. (Regulation 17	SD1 17/5	Mrs Nicola Askew	Medicine	Following completion of re-Baseline Assessment of NICE Guideline NG10 lead by Trust NICE Lead (target date October 2022), the author of Trust Procedural Document CORP/PROT/011 (Lancashire and South Cumbria Shared Care Protocol for the Management of Children and Young People Attending University Hospitals of Morecambe Bay with Emotional, Behavioural and Mental Health Needs. Appendix 9 Rapid Tranquilisation Policy), will use outcomes from the re-Baseline Assessment of NICE Guideline NG10 to inform a review and update of Trust Procedural Document CORP/PROT/011 with support from Pharmacy, Safeguarding and Care Groups. Progress will be monitored/reported at the WACS Care Group Governance Meeting and the Trust Procedural Documents and Patient Information Leaflet Meeting	In progress
Should Do	The trust should continue to actively seek a suitable candidate for recruitment to its stroke consultant vacancy. (Regulation 12)	SD1 18/1	Ms Bongi Gbadebo	Stroke Medicine - GenMed	Medicine Care Group will continue to take steps to recruit a Stroke Medicine Consultant at FGH.	Partially complete
Should Do	The trust should continue to actively seek a suitable candidate for recruitment to its stroke consultant vacancy. (Regulation 12)	SD1 18/2	Ms Bongi Gbadebo	Stroke Medicine - GenMed	Medicine Care Group to provide overview of mitigations that are in place to ensure that Patient safety and the quality of Patient Care and Treatment in Stroke Medicine at FGH is being maintained and developed and this is reflected in the risk on the risk register. Mitigations such as; Cross Bay Consultant cover/working, recruitment of additional Junior Doctors, Recruitment of ANPs/CNSs	Partially complete
Should Do	The trust should ensure it achieves its target for take-home medicines to be ready within one hour. (Regulation 12)	SD1 19/1	Mrs Kam Mom	Pharmacy	Pharmacy to review all documents that contain reference to internal Targets to provide greater clarity on the nature of these targets; - Is it - Informal internal operational target, or formal performance target - Detailing where different targets used for different departments/wards - 1 Hour for Emergency Medicine, 2 Hours for other Departments/Wards	In progress

Should Do	The trust should ensure it achieves its target for take-home medicines to be ready within one hour. (Regulation 12)	SD1 19/2	Mrs Kam Mom	Pharmacy	This actions is also part of an action to address Recommendation MD 126 To Recruit and deploy Pharmacists and Pharmacy Technicians dedicated to support and to improve Medicine Management within the Emergency Departments at RLI 2 x FTE Pharmacist(s) at RLI ED 2 FTE Pharmacy Technicians at RLI ED	Partially complete
Should Do	The trust should review its higher than expected readmission rates for both elective and non-elective admissions	SD1 20/1	Mr Paul Smith	Medicine	Compliance and Assurance Team to review this recommendation with with members of the Medicine Care Group Triumvirate to determine if it is best managed within Medicine Care Group or managed at a Corporate level with input from Medicine Care Group.	Fully complete (Awaiting approval)
Should Do	The trust should review its higher than expected readmission rates for both elective and non-elective admissions	SD1 20/2	Ms Bongi Gbadebo	Medicine	Medicine Care Group to undertake a review of readmission rates for Medical elective Patients and Medical non-elective admissions, this review will; - confirm the scale of the higher than average re-admission rates within Specialties and/or in Treatment Pathways - investigate the internal and external causes of the the higher than average re-admission rates - identify potential actions to address the higher than average re-admission rates - Implement any Trust Internal Actions to address the higher than average re-admission rates - Ensure that any system wide actions are communicated to the relevant partner organisations for them to review Progress to be reported to the Trust Clinical Effectiveness Group	In progress
Should Do	The trust should ensure that the minors waiting area and the paediatric provision of the department has sufficient staffing and patient oversight after 5PM. Regulation 12(2)(a)	SD1 23/1	Mrs Melanie Woolfall	Accident and Emergency	Medicine Care Group, with support from Paediatrics, to undertake of a review of the paediatric staffing provision of FGH ED to identify potential actions to ensure that staffing provision is maximised and that safe care and treatment is maintained as well as it practically possible.	Partially complete

Should Do	The trust should ensure that the minors waiting area and the paediatric provision of the department has sufficient staffing and patient oversight after 5PM. Regulation 12(2)(a)	SD1 23/2	Ms Bongi Gbadebo	Accident and Emergency	Medicine Care Group to submit a Business Case to improve Triage facilities/service at FGH ED to improve oversight of patients in the Paediatric waiting area, subsequent to approval, Medicine Care Group, with support from Estates, will then implement the requirements of Business Case.	Partially complete
Should Do	The trust should ensure that the minors waiting area and the paediatric provision of the department has sufficient staffing and patient oversight after 5PM. Regulation 12(2)(a)	SD1 23/3	Mrs Melanie Woolfall	Accident and Emergency	Medicine Care Group to liaise with Safeguarding Team to undertake review of process for overseeing patients in the paediatric waiting areas at FGH ED, to identify any areas of concern and to help ensure that these are addressed and that there is appropriate safeguarding of these patients whilst in the Paediatric Waiting area	In progress
Should Do	The trust should ensure that the minors waiting area and the paediatric provision of the department has sufficient staffing and patient oversight after 5PM. Regulation 12(2)(a)	SD1 23/4	Mrs Melanie Woolfall	Accident and Emergency	FGH ED Management Team to undertake a review of the current mechanisms for clinical observation and observation of patients in the minors waiting area after 5PM, to identify practical solutions to improve the observation and observation of patients to help ensure patient safety in the minors waiting area.	In progress
Should Do	The trust should consider a system to monitor staff wellbeing in relation to usage of bank and agency, to assist in the prevention of staff burnout	SD1 24/1	Ms Bongi Gbadebo	Accident and Emergency	Medicine Care Group to undertake review of the utilisation of Overtime, Bank Staff and Agency Staff to fulfil staffing requirements at FGH ED over the last 12 months to identify; - Is the Trust compliant with Working Time regulations - Is the Trust compliant with safe staffing standards - if there is a chronic/persistent issue with under staffing due low head count - if there are sporadic periods of under staffing due to short term absence etc. The results of the review will then be used to determine next steps, if no significant issue is identified, this may require a request for further clarification from the CQC on the basis of this recommendation.	Partially complete
Should Do	The service should consider reviewing the arrangements for the implementation of the mental capacity act and deprivation of liberties safeguarding within the emergency department and align the trust policy to the practice	SD1 25/1	Ms Bongi Gbadebo	Accident and Emergency	Compliance and Assurance Team to review this recommendation with with members of the Medicine Care Group Triumvirate to determine if Recommendation SD133 it is a 'duplicate' of this recommendation, and if it is a duplicate whether a	Fully complete (Awaiting approval)

					separate action is required or not to address Recommendation SD133.	
Should Do	The service should consider reviewing the arrangements for the implementation of the mental capacity act and deprivation of liberties safeguarding within the emergency department and align the trust policy to the practice	SD1 25/2	Mrs Melanie Woolfall	Accident and Emergency	Medicine Care Group to work with Trust Safeguarding Team to review the implementation of the Mental Capacity Act (MCA) in the ED's at FGH and RLI compared to Trust Policy and to identify potential actions, Medicine will address any identified issues of ED staff awareness, training and practice of the MCA. The Safeguarding Team will address any issued identified with the Trust Policy related to the MCA ED staff awareness, training and practice of the MCA.	In progress
Should Do	The service should consider reviewing the arrangements for the implementation of the mental capacity act and deprivation of liberties safeguarding within the emergency department and align the trust policy to the practice	SD1 25/3	Ms Liz Thompson	Accident and Emergency	Compliance and Assurance Team to confirm with Safeguarding Team the legal applicability of Depravation of Liberties Safeguards (DoLS) to patients attending at an Emergency Department, as opposed to Patient's admitted to an In-Patient Ward/Unit, Need to consider the status of Patients with DTA, but who have been in ED for more than 12 hours as, in effect, they have become inpatients. If it is confirmed that DoLS has no legal applicability to patients attending at an Emergency Department, then the Compliance and Assurance Team will raise a query with the CQC to seek clarification regarding the DoLS element of this recommendation.	Partially complete
Should Do	The service should consider whether the triage service in the walk-in waiting area can be improved so that the triage nurse can observe patients in the waiting area more easily	SD1 29/1	Ms Bongi Gbadebo	Accident and Emergency	Compliance and Assurance Team to review this recommendation with with members of the Medicine Care Group Triumvirate to determine if it is a 'duplicate' of Recommendation SD24, and if it is a duplicate whether a separate action is required or not.	Partially complete
Should Do	The service should consider whether the triage service in the walk-in waiting area can be improved so that the triage nurse can observe patients in the waiting area more easily	SD1 29/2	Mrs Melanie Woolfall	Accident and Emergency	Medicine Care Group will investigate alternative solutions (not Estates Works) to improve observation of Patients in the triage and waiting areas, consideration to be given to some form of regular intentional rounding of the ED Waiting Areas.	In progress

Should Do	The service should continue to work closely with all system partners to tackle the capacity pressures on urgent and emergency care in the health and social care system.	SD1 30/1	Ms Bongi Gbadebo	Accident and Emergency	Compliance and Assurance Team to review this recommendation with with members of the Medicine Care Group Triumvirate to determine if it is best managed within Medicine Care Group or managed at a Corporate level with input from Medicine Care Group	Fully complete (Awaiting approval)
Should Do	The service should continue to work closely with all system partners to tackle the capacity pressures on urgent and emergency care in the health and social care system.	SD1 30/2	Mr Scott McLean	Accident and Emergency	The Trust will continue to work with system partners to deliver the Bay Health and Care Partners (BHACP) Urgent and Emergency Care (UEC) Improvement Plan for 2022-23, progress against the the BHACP UEC Improvement Plan is monitored at the A&E delivery Board with Escalation to the Trust Board and System Improvement Board.	Partially complete
Should Do	The service should continue to work closely with all system partners to tackle the capacity pressures on urgent and emergency care in the health and social care system.	SD1 30/3	Ms Bongi Gbadebo	Accident and Emergency	Medicine Care Group to undertake a review of lessons learnt from ED RLI when operating well at OPEL 4 and what can be learned from this to improve performance at lower levels. Outcomes from this review will be reported to Care Group Management Meeting and to the A&E Delivery Board.	In progress
Should Do	The service should consider ways for staff to have oversight of children waiting to be triaged.	SD1 31/1	Mrs Melanie Woolfall	Accident and Emergency	Medicine Care Group will investigate alternative solutions (not Estates Works) to improve observation and clinical oversight of Paediatric Patients in the waiting areas, consideration to be given to some form of regular intentional rounding of the ED Waiting Areas.	In progress
Should Do	The service should consider reviewing the advanced paediatric life support to make sure that all band 6 staff have the correct qualification	SD1 32/1	Mrs Melanie Woolfall	Accident and Emergency	Medicine Care Group will undertake a review, with support from Resus practioneers of the two training courses used for paediatric life support; advanced paediatric life support (APLS) and European paediatric life support (EPLS), to ensure that both courses are of the required standard. If they are of the required standard, then Medicine will review relevant documentation, monitoring and reporting to ensure that both APLS and EPLS training is recorded when assessing paediatric life support competency for Nursing staff.	In progress

Should Do	The service should consider reviewing the advanced paediatric life support to make sure that all band 6 staff have the correct qualification	SD1 32/2	Mrs Melanie Woolfall	Accident and Emergency	Medicine Care Group to consider introducing a White Board system that lists the staff members on duty/shift who have paediatric life support qualifications/training, this will ensure that all staff (especially Bank/Agency) can easily identify and locate them in an emergency situation.	In progress
Should Do	The service should consider reviewing the arrangements for the implementation of the mental capacity act and deprivation of liberties safeguarding within the ED department and align the trust policy to the practice.	SD1 33/1	Ms Bongi Gbadebo	Accident and Emergency	Compliance and Assurance Team to review this recommendation with with members of the Medicine Care Group Triumvirate to determine if it is a 'duplicate' of Recommendation SD125, and if it is a duplicate whether a separate action is required or not.	Partially complete
Should Do	The service should review the staffing levels within ACU and SDEC ensuring that staffing levels are maintained and risks to staffing establishment captured and monitored.	SD1 34/1	Ms Bongi Gbadebo	Accident and Emergency	Medicine Care Group to develop and, if approved, implement a business case to improve staffing levels on the RLI ACU and SDEC	In progress
Should Do	The service should review the staffing levels within ACU and SDEC ensuring that staffing levels are maintained and risks to staffing establishment captured and monitored.	SD1 34/2	Ms Bongi Gbadebo	Accident and Emergency	Medicine Care Group to ensure that staffing levels within ACU and SDEC are captured within the Care Group Risk on 'Staffing Levels' by reviewing and updating Risk 2805 (RLI ED Staffing Levels) and that processes are in place for Risk 2805 to be regularly monitored at the Care Group Governance and/or Management Team meetings and that any issues of concern are escalated to the Trust Risk Management Group	In progress
Should Do	The service should consider reviewing the opportunities for safety incident report and review when and what incidents, staff need to report and monitor that they have the support to do this in an appropriate manner.	SD1 35/1	Mrs Melanie Woolfall	Accident and Emergency	Medicine Care Group to work with Trust Patient Safety Team to review Incident reporting in RLI ED to ensure that all incidents are reported and there is a new focus on the four incident types specifically identified by the CQC; Staffing Levels, Long Waits, Paediatric Triage and Inappropriate GP Referrals. Consideration will be given to identifying any barriers to staff reporting incidents and where practical removing or reducing these barriers. The Outcome of this review will be reported at the Trust Quality, Governance & Patient Safety Group.	Partially complete
Should Do	The service should continue with plans to improve staffing levels medical staff to full establishment.	SD1 36/1	Ms Bongi Gbadebo	Accident and Emergency	The Medicine Care Group will implement the recruitment plan improve Medical Staffing levels at RLI ED towards full establishment levels and ensure that risk 2805 (RLI ED Staffing) is regularly reviewed and	In progress

					updated , with regular monitoring at Care Group meeting and escalation to Trust Management Group.	
Should Do	The service should review the perception in the ED of limited senior and executive visibility, recognition, understanding and support.	SD1 37/1	Mrs Lynne Wyre	Accident and Emergency	The Executive Chief Nurse has a scheduled Walkaround of all clinical areas at RLI every Friday morning, this includes RLI ED, these will continue to help maintain/increase the visibility of Executive and Senior Nursing staff at RLI ED.	Partially complete
Should Do	The service should review the perception in the ED of limited senior and executive visibility, recognition, understanding and support.	SD1 37/2	Ms Bongi Gbadebo	Accident and Emergency	Medicine Care Group will undertake a review of staff perceptions in ED in relation to the visibility, recognition, understanding and support from Executives and Senior Management, this will take place in September 2023. The findings of this review will then be used to identify potential solutions that can then be developed into an Action Plan.	In progress
Should Do	The service should further explore the opportunities for collaborative working from the emergency department, assessment units and specialist services	SD1 38/1	Ms Bongi Gbadebo	Accident and Emergency	Compliance and Assurance Team to review this recommendation with with members of the Medicine Care Group Triumvirate to determine if it is best managed within Medicine Care Group or managed at a Corporate level with input from Medicine Care Group.	Fully complete (Awaiting approval)
Should Do	The service should further explore the opportunities for collaborative working from the emergency department, assessment units and specialist services	SD1 38/2	Mr Paul Smith	Accident and Emergency	Medicine Care Group to undertake a review of engagement between Emergency Medicine with the Other Medical and Surgical Specialities (and tertiary services), the review will include a review of the current Trust Process for collaboration and the relevant professional standards documentation. The outcomes of the review will be shared with the Trust Clinical Effectiveness Group	In progress
Should Do	The service should consider reviewing the arrangements for medicines held by patients particularly in relation to those on trolleys, formalise the process in place and ensure that all staff are aware of the practice needed to maintain patient safety.	SD1 39/1	Mrs Kam Mom	Accident and Emergency	The Trust will undertake a best practice review with input from other ICS Pharmacy Teams to review the arrangements for medicines held by patients and to investigate potential solutions that would be appropriate for ED attendance and all subsequent patient movements, this will then be used to update the Patients own Medicine sections of Procedural Document CORP/POL/039 (Administration, Safe Storage, Supply, Disposal and Monitoring of Medicines).	In progress

Table 6: NICHE Improvement Plan Dashboard (Still in development in AMaT)

Inspection	Recommendation	Ref	Person Responsible	Service	Action	Progress Status
NICHE	Recommendation 1 - Oversight of Urology through Trust governance structures: Reporting lines need to be clearly articulated in the terms of reference for each of the groups and committees which have been established for oversight of the Urology service and depicted in an organogram. Links to the Urology department, care group, committee and Board governance structure should also be confirmed	MD1/1	Mr Richard Sachs	TRUSTWIDE	Urology TFG, Chaired by Aaron Exec and Non Exec Stood down, Urology Oversight Group evolved into System Improvement Board Urology meetings in place: Urology Business Meeting (Full MDT), Clinical Business Unit (Triumverate) Urology Audit Meeting - feed into SGAG and SMB, then on SCC Triuniverate - Performance reviews and TMG Urology Action plan presented monthly at QAC. GGI Work completed for Care Group, Committee and Board Structure - update from CQC Plan/Paul Jones	In progress
NICHE	Recommendation 1 - Oversight of Urology through Trust governance structures: Reporting lines need to be clearly articulated in the terms of reference for each of the groups and committees which have been established for oversight of the Urology service and depicted in an organogram. Links to the Urology department, care group, committee and Board governance structure should also be confirmed	MD1/2	Mr Richard Sachs	Urology	Establish and detail organisational flow chart, with reference to Urological oversight in organisational teams. This will include: Terms of reference, escalation processes to signal 'hotspots' to highlight potential issues. Measure: Agree with trust wide action to implement a process review for all urology themes throughout established care group committees.	Fully complete (Awaiting approval)
NICHE	Recommendation 1 - Oversight of Urology through Trust governance structures: Reporting lines need to be clearly articulated in the terms of reference for each of the groups and committees which have been established for oversight of the Urology service and depicted in an organogram. Links to the Urology department, care group, committee and Board governance structure should also be confirmed	MD1/3	Mr Richard Sachs	TRUSTWIDE	Agree and implement GGI structure with care group committees with particular reference to urology at point of implementation. Establish and implement a regular process review of governance within care groups. (potential to review minutes of meetings to evidence this)	Partially complete

NICHE	Recommendation 2 - Quality and safety data in the Integrated Performance Report: The quality and safety data in the Integrated Quality and Performance Report (IQPR) should be expanded to include trend and thematic analysis. Key quality and safety metrics should be included in a new upfront performance dashboard and hotspot reporting should include more detailed analysis on key risks	MD2/1	Miss Leanne Cooper	TRUSTWIDE	Review of IQPR quality and Safety data to include; trend and thematic analysis, headline Dashboard, hotspot reporting To be completed in time for start of 2022/23 Financial year	In progress
NICHE	Recommendation 2 - Quality and safety data in the Integrated Performance Report: The quality and safety data in the Integrated Quality and Performance Report (IQPR) should be expanded to include trend and thematic analysis. Key quality and safety metrics should be included in a new upfront performance dashboard and hotspot reporting should include more detailed analysis on key risks	MD2/2	Miss Leanne Cooper	Urology	Monitor and establish oversight IPR (Urology Specialty Scorecard) specialty performance reviews aligned with Trust wide IPR. Linked to Niche/R01. Measure: link to dashboards	Fully complete (Awaiting approval)
NICHE	Recommendation 2 - Quality and safety data in the Integrated Performance Report: The quality and safety data in the Integrated Quality and Performance Report (IQPR) should be expanded to include trend and thematic analysis. Key quality and safety metrics should be included in a new upfront performance dashboard and hotspot reporting should include more detailed analysis on key risks	MD2/3	Miss Leanne Cooper	TRUSTWIDE	Establish link speciality reviews across the organisation to provide oversight 'hotspots' through trust wide IPR Measure: Link to trust wide IPR.	In progress
NICHE	Recommendation 3 - Performance framework for Urology: Introduce a performance and accountability framework which clearly sets out the approach to corporate and care group scrutiny of Urology and, where necessary, support from the Enhanced Support Programme (ESP)	MD3/1	Mr Chris Adcock	TRUSTWIDE	In place fro Urology, Monthly Safe today with 'At a Glance' scorecard with Quality and safety, workforce and finance metrics - mini IPR Safe today provide triangulaton of Incident, Patient Relations in terms of Care Hours Monthly Exec to Service Review with Clinical Lead and CSM - still in place ? - also undertaken for other ESP Specialities: T&O, Paeds, Maternity	In progress

NICHE	Recommendation 3 - Performance framework for Urology: Introduce a performance and accountability framework which clearly sets out the approach to corporate and care group scrutiny of Urology and, where necessary, support from the Enhanced Support Programme (ESP)	MD3/2	Mr Chris Adcock	TRUSTWIDE	As per response to MD1 & MD2 Completed for urology ?Wider Applicability	In progress
NICHE	Recommendation 3 - Performance framework for Urology: Introduce a performance and accountability framework which clearly sets out the approach to corporate and care group scrutiny of Urology and, where necessary, support from the Enhanced Support Programme (ESP)	MD3/3	Mr Chris Adcock	TRUSTWIDE	Agree and establish organisation accountability framework - greater scrutiny of performance IPR reports. Mapping of locations between different systems and align a performance and accountability framework - allowing oversight and of specialty level reporting in care groups. Measure: Performance monitoring of IPR.	In progress
NICHE	Recommendation 3 - Performance framework for Urology: Introduce a performance and accountability framework which clearly sets out the approach to corporate and care group scrutiny of Urology and, where necessary, support from the Enhanced Support Programme (ESP)	MD3/4	Mr Chris Adcock	Urology	Establish performance and accountability framework to be adopted at trust level for all specialities. Measure: monitor trust wide IPR reporting.	Fully complete (Awaiting approval)
NICHE	Recommendation 4 - Urology audit: The newly appointed Urology Audit Lead should have dedicated and experienced support to provide best practice guidance on conducting audit and governance meetings. The terms of reference and agendas for the audit meeting should be drawn from best practice in other Urology services	MD4/1	Mr Muhammad Saleem Naseem	Urology	Trust Clinical Audit Team to work with Audit Lead for Urology (Mr Saqib), Service Manager for Urology (Rebecca Cullen) and Care Group Governance Business Partner (Gregg Peers) to ensure appropriate support is in place for Urology Audit Meeting.	Partially complete
NICHE	Recommendation 4 - Urology audit: The newly appointed Urology Audit Lead should have dedicated and experienced support to provide best practice guidance on conducting audit and governance meetings. The terms of reference and agendas for the audit meeting should be drawn from best practice in other Urology services	MD4/2	Mr Muhammad Saleem Naseem	Urology	Place Holder for Governance Meeting Action	In progress

NICHE	Recommendation 4 - Urology audit: The newly appointed Urology Audit Lead should have dedicated and experienced support to provide best practice guidance on conducting audit and governance meetings. The terms of reference and agendas for the audit meeting should be drawn from best practice in other Urology services	MD4/3	Mr Muhammad Saleem Naseem	Urology	Trust Clinical Audit Team to review ToR of Urology Audit Meeting against prevailing best practice ToR in the Trust (as per GGI Governance Review) and to consider best practice from other Urology Services.	Partially complete
NICHE	Recommendation 4 - Urology audit: The newly appointed Urology Audit Lead should have dedicated and experienced support to provide best practice guidance on conducting audit and governance meetings. The terms of reference and agendas for the audit meeting should be drawn from best practice in other Urology services	MD4/4	Mr Richard Sachs	TRUSTWIDE	Trust Wide Action - Linked to RSP Workstream 2 Quality and Safety (Clinical Effectiveness) 1. Trust Clinical Audit Team to review the Urology terms of reference and agendas for the audit meeting drawn from best practice in other Urology Services (as per data provided by RSP team). 2,. Trust Clinical Audit Team to implement best practice drawn from Urology into Trust Wide standardised Formats/ Templates for Audit Meeting ToR and Audit Meeting Agenda's	Partially complete
NICHE	Recommendation 4 - Urology audit: The newly appointed Urology Audit Lead should have dedicated and experienced support to provide best practice guidance on conducting audit and governance meetings. The terms of reference and agendas for the audit meeting should be drawn from best practice in other Urology services	MD4/5	Mr Muhammad Saleem Naseem	Urology	Link with Clinical Audit team and align audit processes to support Urology audit workstreams and deliver agreed audit expectations.	Fully complete (Awaiting approval)
NICHE	Recommendation 4 - Urology audit: The newly appointed Urology Audit Lead should have dedicated and experienced support to provide best practice guidance on conducting audit and governance meetings. The terms of reference and agendas for the audit meeting should be drawn from best practice in other Urology services	MD4/6	Mr Muhammad Saleem Naseem	Urology	Trust Clinical Audit team to work with Urology Audit Lead and embed best practice process for audit. Procedural document to be developed/adopted to support all specialties to be identified. Measure: Minutes of Clinical Audit Meetings.	Partially complete

NICHE	Recommendation 5 - Safe Today Report: The Safe Today Report should be received at department and care group level before presentation to UT&FG and UQOC33. It should also be developed further to provide more appropriate measures of assurance with: • inclusion of an overarching scorecard to enable the reader to understand performance 'at a glance'; • a reduction in the narrative analysis throughout the report; • greater emphasis on prospective performance through the use of early warning indicators and forecasting in order to allow timely identification of deteriorating performance; • more same causal factor analysis of complaints, litigation, incidents and Patient Advice and Liaison Service (PALS) feedback; • an expansion of the quantitative and qualitative data relating to patient and staff experience, including patient feedback in the form of real time and retrospective data collection, staff pulse surveys and a wider range of workforce metrics (e.g. turnover, appraisals, training, use of agency staff, staff sickness, as well as concerns raised by staff)	MD5/1	Ms Claire Alexander	TRUSTWIDE	UQOC - Urology Quality Oversight Committee As per Recommendation 2 - Inclusion of SPC for trajectories - Safe Today App, Completed for Urology Completed for other ESP Specialities Wider Trust Applicability to be confirmed - Safe today produced monthly, transferred from QAC to PSQG as monthly Agenda Item	In progress

NICHE	Recommendation 5 - Safe Today Report: The Safe Today Report should be received at department and care group level before presentation to UT&FG and UQOC33. It should also be developed further to provide more appropriate measures of assurance with: • inclusion of an overarching scorecard to enable the reader to understand performance 'at a glance'; • a reduction in the narrative analysis throughout the report; • greater emphasis on prospective performance through the use of early warning indicators and forecasting in order to allow timely identification of deteriorating performance; • more same causal factor analysis of complaints, litigation, incidents and Patient Advice and Liaison Service (PALS) feedback; • an expansion of the quantitative and qualitative data relating to patient and staff experience, including patient feedback in the form of real time and retrospective data collection, staff pulse surveys and a wider range of workforce metrics (e.g. turnover, appraisals, training, use of agency staff, staff sickness, as well as concerns raised by staff)	MD5/2	Ms Claire Alexander	Urology	Add an overarching scorecard to enable the reader to understand performance 'at a glance.	Fully complete (Awaiting approval)

NICHE	Recommendation 5 - Safe Today Report: The Safe Today Report should be received at department and care group level before presentation to UT&FG and UQOC33. It should also be developed further to provide more appropriate measures of assurance with: • inclusion of an overarching scorecard to enable the reader to understand performance 'at a glance'; • a reduction in the narrative analysis throughout the report; • greater emphasis on prospective performance through the use of early warning indicators and forecasting in order to allow timely identification of deteriorating performance; • more same causal factor analysis of complaints, litigation, incidents and Patient Advice and Liaison Service (PALS) feedback; • an expansion of the quantitative and qualitative data relating to patient and staff experience, including patient feedback in the form of real time and retrospective data collection, staff pulse surveys and a wider range of workforce metrics (e.g. turnover, appraisals, training, use of agency staff, staff sickness, as well as concerns raised by staff)	MD5/3	Ms Claire Alexander	Urology	Reduce the narrative analysis throughout the report	Partially complete

NICHE	Recommendation 5 - Safe Today Report: The Safe Today Report should be received at department and care group level before presentation to UT&FG and UQOC33. It should also be developed further to provide more appropriate measures of assurance with: • inclusion of an overarching scorecard to enable the reader to understand performance 'at a glance'; • a reduction in the narrative analysis throughout the report; • greater emphasis on prospective performance through the use of early warning indicators and forecasting in order to allow timely identification of deteriorating performance; • more same causal factor analysis of complaints, litigation, incidents and Patient Advice and Liaison Service (PALS) feedback; • an expansion of the quantitative and qualitative data relating to patient and staff experience, including patient feedback in the form of real time and retrospective data collection, staff pulse surveys and a wider range of workforce metrics (e.g. turnover, appraisals, training, use of agency staff, staff sickness, as well as concerns raised by staff)	MD5/4	Ms Claire Alexander	TRUSTWIDE	Strengthen the emphasis on prospective performance through the use of early warning indicators and forecasting in order to allow timely identification of deteriorating performance; - Done (through SPC - Safe Today App. Safe today produced monthly, transferred to Quality Governance and Patient Safety Group. (QGPSG)).	In progress

NICHE	Recommendation 5 - Safe Today Report: The Safe Today Report should be received at department and care group level before presentation to UT&FG and UQOC33. It should also be developed further to provide more appropriate measures of assurance with: • inclusion of an overarching scorecard to enable the reader to understand performance 'at a glance'; • a reduction in the narrative analysis throughout the report; • greater emphasis on prospective performance through the use of early warning indicators and forecasting in order to allow timely identification of deteriorating performance; • more same causal factor analysis of complaints, litigation, incidents and Patient Advice and Liaison Service (PALS) feedback; • an expansion of the quantitative and qualitative data relating to patient and staff experience, including patient feedback in the form of real time and retrospective data collection, staff pulse surveys and a wider range of workforce metrics (e.g. turnover, appraisals, training, use of agency staff, staff sickness, as well as concerns raised by staff)	MD5/5	Ms Claire Alexander	Urology	Increase same causal factor analysis of complaints, litigation, incidents and Patient Advice and Liaison Service (PALS) feedback.	Partially complete

NICHE	Recommendation 5 - Safe Today Report: The Safe Today Report should be received at department and care group level before presentation to UT&FG and UQOC33. It should also be developed further to provide more appropriate measures of assurance with: • inclusion of an overarching scorecard to enable the reader to understand performance 'at a glance'; • a reduction in the narrative analysis throughout the report; • greater emphasis on prospective performance through the use of early warning indicators and forecasting in order to allow timely identification of deteriorating performance; • more same causal factor analysis of complaints, litigation, incidents and Patient Advice and Liaison Service (PALS) feedback; • an expansion of the quantitative and qualitative data relating to patient and staff experience, including patient feedback in the form of real time and retrospective data collection, staff pulse surveys and a wider range of workforce metrics (e.g. turnover, appraisals, training, use of agency staff, staff sickness, as well as concerns raised by staff)	MD5/6	Ms Claire Alexander	Urology	Expand the quantitative and qualitative data relating to patient and staff experience, including patient feedback in the form of real time and retrospective data collection, staff pulse surveys and a wider range of workforce metrics (e.g. turnover, appraisals, training, use of agency staff, staff sickness, as well as concerns raised by staff).	Partially complete

NICHE	Recommendation 5 - Safe Today Report: The Safe Today Report should be received at department and care group level before presentation to UT&FG and UQOC33. It should also be developed further to provide more appropriate measures of assurance with: • inclusion of an overarching scorecard to enable the reader to understand performance 'at a glance'; • a reduction in the narrative analysis throughout the report; • greater emphasis on prospective performance through the use of early warning indicators and forecasting in order to allow timely identification of deteriorating performance; • more same causal factor analysis of complaints, litigation, incidents and Patient Advice and Liaison Service (PALS) feedback; • an expansion of the quantitative and qualitative data relating to patient and staff experience, including patient feedback in the form of real time and retrospective data collection, staff pulse surveys and a wider range of workforce metrics (e.g. turnover, appraisals, training, use of agency staff, staff sickness, as well as concerns raised by staff)	MD5/7	Ms Claire Alexander	TRUSTWIDE	Automation of ESP Safe Today Report in Every Service.	In progress

NICHE	Recommendation 6 - Meeting administration: Meeting administration must be improved. This should include: • a review of the ToR for all meetings at departmental and care group level to ensure they are in date, aligned to the objectives required of the meeting, and also other key meetings, with agendas planned to reflect these; • the introduction of standardised templates for agendas, minutes, and action logs; and • the provision of training for individuals with minute-writing responsibilities and all minutes should be reviewed by the relevant Chair before distribution	MD6/1	Mr Paul Jones	TRUSTWIDE	Trust Wide - Largely completed as part of GGI review. Map and review the governance meeting structure within all services meetings. This should include: 1.1 New standardised ToR Format/Template now in use across Trust - issued to all Meeting Chairs/Secs 1.2. New standardised ToR Format/Template now in use across Trust - Include sections on; Accountability (to parent meeting), Purpose, Duties, Standing Agenda Items, reporting sub-meetings, communication responsibilities, 2 New standardised Templates now in use across Trust - agendas, minutes, action logs, papers and escalation (3A's) Report 3.1 Provision of Minute writing training 3.2 Review of Minutes by Chair's before distribution	Partially complete
NICHE	Recommendation 6 - Meeting administration: Meeting administration must be improved. This should include: • a review of the ToR for all meetings at departmental and care group level to ensure they are in date, aligned to the objectives required of the meeting, and also other key meetings, with agendas planned to reflect these; • the introduction of standardised templates for agendas, minutes, and action logs; and • the provision of training for individuals with minute-writing responsibilities and all minutes should be reviewed by the relevant Chair before distribution	MD6/2	Mr Paul Jones	Urology	Scoping to review the governance within all urology service meetings.	Fully complete (Awaiting approval)

NICHE	Recommendation 6 - Meeting administration: Meeting administration must be improved. This should include: • a review of the ToR for all meetings at departmental and care group level to ensure they are in date, aligned to the objectives required of the meeting, and also other key meetings, with agendas planned to reflect these; • the introduction of standardised templates for agendas, minutes, and action logs; and • the provision of training for individuals with minute-writing responsibilities and all minutes should be reviewed by the relevant Chair before distribution	MD6/3	Mr Paul Jones	TRUSTWIDE	Map and review the governance meeting structure within all services meetings. This should include: 1, Review of the ToR for all meetings at departmental and care group level to ensure they are in date, aligned to the objectives required of the meeting, and also other key meetings, with agendas planned to reflect these. 2, The introduction of standardised templates for agendas, minutes, and action logs. 3, The provision of training for individuals with minute-writing responsibilities and all minutes should be reviewed by the relevant Chair before distribution.	Fully complete (Awaiting approval)
NICHE	Recommendation 7 - Risk registers at service, care group and Trust level: The challenges currently being faced by the Urology service should be reviewed to determine whether the risks are sufficient to warrant inclusion on the service, care group or Corporate Risk Register (CRR) or the Board Assurance Framework (BAF); this includes the difficulties with on call cover at Furness General Hospital (FGH) and continuing fractured relationships as a patient safety risk. Departmental and care group meetings should include risk as a standing agenda item and the risk profile of the service should be reviewed at least quarterly	MD7/1	Mr Gregg Peers	Surgery and Critical Care Services	Review Urology risk register with ADOP and Gov BP to confirm all risks identified and assigned to appropriate level of the Risk Register or to add any further risks. Provide assurance to Risk Management Group 27th January 2022 for acceptance. Identify whether risks are discussed at Urology meetings as standing agenda item and that risk profile is considered quarterly at GAG.	In progress

NICHE	Recommendation 7 - Risk registers at service, care group and Trust level: The challenges currently being faced by the Urology service should be reviewed to determine whether the risks are sufficient to warrant inclusion on the service, care group or Corporate Risk Register (CRR) or the Board Assurance Framework (BAF); this includes the difficulties with on call cover at Furness General Hospital (FGH) and continuing fractured relationships as a patient safety risk. Departmental and care group meetings should include risk as a standing agenda item and the risk profile of the service should be reviewed at least quarterly	MD7/2	Mrs Anna Smith	TRUSTWIDE	Trust Wide Action Health Safety and Risk Team will review the ToR's and Agenda's of 'Governance' Meetings (at Care Group, Speciality, Departmental level) and ensure that it includes regular risk management review / risk register review and a quarterly risk profile review as a standing agenda items	Partially complete
NICHE	Recommendation 7 - Risk registers at service, care group and Trust level: The challenges currently being faced by the Urology service should be reviewed to determine whether the risks are sufficient to warrant inclusion on the service, care group or Corporate Risk Register (CRR) or the Board Assurance Framework (BAF); this includes the difficulties with on call cover at Furness General Hospital (FGH) and continuing fractured relationships as a patient safety risk. Departmental and care group meetings should include risk as a standing agenda item and the risk profile of the service should be reviewed at least quarterly	MD7/3	Mr Richard Sachs	Urology	Departmental meetings should include risk as a standing agenda item and the risk profile of the service should be reviewed at least quarterly.	Fully complete (Awaiting approval)

NICHE	Recommendation 8 - Quality of investigations in Urology services: All reported incidents and complaints received in relation to Urology services should, for a period of at least 12 months, be investigated by a dedicated independent team outside the department which has access to independent Urology advice. This would remove pressure on the existing team to investigate each other and provide room to work on relationship development. It would also help to set a standard for future high-quality investigations. [This recommendation related to incidents and complaints requiring investigation not all cases]	MD8/1	Mr Richard Sachs	Urology	Development and implementation of Independent Investigation Team (IIT) for all Urology incidents/RCA's for a period of 8 months	Partially complete
NICHE	Recommendation 8 - Quality of investigations in Urology services: All reported incidents and complaints received in relation to Urology services should, for a period of at least 12 months, be investigated by a dedicated independent team outside the department which has access to independent Urology advice. This would remove pressure on the existing team to investigate each other and provide room to work on relationship development. It would also help to set a standard for future high-quality investigations. [This recommendation related to incidents and complaints requiring investigation not all cases]	MD8/2	Mr Richard Sachs	Urology	Working with organisation, establish a dedicated independent team outside the department which has access to independent Urology advice.	Fully complete (Awaiting approval)

NICHE	Recommendation 8 - Quality of investigations in Urology services: All reported incidents and complaints received in relation to Urology services should, for a period of at least 12 months, be investigated by a dedicated independent team outside the department which has access to independent Urology advice. This would remove pressure on the existing team to investigate each other and provide room to work on relationship development. It would also help to set a standard for future high-quality investigations. [This recommendation related to incidents and complaints requiring investigation not all cases]	MD8/3	Mr Richard Sachs	TRUSTWIDE	Trust Wide Action Head of Patient Safety & Complaints to review learning from the Urology Independent Investigation Team (IIT) to identify any best practice that can be integrated into wider Trust processes to improve the quality of the investigation, management and resolution of Incidents and complaints. identified Best Practice must be consistent with the principles of the incoming Patient Safety Framework (PSIRF) and the new national Learn from Patient Safety Events (LFPSE) System.	Fully complete (Awaiting approval)
NICHE	Recommendation 9 - Thematic review: Quality performance reporting should include thematic and same causal factor analysis of complaints, litigation, incidents, and PALS information to ensure that lessons can be learned, and actions taken to prevent recurrence of the same. Themes should be discussed at departmental, care group, and committee level with a clear focus on actioning improvement	MD9/1	Mr Richard Sachs	TRUSTWIDE	Recommendations 2 & 4 - Safe Today Completed fro Urology Completed for other ESP Specialties Query Wide Trust?	In progress
NICHE	Recommendation 9 - Thematic review: Quality performance reporting should include thematic and same causal factor analysis of complaints, litigation, incidents, and PALS information to ensure that lessons can be learned, and actions taken to prevent recurrence of the same. Themes should be discussed at departmental, care group, and committee level with a clear focus on actioning improvement	MD9/2	Mr Richard Sachs	Urology	Provide access to care group governance teams to CGAG Qlik Sense - to be reviewed at service level and Care Group Meetings. Implement and develop Governance Business Partners job description to ensure attendance at monthly speciality meetings	Fully complete (Awaiting approval)

NICHE	Recommendation 9 - Thematic review: Quality performance reporting should include thematic and same causal factor analysis of complaints, litigation, incidents, and PALS information to ensure that lessons can be learned, and actions taken to prevent recurrence of the same. Themes should be discussed at departmental, care group, and committee level with a clear focus on actioning improvement	MD9/3	Mr Richard Sachs	TRUSTWIDE	Agree and Implement Governance Business Partners Job Descriptions updated to ensure part of role is to attend monthly specialty meetings to provide quality / safety data.	In progress
NICHE	Recommendation 10 - Mortality review (Link to R15 and R26) Every inpatient Urology death must have a case review conducted by Consultant Urologists with external support in using structured judgement review (SJR) methodology (Royal College of Physicians) or other recognised case note review methodology and be subject to Trust level scrutiny (as per Trust Policy). Every death must then be presented without exception to a Urology mortality meeting. These should be separate from audit and multidisciplinary team (MDT) meetings until such time that mortality review becomes an accepted and business as usual activity	MD10/ 1	Ms Jane McNicholas	TRUSTWIDE	Completd - see Email from Claire Check with Helen Irving that all Urology Deaths reviewed - 12 cases? 4 outstanding, check for evidence of review On agenda at Mortality Meeting and Clinical Effectiveness. Trust Wide - Check with Helen, applicability to chronic conditions etc. SJR review Links to ME triage, new process Learning from Deaths RSP Workstream 2 - Mortality	In progress
NICHE	Recommendation 10 - Mortality review (Link to R15 and R26) Every inpatient Urology death must have a case review conducted by Consultant Urologists with external support in using structured judgement review (SJR) methodology (Royal College of Physicians) or other recognised case note review methodology and be subject to Trust level scrutiny (as per Trust Policy). Every death must then be presented without exception to a Urology mortality meeting. These should be separate from audit and multidisciplinary team (MDT) meetings until such time that mortality review becomes an accepted and business as usual activity	MD10/ 2	Mr Richard Sachs	Urology	Agree process for case review of Urology patients with the trust mortality team inline with the recommendation.	Fully complete (Awaiting approval)

NICHE	Recommendation 10 - Mortality review (Link to R15 and R26) Every inpatient Urology death must have a case review conducted by Consultant Urologists with external support in using structured judgement review (SJR) methodology (Royal College of Physicians) or other recognised case note review methodology and be subject to Trust level scrutiny (as per Trust Policy). Every death must then be presented without exception to a Urology mortality meeting. These should be separate from audit and multidisciplinary team (MDT) meetings until such time that mortality review becomes an accepted and business as usual activity	MD10/ 3	Ms Jane McNicholas	TRUSTWIDE	Agree case review recommendations for urology and added on AMaT - MaMR module.	In progress
NICHE	Recommendation 11 - Professional relationships: Intelligence from the InterBe meeting in August 2020 should be used to assess the severity of concerns associated with relationships between senior clinical staff to determine whether issues can be resolved or if other remedial action needs to be taken	MD11/ 1	Mr David Wilkinson	Urology	Urology Only Completed, presented to CEO on 26/04/21 Video session available as evidence of completion	Fully complete (Awaiting approval)
NICHE	Recommendation 12 - Pooled model of patient care • There is an urgent need to review the pooling of patient referrals and the way in which patients are allocated to, and reviewed by, clinicians in Urology to ensure that continuity of care is optimised. • There should be clear procedures for allocating patients against specific pathways (including in line with Cancer MDT guidance). Any subsequent changes to management plans should be agreed with the named Consultant/an appropriate clinician especially if there are clinic cancellations or delays to treatment.	MD12/ 1	Ms Jane McNicholas	TRUSTWIDE	Named clincian process in place from Jan 21 for Urology Six monthly Audit - check detais - latest results Require more evidence on clear procedures, action number 6 on teh T&O RCS Action Plan Wider applicability?	In progress

NICHE	Recommendation 12 - Pooled model of patient care • There is an urgent need to review the pooling of patient referrals and the way in which patients are allocated to, and reviewed by, clinicians in Urology to ensure that continuity of care is optimised. • There should be clear procedures for allocating patients against specific pathways (including in line with Cancer MDT guidance). Any subsequent changes to management plans should be agreed with the named Consultant/an appropriate clinician especially if there are clinic cancellations or delays to treatment.	MD12/ 2	Ms Jane McNicholas	Urology	Task and finish group to be established to review Pooling Pathways in Urology.	Fully complete (Awaiting approval)
NICHE	Recommendation 12 - Pooled model of patient care • There is an urgent need to review the pooling of patient referrals and the way in which patients are allocated to, and reviewed by, clinicians in Urology to ensure that continuity of care is optimised. • There should be clear procedures for allocating patients against specific pathways (including in line with Cancer MDT guidance). Any subsequent changes to management plans should be agreed with the named Consultant/an appropriate clinician especially if there are clinic cancellations or delays to treatment.	MD12/ 3	Ms Jane McNicholas	TRUSTWIDE	Organisation to conduct a review the pooling of patient referrals and the way in which patients are allocated to, and reviewed by, clinicians in Services to ensure that continuity of care is optimised.	In progress
NICHE	Recommendation 13 - Monitoring of additional activity sessions (AASs) Introduce a robust policy and controls to retrospectively and prospectively review AAS activity in the Urology department, including a quarterly analysis of the number, value, and justification for AASs undertaken on a clinician-by-clinician basis.	MD13/ 1	Miss Leanne Cooper	TRUSTWIDE	Urology Only Review of AAS included in Safe Today (Recommendation 2&4) to include rational for additional activity and agency - confirmed Query? Policy in Finance to monitor/review SCC oversight of AAS, still in place?, check with Carol Park	In progress

NICHE	Recommendation 13 - Monitoring of additional activity sessions (AASs) Introduce a robust policy and controls to retrospectively and prospectively review AAS activity in the Urology department, including a quarterly analysis of the number, value, and justification for AASs undertaken on a clinician-by-clinician basis.	MD13/ 2	Miss Leanne Cooper	Urology	Implement a procedural document which details expectations of AAS activity in Urology clinics. This should be aligned with departmental clinic-by-clinic controls.	Fully complete (Awaiting approval)
NICHE	Recommendation 13 - Monitoring of additional activity sessions (AASs) Introduce a robust policy and controls to retrospectively and prospectively review AAS activity in the Urology department, including a quarterly analysis of the number, value, and justification for AASs undertaken on a clinician-by-clinician basis.	MD13/ 3	Miss Leanne Cooper	TRUSTWIDE	Agree with all care groups for an organisational process for monitoring and controlling additional activity sessions undertaken by clinicians.	In progress
NICHE	Recommendation 14 - Fluid balance monitoring Fluid balance practice should be audited and a programme of high-quality recording put in place for Urology patients.	MD14/ 1	Mrs Lynne Wyre	TRUSTWIDE	Current Case Review Action Evidence taken from QAAS assessment of Wards/Departments RSP Workstream 2 - Quality and Safety (Fundamentals of Care) Completed for Urology Query sustainability across wider trust	Partially complete
NICHE	Recommendation 14 - Fluid balance monitoring Fluid balance practice should be audited and a programme of high-quality recording put in place for Urology patients.	MD14/ 2	Mrs Lynne Wyre	Urology	Introduce and monitor fluid balance assurance check for urology patients on AMaT.	Fully complete (Awaiting approval)
NICHE	Recommendation 14 - Fluid balance monitoring Fluid balance practice should be audited and a programme of high-quality recording put in place for Urology patients.	MD14/ 3	Mrs Lynne Wyre	TRUSTWIDE	Ward/unit fluid balance assurance check to be developed and implemented in all appropriate clinical areas.	Partially complete

NICHE	Recommendation 15 - Mortality review (Link to R10 and R26) • Following on from our recommendation on mortality review in our Draft Current Controls Assessment Report, the Trust must develop a robust mechanism for identifying deaths by speciality using both admission and treatment function codes and other identifiers. This should include deaths up to 30 days post-discharge. • The HOGAN and National Confidential Enquiry into Patient Outcome and Death (NCEPOD) scoring arising from mortality reviews must be subject to audit and further scrutiny within the Trust. • All NCEPOD or HOGAN scores of 2 or above should give rise to further review by the Trust, investigation where appropriate and the potential need for Duty of Candour processes.	MD15/ 1	Ms Jane McNicholas	TRUSTWIDE	See response to Recommendation 10 RSP Workstream 2 - Quality & Safety - Mortality Query ME process in Trust	In progress
NICHE	Recommendation 15 - Mortality review (Link to R10 and R26) • Following on from our recommendation on mortality review in our Draft Current Controls Assessment Report, the Trust must develop a robust mechanism for identifying deaths by speciality using both admission and treatment function codes and other identifiers. This should include deaths up to 30 days post-discharge. • The HOGAN and National Confidential Enquiry into Patient Outcome and Death (NCEPOD) scoring arising from mortality reviews must be subject to audit and further scrutiny within the Trust. • All NCEPOD or HOGAN scores of 2 or above should give rise to further review by the Trust, investigation where appropriate and the potential need for Duty of Candour processes.	MD15/ 2	Ms Jane McNicholas	Urology	Review all mortality cases Activate MaMR and medical examiner triage Establish Mortality Steering group	Fully complete (Awaiting approval)

NICHE	Recommendation 15 - Mortality review (Link to R10 and R26) • Following on from our recommendation on mortality review in our Draft Current Controls Assessment Report, the Trust must develop a robust mechanism for identifying deaths by speciality using both admission and treatment function codes and other identifiers. This should include deaths up to 30 days post-discharge. • The HOGAN and National Confidential Enquiry into Patient Outcome and Death (NCEPOD) scoring arising from mortality reviews must be subject to audit and further scrutiny within the Trust. • All NCEPOD or HOGAN scores of 2 or above should give rise to further review by the Trust, investigation where appropriate and the potential need for Duty of Candour processes.	MD15/ 3	Ms Jane McNicholas	TRUSTWIDE	Develop and implement a Mortality Review Policy Mortality Steering Group in Place Roll out training strategies for staff undertaking mortality reviews Development of Quality Review Process is underway	In progress
NICHE	Recommendation 15 - Named Consultants • Named Consultants, for complex patients, should be introduced in Urology. This should include non-cancer patients. Complex cases without a diagnosis should be discussed at MDT or Radiology meetings. • Clinicians should be allocated clinical responsibility for the oversight of pathways including by cancer type to develop greater ownership and to drive improvements in services. (See R54(E)).	MD16/ 1	Mr Carl Foulkes	TRUSTWIDE	As per Recommendation 12 Completed for Urology	Fully complete (Awaiting approval)
NICHE	Recommendation 15 - Named Consultants • Named Consultants, for complex patients, should be introduced in Urology. This should include non-cancer patients. Complex cases without a diagnosis should be discussed at MDT or Radiology meetings. • Clinicians should be allocated clinical responsibility for the oversight of pathways including by cancer type to develop greater ownership and to drive improvements in services. (See R54(E)).	MD16/ 2	Ms Jane McNicholas	TRUSTWIDE	Trust Wide Action - The Trust will review whether Clinicians should be allocated clinical responsibility for the oversight of pathways including by cancer type to develop greater ownership and to drive improvements in services.	In progress

NICHE	Recommendation 17 - Capacity and best interests: applying the Mental Capacity Act 2005 • Capacity assessment and best interest decision-making should be improved through audit, training, and best practice examples. • An enhanced focus should be given to people presenting with dementia or confusion and those with a learning disability. • A thematic review examining the pathway, management and replacement of suprapubic catheters should be undertaken.	MD17/ 1	Mrs Bridget Lees	TRUSTWIDE	Trust Wide Actions Trust to Undertake reviews of : Capacity and best interests: applying the Mental Capacity Act 2005 1) Capacity assessment and best interest decision-making should be improved through audit, training, and best practice examples. 2) An enhanced focus should be given to people presenting with dementia or confusion and those with a learning disability. The Thematic review of the pathway, management and replacement of suprapubic catheters is Urology only and will only be addressed through ActionMD17/2	In progress
NICHE	Recommendation 17 - Capacity and best interests: applying the Mental Capacity Act 2005 • Capacity assessment and best interest decision-making should be improved through audit, training, and best practice examples. • An enhanced focus should be given to people presenting with dementia or confusion and those with a learning disability. • A thematic review examining the pathway, management and replacement of suprapubic catheters should be undertaken.	MD17/ 2	Mr Carl Foulkes	Urology	Urology Service to undertake review of: 1) Capacity assessment and best interest decision-making should be improved through audit, training, and best practice examples. 2) An enhanced focus should be given to people presenting with dementia or confusion and those with a learning disability. 3) A thematic review examining the pathway, management and replacement of suprapubic catheters should be undertaken.	In progress

NICHE	Recommendation 18 - Consent Consent for operations must be completed on every occasion. Any consent not completed correctly must be reported and investigated to improve practice. Consenting practice should be subject to audit and should include whether the patient dated the consent and the practice of confirmation of consent where the operating surgeon is different from the consenting surgeon. Theatre staff should be alerted to our concerns regarding consenting practice and be authorised to report all incidents where consent is not compliant with expected practice.	MD18/ 1	Ms Jane McNicholas	TRUSTWIDE	Action ahead of Trust Wide Electronic Consent Project CA - to check/confirm Evidence for Improvements in Urology Trust Wide process still not gone live - check dates	In progress
NICHE	Recommendation 18 - Consent Consent for operations must be completed on every occasion. Any consent not completed correctly must be reported and investigated to improve practice. Consenting practice should be subject to audit and should include whether the patient dated the consent and the practice of confirmation of consent where the operating surgeon is different from the consenting surgeon. Theatre staff should be alerted to our concerns regarding consenting practice and be authorised to report all incidents where consent is not compliant with expected practice.	MD18/ 2	Mr John Wilson	Urology	Implement Go-live electronic Consent process for Urology.	Fully complete (Awaiting approval)

NICHE	Recommendation 18 - Consent Consent for operations must be completed on every occasion. Any consent not completed correctly must be reported and investigated to improve practice. Consenting practice should be subject to audit and should include whether the patient dated the consent and the practice of confirmation of consent where the operating surgeon is different from the consenting surgeon. Theatre staff should be alerted to our concerns regarding consenting practice and be authorised to report all incidents where consent is not compliant with expected practice.	MD18/ 3	Ms Jane McNicholas	TRUSTWIDE	Implement Go-Live of electronic Consent Process for the whole organisation. Considerations: 1. Trust wide consent Policy 2. Training / Knowledge awareness 3. Trust wide audit of consent. 4. Evidence exists for Improvements in Urology	In progress
NICHE	Recommendation 19 - Lorenzo All scan and clinical results should be acknowledged by the requester. Clinicians should be trained on the use of Lorenzo to ensure that they are aware of how to complete this activity. It should be made clear to all staff in which part of Lorenzo key documentation should be filed to reduce the amount of time spent finding key clinical information. A record of stent register status should be clearly marked and visible.	MD19/ 1	Dr William Lumb	TRUSTWIDE	All scan and clinical results should be acknowledged by the requester - in place Clinicians should be trained on the use of Lorenzo to ensure that they are aware of how to complete this activity - in place It should be made clear to all staff in which part of Lorenzo key documentation should be filed to reduce the amount of time spent finding key clinical information. - in progress see Mel Waszkiel part of Documentation TFG A record of stent register status should be clearly marked and visible. - Completed Complete for Urology ? Trust Wide applicability	In progress

NICHE	Recommendation 19 - Lorenzo All scan and clinical results should be acknowledged by the requester. Clinicians should be trained on the use of Lorenzo to ensure that they are aware of how to complete this activity. It should be made clear to all staff in which part of Lorenzo key documentation should be filed to reduce the amount of time spent finding key clinical information. A record of stent register status should be clearly marked and visible.	MD19/ 2	Mr John Wilson	Urology	Ensure a record of stent register is clearly marked and visible. Confirm R&R Status.	Fully complete (Awaiting approval)
NICHE	Recommendation 19 - Lorenzo All scan and clinical results should be acknowledged by the requester. Clinicians should be trained on the use of Lorenzo to ensure that they are aware of how to complete this activity. It should be made clear to all staff in which part of Lorenzo key documentation should be filed to reduce the amount of time spent finding key clinical information. A record of stent register status should be clearly marked and visible.	MD19/ 3	Dr William Lumb	TRUSTWIDE	Agree and implement a training strategy for the trust to ensure clinicians are aware of trust wide standards. Ensure clarity of information require on completion of adding information on Lorenzo and acknowledgement of request status.	In progress
NICHE	Recommendation 20 - Recording of ethnicity • The sample provided does not include information on ethnicity other than White or Unknown/Mixed. The Trust should examine whether it is recording ethnicity in its records in line with expected practice.	MD20/ 1	Ms Jane McNicholas	TRUSTWIDE	Trust Wide Action Trust to review the recording of patient ethnicity in its EPRs/records in line with expected practice	In progress
NICHE	Recommendation 20 - Recording of ethnicity • The sample provided does not include information on ethnicity other than White or Unknown/Mixed. The Trust should examine whether it is recording ethnicity in its records in line with expected practice.	MD20/ 2	Mr Carl Foulkes	Urology	Urology Action No Action will be taken in Urology, A Trust wide response is required to the recording of Patient ethnicity in EPRs This will be managed thorough Action MD20/1	Fully complete (Awaiting approval)

NICHE	Recommendation 21 - Case note review • There should be a repeat case note review (100 cases) in 12 months (Autumn 2022) to assess if improvements have been sustained and embedded.	MD21/ 1	Mr Carl Foulkes	Urology	Trust Clinical Audit Team to work with Urology Audit Lead (Mr Saqib) to ensure that Repeat Audit of 100 Case Notes is added to the Trust Forward Audit Plan for 2022-23, Audit will take place in Quarter 2/3 of 2022/23, with completion in Quarter 3 of 2022/23.	Partially complete
NICHE	Recommendation 21 - Case note review • There should be a repeat case note review (100 cases) in 12 months (Autumn 2022) to assess if improvements have been sustained and embedded.	MD21/ 2	Mr Richard Sachs	Urology	Action for NICHE, not UHMBT - not started/completed Query - Any Audit recorded on Forward Plan?	Fully complete (Awaiting approval)

NICHE	Recommendation 22 (Cancer Alliance) - Improving the pathway for bladder cancer diagnosis • Where appropriate, conducting a flexible cystoscopy on the day of attending the One Stop Clinic would make this a truly one-stop service. • Patients meeting the two-week wait criteria with visible haematuria and normal estimated glomerular filtration rate (eGFR) should be triaged to have a CT Urogram prior to attending clinic to streamline the service. • Patients requiring ongoing monitoring following chemotherapy/radiotherapy should be referred back via the MDT to a named Consultant at the Trust, on completing their therapy, who is then responsible for co-ordinating on-going care (e.g. in this case, being clear about the rationale for examination under anaesthetic (EUA), biopsy, cystoscopy and stenting). The MDT will need to ensure there is a clear management plan and processes put in place to ensure Urology actions are implemented. This will also allow time to plan dates for surgery to meet required timescales. • Lancashire and South Cumbria Cancer Alliance follow up protocols should be agreed and followed. • All patients should be listed on the stent register. If they are transferred to another Trust with the expectation that the stent is removed, this should be explicitly stated; if patients are transferred into the Trust with a stent in situ, they should be added to the Trust's stent register.	MD22/ 1	Ms Jane McNicholas	TRUSTWIDE	Urology Completed lexible cystoscopy on the day of attending the One Stop Clinic would make this a truly one-stop service - In Place two-week wait criteria with visible haematuria and normal estimated glomerular filtration rate (eGFR) should be triaged to have a CT Urogram - completed Patients requiring ongoing monitoring following chemotherapy/radiotherapy should be referred back via the MDT to a named Consultant at the Trust All patients should be listed on the stent register Need to review for Trust lexible cystoscopy on the day of attending the One Stop Clinic would make this a truly one-stop service - In Place two-week wait criteria with visible haematuria and normal estimated glomerular filtration rate (eGFR) should be triaged to have a CT Urogram - completed Patients requiring ongoing monitoring following chemotherapy/radiotherapy should be referred back via the MDT to a named Consultant at the Trust All patients should be listed on the stent register Lancashire and South Cumbria Cancer Alliance - update require, raise with Trust Cancer Lead Lancashire and South Cumbria Cancer Alliance follow up protocols should be agreed and followed.	In progress

NICHE	Recommendation 22 (Cancer Alliance) - Improving the pathway for bladder cancer diagnosis • Where appropriate, conducting a flexible cystoscopy on the day of attending the One Stop Clinic would make this a truly one-stop service. • Patients meeting the two-week wait criteria with visible haematuria and normal estimated glomerular filtration rate (eGFR) should be triaged to have a CT Urogram prior to attending clinic to streamline the service. • Patients requiring ongoing monitoring following chemotherapy/radiotherapy should be referred back via the MDT to a named Consultant at the Trust, on completing their therapy, who is then responsible for co-ordinating on-going care (e.g. in this case, being clear about the rationale for examination under anaesthetic (EUA), biopsy, cystoscopy and stenting). The MDT will need to ensure there is a clear management plan and processes put in place to ensure Urology actions are implemented. This will also allow time to plan dates for surgery to meet required timescales. • Lancashire and South Cumbria Cancer Alliance follow up protocols should be agreed and followed. • All patients should be listed on the stent register. If they are transferred to another Trust with the expectation that the stent is removed, this should be explicitly stated; if patients are transferred into the Trust with a stent in situ, they should be added to the Trust's stent register.	MD22/ 2	Mr John Wilson	Urology	Review pathway for bladder cancer diagnosis. consult with key stakeholders to review and implement improved pathway.	Fully complete (Awaiting approval)

NICHE	Recommendation 22 (Cancer Alliance) - Improving the pathway for bladder cancer diagnosis • Where appropriate, conducting a flexible cystoscopy on the day of attending the One Stop Clinic would make this a truly one-stop service. • Patients meeting the two-week wait criteria with visible haematuria and normal estimated glomerular filtration rate (eGFR) should be triaged to have a CT Urogram prior to attending clinic to streamline the service. • Patients requiring ongoing monitoring following chemotherapy/radiotherapy should be referred back via the MDT to a named Consultant at the Trust, on completing their therapy, who is then responsible for co-ordinating on-going care (e.g. in this case, being clear about the rationale for examination under anaesthetic (EUA), biopsy, cystoscopy and stenting). The MDT will need to ensure there is a clear management plan and processes put in place to ensure Urology actions are implemented. This will also allow time to plan dates for surgery to meet required timescales. • Lancashire and South Cumbria Cancer Alliance follow up protocols should be agreed and followed. • All patients should be listed on the stent register. If they are transferred to another Trust with the expectation that the stent is removed, this should be explicitly stated; if patients are transferred into the Trust with a stent in situ, they should be added to the Trust's stent register.	MD22/ 3	Ms Jane McNicholas	TRUSTWIDE	Review adherence to cancer pathways from other services in the organisation. Review cancer care pathways.	In progress

NICHE	Recommendation 23 - Clinical monitoring The Trust should continue to embed good practice and use of: • Venous thromboembolism (VTE) assessment. • Nutrition, hydration and associated food/fluid balance monitoring must be enforced as fundamental standards. Use of the Malnutrition Universal Screening Tool (MUST) should be audited at specified intervals to ensure scoring and onward actions are appropriate. Total Parenteral Nutrition (TPN) guidelines should be reviewed and monitored to ensure that this option is considered early for all patients who are at risk of malnutrition. • The Trust should monitor the recent implementation of the electronic NEWS2 charts to ensure that the new system is successful in identifying and responding to deteriorating patients. • Access to formal on call microbiology advice out-of-hours should be provided.	MD23/ 1	Ms Jane McNicholas	TRUSTWIDE	The Trust Will continue to embed good practice and use of: 1) Venous thromboembolism (VTE) assessment 2) Nutrition, hydration and associated food/fluid balance monitoring must be enforced as fundamental standards. 3) Total Parenteral Nutrition (TPN) guidelines should be reviewed and monitored 4) Monitor the recent implementation of the electronic NEWS2 charts 5) Access to formal on call microbiology advice out-of-hours	Partially complete

NICHE	Recommendation 23 - Clinical monitoring The Trust should continue to embed good practice and use of: • Venous thromboembolism (VTE) assessment. • Nutrition, hydration and associated food/fluid balance monitoring must be enforced as fundamental standards. Use of the Malnutrition Universal Screening Tool (MUST) should be audited at specified intervals to ensure scoring and onward actions are appropriate. Total Parenteral Nutrition (TPN) guidelines should be reviewed and monitored to ensure that this option is considered early for all patients who are at risk of malnutrition. • The Trust should monitor the recent implementation of the electronic NEWS2 charts to ensure that the new system is successful in identifying and responding to deteriorating patients. • Access to formal on call microbiology advice out-of-hours should be provided.	MD23/ 2	Mr Carl Foulkes	Urology	Urology Action Urology Will continue to embed good practice and use of: 1) Venous thromboembolism (VTE) assessment 2) Nutrition, hydration and associated food/fluid balance monitoring must be enforced as fundamental standards. 3) Total Parenteral Nutrition (TPN) guidelines should be reviewed and monitored 4) Monitor the recent implementation of the electronic NEWS2 charts 5) Access to formal on call microbiology advice out-of-hours	Partially complete

NICHE	Recommendation 24 - Standard operating policies and procedures The Trust must ensure the following are up-to-date and subject to regular audit: • the identification and management of Urosepsis and obstructed kidneys; • the identification and management of sepsis and the deteriorating patient; • the management and registration of stents; • handover of patients between on call Consultants; • consenting guidelines, including actions to be taken when patients cannot consent and when emergency surgery is required; • interspecialty referral processes; and • recording decisions made when a patient is referred to Intensive Treatment Unit (ITU), the escalation of capacity issues and a clear protocol regarding options when ITU is full.	MD24/ 1	Mr Muhammad Saleem Naseem	Urology	Trust Procedural Documents Team to work with Surgery and Critical Care Care Group to review the following documents and ensure they contain a requirement for regular Audit • the identification and management of Urosepsis and obstructed kidneys; • the management and registration of stents; • recording decisions made when a patient is referred to Intensive Treatment Unit (ITU), the escalation of capacity issues and a clear protocol regarding options when ITU is full.	Fully complete (Awaiting approval)
NICHE	Recommendation 24 - Standard operating policies and procedures The Trust must ensure the following are up-to-date and subject to regular audit: • the identification and management of Urosepsis and obstructed kidneys; • the identification and management of sepsis and the deteriorating patient; • the management and registration of stents; • handover of patients between on call Consultants; • consenting guidelines, including actions to be taken when patients cannot consent and when emergency surgery is required; • interspecialty referral processes; and • recording decisions made when a patient is referred to Intensive Treatment Unit (ITU), the escalation of capacity issues and a clear protocol regarding options when ITU is full.	MD24/ 2	Mrs Bridget Lees	TRUSTWIDE	Trust Procedural Documents Team to work with Patient Safety Matron to review the following documents and ensure they contain a requirement for regular Audit • the identification and management of sepsis and the deteriorating patient;	Fully complete (Awaiting approval)

NICHE	Recommendation 24 - Standard operating policies and procedures The Trust must ensure the following are up-to-date and subject to regular audit: • the identification and management of Urosepsis and obstructed kidneys; • the identification and management of sepsis and the deteriorating patient; • the management and registration of stents; • handover of patients between on call Consultants; • consenting guidelines, including actions to be taken when patients cannot consent and when emergency surgery is required; • interspecialty referral processes; and • recording decisions made when a patient is referred to Intensive Treatment Unit (ITU), the escalation of capacity issues and a clear protocol regarding options when ITU is full.	MD24/ 3	Ms Jane McNicholas	TRUSTWIDE	Trust Procedural Documents Team to work with Medical Director to review the following documents and ensure they contain a requirement for regular Audit • handover of patients between on call Consultants; • consenting guidelines, including actions to be taken when patients cannot consent and when emergency surgery is required; • interspecialty referral processes;	Fully complete (Awaiting approval)
NICHE	Recommendation 24 - Standard operating policies and procedures The Trust must ensure the following are up-to-date and subject to regular audit: • the identification and management of Urosepsis and obstructed kidneys; • the identification and management of sepsis and the deteriorating patient; • the management and registration of stents; • handover of patients between on call Consultants; • consenting guidelines, including actions to be taken when patients cannot consent and when emergency surgery is required; • interspecialty referral processes; and • recording decisions made when a patient is referred to Intensive Treatment Unit (ITU), the escalation of capacity issues and a clear protocol regarding options when ITU is full.	MD24/ 4	Mr Richard Sachs	TRUSTWIDE	Trust Clinical Audit Team to work with Trust Procedural Documents Team to ensure Audits from the following documents are placed on the 2022/23 Audit Forward Plan: • the identification and management of Urosepsis and obstructed kidneys; • the identification and management of sepsis and the deteriorating patient; • the management and registration of stents; • handover of patients between on call Consultants; • consenting guidelines, including actions to be taken when patients cannot consent and when emergency surgery is required; • interspecialty referral processes; and • recording decisions made when a patient is referred to Intensive Treatment Unit (ITU), the escalation of capacity issues and a clear protocol regarding options when ITU is full.	Partially complete

NICHE	Recommendation 24 - Standard operating policies and procedures The Trust must ensure the following are up-to-date and subject to regular audit: • the identification and management of Urosepsis and obstructed kidneys; • the identification and management of sepsis and the deteriorating patient; • the management and registration of stents; • handover of patients between on call Consultants; • consenting guidelines, including actions to be taken when patients cannot consent and when emergency surgery is required; • interspecialty referral processes; and • recording decisions made when a patient is referred to Intensive Treatment Unit (ITU), the escalation of capacity issues and a clear protocol regarding options when ITU is full.	MD24/ 5	Mr Muhammad Saleem Naseem	Urology	Urology Audits 1) the identification and management of Urosepsis and obstructed kidneys 2) the identification and management of sepsis and the deteriorating patient 3) the management and registration of stents 4) handover of patients between on call Consultants 5) consenting guidelines, including actions to be taken when patients cannot consent and when emergency surgery is required 6) interspecialty referral processes; 7) recording decisions made when a patient is referred to Intensive Treatment Unit (ITU), the escalation of capacity issues and a clear protocol regarding options when ITU is full	Partially complete
NICHE	Recommendation 25 (ICS &CCG) - Nephrostomy service • The Trust and Clinical Commissioning Groups (CCGs) should review arrangements for out-of-hours nephrostomy provision, including over bank holidays and emergency cover. • The arrangements that have been put in place should be assessed to ensure that standards for accessing nephrostomy provision out of hours and for returning patients to the Trust are appropriate, agreed, and form part of a standard operating procedure that is audited to confirm compliance.	MD25/ 1	Mr Muhammad Saleem Naseem	TRUSTWIDE	Urology only? Completed? Procedure approved at TPDIG - August 21 Agreed SLA - Neil Swindlehurst ICS SOP in place Has this been signed off by the ICS?	In progress

NICHE	Recommendation 25 (ICS &CCG) - Nephrostomy service • The Trust and Clinical Commissioning Groups (CCGs) should review arrangements for out-of-hours nephrostomy provision, including over bank holidays and emergency cover. • The arrangements that have been put in place should be assessed to ensure that standards for accessing nephrostomy provision out of hours and for returning patients to the Trust are appropriate, agreed, and form part of a standard operating procedure that is audited to confirm compliance.	MD25/ 2	Mr John Wilson	Urology	Agree a process and procedural document for SLA and ICS for Urology service in line with the trust procedural document process.	Fully complete (Awaiting approval)

NICHE	Recommendation 26 (National) - Mortality review (Link to R10 and R15) • Any post-operative death should be subject to rigorous and contemporaneous case review and monitored at Trust level. This would also help support accurate reports to the Coroner if required to be written some months post death. • Death summaries and sudden death reports to the Coroner should be audited for quality and accuracy. • Every inpatient death within the Surgical and Critical Care Group (S&CCG) should be reported and subject to case review, this review should be shared within the department and at Trust level. • Every inpatient death in Urology services and other surgical specialties should be discussed in departmental meetings. • Every inquest involving the Trust must include consideration of whether an incident might have occurred that requires investigation and to prepare statements and reports in an adequate timeframe. • Statements to Coroners written in relation to whole episodes of care involving a team or a Trust service should be subject to validation by legal or corporate services to ensure that all parties have a right of reply (where needed) and that statements made are accurate. This is distinct from an individual health care professional providing a witness statement solely in relation to their own input. • Failures in care identified as a result of producing a Coroner's statement must be reported as an incident and any named individuals given a right of reply. • The Trust's Providing Statements to the Coroner Standard Operating Procedure should be revised to include the above. • The Trust must assure themselves that the Providing Statements to the Coroner Standard	MD26/ 1	Ms Jane McNicholas	TRUSTWIDE	The Trust will review its Mortality review processes to address the following actions: 1) Any post-operative death should be subject to rigorous and contemporaneous case review and monitored at Trust level. This would also help support accurate reports to the Coroner if required to be written some months post death. 2) Death summaries and sudden death reports to the Coroner should be audited for quality and accuracy. 3) Every inpatient death within the Surgical and Critical Care Group (S&CCG) should be reported and subject to case review, this review should be shared within the department and at Trust level. 4) Every inpatient death in Urology services and other surgical specialties should be discussed in departmental meetings. 5) Every inquest involving the Trust must include consideration of whether an incident might have occurred that requires investigation and to prepare statements and reports in an adequate timeframe. 6) Statements to Coroners written in relation to whole episodes of care involving a team or a Trust service should be subject to validation by legal or corporate services to ensure that all parties have a right of reply (where needed) and that statements made are accurate. This is distinct from an individual health care professional providing a witness statement solely in relation to their own input. 7) Failures in care identified as a result of producing a Coroner's statement must be reported as an incident and any named individuals given a right of reply. 8) The Trust's Providing Statements to the Coroner Standard Operating Procedure should be revised to include the above. 9) The Trust must assure themselves that the Providing Statements to the Coroner Standard	Partially complete

	Operating Procedure is being complied with. Statements should differentiate between fact and opinion. In addition, there should be a clear indication of how the statement has been compiled. • The Trust should ensure that records are retained post-death and copies made for the purposes of review and investigation to mitigate the risk of retrospective entry. [The Medical Examiner role was introduced in the Trust in April 2020; this function should be assessed against the above recommendations].				Operating Procedure is being complied with. Statements should differentiate between fact and opinion. In addition, there should be a clear indication of how the statement has been compiled. 10) The Trust should ensure that records are retained post-death and copies made for the purposes of review and investigation to mitigate the risk of retrospective entry.	

NICHE	Recommendation 26 (National) - Mortality review (Link to R10 and R15) • Any post-operative death should be subject to rigorous and contemporaneous case review and monitored at Trust level. This would also help support accurate reports to the Coroner if required to be written some months post death. • Death summaries and sudden death reports to the Coroner should be audited for quality and accuracy. • Every inpatient death within the Surgical and Critical Care Group (S&CCG) should be reported and subject to case review, this review should be shared within the department and at Trust level. • Every inpatient death in Urology services and other surgical specialties should be discussed in departmental meetings. • Every inquest involving the Trust must include consideration of whether an incident might have occurred that requires investigation and to prepare statements and reports in an adequate timeframe. • Statements to Coroners written in relation to whole episodes of care involving a team or a Trust service should be subject to validation by legal or corporate services to ensure that all parties have a right of reply (where needed) and that statements made are accurate. This is distinct from an individual health care professional providing a witness statement solely in relation to their own input. • Failures in care identified as a result of producing a Coroner's statement must be reported as an incident and any named individuals given a right of reply. • The Trust's Providing Statements to the Coroner Standard Operating Procedure should be revised to include the above. • The Trust must assure themselves that the Providing Statements to the Coroner Standard	MD26/ 2	Mr Carl Foulkes	Surgery and Critical Care Services	SCC/Urology Actions Every inpatient death within the Surgical and Critical Care Group (S&CCG) should be reported and subject to case review, this review should be shared within the department and at Trust level. Every inpatient death in Urology services and other surgical specialties should be discussed in departmental meetings. Other Action Points will be addressed through Action MD26/1	In progress

	Operating Procedure is being complied with. Statements should differentiate between fact and opinion. In addition, there should be a clear indication of how the statement has been compiled. • The Trust should ensure that records are retained post-death and copies made for the purposes of review and investigation to mitigate the risk of retrospective entry. [The Medical Examiner role was introduced in the Trust in April 2020; this function should be assessed against the above recommendations].					

NICHE	Recommendation 27 - Managing complaints and compound family questions • The Trust's Management Procedure for the Investigation and Resolution of Complaints should be reviewed to ensure advice is clear on the handling of persistent/compound complaints that are not vexatious. • Repeated approaches/compound questions from a family in relation to concerns in care, including the death of a loved one, should be formally logged as a complaint. These cases should be allocated an appropriate single point of contact or family liaison officer to manage the process and support the family. These cases should also be flagged and carefully monitored as they have potential for extended resolution timescales. • Any case involving an inquest or complaint from a family should also be reviewed to determine whether it should be recorded as an incident(s). Any subsequent investigation and complaints processes should be managed in a coordinated fashion. • Compound complaints often arise once medical records are provided as these may be incomplete (due to archiving and multiple patient record systems). The Trust should ensure that full sets of medical records are provided at the outset of the request in line with existing Freedom of Information Act (FOIA), Subject Access Requests (SAR) and Access to Health Records Policies. • Clear guidance on sharing the medical records of deceased patients with families should be set out to ensure that relatives are provided with requested information promptly and in line with the appropriate legislation. • When FOIA or SAR include requests for email-based information, all searches should be formally logged and centrally managed so that	MD27/ 1	Mr Richard Sachs	TRUSTWIDE	Trust Action 1 - The Trust's Management Procedure for the Investigation and Resolution of Complaints should be reviewed to ensure advice is clear on the handling of persistent/compound complaints that are not vexatious 2- Repeated approaches/compound questions from a family in relation to concerns in care, including the death of a loved one, should be formally logged as a complaint. 3 - These cases should be allocated an appropriate single point of contact or family liaison officer to manage the process and support the family. These cases should also be flagged and carefully monitored as they have potential for extended resolution timescales. 4 - Any case involving an inquest or complaint from a family should also be reviewed to determine whether it should be recorded as an incident(s). Any subsequent investigation and complaints processes should be managed in a coordinated fashion. 5 - Compound complaints often arise once medical records are provided as these may be incomplete (due to archiving and multiple patient record systems). The Trust should ensure that full sets of medical records are provided at the outset of the request in line with existing Freedom of Information Act (FOIA), Subject Access Requests (SAR) and Access to Health Records Policies. 6 - Clear guidance on sharing the medical records of deceased patients with families should be set out to ensure that relatives are provided with requested information promptly and in line with the appropriate legislation. 7 - When FOIA or SAR include requests for email-based information, all searches should be formally logged and centrally managed so that the Trust has a full record of searches available to them.	Partially complete

	the Trust has a full record of searches available to them.					

NICHE	Recommendation 27 - Managing complaints and compound family questions • The Trust's Management Procedure for the Investigation and Resolution of Complaints should be reviewed to ensure advice is clear on the handling of persistent/compound complaints that are not vexatious. • Repeated approaches/compound questions from a family in relation to concerns in care, including the death of a loved one, should be formally logged as a complaint. These cases should be allocated an appropriate single point of contact or family liaison officer to manage the process and support the family. These cases should also be flagged and carefully monitored as they have potential for extended resolution timescales. • Any case involving an inquest or complaint from a family should also be reviewed to determine whether it should be recorded as an incident(s). Any subsequent investigation and complaints processes should be managed in a coordinated fashion. • Compound complaints often arise once medical records are provided as these may be incomplete (due to archiving and multiple patient record systems). The Trust should ensure that full sets of medical records are provided at the outset of the request in line with existing Freedom of Information Act (FOIA), Subject Access Requests (SAR) and Access to Health Records Policies. • Clear guidance on sharing the medical records of deceased patients with families should be set out to ensure that relatives are provided with requested information promptly and in line with the appropriate legislation. • When FOIA or SAR include requests for email-based information, all searches should be formally logged and centrally managed so that	MD27/ 2	Mr Carl Foulkes	Urology	Urology Action Managing complaints and compound family questions 1 - The Trust's Management Procedure for the Investigation and Resolution of Complaints should be reviewed to ensure advice is clear on the handling of persistent/compound complaints that are not vexatious. 2 - Repeated approaches/compound questions from a family in relation to concerns in care, including the death of a loved one, should be formally logged as a complaint. These cases should be allocated an appropriate single point of contact or family liaison officer to manage the process and support the family. These cases should also be flagged and carefully monitored as they have potential for extended resolution timescales. 3 - Any case involving an inquest or complaint from a family should also be reviewed to determine whether it should be recorded as an incident(s). Any subsequent investigation and complaints processes should be managed in a coordinated fashion. 4 - Compound complaints often arise once medical records are provided as these may be incomplete (due to archiving and multiple patient record systems). The Trust should ensure that full sets of medical records are provided at the outset of the request in line with existing Freedom of Information Act (FOIA), Subject Access Requests (SAR) and Access to Health Records Policies. 5 - Clear guidance on sharing the medical records of deceased patients with families should be set out to ensure that relatives are provided with requested information promptly and in line with the appropriate legislation. 6 - When FOIA or SAR include requests for email-based information, all searches should be formally logged and centrally managed so that	Partially complete

	the Trust has a full record of searches available to them.				the Trust has a full record of searches available to them.	

NICHE	Recommendation 28 - Consultant relationships (Link to R65(E)) • The Trust should pay particular attention to any grievance raised by a Consultant or senior medical member of staff about another peer. Prompt and diligent investigations should be undertaken to ensure that the basis of concerns is fully understood and properly actioned to resolve peer-to-peer difficulties and concerns in a transparent and effective manner. • The Board should be made aware at an early stage of any specialty where relationships may be failing as this is a key patient safety marker. The Board should monitor actions to achieve improvement. This should be undertaken via the Employee Relations Report. • The Medical Director should be informed of any concerns about Consultant relationships (as Responsible Officer).	MD28/ 1	Mr David Wilkinson	TRUSTWIDE	Urology Completed/processes in place - Ongoing Monitoring RSP Workstream 4: Culture & Leadership - The Trust should pay particular attention to any grievance raised by a Consultant or senior medical member of staff about another peer - The Board should be made aware at an early stage of any specialty where relationships may be failing - EDG Hotspot reporting MD is on EDG - The Medical Director should be informed of any concerns about Consultant relationships - Medical Director is now RO - completed Trust Wide - Ongoing RSP Workstream 4: Culture & Leadership	In progress
NICHE	Recommendation 28 - Consultant relationships (Link to R65(E)) • The Trust should pay particular attention to any grievance raised by a Consultant or senior medical member of staff about another peer. Prompt and diligent investigations should be undertaken to ensure that the basis of concerns is fully understood and properly actioned to resolve peer-to-peer difficulties and concerns in a transparent and effective manner. • The Board should be made aware at an early stage of any specialty where relationships may be failing as this is a key patient safety marker. The Board should monitor actions to achieve improvement. This should be undertaken via the Employee Relations Report. • The Medical Director should be informed of any concerns about Consultant relationships (as Responsible Officer).	MD28/ 2	Mr David Wilkinson	TRUSTWIDE	Work with the Leadership and Culture Workstream / IBD to develop procedural documents for whistleblowing and embed best practice in the Urology service. Focus: The Board should be made aware at an early stage of any specialty where relationships may be failing as this is a key patient safety marker. The Medical Director should be informed of any concerns about Consultant relationships (as Responsible Officer). Grievances by consultants should be picked up as part of Leadership and Culture Workstream - to ensure early resolution	In progress

NICHE	Recommendation 28 - Consultant relationships (Link to R65(E)) • The Trust should pay particular attention to any grievance raised by a Consultant or senior medical member of staff about another peer. Prompt and diligent investigations should be undertaken to ensure that the basis of concerns is fully understood and properly actioned to resolve peer-to-peer difficulties and concerns in a transparent and effective manner. • The Board should be made aware at an early stage of any specialty where relationships may be failing as this is a key patient safety marker. The Board should monitor actions to achieve improvement. This should be undertaken via the Employee Relations Report. • The Medical Director should be informed of any concerns about Consultant relationships (as Responsible Officer).	MD28/ 3	Mr David Wilkinson	TRUSTWIDE	Grievance and whistleblowing procedural document to be developed and implemented trust wide. Focus 1. Trust should pay particular attention to any grievance raised by a Consultant or senior medical member of staff about another peer. Prompt and diligent investigations should be undertaken to ensure that the basis of concerns is fully understood and properly actioned to resolve peer-to-peer difficulties and concerns in a transparent and effective manner. 2. Greater oversight from the Board to ensure informed at an early stage of any specialty where relationships may be failing as this is a key patient safety marker. The Board should monitor actions to achieve improvement. This should be undertaken via the Employee Relations Report. (EDG Hotspots - weekly slot)	In progress
NICHE	Recommendation 29 - Triggers for external investigations • Terms of reference for all externally commissioned investigations should be scoped individually and quality assured to ensure that patient/family questions are included and that specific Trust concerns are addressed. (This principle should be followed for all root cause analysis (RCA) and serious incident (SI) reports undertaken internally in line with good practice). The Trust should develop a set of triggers for external investigations to be undertaken including when departmental dysfunction is apparent. • The Trust should revisit its tolerance for requesting external support in investigations.	MD29/ 1	Mr Richard Sachs	TRUSTWIDE	Trust Wide Action - Will also address Urology Action Trust will develop and implement Procedural document to establish and record the following: - The tolerance/triggers for requesting external support in investigations - How the Terms of Reference for externally commissioned investigations should be developed, drafted and approved - To ensure these Terms of Reference incorporate patient/family questions - To ensure these Terms of Reference incorporate any specific Trust concerns	In progress

NICHE	Recommendation 29 - Triggers for external investigations • Terms of reference for all externally commissioned investigations should be scoped individually and quality assured to ensure that patient/family questions are included and that specific Trust concerns are addressed. (This principle should be followed for all root cause analysis (RCA) and serious incident (SI) reports undertaken internally in line with good practice). The Trust should develop a set of triggers for external investigations to be undertaken including when departmental dysfunction is apparent. • The Trust should revisit its tolerance for requesting external support in investigations.	MD29/ 2	Mr Richard Sachs	Urology	Urology Action This recommendation requires the development and implementation of Trust Wide standards and processes - See Action SD29/1. No separate action for Urology will be developed or implemented.	Fully complete (Awaiting approval)
NICHE	Recommendation 30 (ICS/CCG) - Clinical records in the form of emails (Link to R34(E)) • The Trust should add all Consultant staff email accounts to their Very Important Persons (VIP) list for a period of seven years once employment is ended. • The Trust should revisit its record-keeping policy as regards the use of email communications between clinicians containing clinical information. This should include: - clarification of what is an acceptable use of email in sharing patient specific clinical information, both internally and externally, to the Trust (including in clinical networks); - ensuring that where patient specific clinical information is shared by email (if appropriate) that these communications are retained as part of the clinical record; - revisiting the Trust email archiving policy, in light of the above, to ensure that emails can be retrieved where necessary (for example for SAR purposes); and - that all professionals should record the fact that an onward communication has been made within the clinical record.	MD30/ 1	Ms Jane McNicholas	TRUSTWIDE	The Trust needs top review Clinical records in the form of emails 1) The Trust should add all Consultant staff email accounts to their Very Important Persons (VIP) list for a period of seven years once employment is ended. 2) The Trust should revisit its record-keeping policy as regards the use of email communications between clinicians containing clinical information. This should include: 2.1) clarification of what is an acceptable use of email in sharing patient specific clinical information, both internally and externally, to the Trust (including in clinical networks); 2.2) ensuring that where patient specific clinical information is shared by email (if appropriate) that these communications are retained as part of the clinical record; 2.3) revisiting the Trust email archiving policy, in light of the above, to ensure that emails can be retrieved where necessary (for example for SAR purposes); and 2.4) that all professionals should record the fact that an onward communication has been made within the clinical record.	Partially complete

NICHE	Recommendation 30 (ICS/CCG) - Clinical records in the form of emails (Link to R34(E)) • The Trust should add all Consultant staff email accounts to their Very Important Persons (VIP) list for a period of seven years once employment is ended. • The Trust should revisit its record-keeping policy as regards the use of email communications between clinicians containing clinical information. This should include: - clarification of what is an acceptable use of email in sharing patient specific clinical information, both internally and externally, to the Trust (including in clinical networks); - ensuring that where patient specific clinical information is shared by email (if appropriate) that these communications are retained as part of the clinical record; - revisiting the Trust email archiving policy, in light of the above, to ensure that emails can be retrieved where necessary (for example for SAR purposes); and - that all professionals should record the fact that an onward communication has been made within the clinical record.	MD30/ 2	Mr Carl Foulkes	TRUSTWIDE	Urology Action This Recommendation requires a Trust Wide Response and will be managed through Action MD30/1 No Urology Specific Action required	Fully complete (Awaiting approval)

NICHE	Recommendation 31 - Clinical dispute resolution • The Trust should introduce a mechanism of escalation, separate to the existing grievance and Freedom to Speak Up processes, whereby clinical disputes (in MDTs, between individuals or within departments) are formally mediated and resolved. The responsibilities for professionals involved in the event to engage in this mechanism of escalation should be made clear. This should be supported by a formal policy and should detail timescales for reporting, arbitration, resolution, and the trigger for the involvement of independent clinical adjudicators. Processes to report into other forums (such as Clinical Governance, mortality review, Ethics Committee and Revalidation) should be made clear within this policy.	MD31/ 1	Mr David Wilkinson	TRUSTWIDE	The Trust should introduce a mechanism of escalation, separate to the existing grievance and Freedom to Speak Up processes, whereby clinical disputes (in MDTs, between individuals or within departments) are formally mediated and resolved. 1) The responsibilities for professionals involved in the event to engage in this mechanism of escalation should be made clear. 2) This should be supported by a formal policy and should detail timescales for reporting, arbitration, resolution, and the trigger for the involvement of independent clinical adjudicators. 3) Processes to report into other forums (such as Clinical Governance, mortality review, Ethics Committee and Revalidation) should be made clear within this policy.	In progress
NICHE	Recommendation 31 - Clinical dispute resolution • The Trust should introduce a mechanism of escalation, separate to the existing grievance and Freedom to Speak Up processes, whereby clinical disputes (in MDTs, between individuals or within departments) are formally mediated and resolved. The responsibilities for professionals involved in the event to engage in this mechanism of escalation should be made clear. This should be supported by a formal policy and should detail timescales for reporting, arbitration, resolution, and the trigger for the involvement of independent clinical adjudicators. Processes to report into other forums (such as Clinical Governance, mortality review, Ethics Committee and Revalidation) should be made clear within this policy.	MD31/ 2	Mr Carl Foulkes	Urology	Urology Action This Recommendation requires a Trust Wide resolution, no further Urology Specific Action will be undertaken.	Fully complete (Awaiting approval)

NICHE	Recommendation 59 (National) - Protecting patient confidentiality Examine ways in which confidential patient information is appropriately anonymised for the purposes of employment tribunal hearings. Guidelines should include: • advice to healthcare professionals on the use of patient information in these proceedings in line with Good Medical Practice guidance and GMC guidance on the use of personal information; • advice on the relevant GDPR and Data Protection regulations and the right to protect private information for both patients, their families and other individuals; • information relating to circumstances where patients do consent to the use of their personal information being used; and • the application of how Duty of Candour applies in such circumstances.	MD59/ 1	Ms Claire Alexander	TRUSTWIDE	The Compliance and Assurance Team will review this 'national' recommendation from the NICHE Report with the RSP (Recovery Support Programme) Improvement Director to confirm if the Recommendation has any direct relevance and/or action for the Trust to undertake.	Fully complete (Approved)
NICHE	Recommendation 60 (National) - Never Event review Revisit the Never Events cases highlighted in this review and ensure that the Trust applies rigour to all possible Never Events reporting.	MD60/ 1	Ms Claire Alexander	TRUSTWIDE	The Compliance and Assurance Team will review this 'national' recommendation from the NICHE Report with the RSP (Recovery Support Programme) Improvement Director to confirm if the Recommendation has any direct relevance and/or action for the Trust to undertake.	Fully complete (Approved)
NICHE	Recommendation 61 (National) - Learning from Deaths Consider a revision to the Learning from Deaths guidance to ensure that patient records on death are suitably managed in original form by professionals to reduce the risk of posthumous amendment.	MD61/ 1	Ms Claire Alexander	TRUSTWIDE	The Compliance and Assurance Team will review this 'national' recommendation from the NICHE Report with the RSP (Recovery Support Programme) Improvement Director to confirm if the Recommendation has any direct relevance and/or action for the Trust to undertake.	Fully complete (Approved)

NICHE	Recommendation 32 (National) - Coroner's statements NHS England and NHS Improvement should develop guidance for Trusts and NHS organisations more widely in relation to the following aspects of recommendation 5 (R26) above: • Statements to Coroners written in relation to whole episodes of care involving a team or a Trust service should be subject to validation and where a statement includes or implies failures in care all individuals named should be given a right of reply. This is distinct from an individual health care professional providing a witness statement solely in relation to their own input. • Where failures in care are identified as a result of the production of a statement and a new incident is reported, the Coroner should be informed to determine if an investigation report will be required for any further proceedings. • Trusts must assure themselves that their policies in relation to providing statements to the Coroner are being complied with. Statements should be based on fact rather than opinion and there should be a clear indication of how the statement has been compiled.	SD32/1	Ms Claire Alexander	TRUSTWIDE	The Compliance and Assurance Team will review this 'national' recommendation from the NICHE Report with the RSP (Recovery Support Programme) Improvement Director to confirm if the Recommendation has any direct relevance and/or action for the Trust to undertake.	Fully complete (Approved)
NICHE	Recommendation 33 (National) - Clinical practice NHS England and NHS Improvement should consider what relevant guidance could be developed for Trusts and NHS organisations more widely in relation to recommendations 1–8 made in this report and how these lessons might be shared. The learning from this report would be of benefit to the wider NHS community through an anonymised case study which will be developed from this case.	SD33/1	Ms Claire Alexander	TRUSTWIDE	The Compliance and Assurance Team will review this 'national' recommendation from the NICHE Report with the RSP (Recovery Support Programme) Improvement Director to confirm if the Recommendation has any direct relevance and/or action for the Trust to undertake.	Fully complete (Approved)

NICHE	Recommendation 34 (National) - Clinical records and email communications NHS England and NHS Improvement should decide whether more guidance is needed in relation to the uses and retention of email correspondence (or other electronic communications) as part of health records and any regional or national implications of recommendation 9 above.	SD34/1	Ms Claire Alexander	TRUSTWIDE	The Compliance and Assurance Team will review this 'national' recommendation from the NICHE Report with the RSP (Recovery Support Programme) Improvement Director to confirm if the Recommendation has any direct relevance and/or action for the Trust to undertake.	Fully complete (Approved)
NICHE	Recommendation 35 - Review Niche patient case studies The Trust should review all Niche case studies in priority order to contact patients in respect of Duty of Candour or ensure appropriate investigations have been completed to a high standard and actions have been implemented.	SD35/1	Mr Richard Sachs	Urology	Urology only - The Trust will ensure that all Patients/Families involved in the NICHE Cas Studies, have received formal communication from the Trust, in accordance with the principles of the Duty of Candour regulations.	Partially complete
NICHE	Recommendation 36 - Urology pathway priority management • There is a need to redesign follow-up pathways for Urology patients to match capacity and demand to prevent backlogs and balance this with the faster response for new referrals. Clear protocols for long-term active surveillance which ensures cases are appropriately seen at the right intervals are required. • Advance booking for long-term surveillance procedures should be introduced (including stent replacement and cystoscopy) and audited to ensure delays are minimised.	SD36/1	Mr Muhammad Saleem Naseem	Urology	Urology - Partially completed COM review of Follow Up Pathways - ongoing Long Term Surveillance in Place	Partially complete
NICHE	Recommendation 37 - Capacity and demand modelling in Urology The Trust should undertake a capacity and demand modelling exercise (including the use of PLICS information) to provide an up to date baseline for the service and to support job planning. This should include: • Medical staffing levels • Junior staffing resources • Administrative resource	SD37/1	Mr Carl Foulkes	Urology	Urology to undertake a capacity and demand modelling exercise	Fully complete (Awaiting approval)

	• Nursing skills and a clinical nurse specialist role review					
NICHE	Recommendation 38 - Revisit and align all reporting policies The Trust should revisit and recommunicate the following policies to ensure that the purpose is clear, that they are aligned to each other and that they are workable for staff to readily follow and apply when escalation is required. This should include a flow diagram so staff can see which policy to follow in which situation. • Incident reporting • Raising Concerns • Grievance management • Whistleblowing • Freedom to Speak Up	SD38/1	Mr Richard Sachs	TRUSTWIDE	Trust Procedural Document Team to work with Patient Safety Team (Incident Reporting), People & Organisational Development (Grievance Management) and Corporate Nursing (Raising Concerns, Freedom to Speak Up, Whistleblowing) to review, update and recommunicate the following policies: 1) Incident Reporting - CORP/PROC/022: Reporting and Management of Incidents including Serious Incidents 2) Raising Concerns - CORP/POL/112: Freedom to Speak Up & Raising Concerns 3) Grievance Management - CORP/POL/123: Grievance & Resolution 4) Whistleblowing - CORP/POL/112: Freedom to Speak Up & Raising Concerns 5) Freedom to Speak Up - CORP/POL/112: Freedom to Speak Up & Raising Concerns The Review will ensure that: 1) The purpose of each document is clear and, where possible, distinct from the other two documents 2) The documents clearly reference each other and are, where possible, aligned with each other 3) The documents Include clear escalation triggers 4) Each document includes a common 'flow	Partially complete

					diagram' to indicate which document is most relevant to given situation.	

NICHE	Recommendation 38 - Revisit and align all reporting policies The Trust should revisit and recommunicate the following policies to ensure that the purpose is clear, that they are aligned to each other and that they are workable for staff to readily follow and apply when escalation is required. This should include a flow diagram so staff can see which policy to follow in which situation. • Incident reporting • Raising Concerns • Grievance management • Whistleblowing • Freedom to Speak Up	SD38/2	Mr Richard Sachs	TRUSTWIDE	This recommendation requires the development and implementation of Trust Wide standards and processes - See Action SD38/1. No separate action for Urology will be developed or implemented.	Fully complete (Awaiting approval)
NICHE	Recommendation 39 (ICS/CCG) - A specialty focus The Trust should identify key specialty metrics that enable focus on harms to be triangulated in subspecialties of the Surgical and Critical Care Group (S&CCG). This should include: • A single monthly report on claims, incidents, Parliamentary Health Service Ombudsman (PHSO), Never Events and complaints with a cumulative analysis of themes arising. • At least biannual thematic reviews (regardless of whether complaints or claims are upheld) to understand any concerns being raised at the earliest possible opportunity. • An annual reconciliation of claims and complaints and their conversion to incident reports should be undertaken to ensure all patient safety concerns are logged through the incident reporting process for learning. • Learning and sharing relevant patient safety issues arising from MHPS investigations (which should be logged as incidents where appropriate). • Use of the annual GMC National Trainee Survey results to ensure information on junior	SD39/1	Mr Richard Sachs	TRUSTWIDE	Some progress in SCC - check with Greg Trust Quality standards with CCG - check with Stuart Bates	In progress

	doctors' experience is considered as part of these metrics.					

NICHE	Recommendation 40 - Implement clinical audit programme (Link to R4, R9, R14, R18, R25, R41, R47) A standard should be set for each of the following against which a clinical audit programme should be implemented: • Handover quality • Emergency surgery including access to and use of theatres out of hours • Emergency transfers from FGH to RLI • Stent register compliance • Results review and acknowledgement • MDT referrals, implementation of actions, attendance and quality of behaviours • Out-of-hours support from junior doctors • Ward round management • Consenting practice • Continuity of care • Harms as a result of delayed follow ups and IRDs • Application of National Institute for Clinical Excellence (NICE) guidance	SD40/1	Mr Richard Sachs	TRUSTWIDE	Clinical Audit Leads to work with Trust Clinical Audit Team to ensure that the below Audits are included in the Trust Forward Audit Plan for 2022-23, as standalone Audits or as a standard(s) within an Audit. Audits to take place in Audit Year 2022/23, with completion across 2022/23, Progress to be reported at Care Group / Speciality Audit Meetings and/or to Trust Clinical Audit Standards Group Meeting. • Handover quality • Emergency surgery including access to and use of theatres out of hours • Emergency transfers from FGH to RLI • Stent register compliance • Results review and acknowledgement • MDT referrals, implementation of actions, attendance and quality of behaviours • Out-of-hours support from junior doctors • Ward round management • Consenting practice • Continuity of care • Harms as a result of delayed follow ups and IRDs • Application of National Institute for Clinical Excellence (NICE) guidance	Partially complete

NICHE	Recommendation 40 - Implement clinical audit programme (Link to R4, R9, R14, R18, R25, R41, R47) A standard should be set for each of the following against which a clinical audit programme should be implemented: • Handover quality • Emergency surgery including access to and use of theatres out of hours • Emergency transfers from FGH to RLI • Stent register compliance • Results review and acknowledgement • MDT referrals, implementation of actions, attendance and quality of behaviours • Out-of-hours support from junior doctors • Ward round management • Consenting practice • Continuity of care • Harms as a result of delayed follow ups and IRDs • Application of National Institute for Clinical Excellence (NICE) guidance	SD40/2	Mr Richard Sachs	Urology	Urology Confirm with Urology Audit Lead, regarding the below audits - are these Audits on the Urology Forward Audit Plan for 2022-23, as standalone Audits, or as a standard within an Audit. - or, are these Audits being dealt with via the Trust Forward Audit Plan for 2022-23, as standalone Audits, or as a standard within an Audit. • Handover quality • Emergency surgery including access to and use of theatres out of hours • Emergency transfers from FGH to RLI • Stent register compliance • Results review and acknowledgement • MDT referrals, implementation of actions, attendance and quality of behaviours • Out-of-hours support from junior doctors • Ward round management • Consenting practice - Subject to Trust Wide Audit Audit 2875 • Continuity of care • Harms as a result of delayed follow ups and IRDs • Application of National Institute for Clinical Excellence (NICE) guidance - Need to confirm if this relates to the NICE Process or individual NICE Guidance	Partially complete

NICHE	Recommendation 41 (Cancer Alliance) - Cancer MDT management The Trust, with the Cancer Alliance, should: • Agree and implement new Standards of Care (SoC) in line with the advice of the Streamlining MDT Meetings guidance. • Clarify the expectations of core members at both local and network MDTs and the expectation for named Consultant Urologists to present their cases. A deputy role for the chair of the local MDT should be put in place. • Ensure that all core members attend the MDT as agreed above. • Audit the new processes to ensure alignment with the introduction of the named Consultant. • Ensure responsibility for actioning decisions made at the local MDT is maintained within the Trust. • Ensure there is clarity for responsibility for actioning decisions made at the network MDT. • Ensure that professional behaviours are demonstrated at both local and network MDTs and confirmed through observation and transparent feedback on a regular basis for all attendees.	SD41/1	Mr Muhammad Saleem Naseem	TRUSTWIDE	Urology - Partially complete Trust Wide Only - Partially complete Need to review with Sarah Hauxwell and update	In progress
NICHE	Recommendation 42 - 104 day cancer breach root cause analysis • Ensure all 104 day cancer waiting time breaches are subject to a root cause analysis (RCA) and thematic reviews are acted upon to ensure pathway problems are properly identified and improved. • The Trust should follow the newly released (October 2021) North West Guideline: Managing Long Waiting Cancer Patients	SD42/1	Miss Leanne Cooper	TRUSTWIDE	Trust Wide Only - Completed Revised 104 process in place Update from Sarah Hauxwell	In progress

NICHE	Recommendation 42 - 104 day cancer breach root cause analysis • Ensure all 104 day cancer waiting time breaches are subject to a root cause analysis (RCA) and thematic reviews are acted upon to ensure pathway problems are properly identified and improved. • The Trust should follow the newly released (October 2021) North West Guideline: Managing Long Waiting Cancer Patients	SD42/2	Miss Leanne Cooper	Urology	Embed and implement North West Guideline: Managing Long Waiting Cancer Patients guidelines.	Partially complete
NICHE	Recommendation 42 - 104 day cancer breach root cause analysis • Ensure all 104 day cancer waiting time breaches are subject to a root cause analysis (RCA) and thematic reviews are acted upon to ensure pathway problems are properly identified and improved. • The Trust should follow the newly released (October 2021) North West Guideline: Managing Long Waiting Cancer Patients	SD42/3	Miss Leanne Cooper	TRUSTWIDE	Embed and implement the North West Guideline: Managing Long Waiting Cancer Patients guideline in all services who support cancer patient appointments and referral times.	In progress
NICHE	Recommendation 43 - Emergency theatre access • The Trust should monitor the use of emergency theatres out of hours in Urology (building on the analysis provided in this report) to establish whether the existing Standard Operating Procedure (Theatre Access) is effective in changing the pattern of practice highlighted by this report. • This should be examined in the context of whether some emergency theatre demand could be reduced through the provision of ward based facilities.	SD43/1	Mr Daniel Bakey	TRUSTWIDE	Trust Wide Only - Partially complete SOP in Place - Consultants do not always follow policy - needs to be embedded	In progress

NICHE	Recommendation 43 - Emergency theatre access • The Trust should monitor the use of emergency theatres out of hours in Urology (building on the analysis provided in this report) to establish whether the existing Standard Operating Procedure (Theatre Access) is effective in changing the pattern of practice highlighted by this report. • This should be examined in the context of whether some emergency theatre demand could be reduced through the provision of ward based facilities.	SD43/2	Mr Carl Foulkes	TRUSTWIDE	Urology Action This recommendation requires a Care Group Wide / Trust Wide response, this will be managed through Action SD43/1 No Urology Specific Action will be undertaken	Fully complete (Awaiting approval)
NICHE	Recommendation 44 - Patient handover Handover of patients between Consultants should include: • a formal handover arrangement between Consultants for out of hours cover. • a handover for patients who are transferred between Consultants.	SD44/1	Mr Carl Foulkes	TRUSTWIDE	Trust Wide Action Handover of patients between Consultants should include: • a formal handover arrangement between Consultants for out of hours cover. • a handover for patients who are transferred between Consultants	In progress
NICHE	Recommendation 44 - Patient handover Handover of patients between Consultants should include: • a formal handover arrangement between Consultants for out of hours cover. • a handover for patients who are transferred between Consultants.	SD44/2	Mr John Wilson	Urology	Develop and embed robust handover process for urology patients: Focus 1. formal handover arrangement between Consultants for out of hours cover. 2. handover for patients who are transferred between Consultants.	Fully complete (Awaiting approval)

NICHE	Recommendation 45 - Managing team dysfunction A uniform approach should be applied to team dysfunction. This should include: • Clear communication from the Trust re the service strategy, goals and objectives - particularly around behavioural standards • Holding to account against professional standards in Good Medical Practice • Sustained visible leadership and "sponsorship" from the Board • Intelligent review of patient outcomes and harms • Follow-up, monitoring and review to ensure that behavioural improvements are sustained.	SD45/1	Mr Carl Foulkes	TRUSTWIDE	Trust - Ongoing - RSP Workstream 4 A uniform approach should be applied to team dysfunction. This should include: • Clear communication from the Trust re the service strategy, goals and objectives - particularly around behavioural standards • Holding to account against professional standards in Good Medical Practice • Sustained visible leadership and "sponsorship" from the Board • Intelligent review of patient outcomes and harms • Follow-up, monitoring and review to ensure that behavioural improvements are sustained.	In progress
NICHE	Recommendation 45 - Managing team dysfunction A uniform approach should be applied to team dysfunction. This should include: • Clear communication from the Trust re the service strategy, goals and objectives - particularly around behavioural standards • Holding to account against professional standards in Good Medical Practice • Sustained visible leadership and "sponsorship" from the Board • Intelligent review of patient outcomes and harms • Follow-up, monitoring and review to ensure that behavioural improvements are sustained.	SD45/2	Mr John Wilson	Urology	Implement and embed procedures to improve adoption of the Behavioural Standards Framework in the Urology service. This should include: • Clear communication from the Trust re the service strategy, goals and objectives - particularly around behavioural standards. • Holding to account against professional standards in Good Medical Practice. (Medical Appraisal and MHPS Process) • Sustained visible leadership and "sponsorship" from the Board (ESP - Urology Task and Finish and Urology Oversight Committee and Safe Today) • Intelligent review of patient outcomes and harms (Ongoing Governance Processes) Measure: • Follow-up, monitoring and review to ensure that behavioural improvements are sustained.	Fully complete (Awaiting approval)

NICHE	Recommendation 46 - Duty to monitor staff wellbeing The Trust has a duty to monitor staff stress levels and wellbeing and to intervene to support and understand the underlying issues before burn out affects patient care. The Trust should develop a cultural dashboard to identify key metrics that can provide early warning of team stress e.g. Occupational Health referral, employee relations concerns, engagement scores.	SD46/1	Mr Carl Foulkes	TRUSTWIDE	Trust Wide Actions 1) monitor staff stress levels and wellbeing and to intervene to support and understand the underlying issues before burn out affects patient care 2) develop a cultural dashboard to identify key metrics that can provide early warning of team stress e.g. Occupational Health referral, employee relations concerns, engagement score	Partially complete
NICHE	Recommendation 46 - Duty to monitor staff wellbeing The Trust has a duty to monitor staff stress levels and wellbeing and to intervene to support and understand the underlying issues before burn out affects patient care. The Trust should develop a cultural dashboard to identify key metrics that can provide early warning of team stress e.g. Occupational Health referral, employee relations concerns, engagement scores.	SD46/2	Mr Carl Foulkes	Urology	Urology Actions 1) monitor staff stress levels and wellbeing and to intervene to support and understand the underlying issues before burn out affects patient care	In progress
NICHE	Recommendation 47 - Appraisals for medical staff (Link to R40) • Appraisals may identify colleagues who are having difficulties and a protocol should be put in place to safeguard staff when concerns are apparent. • The Responsible Officer should explicitly monitor appraisals which may demonstrate team dysfunction as a means of early warning and to instigate remedial interventions. • Specialty interests with key outcome measures at unit level should be agreed. Individual Consultants should be given lead responsibility for specialist areas with outcomes linked to the clinical audit programme and fixed into appraisal processes.	SD47/1	Mr Carl Foulkes	TRUSTWIDE	Trust Wide Action - Relates to Medical Appraisal Only 1) Develop and Implement protocol for safeguarding staff that are identified as 'having difficulties' 2.1) The RO will monitor any appraisals that demonstrate early signs of 'Team Dysfunction' 2.2) The RO will investigate and, where possible, instigate 'remedial Interventions' 3.1) The Key Outcome Measures for Speciality Units will be agreed 3.2) The Key Outcome Measures for Speciality Units should be allocated to Responsible Consultants and monitored through Clinical Audit	In progress

NICHE	Recommendation 47 - Appraisals for medical staff (Link to R40) • Appraisals may identify colleagues who are having difficulties and a protocol should be put in place to safeguard staff when concerns are apparent. • The Responsible Officer should explicitly monitor appraisals which may demonstrate team dysfunction as a means of early warning and to instigate remedial interventions. • Specialty interests with key outcome measures at unit level should be agreed. Individual Consultants should be given lead responsibility for specialist areas with outcomes linked to the clinical audit programme and fixed into appraisal processes.	SD47/2	Mr Carl Foulkes	Urology	Urology Action This recommendation requires a consistent Trust Wide approach to avoid any inadvertent disparity of approach and practice No further Urology Specific Action will be taken	Fully complete (Awaiting approval)
NICHE	Recommendation 48 - Engagement with Consultant body • Engagement by executive and non-executive members of the Board with the Consultant body should be examined and options provided to facilitate increased opportunities for interaction. • This should include a clear programme of engagement at sub-specialty level over a rolling programme. This should be in addition to existing Medical Advisory Committee meetings.	SD48/1	Mr Carl Foulkes	TRUSTWIDE	Trust Wide Actions 1) Increase Engagement by executive and non-executive members of the Board with the Consultant body 2) Develop and implement a rolling programme of Trust Board engagement at sub-specialty level	Partially complete
NICHE	Recommendation 48 - Engagement with Consultant body • Engagement by executive and non-executive members of the Board with the Consultant body should be examined and options provided to facilitate increased opportunities for interaction. • This should include a clear programme of engagement at sub-specialty level over a rolling programme. This should be in addition to existing Medical Advisory Committee meetings.	SD48/2	Mr Carl Foulkes	Urology	Urology Actions Improve Engagement with the Urology Consultant body from Trust Board (Excs and Non-Execs)	Partially complete

NICHE	Recommendation 49 - Trust Management of Royal College reports • The Trust should inform regulators (CQC and NHS England and NHS Improvement) and commissioners of any plans for external reviews for quality and safety concerns, including Royal College Invited Service Reviews as soon as they are confirmed. This will ensure that regulators and commissioners can take this into account in their assurance activity in real time. • Advisory reports from the Royal Colleges should be shared, in full or in summary where appropriate, by the Trust with the Trust Board. • The Trust should formally inform the regional or local NHS England and NHS Improvement team, the Care Quality Commission and relevant fitness to practice investigations conducted by the GMC and commissioners of relevant Royal College reports and share these where appropriate. • Transparent action plans arising from all Royal College reports should be developed by the Trust, shared with the Trust Board and formally monitored through the Trust Quality Committee.	SD49/1	Mr Richard Sachs	TRUSTWIDE	The Trust should inform regulators (CQC and NHS England and NHS Improvement) and commissioners of any plans for external reviews for quality and safety concerns, including Royal College Invited Service Reviews as soon as they are confirmed. This will ensure that regulators and commissioners can take this into account in their assurance activity in real time. • Advisory reports from the Royal Colleges should be shared, in full or in summary where appropriate, by the Trust with the Trust Board. • The Trust should formally inform the regional or local NHS England and NHS Improvement team, the Care Quality Commission and relevant fitness to practice investigations conducted by the GMC and commissioners of relevant Royal College reports and share these where appropriate. • Transparent action plans arising from all Royal College reports should be developed by the Trust, shared with the Trust Board and formally monitored through the Trust Quality Committee. - Check QAC ToR	In progress

NICHE	Recommendation 49 - Trust Management of Royal College reports • The Trust should inform regulators (CQC and NHS England and NHS Improvement) and commissioners of any plans for external reviews for quality and safety concerns, including Royal College Invited Service Reviews as soon as they are confirmed. This will ensure that regulators and commissioners can take this into account in their assurance activity in real time. • Advisory reports from the Royal Colleges should be shared, in full or in summary where appropriate, by the Trust with the Trust Board. • The Trust should formally inform the regional or local NHS England and NHS Improvement team, the Care Quality Commission and relevant fitness to practice investigations conducted by the GMC and commissioners of relevant Royal College reports and share these where appropriate. • Transparent action plans arising from all Royal College reports should be developed by the Trust, shared with the Trust Board and formally monitored through the Trust Quality Committee.	SD49/2	Mr Richard Sachs	Urology	Urology Action This recommendation must be addressed through a common Trust Wide Approach/process - See Action SD49/1	Fully complete (Awaiting approval)
NICHE	Recommendation 50 - Clarify role of governors and escalation mechanisms • Governor training and induction programmes should be revisited to confirm that methods for escalating concerns are clearly set out and understood. • Procedures for escalation should include processes for resolution where governors remain dissatisfied with responses to issues raised.	SD50/1	Mr Paul Jones	TRUSTWIDE	Trust Wide Action - Role of governors and escalation mechanisms 1) Review and update Governor training and induction programmes and ensure that methods for escalating concerns are clearly set out and understood 2) Develop and implement an escalation and resolution process where governors remain dissatisfied with responses to issues raised	In progress

NICHE	Recommendation 50 - Clarify role of governors and escalation mechanisms • Governor training and induction programmes should be revisited to confirm that methods for escalating concerns are clearly set out and understood. • Procedures for escalation should include processes for resolution where governors remain dissatisfied with responses to issues raised.	SD50/2	Mr Paul Jones	Urology	Urology Action This recommendation requires the development and implementation of Trust Wide standards and processes - See Action SD50/1. No separate action for Urology will be developed or implemented.	Fully complete (Awaiting approval)
NICHE	Recommendation 51 - Institutional memory Formal handover procedures should be in place for all incoming and outgoing Board members (including postholders with committee chair roles). These handovers should include employee relations issues and sub-specialty summaries.	SD51/1	Miss Laura Robertson	TRUSTWIDE	Executive handover procedure to be developed and implemented by March 2022.	Fully complete (Awaiting approval)
NICHE	Recommendation 51 - Institutional memory Formal handover procedures should be in place for all incoming and outgoing Board members (including postholders with committee chair roles). These handovers should include employee relations issues and sub-specialty summaries.	SD51/2	Mr Paul Jones	TRUSTWIDE	Trust Procedural Document Team to 1) Include 'Roles and Responsibilities' as defined/required section Procedural Document Format 2) Work with Company Secretary to Agree Standard 'Role Names' for Executive Directors and other Senior Directors (e.g. Deputies to Executives) 3) Use agreed Standard 'Role Names' to initiate and complete a 'find and replace' review of all procedural documents to ensure correct role names are used. 4) Develop process for identifying, collating and reporting all responsibilities allocated to a Standard 'Role Names'	Partially complete
NICHE	Recommendation 51 - Institutional memory Formal handover procedures should be in place for all incoming and outgoing Board members (including postholders with committee chair roles). These handovers should include employee relations issues and sub-specialty summaries.	SD51/3	Mr Paul Jones	Urology	This recommendation requires the development and implementation of Trust Wide standards and processes - See Action SD51/1. No separate action for Urology will be developed or implemented.	Fully complete (Awaiting approval)

NICHE	Recommendation 52 - Media articles Revise advice and guidance on dealing with media articles that name individuals and provide support to ensure an appropriate right of reply is sought (also in line with GMC guidance on responding to criticism in the media).	SD52/1	Mr Carl Foulkes	TRUSTWIDE	Director of Corporate Affairs to review and update Trust Advise and Guidance on Media Articles that Name Individuals 1) To ensure that an appropriate right of reply is sought 2) and to ensure that this is in line with GMC guidance on responding to criticism in the media	Fully complete (Awaiting approval)
NICHE	Recommendation 52 - Media articles Revise advice and guidance on dealing with media articles that name individuals and provide support to ensure an appropriate right of reply is sought (also in line with GMC guidance on responding to criticism in the media).	SD52/2	Mr Phil Woodford	Urology	Urology Action This recommendation requires the development and implementation of Trust Wide standards and processes - See Action SD52/1. No separate action for Urology will be developed or implemented.	Fully complete (Approved)
NICHE	Recommendation 53 (ICS/CCG) - As part of the work underway to establish system governance, commissioners should agree shared mechanisms to enable proactive commissioning and visibility of the Trust's services at specialty/sub-specialty level.	SD53/1	Ms Claire Alexander	TRUSTWIDE	The Compliance and Assurance Team will review this 'national' recommendation from the NICHE Report with the RSP (Recovery Support Programme) Improvement Director to confirm if the Recommendation has any direct relevance and/or action for the Trust to undertake.	Fully complete (Approved)
NICHE	Recommendation 54 (ICS/CCG) - Alternative mechanisms for specialty/sub-specialty level scrutiny as part of routine assurance processes should be examined, for example cyclical deep dives as part of an annual work plan led by commissioning managers for scrutiny by quality assurance forums. The heat map approach (as in Appendix 10) developed by the CCG provides a useful model for this purpose. The CCG should add an analysis of complaints/concerns/incidents from GP practices at a specialty level on at least an annual basis as part of this scrutiny.	SD54/1	Ms Claire Alexander	TRUSTWIDE	The Compliance and Assurance Team will review this 'national' recommendation from the NICHE Report with the RSP (Recovery Support Programme) Improvement Director to confirm if the Recommendation has any direct relevance and/or action for the Trust to undertake.	Fully complete (Approved)

NICHE	Recommendation 55 (ICS/CCG) - A reporting template should be developed which brings together quality, activity, and performance information at a specialty level. A programme of reporting at this level should be agreed with the Trust, with frequency of reporting for each specialty to reflect jointly agreed priorities. This should provide a single source of reporting to all relevant governance groups. The Safe Today report provides a sound basis for development.	SD55/1	Ms Claire Alexander	TRUSTWIDE	The Compliance and Assurance Team will review this 'national' recommendation from the NICHE Report with the RSP (Recovery Support Programme) Improvement Director to confirm if the Recommendation has any direct relevance and/or action for the Trust to undertake.	Fully complete (Approved)
NICHE	Recommendation 55 (ICS/CCG) - A reporting template should be developed which brings together quality, activity, and performance information at a specialty level. A programme of reporting at this level should be agreed with the Trust, with frequency of reporting for each specialty to reflect jointly agreed priorities. This should provide a single source of reporting to all relevant governance groups. The Safe Today report provides a sound basis for development.	SD55/2	Ms Claire Alexander	TRUSTWIDE	The Compliance and Assurance Team will review this 'national' recommendation from the NICHE Report with the RSP (Recovery Support Programme) Improvement Director to confirm if the Recommendation has any direct relevance and/or action for the Trust to undertake.	Fully complete (Approved)
NICHE	Recommendation 56 (ICS/CCG) Terms of reference for all quality assurance forums should be explicit about specific areas of focus, reports to be considered and how issues should be monitored. Key Issues Reports should be used for escalation. An issues log should be maintained which identifies concerns with departments/specialties involved and this should be shared, populated and reviewed at key governance forums.	SD56/1	Ms Claire Alexander	TRUSTWIDE	The Compliance and Assurance Team will review this 'national' recommendation from the NICHE Report with the RSP (Recovery Support Programme) Improvement Director to confirm if the Recommendation has any direct relevance and/or action for the Trust to undertake.	Fully complete (Approved)

NICHE	Recommendation 57 (ICS/CCG) - Internal audit should test the efficacy of CCG assurance at a Trust specialty level as part of its annual work programme.	SD57/1	Mr Carl Foulkes	TRUSTWIDE	Compliance and Assurance Team to liaise with UHMBT Company Secretary and MB CCG Company Secretary to confirm whether this recommendation relates to: - Assurance of the CCG's monitoring of the UHMBT Internal Audit programme at Trust specialty level - Assurance of the CCG's Internal Audit programme for monitoring the Trust at specialty level	In progress
NICHE	Recommendation 58 (ICS/CCG) - The CCG should ensure that its contractual requirements with the Trust relating to incident reporting, and as set out in the Quality Schedule to the latest contract (2021/22), are met.	SD58/1	Ms Claire Alexander	TRUSTWIDE	The Compliance and Assurance Team will review this 'national' recommendation from the NICHE Report with the RSP (Recovery Support Programme) Improvement Director to confirm if the Recommendation has any direct relevance and/or action for the Trust to undertake.	Fully complete (Approved)
NICHE	Recommendation 62 (National/ICS/CCG) - Networked support for team development NHS England and NHS Improvement and the CCG should seek stronger working relationships between the Trust and tertiary centres to support Consultants in facilitating the provision of sub-specialty services at the Trust.	SD62/1	Ms Claire Alexander	TRUSTWIDE	The Compliance and Assurance Team will review this 'national' recommendation from the NICHE Report with the RSP (Recovery Support Programme) Improvement Director to confirm if the Recommendation has any direct relevance and/or action for the Trust to undertake.	Fully complete (Approved)

NICHE	Recommendation 63 - Development of safe services and specialist interests A Urology strategy should be developed involving all key Urology medical staff and other relevant healthcare professionals to set the context for the following actions: • The Trust should undertake an equipment stocktake for Urology and plan into the capital replacement programme the need for cystoscopes, bipolar diathermy and suction equipment both in the short term and over the medium term or consider lease options. • Examine, with the Trust and CCG, the development of Urology sub-specialisms building on Andrology and stone services, the management of superficial bladder cancer, local anaesthetic transperineal biopsy work and paediatrics. • Examine, through the provider collaborative network, the viability of Urology provision across two sites and its associated support services in the long term should be examined in respect of future provision at Furness General Hospital. Formal consideration of centralising inpatient and emergency Urology services on one site should be revisited. This should include options for dedicated ward based facilities.	SD63/1	Mr Carl Foulkes	Urology	The Trust should undertake an equipment stocktake for Urology and plan into the capital replacement programme the need for cystoscopes, bipolar diathermy and suction equipment both in the short term and over the medium term or consider lease options. - Completed • Examine, with the Trust and CCG, the development of Urology sub-specialisms building on Andrology and stone services, the management of superficial bladder cancer, local anaesthetic transperineal biopsy work and paediatrics. - Ongoing • Examine, through the provider collaborative network, the viability of Urology provision across two sites and its associated support services in the long term should be examined in respect of future provision at Furness General Hospital. Formal consideration of centralising inpatient and emergency Urology services on one site should be revisited. This should include options for dedicated ward based facilities. - Ongoing	In progress

NICHE	Recommendation 64 (National) - Regulation and oversight of team dysfunction (Link to R65(E)) • NHS England and NHS Improvement should discuss the lessons learned from this review with the Care Quality Commission and share them with the National Quality Board or similar regulatory oversight group, in respect of the failings to resolve the long standing dysfunction in this team. • NHS England and NHS Improvement should provide clear guidance about what external support might be available to Trusts from the regional medical directors' teams and the advisory options when there is team dysfunction emerging. • Regulatory activity should review the effective functioning of the Responsible Officer role in regard to managing concerns where team dysfunction may be apparent. • Guidance should include ensuring Trusts are encouraged to seek early support where team dysfunction may put patient safety at risk.	SD64/1	Ms Claire Alexander	TRUSTWIDE	The Compliance and Assurance Team will review this 'national' recommendation from the NICHE Report with the RSP (Recovery Support Programme) Improvement Director to confirm if the Recommendation has any direct relevance and/or action for the Trust to undertake.	Fully complete (Approved)

NICHE	Recommendation 65 (National) - Guidance and support to Responsible Officers from NHS England and NHS Improvement Regional Medical Directors • NHS England and NHS Improvement should ensure that guidance to ROs is up to date and a final version is in force to include the 2013 RO regulation amendments and learning since the role was introduced. Regional Medical Directors should use this investigation as a case study to reinforce escalation processes for Responsible Officers who may be facing conduct difficulties within their medical workforce. • The North West Regional Medical Director should share this case study with other Regional Medical Directors to reinforce the importance of the RO role, appointment processes and the lessons learned from this investigation. • Good practice should be shared between Trusts to provide clarity on the best approaches for dealing with and escalating behavioural and conduct issues that are impacting on patient safety in line with Good Medical Practice. • The Trust Board should revisit its understanding of the role of the RO and assure itself that there is clarity of duties between the Medical Director (now as RO) and the wider team in exercising duties to meet the RO regulations.	SD65/1	Mr Carl Foulkes	TRUSTWIDE	Only one action for Trust The Trust Board should revisit its understanding of the role of the RO and assure itself that there is clarity of duties between the Medical Director (now as RO) and the wider team in exercising duties to meet the RO regulations.	Partially complete

NICHE	Recommendation 65 (National) - Guidance and support to Responsible Officers from NHS England and NHS Improvement Regional Medical Directors • NHS England and NHS Improvement should ensure that guidance to ROs is up to date and a final version is in force to include the 2013 RO regulation amendments and learning since the role was introduced. Regional Medical Directors should use this investigation as a case study to reinforce escalation processes for Responsible Officers who may be facing conduct difficulties within their medical workforce. • The North West Regional Medical Director should share this case study with other Regional Medical Directors to reinforce the importance of the RO role, appointment processes and the lessons learned from this investigation. • Good practice should be shared between Trusts to provide clarity on the best approaches for dealing with and escalating behavioural and conduct issues that are impacting on patient safety in line with Good Medical Practice. • The Trust Board should revisit its understanding of the role of the RO and assure itself that there is clarity of duties between the Medical Director (now as RO) and the wider team in exercising duties to meet the RO regulations.	SD65/2	Ms Claire Alexander	TRUSTWIDE	The Compliance and Assurance Team will review this 'national' recommendation from the NICHE Report with the RSP (Recovery Support Programme) Improvement Director to confirm if the Recommendation has any direct relevance and/or action for the Trust to undertake.	Fully complete (Approved)
NICHE	Recommendation 66 (National) - Whistleblowing Guidance on setting up appropriate governance processes should be developed to support intractable whistleblowing cases. It should aim to provide resolution to concerns and facilitate learning in relation to patient safety.	SD66/1	Ms Claire Alexander	TRUSTWIDE	The Compliance and Assurance Team will review this 'national' recommendation from the NICHE Report with the RSP (Recovery Support Programme) Improvement Director to confirm if the Recommendation has any direct relevance and/or action for the Trust to undertake	Fully complete (Approved)

NICHE	Recommendation 67 (National) - Assurance review NHS England and NHS Improvement should commission a Phase 5 review (Autumn 2022) in line with the Terms of Reference to include assurance on key elements such as: • continuity of care; • named Consultant; • MDT management; • follow-up patient pathways; • the quality of incident reporting and investigations; • team development opportunities; and • mortality governance. to establish if implemented changes have become embedded and are sustainable.	SD67/1	Ms Claire Alexander	Urology	The Compliance and Assurance Team will review this 'national' recommendation from the NICHE Report with the RSP (Recovery Support Programme) Improvement Director to confirm if the Recommendation has any direct relevance and/or action for the Trust to undertake	Fully complete (Approved)
NICHE	Recommendation 68 (National) - Role of the GMC in relation to team dysfunction The GMC should reflect on this investigation. They should: • seek to understand how and if team dysfunction issues impact on fitness to practice investigations. • whether the role of medical managers and their fitness to practice (in relation to their management function) have been sufficiently considered in this case. • ensure that GMC guidance in relation to the RO regulations is up to date and considers the 2013 amendments to the regulations and learning since the role was introduced. • indicate to Trusts that the GMC Connect dashboard can be made accessible to Medical Directors as well as the RO team.	SD68/1	Ms Claire Alexander	TRUSTWIDE	The Compliance and Assurance Team will review this 'national' recommendation from the NICHE Report with the RSP (Recovery Support Programme) Improvement Director to confirm if the Recommendation has any direct relevance and/or action for the Trust to undertake.	Fully complete (Approved)

NICHE	Recommendation 69 (National) - Enforcement and follow up of actions from Royal College Invited Service Reviews Invited Service Reviews should include: • clear expectations for Royal College Invited Service Review reports to be shared, in full, by the Trust with the relevant Trust Board; • expectations for when Royal College Invited Service Review reports should be shared, in full, by the Trust with regulators; and • clarity about the implementation of action plans arising from Invited Service Reviews to enable the Royal College to be satisfied that recommendations have been fully addressed to end their active involvement.	SD69/1	Ms Claire Alexander	TRUSTWIDE	The Compliance and Assurance Team will review this 'national' recommendation from the NICHE Report with the RSP (Recovery Support Programme) Improvement Director to confirm if the Recommendation has any direct relevance and/or action for the Trust to undertake.	Fully complete (Approved)
NICHE	Recommendation 70 (National) - Sharing of information between regulatory bodies The effectiveness and intention of the Emerging Concerns Protocol https://www.cqc.org.uk/what-we-do/how-we-work-people/emerging-concerns-protocol should be revisited in the context of the findings of this case. The inclusion of additional signatories (e.g. Royal Colleges, NHS England and NHS Improvement) should be considered. This may be the most appropriate process to improve information sharing.	SD70/1	Mr Paul Jones	TRUSTWIDE	Company Secretary to review National Recommendation R70 to determine whether the Recommendation has any applicability to the Trust and, if so, to initiate the development of an action/implementation Plan for this recommendation.	Fully complete (Approved)
NICHE	Recommendation 70 (National) - Sharing of information between regulatory bodies The effectiveness and intention of the Emerging Concerns Protocol https://www.cqc.org.uk/what-we-do/how-we-work-people/emerging-concerns-protocol should be revisited in the context of the findings of this case. The inclusion of additional signatories (e.g. Royal Colleges, NHS England and NHS Improvement) should be considered. This may be the most appropriate process to improve information sharing.	SD70/2	Ms Claire Alexander	TRUSTWIDE	The Compliance and Assurance Team will review this 'national' recommendation from the NICHE Report with the RSP (Recovery Support Programme) Improvement Director to confirm if the Recommendation has any direct relevance and/or action for the Trust to undertake.	Fully complete (Approved)

NICHE	Recommendation 71 (National) - Assessing the effective role of the Responsible Officer in Well-Led assessments The role of the RO and its development since the introduction of this function in 2010 should form a regular and consistent part of examination as part of internal and external Well-Led and governance reviews.	SD71/1	Mr Paul Jones	TRUSTWIDE	Company Secretary to review National Recommendation R71 to determine whether the Recommendation has any applicability to the Trust and, if so, to initiate the development of an action/implementation Plan for this recommendation.	Fully complete (Approved)
NICHE	Recommendation 71 (National) - Assessing the effective role of the Responsible Officer in Well-Led assessments The role of the RO and its development since the introduction of this function in 2010 should form a regular and consistent part of examination as part of internal and external Well-Led and governance reviews.	SD71/2	Ms Claire Alexander	TRUSTWIDE	The Compliance and Assurance Team will review this 'national' recommendation from the NICHE Report with the RSP (Recovery Support Programme) Improvement Director to confirm if the Recommendation has any direct relevance and/or action for the Trust to undertake.	Fully complete (Approved)
NICHE	Recommendation 72 (National) - Testicular Implant Recall NHS England and NHS Improvement should share the findings from the testicular implant recall exercise with relevant bodies and agree the next steps at a local or national level.	SD72/1	Ms Claire Alexander	TRUSTWIDE	External Urology Consultant Report on testicular implant recall exercise commissioned by NHSE/I, developed/drafted and expected by end of Jan 2022.	Partially complete

Table 7: RCS Improvement Plan Dashboard

Inspection	Recommendation	Action Ref	SRO	Oversight Meeting	Service	Action	Progress Status	Comments
RCS Report	Actions the Trust Must take to ensure patient safety is protected: A review of redacted clinical activity in performing unicompartmental knee replacements is required given the review may indicate an insufficient number of these procedures being undertaken to maintain the appropriate skill set required for the techniques involved.	MD1/1	Ms Claire Alexander		Trauma and Orthopaedics	OS Action - 1. Request data for all Unicompartmental knee replacement procedures carried out by surgeon 1 from 2015 - 2018 - 5 cases identified between 2015 and 2018. Awaiting Clinical Review. 2. Request data for all anterior approach to hip replacement - This cannot be done as anterior / posterior isn't currently coded separately - Total Number of Hip cases is 105. (25 cases for further review) 3. Request data for all no complex total Hip and total Knee replacement procedures completed by Surgeon 1 - Total Number of Knee cases is 216. (A sample of 25 cases for further review) 4. Complete a case note review of all Unicompartmental knee replacement procedures carried out by surgeon 1 from 2015 - 2018. Links to 1 5. Complete a case note review of all anterior approach procedures carried out by surgeon 1 from 2015 - 2018.	In progress	

						Links to No 2 6. Complete a randomised case note review of non-complex THR and TKR procedures carried out by surgeon 1 from 2015 - 2018. Links to 2 and 3		
RCS Report	Actions the Trust Must take to ensure patient safety is protected: Assure evidence of redacted training in anterior approach surgery before further anterior approach hip replacements are performed.	MD2/1	Mr Harry Rogers		Trauma and Orthopaedics	OS Action - Surgeon 1 working under full supervision with a detailed training plan - (Practitioner Performance Advice PPA) in place based on identified themes in the RCS Report	In progress	
RCS Report	Actions the Trust Must take to ensure patient safety is protected: In respect of more complex cases, more effective utilisation of MDT to: (i) Improve governance in respect of clear decision making, transfer/handover of	MD3/1	Mr Harry Rogers		Trauma and Orthopaedics	"OS Action - ADOP Surgery is currently completing these 2 items by the end of March 2022. SEE ALSO NICHE/R41??"	In progress	

	care documentation. (ii) Ensure appropriate consultant surgeon involvement.							
RCS Report	Actions the Trust Must take to ensure patient safety is protected: The consent pro-forma should ensure that the potential risks of the planned surgery are clearly documented for the patient to assimilate and space to record that these have been explained to the patient.	MD4/1	Mr Harry Rogers		Trauma and Orthopaedics	OS Action - ADOP Surgery is currently completing these 2 items by the end of March 2022. SEE ALSO NICHE/R18	In progress	
RCS Report	Actions the Trust Must take to ensure the Trauma and Orthopaedic Service is improved: redacted may benefit as part of learning to reflect upon and discuss with colleagues case AXX in particular, possible reasons for the femoral notch (which was not documented in the operation note) occurring.	MD5/1	Mr Harry Rogers		Trauma and Orthopaedics	OS Action - Completed	In progress	
RCS Report	Actions the Trust Must take to ensure the Trauma and Orthopaedic Service is improved: The Trust should take steps to improve the continuity of care for patients through their pre-operative, intra-operative and post-operative care pathway. This may include, but is not limited to, listing patients, wherever possible, on the operating surgeon clinic list.	MD6/1	Mr Harry Rogers		Trauma and Orthopaedics	The trust should take steps to improve the continuity of care for patients through their pre-operative, Intra-operative and post-operative care pathway. This may include, but is not limited to, listing patients, wherever possible, on the operating surgeon clinic list.	In progress	

RCS Report	Actions the Trust Should consider as part of its development of the Trauma and Orthopaedic service: If the Trust identifies primary concerns about an individual surgeon, then a formal review of their clinical practice is recommended. If the Trust identifies concerns associated with the surgical service then a review of the service is recommended.	SD7/1	Ms Jane McNicholas		Trauma and Orthopaedics	OS Action - The Director of Governance and the Medical Director will draft a Standard Operating Procedure that articulates clearly and transparently the process associated with instigating a formal review of individual practice and the criteria for triggering a review of a surgical or medical service based on triangulated intelligence, evidence and patient feedback. Timescale TBC.	In progress	

Minutes of the Audit Committee held on Tuesday 21 June 2022 in the Damson Meeting Room, Junction 36 Auction Centre, Crooklands, Milnthorpe, Cumbria LA7 7NU

The meeting also took place via Microsoft Teams.

Present:	Liz Sedgley	Non-Executive Director (Chair)
	Adrian Leather	Non-Executive Director
	Sarah Rees	Non-Executive Director
	Stephen Ward	Non-Executive Director
In Attendance:	Chris Adcock	Director of Finance / Deputy Chief Executive
	Richard Anderson	Engagement Manager Grant Thornton
	Nicola Barnes	Trust Board Administrator
	Paul Jones	Company Secretary
	Gareth Kelly	Engagement Lead Grant Thornton
	Jane Stanley	Head of Financial Services
	Lisa Warner	Internal Audit Manager Mersey Internal Audit Agency

22/31 Welcome and Introductions

Apologies

Apologies were received from Louise Cobain, Bridget Lees, Hugh Reeve and Jill Stannard.

Declarations of Conflicts of Interest

None.

22/32 Minutes of the Audit Committee held on 12 May 2022

Decision: That the Minutes of the meeting held on 12 May 2022 be agreed as an accurate record.

22/33 Action Sheet and Matters Arising from the Minutes of the Audit Committee held on 14 April 2022 and 12 May 2022

Decision: The Committee considered the action sheet and noted the actions taken.

22/34 Items for Approval from Meetings on 14 April 2022 and 12 May 2022

The meetings on 14 April 2022 and 12 May 2022 were not quorate so it was agreed to include those items that required approval:

Item 2 – Minutes of the meeting on 24 February 2022;

Item 5 – Internal Audit Plan 2022/23 and Internal Audit Charter;
Item 6 – ISA 570 Going Concern;
Item 20 – Minutes of the meeting on 14 April 2022;
Item 21 – Accounting Policies 2021/22;
Item 22 – Informing the Audit Risk Assessment; and
Item 24 – Trust Modern Slavery Statement

Decision: The Committee approved all the items listed above.

22/35 Annual Report and Accounts 2021/22

Consideration was given to a report presented by Jane Stanley.

The following points were made in discussion:
1. The report outlined the order in which to approve the following reports.
2. The Committee considered the reports as set out below.

Decision: That the report be noted.

35a Annual Governance Statement 2021/22

Consideration was given to a report presented by Paul Jones (PJ).

The following points were made in discussion:
1. PJ advised the Annual Governance Statement (AGS) reflected a challenging year for the Trust. The auditors had provided comments and suggested amendments, which had been made.
2. PJ highlighted the "*conclusion"* section of the AGS which demonstrated three weaknesses; the first risk was in the confidence in UHMB as a great place to be cared for, a great place to be work caused by past and ongoing concerns in a number of specialties and the findings of CQC reports. The second arose from the delivery of improvement measures at pace and scale to ensure the Trust provides consistently safe, responsive, high-quality care while we continue to develop a positive and open reporting culture as a learning organisation. The weaknesses relate specifically to safety, meeting regulatory requirements, culture and leadership. The final weakness related to the Trust achieving financial balance in the medium to long term. Achieving financial balance is one of the Board's key objectives and working with the wider Integrated Care System.
3. PJ advised these had been discussed with the auditors.
4. The auditors were satisfied with the content of the AGS.

During deliberation of this item the following points were considered:
5. Steve Ward (SW-NED) challenged the relevance of including the briefing notes as part of listing the opinions of the internal audit reports in the AGS.
6. Lisa Warner (LW) clarified that although they were not formal reports, LW recommended they were included as they contributed to the overall Head of Internal Audit opinion.
7. It was agreed to include the word "funded" in a paragraph of the "*review of effectiveness*" section of the AGS.
8. Referring to the *"Chair and Chief Executive's Welcome"* section of the Annual Report, SW-NED challenged whether the title "Improved financial performance" accurately reflected the content of the paragraph. It was agreed to change the

title to "New Hospitals Programme" to accurately reflect content.

9. Referring to the AGS, Sarah Rees (SR-NED) recommended a paragraph of the "*review of effectiveness*" section was updated to "2021/22" rather than "2020/21".
10. Adrian Leather (AL-NED) sought assurance on the learning of the personal data related incidents contained within the AGS. Paul Jones (PJ) explained that for the purposes of the AGS it was to report this data and suggested a further report to the Committee regarding the assurance of learning and how this mitigated the issues identified as weaknesses in the system.

Decision:

1. That the Audit Committee approved the Annual Governance Statement 2021/22; and
2. A report on the Trust's response to the personal data related incidents as reported in the AGS.

35b Annual Report 2021/22

Consideration was given to a report presented by Paul Jones (PJ).

The following points were made in discussion:

1. PJ presented the annual report and advised the auditors had provided comments and suggested amendments, which had been made.
2. PJ explained the narrative in relation to the "*environment*" section of the annual report had been strengthened following approval of the UHMB Green Plan by the Board of Directors earlier this year.
3. Jane Stanley (JS) advised that one change had been made to the remuneration table in relation to the pension benefits attributed to Leanne Cooper, Acting Chief Operating Officer. The report had been updated to reflect late receipt of information regarding her pension and lump sum.

During deliberation of this item the following points were considered:

4. Steve Ward (SW-NED) sought clarity on whether the Assurance Committee annual reports contributed to the annual report. PJ advised they did not require inclusion in the main annual report. The mandated reports were Audit Committee and Nominations Committee only.

Decision: That the Audit Committee approved the Annual Report 2021/22.

35c Annual Accounts 2021/22

Consideration was given to a report presented by Jane Stanley (JS).

The following points were made in discussion:

1. JS advised the Committee of the amendments made since presentation of the draft accounts at the meeting of the Committee on 12 May 2022. A copy of the audit log, which outlined the amendments, had been appended to this report. The auditors were content with the accounts presented to the Committee for approval.
2. JS advised that two further amendments had been made since distribution of the Committee agenda. These included a note in the accounting policy which referred to the correction of prior period adjustments due to the change made to the Losses note in respect of the Flowers judgement; and the annual leave

accrual has increased from last year and has been calculated including an assumption that the use of agency staff to cover leave inflates the accrual. This should have been explained as it was a change in judgement from last year.

Decision: That the Audit Committee approved the Annual Accounts 2021/22 subject to the remuneration change regarding the Acting Chief Operating Officer and the two changes to the accounting policies as outlined in paragraph 2.

35d Letter of Representation

Consideration was given to a report presented by Jane Stanley (JS).

The following points were made in discussion:

1. JS advised this was the standard letter to provide assurance to the auditors as part of the accounts process. The letter stated that the Trust had no other material facts which should be disclosed, which had an impact on the financial standing of the Trust and/or the accounts and reports produced. Specific disclosures were made in respect of the amendments to the prior year for special payments in respect of the Flowers judgement and to confirm the full utilisation of the £6.5 million payment bond paid in March 2021.
2. The auditors agreed the content of the letter had been accurately reflected.

Decision: That the Audit Committee approved the Letter of Representation.

35e Audit Findings Report

Consideration was given to a report presented by Gareth Kelly (GK).

The following points were made in discussion:

1. GK advised it had been a challenging audit and commended Jane Stanley's team and Chris Adcock's support.
2. The audit had revealed a couple of areas where control weaknesses were identified which meant increased testing in areas such as journals and payroll.
3. GK advised the key control weakness areas identified were critical segregation of duties conflict between system administration and finance team users. Due to the enhanced audit testing, software was applied which resulted in finding the segregation of duties as outlined in the report. The auditors also identified weaknesses in the Trust's controls for processing leavers which resulted in a change of methodology which increased testing.
4. GK advised engagement by the Trust had been good and a hybrid approach had been adopted by the auditors when carrying out the audit.
5. Referring to the value for money (VFM) conclusion, the auditors identified three significant weakness areas: arrangements for development of a medium-term financial plan which would return the Trust to a financial balance, the adequacy of the Trust governance arrangements sustainably, and Trust's response in relation to the Niche report regarding urology, the Royal College of Surgeons' report regarding trauma and orthopaedics and the CQC report in relation to the provision of stroke care.
6. The statutory deadline for completion of the VFM assessment was 22 September 2022 with the aim of completing this by mid-August.
7. GK advised the VFM assessment would reflect the significant work to address and bring the Trust back into financial balance.

8. Due to the enhanced audit, GK advised a review of the Grant Thornton audit fee would take place.
9. Richard Anderson (RA) advised that the areas of work outstanding to complete the auditor's report included testing of journals, testing of employee benefits, testing of assets under construction, agreement of the remuneration report and a review of the final set of financial statements. RA assured the Committee this work would be completed by the end of the day
10. In terms of significant risks, the auditors had concluded there were no issues to bring to the Committee's attention
11. The audit reflected the fact that the auditors agreed that the New Hospital Programme funding had been correctly accounted for as an asset under construction in the accounts in the Trust's accounts.
12. The report outlined the change to the accounts regarding the property transfer to UHMB from Millom.
13. The auditors completed a review of the Trust's IT environment to support their financial statements audit. The application in scope of this audit was Oracle Cloud. The review identified two significant deficiencies and a further deficiency relating to the management and monitoring of generic accounts. The auditor's review of payroll controls identified two significant deficiencies which indicated weaknesses in the Trust's control environment. RA outlined the issues and risks identified in relation to intangible assets, property plant and equipment.
14. The auditors had made recommendations following their review; these were:
    - Nil net book value assets – to ensure they were operational and that the asset lives assigned were appropriate;
    - IT general controls – there were a number of recommendations which included a review of users with system administration roles in Oracle Cloud and a review of its management of Oracle Cloud to understand current skills gaps and capacity issues; and
    - Payroll notification of leavers – to ensure that the service provided by the Trust's payroll provider (ELFS) included controls that were designed, implemented and operated effectively during the financial year.
15. The Trust accepted all these recommendations.

During deliberation of this item the following points were considered:

16. Jane Stanley (JS) advised that the figure quoted in the report relating to the Trust's retained deficit on retained earnings was incorrect. RA agreed to address this and ensure the correct figure was included in the final report.
17. Chris Adcock (CA) advised that in relation to stroke care provision, the CQC had agreed to support the Trust; CA would provide further details which could be included in the auditor's value for money assessment. Regarding late notification of employees leaving the Trust , CA commented this was disappointing that it had impacted the auditor's assessment having discussed this in detail at previous Committee meetings. CA explained that monitoring of late leaver data would be undertaken through performance meetings with additional finance support to the Care Groups. CA advised that the recommendations of the audit findings would be implemented.
18. Liz Sedgley (LS-NED) suggested that the issues identified in respect of the Trust's IT controls regarding segregation of duties within Oracle Cloud be discussed at the next meeting of the Committee. CA supported this.
19. Sarah Rees (SR-NED) sought assurance in terms of addressing the recommendations.
20. Paul Jones (PJ) advised the value for money conclusion would contain a series

of recommendations but if there were supplementary recommendations, these would be captured. CA advised that the Trust had accepted the recommendations and would present the Trust's response to the recommendations set out in the report at the next meeting of the Committee on 21 July 2022.

Decision:
1. That the report be noted;
2. That the Committee agreed IT controls in respect of segregation of duties within Oracle Cloud would be discussed further at the next meeting of the Committee on 21 July 2022; and
3. That the Committee agreed a report on the Trust's response to the recommendations set out in the auditor's report would be presented to the Committee at their next meeting on 21 July 2022.

22/36 Head of Internal Audit Opinion 2021/22

Consideration was given to a report presented by Lisa Warner (LW)

The following points were made in discussion:
1. LW advised the report contained the final Head of Internal Audit Opinion. The draft opinion was presented to the Committee on 12 May 2022. The overall opinion was Moderate Assurance; the final opinion had been updated to include a report regarding payroll.

Decision: That the report be noted.

22/37 Items to be recommended for decision or discussion by the Board or other Committees

Decision:
1. Approval of Annual Report and Accounts 2021/22.
2. The auditors' identification of 3 risks:
   - Nil net book value assets;
   - IT controls in respect of segregation of duties within Oracle Cloud which would be discussed further at the next meeting of the Committee on 21 July 2022; and
   - Payroll notification of leavers.

22/38 Schedule of Business

Noted.

22/39 Attendance Monitoring Register

Noted.

22/40 Urgent business

None.

22/41 Date and time of next meeting:

It was noted that the next meeting of the Audit Committee would be held on Thursday 21 July 2022 at 9am the Board Room, Westmorland General Hospital, Kendal LA9 7RG.

THIS PAGE IS INTENTIONALLY BLANK

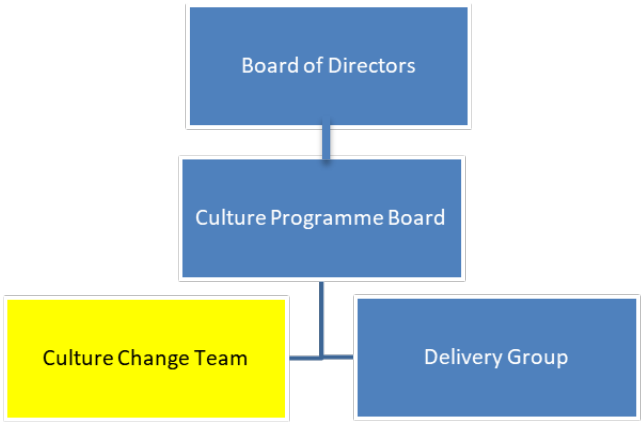
CULTURE PROGRAMME BOARD

Terms of Reference – FOR APPROVAL AT BOARD

CONSTITUTION

1. The Culture Programme Board will steer and oversee the development and delivery of the Moving Forward: Making Changes Together integrated programme of cultural transformation. Overall progress and impact will be measured via the Trust's Culture Dashboard, with formal reporting of programme delivery to this subcommittee of the Board of Directors and as part of the Trust's Recovery Support Programme.

2. Programme structure:



DUTIES

3. A subcommittee of the Trust Board, the Culture Programme Board will provide steer, oversee implementation and provide assurance on the development and delivery of the cultural transformation programme.

4. Workstream leads will attend where appropriate for steer / approval for programmes of work. They will be responsible for reporting on progress and ensuring connectiveness across the wider programme including engagement with the culture change team.

5. To be a forum to raise thematic issues regarding cultural transformation

6. To review and approve proposals for transformational change in line with the priority areas and advise/propose/lead mechanisms for implementation to achieve goals.

7. To sponsor and promote the benefits of creating a just, fair, inclusive and positive colleague climate at all levels

8. To assess and respond to any risks related to the programme brought to the attention of the group.

9. To provide strategic direction and assurance in relation to matters of cultural transformation.

10. To oversee and monitor performance against agreed metrics and review progress against agreed action plans, to be accountable to the cultural transformation programme.

MEMBERSHIP

11. The programme will report formally into the Board of Directors and will have the following key members:
    - i) CEO (chair)
    - ii) Chief People Officer (deputy chair)/ Director of People & OD
    - iii) Chief Operating Officer or nominated operations representative
    - iv) Executive Chief Nurse or nominated nursing representative
    - v) Chief Medical Officer or nominated medical representative
    - vi) Union Staff Side Chair
    - vii) Director of Governance
    - viii) Director of Midwifery or nominated midwifery representative
    - ix) Assistant Director of OD & Learning
    - x) Head of Culture & OD
    - xi) Head of Inclusion & Engagement
    - xii) Head of L&D
    - xiii) Associate Director of Improvement
    - xiv) Associate Director of Clinical Professions or nominated clinical profession representative
    - xv) Corporate Services representative
    - xvi) Estates and Facilities representative
    - xvii) Inclusion network chair representative (on behalf of inclusion networks and the Inclusion and Diversity Steering Group)
    - xviii) Freedom to Speak Up Guardian
    - xix) Non-Executive & Wellbeing Guardian
    - xx) Patient Governor
    - xxi) Patient Representative
    - xxii) Communications Manager
    - xxiii) Open observer place: available for any colleague to join on a rotational basis

    Where a member is unable to attend, a deputy should attend.

    Other Trust staff including workstream leads and culture change team members may be co-opted or invited to attend meetings as necessary. Other members to be co-opted as required.

ATTENDANCE

12. Members of the Programme Board are to attend at least 80% of meetings.

ROLE & RESPONSIBILITY OF MEMBERS AND ATTENDEES

13. Members of the Programme Board have a responsibility to:
    - i) read all papers beforehand;

ii) actively engage with colleagues outside of the meeting space; disseminating information and good practice – active advocates of the cultural transformation programme;
iii) identify agenda items to the Chair/Programme Board administrator at least two weeks before the meeting;
iv) if unable to attend, send their apologies to the Chair/ Programme Board administrator prior to the meeting and, send a deputy to attend on their behalf;
v) when matters are discussed in confidence at the meeting, to maintain such confidences;
vi) declare any conflicts of interest / potential conflicts of interest in accordance with the University Hospitals of Morecambe Bay NHS Foundation Trust's policies and procedures;

QUORUM

1. There must be minimum six members of the Group in attendance to include the Chair or Deputy-Chair.

FREQUENCY

14. The group will meet formally every two months.

REPORTING

15. The Programme Board will formally report into the Board of Directors.

ADMINISTRATIVE ARRANGEMENTS

16. The Chair of the Programme Board has responsibility for:
    i) overseeing all aspects of the work of the Cultural Transformation Programme;
    ii) effectively facilitating meetings to ensure agenda is covered and diverse views actively sought and considered;
    iii) encouraging and facilitating open conversations that may at times be difficult, working towards consensus amongst all members.

17. The Sub Chair for the Programme Board will be responsible for:
    i) overseeing the delivery of the administrative and project management duties;
    ii) producing an action list following each meeting and ensuring any outstanding actions are carried forward on the action list until complete;
    iii) producing a schedule of meetings to be agreed for each calendar year and making the necessary arrangements for confirming these dates and booking appropriate rooms and facilities;
    iv) providing appropriate support to the Chair and Programme Board members;
    v) providing notice of each meeting and requesting agenda items to receive no later than two weeks before a meeting;
    vi) agreeing the agenda with the Chair prior to sending the agenda and papers to members no later than five working days before the meeting.

18. The Administrative support for the Programme Board will be responsible for:
    i) attending the meeting;

ii) ensuring correct and formal minutes are taken in the format prescribed in the Governance Strategy and, once agreed by the Chair, distributing minutes to the members within 1 week of the meeting;
iii) keeping a record of matters arising and issues to be carried forward.
iv) Keeping a record of all risks and issues
v) Chasing all project leads for updates on their projects and actions for reporting purposes to the board

REVIEW

Terms of Reference will normally be reviewed annually, with recommendations on changes submitted to the Programme Board for approval.

Date approved and issued:	
Version number:	1.0
Next review:	
To be reviewed by:	Head of Culture Transformation
To be approved by:	Culture Programme Board
Executive responsibility:	Aaron Cummins, CEO
Author:	Karmini McCann, Head of Culture Transformation
ID No:	

Programme	Leadership and Culture
SRO	David Wilkinson

Reporting period	1st July - 25th July 2022
Leads	Karmini McCann, Matt France and Peta Heron

PROGRAMME BACKGROUND

As a result of the regulatory notices and CQC report a decision was taken by NHSEI to place the Trust in segment 4 of the System Oversight Framework (SOF) with support being provided through the Recovery Support Programme (RSP). NHSEI has appointed a full time support Director to support the Trust in developing an Improvement plan, to provide support to enable the Trust to make the required improvements and ensure there are resources in place to achieve this. The resulting Improvement plan is set out across a number of key themes as follows:

1. Regulatory requirements e.g. maternity, stroke
2. Quality & Safety
3. Operations & Performance e.g. theatre utilisation work
4. People & organisation development e.g. work on clinical engagement/leadership and culture
5. Sustainable Financial Improvement Programme

The Improvement plan is to be delivered through a Transformation and Improvement office and oversight and reporting will be through a Programme Board and Trust Management Board in addition to assurances being provided to the Quality & Safety Committee and Trust Board.

AIMS & OBJECTIVES

The Leadership and Culture Workstream has 3 main elements that aim to deliver the following:

4.1 - Cultural Engagement (Leading to a Cultural Development Plan) - This is a large long term programme of work that seeks to improve the culture in the organisation across the 7000 staff that work in University Hospitals of Morecambe Bay

4.2 - Revision and Refresh of Organisational Development Strategy - This programme seek sto reset and relign the key organisation development objective in such a way that they meet the business need of the organisation.

4.3 - Revised Leadership and Management Development Strategy & Plan (At all levels in the Organisation) - This programme of work is designed to improve Leadership at all levels of the organisation in a structured way via a Leadership Development Programme that is designed to improve leadership, capacity and capability it all levels.

Report	1st July to 25th July
ALERT	The Programme wishes to alert that: - SRO and Programme Lead both leaving UHMB in September. Planning underway for transition. CPO recruitment is underway. Recruitment to a permanent Head of OD and Culture is underway with interviews scheduled for 15th Sept. - Core Leadership Development Programme (Phase 1) commenced on 4th July with expectation that 95% of identified leaders, managers and supervisors will have completed the taught module and e-learning by 31st December. As at 23rd August 330 colleagues had completed the module, meaning that 57% of the full cohort had already completed the programme or booked to attend. However, we are receiving reports from care groups that attendance under current staffing and operational pressures is challenging. Conversations with ADOps will take place to understand the problem and if necessary to adjust the attedance forecast. - The Triumvirate Leadership Programme was scoped by end July, with planned commencement in September. However, unsatisfactory responses from the provider mean that the programme is likely to start in October. NHSEI colleagues are pressing the provider for ammendments and expediation.
ASSURANCE	The Programme wishes to assure that: - Revised governance and engagement structures in place: CEO led Programme Board reporting directly to the Board of Directors, Fortnightly Delivery Group (with revised structure including workstream deep dives) and the Culture Change Team - New Trust Strategy, Vision and Values (incorporating Moving Forward feedback) - visible communications campaign following launch - Behavioural Standards Framework (BSF) review commenced in June: conversations opened with colleagues via multiple routes: a digital survey, culture and leadership roadshows, BSF face to face pop ups around Trust sides and Microsoft Teams engagement sessions. Focus of a Culture Change Team session on 14.7.22. Outcome: to transition from the BSF document to focussing on the new Trust Values and Behaviours (which map across to the BSF). Plan to be presented to the Culture Programme Board in September. - Formal engagement for the development of a new reward and recognition strategy has commenced with workshops open to all colleagues during July and early August. This was the focus of the August Culture Change team workshop, ahead of recommendations being presented to the Culture Programme Board in September. - Board Development Programme was signed off at the Board of Directors meeting in June 22 and is 60 % complete. - 51 colleagues have been appointed as Culture Change Agents, with the majority attending an initial workshop on 14.7.22 to welcome them into role, clarify expectations and input into one of the initial priority areas on civility and respect
ADVISE	The Programme wishes to advise that: - Executive Development Programme has been commissioned through procurement, with scheduled commencement in September. Provider is ASK Europe. - FTSU improvement plan in development (with support from NHSEI). This is being brought into this programme for oversight, governance and connecting to the wider culture and leadership programme. - Proposal for Moving Forward Phase 2 (delivery) engagement approved at the Culture Programme Board in July with the Culture Change Team at its core and developments for all colleague engagement / conversation: a)Multi method proactive engagement with colleagues for specific workstreams (as with the BSF review) working with the culture change team (from July 2022) b) Development of UHMB's National Staff Survey engagement approach and response – utilising the culture change team to review and better understand the results and implications for culture related priorities (Jan – March 2023) c) Development of an ongoing methodology for digital conversations with colleagues, such as the use of Facebook, an internally developed platform or external platform (full options appraisal and agreement of approach by Dec 2022, implementation by March 2023). An additional action was requested: to explore funding and develop a plan for a further conversation on the Clever Together platform - National Staff Survey commences Septemeber 19th, with results available internally in December.

KEY RISKS & MITIGATION

Risk / Issue	Mitigating Action	Lead	Review Date
OD & Learning resources not aligned to delivery of OD Plan on a Page & cultural transformation	Careful allocation of existing resources, combined with selection of priorities and the sequencing of activity should mitigate the risk. Links to review of POD structure.	Matt France	31/09/2022
People & OD Team resources need to be realigned to meet revised priorities of organisation	Considering allocation of resources, requirements of Future of HR & OD in the NHS and how to redeploy/reallocate resources. External review of POD	David Wilkinson	31/09/2022
SRO & Programme lead leaving in September. Identification of single points of failure (workstream delivery)	Development of transition plan ahead of new Chief People Officer being recruited, approval to recruit permanently to a Head of OD & Culture (EDG 19.7.22). Development of programme approach to reduce the potential for single points of failure.	David Wilkinson	31/07/2022
18.5% CIP challenge within People & OD is a major risk to service delivery of this programme alongside business as usual activity.	Development of CIP Plans supported by QIAs to understand impact and inform corporate-level decision-making	David Wilkinson	31/07/2022
Leadership Development Programme: long term resources and venue for 2023 delivery not identified.	Exploration of options - plan to be developed	Matt France / Peta Heron	31/09/2022
Lack of funding to support a further conversation via the external Clever Together Platform (requested at the July Programme Board)	RSP funding being revisited	David Wilkinson, Rebekah Coombes (NHSEI)	31/08/2022

PROGRAMME KEY MILESTONES

Key Milestones to Support Programme Delivery - 22/23

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Original Target	Revised Date	Comments
LEADERSHIP AND MANAGEMENT															
Leadership for All															
Plan developed	●												Mar-22		Completed
Plan socialised	●												Apr-22		Completed
Plan approved by People Committee		●											May-22		Completed
Programme Launched			●										Jun-22		Programme Launched WC 27/06
Triumvirate															
Programme Launched			●			●							Sep-22		2 dates - also included in Leadership for All
Board															
Programme Launched			●	●									Jul-22		2 dates - also included in Leadership for All
OUR WORKPLACE															
Civility, Respect and Values															
Undertake a comparative audit		●											May-22		Completed and presented to TMG June 22. Yr 1 plan approved and implementation commenced
Review and Undertake BSF refresh					●								Aug-22		In response to colleague feedback, developing plan for focus on the new Values and Behaviours. Proposed plan to be agreed at Sept Culture Programme Board.
Launch Refreshed BSF						●							Sep-22		
Improved access to Breaks, Hydration and Nutrition															
Development of Plan					●								Aug-22		
Implementation of Plan												●	Mar-23		
TRANSFORMING HR															
Future of HR & OD in the NHS															
Identify External Lead	●												Apr-22		Completed
Develop Programme Plan		●											May-22		Completed
Consult on Outcomes						●							Sep-22		
Implement Plan (Subject to CPO)							●						Oct-22		
Fair and Inclusive Recruitment															
Establish Steering Group		●											May-22		Completed
Develop Programme Plan			●										Aug-22		Completed
Implement Programme Plan						●							Sep-22		
STRATEGY & ENGAGEMENT															
Aligning Plans with People Plan															
Ensure Congruence	●												Apr-22		Completed
Reward and Recognition															
Scope External Best Practice		●											May-22		Completed
Develop Options for Consideration					●								Aug-22		
Consult and Agree Option						●							Sep-22		
Trust Strategy															
New Strategy	●												Apr-22		Completed
New Vision and Values		●											May-22		Completed
CULTURE AND WELLBEING															
Cultural Transformation															
Reformat Change Team				●									Jul-22		Completed
Recruit and Train Change Agents				●									Jul-22		Workshop 14th July
Equality and Diversity															
Establish Interim Structure		●	●										May-22	Jun-22	Interviews 17th June
Develop Programme Plan		●	●										May-22	Jun-22	Positive Difference Action Plan developed to be formally approved at People Committee in July
Implement Programme Plan			●										Jun-22		Implementation commenced (existing work programmes)
Just and Learning															
Develop Y1 Plan	●												Apr-22		Completed
Implement Y1 Plan		●											May-22		Completed.
OTHER															
Culture Dashboard															
Refine & Trial Metrics	●												Apr-22		Completed
Launch Dashboard		●											May-22		Completed
Moving Forward Phase 2															
Define approach for phase 2			●		●								Jun-22		Paper to Culture Programme Board 11.7.22 - recommendations approved, with additional ask for 1 further conversation via the Clever Together Platform - funding to be sourced. 2nd milestone for exploration of funding options and agreeing timing of additional conversation.

FINANCIAL OPPORTUNITY

Metrics	Q3	Q4	2021/22	Q1	Q2	Q3	Q4	22/23	24/25	25/26	Total	Target
Metric A	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Metric B	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Metric C	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Metric D	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Metric E	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Metric F	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Total	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0

Key:

Red	Off track / trajectory - milestone / timescales breached. Recovery plan required
Amber	Delivery feasible issues / risks require additional intervention to deliver the req'd improvement e.g., milestones breached
Green	Improvement on trajectory either: a) On track - not yet completed or not yet started
Blue	Completed. Improvement /action delivered, and evidence provided

University Hospitals of Morecambe Bay NHS Foundation Trust

Quality Governance & Accountability Framework

FINAL Draft V1.5

July 2022

	• (3.3) Clinical Support Services • (3.4) Integrated Community Care Services	
Appendix 4	(4.1) Care Group Quality Meeting • Terms of reference and membership • Agendas (4.2) Specialty/Service/Departmental Quality Meeting • Terms of reference and membership • Agendas (4.3) Specialty/Service/Departmental Quality & Business Meeting • Terms of reference and membership • Agendas (4.4) Specialty/Service Department Mortality & Morbidity Meeting • Terms of reference and membership • Agendas (4.5) Specialty/Service Department Clinical Audit Meeting • Terms of reference and membership • Agendas	

1. Introduction

University Hospitals Morecambe Bay NHS Foundation Trust ("the Trust") is a statutory body that was established in 1998 and became a Foundation Trust on 1 October 2010. As a statutory body the Trust is required to operate within the NHS legal framework and to comply with all related statutory and regulatory requirements.

NHS Trust Boards have a duty to conduct their affairs effectively and demonstrate measurable outcomes that build patient, public and stakeholder confidence that the organisation is providing high quality, sustainable care. The Board of Directors ("trust board") has a specific statutory duty to put and keep in place arrangements for the purpose of monitoring and improving the quality of health care provided by and for the organisation.

This document is intended to set the arrangements that are in place that ensure that the trust board meets this duty.

2. Accountability

The trust board is ultimately accountable for the quality of services that the trust provides.

The Executive Chief Nurse is accountable to the Chief Executive and the trust board for ensuring that there is a robust governance framework in place from point of care delivery to trust board, that provides effective line of sight to quality performance and is supported to do so by the Chief Medical Officer and Director of Governance.

The Director of Governance is accountable to the Executive Chief Nurse for ensuring the Quality Governance Framework is kept up to date, meets best practice requirements and is operationalised, and for providing expert advice and assurance to the Chief Nurse that any changes that are made will not undermine the efficacy of the trust's quality governance architecture.

The Care Group leadership team is accountable for ensuring that effective governance processes operate across the entirety of their Care Group, supported by Corporate Teams and departments.

3. Purpose of this document

This framework is intended for use at all levels of the organisation and sets out the trust's approach to ensuring that roles, responsibilities, reporting and escalation lines are clear and that there are robust systems of governance and accountability in place at all levels to support the delivery of high quality, sustainable services.

It describes the governance structures that are in place within each Care Group and how quality performance, risks and issues are reported and escalated through the wider organisational structures up to the trust board to provide effective line of sight.

Governance structures and processes are not static and in line with the requirements of the Well Led Framework, will be subject to regular review and to change. The meeting structures and terms of reference are therefore purposefully provided as appendices to this document so they can be updated as structures and processes are reviewed and evolve.

4. Document Status

This document is an integral part of the Trust's overall governance framework and as such is subject to trust board approval and is mandated.

In line with trust values, the Director of Governance will work in partnership with Care Group leaders to ensure that structures and processes meet the needs of the diverse services the trust provides. Any changes to appendices to this document must however follow the approval process outlined in section 10 to ensure that the Executive Chief Nurse and trust board has assurance that these changes will not affect the robustness of the overall quality governance architecture and the effectiveness of trust board line of sight.

Although this document is primarily focused on quality governance, we recognise that quality, operational and financial performance are interlinked and as such, the Care Group structures set out in appendix 3 also provide for effective oversight of each of these areas within each Care Group.

5. What is Governance?

Effective governance is the cornerstone of well-run organisations. At its core, governance can be described as the systems and processes by which the organisation is controlled and directed in order to meet its objectives.

Governance and effective risk management are fundamental to ensuring that safe, high-quality care is provided to patients and service users and that services focus on continuous improvement in the quality of care. As such it is Key Line of Enquiry (KLOE) in the CQC Well Led Domain. We have organised our quality governance framework around the accepted definition of quality in the NHS, which is to provide care that is effective, safe and provides as positive an experience as possible. Risk management is an integral part of our quality governance framework and is embedded in meetings at all levels of the organisation. All staff have a responsibility to report risks to quality, operational and financial performance.

Quality Governance can be described as the combination of structures and processes at and below board level that are in place to deliver trust-wide quality services, which should ensure that:

- Essential standards are delivered
- There is continuous oversight of, and improvement in care quality

- Issues and risks are escalated to the appropriate level
- The board is sighted on issues and concerns in a timely way
- All aspects of quality delivery can be evidenced

Figure 1:

6. Values Based Governance

This document sets out how our organisation is run, structured, led and held to account but as a values driven organisation, structures and processes are only one element of effective governance. The values, principles and behaviours that determine how this control and direction will be exercised are of equal importance and we strive to embed a values-based governance culture that is focused on driving up quality of care.

The Executive Chief Nurse and Director of Governance commit to engaging widely with the organisation to put into place a system of governance that is lean and effective, avoids bureaucracy and minimises meeting burden. We have engaged widely with our Care Groups and corporate teams in the development of the structures and processes that are set out in appendices 1, 2 and 3, and will continue to do so as these are refined and adapt over time.

Through a process of engagement, the Trust has developed 4 organisational values and we have set out below how each of these values have driven a set of principles that we have used to inform the development of our Quality Governance framework. We will continue to utilise these principles as the organisation evolves.

Figure 2:

Compassionate		We establish our governance systems with the purpose of ensuring that we work together to deliver, safe, effective, high-quality and sustainable care to our patients and service users and we ensure that patients are at the centre of all governance activity. It is the mechanism that we use to demonstrate that our services are safe and to identify and take swift action where we need to improve, so that we can be proud of the services we deliver.
Respectful & Inclusive		We frequently review the effectiveness of our governance systems and processes through a process of engagement to ensure that in effectively overseeing our quality performance, we are respectful of time and optimise the skills and contributions of all colleagues. We listen to our colleagues and make changes where necessary and work on the principle that the right people, with the right skills will be at the right meetings.
Ambitious		Our corporate functions and clinical teams work together in partnership to drive up quality and we are clear that the role of our corporate teams is to support clinicians to deliver high quality care. We work collaboratively to ensure that our governance processes meet the diverse needs of our clinical services and are used to drive up quality improvement.
Open, honest & transparent		We are clear on accountability for quality at all levels of the organisation and build our governance systems based upon our devolved accountability structure. Our governance processes are built, and will be operated in a fair and consistent way, where respectful, constructive challenge is the means by which we improve quality of care.

7. Our Clinical Services Structure

The Trust operates a devolved accountability structure and manages the delivery of clinical services through 5 Care Groups. Each Care Group is accountable, via the Clinical Director, to the Executive Team, for all aspects of performance and contribution to achievement of the Trust's objectives, which underpin the delivery of the overarching strategic objectives and for effective oversight of the performance of the services that sit within the Care Group.

7.1 Supporting Corporate Functions

There are corporate functions in place to support the Care Groups to deliver, safe, high-quality care and to achieve their annual objectives. These include finance; workforce; quality governance and risk, information technology, performance and

programme management office, quality improvement and the corporate affairs function. Corporate functions are accountable to the Executive Director under whose portfolio they sit for their performance and achievement of targets. As articulated in figure 2, the role of our corporate teams is to support clinicians to provide, high quality care on a sustainable basis.

8. Care Group Accountability & Leadership Structure

8.1 What is accountability?

In a devolved accountability system, it is essential that there is clarity around roles, responsibilities so that leaders understand what they are accountable for and to whom, and that there are clear and effective reporting and escalation lines.

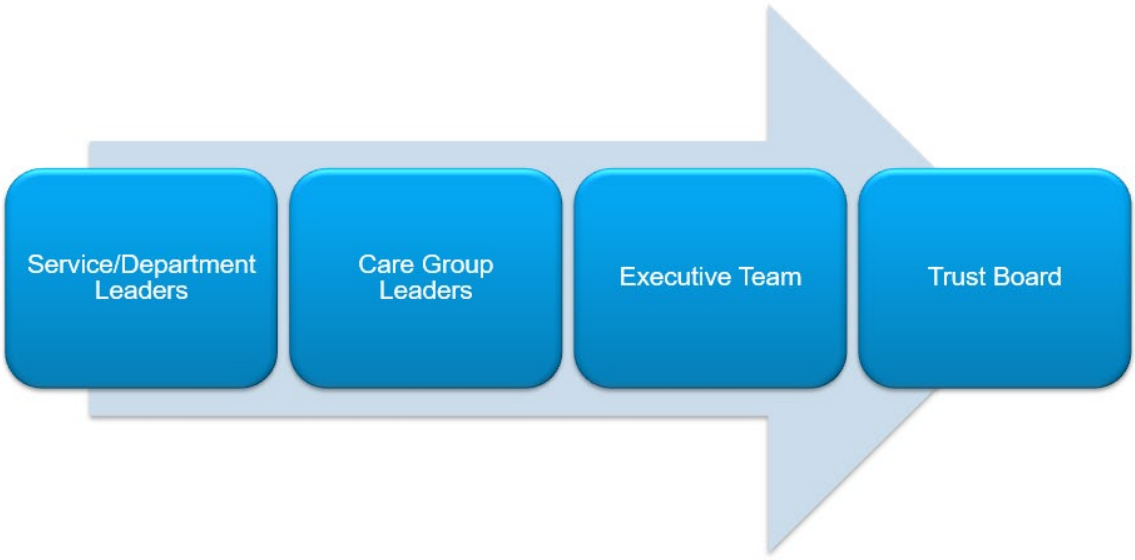
We have set out board level accountability for quality in section 2 and we define accountability at Care Group level as being answerable to the executive for all aspects of the performance and outcomes of the Care Group. We expect Care Group senior leaders to monitor, report on, explain and improve performance and outcomes where this is warranted and as indicated above, there are a number of corporate functions in place to support them to do so.

In turn, we expect the leaders of our specialties, services and departments who are accountable to the Care Group Leadership Team to monitor, report on, explain and improve performance within their areas.

8.2 Chain of Accountability

The chain of accountability in our organisation is as follows:

Figure 3



8.3 Care Group Leadership & Accountability Structure

Each Care Group is led and managed by a Senior Management Team known as the triumvirate, which comprises a Clinical Director, Associate Director of Nursing/AHP and an Associate Director of Operations. Maternity services, which sit within the Women and Childrens Care Group (WACS) have different leadership arrangements to reflect national requirements. Whilst the underlying principles set out in this document to apply to the WACS Care Group, their specific governance and accountability arrangements are set out separately in appendix 2 to this document.

Figure 4

The triumvirate team is headed by the Clinical Director but is collectively accountable to the Executive Team for the following:

- Providing effective leadership to the Care Group
- All aspects of Care Group performance (quality, operational and financial)
- Ensuring that the governance processes within the Care Group are operated effectively and provide oversight of the services that sit within in their Care Group
- Holding the specialties/departments to account for all aspects of quality performance and for operating effective specialty/departmental governance processes
- Effective management, mitigation and oversight of risks in the Care Group
- Escalating risks to all aspects of performance to the executive team through the trust structures

Each member of the triumvirate is professionally accountable to, and line managed by members of the executive team as set out below:

Role	Accountable to
Clinical Director	Medical Director
Associate Director of Nursing/AHP	Executive Chief Nurse
Associate Director of Operations	Chief Operating Officer

8.4 Specialty/Service/Departmental Leadership Structure[1]

The leadership and management structure of our Care Groups below triumvirate level is different depending on the services that they provide. Although there are job descriptions in place for each individual role, we have set out broadly below what each service/department/specialty will have the following in place and a summary of their areas of accountability:

Role	Accountable for	Accountable to
Clinical Leads/ Heads of Service	Providing clinical leadership to their service/area and for ensuring that governance processes are robust, including the arrangements for clinical audit, mortality and morbidity processes and all other aspects of quality governance and risk.	Clinical Director
Matrons/Lead Nurses/AHPs	Providing nursing/AHP/midwifery leadership to their wards/areas and for ensuring that professional standards are met, including Infection Prevention & Control, safeguarding, fundamentals of care and safe staffing	Associate Director of Nursing
Service Leads	All aspects of day-to-day operational service delivery	Associate Director of Operations

The service/departmental/specialty leadership teams are accountable to the Care Group Triumvirate Teams for the following:

- Providing effective leadership to their service/specialty
- All aspects of service/specialty performance (quality, operational and financial)
- Operating effective governance processes within the service/specialty
- Effective management, mitigation and oversight of risks in the Care Group
- Escalating risks to all aspects of performance to the Care Group Leadership Team

[1] These duties are a summary and are not intended to be exhaustive

8.5 Other Lead Specialty/Service Roles[2]

Role	Accountable for	Accountable to
Specialty Clinical Audit Lead	Providing leadership for the completion of clinical audits and overseeing/driving progress against the clinical audit plan within the specialty and supporting colleagues to undertake audit.	Clinical Director
Specialty Governance Lead	Providing clinical leadership in relation to the quality governance agenda and supporting the implementation and operation of sound governance processes across the service/specialty	Clinical Director
Specialty M&M Lead	Overseeing the mortality and morbidity review process within their specialty and ensuring that required standards are met in relation to Learning from Deaths	Clinical Director

8.6 Corporate Supporting Function Roles[3]

Role	Accountable for	Accountable to
Governance Business Partners	Providing specialist governance support and expertise to the Care Groups and acting as a critical friend, challenging leaders in relation to all aspects of quality governance and risk and ensuring that issues/risks are escalated appropriately through the structures.	Head of Patient Safety & Complaints
HR Business Partners	Providing specialist HR and OD support to the Care Groups, acting as a critical friend and challenging leaders in relation to the People & OD agenda and performance against key metrics. Ensuring that risks/issues are escalated to the tier 2 groups/Risk Management Group.	
Finance Business Partners	Providing specialist support and advice around the finance agenda and acting as a critical friend, challenging leaders in relation to financial performance and supporting them to identify solutions to financial challenges. Ensuring that finance risks/issues are escalated to the relevant tier 2 groups/Risk Management Group.	

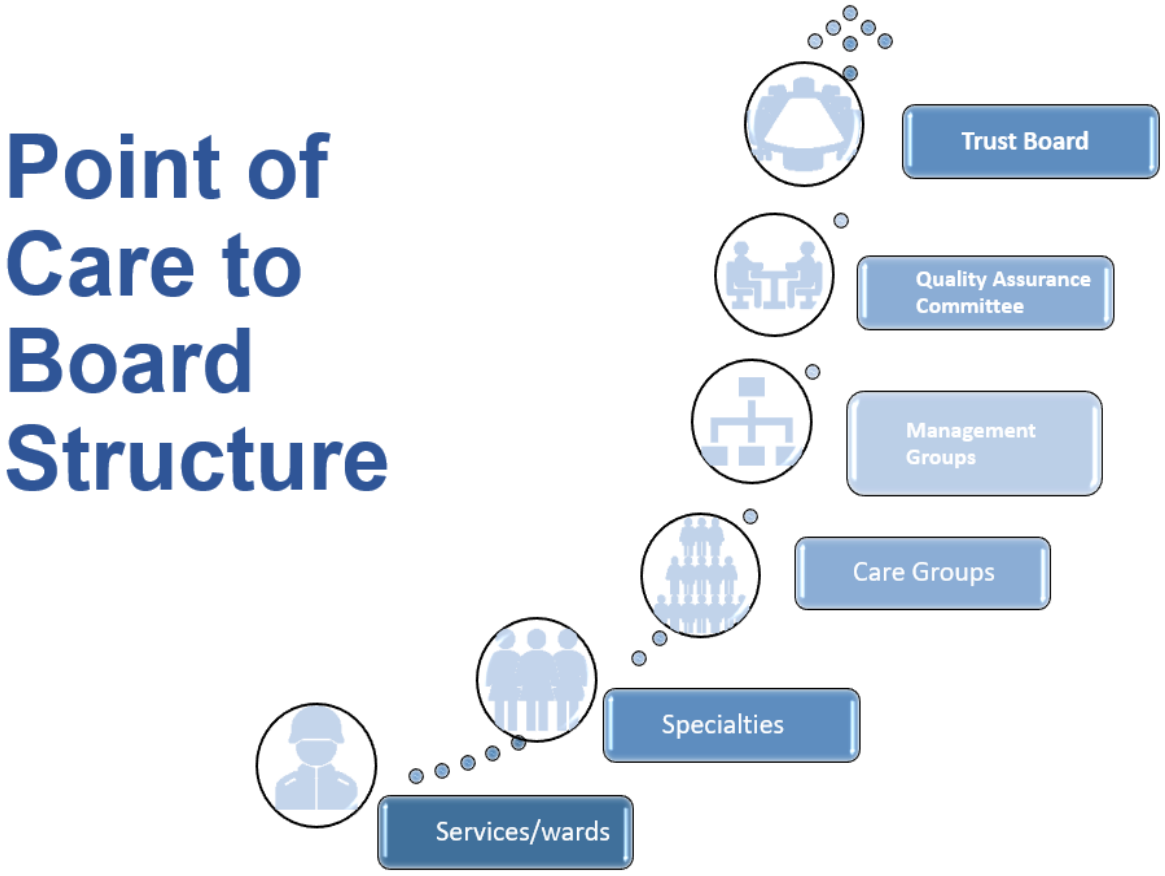
[2] These duties are a summary and are not intended to be exhaustive

[3] These duties are a summary and are not intended to be extensive

9. Quality Governance Structure

Our point of care to trust board structure is set out pictorially below and we will describe the arrangements that are in place at each level in further detail within this section:

Figure 5



9.1 Care Group Meeting Structures

The clinical services that sit within our Care Groups are diverse and as such there is no single approach to governance structures that meets all needs. For example, some services will not require separate Morbidity & Mortality (M&M) and Clinical Audit Meetings as they may have limited activity owing to the nature of their services, and it may be appropriate in some specialties, services and departments to hold a single meeting at which all aspects of quality, operational and financial business are discussed. Similarly, maternity services and the wider Women & Children's Care Group (WACS) have specific governance arrangements that are set out in appendix 2.

We have been mindful not to create meeting burden but as a clinically led organisation, we have purposefully defined a structure in which there is sufficient and dedicated time to allow clinicians to focus on quality and we can ensure that clinical audit and M&M meetings for example are open to wider attendance, for example, junior doctors and

nursing, midwifery and AHP staff. This is because we recognise that our clinicians and clinical leaders are best placed to understand the quality challenges within their services and develop sustainable solutions to these.

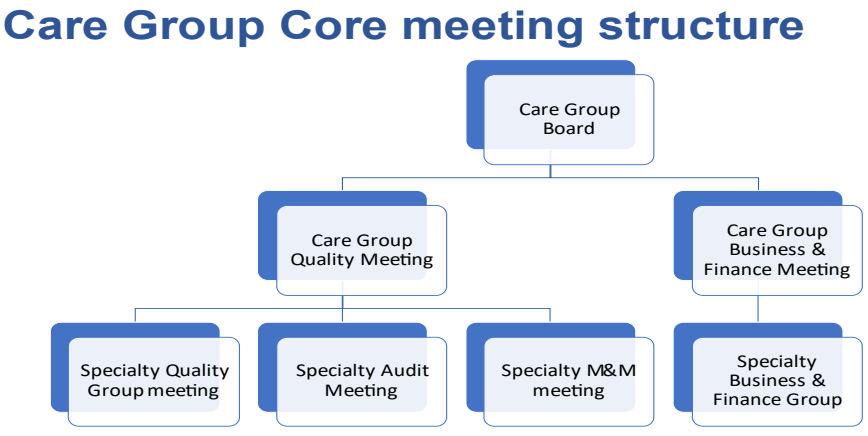
The membership of the groups set out within our quality meeting structure are based upon the right people, with the right skills, being in the right meeting, rather than the same attendees being present at all meetings. All service/department/specialty quality meetings will however report through the agreed structure into the overall Care Group Quality Meeting, to ensure that appropriate reporting, oversight and escalation mechanisms are in place.

Following a process of engagement, we have built the Care Group governance structures based on the core structure that is outlined in figure 5 below, with deviation from this where this is warranted based on the size, complexity and specific requirements of the different services, departments and specialties. Any deviation from the core structure has been subject to the agreement of the Director of Governance and in the case of maternity services, subject to the agreement of both the Director of Midwifery and the Director of Governance.

This reflects our commitment to design governance processes that are tailored to the needs of each service but at the same, ensures that the balance between the autonomy of Care Group leaders to put into place arrangements that meet the needs of their services, and the integrity and effectiveness of the overall quality governance framework is maintained.

Although we are fully committed to working in partnership with our clinical service leaders to reflect our delegated accountability arrangements, the final decision on any changes to the quality governance meeting structures at all levels of the organisation will be taken by the Director of Governance who is accountable to the Executive Chief Nurse for ensuring that the quality governance framework is robust and delivers effective line of sight.

Figure 6



The governance structures for each Care Group, which includes the agreed specialty/ department/locality structures are set out in the Care Group structure charts in appendix 3.

9.2 Care Group Areas of Oversight/Escalation

As we have articulated, the meeting structures for the services, specialities and departments are tailored to meet their individual requirements, but whatever meeting structured is adopted within each Care Group, we expect the areas set out in the table below to be discussed on a monthly basis across all services/specialty/departmental meetings, to the extent to which they are applicable e.g., not all Care Groups have ward-based services

Quality Governance	**Business & Finance**
Patient Safety	Financial Performance
Fundamentals of Care	Operational performance & delivery plans
Ward Dashboards	Theatre and clinic efficiency (where appropriate)
Morbidity & Mortality/Perinatal Mortality Review	Business Cases
Safe Staffing & Staff Experience	
Patient Experience	
Clinical Audit & Effectiveness	
Health & Safety	
Risk Management	
Issues for escalation	

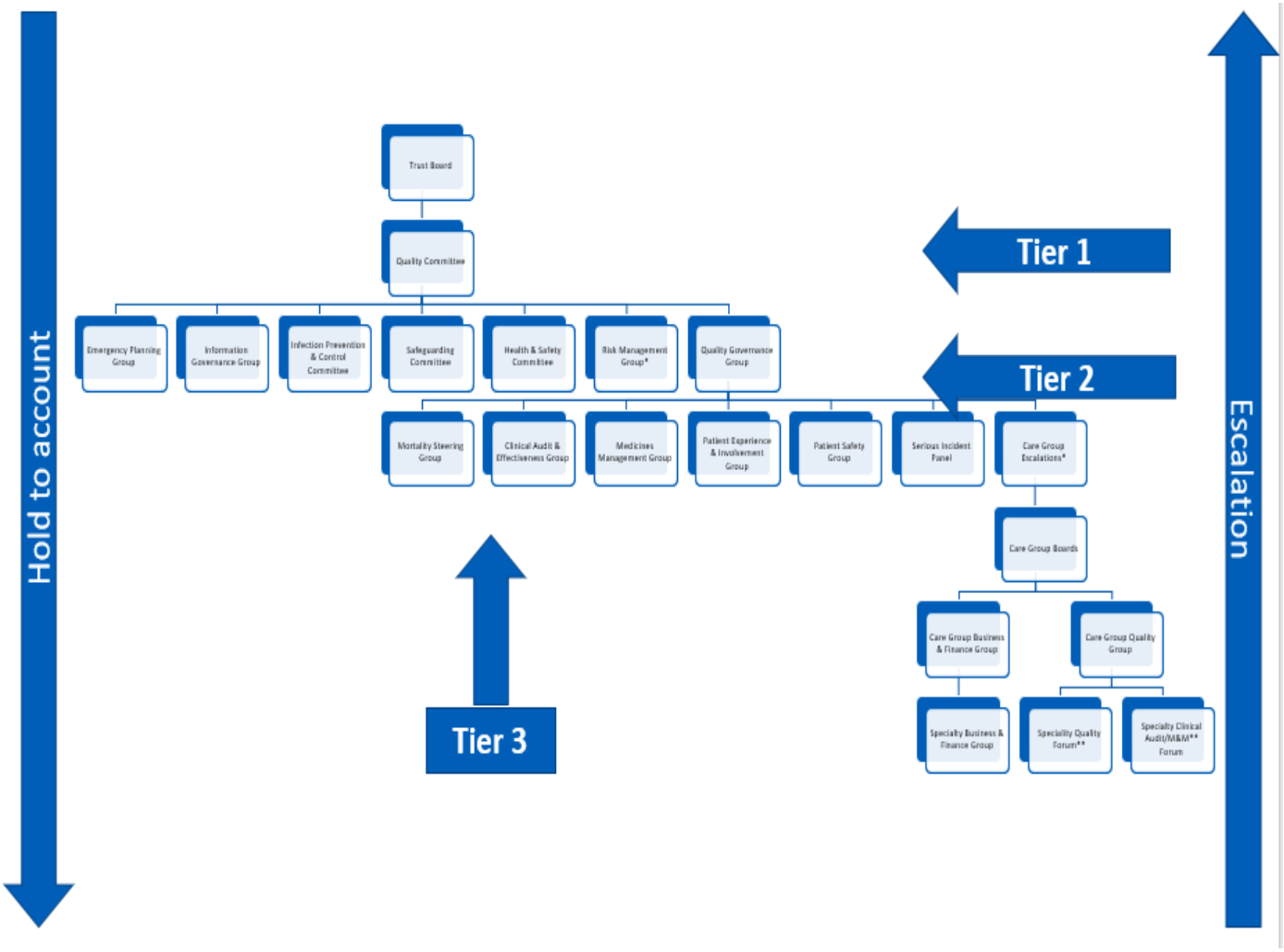
The areas included in the table above are broad areas and we have developed standardised terms of reference and agendas at appendix 4 which provide additional detail on what should be discussed under each area. Whilst we expect these agendas and terms of reference to be adopted at Care Group level, we recognise that there are different structures in place within our specialties, services and departments. The specialty agendas at (4.2), (4.3), (4.4) & (4.5), can be used as a basis to develop terms of reference and agendas that reflect agreed meeting structures where these differ.

9.3 Corporate Quality Structure

Our point of care to board Quality Governance Framework has been developed using the principle that there should be minimal layers between our specialties/ services and the trust board, to ensure that issues can be escalated in a timely and effective way.

The structure is set out at high level pictorially in figure 7 below and depicts the reporting relationship between clinical services and the trust board.

Figure 7



The structure purposefully reflects the delegated accountability arrangements that the trust has in place and is structured into tiers:

Tier	Status	Role	Chair
1	Board Assurance committee	Assurance committee will receive regular escalation reports from the 5 reporting groups and a series of assurance[4] based reports based on an annual programme of work that will provide oversight of the 3 domains of quality and risk.	Non-Executive Director
2	Executive Scrutiny Group	Forum for the executive directors to hold Clinical Groups and corporate leads to account for quality performance and oversight of agreed actions to improve performance. The	Executive Director

[4] NB assurance reporting is not management information and reports to tier 1 committees will take on an assurance focus

		purpose of these groups is to allow the executive directors to seek, and in turn to provide assurance to the board through regular reporting and to ensure that issues/risks to quality are escalated to the Quality Committee and trust board	
3	Operational Groups	Groups established for the operational management of the organisation to ensure that there is sufficient focus on key areas of focus from a quality and risk perspective	Deputy Director

Full details of the structure and reporting substructure are set out in appendices 1,2 and 3 and again, we have adopted the principle of ensuring that the right people, with the right skills are in the right meeting, balancing meeting attendance with the need to ensure that clinical time is optimised.

10. Changes to the Quality Governance Framework

We have highlighted throughout this document the importance of striking the balance between the autonomy of our leaders and the need to maintain a robust, effective, point of care to board quality governance structure, which provides oversight and allows the board to fulfil its statutory duties.

As we have engaged widely with Care Group leaders to develop their meeting structures, we expect all Care Groups to operate to these and as is outlined in section (9.1) any changes to the structures will need to be formally approved by the Director of Governance (and Director of Midwifery in the case of Maternity Services) to ensure that the integrity of the quality governance architecture is maintained.

We also expect every meeting within the Care Group and corporate structures to operate to formally approved and adopted terms of reference, membership and reporting requirements. As indicated in section (9.2) above, it is our intention that the terms of reference set out in appendix 4 will be adopted by the Care Groups across their services, albeit it these will need to be tailored to reflect the agreed meeting structures at individual speciality/service/departmental level. The principles and broad areas that are set out within these terms of reference and the subject areas in the agendas must however be maintained subject, to their applicability to individual specialties/services/departments.

Any changes to the terms of reference within the Care Group structures must be formally signed off by the Governance Business Partner, triumvirate team and Director of Governance and once agreed, they must then be formally approved and adopted by the ‘parent’ group that the group or meeting reports to within the agreed meeting structure. Specific arrangements for approval and sign off of changes to the maternity governance structure and terms of reference for these meetings are set out in appendix 2.

In the case of the corporate quality meeting structure as set out at appendix 1, the same arrangements apply in that any changes to the meeting structure or to the terms of reference and/or membership, must be approved by the Director of Governance and formally adopted by the parent group/committee.

Any proposed changes to the reporting sub-structure of the Tier 1 Quality Committee will be proposed by the Director of Governance and/or Executive Chief Nurse and shared and consulted upon with the NED Chair of the committee prior to implementation.

11. Approval and Review

The Quality Governance & Accountability Framework document and the specific arrangements that are in place for maternity services/WACS set out at appendix 2 will be formally approved by the Trust Board to reflect its overall accountability for the quality of services that the trust provides and national requirements in relation to maternity services. The framework will be reviewed on an annual basis as part of the trust's commitment to keeping the quality governance framework under regular review and ensuring its overall effectiveness.

The remainder of the appendices will not require trust board approval when changes are made as the intention is that the appendices will be live documents to reflect our evolving organisation and whilst it is appropriate and necessary for a formal mechanism to be in place for changes to be made, this falls within the remit of executive accountability as part of good governance and management and any changes will not therefore require formal trust board approval.

The process for amending the appendices within this document is as set out in (10) above.

Date of Board approval:

REPORT TO (NAME OF MEETING)

DATE OF MEETING:

University Hospitals of Morecambe Bay NHS Foundation Trust

CHAIR'S REPORT

Reporting Group/Committee:				
Data and time:				
Chairperson				
Attendance:	**Quorate:**		**Not Quorate:**	
If not quorate, state reason:				
Key items discussed:	1.			
	2.			
	3.			
	4.			
	5.			
	6.			
	7.			
	8.			
	9.			
	10.			
Items for positive escalation: (where a previously challenging matter has been successfully resolved, assurance can be provided & organisational wide learning might be available for sharing)	1.			
	2.			
	3.			
	4.			
	5.			
Items for negative escalation:	1. Xxx **Actions:**			

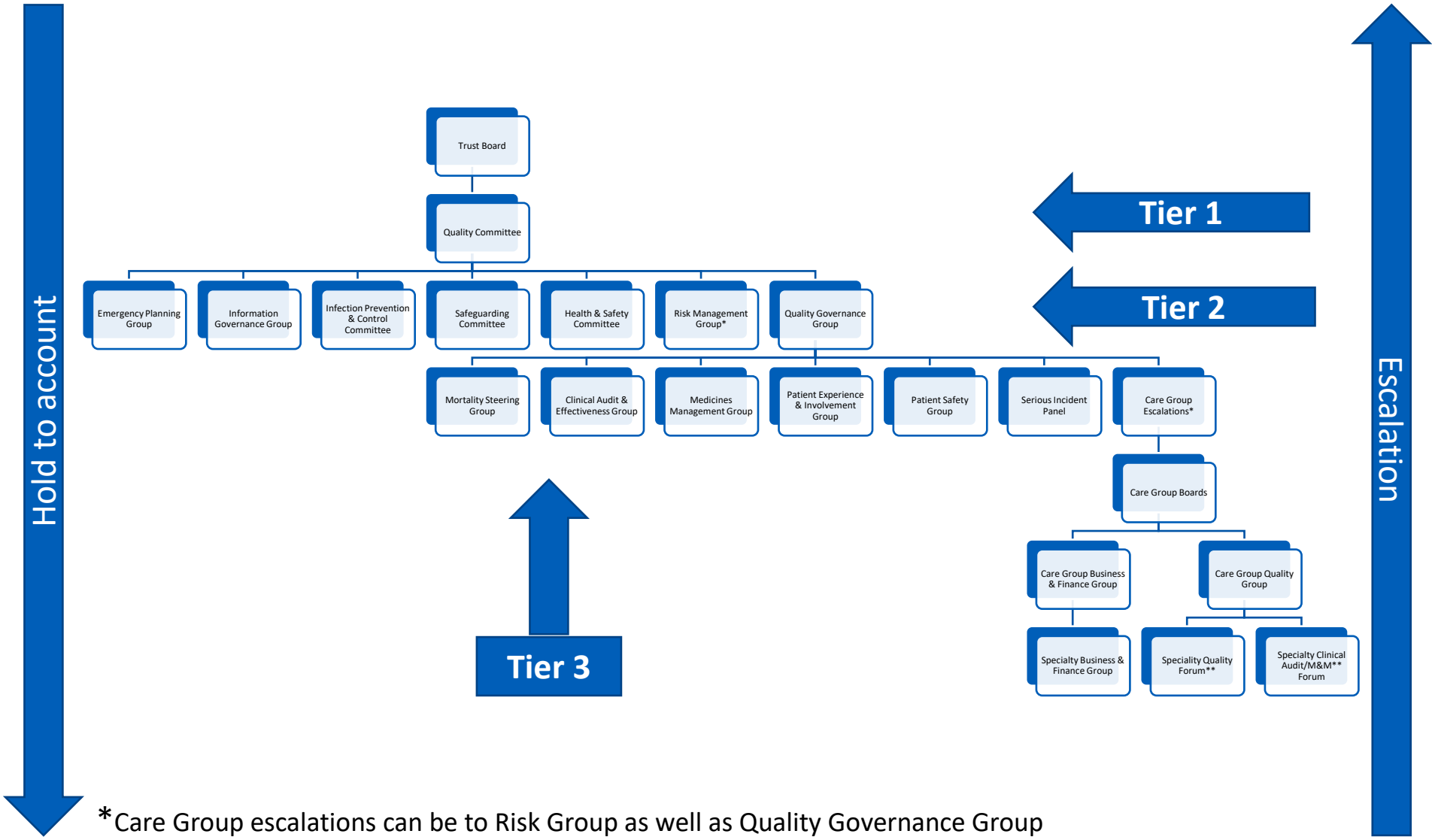
(where a challenging matter has not yet been successfully resolved, assurance cannot yet be provided & organisational wide learning might be available, but the 'parent' committee needs to be aware)	
	2. Xxx **Actions:**
	3. Xxx **Actions:**
	4. Xxx **Actions:**
	5. Xxx **Actions**:
Name of committee for escalation: (parent committee)	
Chair's Narrative on the meeting: (if applicable, covering points otherwise not discussed elsewhere in the template)	
Date, Time & Location of next meeting:	

UHMB NHS FT Point of Care to Board Quality Governance Structure V2.3 Draft

July 2022

NHS England and NHS Improvement

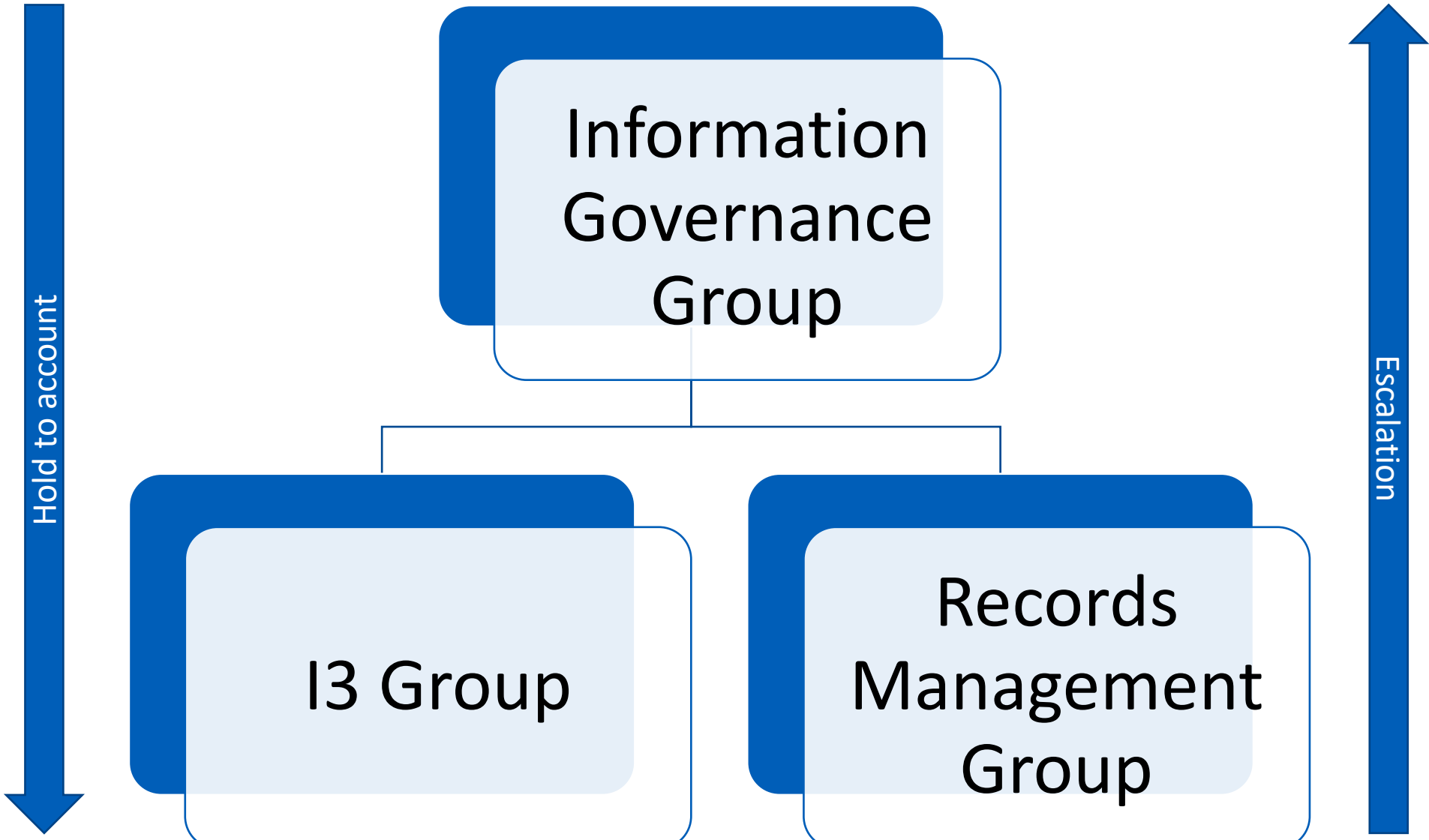
Point of Care to Board Structure



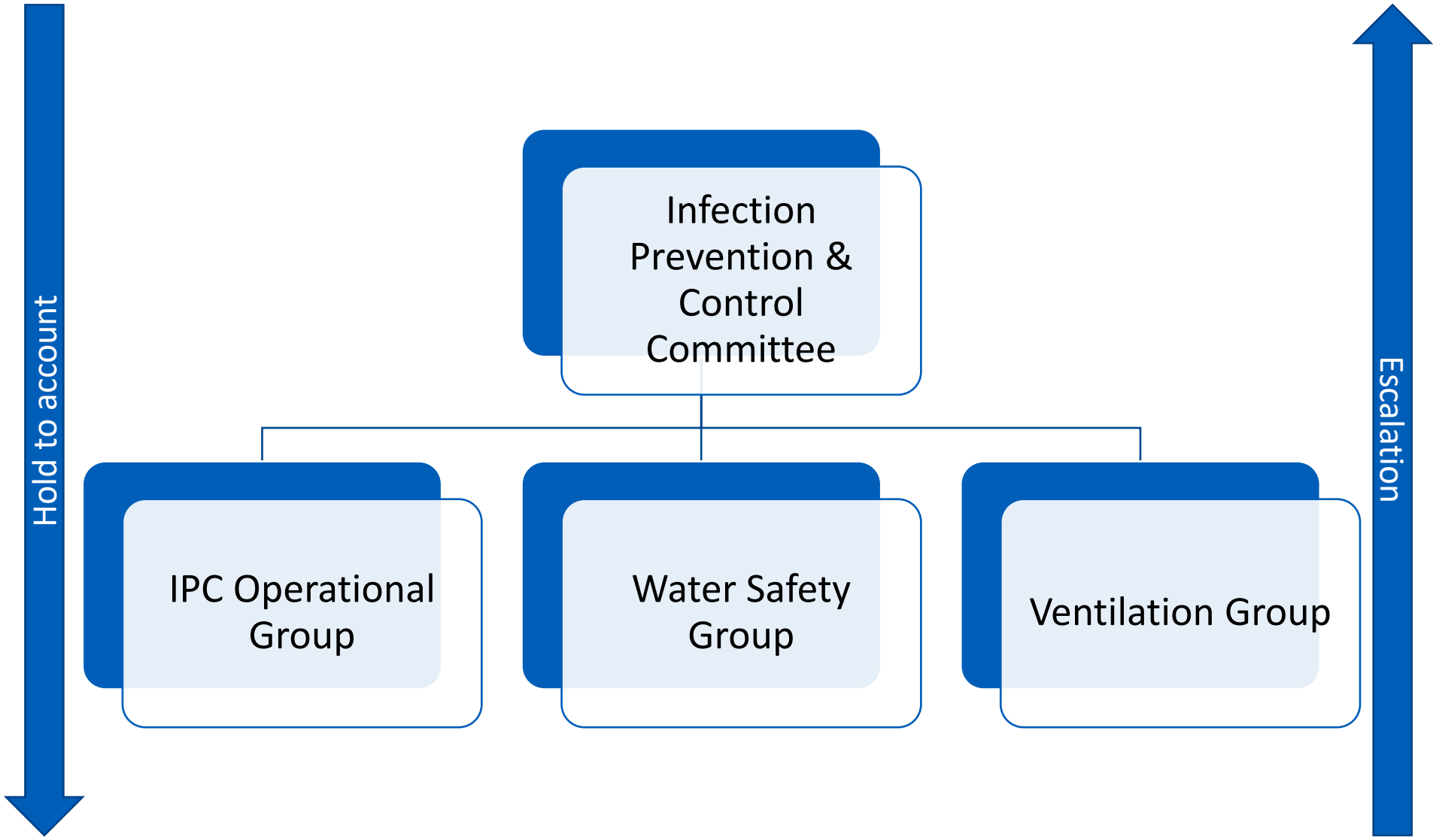
*Care Group escalations can be to Risk Group as well as Quality Governance Group

** Specialty/Service structures are different to meet need – see Quality Governance & Accountability Framework

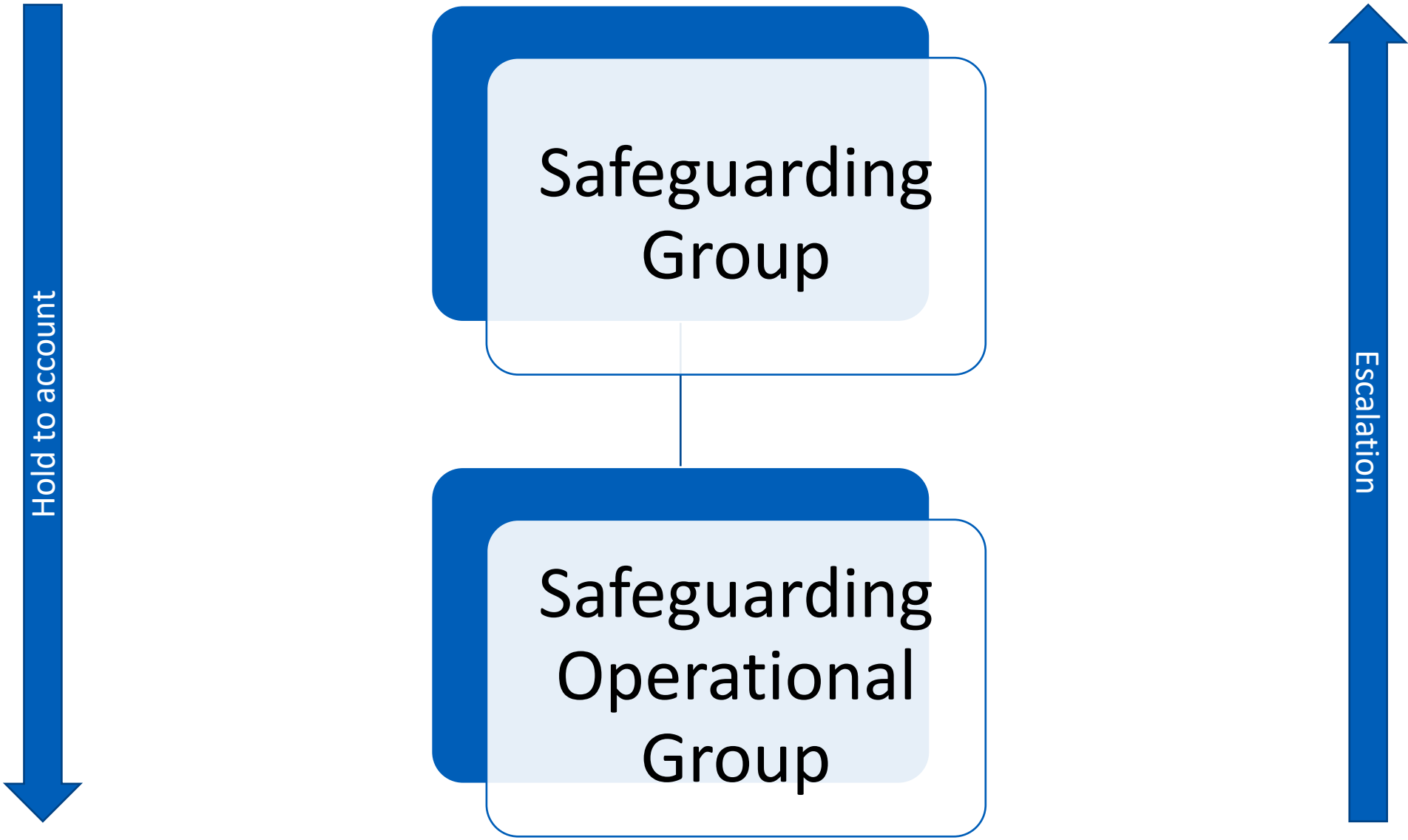
Quality Committee Sub-structure



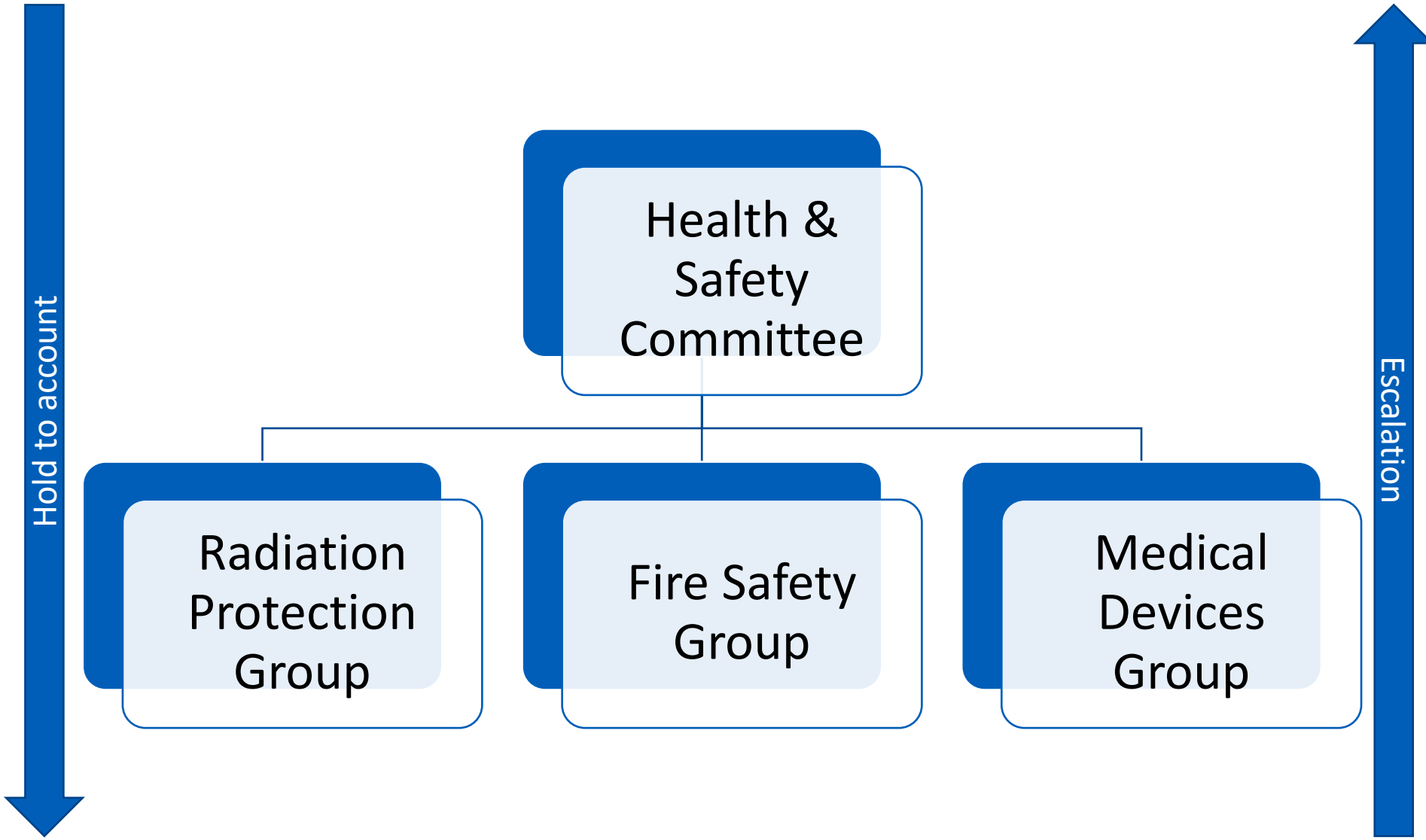
Quality Committee Sub-structure



Quality Committee Sub-structure

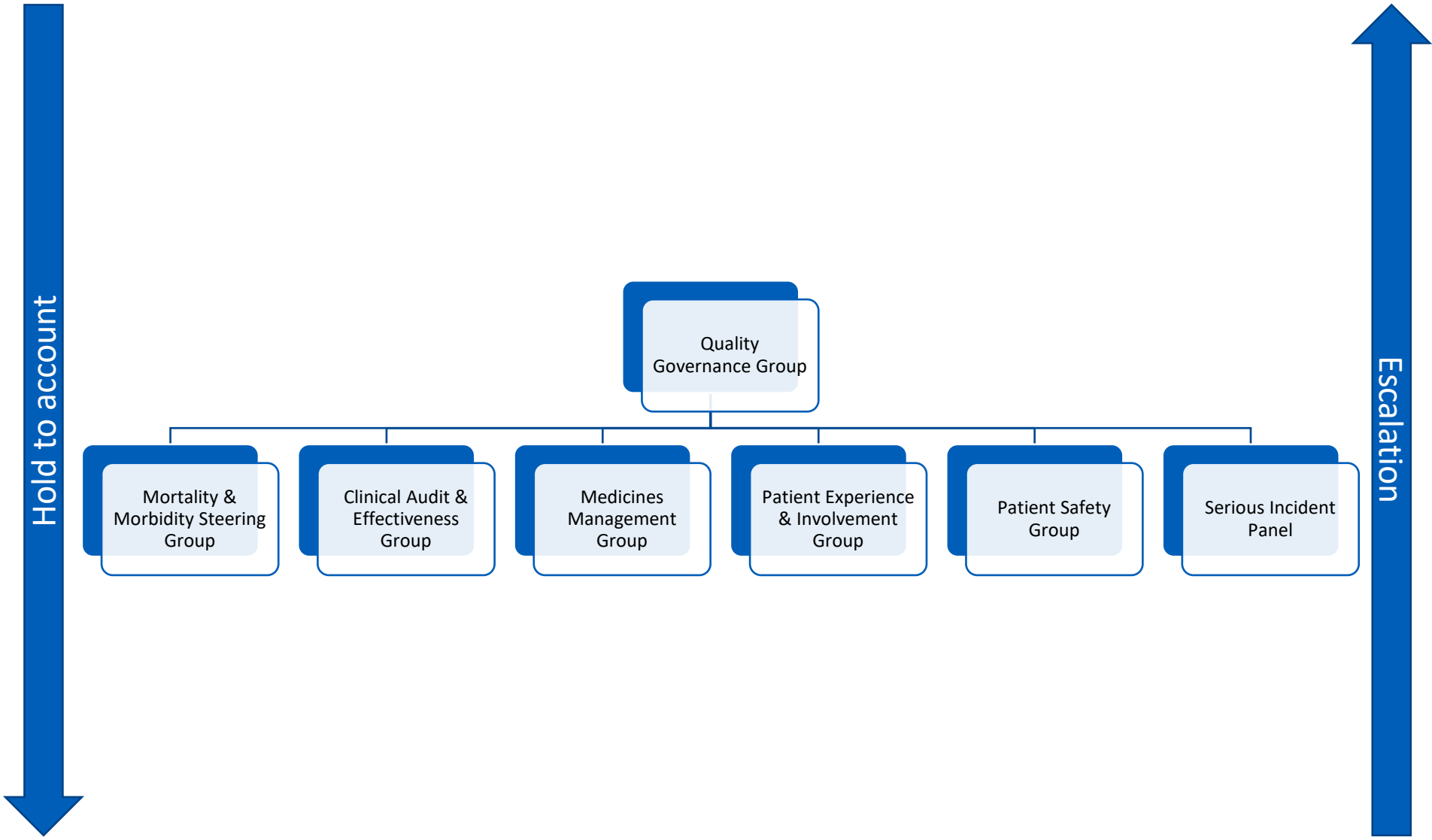


Quality Committee Sub-structure



Quality Committee Sub-structure

Quality Governance Group Sub-structure



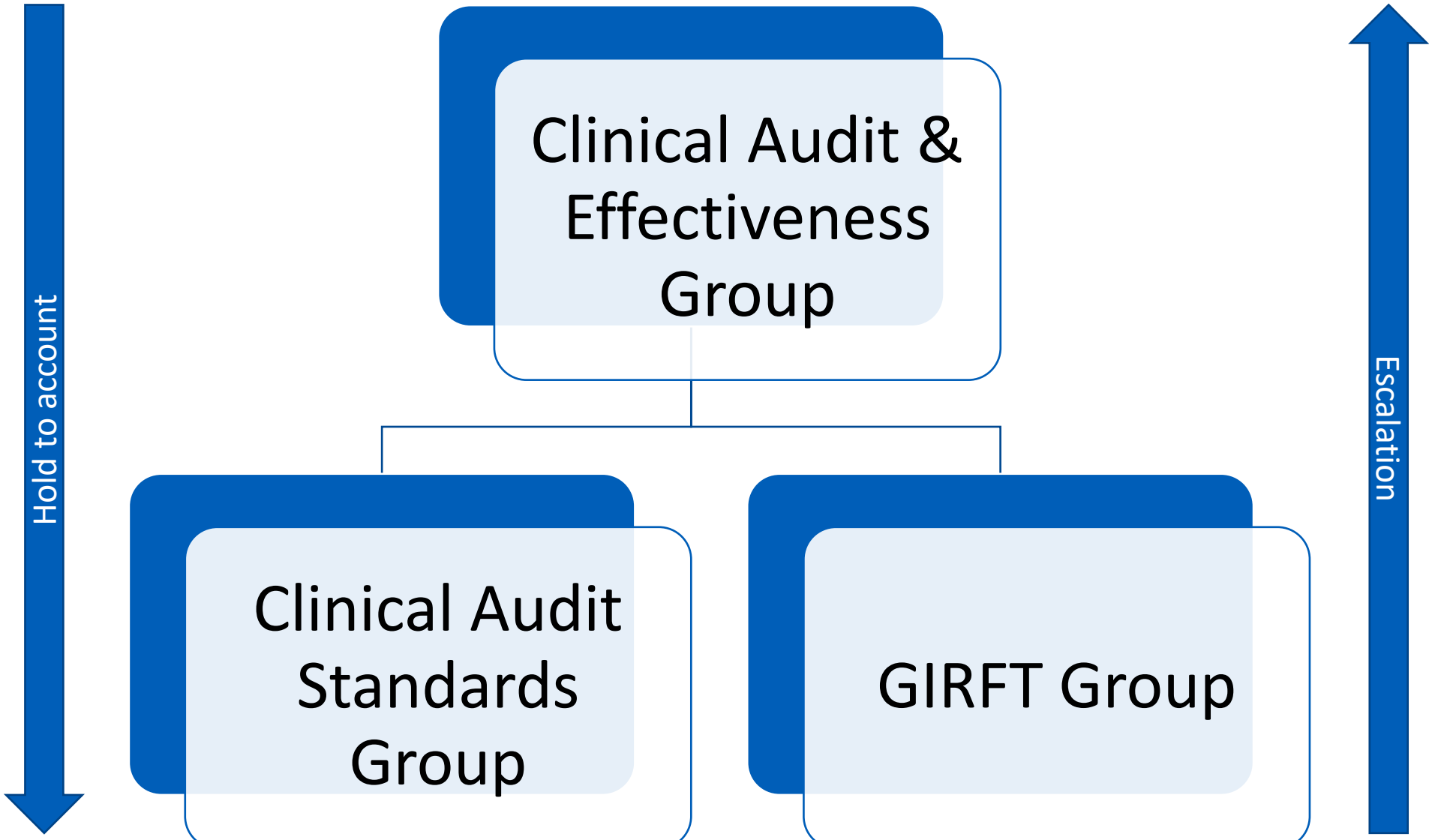
Quality Governance Group Sub-structure

Hold to account

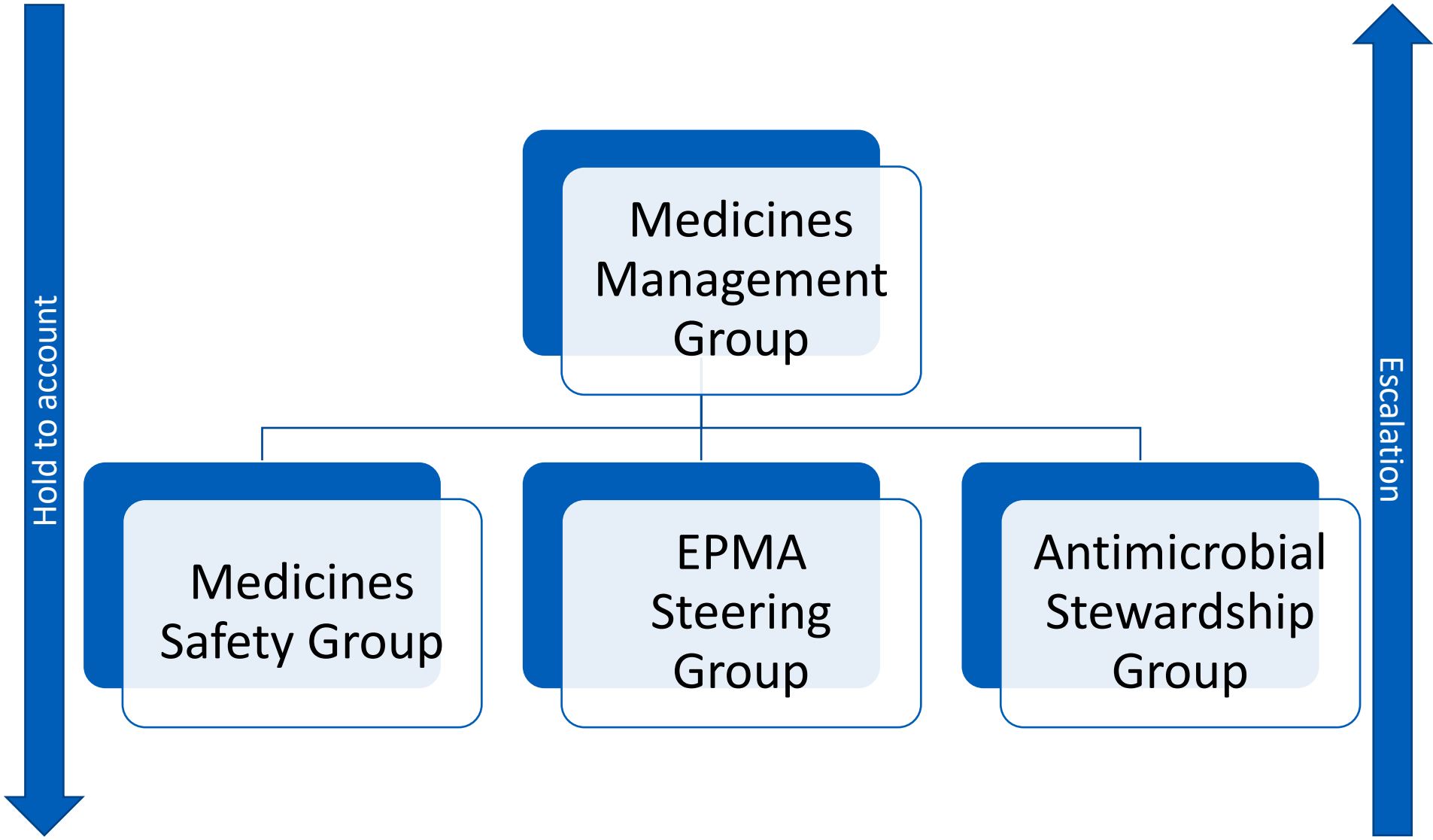
Escalation

Mortality & Morbidity Group

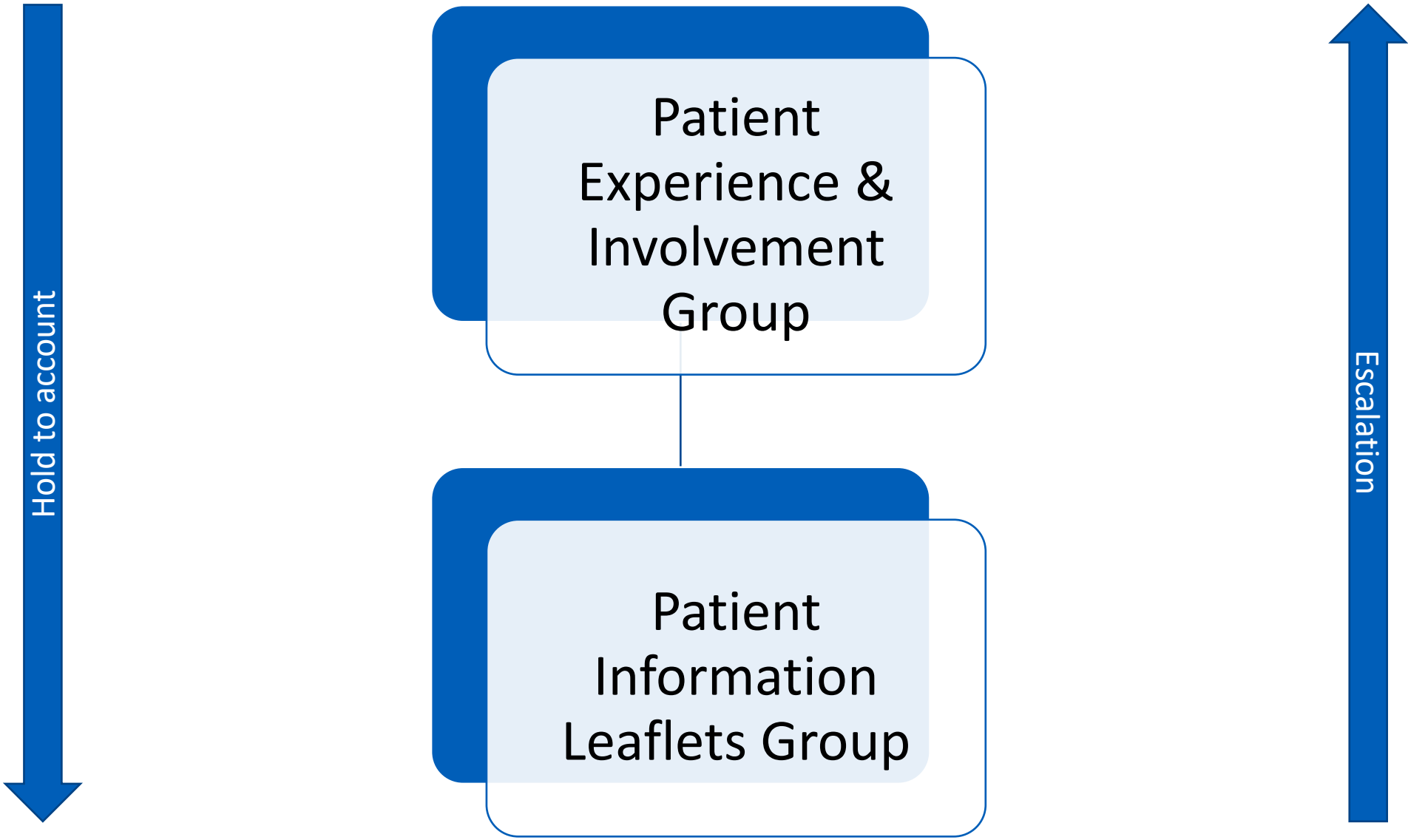
Quality Governance Group Sub-structure



Quality Governance Group Sub-structure



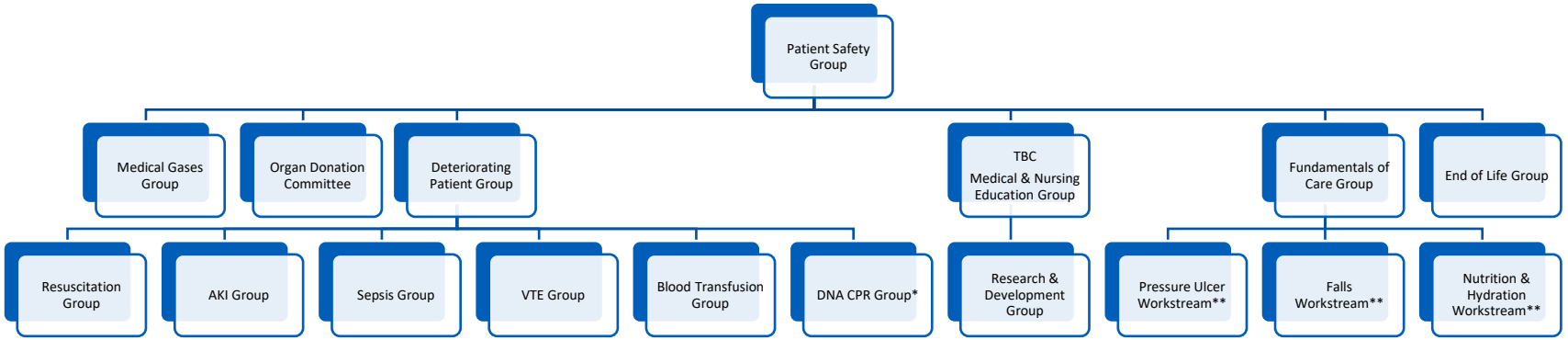
Quality Governance Group Sub-structure



Quality Governance Group Sub-structure

Hold to account

Escalation

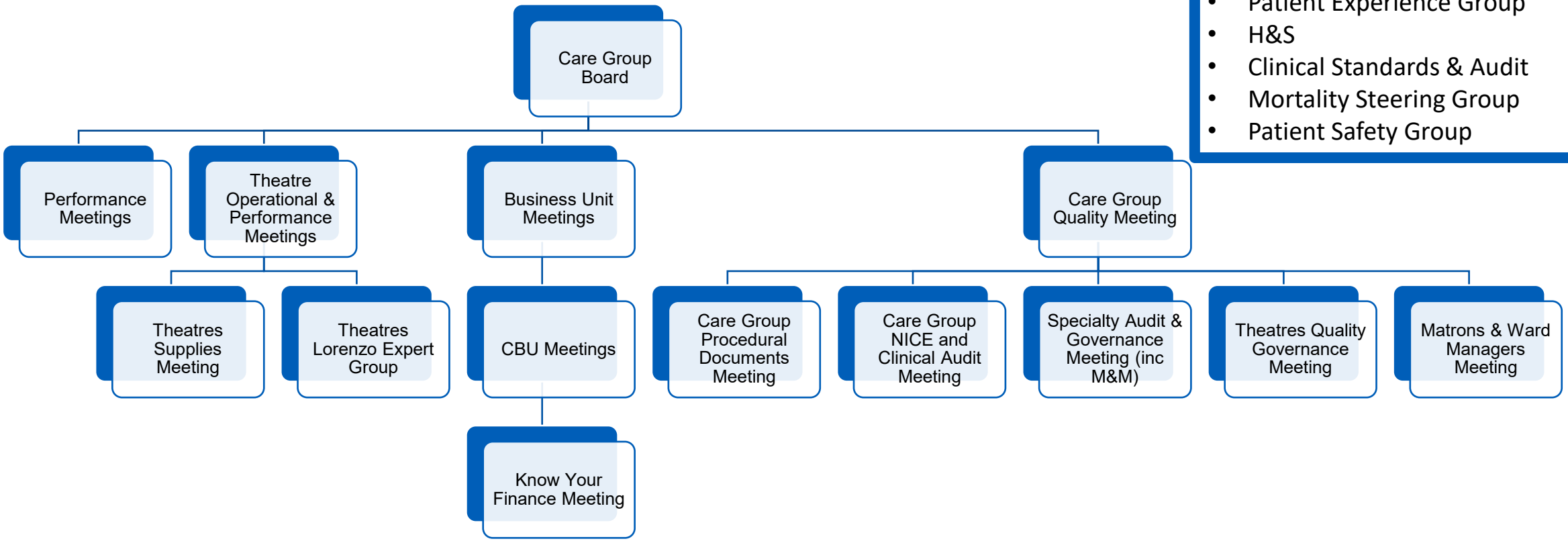


**Workstreams, not formal groups/meetings

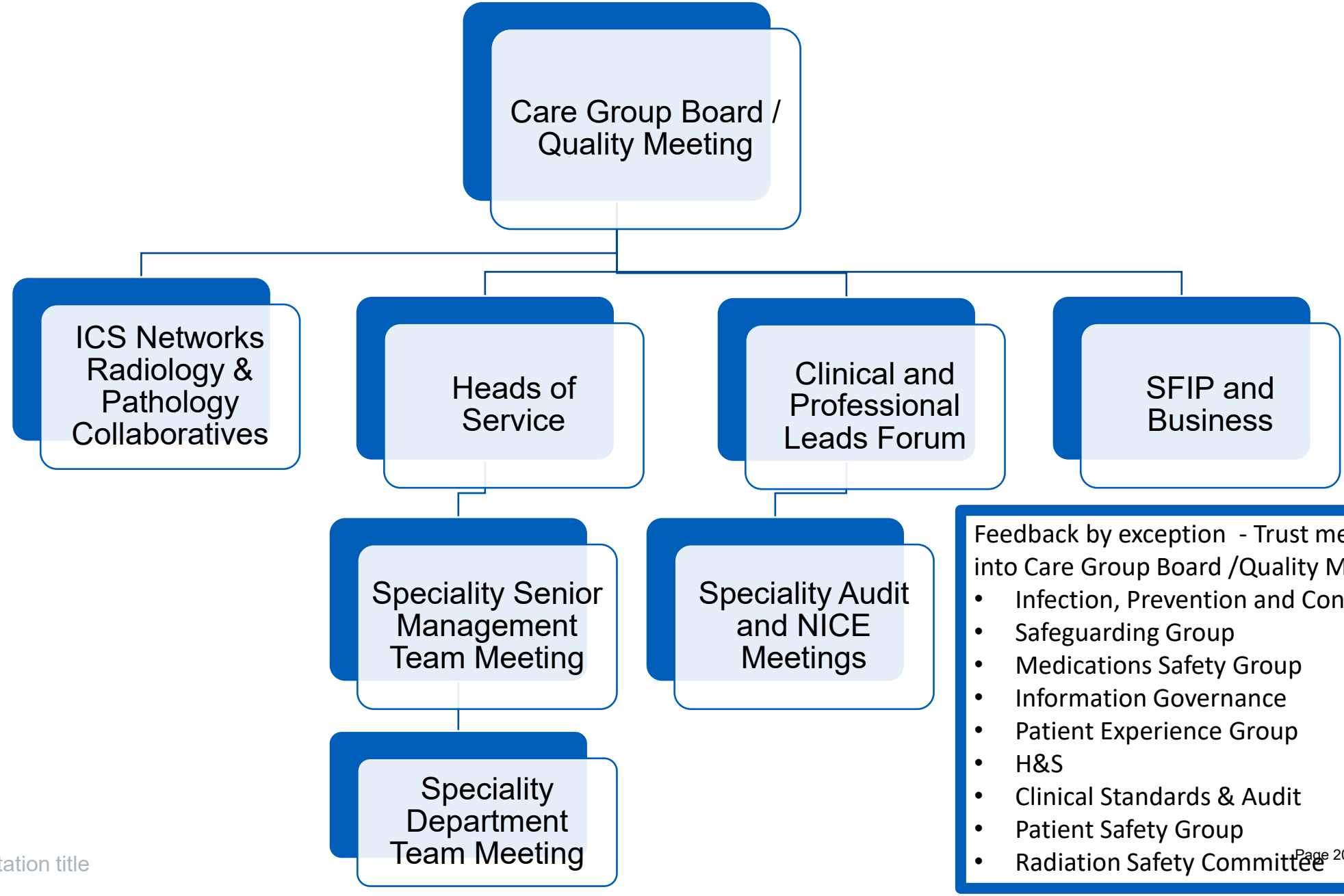
Surgical Care Group Meeting Structure

Feedback from following Trust meetings to feed into Care Group Quality Meeting:

- Infection, Prevention and Control
- Safeguarding Group
- Medications Safety Group
- Harm Free Care
- Information Governance
- Patient Experience Group
- H&S
- Clinical Standards & Audit
- Mortality Steering Group
- Patient Safety Group



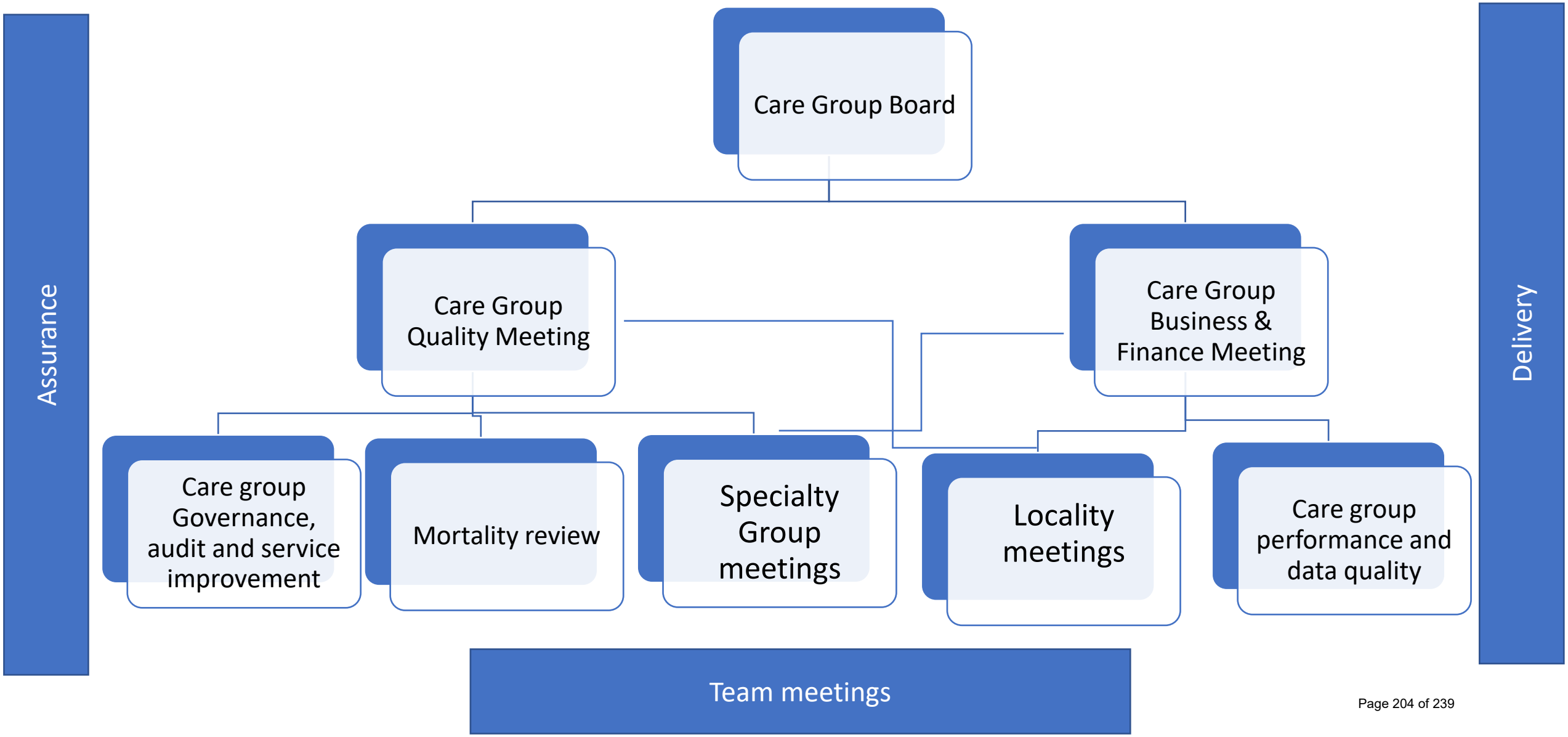
CCS Care Group Meeting Structure



Feedback by exception - Trust meetings to feed into Care Group Board /Quality Meeting:

- Infection, Prevention and Control
- Safeguarding Group
- Medications Safety Group
- Information Governance
- Patient Experience Group
- H&S
- Clinical Standards & Audit
- Patient Safety Group
- Radiation Safety Committee

Integrated Community Care Group meeting structure



Locality Meeting and Specialty Group meeting.

- Locality meeting – 3 month PDSA cycle to be undertaken for services delivered at ICC level e.g. District Nursing. These meetings would be led by Clinical service managers, with over sight of the Triumvirate team during the PDSA cycle.
- Speciality meetings – to review current format of these meetings for services delivered cross bay.
- Both Locality and Speciality meetings to have a Standard agenda and data pack/ dash board.

University Hospitals Morecambe Bay NHS Foundation Trust
Appendix 4A

(Care Group Name) Quality Meeting Agenda

ITEM		PURPOSE	LEAD	FORMAT
Business				
1.	Apologies for Absence Quoracy confirmation	Information	Chair	Verbal
2.	Minutes of the last meeting	Approval	Chair	Verbal
3.	Matters Arising and Action Log	Review	Chair	Verbal
4.	Patient Story	Discussion	Chair	Paper
5.	Good news stories	Discussion	All	Verbal
Oversight and Escalations				
6.	Service/ Speciality 1 (name) Quality Meeting Report Service/Specialty 2 (name) Quality Meeting Report Service/Specialty 3 (name) Quality Meeting Report	Discussion	Specialty Quality Group Chairs	Paper
7. SAFETY				
7.1	**Care Group Incident Report:** • New incidents (by specialty) • Overdue incidents (by specialty) • Themes/trends and actions • Progress against actions arising from incidents/Serious Incidents • Duty of Candour compliance • Never Events & action plans • Clinical Negligence claims & inquest update report	Assurance	Governance Business Partner	Paper
7.2	**CAS Alerts** • New alerts • Progress against previous alerts	Information	Governance Business Partner	Paper
7.3	**Mortality & Morbidity** • Care Group Mortality Dashboard inc: - Deaths	Discussion	Governance Business Partner	Paper

ITEM		PURPOSE	LEAD	FORMAT
	- Mortality rates (specialty and subspecialty) - Inquests - Completed/outstanding Structured Judgement Reviews - Themes, trends and actions		Specialty M&M Lead	
7.4	**Fundamentals of Care Report *(where appropriate)*** • Fluid balance • VTE • MUST • TPN • Deteriorating Patient/NEWS		Associate Director of Nursing	Paper
7.5	**Ward Dashboards *(where appropriate)*** - IPC performance/audits - Pressure ulcers/falls		Associate Director of Nursing	Paper
7.6	**Safe Staffing** • Care Group Staffing Dashboard • Mandatory Training Compliance • Essential to role training compliance • Vacancies • Sickness absence • Turnover • Staff FFT • Concerns • Staff Survey/Pulse Point surveys and action plans (periodically) • GMC Surveys and action plans (periodically)		Associate Director of Nursing (HR Business partner to support)	Paper
7.7	**Health & Safety Report** • New incidents • Themes/trends • Action monitoring • RIDDOR reports • Care Group Employers' Liability Claims		Governance Business Partner (support from H&S Team/legal)	Paper
8. Effectiveness				

ITEM		PURPOSE	LEAD	FORMAT
8.1	**Clinical Audit** • Minutes of specialty audit meetings • Monthly Care Group Audit Report: -Audits Completed (national and local) -Audits Outstanding (national and local) -Audit Actions Progress report	Assurance	Corporate Clinical Audit Lead for Care Group	Paper
8.2	**Effectiveness** • NICE Guidelines Assessment Compliance • Guidelines & Procedural Document approval • Out of Date/Overdue documents • GIRFT Reports		Governance Business Partner	Paper
9.0 Patient Experience				
9.1	• Care Group Patient Experience Report - New complaints (by specialty) - Overdue complaints - Complaint action plan monitoring PALs (themes and trends) - Compliments - FFT - Patient Surveys - Themes, trends and actions	Information	Associate Director of Nursing (support from corporate PE Team)	Paper
10 Risk				
10.1	**Risk Registers** - Care Group Risk Register (all risks) - Emerging risks/concerns	Information	Governance Business Partner	Paper
11 Escalation				
11.1	Escalation report to the Care Group Board • Specific concerns highlighted in 4-10 • Speciality specific concerns • Risks for escalation	Discussion	All	Verbal
10.	**DATE OF NEXT MEETING:**			

(Name) Specialty Quality Meeting Terms of Reference

1. Authority

The Specialty Quality Meeting is established by the Care Group Quality Meeting to oversee all aspects of quality, risk, financial and operational performance within the speciality and to provide assurance to the Care Group Quality meeting that issues and risks to quality are being effectively managed. The meeting will oversee all aspects of the business of the specialty and will escalate risks and issues to the Care Quality Meeting to ensure effective line of sight.

The meeting is authorised to establish sub-groups to support the activity outlined in these terms of reference but must follow the process outlined in the trust's Quality Governance and Accountability Framework in order to maintain the integrity of the trust's quality governance architecture.

2. Membership

Membership of the Group is set out below and has been determined based on our principle of having the right people, with the right skills in the right meeting.

Members
Clinical Lead (Chair)
Heads of Nursing/Matrons (Deputy Chair) *(appropriate nursing/AHP representative for each specialty)*
Service Manager
Specialty Clinical Audit Lead
Specialty Governance Lead
Specialty-Sub-specialty Consultants
Others to be added as appropriate to the specialty/service/department

3. Attendance & Frequency

In line with our trust value of being open and transparent and taking accountability, all members are expected to attend the meeting for its duration to maximise meeting effectiveness and attendance will be monitored and escalated. In exceptional circumstances, a briefed deputy who is authorised to make decisions on their behalf may attend in the member's place. Attendance of deputies must be agreed with the meeting Chair in advance of the meeting.

Other trust staff may be invited to attend the meetings periodically where they are responsible for or can contribute to items on the agenda.

The Clinical Lead will be the chair of the Group and in their absence the Head of Nursing/Matron will deputise *(to be confirmed as per specialty leadership arrangements).*

The Care Group Quality meeting will take place each month at a time that meets the clinical commitments of attendees, reflects the availability of the relevant data and allows a written escalation report to be produced in time for circulation of the Care Group Quality Meeting papers.

4. Quorum

As quorum will comprise:

- 1 of the two specialty clinical leaders
- Minimum number of consultants/a consultant from each sub-specialty
- Minimum number of nurse/AHP representatives
- Minimum number of service managers

In the event that a quorum is not present, the meeting will continue but non-quoracy must be highlighted to the Care Quality Meeting and the Quality Governance Group through the meeting escalation report.

5. Decision Taking

The Specialty Quality Meeting has limited approval powers as accountability rests with the Care Group Board. Where the meeting is authorised to take decisions, for example approving specialty/departmental clinical guidelines, each member will have a vote. In the event of a tie the Chair will cast the deciding vote.

6. Duties

The Specialty Group Quality meeting provides a forum for oversight of quality, risk, financial and operational performance across the Specialty. The membership will take a clinically led approach to identifying where improvements need to be made and ensuring that appropriate, timely actions are put into place to address the issue on a sustainable basis and that actions are monitored to completion. In order to achieve this, the meeting will have regular oversight of the following areas:

- Clinical Audit; progress against the plan and presentation of audits
- Clinical Effectiveness; compliance with NICE guidance, national guidance, clinical guidelines and GIRFT reports
- Mortality & Morbidity; case presentations, mortality rates, SJR completion, inquests
- Patient Safety
    - Incidents
    - CAS alerts
    - Fundamentals of Care/Ward Assurance Reports
    - Safe Staffing
    - Health & Safety
- Patient Experience
    - Complaints
    - PALs
    - Patient Survey results

- Service Improvement Programmes
- Speciality Risk Register
- Finance/Business Cases
- Operational Performance

The Chair of the Group will be responsible for ensuring that a written escalation report related to these areas is produced for submission to the Care Group Quality Meeting and that issues are escalated to the trust's Quality Governance Group.

A standardised agenda for the meeting has been drawn up to ensure that all of the areas outlined above are discussed. This is appended to the Quality Governance & Accountability Framework and will be updated by the Director of Governance from time to time. Care Group leaders are able to tailor the agenda to meet the needs of their services but must ensure that each of the areas identified are discussed with sufficient regularity to maintain appropriate oversight.

Although there will be a suite of KPIs relating to these areas that can be used to identify where improvements need to be made, or where there are themes and trends that need addressing. The purpose of the Group is to oversee and drive-up quality, financial and operational performance by agreeing actions to be taken in response to risks and issues, monitoring completion and providing assurance to the Care Group Board and is not a performance management function.

7. Meeting Conduct & Effectiveness

In line with our value to be respectful and inclusive, the Chair will take the lead in ensuring that challenge is constructive and professional and that all members have the opportunity to contribute to the discussion.

The Chair is responsible for ensuring that meetings are conducted in such a way that the duties set out in these terms of reference are met.

The Governance Business Partner will support an annual process of review of the effectiveness and outputs of the meeting and will propose recommendations for improvement.

8. Meeting Support

As outlined in our Quality Governance & Accountability Framework, our corporate services are committed to supporting clinicians to deliver high quality sustainable care and will ensure that effective, triangulated reports are provided to the meeting to enable effective oversight and the identification of areas of concern.

The meeting will be serviced by XXXX who will be responsible for:

- Ensuring that an annual schedule of meetings is in place and that invitations are issued
- Preparing the agenda for the meeting on behalf of the Chair
- Collating and circulating the papers
- Taking the minutes of the meeting and circulating these to members

- Maintaining and updating an action log

Papers will be circulated 5 days in advance of the meeting to allow attendees the opportunity to read them. Any late papers will only be included with the consent of the Chair. In the event that papers are not provided, this will be escalated to the Care Group Board via the Chair's escalation report.

9. Sub-Groups

Any sub-groups should be listed here and must report into the meeting

A written report/minutes of these meetings will be provided to the Care Group meeting to facilitate effective oversight and escalation processes.

10. Frequency of review

These terms of reference will be reviewed every 12 months at the April meeting and will be presented to the Care Group Quality Meeting for approval. Any material changes that are made prior to the formal review, such as change of duties/Chair must be approved by the Governance Business Partner and the Director of Governance.

Date of Approval
Date of Review

Speciality Quality & Business Meeting Agenda

DRAFT V1.0

ITEM		PURPOSE	LEAD	FORMAT
Business				
1.	Apologies for Absence Quoracy confirmation	Information	Chair	Verbal
2.	Minutes of the last meeting	Approval	Chair	Verbal
3.	Matters Arising and Action Sheet	Review	Chair	Verbal
4.	Good news stories	Assurance	All	Verbal
5. Specialty/Service Oversight and Escalations **this section will need to be made bespoke to the specialty or department in terms of the sub-specialties/services that sit within the specialty or department**				
6.	Sub-specialty 1 (name) Team 1 (name) Department 1 (name) Locality 1 (name)	Discussion	Lead Clinician Team Leader Department Leader	Paper
7. Clinical Audit & Effectiveness				
7.1	**Clinical Audit** • Clinical Audit Presentations • Specialty/Department Audit Plan tracker • Progress against actions arising from clinical audits • New audit requests	Discussion	Lead Clinician (support from corporate clinical audit lead)	Paper
7.2	**Effectiveness** • NICE Guidelines Assessment Compliance • Guidelines & Procedural Document approval • Out of Date/Overdue documents	Discussion/ Approval	Governance Business Partner	Paper
8. Mortality & Morbidity				
8.1	**Mortality & Morbidity** • Case Presentations • Specialty M&M Dashboard (incorp) • Deaths • Mortality rates (specialty and subspecialty)	Discussion	Lead Clinician Governance Business Partner	Paper

ITEM		PURPOSE	LEAD	FORMAT
	• Inquests • Completed/outstanding Structured Judgement Reviews • Themes, trends and actions			
9. SAFETY **the lead for all sections below will depend on the specialty/department and how the services are structured**				
9.1	**(Relevant) CAS Alerts** • New alerts • Overdue alerts • Progress against previous alerts	Information/ Action	Lead Clinician (data to be provided by the Governance Business Partner)	Paper
9.2	**Specialty/Departmental Incident Report:** • New incidents • Overdue incidents • Progress against actions arising from incidents/serious Incidents • Never Events & action plans • Duty of Candour compliance • Themes/trends and actions • Clinical Negligence claims • Themes/trends and actions	Discussion	Lead Clinician Head of Service (data to be provided by Governance Business Partner)	Paper
9.3	**Specialty Health & Safety Report** • New incidents • Themes/trends • Action monitoring • RIDDOR reports • Care Group Employers' Liability Claims	Discussion	Matron/Lead Nurse (support from H&S Team)	Paper
9.4	**Safe Staffing** Specialty/Departmental Staffing Dashboard: • Care Group Staffing Dashboard • Mandatory Training Compliance • Essential to role training compliance • Vacancies • Sickness absence • Turnover • Staff FFT	Discussion	Matron/Lead Nurse (HR Business partner to support)	Paper

Speciality Quality & Business Meeting Agenda

DRAFT V1.0

ITEM		PURPOSE	LEAD	FORMAT
	• Concerns • Staff Survey/Pulse Point surveys and action plans (periodically) GMC Surveys and action plans (periodically)			
10. Patient Experience				
10.1	• Specialty Patient Experience Report - New complaints (by specialty) - Overdue complaints - Complaint action plans - PALs (themes and trends) - Compliments - FFT - Patient Surveys - Themes, trends and actions	Discussion	Lead Nurse (support from corporate PE Team)	Paper
11. Risk				
11.1	**Risk Registers** - Specialty Risk Register - Emerging risks/concerns - Risks for escalation to Care Group Quality Meeting	Discussion	Lead Clinician Data to be provided by Governance Business Partner	Paper
12. Service Improvement/Development				
12.1	Quality Improvement Programme Update	Assurance	Service Manager	Paper/Verbal
13. Escalation				
13.1	Escalation report to the Care Group Quality Meeting • Specific concerns/successes highlighted in 4-12	Discussion	All	Verbal
14. Business & Finance				
14.1 14.2 14.3	Operational Performance Financial Performance Business Cases	Discussion	Service Manager	Paper

ITEM		PURPOSE	LEAD	FORMAT
14.4	Issues to escalate to the Care Group Finance & Performance meeting			
15	**DATE OF NEXT MEETING:**			

(Name) Specialty Quality & Business Meeting Terms of Reference

1. Authority

The specialty Quality & Business Meeting is established by the Care Group Quality Meeting to oversee all aspects of quality, risk, financial and operational performance within the speciality and to provide assurance to the Care Group Quality meeting and Care Group Board that issues and risks to quality are being effectively managed. The meeting will oversee all aspects of the business of the specialty and will escalate risks and issues to quality to the Care Group Quality Meeting and finance/performance issues to the Care Group Board to ensure effective line of sight.

The meeting is authorised to establish sub-groups to support the activity outlined in these terms of reference but must follow the process outlined in the trust's Quality Governance and Accountability Framework in order to maintain the integrity of the trust's quality governance architecture.

2. Membership

Membership of the Group is set out below and has been determined based on our principle of having the right people, with the right skills in the right meeting.

Members
Clinical Lead (Chair)
Heads of Nursing/Matrons (Deputy Chair) (appropriate nursing/AHP representative for each specialty)
Service Manager
Specialty Clinical Audit Lead
Specialty Governance Lead
Specialty-Sub-specialty Consultants
Others to be added as appropriate to the specialty/service/department

3. Attendance & Frequency

In line with our trust value of being open and transparent and taking accountability, all members are expected to attend the meeting for its duration to maximise meeting effectiveness and attendance will be monitored and escalated. In exceptional circumstances, a briefed deputy who is authorised to make decisions on their behalf may attend in the member's place. Attendance of deputies must be agreed with the meeting Chair in advance of the meeting.

Other trust staff may be invited to attend the meetings periodically where they are responsible for or can contribute to items on the agenda.

The Clinical Lead will be the chair of the meeting and in their absence the Head of Nursing/Matron will deputise (to be confirmed as per specialty arrangements).

The Specialty Quality & Business meeting will take place each month at a time that meets the clinical commitments of attendees, reflects the availability of the relevant data and allows a written escalation report to be produced in time for circulation of the Care Group Quality Meeting papers.

4. Quorum

As quorum will comprise:

- 1 of the two specialty clinical leaders
- Minimum number of consultants/a consultant from each sub-specialty?
- Minimum number of nurse/AHP representatives?
- Minimum number of service managers

In the event that a quorum is not present, the meeting will continue but non-quoracy must be highlighted to the Care Quality Meeting and the Quality Governance Group through the meeting escalation report.

5. Decision Taking

The Specialty Quality & Business Group Meeting has limited approval powers as accountability rests with the Care Group Board. Where the meeting is authorised to take decisions, for example approving specialty/departmental clinical guidelines, each member will have a vote. In the event of a tie the Chair will cast the deciding vote.

6. Duties

The Care Group Quality & Business meeting provides a forum for oversight of quality, risk, financial and operational performance across the Specialty. The membership will take a clinically led approach to identifying where improvements need to be made and ensuring that appropriate, timely actions are put into place to address the issue on a sustainable basis and that actions are monitored to completion. In order to achieve this, the meeting will have regular oversight of the following areas:

- Clinical Audit; progress against the plan and presentation of audits
- Clinical Effectiveness; compliance with NICE guidance, national guidance, clinical guidelines and GIRFT reports
- Mortality & Morbidity; case presentations, mortality rates, SJR completion, inquests
- Patient Safety
    - Incidents
    - CAS alerts
    - Fundamentals of Care/Ward Assurance Reports
    - Safe Staffing
    - Health & Safety
- Patient Experience
    - Complaints

    - PALs
    - Patient Survey results
- Service Improvement/Development Programmes
- Speciality Risk Register
- Finance/Business Cases
- Operational Performance

The Chair of the Group will be responsible for ensuring that a written escalation report related to these areas is produced for submission to the Care Group Quality Meeting and that issues are escalated to the trust's Quality Governance Group.

A standardised agenda for the Quality & Business Meeting has been drawn up to ensure that all of the areas outlined above are discussed. This is appended to the Quality Governance & Accountability Framework and will be updated by the Director of Governance from time to time. Care Group leaders are able to tailor the agenda to meet the needs of their services but must ensure that each of the areas identified are discussed with sufficient regularity to maintain appropriate oversight.

Although there will be a suite of KPIs relating to these areas that can be used to identify where improvements need to be made, or where there are themes and trends that need addressing. The purpose of the Group is to oversee and drive-up quality, financial and operational performance by agreeing actions to be taken in response to risks and issues, monitoring completion and providing assurance to the Care Group Board and is not a performance management function.

7. Meeting Conduct & Effectiveness

In line with our value to be respectful and inclusive, the Chair will take the lead in ensuring that challenge is constructive and professional and that all members have the opportunity to contribute to the discussion.

The Chair is responsible for ensuring that meetings are conducted in such a way that the duties set out in these terms of reference are met.

The Governance Business Partner will support an annual process of review of the effectiveness and outputs of the meeting and will propose recommendations for improvement.

8. Meeting Support

As outlined in our Quality Governance & Accountability Framework, our corporate services are committed to supporting clinicians to deliver high quality sustainable care and will ensure that effective, triangulated reports are provided to the meeting to enable effective oversight and the identification of areas of concern.

The meeting will be serviced by XXXX who will be responsible for:

- Ensuring that an annual schedule of meetings is in place and that invitations are issued
- Preparing the agenda for the meeting on behalf of the Chair

- Collating and circulating the papers
- Taking the minutes of the meeting and circulating these to members
- Maintaining and updating an action log

Papers will be circulated 5 days in advance of the meeting to allow attendees the opportunity to read them. Any late papers will only be included with the consent of the Chair. In the event that papers are not provided, this will be escalated to the Care Group Board via the Chair's escalation report.

9. Sub-Groups

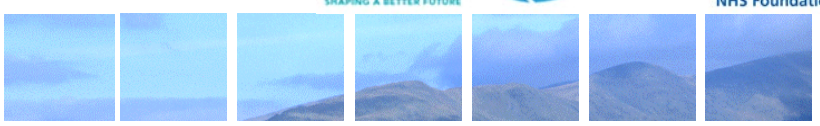
Any sub-groups should be listed here and must report into the meeting

A written report/minutes of these meetings will be provided to the Care Group meeting to facilitate effective oversight and escalation processes.

10. Frequency of review

These terms of reference will be reviewed every 12 months at the April meeting and will be presented to the Care Group Quality Meeting for approval. Any material changes that are made prior to the formal review, such as change of duties/Chair must be approved by the Governance Business Partner and the Director of Governance.

Date of Approval
Date of Review



Document Type: **Strategy**	**Unique Identifier:** CORP/STRAT/015
Document Title: **Membership Strategy & Plan** ~~2019-2021~~2022-24	**Version Number:** 1~~.1~~
	Status: ~~Ratified~~Draft
Scope: Trust Wide	**Classification:** Organisational
Author / Title: ~~Paul Jones, Company Secretary~~ Olivia Caton, Deputy Company Secretary	**Responsibility:** Governance
Replaces: V1.1 – Membership Strategy and Plan 2019 - 2021	**Head of Department:** ~~Andrea Willimott~~, Paul Jones, ~~Director of Governance~~ Company Secretary
Validated By: Council of Governors	**Date:** ~~20/03/2019~~16/08/2022
Ratified By: Board of Directors	**Date:** ~~27/03/2019~~
Review dates may alter if any significant changes are made	**Review Date:** 01/12/2021 (Extended #225)

Which Principles of the NHS Constitution Apply? **Please list from principles 1-7 which apply** Principles	**Which Staff Pledges of the NHS Constitution Apply?** **Please list from staff pledges 1-7 which apply** Staff Pledges

Does this document meet the requirements of the Equality Act 2010 in relation to Race, Religion and Belief, Age, Disability, Gender, Sexual Orientation, Gender Identity, Pregnancy & Maternity, Marriage and Civil Partnership, Carers, Human Rights and Social Economic Deprivation discrimination? **Yes**

Document for Public Display: Yes

Evidence Search Completed by……..Date…….

To be completed by Library and Knowledge Services Staff

Membership Strategy & Plan
2022-2024~~21~~

Prepared by the Foundation Trust and Communications Membership Group of the Council of Governors

Approved by the Council of Governors 16 August 2022

Approved by the Board of Directors ~~27 March 2019~~

THIS PAGE IS INTENTIONALLY BLANK

CONTENTS PAGE

LIST OF TABLES

THIS PAGE IS INTENTIONALY BLANK

EXECUTIVE SUMMARY

Membership is at the heart of being an NHS Foundation Trust. It facilitates local accountability ensuring that those for whom the service exists – patients and the public – have an opportunity to shape, influence, comment upon and constructively challenge it as well as to actively promote it and be a part of celebrating its successes. By seeking to recruit a representative membership, listening to and involving that membership, the Trust seeks to continuously improve its services with the effective involvement of those whose needs it aims to meet.

This membership strategy and plan, prepared by the Trust's Council of Governors, provides a 'roadmap' for the Trust's membership work over the next two years. At its heart is the desire to make membership interesting, rewarding, responsible and effective. Its key focus is on putting in place robust arrangements for ensuring that our members have a loud and clear voice within the organisation, that they have an avenue to contribute to the development of the organisation and that the Trust's services take full account of members' views, ideas and concerns and are seen to do that on all matters in the public domain.

A key component of our membership and engagement work over the next two years will be improving the coordination of our membership work with that in respect of patient experience and patient and public involvement. Active respect for openness, transparency, honesty, verifiable facts and reasoned argument, equality, diversity and human rights are minimum requirements of this public process of accountability. This process will also focus on improving what we know about our Members including what their particular Trust interests are and how they would like to be involved with the Trust. In this way we aim to improve the level and range of Member engagement. All of this will be regularly and clearly communicated and marketed in the public domain in a balanced, wholly representative way.

This strategy and plan includes ~~8~~4 objectives over its two year life-span, focussing on ~~starting in the first year with~~ building on what we already have and raising governor profiles within the organisation ~~and introducing new ways for member involvement. Year two focuses on consolidation of the good outcomes of that evaluation, eradicating the bad~~ and growing interaction with our members.

1.0 PROFILE OF THE TRUST

University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBT) is a large Acute Trust serving a population of 365,000 within a geographical area of approximately 1,000 square miles. Our patient catchment area encompasses South Cumbria, and North Lancashire with approximately five per cent of all patients coming from adjoining populations. In addition, the area has 17 million visitors a year, mainly to the South Lakeland area.

We have three main hospital sites, two of which provide full District General Hospital facilities at Furness General Hospital (Barrow-in-Furness) and the Royal Lancaster Infirmary (Lancaster). Westmorland General Hospital (Kendal) provides a more limited range of services, which include rehabilitation, elective surgery, diagnostics and an Urgent Treatment Centre. Tertiary services are provided mainly from Preston, Blackpool and Manchester.

We employ 7000+ staff and have an annual turnover in excess of £300m. Across our hospitals around 44,000 Inpatients / Day Cases are treated, 125,000 first Outpatient appointments carried out and there are 85,000 first attendances in the Emergency Departments.

Key services offered at Furness General Hospital include:

- Emergency Department
- Oncology Unit
- Critical Care Unit
- Maternity and Special Care Baby Unit
- Outpatient Services

Key services offered at Royal Lancaster Infirmary include:

- Emergency Department
- Oncology Unit
- Critical Care Unit
- Maternity and Special Care Baby Unit
- Outpatient Services

Key services offered at Westmorland General Hospital include:

- Midwifery–led Maternity Unit
- Outpatient services
- Urgent Treatment Centre (UTC)
- Renal Unit
- Medical care and elective surgery
- Cardiac Centre

2.0 OUR PURPOSE & VISION

Our Purpose

Our purpose is to deliver compassionate care and the best possible results for the people of Morecambe Bay.

Our Vision

"Creating a great place to be cared for and a great place to work"

~~We will constantly provide the highest possible standards of compassionate care and the very best patient and colleague experience.~~

~~We will listen to and involve our patients, service users, colleagues and partners.~~

3.0 OUR VALUES

We are...Compassionate
We will:

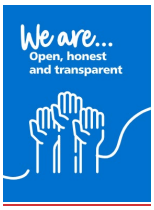
- Be kind and caring to each other; our patients and families and our partners
- Consider the feelings of others
- Work together to deliver safe care and a safe working environment
- Be proud of the role we do and how this contributes to patient care

We are... Respectful and inclusive
We will:

- Show respect to and for everyone
- Act professionally at all times
- Communicate Effectively - listen to others and seek clarity when needed
- Value each other and the contribution of everyone

We are...Ambitious
We will:

- Go beyond traditional boundaries; being positively receptive to change and improvement
- Work with colleagues and system partners to improve services for our patients, families and carers
- Support each other to listen, learn and develop
- Collaborate with and empower each other



We are...Open, honest and transparent
We will:

- Seek out feedback and act on it
- Take personal responsibility and accountability for our own actions
- Not be afraid to be challenged
- Ensure consistency and fairness in our approach

~~Our patients will be treated with compassion, dignity and respect; patient experience is our most important measure of achievement.~~

~~Our colleagues (employees and volunteers) are the ones who make a difference; colleagues understand and share our values and this is reflected in everything they do.~~

~~Our progress will be improved through innovation, education, research and technology to meet the challenges of the future.~~

~~Our partnerships make us strong; by investing in them, we will deliver the best possible care to our communities.~~

~~Our performance drives our organisation. Providing consistently safe, high quality care is how we define ourselves and our success.~~

4.0 AIMS OF THE MEMBERSHIP STRATEGY

The aim of the Membership Strategy is to help underpin the Trusts Vision to listen to and involve our patients, staff, members and partners. Through the Membership Strategy the Trust will:

- Recruit and retain a representative membership that acknowledge the challenges that having 3 main hospital sites brings, particularly in relation to the distinctive characteristics of the communities across South Cumbria and North Lancashire and the geographical logistics of service delivery.
- Communicate and interact with our members.
- Involve members in the activities of University Hospitals of Morecambe Bay NHS Foundation Trust including their right to attend Council of Governors, Public Trust Board and ~~plus~~ Annual Members meetings.
- Invite Members to help inform the work of the Trust and provide feedback on actions taken.

(Note: Through its Communication Strategy the Trust will seek to involve the wider community in its work in addition to the membership)

5.0 OUR MEMBERS

Membership is at the heart of being an NHS Foundation Trust. The Trust and its Members are bound to facilitate local accountability ensuring that those for whom the service exists, the public, have opportunities to shape, influence, comment upon and constructively challenge Trust provision. The Trust and its Members are expected to positively and responsibly promote the Trusts work and be a part of its successes. By seeking to recruit a representative Membership, listening and hearing what it has to say and actively involving our Members in appropriate Trust business, the Trust seeks to continuously improve its services to the public at large bearing in mind that Members may be patients too.

5.1 What is membership for?

Membership is essentially about local accountability. It is a characteristic of all Foundation Trusts who must fulfil their role as locally accountable organisations. All Foundation Trusts are required to have members and to have in place a membership strategy.

Members have an opportunity to influence and shape the services the Trust provides. They also have a role in helping the Trust to understand whether or not the services it provides meet patients' needs.

5.2 Defining the membership community

We aim to recruit and sustain a sizeable and engaged membership recruited from the general public, carers, patients and staff and will be representative of, and reflect the population and communities we serve.

The Trust aims to keep an active public membership of between 5,000 and 7,500 but with no limit.

We will ensure we have adequate membership from each constituency representative of the local population with no constituency having less than 100 members.

5.3 Who can be a member?

Membership is open to individuals who are patients, carers, staff, volunteers and the public, aged 16 and over who live within a public constituency of the Trust set out below. Public members 'opt in' to membership by completing a membership form. Employees eligible for the staff constituency will automatically become members unless they 'opt out' provided they are employed by the Trust under a contract of employment.

Being a member is a responsible position and people wishing to become members must meet the eligibility criteria detailed in the Trust's constitution.

5.4 Who are our members?

The Trust has two constituencies of membership – public and staff.

Table 1: Trust membership

Constituency	Number
Public	
• Barrow and West Cumbria	~~1,875~~1,811
• Lancashire and North Yorkshire	~~2,089~~2,035
• South Lakeland and North Cumbria	~~1,345~~1,218
• Rest of England	12~~89~~
• Out of Trust Area	~~82~~11
Public total	**5,~~5~~203**
Staff	
• Registered medical and dental practitioners.	563
• Registered nurses and midwives	~~1,935~~2,785
• Allied health professions.	~~2,482~~1,072
• Estates and ancillary.	~~666~~603
• Management and administration	1,~~455~~390
• Community Services	80~~59~~
Staff total	**7,~~910~~218**
Total membership (both constituencies)	**1~~3,430~~2,421**

Formatted Table

Table 2: Age profile of members

Constituency	0-16	17-21	22-29	30-39	40-49	50-59	60-74	75+
Public	1	10~~8~~	~~195~~91	43~~919~~	385~~42~~ ~~3~~	588~~62~~ ~~5~~	1,248~~4~~ ~~16~~	1,138~~9~~ ~~93~~
Staff	0	54~~18~~ ~~2~~	967~~1,2~~ ~~17~~	1,840~~7~~ ~~39~~	1,568~~7~~ ~~42~~	1,981~~2~~ ~~,238~~	8177~~8~~ ~~3~~	7~~9~~

~~1,430~~ (tbc) public members are recorded as 'not specified' and so are not included in the figures above.

5.4.1 Gender profile of our members

Across Morecambe Bay approximately 170,000 of the population are female and 160,000 are male. Below is the gender profile of our members by constituency.

Table 3: Sex profile of members

Members	Public	Staff
Female	3,166~~396~~	4,140~~6,476~~
Male	~~2,051~~1,891	~~1,434~~901

~~73~~ public members are recorded as 'not specified' and so are not included in the figures above.

5.4.2 Ethnic origin profile of our members

The 2011 census showed that approximately 6% of South Cumbria and North Lancashire residents were from Asian, Black, Mixed or Other origins. The known ethnic origin of our members is shown in the table below.

Table 4: Ethnic origins of members

Ethnic origin	Public	Staff*
Asian	5~~3~~0	~~94~~76
Black	~~7~~12	~~10~~7
Mixed	~~38~~36	~~38~~32
Other	1~~1~~2	1~~4~~6
White	3,749~~977~~	~~3,779~~2,783

~~3,973~~4,322 staff are recorded as 'not specifi~~ed~~ed~~ed~~' and so are not included in the figures above.

1,~~436~~ 290 public are recorded as 'not specified' and so are not included in the figures above. This table shows that only 2.9~~6~~% of the public membership is from Asian, Black, Mixed or Other origins.

6.0 OUR COUNCIL OF GOVERNORS

6.1 What is the role and purpose of the Council of Governors?

All Foundation Trusts have a Council of Governors. They are an integral component of a Foundation Trusts governance structure and are amongst other things responsible for:

- Ensuring that the interests of the communities served by the Trust are properly represented with reference to the Trust's constitution.
- Preparing and regularly reviewing a membership strategy
- Presenting details of the steps taken to ensure that the Trust's membership is representative, together with progress in respect of the membership strategy, at the Annual Members' Meeting and Members provided sufficient time to put questions and points to the Board of Directors at that meeting and what is said during that process is minuted.
- Maintaining a policy for the composition of the Council of Governors that takes account of the membership strategy

Governors' role is therefore central to the Trust's work with its members. Governors lead the Trust's work with our members and act as the essential link between members, the Board of Directors and the rest of the organisation.

Public Governors

Public governors are elected by the members of the trust's public constituency and are responsible for holding the Non-Executive Directors, individually and collectively, to account for the performance of the Board of Directors and for representing their constituency. An NHS foundation trust will typically divide its public constituency into areas covering the geographical areas where the majority of the trust's patients and/or service users reside. Members of these areas will elect governors to represent their area. A trust may also choose to have a "rest of England" constituency if its patients or service users are particularly widely dispersed, as may be the case for some specialist trusts in particular.

Staff Governors

Staff governors have the same role as public governors and patient/carer/service user governors in that they are responsible for holding the Non-Executive Directors, individually and collectively, to account for the performance of the Board of Directors, and for representing the members of the staff constituency, the members of the NHS foundation trust as a whole, and the public. A staff governor should not seek to act as a staff representative or union representative on employment issues, as there are other channels for dealing with such concerns.

Appointed Governors

Legislation requires that the council of governors also appoints representatives of certain defined stakeholders to help tailor its governance to local circumstances. These appointed governors are representatives of organisations with whom NHS foundation trusts may wish to have a strong relationship and are responsible for holding the Non-Executive Directors, individually and collectively, to account for the performance of the Board of Directors and for representing their constituency. They can be from any organisation, providing appointed governors are drawn from one or more qualifying local authorities and, where the trust includes a university medical or dental school, one appointed governor is from the university/school.

The Trust's Council of Governors comprises governors who have been elected or appointed to serve for a specific period of time. Composition is shown below:

Class	Number of Governors
Public	
• Barrow and West Cumbria	**5**
• Lancashire and North Yorkshire	**7**
• South Lakeland and North Cumbria	**5**
Staff	
• Registered medical and dental practitioners.	**1**
• Registered nurses and midwives	**2**
• Allied health professions.	**1**
• Estates and ancillary.	**1**
• Management and administration	**1**
• Community Services	**1**
Partners	**8**
Total Number of Governors	**32**

7.0 OUR MEMBERSHIP ACHIEVEMENTS SO FAR

7.1 What have we achieved so far?

This membership strategy draws on our experience of recruiting and engaging members since the Trust was established as a Foundation Trust in 2010. Our achievements and activities since becoming established include:

- Successfully recruiting over 5,500 public members

- Consulting, and talking with our members at a wide range of community and trust-based events such as County Shows, road-shows, voluntary organisation meetings and Member's Annual General Meeting.
- Keeping our members fully informed about 'what's going on' at the Trust via regular publication of our newsletter ~~'Fresh Thinking'~~ and via our website
- Actively and effectively seeking our members' views on a range of proposed service changes.
- Inviting our members' comments and ideas.

8.0 STRATEGY AND PLAN PURPOSE

8.1 What is this strategy and plan for?

This document sets out the Trust's plans for:

- Achieving and maintaining a representative membership ~~by recruiting to membership as many people living in our communities as possible~~

- Making membership relevant, interesting, rewarding and effective.

- Increasing the quality and level of participation in the Trust's democratic structures to enable the organisation to achieve its aims and ensure good governance. The Annual Members' Meeting is crucial to this process.

- Listening to our members and taking their views into account when we are planning developments and/or changes to our services and provide feedback as necessary.

- Encouraging our members to stand for election to the Council of Governors when vacancies arise

8.2 How have we prepared this strategy and plan?

Governors who sit on the Council of Governors' Foundation Trust Membership and Communications Sub Group have led the preparation of this strategy. They have prepared it in the light of experience of working with members since the Trust was established in 2010.

9.0 OUR OBJECTIVES

What do we want to achieve over the next two years?

Our objectives set out what we want to achieve between 20221~~9~~-2124 in respect of membership.

9.1 20~~19~~22-24~~21~~

The Trust has already successfully recruited over 6,000 public members and undertaken a wide range of membership-related activities. This year will focus upon building on that success and in particular, putting in place arrangements to better understand who our members are and their interests and concerns about Trust provision. It will also focus on achieving greater coordination of work across the Trust so that we engage and interact with our members, patients and partners in a transparent and coordinated way that makes effective use of their time and contribution to our work.

20221~~9~~-20242~~1~~	
1	• Developing stronger links and interaction between governors, staff, members, patients and the public: o Governor contribution to membership newsletter~~Circulate a governor newsletter to members~~ o Governor presentation in the community~~'Meet Your Governor' sessions~~ o Promote governor social media activity and contact from members via 'Ask Your Governors'
2	• Introduce future member engagement activities that take place across the Trust, in particular: Patient experience and involvement, including: ~~o Governor involvement in site visits for local groups to promote health education, career opportunities etc.~~ o Grow seminars / talks within hospital and community locations o Continue to involve both our patients *and* members in reviewing, influencing, monitoring and constructively challenging the care we provide o Seeking our patients' *and* members' views about service changes and developments (Please see our Patient Experience and Involvement Strategy) o With regard to the public constituency, we will build on existing links, ~~with our stakeholders, particularly voluntary organisations, by~~ taking every opportunity to promote membership. This will include identifying and investigating opportunities for the Trust to participate with partners in the communities served (schools, colleges, voluntary organisations etc.).

~~3~~	~~• Explore Developing Links:~~ ~~○ Links with schools and colleges~~ ~~○ Links with like-minded local voluntary and other organisations for the benefit of patients (Community and support groups, Patient and carer support groups, Volunteers, Fundraisers and donors to the Trust's charitable fund).~~ ~~○ Links with our NHS partners in respect of public health initiatives~~ ~~○~~
~~4~~ 3	• Promoting Equality, diversity and human rights, including: ○ Seeking to ensure minority communities and those with physical and/or learning disabilities together with other under-represented and seldom heard groups are represented in our membership profile and ensure their views are sought and listened to
~~5~~	~~• Marketing and communication, including:~~ ~~○ Grow the membership and gain views by enabling patients to become members~~ ~~○ Work with our members to improve the way the Trust communicates and markets its services~~ ~~○ Increase 'interaction' with our members~~
~~6~~	~~Regular engagement of members (and patients) e.g. through surveys, reviewing patient information leaflets, etc. and consider a family approach to membership activities.~~
~~7~~ 4	Maintain the ~~members' section on the~~ Trust's website in order to keep members and the public ~~informed~~ updated about Trust events and facilitate member and governor communication and provision for Members to present feedback and suggestions.
~~8~~	~~Use of social media e.g. Facebook and Twitter to recruit and engage members.~~

Formatted: Indent: Hanging: 0.59 cm, Bulleted + Level: 1 + Aligned at: 1.32 cm + Tab after: 1.96 cm + Indent at: 1.96 cm, Tab stops: 1.12 cm, List tab

Formatted: Left

~~9.3~~ Across the years

Formatted: Indent: Left: 1.25 cm, No bullets or numbering

Some activities will routinely happen across the two year life of this strategy and plan. They are:

Across the years	
A	Take every opportunity to recruit new members and regularly review our membership profile
B	Proactively encourage members to consider standing for election to the Council of Governors
C	Have in place an annual programme of member recruitment and engagement events that are coordinated with Trust events that take place in respect of patient experience/patient and public involvement, corporate social responsibility, equality, diversity and human rights and marketing and communication. This work will also take account of opportunities to work with our partner organisations. ~~such Clinical Commissioning Group.~~
D	The success of the Membership Strategy will be evaluated by Governors who will: • Quarterly review via the FT & Communication group ~~annually review this strategy and adjust plans accordingly.~~ • set criteria for monitoring the success of this strategy and its implementation; • publish an annual review of this strategy and the progress made~~; and~~ ~~• publish an annual membership report incorporating Members' feedback.~~ •

Formatted: Default, Justified, Indent: Left: 0 cm, Hanging: 1 cm, Bulleted + Level: 1 + Aligned at: 0.63 cm + Indent at: 1.27 cm, Don't keep lines together

10.0 CONCLUSION

Making membership relevant, interesting and rewarding lies at the core of this strategy and plan. By involving our members in ways and at times and places which suit them, we plan to give them a loud, clear and effective voice with two aims: to make University Hospitals of Morecambe Bay NHS Foundation Trust the best it can be, and to ensure the model of local accountability works effectively.