Manchester University
NHS Foundation Trust

Public Board of Directors
Wednesday 20 May 2026

Paper title:	Paediatric ENT	**Agenda Item 11.2**
Presented by:	Kimberley Salmon Jamieson, Interim Deputy Chief Executive/Chief Nurse Sohail Munshi, Joint Chief Medical Officer Ursula Martin, CEO Specialist Hospitals Clinical Group	
Prepared by:	Ursula Martin, CEO Specialist Hospitals Clinical Group	
Meetings where content has been discussed previously	Quality, Safety and Performance Board Committee, 21st April 2026 Trust Leadership Team Committee 25th March 26 Specialist Hospitals Clinical Group Senior Leadership Team meeting weekly ENT weekly Incident Management Group	
Purpose of the paper Please check **one** box only:	☐ For approval ☐ For support ☒ For discussion	

Executive summary / key messages for the meeting to consider

In November 2024, concerns were identified regarding incomplete outpatient documentation by a Paediatric ENT Consultant. This prompted a comprehensive review of 2,586 patient records covering the period September 2022 to February 2025. As a result, 400 children underwent follow-up clinical review, either through outpatient appointments or telephone consultations, based on clinical need. All children have now been reviewed appropriately, with robust follow-up undertaken via General Practitioners, with a small number of families who did not respond. Of this cohort of 400, 75 children required follow up procedures; 71 procedures will be completed by the end of May 2026, with the remaining procedures scheduled by October 2026, due to family choice.

Patient safety has remained the Trust's overriding priority throughout. As part of the recall programme, 125 incidents were reported, of which 15 were confirmed as resulting in moderate (11 incidents) or severe harm (4 incidents), due to avoidable delays in care (there were no deaths reported). Incident investigations have been completed and included independent scrutiny from an experienced external ENT Consultant and a recently retired Head of Patient Safety. Duty of Candour requirements have been met, with affected patients and families contacted, apologies issued and offers of further meetings and support provided.

In parallel, the Trust commissioned an independent governance learning review of the paediatric ENT service, to examine a four-year retrospective timeline and identify organisational learning. The review concluded that, whilst appropriate systems were in place in terms of the governance framework, they were not always applied consistently or in a sufficiently coordinated way to identify and respond to developing risk at an earlier stage. The review highlights the importance of explicit patient safety risk assessment in the context of team dysfunction, professional

behaviour and workforce wellbeing. Fifteen recommendations were made, focused on strengthening professional matters governance, risk management, communication, culture and clinical oversight.

The Trust has already implemented a comprehensive action plan in response to these recommendations, building upon existing improvement activity. This approach places a strong emphasis on organisational learning, system-wide improvement, and robust measures to prevent recurrence.

Progress will continue to be monitored through established quality and safety governance structures, with learning shared Trustwide. The Trust remains committed to openness, learning and continuous improvement, and has offered apologies to all patients, families and staff for the distress and concern these events have caused.

Recommendation(s)
The Board of Directors is asked to note the update, the enclosed Niche independent review and the accompanying action plan, and to gain ongoing assurance through the Quality, Safety and Performance Board Committee that the Committee will maintain continued oversight, scrutiny and reporting to the Board on full implementation of the recommendations and Trust-wide learning.

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?	☐ **Yes** (please set out in your report what action has been taken to address this) ☒ **No**

Relationship to the strategic objectives			
The work contained with this report contributes to the delivery of the following strategic objectives (see key below)			
LHL objective 1	☒	LHL objective 2	☒
HQSC objective 1	☒	HQSC objective 2	☒
HQSC objective 3	☒	PEW objective 1	☒
PEW objective 2	☒	VfP objective 1	☐
VfP objective 2	☐	R&I objective 1	☐
R&I objective 2	☐	Good Governance	☒

Links to Trust Risks	The work contained with this report links to the following strategic, corporate or operational risks: • A corporate risk is included regarding the ENT recall incident	
Care Quality Commission domains Please check **all** that apply	☒ Safe ☒ Effective ☒ Responsive	☒ Caring ☒ Well-Led

Compliance & regulatory implications	The following compliance and regulatory implications have been identified as a result of the work outlined in this report: • Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (as amended) – Regulation 12: Safe Care and Treatment – Regulation 17: Good Governance – Regulation 18: Staffing – Regulation 20: Duty of Candour • Patient Safety Incident Response Framework (PSIRF), governing proportionate investigation, learning, and system improvement following patient safety incidents • Maintaining High Professional Standards (MHPS) Framework, for the management of concerns regarding doctors' conduct, capability, or health • General Medical Council (GMC) – Good Medical Practice (2024), setting professional standards for doctors, including patient safety, documentation, openness, accountability, and raising concerns • Nursing and Midwifery Council (NMC) – The Code, setting professional standards for nurses, midwives, and nursing associates, including supervision, delegation, and preserving safety • NHS Workforce and Professional Oversight Standards, including Responsible Officer duties, appraisal, revalidation, and professional matters governance

Main report

1. Background and Introduction

Concerns were raised in November 2024 regarding incomplete outpatient documentation by a Paediatric ENT Consultant, which triggered a full review of 2,586 patient records (Sept 2022–Feb 2025). Follow up clinical review was undertaken of 400 patients, with children recalled either for a clinic appointment or telephone follow-up, dependent on clinical need. All children have been clinically reviewed appropriately, with any patients who did not respond (a small number of families) having a follow up letter issued via their General Practitioner. Of the cohort of 400, 75 children were found to have experienced avoidable delays to a required surgical intervention and have been subsequently scheduled for their procedures. Of these, 71 will be completed end May, with remaining procedures scheduled for completion by October (due to family choice).

2. Patient Safety and Independent Review

As part of the recall programme, 125 incidents were reported, of which 15 have been confirmed as resulting in moderate or severe harm (4 severe harm incidents). Incident investigations have now been completed, incorporating independent review from an experienced independent external ENT Consultant and recently retired Head of Patient Safety. Duty of Candour obligations have been completed, with proactive communication and written apologies issued. Follow-up letters and meetings are scheduled with affected patients and families who have taken up this offer, supported by senior clinical and governance engagement.

In addition, a Governance Review was commissioned for learning purposes, examining a four-year retrospective timeline during which concerns were raised over a prolonged period. This review of the paediatric ENT service has now concluded and is appended. This report has been

shared with the fifteen families affected as part of the harm reviews ahead of this Board meeting and offers of meetings have been given to each family to discuss the findings and actions.

Appropriate professional and regulatory processes have also been initiated in line with Maintaining High Professional Standards (MHPS) and related frameworks. These processes are ongoing and are being managed with oversight from senior clinical, managerial and workforce leadership, ensuring proportionality, procedural fairness and support for staff, while ensuring we safeguard patient safety.

2.1 Key findings of the Niche Review and actions

The Trust commissioned an independent learning review from Niche Consulting to consider organisational learning arising from concerns within the Paediatric ENT service at Royal Manchester Children's Hospital.

The purpose of the review was to provide an objective, system-focused assessment of how concerns developed over time, how effectively Trust processes and governance arrangements identified and managed risk, and what learning could be applied to strengthen patient safety, workforce support and organisational assurance. The purpose of the review was not to apportion individual blame.

The review identified that, over a prolonged period, a range of concerns emerged relating to professional behaviours, team working, clinical documentation and oversight arrangements in the Paediatric ENT Service. While the Trust had appropriate systems in place for managing concerns, professional matters and clinical governance, these processes were not always applied in a sufficiently coordinated, timely or consistent way. This limited the organisation's ability to fully appreciate the cumulative impact of issues as they evolved.

A key theme from the review is the importance of explicitly and continuously assessing the potential patient safety implications of team dysfunction and behavioural concerns, alongside appropriate consideration of staff health and wellbeing. The review noted that actions taken in response to individual issues were often reasonable in isolation; however, greater emphasis on structured risk assessment, documentation, escalation and assurance may have enabled earlier intervention.

The review also highlights opportunities to strengthen communication, line management oversight and the use of intelligence from incidents, complaints and staff concerns. Feedback to staff who raised concerns was not always visible, which affected confidence in escalation mechanisms. In addition, the review identified scope to improve the routine use of risk registers, digital system reporting and exception monitoring, to provide earlier organisational insight.

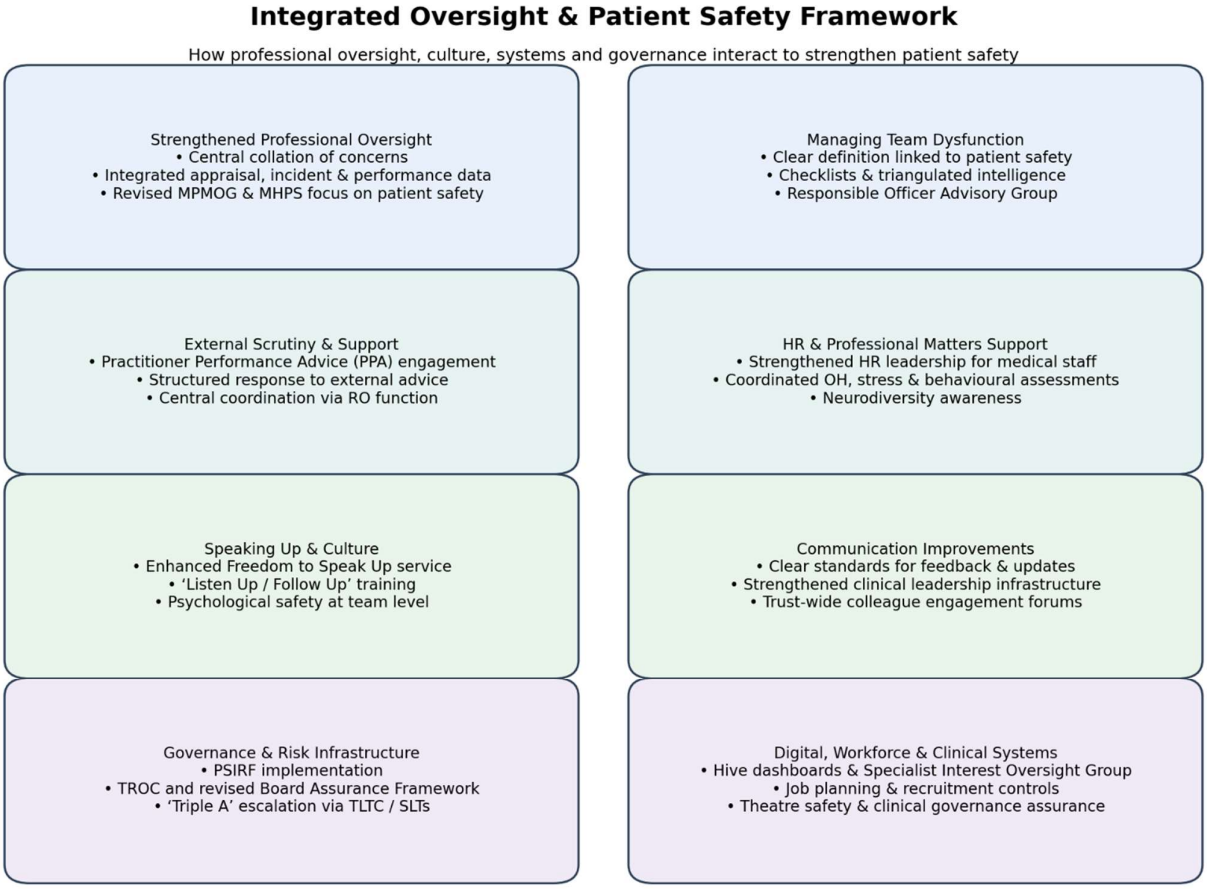
The introduction of the Trust's electronic patient record system in 2022 represented a significant step forward in clinical governance and patient safety. The review concludes that earlier and more systematic use of available tools and data that the system can generate, could have provided additional assurance and earlier identification of issues.

Overall, the review recognises the complexity of managing professional matters in a manner that balances patient safety, workforce wellbeing and fairness. It concludes that there is valuable learning for the Trust in strengthening professional matters governance, risk management, team oversight and organisational assurance. A comprehensive set of recommendations has been made to support continuous improvement and to reduce the risk of similar issues arising in future.

The report makes 15 recommendations, themed around governance, professional matters, patient safety, and organisational culture:

1. **Management of professional matters cases**
   Establish continuous patient-safety-focused risk assessment for protracted professional matters cases, with improved intelligence collation, RO oversight, strengthened MPMOG governance, clearer documentation, and an updated MHPS policy aligned to the Trust operating model.
2. **Team dysfunction**
   Ensure concerns about team dysfunction trigger a formal patient safety review with RO/JCMO oversight, supported by a structured checklist and sufficient governance resources.
3. **External advice and support**
   Seek earlier and more frequent external support (e.g. PPA, RCS, GMC) where there are intractable relationship or behavioural issues, with oversight by the RO team.
4. **HR advice and support**
   Strengthen HR oversight of professional matters cases, ensuring consistent advice, clear documentation, coordinated assessments, and alignment between Trust, hospital and divisional managers.
5. **Raising concerns**
   Improve psychological safety for staff raising concerns, promote equity of treatment, enhance feedback mechanisms, provide bespoke training on incident reporting, and strengthen awareness and use of the Freedom to Speak Up service.
6. **Communication during and after investigations**
   Improve transparency and feedback during investigations, ensure staff are informed of progress and outcomes, and improve visibility of RO involvement while maintaining confidentiality.
7. **Departmental risk recording**
   Introduce departmental-level risk registers to support early identification and escalation of patient safety and workforce risks into divisional governance.
8. **Insight from incidents**
   Improve visibility and analysis of conduct-related incidents at specialty and individual level, including reviewing system functionality to support this.
9. **Line management**
   Strengthen clinical line management arrangements with sufficient job-planned time, clear accountability, and regular oversight of performance, wellbeing and job plan compliance.
10. **Conflicts of interest**
    Improve identification, declaration and management of potential conflicts of interest, including auditing recruitment and approval processes.
11. **Oversight of use of HIVE**
    Prioritise routine monitoring and reporting of compliance with clinical documentation tasks and undertake regular quality audits of patient records.
12. **Proficiency in clinical systems**
    Ensure all users receive adequate training and protected time to become proficient in digital systems, with clear escalation routes for additional support.
13. **Job planning**
    Ensure issues identified regarding job planning, teamwork, administrative time and system training are addressed through the Trust-wide job planning review.
14. **Theatre processes**
    Strengthen assurance over theatre safety processes, including audit of surgical safety checklists, debriefs, conduct standards and equipment availability.
15. **Clinical governance structures**
    Clearly define and communicate an organisational accountability framework for patient safety, governance and risk management following recent structural changes.

An overview of the recommendations is shown below.



An action plan has been developed, which is also appended, building on the work that has already been initiated across a number of areas within the recommendations in the review and the incident investigations conducted. This reflects not only the specific findings of the review and also the broader organisational learning relevant to all Clinical Groups across the Trust. The following provides an overview, with the full plan appended. Implementation and progress will be monitored through existing quality and safety governance mechanisms to ensure sustained oversight and embedding of learning.

Strengthening Oversight of Professional issues

Action has been taken to strengthen oversight through the review of systems to centrally collate professional concerns, including exploration of the digital system to integrate appraisal, incident, and performance data. The Responsible Officer (RO) has initiated revisions to the Medical Professional Matters Oversight Group (MPMOG) Terms of Reference, with a further focus on explicit patient safety risk assessment and improved documentation of decisions. The MHPS policy is also under review to reinforce patient safety considerations throughout investigatory assessment. Further work will focus on finalising system solutions, embedding consistent use across the organisation, and ensuring sufficient administrative and digital support to enable effective oversight and real-time risk identification.

Managing Team Dysfunction
A clearer organisational definition of team dysfunction has been established, explicitly linking it to patient safety risks. Initial work has commenced to develop structured processes, including a checklist for responding to team dysfunction and improved triangulation of data across professional groups. The Trust is also reviewing the capacity and structure of the Professional Matters function and establishing a Responsible Officer Advisory Group to strengthen oversight. Next steps include embedding these processes across clinical areas, ensuring consistent application, and enhancing multidisciplinary engagement to identify and address concerns earlier.

External Scrutiny & Support
Regular engagement with Practitioner Performance Advice (PPA) has been established, with plans to centralise coordination of all external interactions through the RO function. A more formalised process is being introduced whereby external advice triggers a structured review of management actions and patient safety implications. Further actions will focus on embedding early escalation to external bodies in complex cases and ensuring all interactions are consistently documented and aligned with patient safety priorities.

HR & Professional Matters Support
The Trust has initiated a review of HR support for professional matters, including consideration of a dedicated HR leadership role for medical staff and enhanced training for both HR professionals and medical managers. Work is underway to improve documentation and coordination of assessments, including stress risk, behavioural, and occupational health processes. Additional initiatives include neurodiversity awareness training and streamlined access to occupational health assessments. Further work will focus on implementing a strengthened HR model and ensuring consistent, high-quality support for complex cases across the organisation.

Speaking Up & Culture
Significant progress has been made to strengthen the speaking up culture, including the introduction of “Listen Up” and “Follow Up” training for managers and enhancements to the Freedom to Speak Up (FTSU) service. Diversity monitoring and refreshed FTSU plans are supporting a more inclusive and responsive approach. In parallel, a programme of work is underway to improve incident reporting through training and system optimisation. Next steps will focus on embedding psychological safety at team level, increasing awareness and utilisation of FTSU, and ensuring staff receive timely feedback when concerns are raised.

Communication Improvements
The Trust has acknowledged the need to improve communication with staff involved in investigations and has begun developing guidance to support more consistent, timely and transparent feedback, while maintaining appropriate confidentiality. This work is being supported by the new MFT operating model, which has invested in strengthened clinical leadership infrastructure, providing clearer leadership accountability and improved oversight at divisional and specialty level.

In addition, the Trust has invested in communications infrastructure to support more effective internal engagement. There are also colleague engagement forums across Clinical Groups and A Trust forum being established, which will be chaired by MFT CEO.

Further actions will focus on embedding clear standards for communication with staff involved in investigations, including regular updates on progress, expected timescales and outcomes. The intended impact is to ensure staff feel informed, supported and reassured that concerns are being

taken seriously and addressed appropriately, reinforcing trust, professional confidence and a positive safety culture.

Governance & Risk Infrastructure
A Trust-wide programme to strengthen risk management is in place, aligned with the implementation of the Patient Safety Incident Response Framework (PSIRF). This includes the establishment of a Task and Finish Group to review and standardise risk register structures, strengthen risk escalation, and improve the quality and consistency of risk reporting. A new Trust Risk Oversight Committee (TROC) has been established to provide focused executive scrutiny of principal operational and corporate risks, alongside a revised Board Assurance Framework (BAF), to strengthen line of sight between strategic risks, controls and assurances.

Risk reporting arrangements have been refreshed to ensure clearer and more consistent flow of information through sub-committees and into Board-level oversight. This includes enhanced reporting through the Trust's "Triple A" approach (Alert, Advise. Assure), with risks escalated and reviewed via Trust Leadership Team Committee (TLTC) or Senior Leadership Teams (SLTs), as appropriate.

As part of PSIRF implementation, improvements to incident and risk data systems are underway to support more granular, specialty-level analysis and reporting. A new PSIRF-aligned risk and safety training programme is in development to build staff capability in identifying, reporting and escalating risks, and to support a learning-focused patient safety culture.

The intended impact of this work is improved visibility of emerging risks, clearer ownership and accountability, more timely and proportionate responses to safety concerns, and strengthened organisational learning. Next steps include full implementation of the revised risk framework, rollout of training, and embedding enhanced risk and safety reporting within formal governance and leadership structures.

Digital & Clinical Systems (Hive)
Governance of digital systems has been strengthened through existing reporting mechanisms and the establishment of the Specialist Interest Oversight Group (SIOG), chaired by the Joint Chief Medical Officer, with attendees including senior Executives and Clinical Group senior leadership. Work is underway to develop enhanced dashboards to provide visibility of compliance and performance at individual and organisational levels. Training programmes are being refreshed to ensure staff proficiency in system use. Future actions will focus on embedding routine monitoring, ensuring accountability for system use, and aligning digital performance metrics with patient safety and quality governance processes.

Workforce & Operational Controls
A new Trust-wide job planning process has been implemented, with a focus on team-based planning, improved alignment with service needs, and clearer expectations of roles and responsibilities. Recruitment processes are also under review to strengthen controls around conflicts of interest. Further work will focus on embedding these processes, ensuring compliance, and strengthening line management capability to provide effective oversight of performance, behaviour, and wellbeing.

Theatre & Safety Processes
Monitoring of theatre safety processes has been strengthened through regular reporting of compliance with surgical safety checklists and a comprehensive review of equipment-related risks. The establishment of the Interventional Procedures Safety Group is driving improvement across key areas, including human factors, equipment management, and observational practice.

Next steps include completion of this programme of work, wider rollout of best practice tools, and continued assurance of safe and effective theatre processes.

Clinical Governance Framework
The Trust has implemented a revised clinical governance structure and operating model, with ongoing work to standardise and strengthen governance arrangements across the organisation. A Trust-wide Clinical Governance Framework is in development, alongside a review of the effectiveness of the new operating model with external support. Further actions will focus on clarifying roles and accountabilities, strengthening alignment between corporate and clinical governance functions, and ensuring sustainable oversight of patient safety and quality across all services.

3. Communications, openness and transparency
The Trust fully recognises the impact that these events and the subsequent patient recall and review have had on patients, families, carers and staff. From the outset, the Trust has sought to act openly, transparently and compassionately.

Patients and families directly affected have been contacted and offered information about the review being undertaken, the reasons for it, and what it means for their care. Where incidents of harm and delay were identified, the Trust has offered its sincere apologies for the failings, opportunities for discussion, and appropriate clinical review. Dedicated senior clinical, managerial and governance support has been provided to ensure that those families have access to timely information, reassurance and routes to raise questions or concerns throughout the process.

The Trust has also proactively engaged with key external stakeholders to ensure awareness, oversight and assurance. This has included regular communication with NHS England, the Care Quality Commission (CQC), the Integrated Care Board (ICB), and relevant general practitioners, to ensure there is transparency regarding the issues identified, the actions being taken and the independent nature of the learning review.

Through this engagement, we have sought to demonstrate openness, maintain public confidence and ensure that appropriate assurance is provided to regulators and system partners. The independent learning review forms a key part of this commitment, providing objective insight and helping to inform further improvement actions.

The Trust would like to reiterate its sincere apologies to all patients and families for the distress, uncertainty and concern this situation has caused, recognising that the experience for those affected has been upsetting, and it is deeply sorry for this impact. The Trust is fully committed to learning from the findings of the review and embedding the recommendations into everyday practice. A programme of actions is underway to strengthen governance, oversight, professional practice processes and patient safety systems, alongside a continued focus on staff wellbeing and fostering a culture that supports early escalation and speaking up.

Recent discussions at the Trust Quality, Safety and Performance Board Committee highlighted the importance of testing the effectiveness of existing systems as part of the internal control and assurance framework, including through internal and clinical audit and accreditation processes. The Trust will continue to provide assurance to the Board, regulators and the public regarding progress made and the effectiveness of the improvements implemented.

4. Conclusion
The concerns identified in November 2024 regarding incomplete outpatient documentation prompted a comprehensive and necessary review of paediatric ENT practice, governance, and

oversight within the Trust. The recall and follow-up programme has now been completed, with all affected children clinically reviewed and appropriate interventions undertaken or scheduled, to meet patient/family choice. Incident investigations are complete, Duty of Candour requirements have been met and continue through follow-up engagement with families, and independent clinical and patient safety scrutiny has provided further assurance and challenge.

The review has concluded and provides a thorough assessment of systemic issues that contributed to delayed escalation and intervention over a prolonged period. While multiple governance and safety systems were in place, the review has demonstrated that inconsistency in their application in the Paediatric ENT service, combined with cultural and organisational barriers, limited their effectiveness and led to missed opportunities to address risks earlier.

The Trust has already taken significant action to address these findings, including strengthening professional oversight, improving risk management, enhancing the speaking up culture, and reinforcing the links between team functioning, accountability and patient safety. A comprehensive action plan has been developed and is appended, incorporating both immediate and longer-term improvements across governance, workforce, digital systems and clinical practice.

Progress and impact are overseen through strengthened triangulation at sub-Board level, bringing together intelligence from incidents, complaints, workforce data, quality metrics and risk registers to provide a more rounded and timely understanding of emerging issues. The re-established Quality, Safety and Medical Committee (QSMC) plays a key role in this process, providing focused scrutiny of quality and safety themes, reviewing data variances, and considering patient safety issues escalated through operational and clinical governance routes. This approach supports earlier identification of risk, clearer escalation, and more coordinated system responses, ensuring that learning and assurance are effectively translated into action at both operational and Board levels.

The Trust remains committed to transparency, learning, and improvement. Continued oversight through established quality and safety governance structures, alongside ongoing engagement with families, staff, and external regulators, will be in place, as they are critical to restoring and maintaining confidence and ensuring that the learning from this review will lead to sustained and meaningful change.

5. Recommendations

The Board of Directors is asked to note the update, the Niche independent review and the accompanying action plan, and to gain ongoing assurance through the Quality, Safety and Performance Board Committee that the Committee will maintain continued oversight, scrutiny and reporting to the Board on full implementation of the recommendations and Trust-wide learning.

6. Appendices
- Independent learning review regarding the Paediatric ENT service
- Action Plan

Independent learning review regarding the Paediatric ENT service at Manchester University NHS Foundation Trust

April 2026

reliably independent

Report Advisory Notice

This report deals with difficult subjects. We have made efforts to write our report in a way which is not overly descriptive and limits the use of third-party and non-relevant personal information. However, there are instances where information is necessary, for example, where it is relevant to quote an opinion or where a specific act has been documented. We do advise caution for those who may be triggered by reading information which might be distressing, particularly, and ask that they are helped to read this report in a safe and supported way.

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Author: Niche Health and Social Care Consulting

Conveyed to: Chief Executive, Specialist Hospitals Clinical Group, Manchester University NHS Foundation Trust

Conveyed on: 12 April 2026

Independent learning review regarding the ENT service

This is a report which summarises issues relating to the Paediatric ENT service at MUFT. This summary is provided under strict terms of transmittal for receipt at the MUFT Board of Director meeting held in public.

1. Executive summary

Introduction

1.1 Niche were commissioned by Manchester University NHS Foundation Trust (MFT or 'the Trust') to undertake an independent, external learning review within Paediatric Ear Nose and Throat (ENT) services provided at the Royal Manchester Children's Hospital (RMCH) which is part of the Specialist Hospitals Clinical Group (SHCG). This was requested in response to concerns raised about the conduct and clinical practice of a Paediatric ENT consultant. These concerns have culminated in the Trust implementing a formal patient recall programme to review patient care and to fulfil a Duty of Candour to patients and families affected.

1.2 Issues have emerged over several years relating to the consultant's professional behaviour, probity and the accuracy and completeness of clinical documentation. This learning review seeks to understand from a systems perspective how events may have arisen historically and the extent to which actions have been implemented to address the issues identified and ensure learning is embedded to provide assurance on safety for patients and staff. The review is not an investigation into individuals' behaviours or seeking to apportion blame.

1.3 In gathering evidence for the report's findings, we highlight that, in several areas, there were conflicting views and descriptions of events and experiences between staff members interviewed. This is understandable given the issues involved and the passage of time. We note however, that the different perspectives shared on events has not had a material impact on our key findings and recommendations for learning.

1.4 This report covers a range of sensitive, complex and inter-related concerns which span several years. We are cognisant of the significant, personal impact on staff of the events concerned and the ongoing challenges for those involved in the patient recall. We are very grateful to Trust staff who were willing to engage with this review through conversations with our team and by providing information. We sincerely hope that in revisiting their experiences with us that this did not cause further distress.

1.5 In constructing the detailed timeline of events, we have used documentary and email evidence provided by the Trust and sought to validate and understand the context of this through interviews with relevant Trust staff. This report preserves the anonymity of discussions we have held with staff involved in this review.

1.6 There have been some significant organisational restructures at the Trust and changes in job roles over the period of this review. Job titles used refer to those in place at the point in time they are referred to in the narrative.

Key learning points

1.7 A review of this nature has the benefit of hindsight and an independent view of all of the evidence provided by the Trust over the entire timeline. It is also informed by subsequent reflection by staff about how events transpired. In drawing our conclusions, we acknowledge these aspects, as well as the fact that decisions and actions taken at the time, in the context of this case, were not unreasonable, but, with hindsight, do present opportunities for learning to reduce the risk of such events reoccurring.

1.8 We have set out below a summary of the learning from this review under two main headings: **patient safety focus** and **opportunities for earlier intervention**. These two learning themes are core to understanding the need for strengthening the application of patient safety systems and processes which we identify in this case.

1.9 We note that there were areas of good practice and that some actions have been taken by the Trust to improve controls in some areas; we have recognised these throughout our report where relevant.

Patient safety focus

1.10 The diagram below summarises those aspects of the patient safety system where we have identified learning in this case. Our commentary below focuses on those aspects of the system highlighted in the blue boxes.

1.11 There are a multitude of systems set up within the Trust that are designed to identify concerns and patient safety risks or events and, that provide staff with the ability to raise issues and worries. Whilst, in the main, these systems were being used throughout this period and, with some areas of good practice identified, they were not always used appropriately. This review demonstrates where there is a potential need for improvement in how staff follow Trust processes.

1.12 There were multiple opportunities for earlier intervention which show how systems and processes were not used effectively by Trust staff to ensure potential risks to patient safety were mitigated. These are outlined further below. All processes for raising concerns identified in the above diagram should have patient safety explicitly as a core purpose.

1.13 We highlight that the issues raised during the timeline prior to the patient recall in 2025, did not involve concerns about direct patient harm but, in our view, did imply potential risks to patient safety. A core learning point from this review is that 'team dysfunction' and 'poor conduct/inappropriate behaviours' are central to patient safety but throughout the chronology there is little explicit reference to any ongoing assessment of the risks to patient safety from this case. Whilst officers consider this is implicit in all actions and decisions, the Trust should reflect on whether the explicit question, 'Is there a patient safety risk?' is asked overtly in similar cases.

1.14 There were opportunities for improvement in terms of how the medical and nursing hierarchies within RMCH worked together to act in a timely manner to early warnings of individual performance or department challenges.

Opportunities for earlier intervention

1.15 There were multiple points where we identified potential missed opportunities to intervene which may have made a difference in this case to address concerns raised. If action had been taken earlier, this could have prevented the sequence of events which led to the patient recall. Instead, the issues became intractable and patient safety and staff health and wellbeing risks compounded. The summary timeline below highlights the most important points.

1.16 The potential impact of a formal investigation process on the consultant's health and wellbeing was appropriately considered and resulted in a decision to manage the case informally. However, we found little evidence of any examination of any potential risks to patient safety due to these health and wellbeing concerns and associated behaviours. Risk assessment may have led to a different approach which might have included consideration of time off work, earlier removal of the clinical leadership and supervision roles or restriction on clinical duties.

Pre-2021

1.17 We were told of tensions in relationships between ENT consultants prior to the Covid-19 pandemic. A divide was described between sub-specialties in ENT (Otology/Airways) due to tensions between consultants. Team dysfunction was apparent but there was no evidence of intervention by divisional or hospital management at this time. The breakdown in relationships, combined with the knock-on impact on individuals' workplace stress, conduct, communication and team cohesion was, in our view, a potential risk to patient safety.

2021 – Appointment and role of a trainee practitioner

1.18 There was an opportunity to explore issues raised by staff around the recruitment of a trainee practitioner (part of the nursing team) in September 2021. This was a new post and the job description/specification was inadequately defined (and remained under development until April 2024). Concerns were also raised by staff involved in the recruitment about probity and a potential conflict of interest (due to allegations of a personal relationship between the applicant and the consultant which were refuted).

1.19 This appointment was seen by some ENT staff as a key contributory factor to the sequence of events that unfolded as it significantly exacerbated the relationship challenges within the ENT team as the role had not been agreed with all consultants.

1.20 Although escalated to divisional management, there was no evidence of prompt action at the time with regard to the lack of clarity on the job scope and other allegations. If further exploration had taken place, the subsequent events which transpired relating to this role, including alleged unprofessional behaviours and impact on surgical trainee experience, as well as the tension this created within the ENT team, may have been avoided.

1.21 We have not been able to establish as fact whether there was any conflict of interest. However, there was sufficient soft intelligence to warrant further exploration of the impact of relationships between individuals within the ENT team.

2022 – Early team dysfunction, trainee practitioner scope of practice, bullying allegations and equipment issues

1.22 There was no evidence of immediate action in early 2022 to explore the sensitive issues which were creating team dysfunction through direct, individual engagement with the whole ENT team (including consultants, nursing and theatre staff and trainees). This was a missed opportunity to intervene and discuss directly with the team options for resolution which they could all potentially buy into. Joint Chief Medical Officer/Responsible Officer (JCMO/RO) oversight at this stage given their responsibilities for team dysfunction would have been helpful.

1.23 Suggestions were made in mid-2022 that an external review of the department may be helpful. There was no evidence that an external review by respected peers was considered, for example by the Royal College of Surgeons (RCS), NHS Resolution's Practitioner Performance Advice (PPA) service or the General Medical Council (GMC). Support from the PPA service could have been sought much earlier when the relationship issues between consultants first surfaced. The Trust's Maintaining High Professional Standards (MHPS) policy states: *"Even apparently simple or early concerns should be referred, as these are easier to deal with before they escalate."*

1.24 Bullying allegations by theatre staff and trainees within RMCH were not rigorously addressed by divisional management at the time. It was unreasonable that staff were put in a position of accepting this behaviour as the 'norm.' There was a missed opportunity for RMCH medical and nursing senior leadership to work together to prevent these continuing behaviours and provide better support to affected staff.

1.25 Throughout 2022, there were missed opportunities to undertake a full investigation into the lack of equipment issues being experienced by the consultant in theatre. A broader, divisional level review may have addressed what was clearly a trigger for alleged unprofessional behaviours in theatre. We were told that there was a failure to follow the booking system as too many similar operations were being booked on the same list leading to equipment provision challenges.

1.26 There was a missed opportunity to follow up a learning assessment relating to an incident in theatre in June 2022 regarding an incomplete safety checklist. This was a 'near miss' and highlighted individual failure to follow Trust systems and processes in that, for some time, a workaround had been in place for missing paperwork to minimise delays. There was a further similar incident in November 2022; a recommendation was made to undertake spot check audits to determine the scale of the issue noting that this would be a professional matters issue should the non-compliance continue. We saw no evidence that this audit was undertaken.

1.27 Concerns were first raised about the trainee practitioner's scope of practice in September 2022. This had triggered a review of the job description; it did not however trigger a direct

conversation with the consultant as the trainee practitioner's Clinical Supervisor. This was a missed opportunity to understand the associated behaviours and was an example of a missing link between the nursing and medical hierarchy within RMCH.

1.28 In late 2022, the consultant raised concerns as part of a stress risk assessment about the HIVE system (the new integrated electronic patient record system implemented in September 2022) and having to type clinic letters. The consultant referenced a backlog of administrative tasks which might contain important clinical information. This was an early warning about the completion of administrative tasks on HIVE by the consultant. The link to patient safety was not made by management in RMCH and there was a missed opportunity to fully understand the implications of this.

1.29 Investigation into the trainee practitioner's scope of practice incidents in December 2022 focused on the role of the trainee practitioner. There was no evidence that the consultant was robustly challenged on their role in supervising the trainee, particularly with the knowledge that the nursing team were reviewing the trainee's role definition. The consultant's role as Clinical Supervisor ceased in February 2023 but this action could have been considered earlier given the perception by some staff that there was a conflict of interest.

2023 – Trainee practitioner's scope of practice and consultant attendance

1.30 In July 2023 a further incident in theatre regarding the trainee practitioner's scope of practice warranted a more robust stance by the case manager as the consultant had disregarded a clear management instruction.

1.31 The consultant had been persistently late to clinics and theatre and this had been normalised. There was a missed opportunity to have investigated these issues as we were told that they were widely known within RMCH.

2024 – PPA processes, probity concerns and trainee practitioner's job role

1.32 There was a missed opportunity to re-assess the approach to case management in January 2024 following the PPA behavioural assessment undertaken for the consultant. This concluded that remediation would be very difficult and the repair of relationships was described as *"challenging if not impossible."*

1.33 There were several instances of potential probity issues for the consultant including private practice in NHS time and unauthorised absences. These issues were not addressed at the time but there were indications that these issues were known by staff (although not reported).

1.34 In October 2024, there was a further incident which highlighted that the trainee practitioner was not attending theatre sessions led by other consultants per their job plan and did not have the approval of their Clinical Supervisor for this. This was highlighted to nursing management but there was a missed opportunity to have addressed this issue sooner to understand the complexities involved given the absence of an agreed job specification for the trainee practitioner.

The effectiveness of patient safety systems

Management of concerns

1.35 There were several examples of good practice in the management of concerns in this case:

- It was evident that the Medical Director (RMCH then SHCG) and departmental medical management were making efforts to seek resolution to the difficulties being experienced by the ENT team whilst being as supportive as possible to the consultant with regards to their health and wellbeing and ensuring the protection of the individual in terms of confidentiality.
- The Trust's medical leadership were cognisant of the national and local context regarding the vulnerability of doctors under investigation. The GMC and British Medical Association have reported on these issues. The Trust adhered to guidance from NHS Improvement in 2019 to ensure that investigation processes were being undertaken with compassion and with appropriate safeguards for an individual's dignity, health and wellbeing.
- It was noteworthy that several ENT consultants tried their utmost to resolve their concerns directly with the consultant concerned in an open and honest way as both colleagues and friends.
- The consultant was appropriately signposted to relevant support services when mental health and wellbeing concerns became prominent and workplace adjustments were made in response to a stress risk assessment and advice from the Employee Health and Wellbeing (EHW) service.

1.36 Positively, the advice of the PPA service was sought throughout the management of the case. The PPA confirmed that the Trust approach was compliant with guidance in Maintaining High Professional Standards (MHPS) and from the General Medical Council (GMC) which advise that disciplinary action should not be taken when health concerns are a factor. However, the consultant subsequently disengaged with the remediation action plan proposed.

1.37 Over an extended period, from late 2022 until the start of 2025, multiple concerns regarding the consultant's behaviour and conduct had been raised through different routes; some concerns had not been formally reported so the potential risks to patient safety were not visible to management. Although implicitly the focus of medical professionals involved in this case, we found that the associated potential risks to patient safety were not prominent in communications and documentation, for example in terms of risk assessment.

1.38 Given the context of national focus on the vulnerability of doctors under investigation, including cases of self-harm both locally and nationally, the significant concerns raised regarding the health and wellbeing of the consultant became the primary focus and drove associated management actions.

1.39 Throughout the management of this protracted and complex case, balancing the potential risks to patient safety with the risks to a consultant's health and wellbeing was extremely challenging and a compassionate, supportive approach was prioritised. However, in terms of learning, external advice and support from the PPA might have been considered earlier in 2022 when concerns first arose. In addition, it may have been appropriate to have proactively sought earlier support from the EHW service when concerns about workplace stress were first raised

(April/May 2022) by the consultant. Other wraparound support might have been considered at this point, for example additional supervision or day-to-day operational support.

1.40 This situation caused further damage to the cohesion of the RMCH ENT team and left both RMCH ENT colleagues and wider theatre team members feeling alienated and not listened to as they perceived that there had been no action in response to the concerns they had raised. Communication regarding processes ongoing was limited, evidently due to the need to protect the confidentiality of Consultant X.

1.41 Soft intelligence from the ENT team and wider was not used to probe potential probity, conflict of interest and behavioural concerns within the department-so these issues appeared to become subject to rumour and gossip.

1.42 Reassurance was accepted by senior medical leaders that there were no patient safety concerns because of poor team cohesion and behaviours by individuals. A more robust evaluation was needed to understand at what point team dysfunction, relationship issues and individual capability and conduct might become a patient safety issue. There were a number of 'red flags' which warranted further investigation, for example:

- Staff described how the consultant and trainee practitioner visibly worked in isolation of the rest of the team and directly undermined medical colleagues and surgical trainees.
- We were told that it was widely known that the consultant relied significantly on the trainee practitioner for clinical administrative support creating a risk that actions would be missed.
- We were told that a specialist one-stop ear clinic which received referrals from another Trust was impacted by the relationship issues between consultants. There was conflicting evidence as to whether this clinic ceased due to this situation.
- There were concerns about alleged bullying behaviours by the consultant in theatre, as well as allegations of bullying of trainees in the department.
- Safety risks were highlighted about the trainee practitioner's scope of practice.
- Incidents were reported regarding adherence to safety checklists in the consultant's theatre, consent issues and rushed procedures.
- The consultant was often late for clinic or theatre and took unauthorised absences; we were told that other staff worked around these issues rather than raise them as concerns.

1.43 We acknowledge the challenges in managing conflict between consultants appropriately, particularly in circumstances when team dynamics are impacting on team behaviours and wellbeing. There were clear efforts made by the RMCH Senior Leadership Team (SLT) to resolve the issues locally in a way that would be supportive to the team. However, it would have been helpful to have reassessed the approach taken more regularly. A multi-faceted approach was required to address individual behaviours as well as the team dynamic. We did not see substantive evidence of different options being considered.

1.44 Attempts to organise external mediation with organisational development specialists to address individual relationships failed as one of the consultants involved did not wish to engage with this and it was a voluntary process.

1.45 External team facilitation was not well received by the consultant group as it did not touch on the sensitive issues which were at the root of the problems and organising these sessions caused a delay to consideration of other options for intervention. Enabling change from culture diagnostic/team development work is typically a lengthy and continuous process.

1.46 A deep dive and listening exercise into the myriad of concerns being raised was required involving both medical and nursing leadership jointly, to gain a full picture of the concerns raised and demonstrate to staff that their concerns were being heard. This did not happen.

1.47 Throughout the management of the case, a careful balance needed to be struck to allow a continuous assessment of patient safety risks whilst being mindful of the impact of events on the consultant's health and wellbeing. The impression given to staff was that significant efforts were made to support the consultant's health and wellbeing but the consultant was not held to account for their behaviours and actions required of them. In our view, the informal management of this case due to health concerns, continued for too long and needed more frequent reassessment from all perspectives with 'fresh eyes.' There was a need to 'think the unthinkable' with regards to the potential impact on patient safety.

1.48 In late 2022, patient safety risk was considered following several incidents being reported regarding the trainee practitioner operating outside their scope of practice in theatre. Senior management acted in November 2022 to assess whether there had been any patient harm by examining cases over the period from September to December 2022. No harm was identified but it may have been prudent to have extended the review to cover the full period over which the trainee practitioner had been in post. A review of the trainee practitioner's role and job description/specification was also requested but this was not resolved until April 2024 and during this time further, similar incidents occurred. These incidents all occurred under the direction and supervision of the consultant.

1.49 The PPA had visibility of the concerns about the consultant's behaviours, health and the trainee practitioner issue, however the behaviours reported in theatres were not referenced. A disadvantage of the behavioural assessment was that it takes the perspective of the individual being assessed only. The consultant did not refer to the challenges they had previously articulated about administrative duties. The extent of discussion with the PPA on patient safety risk was unclear.

1.50 More involvement by RMCH nursing leadership would have been helpful given the interwoven issues impacting members of the nursing team. There was little evidence of liaison between the medical case manager and the nursing team and there did not appear to be a direct line of sight up to medical and nursing management over the compounding risks emerging. Intelligence was not collated in one place and assessed as a whole. There were weaknesses in the handover of the case to the Divisional Directors in 2024 as they were not fully aware of the historical concerns.

1.51 In October 2024, approximately 18 months since the fact finding investigation in December 2022 into two incidents in theatre (and more than two years since concerns had first been raised about the behaviours of the consultant), there was a direct alert about the completion of patient documentation by the consultant; this triggered robust action by divisional management. This incident subsequently led to the patient recall exercise and was due to the diligence of an operational manager who had identified a waiting list breach.

1.52 The JCMO/RO became aware of the extent of the potential patient recall in April 2025. There was a failing in governance processes as the gravity of the issue had not been escalated promptly to the JCMO/RO either from divisional or hospital management through clinical governance routes, or through the Trust's Professional Matters team.

1.53 Notwithstanding the over-riding health and wellbeing concerns, there were many 'red flags' about the consultant's conduct from 2021 to 2024 which had implications for patient safety. We did not see evidence of a comprehensive re-assessment at any stage to consider whether a formal HR process might be appropriate. An informal process continued over several years while further concerns arose and with no plan for closure of this case.

Raising concerns and incidents

1.54 The ENT consultant concerned was in a position of power and influence as a respected senior consultant and surgeon at the Trust as well as the RMCH ENT Clinical Lead. This created an environment within which staff did not feel safe to raise concerns or report incidents transparently without fear of retribution, or, if they did so, that these would be ignored.

1.55 Many incidents associated with this case were not formally reported by staff. While governance systems and escalation mechanisms were in place, their effectiveness relies on incidents being formally reported and escalated through those channels. Governance arrangements at the Trust are consistent with those in place across the NHS but if these systems are not used appropriately by staff, this limits the ability of governance processes to identify patterns, undertake systematic review and escalate issues in a timely and structured way.

1.56 The incident reporting system was not always used in the right way. Some incidents were reported with inappropriately high gradings as a mechanism to draw attention to an issue. In addition, incidents were typically reported with anonymisation, so it was difficult to identify the staff members involved.

Risk management

1.57 Risk registers were not used effectively as a routine mechanism to highlight and escalate the emerging concerns relating to the RMCH ENT department; team dysfunction and equipment availability did not feature on risk registers at any level.

1.58 There are no risk registers held at departmental or specialty level so there was no systematic process to locally assess and document risks relating to the emerging concerns in ENT. Combined with a lack of incident reporting on these issues, processes did not work for escalation and organisational visibility of these increasingly significant concerns.

1.59 In August 2022, a risk is recorded relating to adequate preparation for the implementation of HIVE (risk score 12) which is marked as closed in December 2022. The closure of this risk was perhaps premature given the later findings relating to outstanding actions on HIVE across the Division of Surgery and Theatres. The Trust described the comprehensive controls put in place to mitigate HIVE implementation risks (see below, Operational Controls for further detail).

1.60 The issues around the effective use of risk registers to highlight concerns within specialties have been recognised by the Trust. Improved reporting to quality and safety governance forums on potential safety risk hotspots is being established with 'heat maps' recognising both hard

and soft intelligence relating to patient safety or staff wellbeing concerns. These are intended to strengthen risk management, but do not remove the need for departmental risk registers.

Management of professional matters

1.61 This case involved serious concerns and potential risk to patient safety so we would have anticipated continued oversight by the RO and in their role as JCMO responsible for patient safety. The JCMO/RO office was aware from mid-2022 of the emerging issues in the RMCH ENT team, associated team dysfunction and actions being taken to address these issues.

1.62 JCMO/RO oversight was, on occasion, constrained, as they were not always aware of the extent of the issues identified at an early enough stage. When the JCMO/RO was made aware of the extent of concerns, they took proactive action to engage with the ENT team, request further fact finding and liaison with the PPA.

1.63 The effectiveness of the RO role depended on the medical hierarchy at Trust, hospital and divisional levels and HR support, to escalate concerns and this did not always work as intended. In addition, escalation of concerns via the RMCH nursing leadership was not effective. A contributory factor to this may have been the culture between the medical and nursing hierarchies and a reluctance by nursing management to raise concerns about doctors. In addition, we were told that although the role of CMO is known to nurses, the RO role is generally less familiar as there is no equivalent in the nursing profession.

1.64 The Chief Nurse described work focusing on the continuous improvement in liaison between the nursing leadership and the RO office. Executive awareness of team dysfunction needs to be raised in relation to its potential broad impact across all professional groups. We are aware that work in these areas has been taken forward.

1.65 From January 2023, oversight of the management of the case commenced through the Medical Professional Matters Oversight Group (MPMOG). The MPMOG was put in place in 2018 for regular meetings regarding professional matters between the Trust medical leadership with Medical Directors and HR.

1.66 Notes of the MPMOG meetings provided were extremely limited, we were told due to confidentiality reasons. We therefore had no substantive evidence of the discussion at MPMOG on how the case should be managed going forwards, the associated risks and plans for closure of the case. The reticence to record discussions at these meeting, while preserving confidentiality, and we were informed in line with guidance from the GMC Employee Liaison Advisor, needs to be addressed so that the rationale for decisions is documented clearly.

1.67 It was also unclear whether staff at department and team levels, are aware that the MPMOG exists for senior level oversight of cases which is important for their reassurance. Clinical managers spoke of a lack of transparency on the management of professional matters. The Trust needs to consider how to communicate appropriately to staff who have raised concerns, with confidentiality protected as far as possible. The RO office's involvement was not always visible to affected staff in terms of their oversight; greater visibility might have provided more assurance to staff that appropriate action was being taken.

1.68 We were told that there is a need for a central repository of information for professional matters cases, for example incidents, complaints, concerns raised, including hard and soft

intelligence. The Trust has previously looked into the feasibility of an employee relations system and options are being pursued.

1.69 The RO office has limited resources and their capacity to provide advice and support on professional matters to hospital medical leaders, given their extensive remit, remains challenging. This has been exacerbated as a consequence of the major restructure of the Trust ('One MFT') which has been taking place since September 2024. We were told that a review of the RO office structure and functions is planned for 2026.

Line management

1.70 There was a lack of effective medical and nursing line management in this case to manage inappropriate behaviours. Medical line management discussions with the Divisional Clinical Director focused predominantly on the consultant's health concerns but more balance was needed. As a result, behaviours remained unchecked over an extended period.

1.71 There were examples of nurse managers challenging the consultant on their behaviours but with no impact and no further escalation through the nursing hierarchy. Some staff did not feel supported by nursing line management, so they raised formal concerns through the medical hierarchy. Medical staff lost confidence in the ability of the RMCH Senior Leadership Team (SLT) to resolve their concerns which led to escalation to the most senior levels of the Trust.

1.72 The potential link between the consultant's behaviours and a potential conflict of interest situation with the trainee practitioner did not appear to have been made, so the appropriate questions were not asked to determine whether a conflict of interest was present. We were also made aware of a further potential conflict of interest issue within the team. We were left with the impression that although subject to rumour and gossip, these issues were not explored by line management due to a fear of causing further upset to consultants with potential further adverse consequences for the wider team.

1.73 There was no regular review of the consultant's performance with their medical line manager. Medical line management was constrained as there was no single place where a manager had routine oversight of the various concerns arising regarding the consultant.

HR processes

1.74 Controls around the recruitment process for the trainee practitioner were not robust; the job description documentation was not appropriate to the role and concerns were raised by staff about meeting the person specification requirements and potential conflicts of interest. We were told of subsequent improvements to controls over recruitment to address these issues.

1.75 Whilst acknowledging that Trust policies and employment law must be followed, formal and lengthy HR investigation processes were not the preferred option for staff seeking resolution of their concerns. Local management of concerns was not effective, mainly due to the culture described above which was allowed to permeate; direct, senior intervention was needed at an early stage to stop the escalation of unprofessional behaviours.

1.76 The theatre team felt obligated to raise concerns under formal policy due to patient safety risks and the stress caused to individuals. The investigation under the Dignity and Respect at Work Policy failed from the perspective of those staff involved as there was no resolution of their concerns. There was no evidence that affected staff received feedback on their concerns. A

fact finding/investigation report into the behavioural concerns raised by theatre staff in 2022 was not provided by the Trust. The consultant refuted all allegations and their response demonstrated a lack of self-awareness of the impact of their behaviours on the team and the risk to patient safety.

1.77 A letter to the PPA in December 2022 confirmed that the Trust had no plans to take forward the complaints from staff under the formal Dignity and Respect at work policy as the consultant's behaviours could be due to workplace stressors and/or health issues. The PPA confirmed that the Trust's approach was compliant with guidance for when there are health concerns. We do not know if any risk assessment was undertaken with regards to patient safety which the MHPS policy requires as the over-riding duty in the management of such concerns.

1.78 We noted that the Dignity and Respect at Work Policy does not recognise the impact of the working environment, team dynamic and behaviours on patient safety which requires addressing by the Trust in the next update. No concerns relating to this case were raised with the Freedom to Speak Up Guardian service despite its intention to provide a safe space for raising concerns. We were told of a lack of confidence by staff in the ability of this service to provide resolution.

1.79 We noted that HR advice was sought during this case although we did not have access to any HR records. We were told that HR support to divisional and departmental managers was inconsistent over the period and that training is limited for medical leaders on the management of HR cases. Given some of the gaps we have encountered between events and actions taken, conversations were possibly held and decisions made without being documented.

1.80 There was a disjointedness between divisional and hospital management on the oversight and monitoring of the consultant's stress risk assessment. It was incumbent on both the consultant and departmental and divisional management to ensure the actions set out were completed.

1.81 There was appropriate signposting for the consultant and other members of the ENT team to HR support services for their health and wellbeing needs including the EHW service. However, there was no evidence of a similar level of support for theatre staff or trainees (including the trainee practitioner) who had raised concerns whilst feeling afraid of the repercussions of this.

1.82 The trainee practitioner described their workplace stress due to the lack of a clear job role, with the additional friction this created with the rest of the ENT team. In our view, the incident investigations regarding the trainee practitioner's scope of practice appeared inequitably balanced as they focused on the trainee's role rather than taking account of the significance of ENT consultant responsibility for oversight.

1.83 We found other examples of inequitable treatment of medical and nursing staff following investigations and disparities in the support and communication provided when concerns had been raised, for example:

- theatre staff did not receive feedback following their formal concerns raised; however, the consultant concerned received feedback directly from the Medical Director (RMCH); and
- there was no substantive evidence that the concerns raised by trainees regarding bullying and intimidation by the consultant were addressed.

Operational controls

1.84 The introduction of HIVE (the EPIC integrated electronic patient record system) in September 2022 was a major undertaking for the Trust. The new system required a major change in how consultants worked with regards to clinical administration.

1.85 The Trust described a range of controls put in place to ensure a successful, clinically led implementation which included:

- extensive clinical engagement with oversight by the Trust's medical leadership;
- a structured governance model with forums ('Pathway Councils') for ongoing clinical engagement and dashboard reporting on system deficiencies;
- monitoring of performance metrics on system proficiency and results acknowledgement tracking; and
- mandatory training for all staff as relevant to their role with allocated training time.

1.86 There was much positive feedback from the staff about the functionality of HIVE from a patient safety perspective, its ease of use and reporting capabilities. However, as is typical for major systems change, there was recognition that an investment of time by individuals was needed to gain the benefits of the new system.

1.87 HIVE functionality for exception reporting facilitated the identification of the extent of the non-compliance issue for the consultant concerned in October 2024. Whilst appreciating the challenges of embedding a new system, there was perhaps a missed opportunity from September 2022 onwards for management to start to use this exception reporting routinely.

1.88 There were mixed views from some ENT consultants regarding the quality of training on the new system and there were conflicting views expressed as to whether consultants had dedicated time for HIVE training. We were told that most members of staff are now using the system adequately but perhaps not making the best use of its functionality. We note the Trust's plans to repeat the mandatory training within SHCG.

1.89 The controls over clinical documentation afforded by the HIVE system did not work as intended as the consultant did not access the system to clear outstanding tasks. This was an individual failure by the consultant to invest their time in training, complete tasks in HIVE as required as part of their clinical role, and also to escalate their challenges with completing HIVE actions.

1.90 Theatre debriefs did not work effectively to capture the persistent problem experienced on equipment availability so full investigation of this issue did not happen. Issues were also identified with the completion of safety checklists in theatre but we saw no evidence of these being addressed.

1.91 Job planning was not always undertaken as a team exercise and adherence to job plans and unauthorised absence was not monitored closely enough in the department.

Clinical governance structures

1.92 Much work has been undertaken by the Trust to improve the patient safety culture through changes to clinical governance roles and responsibilities and the introduction of additional controls for the oversight of patient safety issues.

1.93 There has been significant restructuring of leadership at Trust, hospital and divisional levels and this continues. The Trust will need to be mindful of the impact of this on guidance for staff in policies and procedures relating to the management and escalation of patient safety concerns.

Communication protocols

1.94 There were many examples of weaknesses in lines of communication both for escalation of concerns and reporting back to staff on actions to address their concerns. Escalation of concerns did not always follow hierarchical reporting lines; this was mainly due to staff not seeing resolution or action through local, divisional and hospital management.

1.95 Confidentiality was frequently cited as the reason for the lack of transparency but there was no evidence that options had been considered on how to provide some feedback on the progress of investigations or HR processes whilst protecting confidentiality.

1.96 Communication protocols between the ENT team were not addressed and consultant meetings were not in place.

2. Recommendations

Recommendation 1 – Management of professional matters cases

For protracted cases which might involve individual professional matters and/or when team dysfunction is highlighted, the Trust should put in place a continuous process of risk assessment from a patient safety perspective and ensure there are appropriate systems and resources in place to enable oversight. This should include:

- Collation of hard and soft intelligence relating to behaviours, team relationships and performance via clinical systems, incident reporting, patient complaints and staff concerns as well as details on private practice activity. The Trust should progress the development of the functionality of the medical appraisal and revalidation system or other feasible options for this purpose.
- Oversight and direction via the Responsible Officer (RO) team through the delegated authority of the Associate Chief Medical Officers and via the Medical Professional Matters Oversight Group (MPMOG) which must discuss next steps and plans for closure of cases and any additional support required by hospital site Medical Directors managing such cases.
- Updating the terms of reference for the MPMOG ensuring advice is sought on requirements for the recording of discussions which avoid inaccurate documentation of personal information. The requirements under relevant legislation should be taken into account and clearly understood, including the Freedom of Information Act and General Data Protection Regulations.
- Refreshing the Trust's Maintaining High Professional Standards (MHPS) policy to ensure the respective responsibilities of the RO team and Clinical Groups are clear and reflect the Trust's operating model following changes implemented in October 2024. This update should reflect the requirements of any forthcoming national guidance on MHPS.

Recommendation 2 – Team dysfunction

When team dysfunction concerns are raised, this should trigger a wider review of patient safety implications by the clinical governance team, with oversight by the JCMO/RO responsible for patient safety and team dysfunction:

- In the context of Trust-wide learning from this review, the Trust should reflect on the definition of team dysfunction, how it may encompass multiple professional groups and how the RO role interacts with these groups to fulfil their statutory duties relating to team dysfunction.
- A checklist of actions to be taken in such circumstances should be developed to include review of departmental and consultant level information on incidents, complaints and operational performance as well as one-to-one discussions with all affected staff, including trainees, to provide a safe space for the discussion of sensitive issues.
- The Trust should assess the level of resources available to relevant teams (RO office and clinical governance) to facilitate this.

Recommendation 3 – External advice and support

Whilst acknowledging that advice was sought appropriately from the PPA, the Trust should consider seeking appropriate external support more frequently as soon as significant concerns arise which involve intractable relationships between consultants and potential team dysfunction, including options available for team support through the PPA, Royal College of Surgeons (RCS) and the General Medical Council (GMC). The RO team should be informed of all interactions with external bodies.

Recommendation 4 – HR advice and support

HR oversight of professional matters cases must be reviewed to ensure:

- advice, support and training are readily available to medical managers tasked with the management of such cases;
- advice, records of meetings and action plans are accurately documented and retained;
- appropriate liaison between Trust, hospital and divisional management, ensuring governance input on potential patient safety aspects of the case; and
- coordination between different assessments undertaken (stress risk, behavioural and occupational health assessments).

Recommendation 5 – Raising concerns

Staff must be supported to raise concerns and report incidents at the time of occurrence without fear of retribution. If the working environment is not conducive to openness or when concerns involve a more senior member of staff, mechanisms for raising concerns must provide options which provided psychological safety:

- Line managers must provide guidance on the best route to raise concerns and wellbeing support after raising concerns, so that a staff member does not feel anxious or isolated.
- The Trust must ensure there is equity of treatment with regards to the outcome of any investigations for all staff irrespective of professional or workplace background and protected characteristics.
- Communication and feedback to staff who have raised concerns via a formal or informal route must be prioritised.
- Bespoke training on incident reporting must be provided to clinical staff to ensure the system is used appropriately to ensure patient safety and conduct incidents are captured and investigated. This training must include guidance on how to use the system to report confidentially if required.
- The Freedom to Speak Up (FTSU) service must be promoted to staff in terms of how it can support staff who wish to be listened to (without further action) or who wish to trigger further action by this route. Awareness must be raised on how the FTSU processes work for protecting the identity of staff raising concerns and the confidentiality of discussions.

Recommendation 6 – Communication during and after investigations

Communication regarding investigations being undertaken into concerns raised by staff must be more transparent so that they are assured that their concerns are being acted upon and they have been listened to. The Trust should review how the visibility of the RO office involvement in cases can be enhanced to provide assurance to staff that their concerns are being managed appropriately. The need for confidentiality around the detail of HR processes must be reflected in communications in a way which avoids prejudice and inappropriate disclosure, but as a minimum:

- staff must receive a communication that further investigation is ongoing and the expected timescale for completion;
- staff must receive feedback on the outcome of any investigation into their concerns and have an opportunity to discuss this.

Recommendation 7 – Departmental risk recording

Risk registers should be introduced at departmental level so that frontline staff have an additional mechanism by which to raise concerns which might impact on patient safety or health and wellbeing. These should be used as the basis for feeding the divisional risk register which must identify the department for which a risk is recorded.

Recommendation 8 – Insight from incidents

Incidents raised regarding conduct issues must be more visible in terms of identification to specialty level, clinical area and individual so that these can be periodically reviewed and reported on by the governance team to line managers and divisional management. The Ulysses system functionality must be reviewed to understand if this is feasible within the constraints of the system.

Recommendation 9 – Line management

Line management of clinical staff must be strengthened ensuring sufficient time in medical line managers' job plans to perform this role effectively which should include:

- direct and regular liaison with clinical supervisors and colleagues for feedback;
- acting as a single point of reference for information relating to an individual's performance as well as health and wellbeing;
- oversight of job plans, operational performance and compliance with HR policies.

Recommendation 10 – Conflicts of interest

The Trust should apply more focus to potential conflict of interest situations in the workplace:

- Where soft intelligence and/or workplace behaviours between individuals signal potential concerns about a conflict of interest, the staff concerned should be alerted to their obligation under Trust policy to make appropriate disclosure of personal relationships.
- The Trust must undertake periodic audit of compliance with revised approval processes for recruitment ensuring potential conflicts of interest have been discussed at the divisional panel.

Recommendation 11 – Oversight of use of HIVE

Monitoring of consultant use of HIVE must be prioritised by:

- the Trust progressing at pace to establish routine reporting to divisional management and line management on individual and departmental performance on completion of HIVE tasks as these are fundamental to clinical safety and patient flow; and
- regular audit of the quality of a random sample of clinical records.

Recommendation 12 – Proficiency in the use of clinical systems

The Trust must ensure that consultants and other clinical users are fully trained and proficient in the use of patient administration systems:

- The Trust must alert all users to escalate any need for specific training where required.
- Job plans should reflect additional time required to allow for familiarisation with the system and training.

Recommendation 13 – Job planning

The Trust must ensure that the issues identified in this report relating to job planning (including collaborative team planning, adherence to job plans and administrative/training time for new digital systems) are covered by the Trust-wide review commissioned in late 2025.

Recommendation 14 – Theatre processes

The Trust must ensure the efficacy of controls in theatre to identify patient safety concerns:

- The quality and completeness of theatre surgical safety checklists including pre-list planning and post-list debriefs must be monitored through routine audit to ensure issues identified are escalated and addressed. These processes should include conduct and behaviour expectations.
- The Trust must seek assurance that equipment availability issues in theatre have been resolved.

Recommendation 15 – Clinical governance structures

Given recent significant restructuring in clinical governance structures, the Trust should set out in detail an accountability framework across the organisation for responsibilities from Trust to divisional level for patient safety, governance and risk management.

Appendix A – Glossary

EHW	Employee Health and Wellbeing
ENT	Ear Nose and Throat
FTSU	Freedom to Speak Up
GMC	General Medical Council
HR&OD	Human Resources and Organisational Development
JCMO	Joint Chief Medical Officer
MHPS	Maintaining High Professional Standards
MFT	Manchester University NHS Foundation Trust
MPMOG	Medical Professional Matters Oversight Group
PPA	Practitioner Performance Advice
RCS	Royal College of Surgeons
RMCH	Royal Manchester Children's Hospital
RO	Responsible Officer
SHCG	Specialist Hospitals Clinical Group
SLT	Senior Leadership Team

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Manchester University NHS Foundation Trust

Paediatric ENT Review Improvement Plan

Recommendation 1 – HR cases and patient safety risk

For protracted cases which might involve individual professional matters and/or when team dysfunction is highlighted, the Trust should put in place a continuous process of risk assessment from a patient safety perspective and ensure there are appropriate systems and resources in place to enable oversight.

This should include:

- Collation of hard and soft intelligence relating to behaviours, team relationships and performance via clinical systems, incident reporting, patient complaints and staff concerns as well as details on private practice activity. The Trust should progress the development of the functionality of the medical appraisal and revalidation system or other feasible options for this purpose.
- Oversight and direction via the Responsible Officer (RO) team through the delegated authority of the Associate Chief Medical Officers and via the Medical Professional Matters Oversight Group (MPMOG) which must discuss next steps and plans for closure of cases and any additional support required by hospital site Medical Directors managing such cases.
- Updating the terms of reference for the MPMOG ensuring advice is sought on requirements for the recording of discussions which avoid inaccurate documentation of personal information. The requirements under relevant legislation should be taken into account and clearly understood including the Freedom of Information Act and General Data Protection Regulations.
- Refreshing the Trust's Maintaining High Professional Standards (MHPS) policy to ensure the respective responsibilities of the RO team and Clinical Groups are clear and reflect the Trust's operating model following changes implemented in October 2024. This update should reflect the requirements of any forthcoming national guidance on MHPS.

Responsible Executive Director: Chief Medical Officer

Work already completed within the last 6 months that addresses one or more elements of recommendation 1

Action taken	Responsibility	Governance oversight	Date completed	Update
Review undertaken to establish the suitability of the Empactis system for	Responsible Officer	Joint Chief Medical Officer's Office	Q3 2025/26	The Empactis system was not deemed to be suitable

recording medical appraisal and revalidation				
Implementation of regular monthly meetings between the RO and ACMO appraisal and revalidation lead	Responsible Officer	Joint Chief Medical Officer's Office	Complete / in place	Impact has been improved communication between the RO and revalidation lead
Review of Nursing, Midwifery and Allied Health Professional (NMAHP) appraisal revalidation processes	Deputy Chief Nursing Officer	Chief Nursing Officer's Office	Q4 2025/26	Confirmed appropriate processes are in place in accordance with Trust standards and those of regulatory bodies

Work already underway that addresses one or more elements of recommendation 1

Action	Responsibility	Governance oversight	Planned completion date	Planned Impact	Progress update
Assessment of functionality of SARD (currently used as the medical appraisal and revalidation system) to determine whether this can also be used for medical professional matters, collating all appropriate information	Responsible Officer	Medical Professional Matters Oversight Group Workforce and Education Management Committee	Q2 2026/27	This system will be held centrally with the RO, JCMOs and ACMOs having access to all information, and with sites having access to relevant areas, rather than sites holding their own information locally	Draft cost received, specification to be reviewed via MPMOG in preparation for business case production
Assessment of an appropriate level of administrative and IT support for appraisal and revalidation at both Corporate and site level	Responsible Officer	Medical Professional Matters Oversight Group	Q1 2026/27	Clarity on roles and responsibilities of all stakeholders confirmed and agreed in SOP	Draft proposal ready to be shared for wider consultation

New work planned to address one or more elements of recommendation 1

Action	Responsibility	Governance oversight	Planned completion date	Planned Impact	Progress update
Review of MPMOG Terms of Reference (ToR), reflecting changes to Trust structures in relation to OneMFT	Responsible Officer	Joint Chief Medical Officer's Office	15th May 26	The ToR will include the need to overtly assess patient safety, including the safety of patients treated by the doctor within the private sector, through a described process of contacting the relevant private sector RO(s). MPMOG meetings will not be cancelled at short notice, a register of attendance will be kept, and the RO and Corporate HR Director will hold colleagues to account. In addition, there will be a review process for documentation of MPMOG discussions to include assessment of patient safety risk; rationale for decisions; and actions – taking into account requirements for confidentiality and data protection	Draft currently being created
Consideration of formal monthly meeting with RO, Professional Matters/Appraisals ACMO, Head of Programmes/Director of Clinical Governance/Director of People/Deputy Chief Nurse	Responsible Officer	Joint Chief Medical Officer's Office	30th April 26	Full consideration of scope underway. These will ensure understanding of breadth of information across portfolios and triangulation to inform actions and interventions. Outputs will be briefing to the JCMOs	Agreed meeting in principle. ToR to be developed with first meeting by end of May 2026
Hard and Soft Intelligence Data Process	Joint Chief Medical Officer, Chief Nursing	Trust Leadership Team Committee	Q1 2026/27	Data used to better understand potential patient safety issues before they arise to improve actions and mitigations	Incorporated into above ToR

	Officer, Chief People Officer				
Update to MHPS Policy	Responsible Officer / Joint Chief Medical Officer	Workforce & Education Management Committee	Q1 2026/27	Clarity on new MFT Structures in relation to MHPS	On track

Recommendation 2 – Team dysfunction

When team dysfunction concerns are raised, this should trigger a wider review of patient safety implications by the clinical governance team, with oversight by the JCMO responsible for patient safety and team dysfunction:

- In the context of Trust-wide learning from this review, the Trust should reflect on the definition of team dysfunction, how it may encompass multiple professional groups and how the RO role interacts with these groups to fulfil their statutory duties relating to team dysfunction.
- A checklist of actions to be taken in such circumstances should be developed to include review of departmental and consultant level information on incidents, complaints and operational performance as well as one-to-one discussions with all affected staff, including trainees, to provide a safe space for the discussion of sensitive issues.
- The Trust should assess the level of resources available to relevant teams (RO office and clinical governance) to facilitate this.

Responsible Executive Director: Chief Medical Officer

Work already completed within the last 6 months that addresses one or more elements of recommendation 2

Action taken	Responsibility	Governance oversight	Date completed	Update
Communications campaign focussing on the importance of patient safety cultures – 'Safety starts with us'	Director of Clinical Governance	Quality & Safety Management Committee	BAU	Recurrent campaign under 'Safety Starts with Us' banner embedded across multiple channels, including launch of Patient Safety hub (intranet site), regular inclusion of patient safety / safety culture messages in MFT time and CEO weekly messages, 'behind the scenes of safety' stories, promotion of the Patient Safety champion role

Launch and embedding Patient Safety champion role across MFT	Director of Clinical Governance	Quality & Safety Management Committee	BAU	Over 170 Champions now in place, supported by the corporate Patient Safety team. This include colleagues from across all Clinical groups and professional areas, including medical, AHP, nursing and theatre staff as well as others
Clinical Groups have launched work against the Civility and Respect Framework	Deputy Chief People Officer	Workforce and Education Management Committee	2025/26	Local work has been completed to support the roll out of the toolkits to support the NHS England Civility and Respect Framework.
Leadership Summit which prioritised Culture and engagement held. Attended by all Executive Directors, Clinical Group Senior Leadership Teams and Clinical Heads of Divisions	Chief People Officer	Trust Leadership Team Committee	November 2025	Summitt focussed entirely on culture and leadership. Breakout sessions were held led by Clinical Group CEOs, feedback gathered and actions agreed at the end of the day which culminated in the agreement of 6 cultural experiments that each Clinical Group would take the lead on trialling.

Work already underway that addresses one or more elements of recommendation 2

Action	Responsibility	Governance oversight	Planned completion date	Planned Impact	Progress update
Review of administrative and digital resources available to the CMOs, CNO, RO and clinical governance teams	Responsible Officer	Joint Chief Medical Officer's Office	Q1 2026/27	Improvements in efficiency and timeliness	Linked to case management system – linked recommendation 1
Delivery of 'Civility Saves Lives' train the trainer programme	Director of Clinical Governance	Quality & Safety Management Committee	Q2 2026/27	Heightened awareness within clinical teams of the importance and impact of civility and incivility on clinical practice and team dynamics.	Programme under development as part of wider patient safety education programme

CEO Led Culture and Staff Experience Forum designed and agreed	Chief People Officer	Workforce & Education Management Committee	May 2026	By having a forum of this kind the Trust creating a consistent mechanism for staff to have a structured space to give feedback on how the organisation behaves and functions and inform future changes	First forum due to be held 8th May 2026

New work planned to address one or more elements of recommendation 2

Action	Responsibility	Governance oversight	Planned completion date	Planned Impact	Progress update
Develop and strengthen a checklist of actions to be taken where team dysfunction is identified	Responsible Officer / Deputy Chief People Officer	Workforce & Education Management Committee	Q2 2026/27	Will include a review of departmental and consultant level information on incidents, complaints and operational performance as well as one-to-one discussions with all affected staff, including trainees, to provide a safe space for the discussion of sensitive issues	In progress
Review the structure and operation of Professional Matters team	Joint Chief Medical Officer	Medical Professional Matters Oversight Group	Q1 2026/27	This will include the role of the Director of Clinical Governance and the level of administrative support required to appropriately manage professional matters, both at Corporate and Clinical Group level	In progress. Exploring possibility of enhancing training offer to clinical leaders to support the professional matters portfolio

Development of a Responsible Officer Advisory Group (ROAG)	Responsible Officer	Medical Professional Matters Oversight Group	Q1 2026/27	Formal minutes will be kept which will include the rationale for decisions	Linked to recommendation 1 – first meeting in May
NMAHP triangulation meetings to be established	Deputy Chief Nursing Officer	Chief Nursing Officer's Office	Q1 2026/27	Triangulation of data relating to professional matters, including any patient safety implications. These meetings will ensure a clear and full understanding of professional matters supported by clear actions and accountability.	Linked back to earlier recommendation

Recommendation 3 – External advice and support

Whilst acknowledging that advice was sought appropriately from the PPA, the Trust should consider seeking appropriate external support more frequently as soon as significant concerns arise which involve intractable relationships between consultants and potential team dysfunction, including options available for team support through the PPA, Royal College of ENT Learning Review – Manchester University NHS Foundation Trust, February 2026 20 Surgeons (RCS) and the General Medical Council (GMC). The RO team should be informed of all interactions with external bodies.

Responsible Executive Director: Chief Medical Officer

Work already completed within the last 6 months that addresses one or more elements of recommendation 3

Action taken	Responsibility	Governance oversight	Date completed	Update
Regular meetings with the PPA	Responsible Officer	Medical Professional Matters Oversight Group	Q3 2025/26	These are now well established

New work planned to address one or more elements of recommendation 3

Action	Responsibility	Governance oversight	Planned completion date	Planned Impact	Progress update
Consider centrally coordinating all contact with PPA via the RO office, with the involvement of the site MD and Director of Workforce & OD	Responsible Officer	Medical Professional Matters Oversight Group	Q1 2026/27	Improved visibility to inform support/actions	Discussions underway – linked to case management system
Agree with PPA that all discussions will include an overt discussion of patient safety, which will be recorded in correspondence	Responsible Officer	Medical Professional Matters Oversight Group	Q1 2026/27	Improved visibility to inform support/actions	COMPLETE

Recommendation 4 – HR advice and support

HR oversight of professional matters cases must be reviewed to ensure:

- advice, support and training are readily available to medical managers tasked with the management of such cases;
- advice, records of meetings and action plans are accurately documented and retained;
- appropriate liaison between Trust, hospital and divisional management, ensuring governance input on potential patient safety aspects of the case; and
- coordination between different assessments undertaken (stress risk, behavioural and occupational health assessments).

Responsible Executive Director: Chief Medical Officer

Work already completed within the last 6 months that addresses one or more elements of recommendation 4

Action taken	Responsibility	Governance oversight	Date completed	Update
Each Clinical Group has a designated HR Team who are embedded within the clinical group setting. The Team is	Chief People Officer	Clinical Group Senior Leadership Teams	October 2025	Structure agreed as part of the design authority for One MFT and recognised importance of embedded role of HR professional within the Clinical Group SLT

led by a Director of Workforce & OD who sits as part of the Clinical Group Senior Leadership Team and works closely with the Medical Director, other SLT colleagues.				
Employee Relations Oversight Group (EROG) in place which oversees the progression of casework.	Director of People	Workforce and Education Management Committee		EROG designed to track and monitor cases, highlight any interdependencies, challenges and themes.
CMO workforce meetings with Clinical Groups in place with Clinical Groups to review professional matters.	Chief of Staff	Joint Chief Medical Officer's Office		Provides oversight of ongoing case work and opportunity for triangulation of other issues that may be linked.

Work already underway that addresses one or more elements of recommendation 4

Action	Responsibility	Governance oversight	Planned completion date	Planned Impact	Progress update
Arrange regular meetings for Director of People, Chief of Staff and RO to ensure additional checkpoint and oversight of professional matters cases.	Director of People	Trust Leadership Team Committee	Q1 2025/26	Through having these regular touch points, relevant colleagues can remain connected on issues of concern and put rapid actions in place to support any challenges, delays or escalation.	To be arranged during May

New work planned to address one or more elements of recommendation 4

Action	Responsibility	Governance oversight	Planned completion date	Planned Impact	Progress update
Development neurodiversity awareness training for all those involved in case investigation and case management for professional matters	Responsible Officer / Deputy Chief People Officer	Workforce & Education Management Committee	Q4 2026/27	Improved understanding of neurodiversity to help support and inform actions	Early consideration underway
Occupational Health pathway to be agreed for expedited health assessments of doctors where MHPS processes are being considered at the request of the Medical Directors, Directors of HR or Medical Professional Matters Team.	Responsible Officer / Deputy Chief People Officer	Workforce & Education Management Committee	Q1 2026/27	More timely support to doctor and advice to managerial teams	Underway, on track to be completed
Clinical Groups need to confirm current training status of teams undertaking MHPS and agree training programme with timescales for any staff member non-compliant	Responsible Officer	Medical Professional Matters Oversight Group	Q1 2026/27	Assurance that leaders involved in cases have the skills and competences	Report planned to MPMOG

Recommendation 5 – Raising concerns

Staff must be supported to raise concerns and report incidents at the time of occurrence without fear of retribution. If the working environment is not conducive to openness or when concerns involve a more senior member of staff, mechanisms for raising concerns must provide options which provided psychological safety:

- Line managers must provide guidance on the best route to raise concerns and wellbeing support after raising concerns, so that a staff member does not feel anxious or isolated.

- The Trust must ensure there is equity of treatment with regards to the outcome of any investigations for all staff irrespective of professional or workplace background and protected characteristics.
- Communication and feedback to staff who have raised concerns via a formal or informal route must be prioritised.
- Bespoke training on the incident reporting must be provided to clinical staff to ensure the system is used appropriately to ensure patient safety and conduct incidents are captured and investigated. This training must include guidance on how to use the system to report confidentially if required.
- The Freedom to Speak Up (FTSU) service must be promoted to staff in terms of how it can support staff who wish to be listened to (without further action) or who wish to trigger further action by this route. Awareness must be raised on how the FTSU processes work for protecting the identity of staff raising concerns and the confidentiality of discussions as required.

Responsible Executive Director: Chief People Officer

Work already completed within the last 6 months that addresses one or more elements of recommendation 5

Action taken	Responsibility	Governance oversight	Date completed	Update
'Listen Up' and 'Follow Up' virtual workshops are now available to all managers	Deputy Chief People Officer	Workforce & Education Management Committee	Q3 2025/26	Emphasises the importance of fostering psychologically safe team environments where staff feel confident to Speak Up locally
FTSU team has introduced an optional diversity monitoring scheme	Deputy Chief People Officer	Workforce & Education Management Committee	September 2025	Gathering equality data on protected characteristics and job banding from staff who use the service, volunteer as FTSU Champions, or attend FTSU training. This information is enabling the Freedom to Speak Up team to identify both staff groups who are not accessing the service and those who are under-represented.
Developing psychological safety of our workforce through increased visibility of leadership	Trust Executive and Clinical Group Directors	Trust Leadership Team Committee	Ongoing	Prioritising the visibility of senior leaders across the workforce helps build the psychological safety of our workforce to feel comfortable to raise concerns more naturally as the perception starts to grow of approachability of leaders. Examples of this are Board of Directors being held on Clinical Group sites and not restricted to Trust Headquarters; and all

				Executive Directors having regular scheduled visits to teams and services.
Executive Lead for Freedom to Speak Up is the Deputy Chief Executive	Deputy Chief Executive	Trust Leadership Team Committee	In place	This has proved highly effective in ensuring that oversight of concerns is not limited to one area and provides the executive lead the opportunity to triangulate information heard and support the removal of any challenges being presented to dealing with concerns.

Work already underway that addresses one or more elements of recommendation 5

Action	Responsibility	Governance oversight	Planned completion date	Planned Impact	Progress update
All Clinical Groups are refreshing their FTSU plans in response to organisational changes over the past two years	Clinical Group Senior Leadership Teams	Clinical Group Hospital Management Boards	Q1 2026	Each group is completing the National Guardian's Office FTSU Assessment & Planning Tool, which will inform a Trust wide improvement plan for 2026–2028	In progress on track to complete by end of quarter

New work planned to address one or more elements of recommendation 5

Action	Responsibility	Governance oversight	Planned completion date	Planned Impact	Progress update
Training programme for use of Ulysses	Deputy Director of Clinical Governance & Risk	Quality and Safety Management Committee	Q2 2026/27	This will include how to interact with the system and how to report incidents	In progress

Recommendation 6 – Communication during and after investigations

Communication regarding investigations being undertaken into concerns raised by staff must be more transparent so that they are assured that their concerns are being acted upon and they have been listened to. The Trust should review how the visibility of the RO office involvement in cases can be enhanced to provide assurance to staff that their concerns are being managed appropriately. The need for confidentiality around the detail of HR processes must be reflected in communications in a way which avoids prejudice and inappropriate disclosure, but as a minimum:

- staff must receive a communication that further investigation is ongoing and the expected timescale for completion; ENT Learning Review – Manchester University NHS Foundation Trust, February 2026 21
- staff must receive feedback on the outcome of any investigation into their concerns and have an opportunity to discuss this.

Responsible Executive Director: Chief Medical Officer

Work already completed within the last 6 months that addresses one or more elements of recommendation 6

Action taken	Responsibility	Governance oversight	Date completed	Update
Employee Relations oversight report published	Chief People Officer	Workforce Education Management Committee	April 2026	Through publicising transparently how we are progressing cases along with timescales and theme provides opportunity to inform staff that we are open and transparent in how we deal with concerns and welcome it.

New work planned to address one or more elements of recommendation 6

Action	Responsibility	Governance oversight	Planned completion date	Planned Impact	Progress update
Agree a set of guidelines to support improved approaches to how feedback will be provided to staff who report concerns, or who are	Responsible Officer /Chief People Officer	Medical Professional Matters Oversight Group	Q2 2026/27	This will include the progress of investigations, timescales for completion and outcomes.	Initial discussions underway

interviewed as part of an investigation					
Develop a more comprehensive and improved intranet presence with regular mailshots / newsletters	Responsible Officer	Medical Professional Matters Oversight Group	Q2 2026/27	Improved visibility of the Medical Professional Matters Team with the wider 'OneMFT' workforce	Not yet started
Employee Relations oversight report will be extended to Freedom to Speak Up and other concerns	Chief People Officer	Workforce Education Management Committee	Q3 2026/27	FTSU Guardian already reports to the Board of Directors in relation to progress of case and themes. This will be formatted in a way that can be published and shared with our workforce to demonstrate that the Trust welcomes the raising of concerns.	In progress (reports every 6 months)

Recommendation 7 – Departmental risk recording

Risk registers should be introduced at departmental level so that frontline staff have an additional mechanism by which to raise concerns which might impact on patient safety or health and wellbeing. These should be used as the basis for feeding the divisional risk register which must identify the department for which a risk is recorded.

Responsible Executive Director: Chief Nursing Officer

Work already completed within the last 6 months that addresses one or more elements of recommendation 7

Action taken	Responsibility	Governance oversight	Date completed	Update
Scoping for Trust wide risk management training	Director of Clinical Governance	Trust Risk Oversight Committee	Q4 2025/26	Scoping completed. Risk Management Training plan under development

Work already underway that addresses one or more elements of recommendation 7

Action (Trust or Clinical Group)	Responsibility	Governance oversight	Planned completion date	Planned Impact	Progress update
Trust - Task and Finish Group for Risk Management	Deputy Director of Clinical Governance & Risk	Trust Risk Oversight Committee	April 2026	The T&F Group holds an action plan that spans risk management across the Trust with the aim of improving processes for, and cultures of risk reporting.	COMPLETE Task and finish group in place. Actions subject to ongoing oversight and escalation to TROC
Trust - Risk Training Programme	Deputy Director of Clinical Governance & Risk	Trust Risk Oversight Committee	Annual ongoing programme	Improve risk management awareness and knowledge	Roll out will commence in Q1 2026/27 – already underway
Clinical Group - Risk Register Hierarchy Review	SHG Assistant Director of Clinical Governance / Deputy Director of Clinical Governance & Risk	Specialist Hospitals Clinical Group Risk Committee	Q2 2026/27	Structured Hierarchies for Risk Registers across the Clinical Group, broken down to Clinical Service	SHCG review has commenced.

Recommendation 8 – Insight from incidents

Incidents raised regarding conduct issues must be more visible in terms of identification to specialty level, clinical area and individual so that these can be periodically reviewed and reported on by the governance team to line managers and divisional management. The Ulysses system functionality must be reviewed to understand if this is feasible within the constraints of the system.

Responsible Executive Director: Chief Nursing Officer

Work already completed within the last 6 months that addresses one or more elements of recommendation 8

Action taken	Responsibility	Governance oversight	Date completed	Update
Review of Patient Safety Incident Response Framework	Director of Clinical Governance	Quality, Safety & Performance Board Committee	July 2025	Internal Audit conducted by KPGM to assess implementation of PSIRF action plan currently in final drafting stages, Indicative outcome is significant assurance with minor areas of improvement.
Delivery of series of training events across all staff groups relating to patient safety incidents / responses	Director of Clinical Governance	Quality and Safety Management Committee	Ongoing programme of work	In 202526 over 1700 people have access the Patient Safety Fundamentals training on the E-learning for Health platform, and increase of over 1200 people from the previous year. In addition, in 2025 498 colleague attended externally facilitated face to face training.
Improved reporting into Quality and Safety Management Committee	Director of Clinical Governance	Quality and Safety Management Committee	March 2026	Refreshed Patient safety Report exploring improvement activity, trends and themes now being received routinely at QSMC

Work already underway that addresses one or more elements of recommendation 8

Action	Responsibility	Governance oversight	Planned completion date	Planned Impact	Progress update
Standardisation of approach to patient safety incidents	Director of Clinical Governance	Quality and Safety Management Committee	Q2 2026/27	Standardisation of patient safety processes across the organisation, strengthening consistency, reducing variation and ensuring best practice is shared to support equitable learning.	Mapping of relevant processes undertaken during March. Policy and procedure currently being consulted on

Improvement programme for Ulysses	Deputy Director of Clinical Governance & Risk	Quality and Safety Management Committee	December 2026	Ongoing programme of work reviewing Ulysses system location/ specialities following the OneMFT restructure of the organisation to ensure accurate mapping of incident reporting	Mapping underway, with ongoing links to Ulysses to explore development options

New work planned to address one or more elements of recommendation 8

Action	Responsibility	Governance oversight	Planned completion date	Planned Impact	Progress update
Establishment of Patient Safety & Complaints data working group	Director of Clinical Governance	Patient Safety Group	Q2 2026/27	Will ensure robust and standardised process (where possible) for data analysis and sharing with the clinical groups to enable leaders to effectively monitor for concerns.	Group established. Work underway to understand scope and need
Review current advice and information for staff to support the escalation of concerns and incidents, specifically within Specialist Hospitals Clinical Group but also to be used as a template across all Clinical Groups	SHG Associate Director of Clinical Governance / Deputy Director of Clinical Governance & Risk	Specialist Hospitals Clinical Group Quality, Safety & Performance Group / Trust Patient Safety Group	Q2 2026/27	To include: • Guidance and promotion of the incident system and who they can approach for support • Guidance and promotion of the Speak up Safely (SuS) Guardian role and reporting methods and who they can approach for support • Advice for administrative staff regarding the types of incidents and concerns that can and should be	Quarterly program of bespoke patient safety workshops within Hospital Quality, Safety and Performance meetings are planned to commence at the end of Q1.

				escalated/reported in relation to their role • Clarifying or retraining for managers on the importance of formalising the reporting of concerns related to patient/staff safety whether identified by themselves or escalated by a member of their team • Ensuring that key policies and SOPs include as part of roles and responsibilities and escalation procedures, the need for staff to report to their line manager and/or into the incident system • How the learning and feedback is provided from incident reporting and SuS to promote improvements and encourage reporting culture.	

Recommendation 9 – Line management

Line management of clinical staff must be strengthened ensuring sufficient time in medical line managers' job plans to perform this role effectively which should include:

- direct and regular liaison with clinical supervisors and colleagues for feedback;
- acting as a single point of reference for information relating to an individual's performance as well as health and wellbeing;
- oversight of job plans, operational performance and compliance with HR policies.

Responsible Executive Director: Chief Medical Officer

Please see the Trust's response to recommendation 13, job planning.

Recommendation 10 – Conflicts of interest

The Trust should apply more focus to potential conflict of interest situations in the workplace:

- Where workplace behaviours between individuals signal potential concerns about a conflict of interest, the staff concerned should be alerted to their obligation under Trust policy to make appropriate disclosure of personal relationships.
- The Trust must undertake periodic audit of compliance with revised approval processes for recruitment ensuring potential conflicts of interest have been discussed at the divisional panel.

Responsible Executive Director: Chief People Officer and Chief Medical Officer

Work already completed within the last 6 months that addresses one or more elements of recommendation 10

Action taken	Responsibility	Governance oversight	Date completed	Update
The Trust utilises a standard question within application forms to identify potential conflicts of interest	Deputy Chief People Officer	Workforce & Education Management Committee	2025	The Trust takes appropriate action where this is declared

Work already underway that addresses one or more elements of recommendation 10

Action	Responsibility	Governance oversight	Planned completion date	Planned Impact	Progress update
Review of Recruitment Policy	Director of Transactional Workforce	Workforce & Education Management Committee	Q3 2026/27	Gives emphasis to conflict of interest question and its uses, appropriate interventions to be applied should a conflict be declared and an audit process will be built in	Policy review is underway, encompasses other elements too making the review broader but is progressing

Recommendation 11 – Oversight of use of HIVE

Monitoring of consultant use of HIVE must be prioritised:

- The Trust must progress at pace to establish routine reporting to divisional management and line management on individual and departmental performance on completion of HIVE tasks as these are fundamental to clinical safety and patient flow.
- Audit of the quality of random clinical records should be regularly undertaken.

Responsible Executive Director: Chief Medical Officer

Work already completed within the last 6 months that addresses one or more elements of recommendation 11

Action taken	Responsibility	Governance oversight	Date completed	Update
Launch of Specialist Interest Oversight Group (SIOG)	Joint Chief Medical Officer	Quality & Safety Management Committee	September 2025	The group is chaired by the Joint Chief Medical Officer and is attended by Trust Clinical Governance, Digital and Clinical Group leadership teams to ensure there is a robust oversight to ensure that digital enablers (including Hive data) is used to inform Quality and Safety governance consistently across all Clinical Groups and so that data is available all levels

Work already underway that addresses one or more elements of recommendation 11

Action	Responsibility	Governance oversight	Planned completion date	Planned Impact	Progress update
Digital quality issues dashboard	Joint Chief Medical Officer	Specialist Interest Oversight Group	Q1 2026/27	Improved visibility on key metrics which will be used by all tiers of the Quality and Safety Governance (Trust and Clinical Group) to monitor performance and provide support and drive intervention as required. The launch of the dashboard will also include clear identification of the responsibility of both individual users and leadership teams in ensuring proficiency and compliance going forward and ensure they are clear about how support can be received where identified.	On track for completion

New work planned to address one or more elements of recommendation 11

Action	Responsibility	Governance oversight	Planned completion date	Planned Impact	Progress update
Digital education programme	Joint Chief Medical Officer	Quality, Safety & Performance Management Committee	Q2 2026/27	Focus on ensuring all staff understand the importance of using digital systems to deliver effective and safe care and the responsibility of all staff who interact with the systems to be proficient in its use	In progress
Form a working group with the Digital team to explore how the workflows and functionality of HIVE can be improved to support addressing the specific	SHG Associate Director of Clinical Governance	Specialist Interest Oversight Group	Q4 2026/27	Incorporation of specific improvements into wider HIVE development programme	In progress

challenges identified in the review.					

Recommendation 12 – Proficiency in the use of clinical systems

The Trust must ensure that consultants and other clinical users are fully trained and proficient in the use of patient administration systems:

- Training must be mandated for initial and ongoing maintenance training.
- Users must escalate their need for specific training where required and the need for additional training should be routinely monitored through audit of compliance with system requirements.
- Job plans should reflect additional time required to allow for familiarisation with the system and training.

Responsible Executive Director: Chief Medical Officer

Work already completed within the last 6 months that addresses one or more elements of recommendation 12

Action taken	Responsibility	Governance oversight	Date completed	Update
Job Plan process for 26/27	Joint Chief Medical Officer	Joint Chief Medical Officer's Office	April 2026	Facilitates detailed planning for all service needs including training

Work already underway that addresses one or more elements of recommendation 12

Action	Responsibility	Governance oversight	Planned completion date	Planned Impact	Progress update
Training programme is currently being refreshed	Joint Chief Medical Officer	Evidence of training will be monitored via the appraisal process and clinical leadership oversight	Q2 2026/27	Evidence demonstrates that proficiency can be maintained by 6 hours of training per annum which should be delivered within established weekly core CPD time (6 hours per week).	Training modules are available, and each Clinical Group is establishing clinical digital networks to allow the delivery. Oversight to be clarified

Recommendation 13 – Job planning

The Trust must ensure that the issues identified in this report relating to job planning (including collaborative team planning and adherence to job plans) are covered by the Trust-wide review commissioned in late 2025.

Responsible Executive Director: Chief Medical Officer

Work already completed within the last 6 months that addresses one or more elements of recommendation 13

Action taken	Responsibility	Governance oversight	Date completed	Update
New job planning process	Joint Chief Medical Officer	Joint Chief Medical Officer's Office	March 2026	The new process has been supported by training for job planners, engagement with clinical teams, operational teams and a single set of supporting materials and guidance

Recommendation 14 – Theatre processes

The Trust must ensure the efficacy of controls in theatre to identify patient safety concerns:

- The quality and completeness of theatre surgical safety checklists including pre-list planning and post-list debriefs must be monitored through routine audit to ensure issues identified are escalated and addressed. These processes should include conduct and behaviour expectations.
- The Trust must seek assurance that equipment availability issues in theatre have been resolved.

Responsible Executive Director: Chief Medical Officer

Work already completed within the last 6 months that addresses one or more elements of recommendation 14

Action taken	Responsibility	Governance oversight	Date completed	Update
Oversight of compliance with the Safer Surgical Checklist	Associate Chief Medical Officer	Via Trust Integrated Performance Report	Complete- BAU	Complete- BAU
Comprehensive deep-dive review of theatre equipment risks	SHG Associate Director of Clinical Governance	Specialist Hospitals Clinical Group departmental governance	Complete - BAU	Complete - BAU

Work already underway that addresses one or more elements of recommendation 14

Action	Responsibility	Governance oversight	Planned completion date	Planned Impact	Progress update
Establishment of checklists workstream as part of new Interventional Procedures (IP) Safety Group and implement programme of work	Director of Clinical Governance	Patient Safety Group	Q3 2026/27	Initial plan is to develop a best practice guide for the use of checklists in MFT and targeted work with teams were this has been a challenge. Will link with work being completed as part of the Safer Surgery checklist work and with digital colleagues as appropriate	Meetings established and workplan initiated.
Establishment of Human Factors workstream as part of new Interventional Procedures Safety Group and implement programme of work	Director of Clinical Governance	Patient Safety Group	Q3 2026/27	Focus of work will be to raise awareness of importance of human factors in IP with focussed attention to impact of distractions, and of incivility, importance of good communication across all areas where IP tasks undertaken	Meetings established and workplan initiated.
Establishment of storage workstream as part of new Interventional Procedures Safety Group and implement programme of work	Director of Clinical Governance	Patient Safety Group	Q3 2026/27	Focus of work will be implants and development of a best practice tool for the storage of implants. Once piloted plan wil be to develop generic tool and other specific tools as required.	Drafted best practice document and audit tool. Currently being refined.

Implement a programme of observational visit to areas where interventional procedures take place workstream as part of new Interventional Procedures Safety Group and implement programme of work	Director of Clinical Governance	Patient Safety Group	Q3 2026/27	To identify areas of IP good practice to share across the organisation and those areas requiring additional support so this can be provided	Tool drafted to help capture observation data. Tested in theatres. Also developed a training resource (video, FAQ, blank report, data capture doc, online summary to collate) to help develop a cohort of staff to complete observations. Next step to test with volunteers and refine and roll out. Alongside, timetable of observations being developed.

Recommendation 15 – Clinical governance structures

Given recent significant restructuring in clinical governance structures, the Trust should set out in detail an accountability framework across the organisation for responsibilities from Trust to divisional level for patient safety, governance and risk management

Responsible Executive Director: Chief Medical Officer and Chief Nursing Officer

Work already completed within the last 6 months that addresses one or more elements of recommendation 15

Action taken	Responsibility	Governance oversight	Date completed	Update
One MFT revised Operating Model	Trust	Trust Leadership Team Committee	October 2025	This established clear roles and responsibilities and introduced a clinical leadership model. All job descriptions were updated, and Clinical Groups developed ways of working documents aligned to, and reinforcing, the Trust's Governance Handbook and Operating Model. Initial reviews of these arrangements are underway, with support from

				Teneo and the Good Governance Institute, to test their effectiveness as part of the Trust's Well-Led preparedness programme
Revised Clinical Governance team structure	Director of Clinical Governance	Trust Leadership Team Committee	July 2025	Standardised structures and approaches

Work already underway that addresses one or more elements of recommendation 15

Action	Responsibility	Governance oversight	Planned completion date	Planned Impact	Progress update
Standardisation and strengthening clinical governance arrangements and approaches across MFT	Director of Clinical Governance	Trust Leadership Team Committee	Q3 2026/27	Standardisation, clarity and alignment	Governance improvement plans under development with Clinical Groups
Develop a Trust-wide Clinical Governance Framework	Director of Clinical Governance	Trust Leadership Team Committee	December 2026	Standardisation, clarity and alignment	Framework out for consultation on 1st May

New work planned to address one or more elements of recommendation 15

Action	Responsibility	Governance oversight	Planned completion date	Planned Impact	Progress
Implement and complete the planned reviews of the One MFT revised Operating Model,	Executive Team	Executive Team and Board	Q2 2026/27	working with Teneo and the Good Governance Institute to assess the effectiveness of roles, responsibilities, clinical leadership arrangements, and associated ways of working. Findings,	Close down report received. COMPLETE

				recommendations, and any required improvements will be reported, with an agreed action plan and timescales for implementation.	
Review how the RO role, CMO office, CNO office and clinical governance teams work together	Joint Chief Medical Officer/ Chief Nursing Officer	Chief Medical Officer / Chief Nursing Officer Offices	Q1 2026/27	Ensure transparent, agile, well recorded processes around both clinical governance and also professional matters for all professions	Agreed via ROAG – 1st meeting in May
Implement a Quality Management system across MFT	Chief Nursing Officer / Chief Delivery Officer	Trust Leadership Team Committee	Q4 2026/27	Support the delivery of high-quality services that meet patient and regulatory requirements while fostering continuous improvement, reducing waste, and mitigating risks	Embedded as part of CNO objectives, initial launch workshop held 28.04.26
ENT service to review and standardise the provision of information and literature to patients and families to support consent.	SHG Associate Director of Clinical Governance	Specialist Hospitals Clinical Group Quality, Safety & Performance Group	Q2 2026/27	This should include the information contained on the ENT webpage (produced in 2027), the EIDO forms in the HIVE system and those produced by the ENT UK Professional body. Once developed to learning to be shared across SHG and the Trust more widely to inform further improvements	In progress as part of wider Clinical Group patient information workstream.
Introduce a programme of audit and monitoring in ENT to evaluate clinical practice in line with key policies and procedures	REH Hospital MD (with responsibility for Clinical Effectiveness)	Specialist Hospitals Clinical Group Clinical Audit Meeting	Q2 2026/27	This does not need to be a separate programme of individual audits but could incorporate key elements as follows: • record keeping – entries in notes, operative records,	In progress.

				surgical check lists, process for discharge, clinic letters, etc. consent – two stage process, discussion and provision of information, quality of recording	
Best Practice - ENT Service to establish guidance / process for ensuring patients with complex presentations and diagnosis are treated in line with best practice:	Clinical Head of Division (ENT)	Specialist Hospitals Clinical Group Clinical Audit Meeting	Q2 2026/27	Guidelines to ensure that • Patients are reviewed in a multidisciplinary/ grand round meeting so consensus is achieved amongst clinicians on the proposed options for treatment and care. • that clinical staff in the service are aware of those procedures where key investigations such as imaging, investigations are required to support diagnosis prior to further intervention or treatment proposals for new treatments, (not previously undertaken in ENT), and related to surgery, interventional procedures, medicines, etc. are reviewed within a multidisciplinary/ grand round setting so consensus is achieved amongst clinicians on the proposed options for treatment and care. This should include the feasibility of the service being able to deliver this, that internal/external	In progress.

				advice is sought, correct Trust procedures are followed and that there is evaluation/audit of the new intervention/ procedure if agreed	
Tracheostomy care – review current process for management and oversight of patients between the ENT service and the Tracheostomy Team	Clinical Head of Division (ENT)	Specialist Hospitals Clinical Group Quality, Safety & Performance Group	Q2 2026/27	To include: • A register for children/young people with a tracheostomy under the care of RMCH is maintained within the service and identifies the current plan of care and treatment and is regularly reviewed- *(understand a version of this exists but should be reviewed)* • The expectations of the service in terms of appropriate follow-up and assessment of patients with a tracheostomy i.e. minimum standard for follow-up and review as an outpatient or for airway assessment and when PIFU is acceptable. • Guidance is produced to advise on arrangements for the involvement, support and communication with the Tracheostomy Team prior to any discharge of a patient with a tracheostomy. This should focus on their	In progress.

				involvement in outpatient clinics, transition of care to adult services or where there are concerns about support and provision in the community and where the parents/families have outstanding concerns. • Review and identify arrangements for community support and provision of equipment, etc. across the areas RMCH provide care to patients with a tracheostomy so any gaps in provision can be identified.	
Arrangements for a formal MDT process in ENT should be established. This should include terms of reference (TOR) for multidisciplinary meetings and/or a grand round held in ENT.	Clinical Head of Division (ENT)	Specialist Hospitals Clinical Group Quality, Safety & Performance Group	Q2 2026/27	The TOR should include the following: • A core membership and expectations around consultant / members attendance • A record of minutes and development of an action log for tracking decisions and outcomes • A standardised agenda – outlining key areas for discussion and including review of best practice, complex patient cases, proposal and approval of	In progress.

				new procedures/treatments, audit outcomes and improvements within the service • Define the arrangements for MDT working with other teams and specialties within RMCH or externally • Process for escalation and review of – emerging themes, related to learning from incidents, complaints, improvements, etc.	