University Hospitals of Morecambe Bay NHS Foundation Trust

ANNUAL REPORT AND ACCOUNTS 2011 - 2012
ANNUAL REPORT AND ACCOUNTS
2011 - 2012

“We will be the best – giving excellent compassionate care to the people of Morecambe Bay”
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1. Glossary of terms

This glossary provides information on the general and financial terms used in the annual report and accounts.

1.1 General terms explained

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
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<tbody>
<tr>
<td>CQC – Care Quality Commission</td>
<td>The independent regulator of all health and social care services in England. Its job is to make sure that care provided by hospitals, dentists, ambulances, care homes and services in people’s own homes and elsewhere meets government standards of quality and safety.</td>
</tr>
<tr>
<td>NMC – Nursing and Midwifery Council</td>
<td>The nursing and midwifery regulator for England, Wales, Scotland, Northern Ireland, existing to safeguard the health and wellbeing of the public. It sets standards of education, training, conduct and performance so that nurses and midwives can deliver high quality healthcare consistently throughout their careers.</td>
</tr>
<tr>
<td>Monitor</td>
<td>The independent regulator of NHS foundation trusts. It is independent of central government and directly accountable to Parliament. It determines whether NHS trusts are ready to become NHS foundation trusts, ensures compliance and sees that they are well-led and financially robust.</td>
</tr>
<tr>
<td>CQC Standards</td>
<td>The CQC ensures that essential standards of quality and safety are being met where care is provided, from hospitals to private care homes. It has a wide range of enforcement powers to take action on behalf of people who use services if services are unacceptably poor.</td>
</tr>
<tr>
<td>CQC Warning Notice</td>
<td>If a registered provider or manager is in breach of CQC regulations, a warning notice can be submitted to ensure improvement. The action taken will be proportionate to the impact that the breach has on the people who use the service and how serious it is.</td>
</tr>
<tr>
<td>PWC</td>
<td>PricewaterhouseCoopers (trading as PwC) is a global professional services firm headquartered in London, United Kingdom.</td>
</tr>
<tr>
<td>Definition</td>
<td>Description</td>
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<tr>
<td>Dr Foster</td>
<td>A leading provider of comparative information on health and social care services. Dr Foster produces unique consumer guides to health services, the first of which was published in 2001 - the first time that comparative adjusted death rates for all NHS hospital trusts had ever been published.</td>
</tr>
<tr>
<td>HSMR</td>
<td>The Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality that measures whether the death rate at a hospital is higher or lower than expected. The HSMR compares the expected rate of death in a hospital with the actual rate of death. Dr Foster looks at those patients with diagnoses that most commonly result in death - for example, heart attacks, strokes or broken hips.</td>
</tr>
<tr>
<td>North West Mortality Collaborative Group</td>
<td>A group of nine NHS Trusts and part of a wider strategy to raise standards of care throughout the area, facilitated by the Advancing Quality Alliance (AQuA). In addition to looking at the way mortality is measured, it has looked at a number of initiatives including emergency care pathways, End of Life Care and clinical pathways specific to heart failure, the management of venous thromboembolism and sepsis.</td>
</tr>
<tr>
<td>A&amp;E / ED</td>
<td>A&amp;E departments assess and treat patients with serious injuries or illnesses. You will often see the A&amp;E and ED used interchangeably, and the word “casualty” less so now.</td>
</tr>
<tr>
<td>GPs</td>
<td>Medical practitioners who treat acute and chronic illnesses and provide preventive care and health education for all ages and all sexes. They have particular skills in treating people with multiple health issues.</td>
</tr>
<tr>
<td>Clinical Commissioning Groups / CCGs</td>
<td>Groups of GPs that will, from April 2013, be responsible for designing local health services in England. They will do this by commissioning or buying health and care services.</td>
</tr>
<tr>
<td>Thrombolysis</td>
<td>The breakdown of blood clots by pharmacological means, colloquially referred to as ‘clot busting’. Thrombolysis is usually intravenous, and while other anticoagulants decrease the growth of a clot, thrombolytic agents actively reduce the size of the clot and restore blood flow.</td>
</tr>
<tr>
<td>Lorenzo</td>
<td>Lorenzo is a clinical computer system aimed at being a single point of reference for all service user information that is created and maintained by clinicians and admin staff in...</td>
</tr>
</tbody>
</table>
Radiotherapy is the use of high energy x-rays and similar rays (such as electrons) to treat disease. Many people with cancer have radiotherapy as part of their cancer treatment. It can be given either as external radiotherapy from outside the body using high energy x-rays or internal radiotherapy from a radioactive material placed within the body.

<p>| NIHR – National Institute for Health Research | Aims to create a health research system in which the NHS supports outstanding individuals, working in world class facilities, conducting leading edge research focused on the needs of patients and the public. |
| SIFT – Service Increment for Teaching | Funding for medical education comes from three streams; student fees, Higher Education Funding Council (HEFCE) allocations for teaching to the medical schools, and SIFT to hospitals and GPs. The largest stream is SIFT. |
| MRSA Bacteremia | Methicillin-resistant Staphylococcus aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections in humans. MRSA is any strain of Staphylococcus aureus that has developed resistance to beta-lactam antibiotics, which include the penicillins and the cephalosporins. Strains unable to resist these antibiotics are classified as methicillin-sensitive Staphylococcus aureus, or MSSA. Resistance makes MRSA infection more difficult to treat with standard types of antibiotics and thus more dangerous. |
| C Diff. – Clostridium Difficile | Bacteria present naturally in the gut of around two-thirds of children and 3% of adults. C. difficile does not cause any problems in healthy people. However, some antibiotics that are used to treat other health conditions can interfere with the balance of ‘good’ bacteria in the gut. When this happens, C. difficile bacteria can multiply and produce toxins (poisons), which cause illness such as diarrhoea and fever. |
| Norovirus | Better known as the winter vomiting bug, the most common stomach bug in the UK, affecting people of all ages. The virus, which is highly contagious, causes vomiting and diarrhoea. |
| In-Patient | A patient who is admitted to a hospital or clinic for treatment that requires at least one overnight stay. |</p>
<table>
<thead>
<tr>
<th><strong>NHS Operating Framework</strong></th>
<th>The operating framework for the NHS in England, setting out the business and planning arrangements for the NHS.</th>
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<tbody>
<tr>
<td><strong>RTT – Referral to treatment</strong></td>
<td>Referral To Treatment (RTT) waiting times, which monitor the length of time from referral through to treatment.</td>
</tr>
<tr>
<td><strong>VTE – Venous Thromboembolism</strong></td>
<td>A blood clot (thrombus) that forms within a vein. A classical venous thrombosis is deep vein thrombosis (DVT), which can break off (embolise), and become a life-threatening pulmonary embolism (PE). The conditions of DVT and PE are referred to collectively with the term venous thromboembolism.</td>
</tr>
<tr>
<td><strong>WTE</strong></td>
<td>Whole Time Equivalent (WTE) staff are calculated by aggregating the total number of hours that staff in a grade are contracted to work, and dividing by the standard hours for that grade. In this way, part-time staff are converted into an equivalent number of ‘whole-time’ staff.</td>
</tr>
</tbody>
</table>

### 1.2 Financial terms explained

<table>
<thead>
<tr>
<th><strong>Statement of Financial Position</strong></th>
<th>Shows the Trust’s assets and liabilities at the end of the period</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BPPC</strong></td>
<td>The Better Payments Practice Code requires all valid invoices to be paid within 30 days or other agreed terms</td>
</tr>
<tr>
<td><strong>Cash Flow</strong></td>
<td>The Statement of Cash Flows shows the cash generated and used by the Trust during the period</td>
</tr>
<tr>
<td><strong>Payables</strong></td>
<td>Amounts owed by the Trust to a supplier of goods/services</td>
</tr>
<tr>
<td><strong>CETV</strong></td>
<td>The Cash Equivalent Transfer Value is disclosed for senior managers. This represents the value of their pension at the end of the accounting period</td>
</tr>
<tr>
<td><strong>Current Assets</strong></td>
<td>Inventory, receivables and cash balances</td>
</tr>
<tr>
<td><strong>Receivables</strong></td>
<td>Amounts owed to the Trust for goods/services provided</td>
</tr>
<tr>
<td><strong>Deficit</strong></td>
<td>Where expenditure exceeds income for the period</td>
</tr>
<tr>
<td><strong>Financial Instruments</strong></td>
<td>Financial assets or liabilities due under contract</td>
</tr>
<tr>
<td>Non Current Assets</td>
<td>Land, buildings and equipment owned by the Trust</td>
</tr>
<tr>
<td>--------------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>IFRS</td>
<td>International Financial Reporting Standards are international accounting standards. They are the current guidance used to prepare the Trust’s financial statements.</td>
</tr>
<tr>
<td>Income and Expenditure</td>
<td>The Statement of Comprehensive Income shows all income and expenditure for the period</td>
</tr>
<tr>
<td>Revenue from Patient Care Activities</td>
<td>Refers to income generated from the provision of healthcare to patients</td>
</tr>
<tr>
<td>Other Operating Revenue</td>
<td>Refers to income generated from non-healthcare activity such as education, catering and rents received</td>
</tr>
<tr>
<td>PDC</td>
<td>Public Dividend Capital is issued by the Department of Health based on the originating debt of the Trust and is similar in concept to a public shareholding</td>
</tr>
<tr>
<td>PDC Dividend</td>
<td>The Trust must pay a dividend of 3.5% to the Department of Health based on average net assets during the period</td>
</tr>
<tr>
<td>Prudential Borrowing Limit</td>
<td>This is the maximum amount of borrowing allowed by the Trust at any one time. The Trust is given a long term and short term limit</td>
</tr>
<tr>
<td>Surplus</td>
<td>Where income exceeds expenditure for the period</td>
</tr>
<tr>
<td>Taxpayers Equity</td>
<td>Shows the reserves held by the Trust, including PDC and represents the overall worth of the Trust</td>
</tr>
</tbody>
</table>
2. Introduction from our Chair and Chief Executive

We are pleased to present to you our second annual report as a Foundation Trust and first as Interim Chair and Interim Chief Executive.

Firstly, we would like to thank the public, our stakeholders and staff for their continued support over what has been an incredibly difficult year for the Trust. Whilst the Trust has faced many issues, we believe that the majority of our patients receive good care, day in, day out, from a dedicated team of professionals. However, this Trust has let patients down in a number of areas and this is unacceptable and is being addressed. We want to be clear: providing safe, high quality patient care will always be our priority – we will not preside over unsafe services. All staff are working hard, together with our Clinical Commissioning Groups, to meet national best practice and ensure we have the same standards of care across all of our hospitals.

As the Trust moves forward we want to ensure that the public we serve and our partners recognise the Trust as an open and transparent organisation. As part of our recovery we felt it was important that this introduction provided an honest account of issues over the last year, together providing details and reassurance of the actions being taken to address them.

The last six months has seen a number of significant management changes at the Trust. In November 2011 the Director of Operations and Performance left the Trust, followed by the resignation and departure of the Chair, Professor Eddie Kane in December. In March 2012, four of the non-executive directors also resigned. On the 24 February 2012 we announced that Tony Halsall, Chief Executive was stepping down. The following month, Peter Dyer, the Trust's Medical Director also left. Peter still fulfils his clinical role as Consultant Oral and Maxillofacial Surgeon, as well being involved in a review of education, training and research at our Trust.

REFLECTING ON THE PAST

In July 2011 the Care Quality Commission (CQC) and the Nursing and Midwifery Council (NMC) undertook an unannounced inspection of our maternity services. The CQC published their findings on the 9 September 2011: it showed that University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBT) was found to be ‘compliant’ in four of the ten standards assessed, with ‘major’ concerns in three and ‘moderate’ concerns in three.

The Trust took this report extremely seriously and immediately implemented a series of actions to address the concerns found. Evidence of compliance was submitted to the CQC from the Trust by the required date of 21 November 2011 for inspection. In addition, the Trust took the decision to appoint a team of experts to work with the
Trust: the experts came from a range of different organisations across the country and included a Consultant Midwife and Paediatric Consultants.

Following the publication of the report, the CQC issued a Warning Notice to the Trust in respect of Regulation 10: Assessing and monitoring the quality of service provision.

Foundation Trusts are required, at all times, to remain compliant with their terms of authorisation. This includes ensuring that they meet the required standards in a number of targets and indicators as outlined in Monitor’s Compliance Framework.

As we had received a formal Warning Notice from the CQC this triggered a review as to whether the Trust had breached its terms of authorisation. In October 2011, Monitor confirmed that the Trust was in breach of these terms.

Monitor’s formal intervention notice required the Trust to:

a. Appoint external advisors, to be agreed with Monitor, to undertake a full governance review, including quality governance.
b. Accept the appointment by Monitor of external expert clinical advisors to undertake a diagnostic review of the Trust’s maternity services including their interface with paediatrics.

As part of the intervention from Monitor, PWC, a specialist management consultancy was appointed to undertake the governance review, with consultants from Central Manchester University Hospitals NHS Foundation Trust undertaking the diagnostic review of the Trust’s maternity services.

Two other extremely serious issues came to light near the end of 2011, firstly that the Trust had a higher than expected mortality rate and secondly, that thousands of patients had delayed follow-up outpatient appointments.

HOSPITAL MORTALITY RATES

One of the ways that hospital mortality rates are measured is the Dr Foster Hospital Standardised Mortality Ratio (HSMR). The HSMR is included in the Dr Foster annual hospital guide. The ratio measures deaths of adults whilst in hospital and excludes patients who were on palliative care pathways. To enable comparison each hospital’s score is compared against an average of 100.

At the end of November 2011, Dr Foster reported that Trust had one of the highest mortality rates in the country. The figures suggested that the Trust’s Hospital Standardised Mortality Ratio (HSMR) has increased from 108 in 2009/10 to 124 in 2010/11.

The Trust was very concerned that the Dr Foster figures suggested there had been a significant increase in mortality rates. It has looked very carefully at the detailed
information and has asked its doctors to continually review all deaths within the hospitals to ensure appropriate care was given in each case. The Trust also undertakes clinical audits to identify improvements in clinical care and provides staff with protected time for this.

In December 2011, we invited the Advancing Quality Alliance (AQuA) to undertake a review of mortality across the Trust. In the first of their reports, in January 2012, it would appear that deaths at our Trust had slowly decreased over the last five years, whilst the expected death (calculated) rate had hardly changed. AQuA concurred with our initial findings of issues with the way we have recorded mortality, however it would be complacent to conclude that these were the only contributory factors. A project has been established to fully understand the issues and to ensure our HSMR returns to the correct level, this project is looking at many areas including doctor and nurse ratios per bed, out of hours cover, record keeping, diagnostic accuracy, administration and the discharge process.

**EMERGENCY CARE PATHWAY**

On 17 January 2012 the CQC publicly announced that it was undertaking an investigation into the Trust by virtue of the powers under Section 48 of the Health and Social Care Act 2008.

Section 48 of the Health and Social Care Act 2008 gives the CQC powers to carry out investigations into the provision of English NHS health care and adult social care.

This followed an unannounced inspection visit by the Care Quality Commission (CQC) in the Emergency Department (ED) at the RLI on the evening of Wednesday 21 December 2011.

The Section 48 investigation has focused on the emergency care pathway and is exploring whether there are problems in the Trust’s procedures which need to be addressed in order to achieve future sustainable improvements.

On 6 March 2012 the CQC issued two further Warning Notices relating to issues surrounding the emergency care pathway. The Trust took several immediate actions which included bringing in a mobile operating theatre and extra beds at Royal Lancaster Infirmary which assisted with ensuring that emergency patients are seen as quickly as possible.

Whilst the changes were being made, to immediately provide an additional 34 medical beds, a small number of non-urgent operations were postponed for a short period.

A project is now underway to extend and refurbish the Emergency Department which will also help to address issues of capacity on a sustainable basis. There have been particular pressures at the RLI and we are currently investing £1.5 million in the extension and refurbishment of the Emergency Department. This will put the Trust in
a stronger position to deliver emergency and urgent care services and reduce waiting times for patients, which on occasions we acknowledge have been unacceptable.

TURNING THE TRUST AROUND

A turning point in the year came on 6 February when Monitor again exercised its powers of intervention under Section 52 of the Act to carry out further interventions. This included the appointment of Sir David Henshaw as Interim Chairman, the appointment of a Chief Operating Officer, and the establishment of a Programme Management Office. Monitor also published two highly critical reports following their first formal intervention and a third report into the issues surrounding missed follow-up appointments, copies of the formal intervention notices and reports can be obtained from the Monitor website: www.monitor-nhsft.gov.uk.

We have begun to strengthen the Trust Board with the appointment of an Interim Chief Executive and Juliet Walters has joined the team as Interim Chief Operating Officer. Together with the whole of the Trust Board, we have set about a period of stabilisation and recovery. The stabilisation phase has been focused on ensuring that we are aware of all of the issues and getting them on the table - this has been critical in ensuring safe services.

A considerable amount of work is already underway and we are developing a comprehensive recovery plan for the Trust and when this is complete we look forward to discussing it with local people, our staff and other stakeholders.

The Trust has now established a new robust system of setting up projects/programmes to deliver the actions necessary to meet the requirements of the regulators (Care Quality Commission and Monitor) and to oversee the other areas of improvement activity and cost improvement. The Programme Management Office (PMO) quality assures the project plans, the milestones to delivery and outcomes of all projects. It reports to a Programme Board and through that to the Board of Directors. The issues identified in this introduction are now being overseen by the PMO.

OUTPATIENTS

Around 19,000 patients were affected by the delays in outpatients. All of the urgent and priority patients were seen by the end of last year and most of the remaining patients that needed an appointment were seen by 31 March 2012.

There were about 300 patients who still needed to be seen at the end of March, including some cases where the Trust was arranging additional capacity, people that had other commitments on the dates they were offered appointments and some people it has not been possible to contact yet.
Dealing with the backlog has involved putting on about 1,100 additional clinics.

The key thing now is that we ensure this cannot happen again. We are currently introducing a new booking system which we believe offers a permanent solution to preventing the situation from recurring – ‘booking hubs’.

Some improvements are being made quickly but others will inevitably take longer. The new system of outpatient booking ‘Hubs’ is already running successfully in a number of specialities, including gynaecology, gastroenterology, urology, endocrine and diabetes and dietetic outpatient services.

A clinical lead is involved in each Hub, giving clinicians more involvement in the management of outpatient services. The aim is to have the new system operating for all specialities by the end of May 2012.

Last year saw the return of Chemotherapy services to Westmorland General Hospital (WGH) in Kendal and we remain committed to working with our partners at Lancashire Teaching Hospitals NHS Foundation Trust to bring a state-of-the-art radiotherapy satellite service to Kendal. This would mean easier access, more people having treatment and less travelling time for patients and their families.

Whilst this has been a difficult year, our Council of Governors has remained actively involved in the Trust and continues to represent local constituents with a real sense of purpose and passion. As we further develop and improve the governance arrangements at the Trust, the role of Governors will be pivotal in this, ensuring that appropriate robust challenge of the Board takes place and that they hold the Board to account for its performance.

WHY DID SO MUCH GO WRONG?

We do need to understand this to move forward so that we do not repeat the same mistakes. Many of the issues clearly didn’t happen overnight and may have been there for many years, only coming to light as they became intolerable. What is clear is that there has been a disconnect between managerial decisions and the involvement of clinicians. It is also apparent that we have not worked in true partnership with our commissioners, GPs and other stakeholders, nor have we listened to our patients and acted upon their concerns.

We have recently announced a change in clinical leadership within our hospitals. We are now putting our clinicians in charge of the Clinical Divisions with the appropriate support from managers. After all, who is better placed to deliver services and make changes that benefit our patients than our nurses, allied health professionals, midwives and doctors who treat and care for them every day?
As the Trust moves forward we have a clear vision of where we want to be. We want to be the best – giving excellent compassionate care to the people of Morecambe Bay. This will be achieved by working in partnership with our staff, staff side colleagues, public, Clinical Commissioning Groups and all of our other stakeholders.

This isn’t going to be an easy year, as with the rest of the NHS we still have savings to make. What won’t work is chipping away and cutting year after year, instead, our aim is to deliver services first time, every time – removing the wasted cost in the system.

Once again we would like to thank all of our patients, staff and partners for the continued support and apologise for letting them down in a number of important areas.

SIR DAVID HENSHAW  
INTERIM CHAIR

ERIC MORTON  
INTERIM CHIEF EXECUTIVE
3. Directors’ report

3.1 Principal activities of the Trust

University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBT) was established on 1 October 2010, as a public benefit corporation authorised under the Health and Social Care (Community Health and Standards) Act 2003.

We provide services from three principal sites:

- Furness General Hospital (FGH), Barrow
- Royal Lancaster Infirmary (RLI), Lancaster
- Westmorland General Hospital (WGH), Kendal

In addition, we provide out-patient services at Queen Victoria Hospital (QVH) in Morecambe, Ulverston Health Centre (UHC) and in a range of community facilities.

We serve a dispersed population of 365,000 covering South Cumbria, North Lancashire and surrounding areas.

Our general hospital services consist of:

- 24 hour emergency services
- Intensive, high dependency and coronary care
- Medical services (including general, elderly care, medical oncology, rheumatology and dermatology)
- Surgical services (including general, orthopaedics, ophthalmology, urology, vascular, oral and maxillo-facial)
- Child health
- Maternity
- Gynaecology
- Renal
- Allied health professional services (including physiotherapy and occupational therapy)
- Clinical support services (including pathology and radiology)
We also provide a range of services to the wider population of Cumbria and Lancashire, including:

- Breast screening (for Cancer) - South Cumbria and Lancashire
- Bowel screening (for Cancer) - Cumbria and North Lancashire
- Vascular surgery (emergency) - South Cumbria, North Lancashire and Blackpool

### 3.2 Likely future developments

We have undertaken a significant amount of preparatory work to pave the way for new service developments in future years.

The key developments, by year, are outlined below:

**2011/12**

- Opening of a day-case Chemotherapy Unit to treat cancer patients at Westmorland General Hospital (Summer 2011)
- Launch of a Wet Age-related Macular Degeneration service at Westmorland General Hospital to assist older people avoid blindness (Summer 2011)
- £2.7 M investment into breast services across the Trust with the refurbishment of all three screening units and the introduction of the latest high tech digital imaging equipment
- Launch of new state of the art Telestroke service which transforms and improves the diagnosis and treatment of all stroke patients in Cumbria and Lancashire by providing 24/7 Thrombolysis treatment
- Opening of new, flagship, automated blood science services laboratories at Furness General Hospital and the Royal Lancaster Infirmary which improve, expand and automate laboratory services for patients and GPs
- Introduction of a complex discharge team at the Royal Lancaster Infirmary to provide patients with co-ordinated packages of care in preparation for discharge and help reduce the length of time a patient stays in hospital
- Introduction of a mobile operating theatre and extra beds at the Royal Lancaster Infirmary to help ensure emergency patients are seen as quickly as possible.
2012/13 and beyond

- Announcement of a robust and sustainable turnaround plan which has been developed in conjunction with staff, patients, public, stakeholders and brings Clinical Commissioning Groups (CCGs) into the heart of the Trust
- £1.5m investment for the Emergency Department at the Royal Lancaster Infirmary involving the extension and refurbishment of the department and the development of a new Minor Injuries Unit. Planned to open during 2012/13.
- Review of clinical pathways in partnership with CCGs
- Partnership arrangement with Blackpool Teaching Hospitals NHS Foundation Trust to transform pathology services
- Changing the way clinical service divisions are led, putting clinicians in charge of divisions with managers supporting them
- Further development and rollout of Lorenzo Electronic Patient Record System capability
- Development of a Radiotherapy Satellite Unit at Westmorland General Hospital, in partnership with Lancashire Teaching Hospitals NHS Foundation Trust (subject to business case approval)
- Remodelling of the Royal Lancaster Infirmary site to improve patient flow and efficiency (subject to business case approval)
- Introduction of an Electronic Document Management System (EDMS) to digitalise patient records and make them available on a 24 hour basis via desktop computers (subject to business case approval).
Directors of the Foundation Trust

Directors of the Foundation Trust during 2011/12 financial year
Between 1 April 2011 and 31 March 2012, the Board of Directors consisted of:

Sir David Henshaw
Interim Chair appointed from 06/02/12

Ian Tomlinson
Non-Executive Director/Senior Independent Director/Deputy Chair and Acting Chair (from 13/12/11 to 05/02/12)

Professor Eddie Kane
Chair to 12/12/11

Eric Morton
Interim Chief Executive from 19/03/12

Tim Bennett
Deputy Chief Executive/Director of Finance and Information and Acting Chief Executive (from 25/02/12 to 18/03/12)

Tony Halsall
Chief Executive to 24/02/12

Patricia Thomas, Non-Executive Director to 31/03/12
Frank McLaughlin, Non-Executive Director to 31/03/12
Dr June Greenwell, Non-Executive Director to 15/03/12
Denis Lidstone, Interim Non-Executive Director from 13/03/12
Niven Ballantyne, Non-Executive Director to 29/02/12
Stephen Smith, Non-Executive Director/Senior Independent Director/Deputy Chair to 30/11/11

Peter Dyer, Medical Director to 31/03/12
Jackie Holt, Director of Nursing and Modernisation
Patrick McGahon, Director of Commercial and Service Development
Roger Wilson, Director of Human Resources and Organisational Development
Steve Vaughan, Director of Operations and Performance to 02/12/11

New appointments have been made and take effect in the financial year 2012/13:

Professor Anne Garden, Non-Executive Director from 02/04/12
George Nasmyth, Medical Director from 01/04/12
Juliet Walters, Interim Chief Operating Officer from 02/04/12
3.3 Board of Directors

The Board of Directors has overall responsibility for implementing our strategy and ensuring that performance meets national and local objectives and targets.

During 2012, the Trust will be inviting applications for a permanent Chair and Chief Executive with the experience and proven, successful track record in leading a multi-site, acute NHS Foundation Trust. We want to recruit the best as our Trust aims to deliver safe, excellent compassionate care to the people of Morecambe Bay – we want them to share and believe in this vision and have the desire to make this a reality for all of our services.

At the end of the financial year, there were also four Non-Executive Director vacancies and the recruitment process is well underway. Despite the past, these crucial roles come at an exciting time of progress and development. We are looking for outstanding individuals to serve as Non-Executive Directors and make a personal contribution to the governance of this ambitious Foundation Trust. We aim to have appointed to these positions by June 2012.

Our current Non-Executive Directors have skills and experience in a range of areas including management, programme management, business improvement, audit, law, international business, gynaecology, research and IT.

The Interim Chief Executive provides strong, effective and visible leadership with a proven track record of leading a highly successful NHS Foundation Trust, and acting as a previous Interim Chief Executive.

MONITORING PERFORMANCE

The Trust Board monitors progress against the strategic objectives, receiving regular performance reports on key operating areas. The delivery of the required standards in each of these areas is the responsibility of members of the Executive Team. An Integrated Board Performance Report is in place bringing together a range of indicators. This enables performance to be measured against key national and local targets and provides the necessary assurance in the following areas:

- Activity and access (national targets, activity, waiting lists and productivity)
- Safety, effectiveness and patient experience
- Human resources
- Finance – including Monitor’s risk ratings
The Board has a number of committees to help in discharging its duty effectively (see Committee Arrangements, pages 36). This enables more detailed discussion and examination of specific issues.

As part of the ongoing process to strengthen the performance of the Board, collectively and individually, a Board Development Framework is in place. The framework is used as the basis of training activities and forms an important component of succession planning.

APPRAISAL

An appraisal process is in place for all Board members. The Chief Executive carries out performance reviews of Executive Directors and the Chairman appraises the Chief Executive. The appraisal outcomes are considered by the Board of Directors’ Nominations Committee when considering pay increases in relation to performance.

The Chair undertakes the performance review of the Non-Executive Directors, to be reported via the Council of Governors’ Nominations Committee. The performance review of the Chair is conducted as agreed by the Council of Governors’ Nominations Committee. The outcome will be reported via the Nominations Committee to the Council of Governors.

As part of reviewing governance arrangements, the terms of reference and operations of both the Executive Directors’ Group (formerly known as the Chief Executive’s Group) and Hospital Management Team have been revised and re-launched together with the appropriate administrative support.

Council of Governors
The Council of Governors (CoG) continue to be kept appraised of our performance throughout the financial year. A range of discussions on strategic and operational issues take place with Governors at their quarterly meetings. Many of the Governors have described a feeling of “us and them” in the past. We have listened to them and agreed a programme of improving relationships and better understanding of roles and responsibilities of the CoG and the Trust Board. Whilst it is early days, good progress has been made and we look forward to their continued input, challenge and support.

Hospital Management Team
The Hospital Management Team (HMT) is the operational and performance engine room across the organisation with responsibility for operational and financial performance issues, approving non-clinical policies, considering service changes, overseeing health and safety matters, examining business cases and addressing cross-divisional issues. Its membership consists of Executive Directors, Divisional
Clinical Directors and Divisional General Managers. It is chaired by the Chief Operating Officer. HMT meets monthly.

**Executive Directors’ Group (EDG)**
This Executive Directors’ committee is not a committee of the Board of Directors but a forum that meets weekly to receive assurance on those operational and performance issues delegated to the Executive Directors and to develop the Trust strategy, both of which will usually be subject to further discussion at the Board of Directors. Its membership consists of the all of the Executive Directors of the Trust with support from the Assistant Chief Executive. The EDG rotates around each of our three main sites, with the team visiting wards and departments on the remainder of the day.

**Clinical Management Team**
The Clinical Management Team has operational and organisation-wide responsibility for clinical processes (i.e. reviewing/approving clinical policies, considering national/local clinical reports, mortality reports, research and clinical audit, inquests, clinical education and training, revalidation and professional registration issues) providing overview, scrutiny and assurance on these issues as necessary. Its membership consists of representatives from each Division together with the Chief Nurse and Medical Director.

**Programme Management Office**
A Programme Management Office (PMO) has been established to help the Trust effectively manage the various ongoing projects to address the issues raised by the regulators. It is responsible for setting up and overseeing all projects that are going on across the Trust to deliver improvements to services and cost improvements.

The PMO is playing a key role in helping the Trust to improve the efficiency and strength of the organisation and helping us to meet the strategic aims that we have set ourselves. It will also provide the necessary assurance and confidence that our approach is in the best interest of our patients. It is about changing how we do business for the long term and will play a critical part in the success of the Trust.

**Other Performance Management Processes**
As part of our Performance Framework, we have indicators to assist with monitoring the strategic objectives, and divisions are accountable for the delivery of them.

Regular review meetings take place between the Executive Directors’ Group and individual divisions to monitor progress, so that early action can be taken to address issues. This framework allows a consistent and comprehensive approach across all departments, and ensures we are meeting our clinical quality, finance and governance obligations.
3.4 Board members 2011/12

Board Members 2011/12

Sir David Henshaw, Interim Chair
(Appointment from 6 February 2012)

Sir David Henshaw became Chair of UHMBT in February 2012. Alongside his role at UHMBT, Sir David is Chair at Alder Hey Children’s NHS Foundation Trust. Prior to his role at Alder Hey, Sir David was Chair of NHS North West for four years. Amongst his many achievements, he was responsible for the review of the child support system in the UK in 2007. He was also involved in the Prime Ministers Delivery Unit Capability Review programme of central government departments.

Alongside his valuable experience within the health arena, Sir David has worked in local government for most of his career. He spent ten years at Knowsley Borough Council before spending seven years as Chief Executive of Liverpool City Council. He is also a Non-Executive Director for a number of other public and private organisations including the Chair of Manchester Academy for Health Sciences and Non-Executive Director for Albany Investment PLC.

Board meeting attendance:
Two out of a possible two

Board of Directors’ Nominations Committee meeting attendance:
No meetings have taken place since appointment

Council of Governors’ attendance: One out of a possible one

Council of Governors’ Nominations Committee: Two out of a possible two

Mr Ian Tomlinson
(Appointment from 1 October 2010 to 14 December 2012)

Deputy Chair/Senior Independent Director

Ian has extensive commercial experience in major IT organisations with strategic and senior level IT and marketing experience, together with comprehensive project management skills, including consultancy work on the NHS national IT project.

Chair of the Audit Committee (Member of the Clinical Quality and Safety and remuneration Committees)

Board meeting attendance:
Five out of a possible five
Audit Committee attendance:
Five out of possible six
Clinical Quality and Safety Committee:
Six out of possible six
Board of Directors’ Nominations Committee meeting attendance:
Two out of possible two
Council of Governors’ attendance:
Two out of a possible two
Council of Governors’ Nominations Committee:
Two out of a possible two

Professor Anne Garden
(Appointment from 2 April 2012, with a period of induction from February 2012)

Anne brings with her a wealth of clinical expertise and insight from a career spanning nearly 40 years in the health service and higher education. Currently Head of Lancaster Medical School in the Faculty of Health and Medicine at Lancaster University, one of Professor Garden’s main areas of expertise is Quality Assurance in Medical Education, having served as a Quality Assurance Agency Subject Specialist Reviewer for Medicine from 1998 to 2001.

She is now one of the Team Leaders for the General Medical Council’s Quality Improvement Framework and a member of Council of the newly formed Academy of Medical Educators.

Anne was previously Head of the School of Medical Education at the University of Liverpool, where she developed an interest in paediatric and adolescent gynaecology, setting up a service for the sub-specialty based at Alder Hey Children's Hospital. She has written two books on the subject.

Board meeting attendance:
Two out of a possible two

Mr Denis Lidstone
(Appointment from 13 March 2012 to 13 July 2012)

Denis took up the post as Interim Non-Executive Director in March 2012 for a period of four months on an NHS secondment. He is a highly experienced practitioner in programme management projects in both the public and private sector.

His appointment adds a wealth of knowledge and expertise to the board, with
previous roles including Partnering Director at BAE Systems and director of the UK Council for Electronic Business.

In a career which has spanned 35 years, Denis was employed initially as an electrical design engineer at the Barrow shipyard before undertaking a number of specialised roles in the defence sector. He has also stood as a non-executive director of NHS North of England.

**Board meeting attendance:**
*Two out of a possible two*

**Executive Directors**

**Eric Morton, Interim Chief Executive**  
*(Appointment from 19 March 2012)*

Eric took up post as Interim Chief Executive in March 2012, after his role as Chief Executive at Chesterfield Royal Hospital NHS Foundation Trust between 2001 and March 2012, having previously been employed by the Chesterfield Royal Hospital as their Deputy Chief Executive. He joined the NHS in 1987 and previous posts include Director of Finance at North Derbyshire Health Authority.

He is past Chairman of the Healthcare and Financial Management Association. In 2009, Eric was also appointed as the Interim Chief Executive of Mid Staffordshire NHS Foundation Trust.

**Board meeting attendance:**
*One out of a possible one*

**Tim Bennett, Deputy Chief Executive / Director of Finance and Information**

Tim Bennett joined the Trust in April 2005. He has 20 years of financial experience within the NHS at the Cardiothoracic Centre Liverpool NHS Trust and Wigan and Bolton Health Authority. Tim successfully led the turnaround in our Trust's financial performance from a deficit of £6.5m to a surplus of £2.9m within two years. He’s a former chair of the Healthcare Financial Management Association (North West branch) - the leading industry voice on NHS finance matters.

**Board meeting attendance:**
*Four out of a possible five*

**Clinical Quality and Safety Committee:**
*Six out of a possible six*

**Audit Committee meeting attendance:**
Six out of a possible six

Juliet Walters, Interim Chief Operating Officer
(From 2 April 2012)

Juliet was previously on secondment to Mid Yorkshire Hospitals NHS Trust from Cambridge University Hospitals NHS Foundation Trust (Addenbrooke’s) where she was undertaking the role of Director of Productivity as part of an interim support team. She was appointed as Director of Operations at Addenbrooke’s in 2008 with responsibility for the operational management of the Trust including strategic service improvements and quality.

Prior to Addenbrooke’s, Juliet has held a number of senior management positions with a strong, successful track record of delivery, including Deputy Chief Executive (Operations) at East and North Hertfordshire NHS Trust and Deputy Director/Acting Director of Business and Development at Newcastle upon Tyne Hospitals NHS Foundation Trust.

George Nasmyth, Medical Director
(From 1 April 2012)

George was appointed to Furness General Hospital as a Consultant General Surgeon with a colorectal interest in 1991. After training in Oxford and London, he slowly moved north, via Leicester where he obtained his surgical fellowships and Leeds where he was awarded the Patey Prize of the Surgical Research Society for his work on the functional outcomes of sphincter saving surgery for ulcerative colitis, and a MS degree for his thesis. He went on to complete his higher surgical training in Liverpool, where he was also Chairman of the Mersey Hospital Junior Staff Committee. As well as establishing a colorectal practice in Furness, he has had management roles as Chairman of the Furness Medical Staff Committee, and later as Clinical Director for Surgery and Associate Medical Director for the Division of Surgery and Critical Care. He has also pursued an interest in Postgraduate Medical Education and after holding the post of Clinical Tutor at Furness General Hospital, he was appointed an Associate Postgraduate Dean in 2002 and continues in the latter role.

Jackie Holt, Director of Nursing and Modernisation
(As of 20 May 2012 Director of Nursing and Midwifery/Chief Nurse)

Jackie became a member of the Executive Team and Trust in August 2008. She joined the NHS in 1982 as a Registered General Nurse and has moved through the nursing ranks and into clinical and general management, working in acute and
specialised hospitals in Cheshire and Merseyside. In her previous post, Jackie held board positions in two different roles; Director of Nursing and Governance and Foundation Trust Programme Director. In 1996, Jackie completed her Master’s Degree in Management at Manchester Metropolitan University.

**Board meeting attendance:** Five out of a possible five  
**Clinical Quality and Safety Committee:** Six out of a possible six  
**Council of Governors attendance:** Two out of a possible four

Roger Wilson, Director of Human Resources and Organisational Development

Roger started with the Trust in July 2007. Formerly, he was the Director of Workforce and Learning at the 5 Boroughs Partnership NHS Trust. He joined the NHS in 1987 as a Graduate Finance Trainee at Mersey Regional Health Authority and has worked in many different areas of the NHS, including oncology, mental health and learning disability sectors. He has a Diploma in Strategic Human Resource Management from Manchester Business School and he is a Fellow of the Chartered Institute of Personnel and Development.

In attendance at the Council of Governors’ Nominations Committee.

**Board meeting attendance:** Five out of a possible five  
**Clinical Quality and Safety Committee:** Three out of a possible six

Patrick McGahon, Director of Service and Commercial Development

Patrick commenced in post in July 2007. He previously held the posts of Turnaround Director and various Director of Finance posts in Primary Care Trusts, Acute, Mental Health, Ambulance and not-for-profit sectors. He is a qualified accountant, has a Master’s in Business Administration (MBA) and a BA (Econ) (Hons) in Accountancy and Econometrics.

**Board meeting attendance:**  
Four out of a possible five
Board members who left their positions in 2011/12

Professor Eddie Kane, Chair
(Appointment from 1 October 2010 to 12 December 2011)

Professor Kane has held a wide range of positions in the NHS, Local Government and private and higher education sectors, including Chief Executive of West London Healthcare NHS Trust, NHS Trust Unit Director for North West Thames, National Director of High Security Psychiatric Services, Director of NHS Services West London and Director of Mental Health Services for London.

Professor Kane left the Trust on 12 December 2011.

**Board meeting attendance:**
Four out of a possible five

**Board of Directors’ Nominations Committee meeting attendance:**
Two out of a possible two

**Council of Governors attendance:**
Two out of a possible two

**Council of Governors’ Nominations Committee:**
One out of a possible one

Mr Stephen Smith (appointment from 1 October 2010 to 30 November 2011)
Deputy Chair/Senior Independent Director

A mechanical engineer by training with a first class degree in Engineering Science from Cambridge, Stephen is a senior administrator for Liverpool University’s Faculty of Medicine. Before this, he held a similar position at the University of Manchester and has had posts in senior management in various commercial organisations. He has specific skills in delivering change management through the development of sound structures and processes and through the leadership and motivation of teams.

Stephen left the Trust on 30 November 2011.

(Member of the Audit, Clinical Quality and Safety and remuneration Committees)

**Board meeting attendance:**
Four out of a possible five

**Audit Committee attendance:**
Four out of a possible four

**Clinical Quality and Safety Committee:**
One out of a possible four
Board of Directors’ Nominations Committee meeting attendance:
Two out of a possible two

Dr June Greenwell
(Appointment from 1 October 2010 to 15 March 2012)
Deputy Chair/Senior Independent Director

June has worked for the NHS and in education in many different roles, both in the UK and abroad. Early in her career, she was one of the team caring for the UK’s first renal transplant patient. More recently, she was employed by the former South Cumbria Health Authority as a community nursing research project manager.

June was awarded a PhD for her work in examining different approaches to hospital restructuring. She has worked on various research projects, including studies of the economic and social costs of domestic violence in the UK, nurse retention rates in North West NHS Trusts and inter-professional collaboration and conflict in health care. June was a lecturer and subsequently honorary research fellow at Lancaster University’s Social Science department.

June left the Trust on 15 March 2012.

Chair of the Clinical Quality and Safety Committee. (Member of the Audit and remuneration Committees)

Board meeting attendance:
Five out of a possible five
Audit Committee attendance:
Four out of a possible six
Clinical Quality and Safety Committee:
Six out of a possible six
Board of Directors’ Nominations Committee meeting attendance:
Two out of a possible two

Mrs Patricia Thomas
(Appointment from 1 October 2010 to 31 March 2012)

Patricia is a retired Local Government Ombudsman and Vice-chairman of the Commission for Local Administration in England. She has extensive experience in governance, law and organisational change. Patricia previously held a range of law posts at the University of Leeds and University of Illinois, most recently in the post of Professor of Law at Preston/Lancashire Polytechnic.
She was a part time member of the Administrative Justice and Tribunals Council (2005 to 2010) and the Disciplinary Committee of the Chartered Institute of Management Accountants (2005 to 2008).

Patricia’s voluntary and community activities include being a Governor at Lancaster and Morecambe College of Further Education including Chair of Audit Committee and membership of the Search and Governance Committee.

Patricia left the Trust on 31 March 2012.

(Member of the Audit, Clinical Quality and Safety and remuneration Committees)

**Board meeting attendance:**
Five out of a possible five.

**Audit Committee attendance:**
Six out of a possible six

**Clinical Quality and Safety Committee:**
Six out of a possible six

**Board of Directors’ Nominations Committee meeting attendance:**
Two out of a possible two

Mr Frank McLaughlin  
(Appointment from 1 October 2010 to 31 March 2012)

Frank has worked for many national and international companies, guiding them through major changes and developments. He currently sits on the Independent Monitoring Board at a local prison, overseeing fairness, justice and humanity. He has a great deal of experience in international defence and in 2002, set up his own management company within the industry.

Frank left the Trust on 31 March 2012.

(Member of the Audit, Clinical Quality and Safety, and remuneration Committees)

**Board meeting attendance:**
Four out of a possible five

**Audit Committee attendance:**
Five out of a possible six

**Clinical Quality and Safety Committee:**
Six out of a possible six

**Board of Directors’ Nominations Committee meeting attendance:**
Two out of a possible two
Mr Niven Ballantyne  
(Appointment from 1 October 2010 to 29 February 2012)

Niven is a Scottish Chartered Accountant and a commercially aware senior executive with extensive financial and general management skills gained throughout many years with large PLC companies, including 3i, Bass Group and Luminar Leisure. He is skilled in mergers and acquisitions, property investment and contract negotiations. Niven also runs his own investment pub company.

Niven left the Trust on 29 February 2012.

Chair of the Audit Committee  
(Member of the Clinical Quality and Safety and remuneration Committees)

**Board meeting attendance:**  
Four out of a possible five

**Audit Committee attendance:**  
Six out of a possible six

**Clinical Quality and Safety Committee:**  
Six out of a possible six

**Board of Directors’ Nominations Committee meeting attendance:**  
Two out of a possible two

Steven Vaughan, Director of Operations and Performance  
(To 2 December 2011)

Steven commenced in post in October 2007. During his career with the NHS, he has gained substantial experience in finance, project and operational management across both acute and commissioning sector organisations. Steven is a CIMA qualified accountant and has a Postgraduate Certificate in Health Operational Research and Management Science.

Steven left the Trust on 2 December 2011.

**Board meeting attendance:**  
Four out of a possible four

**Clinical Quality and Safety Committee:**  
Three out of a possible four
Peter Dyer, Medical Director
(To 31 March 2012)

Peter was the Trust’s Medical Director and is a Consultant in Oral and Maxillofacial Surgery. He joined the Trust in 1998 and became the lead clinician for head and neck services shortly after that. He subsequently became the Clinical Director for Surgery, a post he held for two years before being appointed as Medical Director in April 2006.

Peter stepped down from his role as Medical Director on 31 March 2012.

**Board meeting attendance:**
Four out of a possible five

**Clinical Quality and Safety Committee:**
Five out of a possible six

Tony Halsall, Chief Executive
(To 24 February 2012)

Tony joined the Trust in 2007 and was instrumental in leading the Foundation Trust application. Tony joined the NHS in 1980 and has held a range of posts in both clinical and managerial roles. He was previously the Chief Executive of Clatterbridge Centre for Oncology NHS Foundation Trust providing high quality cancer services across Merseyside and Cheshire. Tony is a member of the Institute of Health Service managers and is currently studying for an MA in Leadership and Learning.

Tony left the Trust on 24 February 2012.

In attendance at the Board of Directors Remuneration and Terms of Service Committee.

**Board meeting attendance:**
Five out of a possible five

**Council of Governors’ attendance:**
Four out of a possible four

**Process for the appointment and removal of Non-Executive Directors**

Appointments to the posts of Non-Executive Directors are the responsibility of the Council of Governors. In line with the Trust’s Constitution, a Council of Governors Nominations Committee is in place to oversee the process and make recommendations on such appointments to the full Council. The procedure for the removal of the Chair and Non-Executive Directors is as set out in the Trust Constitution. A copy of our constitution can be obtained from our website: www.uhmb.nhs.uk.
Statement of compliance with the NHS Foundation Trust Code of Governance 2011/12

The Board of Directors and the Council of Governors of the University Hospitals of Morecambe Bay NHS Foundation Trust recognise the importance of good corporate governance, as described in the NHS Foundation Trust Code of Governance published by Monitor in March 2010. Extensive work in the area of governance has been undertaken in 2011/12 following external regulatory reviews. This work will ensure compliance against the Code and ongoing adherence to its provisions.

3.5 Register of interests

All members of the Board of Directors have a responsibility to declare relevant interests, as defined in the Trust Constitution. These declarations, together with the Chairman’s other significant commitments, are made known to the Trust Secretary, reported formally to the Board of Directors and entered into a register, held by the Company Secretary, which must be available to the public. Declarations are available for viewing at Trust Headquarters, Westmorland General Hospital, Burton Road, Kendal, Cumbria, LA9 7RG or by contacting the Company Secretary by email: trustHQ@mbht.nhs.uk or 01539 716684.
3.6 Committees

As part of turning the Trust around we have reviewed the governance processes in the organisation and the committee structure for providing assurance to the Trust Board. As a result of this comprehensive and detailed review, a revised, robust committee structure is being established for 2012/13 and beyond.

The new committees all have revised terms of reference and the appropriate infrastructure. A chart is provided on page 38 depicting their relationships.

Audit Committee
The Audit Committee’s role is to review, on behalf of the Board of Directors, that the Trust has effective processes in place to manage and oversee the systems necessary for integrated governance, risk management and internal control (i.e. financial and clinical management). The Audit Committee is informed by reports of the Trust’s systems and processes prepared by both internal and external auditors. Its membership is drawn solely from Non-Executive Directors (excluding the Chair).

Charity Corporate Trustee Committee
The Charity Corporate Trustee Committee’s role is to allocate, manage and monitor the use of the Trust’s charitable funds in a manner that is prudent and complies with relevant trustee and charity legislation. Its membership consists of the Chair, the Board of Directors and representatives from each of the five clinical divisions.

Clinical Governance & Quality Committee
The Clinical Governance & Quality Committee provides a focus for clinical governance, quality and patient safety issues on behalf of the Board of Directors. It oversees clinical performance and ensures that the Trust responds to clinical issues raised via national/local reports, patient surveys, serious untoward incidents, clinical incidents and inquests. Its membership consists of two Non-Executives (one as Chair), the Chief Nurse, Medical Director and Chief Operating Officer.

Finance & Performance Committee
The Finance & Performance Committee oversees the financial performance of the Trust and the negotiation of contracts (and performance of these contracts) with commissioners, providing assurance or raising concerns with the Board of Directors as necessary. Its membership consists of three Non-Executives (including the Chair of the Audit Committee) and the Director of Finance.

Remuneration & Nominations Committee
The Remuneration & Nominations Committee oversees the appointment of the Trust’s Chief Executive/Executive Directors and agrees the remuneration and terms of services of the Chief Executive/Executive Directors and any staff employed by the
Trust whose terms of service who are not covered by national agreements. Its membership consists of the Chair and Non-Executive Directors and the Chief Executive (who is excluded when discussing his/her terms of service).

There is a separate committee that deals with the recruitment, appointment and terms and conditions of the Chair and the Non-Executive Directors. For more information, see 85.

**Risk Committee**
The Risk Committee oversees the development of, and compliance with, the Trust’s risk management systems and processes, using them to provide assurance to the Board of Directors that risks are identified and that action plans are developed to mitigate these risks and ensure ‘strategically significant’ risks are considered by the Board of Directors. Its membership consists of the Chair, the Chairs of the Audit, Clinical Governance and Quality, and Finance and Performance Committees together with the Chief Executive and Chief Operating Officer.

**Counter Fraud arrangements**
We are required to ensure that we comply with all requirements, guidance and advice of the Counter Fraud and Security Management Service. We have an identified counter fraud specialist, who has undergone appropriate training and the Audit Committee is responsible for approving and monitoring progress against the Annual Counter Fraud Work Plan.
3.7 Research and development

In April 2012 we announced that the eminent Professor Sir George Alberti is to undertake a review of Research and Development (R&D), education and training at UHMBT.

It is a testament to the level of future ambition of the Trust that a highly experienced and respected clinician of Professor Alberti’s stature has agreed to work with UHMBT.

Unfortunately due to circumstances out of Professor Alberti’s control, he is now unable to undertake this work. We will be speaking to a number of senior national recognised specialists to undertake this important review.

The Trust wants ‘university’ in its name to be more than just a title. It is vital that it applies the same academic rigour and standards of excellence to R&D and learning as the very best universities.

This work is now expected to commence in the summer of 2012 and take around two months to complete. During this process, the Trust will ensure that staff, patients and stakeholders are kept informed of progress and the final outcomes.

**Significant activities in the field of research and development**

During 2011/12 the trust has been engaged in 125 active studies, 52 of which were approved to open in this period.

### Research Projects

- **67%** NIHR Portfolio
- **15%** University led
- **10%** Student projects
- **8%** In house
Commercial activity
Commercial clinical trials activity has increased over the last year:

- The musculo-skeletal department has successfully run two commercial trials, with one of them recruiting double the original number of agreed patients, a further three commercial studies have been set-up
- Recruitment continues to a commercial cardiology trial
- Follow up activity to a commercial oncology trial continues
- The Trust took part in its first diabetic clinical trial in 2011/12.

New Areas of Activity

- Recruitment to NIHR portfolio paediatric trials commenced in February 2011 and 25 patients have been recruited
- Trials in urological oncology are being established
- NIHR portfolio neurology trials have opened.

Research Practitioners
The Trust employs 12.89 (WTE) research practitioners, who are funded by the Cumbria and Lancashire Clinical Research Network and the Lancashire and South Cumbria Cancer Research Network; they cover the following specialties: cardiology, childbirth and reproductive health, critical care, dermatology, diabetes, gastroenterology, musculoskeletal, neurology, oncology, paediatrics and stroke.

Research Grants
Professor Andrew Smith was successful in applying for a European Society of Anaesthesiology (ESA) Meta-Analysis Grant entitled “A meta-analysis of enhanced recovery programmes in surgical patients.” The grant is for €19,400.

Developing research at UHMBT
Funding has been earmarked from the SIFT budget to fund one PhD project at £25,000 per annum starting in October 2012. The project will be supervised by Dr Marwan Bukhari, consultant rheumatologist, and a University lecturer. SIFT will also fund up to six MSc degrees for intercalating medical students from October 2012.

Lancaster Patient Safety Research Unit
Work has now started on the Cochrane Collaboration Programme grant reviews on the safety and quality of perioperative care (NIHR, 2011-2014, £420,000.)

Recent findings from unit researchers were presented to Sir Liam Donaldson, Chairman of the National Patient Safety Agency, at a meeting at the Royal Lancaster Infirmary in November 2011.
Analyses of incident reports in anaesthesia have been fed back to anaesthetists and published in speciality journals.
3.8 Staff engagement

We know we need to make significant improvements across all our hospitals. The success of the NHS depends above all on the people who work in it, from the doctors and nurses on the front line through to the porters and administrative staff. It is only by making our hospitals great places to work that we will also be able to deliver the best quality patient care.

It is now four years since the introduction of our People Strategy in 2007. The results of the recent staff survey (published March 2012) indicate we have made some small gains in areas of communication and engagement with our staff and in others we have not progressed as we had planned. In summary, we must, over the coming years see significant improvements in the results of the staff survey and feedback back from staff.

We have implemented a series of engagement activities to ensure our staff are communicated with on the performance of the Trust; they now include regular face to face briefings with staff, delivered by senior executives including the Chair and Chief Executive. Key briefings are also video recorded and made available for all staff via the staff intranet, together with Team Briefings by managers to ensure important updates are cascaded throughout our hospitals. We also make good use of social media with all key public announcements being posted on Facebook and Twitter.

Communication and engagement activities aim to provide our staff with the opportunity to give feedback on performance and changes. We now have a number of ways to do this, in person at briefings, via team meetings, a dedicated email address for suggestions and a discussion forum on the staff intranet – in addition, there is a programme to ensure that the executive team are visible on the wards, corridors and offices of our hospitals and staff are encouraged to provide feedback and suggestions directly to the Chair and Chief Executive if they wish. All feedback is reviewed, responded to and where possible, acted upon.

Awards and recognition

We host three annual events to recognise the hard work and dedication of our staff. At our Long Service Awards, we recognise those staff members who have achieved 25, 35 and 40 years’ service with our Trust and in the NHS. The Staff Achievement Awards celebrate the learning achievements of our staff whilst the Pride of the Bay Awards are a chance for staff to nominate colleagues for outstanding work.

The Pride of the Bay Awards give staff the opportunity to nominate their colleagues in six categories. Members of the public can nominate staff who they consider should be recognised for going the extra mile for patients in the Patients Champion category.
The categories for nomination are:

- People’s Champion
- Quality Champion
- Patient Experience Champion
- Innovation Champion
- Patients Champion
- Office Champion
- Chief Executive’s Champion

We are in the process of reviewing our rewards programme; Whatever the outcome of the review, we are committed to celebrating and recognising where our staff go the extra mile for our patients, in all its forms and at all levels.

**Consulting with our colleagues**

We have a number of ways to consult and receive feedback from all of our staff.

- A weekly news publication is distributed to all staff by email, with hard copies for those staff without regular access to email / for notice boards
- Corporate Communications emails – urgent or important messages sent to all staff and for staff notice boards
- Trust Notification emails – messages about technical issues that directly affect patient care or a matter of operational importance that affects the smooth running of the Trust
- A monthly Team Brief is produced and distributed to all Heads of Departments and Directors for discussion with their staff. Team Brief includes key performance standards and targets - both financial and non-financial, together with key updates on services developments and any contractual proposals or changes
- Regular face to face monthly staff briefings delivered by the Interim Chair and Chief Executive with Q&A sessions and shared by video to all staff
- Dedicated email address for feedback and suggestions, together with an innovative online (intranet) forum for staff to ask questions and receive shared feedback
- Engagement through focus groups to obtain staff, patient and Clinical Commissioning Groups ideas on immediate, environmental change that could be made to the hospitals to enhance patient care and experience (commenced May 2012).
All staff members are encouraged to become involved in aspects of the Trust, with the opportunity to stand to be elected as a Staff Governor. These positions allow staff to strengthen the link between communities and the decision making process.

**Partnership working with our staff**

We are committed to effective partnership working with staff and staff side representatives. To deliver partnership working successfully, it is important to develop good formal and informal working relations that build trust and share responsibility, whilst respecting differences. For us, partnership means a relationship in which we are jointly committed to the success of whatever process or project we are engaged in. To facilitate this, we have agreed with staff side to adopt the following principles when dealing with each other:

- Building trust and a mutual respect for each other's roles and responsibilities
- Openness, honesty and transparency in communications
- Top level commitment
- A positive and constructive approach
- Commitment to work with and learn from each other
- Early discussion of emerging issues and maintaining dialogue on policy and priorities
- Commitment to ensuring high quality outcomes
- Where appropriate, confidentiality and agreed external positions
- Making the best use of resources
- Ensuring a no surprise culture

These principles are taken from the nationally agreed Partnership Agreement between the Department of Health, NHS Employers and NHS Trade Unions. We have also developed our own Respect Charter which sets out how we should behave towards each other.

The membership of the Trust Partnership Forum consists of current Joint Negotiation and Consultation Committee attendees from the Board and Staff Side along with all Staff Governors. A Joint Local Negotiation Committee colleague is also formally invited to join the Trust Partnership Forum. As a Foundation Trust, staff governors are now full members.

We have an Employee Relations Framework which details the consultation and negotiation procedures in place with recognised staff organisations.
Employment policies
We develop our policies in conjunction with our Staff Side Partnership Forum. This ensures that we have widely consulted and considered a variety of views to ensure consistency and fairness. We have a wide range of policies to support our staff from joining our Trust through to their on-going professional development and ensuring a positive work-life balance, including:

- Equality and Human Rights Policy
- Recruitment and Selection Policy
- Dignity and Respect at Work
- Sickness Absence Policy
- Supporting Staff Policy
- Redeployment Policy
- Performance Improvement Policy
- Mandatory Training Policy
- Appraisal and Development Review
- Staff Induction Policy
- Work Life Balance Policy
4. Business review

4.1 Morecambe Bay Hospitals Charity

Despite the continuing economic uncertainty Morecambe Bay Hospitals Charity continues to receive loyal support from the community. We are proud of the links we have forged with charities, businesses and individuals. This year the Charity has been able to utilise these charitable donations to enhance the work carried out by University Hospitals of Morecambe Bay NHS Foundation Trust.

For the first time this year the Trustees held Engagement Days at each of our hospitals to which our supporters were invited. This gave our Trustees the opportunity to meet and personally thank our volunteers and supporters.

We have several connected charities supporting our local hospitals, for which we are extremely grateful. During this past year their loyalty has been steadfast and as a result donations to the Charity have made a tangible difference. Here are some examples of ways in which these charities made a difference.

Westmorland General Hospital League of Friends funded equipment and services including,

- Hydrotherapy Pool Hire, Bladder Scanner, Broadcasting equipment for Hospital Radio, RF Lesion Generator, Streamline Couch and 12 Chairs.

Hospital Equipment Fund for Furness (HEFF) very generously agreed to purchase several items including a Portable Suction Unit, 2 Vital Signs Checkers, 2 Probes and 5 Volumetric Pumps.

Friends of Royal Lancaster Infirmary were once again extremely supportive and made funding available for a Recliner Chair, 2 Armchairs and Settee, 6 Pericalm Pelvic Floor Stimulation Units, Syringe Drivers and Pumps, Personal Alarm System, 3 Sorrento Chairs, 4 Patient Trolley Mattresses, 2 Rapose Companion Sets.

Lancaster and District Special Care Baby Unit Trust Fund who agreed to improvements to the Neonatal Unit and furniture.
Supporting charities this year include:

Rosemere Cancer Foundation
Aromatherapy treatments, literature holders and annual magazine subscriptions

Heart Concern
Dell projector

Sight Savers
Orthotic items

The Jubilee Trust
Operating table

Morecambe Bay Renal Patients Association
Body Composition Monitor, electrodes and cards

The donations and help we receive is never underestimated. With your continued help we can make a difference together, by providing the best possible standards of treatment, care and support. Thank you.

The Charity Office is situated at the Royal Lancaster Infirmary. Our Charity team are always happy to offer help and advice with all fundraising and charity queries. If you are interested in learning more about the good work of the Charity, you may like to visit our website. www.mbhcharity.org.
4.2 Patient care and experience

Throughout the year, we have continued to actively seek the views of our patients and their experience of our services in a number of ways. When we refer to ‘patient experience’, we also include families, carers and visitors.

During 2011/12, we undertook a range of patient surveys, collecting feedback on our services in a variety of ways.

Listening to older people /Patient stories
In May 2011, staff from UHMBT took part in a listening event for older people from the South Lakeland area facilitated by Age UK South Lakeland. This event was attended by over 70 people and provided our patients, their families and carers with the opportunity to tell us how we could improve their experience of services in our hospitals. An action plan picking up the recommendations which came out of this event is being delivered through the Nursing and Midwifery strategy group.

In addition, during 2011/2012 we have collected the detailed stories of over 100 older people who have used our services during 2010 and 2011. These stories are being used as part of a review of elderly services and the themes which have been identified drawn up into an improvement action plan to be taken forward across the range of clinical divisions during 2012/2013.

A group of eleven staff have been working with Lancaster University to support them in developing skills to collect stories from patients about their experiences of our hospitals going forward into 2012/2013. The collection and use of patient stories in filmed, audio or written format for service improvement and staff learning and development is a powerful tool for change, and each public meeting of the Trust board during 2011/2012 has started with a patient story.

Matron’s questionnaire
Each month across all of hospitals, our Matrons ask around 100 patients about their experience whilst in our care. This information is used to inform staff to develop plans to adjust services where appropriate to meet the needs of our patients. Our patients are asked to give their views on a range of issues, from food and cleanliness to privacy, dignity, information and finding a member of staff to discuss their worries and concerns with.

During 2011/2012 we have collected the feedback of 1,008 of patients through the Matron’s questionnaires.

Hand-held electronic feedback devices
The use of hand held electronic feedback devices is now embedded in the Trust and during 2011/2012 a variety of wards and departments have used them as a way of
gathering and responding to patient feedback in a timely way. The devices have been used across our hospitals in the Orthoptics service, to support the roll out and assess the impact of protected mealtimes, to measure the experience of patients using outpatient services, the experience of older people on medical unit 2 at RLI, within the Emergency Department (ED) at RLI and cross Bay physiotherapy services.

This programme will be developed further during 2012/2013 to ensure there is widespread and consistent use of the devices to inform the patient experience agenda.

**Fabio**
A children/young people’s feedback tool called Fabio has been adopted for use within the paediatric department and has been used throughout the year to collect patient experience feedback from children, young people, their parents and carers.

This feedback is real-time and can be responded to quickly where issues arise. In addition, action plans are produced as a result of the feedback given to drive service improvement. The Fabio tool has been used in wards, outpatient areas and Emergency Departments during the year.

**Advancing Quality Programme**
We also continue to collect information from patients as part of the North West Advancing Quality Programme on their experience whilst in our care with a range of conditions. The Advancing Quality programme covers patients with pneumonia, heart failure, acute myocardial infarction and those undergoing elective hip and knee replacement. This information is collected and collated by ward staff and fed back to the Advancing Quality Programme. Collated results are disseminated through the divisional governance structures.

**Emotional touch points**
Coming into hospital is an anxious time for patients and families, whether via a planned or emergency admission. It is well recognised that along the patient journey there are a number of points where emotions and anxiety levels may be particularly raised. Through the therapies profession, work has been undertaken on medical unit 2 to look at the feelings and emotions of patients throughout their journey and in turn this information has been used by ward staff to make improvements which impact on patient experience. The emotional touch points approach has been shared across the divisions and it is hoped to be able to replicate this work during 2012/2013.

**Experience of women using maternity services**
A questionnaire has been developed for completion by all women accessing maternity services, this was launched in 2011 and initial results are currently being analysed.
We are also working closely with Cumbria LINk to understand the experience of maternity service users. Key individuals from the Trust have now been identified to move this forward with LINk and activity is due to commence during the early part of 2012/2013.

**Volunteers**

We provide opportunities for the public to volunteer within our hospitals and the number of volunteers and range of volunteering activity has increased during the year. Our volunteers are a valuable resource in helping us to improve the experience of patients in our hospitals. Volunteering opportunities include: reception duties, meeting and signposting patients and visitors on arrival at our hospitals, ward volunteers, book trolley provision, dining companions, assisting with refreshments as well as those activities provided by WRVS, chaplaincy and hospital radio services.

If you would like to find out more about volunteering with us, please contact Helen.jarram@mbht.nhs.uk.

**Comments, concerns and complaints**

As well as receiving letters and cards of thanks and appreciation, we also receive comments, concerns and formal complaints from patients and families when their experience of care provided by us does not meet their expectations. These comments, concerns and complaints are raised through our complaints process, through frontline staff, our Patient Advice and Liaison Service (PALS) and through patient websites such as NHS Choices and Patient Opinion.

During 2011/2012 we received:

- 600 Formal Complaints
- 704 Concerns
- 1,124 PALS enquiries

We respond to all concerns and complaints and frontline staff and PALS Officers seek to resolve issues before a problem escalates. Where this is not possible or where concerns and complaints are raised in other ways, we handle all responses in line with our Management of Complaints Policy.

The issues that patients and families raise through the complaints process can be an important part of learning and ensuring that staff direct such learning into service improvements.
4.3 Operating review

Events relating to operational management

- The extreme icy conditions experienced at the beginning of February 2012 led to a significant number of patients attending our Emergency Departments at Furness General Hospital and the Royal Lancaster Infirmary. To lessen the impact, the Trust worked with the local media to advise members of the public not to attend the Emergency Departments unless it was absolutely necessary.
- Breakouts of the common but highly contagious winter bug, Norovirus, led to increased pressure at both the Royal Lancaster Infirmary and Furness General Hospital. In March 2012, nine wards at the Royal Lancaster Infirmary had to enforce restrictions on visitors due to the bug.

Celebrations and awards

- The UHMBT Elective Orthopaedic Unit at Barrow reached the milestone of 2,000 operations early in 2012 – over 1,200 of which have been hip and knee replacements.
- Site work commenced early in 2012 on the £1.5m expansion and refurbishment of the Emergency Department at Royal Lancaster Infirmary, including the development of a new Minor Injuries Unit which will deliver additional capacity with five examination rooms, a waiting area, nurse base, clean utility and store.
- The catering services team at Royal Lancaster Infirmary won the highest praise for food safety and hygiene, with the attainment of a series of five star ratings.
- The Trust radio station clocked up 35 years of service and broke a broadcasting record to mark its latest anniversary. Bay Trust Radio raised £1,550 for the station with a marathon broadcast of 60 hours.
- A new approach to improve hospital services and provide patients with co-ordinated packages of care in preparation for discharge was launched at Royal Lancaster Infirmary.
- Consultant appointments included Mr Colin Read (Emergency medicine), Dr Alison Sambrook (consultant Obstetrician and Gynaecologist) and two new orthopaedic consultants, Mr Shyam Kumar and Mr Kuntal Patel, who are delivering surgical techniques for shoulder, elbow, hip, knee and ankle injuries.
- Technological developments and investment in new equipment have boosted local breast screening services for women in North Lancashire and South Cumbria, with the implementation of a digital mammography service. The investment in the latest high tech digital imaging equipment provides higher resolution imaging for increased accuracy in screening results. It replaces traditional x-ray machines and conventional analogue mammography.
• UHMBT officially opened its new, flagship, automated blood science services laboratory for patients throughout Cumbria and North Lancashire, following a multimillion pound investment improving, expanding and automating services for patients and GPs
• UHMBT launched its new £1.2m AMD service in Kendal in July, allowing patients suffering from Age-related Macular Degeneration (AMD) to be seen in a brand new clinic at Westmorland General Hospital (WGH)
• The bowel cancer screening programme for Cumbria and Morecambe Bay received high praise following a two-day inspection by the North West Quality Assurance bowel cancer screening team
• UHMBT was rated highly in stroke prevention procedures with half of all patients who show symptoms of strokes being given life-saving surgery within 14 days across the Trust
• In June, the first patients attended a clinic held in the new Chemotherapy Unit at Westmorland General Hospital by Dr Eaton, Consultant in Medical Oncology
• In May 2011 UHMBT was named in the top two for breast patient information, joint second best out of 135 NHS hospital trusts in the country for providing information to patients undergoing mastectomy and breast reconstruction procedures
• Hospital Equipment Fund for Furness (HEFF) fundraisers were invited to join the Mayor of Barrow in April to celebrate reaching £1,000,000 raised to buy equipment for FGH

4.4 Financial review

Financial summary

The purpose of this review is to provide an analysis of financial performance for the year ended 31 March 2012 and to consider factors which may affect the future financial performance of the Trust.

The Trust obtained Foundation status on 1 October 2010 and the first set of accounts covered the 6 month period to 31 March 2011. The second set of accounts is for the full financial year 1 April 2011 to 31 March 2012, however, the comparative data shows the results for the previous 6 months only.

The Directors can confirm that, so far as they are aware, all relevant information has been made available to the auditors.

Although the Trust is facing some significant challenges, the Directors, having made appropriate enquiries, still have an expectation that we have adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.
Financial performance 2011/12

In the year to 31 March 2012 the Trust has experienced a number of issues of non-compliance with Care Quality Commission standards. These are explained elsewhere in this report. These issues have also resulted in significant financial pressures in order to begin the process of returning the Trust to full compliance.

Additional expenditure incurred as a result of non-compliance amounted to a total of £4.4m. This included; staff employed to provide additional clinical services amounting to £2.7m; engagement of experts and consultancy to review areas and formulate plans totalling £1.2m; and hire of temporary facilities to increase capacity and improve operational performance £0.5m.

Overall the Trust incurred a deficit of £15.9 million during the year. However, this included impairments to land and property values of £13.8m and restructuring costs of £1.1m. For the purpose of calculating financial performance, these items can be classified as exceptional items as they are not elements of our usual operating income and expenditure. After excluding these items, the deficit was £1m.

Restructuring costs are those costs incurred to restructure the Trust’s workforce following a review of staffing in all Divisional areas.

Impairment of land and property values arose as a result of revaluing the Trust's assets at 31 March 2012. There was an overall fall in values of these assets totalling £40.4m. The sum of £26.8m was charged to the Revaluation Reserve against balances held in the reserve relating to these particular assets and £13.7m was charged to expenditure. The sum of £140k was credited to income to reverse previous impairments.

The Trust achieved a financial risk rating of 3 in accordance with the plan (see Regulatory Requirements below). The financial risk rating is an assessment of the underlying financial risks facing a foundation trust (where 1 is deemed high risk and 5 is deemed low risk).
Regulatory requirements

The Trust is required to comply and remain within a Prudential Borrowing Limit which is made up of two elements:

- The maximum cumulative amount of long term borrowing as determined by Monitor, the Independent Regulator of Foundation Trusts; and
- The maximum amount of short term borrowing, known as the working capital facility, also agreed with Monitor.

The Trust has a long term borrowing limit of £48.3 million and an approved working capital facility of £18 million as at 31 March 2012. No loans have been entered into or working capital facilities used during the year ending 31 March 2012. The Trust also has no current plans to borrow against these facilities.

The level of income that the Trust is permitted to receive from private patients is capped. The proportion of private income compared to overall income must not exceed that of the predecessor Trust in 2002/03 (the base year). In 2002/03 the Trust received 0.10% of income from private patients. During the year ending 31 March 2012, only 0.05% of income was from private patients, which was well within the target level.

In respect of financial standing, Monitor use a number of indicators to assess performance. The individual indicators are then weighted and combined to provide an overall risk rating in the range of 1 to 5, with 5 representing the lowest risk and therefore the best performance in terms of financial standing.

For the 2011/12 financial year the Trust achieved an overall risk rating of 3 based on the following performance:

<table>
<thead>
<tr>
<th>Metric</th>
<th>Weighting</th>
<th>Actual 11/12</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Percentage Ratio</td>
</tr>
<tr>
<td>A. EBITDA* Margin</td>
<td>10%</td>
<td>5.14%</td>
</tr>
<tr>
<td>B. EBITDA % Achieved</td>
<td>25%</td>
<td>85.80%</td>
</tr>
<tr>
<td>C. Return on Assets</td>
<td>20%</td>
<td>1.72%</td>
</tr>
<tr>
<td>D. I&amp;E Surplus Margin</td>
<td>20%</td>
<td>-0.85%</td>
</tr>
<tr>
<td>E. Liquidity Ratio**</td>
<td>25%</td>
<td>35.03</td>
</tr>
<tr>
<td><strong>Weighted Average Rating</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
* EBITDA represents earnings before interest, taxes, depreciation and amortisation.

** The liquidity ratio is defined as cash, plus trade receivables (including accrued income), plus unused working capital facilities, minus trade payables, other payables and accruals, expressed as the number of days operating expenses (excluding depreciation) that this would cover.

Results of operations to 31 March 2012

Income and expenditure

Total income for the year ending 31 March 2012 amounted to £252.3m compared to £254.4m received during 2010/11. This represents a decrease of approximately 1%. The Trust’s main activity is patient care and this generates 88% of total income with the balance of 12% being other operating revenue.

Income from patient care activities increased by £1.5m compared to 2010/11. This was in respect of payments made by the Trust’s main commissioners to cover additional activity undertaken.

Other operating revenue decreased by £3m during 2011/12 when compared to 2010/11. This was largely attributable to a reduced level of funding for the new patient administration system (Lorenzo). This has reduced by £2m since last year as the system moves nearer to being fully implemented. Income received for non-patient care services provided to other bodies also reduced by approximately £1m in relation to services transferred out to Cumbria Partnership FT during 2010/11. Expenditure for these services has also been transferred.

Full details of income received is provided in Notes 3 and 4 of the Accounts.

The Trust achieved efficiency savings of £11.5m during 2011/12.

Operating expenditure during 2011/12 compared to 2010/11 remained at a similar level after excluding the effects of the revaluation and the restructuring costs. Savings generated from cost improvements in many areas have been used to fund the additional compliance costs.

Non-current Assets

During the year to 31 March 2012 the Trust spent £8.8m on property, plant and equipment. All capital expenditure has been funded either through the Trust’s internally generated resources (depreciation) or from donations received from the public and connected supporting charities (£570k).
A total of £3.3m has been invested in medical and surgical equipment and £0.6m in information technology systems. In accordance with national priorities £1.8m was invested in a programme to expand breast screening services. A further £2.8 was spent on modifications and upgrades to the Trust’s properties and £0.3m was invested in minor charitable schemes, including a new chemotherapy service at Westmorland General Hospital.

**Inventories**

There were no significant changes to inventory values from 1 April 2011 to 31 March 2012.

**Receivables and payables**

Receivables balances have reduced by £3.2m during the year. This is mainly due to reduced balances for NHS debtors at 31 March 2012, which have reduced by £3.8m, offset by increases in other receivable items totalling £0.6m. A number of large outstanding debts were settled close to the year end and this had an impact on the year end cash balance outlined below.

Payables balances have increased by £4.7m. This is largely attributable to increased capital payables of £2m for large items of equipment not invoiced at the year end and increases in accruals and other payables totalling £2.7m. Much of this increase relates to additional compliance costs incurred but not paid for at 31 March 2012.

**Cash**

Cash balances at 31 March 2012 have increased by £7.2m. This has been largely as a result of the movements in receivables and payables detailed above.

**Better Payment Practice Code**

Under the code the Trust is required to pay all undisputed invoices by the due date or within 30 days of the receipt of goods or a valid invoice, whichever is later. During the year to 31 March 2012 the Trust paid on average 93% of all invoices within this timescale.

Full details of the numbers and values of invoices paid during the year can be found at Note 7.1 of the Trust’s Accounts.

**External auditors**

The majority of work undertaken by the Trust’s external auditors is within the scope of the Audit Code for NHS Foundation Trusts issued by Monitor. During the year ending 31 March 2012 audit fees amounted to £74k for this work. An additional £14k was spent on other service reviews commissioned from the external auditors, the Audit Commission.
The Audit Commission has robust arrangements in place to ensure compliance with the requirements on independence and objectivity contained in Monitor’s Audit Code. All additional services provided are subject to review and approval by the Director – Standards and Technical to ensure that independence is not compromised.

**Strategic risks**

The Trust continues to be committed to ensuring that management of risk is an integral part of its philosophy, practices and business plans.

The Annual Governance Statement, a full copy of which is included in the Accounts, provides details of the extent to which the Assurance Framework has been in place throughout the year. This statement also details the actions taken by the Trust to establish action plans to address gaps in control which have been identified during the year.

**Future Plans**

Following the first 18 months as a Foundation Trust, efforts are now being concentrated on returning the Trust to full compliance with Care Quality Commission standards and ensuring the future viability and sustainability of the Trust. Specific actions include:

- Returning the Trust to full compliance with CQC standards
- Reviewing governance arrangements across the whole organisation
- Strengthening the leadership and skills of the Trust Board
- Developing a Recovery Plan to support future sustainable delivery of services
- Using the Programme Management Office to drive forward and implement required changes in services and governance
- Increased engagement from clinicians to review and change clinical services
- Managing the Trust’s estate to obtain best use of the facilities available
- Working with stakeholders, particularly GP consortia, to develop a whole economy approach to sustainable health care in the Morecambe Bay area.
4.5 Our activity

<table>
<thead>
<tr>
<th>Patient type</th>
<th>2010-11</th>
<th>2011-12</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatients / day-cases</td>
<td>43548</td>
<td>44745</td>
<td>+2.60%</td>
</tr>
<tr>
<td>First outpatient attendances</td>
<td>128750</td>
<td>125723</td>
<td>-2.41%</td>
</tr>
<tr>
<td>A and E attendances (excludes WGH)*</td>
<td>89421</td>
<td>87971</td>
<td>-1.65%</td>
</tr>
<tr>
<td>Emergency admissions</td>
<td>40671</td>
<td>40410</td>
<td>-0.65%</td>
</tr>
</tbody>
</table>

The table above summarises our patient activity in 2011/12 compared to 2010/11.

Accident and Emergency (A&E) attendances have decreased and emergency admissions have again fallen from 2010/11 to 2011/12 demonstrating the impact of emergency admissions avoidance schemes and developments in emergency processes.

The following targets and indicators were met throughout 2011/12;

- Incidence of Clostridium Difficile.
- Cancer 2 week (all cancers)
- Cancer 2 week (breast symptoms)
- Cancer 31 day wait for second or subsequent treatment for surgery, drug treatments and radiotherapy.
- Cancer 31 day waits from decision to treat to start of first treatment all cancers.
- 62 day wait for first treatment from urgent GP referral.
- Referral to treatment time 95th percentile, non-admitted patients.
- Minimising delayed transfers of care
- Access to healthcare for people with a learning disability.

The targets and indicators we failed to meet during the year were;

- Post 48 hour MRSA bacteraemia cases, where we exceeded the trajectory of 3 by 1 in January 2012.
- Cancer 62 day waits for first treatment from a consultant led screening service failed in quarter 2 but has achieved in quarters 3 and 4. The breaches were breast patients that waited a long time for their first breast screening assessment. The booking process for screening appointments was revised along with pathway tracking arrangements.
- Referral to treatment time, 95th percentile, admitted patients achieved from quarters 1 to 3, but failed in quarter 4. The Trust was instructed by the Care Quality Commission to cancel electives admissions earlier in quarter 4 due to bed pressures for emergency admissions. The Trust is currently working through a recovery plan to treat admitted patients.
- Total time in A&E over 4 hours target was met in Q1 and Q2, but failed in Q3 and Q4. A new model of care has been developed and implemented at the Royal Lancaster Infirmary where the majority of the breaches occurred.

An Integrated Performance Report on activity, performance and finance is presented to the Trust Board monthly, summarising and providing commentary on our performance against a range of national targets and indicators. An assessment of the key targets and indicators from the Compliance Framework and actual performance achieved is provided below. These demonstrate that we provide good quality and timely care to patients despite challenging operational difficulties.
<table>
<thead>
<tr>
<th>Target or Indicator (per 2011/12 Compliance Framework)</th>
<th>Threshold</th>
<th>Weighting</th>
<th>Annual Plan At Risk</th>
<th>Q1 Met/Not Met</th>
<th>Q2 Met/Not Met</th>
<th>Q3 Met/Not Met</th>
<th>Q4 Met/Not Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clostridium Difficile -meeting the C.Diff objective</td>
<td>63</td>
<td>1.0</td>
<td>No</td>
<td>Achieved</td>
<td>Achieved</td>
<td>Achieved</td>
<td>Achieved</td>
</tr>
<tr>
<td>MRSA - meeting the MRSA objective</td>
<td>3</td>
<td>1.0</td>
<td>No</td>
<td>Achieved</td>
<td>Achieved</td>
<td>Achieved</td>
<td>Failed to Meet</td>
</tr>
<tr>
<td>Cancer 31 day wait for second or subsequent treatment - surgery</td>
<td>&gt;94%</td>
<td>1.0</td>
<td>No</td>
<td>Achieved</td>
<td>Achieved</td>
<td>Achieved</td>
<td>Achieved</td>
</tr>
<tr>
<td>Cancer 31 day wait for second or subsequent treatment - drug treatments</td>
<td>&gt;98%</td>
<td>1.0</td>
<td>No</td>
<td>Achieved</td>
<td>Achieved</td>
<td>Achieved</td>
<td>Achieved</td>
</tr>
<tr>
<td>Cancer 62 Day Waits for first treatment (from urgent GP referral)</td>
<td>&gt;85%</td>
<td>1.0</td>
<td>No</td>
<td>Achieved</td>
<td>Achieved</td>
<td>Achieved</td>
<td>Achieved</td>
</tr>
<tr>
<td>Cancer 62 Day Waits for first treatment (from Consultant led screening service referral)</td>
<td>&gt;90%</td>
<td>1.0</td>
<td>No</td>
<td>Achieved</td>
<td>Failed to Meet</td>
<td>Achieved</td>
<td>Achieved</td>
</tr>
<tr>
<td>Referral to treatment time, 95th percentile, admitted patients</td>
<td>&lt;23Wks</td>
<td>1.0</td>
<td>No</td>
<td>Achieved</td>
<td>Achieved</td>
<td>Achieved</td>
<td>Failed to Meet</td>
</tr>
<tr>
<td>Referral to treatment time, 95th percentile, non-admitted patients</td>
<td>&lt;18.3Wks</td>
<td>1.0</td>
<td>No</td>
<td>Achieved</td>
<td>Achieved</td>
<td>Achieved</td>
<td>Achieved</td>
</tr>
<tr>
<td>31 Days from decision to treat to start of first treatment: All Cancers</td>
<td>&gt;96%</td>
<td>0.5</td>
<td>No</td>
<td>Achieved</td>
<td>Achieved</td>
<td>Achieved</td>
<td>Achieved</td>
</tr>
<tr>
<td></td>
<td>Percentage</td>
<td>Weight</td>
<td>Achieved</td>
<td>Achieved</td>
<td>Achieved</td>
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<td>----------------------------------------------------------------------------------</td>
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<td></td>
</tr>
<tr>
<td>Cancer 2 week (all cancers)</td>
<td>&gt;93%</td>
<td>0.5</td>
<td>Achieved</td>
<td>Achieved</td>
<td>Achieved</td>
<td>Achieved</td>
<td></td>
</tr>
<tr>
<td>Cancer 2 week (breast symptoms)</td>
<td>&gt;93%</td>
<td>0.5</td>
<td>Achieved</td>
<td>Achieved</td>
<td>Achieved</td>
<td>Achieved</td>
<td></td>
</tr>
<tr>
<td>A&amp;E Clinical Quality - Total Time in A&amp;E (95th percentile)</td>
<td>&lt;4Hrs</td>
<td>0.5</td>
<td>Failed to Meet</td>
<td>Achieved</td>
<td>Achieved</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minimising delayed transfers of care</td>
<td>&lt;=7.5%</td>
<td>1.0</td>
<td>Achieved</td>
<td>Achieved</td>
<td>Achieved</td>
<td>Achieved</td>
<td></td>
</tr>
<tr>
<td>Compliance with requirements regarding access to healthcare for people with a learning disability</td>
<td>N/A</td>
<td>0.5</td>
<td>Achieved</td>
<td>Achieved</td>
<td>Achieved</td>
<td>Achieved</td>
<td></td>
</tr>
</tbody>
</table>

**Governance Risk rating with the CQC enforcement/warning notice**: **RED**
### 4.6 Changes to performance standards and indicators in 2012/13

As in previous years the targets and indicators have been reviewed and updated both at a local and national level.

### 4.7 The Operating Framework 2012/13

The following table shows the 2012/13 Operating Framework targets and indicators and the change from 2011/12 where applicable.

<table>
<thead>
<tr>
<th>Operating Framework Standards 2012/13</th>
<th>Threshold</th>
<th>Weighting</th>
<th>Monitoring Period</th>
<th>Change to 2011/12 indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total time in A&amp;E - 95% of patients should be seen within four hours</td>
<td>95%</td>
<td>94%</td>
<td>1 Weekly</td>
<td>No change</td>
</tr>
<tr>
<td>MRSA</td>
<td>0</td>
<td>&gt;1SD*</td>
<td>1 Monthly</td>
<td>No change</td>
</tr>
<tr>
<td>C Diff</td>
<td>0</td>
<td>&gt;1SD</td>
<td>1 Monthly</td>
<td>No change</td>
</tr>
<tr>
<td>RTT - admitted - 90% in 18 weeks</td>
<td>90%</td>
<td>85%</td>
<td>1 Monthly</td>
<td>2011/12 standard also included 95th percentile- &lt;=23 weeks.</td>
</tr>
<tr>
<td>RTT - non-admitted - 95% in 18 weeks</td>
<td>95%</td>
<td>90%</td>
<td>1 Monthly</td>
<td>2011/12 standard also included 95th percentile- &lt;=18.3 weeks.</td>
</tr>
<tr>
<td>RTT - incomplete 92% in 18 weeks</td>
<td>92%</td>
<td>87%</td>
<td>1 Monthly</td>
<td>2011/12 standard was 95th percentile- &lt;=28 weeks.</td>
</tr>
<tr>
<td>RTT delivery in all specialties- number of treatment functions where standards are not delivered</td>
<td>0</td>
<td>&gt;20</td>
<td>1 Monthly</td>
<td>New indicator 2012/13</td>
</tr>
<tr>
<td>Diagnostic Test Waiting Times- patients waiting 6 weeks or more</td>
<td>&lt;1%</td>
<td>5%</td>
<td>1 Monthly</td>
<td>New indicator 2012/13</td>
</tr>
<tr>
<td>Cancer- 2 week wait from referral to date first seen</td>
<td>93%</td>
<td>88%</td>
<td>0.5 Monthly</td>
<td>2011/12 indicator was monitored quarterly.</td>
</tr>
<tr>
<td>Indicator</td>
<td>Description</td>
<td>Target</td>
<td>Performance</td>
<td>Frequency</td>
</tr>
<tr>
<td>-----------</td>
<td>-------------</td>
<td>--------</td>
<td>-------------</td>
<td>-----------</td>
</tr>
<tr>
<td>Cancer</td>
<td>2 week wait for symptomatic breast patients- referral to date first seen</td>
<td>93%</td>
<td>88%</td>
<td>0.5</td>
</tr>
<tr>
<td>Cancer</td>
<td>31 day wait for second or subsequent surgery</td>
<td>94%</td>
<td>89%</td>
<td>0.25</td>
</tr>
<tr>
<td>Cancer</td>
<td>31 day wait for second or subsequent drug treatment</td>
<td>98%</td>
<td>93%</td>
<td>0.25</td>
</tr>
<tr>
<td>Cancer</td>
<td>First definitive treatment within 31-days of a cancer diagnosis</td>
<td>96%</td>
<td>91%</td>
<td>0.25</td>
</tr>
<tr>
<td>Cancer</td>
<td>31 day wait for second or subsequent radiotherapy</td>
<td>94%</td>
<td>89%</td>
<td>0.25</td>
</tr>
<tr>
<td>Cancer</td>
<td>62-day Wait for First Treatment Following Referral from screening</td>
<td>90%</td>
<td>85%</td>
<td>0.5</td>
</tr>
<tr>
<td>Cancer</td>
<td>62-day Wait for First Treatment Following Referral from GP</td>
<td>85%</td>
<td>80%</td>
<td>0.5</td>
</tr>
<tr>
<td>Delayed transfers of care</td>
<td>3.5%</td>
<td>5%</td>
<td>1</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Mixed Sex Accommodation Breaches</td>
<td>0%</td>
<td>0.5%</td>
<td>1</td>
<td>Monthly</td>
</tr>
<tr>
<td>VTE Risk Assessment</td>
<td>90%</td>
<td>80%</td>
<td>1</td>
<td>Quarterly</td>
</tr>
</tbody>
</table>

The following 2011/12 indicators have not been included in 2012/13:

- A&E Clinical Quality Indicators: time to initial assessment, time to treatment in department, unplanned re-attendance rate & left without being seen
- Patients that have spent more than 90% of their stay in hospital on a stroke unit
- Cancelled operations- breaches of 28 days readmission guarantee as % of cancelled operations.
## 4.8 Monitor targets and indicators

The following table shows the 2012/13 Monitor targets and indicators and the change from 2011/12 where applicable.

<table>
<thead>
<tr>
<th>Monitor Compliance Framework Standards 2012/13</th>
<th>Change to 2011/12 indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Standard</strong></td>
<td><strong>Threshold</strong></td>
</tr>
<tr>
<td>Clostridium Difficile infections</td>
<td>0</td>
</tr>
<tr>
<td>MRSA bacteraemia</td>
<td>0</td>
</tr>
<tr>
<td>Cancer: 31-day wait for second or subsequent treatment, comprising:</td>
<td>94%</td>
</tr>
<tr>
<td></td>
<td>98%</td>
</tr>
<tr>
<td></td>
<td>94%</td>
</tr>
<tr>
<td>Cancer: 62-day wait for first treatment from:</td>
<td>85%</td>
</tr>
<tr>
<td>urgent GP referral for suspected cancer</td>
<td>90%</td>
</tr>
<tr>
<td>NHS Cancer Screening Service referral</td>
<td>85%</td>
</tr>
<tr>
<td>Cancer: two week wait from referral to date first seen, comprising:</td>
<td>93%</td>
</tr>
<tr>
<td>all urgent referrals (cancer suspected)</td>
<td>93%</td>
</tr>
<tr>
<td>for symptomatic breast patients (cancer not initially suspected)</td>
<td>93%</td>
</tr>
<tr>
<td>Cancer: 31-day wait from diagnosis to first treatment</td>
<td>96%</td>
</tr>
<tr>
<td>Maximum time of 18 weeks from point of referral to treatment in aggregate- admitted</td>
<td>90%</td>
</tr>
<tr>
<td>Maximum time of 18 weeks from point of referral to treatment in aggregate- non-admitted</td>
<td>95%</td>
</tr>
</tbody>
</table>
Maximum time of 18 weeks from point of referral to treatment in aggregate - patients on an incomplete pathway  

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Target</th>
<th>Frequency</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E: maximum waiting time of four hours from arrival to admission/transfer/discharge</td>
<td>95%</td>
<td>Quarterly</td>
<td>No change</td>
</tr>
<tr>
<td>Certification against compliance with requirements regarding access to healthcare for people with a learning disability</td>
<td>N/A</td>
<td>0.5</td>
<td>No change</td>
</tr>
</tbody>
</table>

The following 2011/12 indicators have not been included in 2012/13:

- A&E (from Q2): time to initial assessment, time to treatment decision, unplanned re-attendance rate & left without being seen.
- Stroke indicator

### 4.9 Commissioning for Quality and Innovation (CQUIN)

The following areas (page 66) have been agreed with local commissioners as priority areas for development and action within 2012/13.

<table>
<thead>
<tr>
<th>Area</th>
<th>Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Venous thromboembolism (VTE) prevention</td>
<td>Reduce avoidable death, disability and chronic ill health from (VTE)</td>
</tr>
<tr>
<td>Patient experience</td>
<td>Improve responsiveness to personal needs of patients</td>
</tr>
<tr>
<td>Patient Safety Thermometer</td>
<td>Improve collection of data in relation to pressure ulcers, falls, urinary tract infection in those with a catheter, and VTE</td>
</tr>
<tr>
<td>Dementia</td>
<td>Improve awareness and diagnosis of dementia, using risk assessment, in an acute hospital setting</td>
</tr>
<tr>
<td>Advancing Quality</td>
<td>Regionally led quality incentive scheme for Pneumonia, Hip &amp; Knee Replacement,</td>
</tr>
<tr>
<td>Acute Myocardial Infarction, Heart Failure and Stroke</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>End of Life</strong>-</td>
<td></td>
</tr>
<tr>
<td>Improving the standard of End of Life Care</td>
<td></td>
</tr>
<tr>
<td><strong>Diabetes</strong>-</td>
<td></td>
</tr>
<tr>
<td>Delivery of the Diabetes National service framework (NSF)</td>
<td></td>
</tr>
<tr>
<td><strong>Clinical Ownership of Change</strong>-</td>
<td></td>
</tr>
<tr>
<td>Support for clinical teams to lead on the management and delivery of change.</td>
<td></td>
</tr>
</tbody>
</table>

Achievement of these new targets and indicators will mean shorter waiting times for both emergency and elective treatment, improved patient experience and improved clinical outcomes for patients.

The following recently published national policy documents inform and impact upon our performance monitoring regime:

- Publication of the 2012/13 Operating Framework which sets out the national priorities for 2012/13
- Monitor Compliance Framework 2012/13
- Health and Social Care Act.
- 2012/13 Payment by Results Guidance.

## 4.10 Principal risks

2011/12 has been a difficult year for the Trust. Whilst we continue to provide a good care to the majority of our patients standards of care have fallen below the standards expected in a number of areas. We are absolutely committed to returning the Trust to where it should be:

“We will be the best – giving excellent compassionate care to the people of Morecambe Bay”
Care Quality Commission
The Care Quality Commission (CQC) carried out a number of planned and unplanned reviews at the Trust in 2011/12. The table below indicates the reviews that have been undertaken and summary of the results:

<table>
<thead>
<tr>
<th>Date of Review</th>
<th>Date of Report</th>
<th>Type of Review</th>
<th>Area of Review</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2011</td>
<td>June 2011</td>
<td>Planned</td>
<td>Royal Lancaster Infirmary</td>
<td>Trust not meeting one or more essential standards of care</td>
</tr>
<tr>
<td>July 2011</td>
<td>September 2011</td>
<td>Responsive (joint review with the National Midwifery Council)</td>
<td>Maternity – Furness General Hospital, Royal Lancaster Infirmary &amp; Westmorland General Hospital</td>
<td>Trust not meeting one or more essential standards of care Warning Notice Issued - 2 Sept 2011</td>
</tr>
<tr>
<td>December 2011</td>
<td>February 2012</td>
<td>Responsive</td>
<td>A&amp;E Royal Lancaster Infirmary</td>
<td>Trust not meeting one or more essential standards of care Warning Notice Issued</td>
</tr>
</tbody>
</table>

Following the Maternity Review in July 2011 and the publication of the report the Care Quality Commission issued a Warning Notice to the Trust in respect of Regulation 10: Assessing and monitoring the quality of service provision. In February 2012 the Trust a received a second Warning Notice in respect of Regulation 22: Staffing Levels following the visit to the RLI in December 2011.

**Care quality commission – section 48 investigation**
On 17 January 2012 the Care Quality Commission publicly announced that it was undertaking an investigation into the Trust by virtue of its powers under Section 48 of the Health and Social Care Act 2008.

This decision followed the unannounced inspection visit by the Care Quality Commission to the Emergency Department at the Royal Lancaster Infirmary in December 2011. The investigation is scheduled to run for a period of up to 14 weeks including the drafting of a report and commenced in February 2012. The CQC will publish a report on the findings of the investigation, and will make recommendations as appropriate to the Trust and other relevant bodies. During the course of the investigation the Trust has received a further two Warning Notices in relation to Regulation 9 (1) (a) (b) Care and Welfare of Service Users and Regulation 17 (1) (a) Respecting and Involving Service Users.

Monitor – Independent Regulator of NHS Foundation Trusts

As a result of the concerns identified by the Care Quality Commission, Monitor, the Independent Regulator of NHS Foundation Trusts, found the Trust in significant breach of its Terms of Authorisation and exercised its formal powers of intervention on 11 October 2011. This power of intervention is made available to Monitor, under the National Health Service Act 2006: section 52: failing NHS foundation trusts. Monitor found the Trust in significant breach of three terms of its authorisation, namely:

1. Condition 2: the general duty to exercise its functions effectively, efficiently and economically;
2. Condition 5: its governance duty; and
3. Condition 6: its healthcare targets and other standards duty.

The Trust was required by Monitor to carry out the following reviews:

a. **GOVERNANCE REVIEW** - Appoint external advisors to undertake a full governance review including a review of governance. Price Waterhouse Coopers (PWC) were appointed in November 2011 to carry out this review. A copy of the final review was published on 6 February 2012. The Trust is currently reviewing and implementing changes to its governance arrangements as a result of this report. These include strengthening the Board of Directors and a review of risk management within the Trust.

b. **MATERNITY REVIEW** – Accept the appointment by Monitor of external clinical advisors to undertake a diagnostic review of the Trust’s maternity services, including their interface with paediatric services. Central Manchester University Hospitals NHS Foundation Trust was appointed to undertake this review and the report was published in February 2012. The Trust developed a
programme of work to address the issues identified in the Central Manchester report and is currently implementing these changes.

The Trust is in regular communication with both the Care Quality Commission and Monitor to ensure that the necessary improvements are made to patient services to ensure that they are safe and effective. On 20 April 2012 the Trust announced changes to its leadership significantly increasing the level of clinical involvement in decision making at the Trust.

Outpatient follow-up appointments
The Trust also commissioned a third external review into the follow up outpatient’s backlog that was identified in November 2011. Since this time a detailed piece of work has been undertaken to review all patients affected by this issue and ensure those patients requiring appointments were seen as soon as possible. The Trust has also reviewed its outpatient booking processes and is rolling out changes in this area.

Police Investigation
Following a high profile inquest in June 2011, Cumbria Police made an announcement that they were continuing to investigate a number of deaths that occurred after mothers and infants received care at the maternity unit in Furness General Hospital. The Trust is cooperating fully with the police investigation and continues to do so.
5. The environment

Cutting carbon emissions as part of the fight against climate change is a key priority for our Trust. The UK government has identified the NHS sector as key to delivering carbon reduction across the UK in line with the Climate Change Act targets.

In 2011, we embedded the Sustainable Development policy, by ensuring that all staff had the principles included within their Job Descriptions. In addition we were successful in completing the Carbon Trust’s Carbon Management Programme, and with their expert guidance we developed a Carbon Management Plan, which includes a programme that commits the Trust to a target reduction of 20% CO2 by 2016 and underpins potential financial savings to the organisation of around £3.7million by that date.

The governance processes to support the management and reporting of sustainability and carbon management is still being developed, but it is envisaged that it will be based on the following model. The main reporting group will be a new Sustainable Development Steering Group who will report to the Trust Board on a six monthly basis.
5.1 Future priorities and targets

Our future priorities and targets are detailed in our Carbon Trust NHS Carbon Management Plan. Key elements of the plan are:

- Replace existing obsolete boilers at Furness General Hospital and Westmorland General Hospital with modern high efficiency boilers which may include a Biomass solution
- The use of photovoltaic panels to produce a percentage of our own renewable energy
- Replace the existing roof at Furness General Hospital to provide enhanced insulation properties
- Improved recycling and management of waste products
- Roll out of LED lighting and improvements to lighting controls

Finance

The following financial factors are used to benchmark the Trust against other similar organisations as part of the Estate Records Information Collection (ERIC) return.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>CRC Expenditure</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Business Travel</td>
<td>1,846,229</td>
<td>1,899,808</td>
<td>1,884,194</td>
<td>1,697,367</td>
</tr>
<tr>
<td>Waste Disposal</td>
<td>377,482</td>
<td>434,685</td>
<td>394,567</td>
<td>342,045</td>
</tr>
<tr>
<td>Finite Resources (Water Only)</td>
<td>489,692</td>
<td>792,391</td>
<td>538,807</td>
<td>581,050</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2008/09</th>
<th>2009/10</th>
<th>2010/11</th>
<th>2011/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gas kWh CO2</td>
<td>44,481,189</td>
<td>44,749,722</td>
<td>44,670,333</td>
<td>41,310,071</td>
</tr>
<tr>
<td>Elect kWh CO2</td>
<td>16,105,962</td>
<td>16,300,278</td>
<td>17,306,121</td>
<td>17,007,720</td>
</tr>
<tr>
<td>Oil kWh CO2</td>
<td>712,506</td>
<td>833,611</td>
<td>403,671</td>
<td>649,929</td>
</tr>
<tr>
<td>Water M³</td>
<td>198,575</td>
<td>220,139</td>
<td>224,091</td>
<td>192,470</td>
</tr>
</tbody>
</table>

Lease Car Transport Miles (from Knowles Associates)

<table>
<thead>
<tr>
<th>Fuel Type</th>
<th>2010/2011</th>
<th>2011/2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Petrol</td>
<td>290,896</td>
<td>238,004</td>
</tr>
<tr>
<td>Diesel</td>
<td>410,574</td>
<td>444,698</td>
</tr>
</tbody>
</table>
6. **Staff and staff survey**

6.1 **Equality and Diversity**
We recognise the benefits of having a diverse workforce at every level. People who work at the Trust are developed to promote a culture of respect, understanding and fairness. The work is supported by a range of policies that encompass current legislation and good practice.

Our Equality and Human rights agenda is led by the Director of Human Resources and Organisational Development, the Director of Nursing and Midwifery and the Equality and Diversity advisor. We have a Single Equality Scheme (SES) which includes all the protected characteristics in line with current equalities legislation. The key objectives are:

**Patient focus**
- Ensuring Equality and Human Rights are embedded in the way we work
- Ensure patient information is provided in suitable formats
- Complete equality impact assessments for policies and functions

**Collaborative working**
- Provide the opportunity for staff and patients to give feedback on the services we provide, through our website, New Horizons magazine, patient stories and working with local community groups

**Staff development and involvement**
- Providing staff with the knowledge and skills required to ensure they meet the Equality and Human Rights of our patients. Training is provided on induction, yearly through mandatory training work books and workshops
- Development of an intranet site to ensure current advice and information is always available for staff
- Development of policies to ensure staff work in a fair and non-discriminatory way. Provide management training to tackle bullying and harassment
- We are a “two tick” organisation so we ensure a fair workplace for staff who have a disability:
  - We guarantee to interview any applicant who meets the minimum criteria
  - We work with staff to ensure they are able to develop and use their abilities at work with the use of reasonable adjustments as required

**Maximising resources**
- Ensure procurement is undertaken to meet current equalities legislation
In order to ensure progress against the SES objectives, an implementation action plan was introduced. This enabled us to incorporate the CQC requirements as well as those required by the Equality Performance Improvement Toolkit (EPIT). The latter was rolled out by NHS North West and has been instrumental in both supporting trusts to improve their approach to equality and diversity as well as laying the basis for the additional information required from public sector bodies as a result of the Equalities Act 2010.

The implementation action plan has been developed to include a Red/Amber/Green (RAG) rating with progress reported and monitored via Equality & Human Rights (EHR) group, Hospital Management Team and Trust Board.

Work to progress EPIT was undertaken with North Lancashire PCT and Cumbria Council equality services. The latter indicated that in a number of areas, our evidence demonstrated good practice. For example, our staff monitoring reports, the inclusion of Education & Development in the mandatory training workbook and the addition of disability data collection for patients via Lorenzo.

At the end of January 2011, we published the required information to comply with the public sector equality duty. The Trust is also working on the migration of EPIT to the Equality Delivery System (EDS). This is a national requirement which was launched in July 2011. We are working with local NHS organisations to undertake the required consultation on EDS and this will also support the development of our new Single Equality Scheme.

In order to comply with legal requirements, our equalities data is monitored on a 6 monthly basis. The information is collated and analysed and any issues are highlighted and reported on. These are followed up within the relevant areas to see if there is any explanation about the data. The data is published on the Trust’s website.

**Staff monitoring data**
As part of our legal obligation, we collate staff monitoring data, which is published annually on our website (www.uhmb.nhs.uk). A six monthly report is reviewed by the Equality and Human Rights Group which highlights potential issues and gives recommendations for action.
7. **Staff engagement**

7.1 **Staff Survey analysis**

The survey shows that the people who work in this organisation believe it is a fairly good place to work. However, we know we all want to do even better. It is important that everyone in the organisation feels they are part of a team which is committed to driving through improvements and motivated to provide the very best care for all our patients. Above all they need to feel a sense of pride in where they work.

The 2011 NHS Staff Survey shows that UHMBT is rated in the top 20 per cent for ten of the 38 categories and above average in another 12 categories. Areas where the Trust does well compared to other Trusts include job satisfaction; the low number of people thinking about leaving their jobs; the number of staff receiving appraisals; the Trust’s commitment to work-life balance; and staff feeling valued by work colleagues.

The Trust is below average in nine categories including for the number of staff recommending the Trust as a place to work or receive treatment and the percentage of staff agreeing that their role makes a difference to patients, where the Trust ranks in the bottom 20 per cent.

We want to make this not just a good Trust but an excellent one for patients and staff. A key test that we are succeeding will be getting to the point where more of our staff would recommend their own hospitals as places to be treated and more of them feel they can make a difference to patients.

In order to do that, we all need to play our part. As part of the wider recovery plan we are developing, managers need to ensure that staff are properly supported in their jobs and fully involved in improving our services.

We don’t want anyone standing on the side-lines. If anyone, wherever they work and whatever their job, thinks there are aspects of the service we are providing for our patients that are not good enough, they need to take responsibility for ensuring something is done about it.
### Staff Survey Analysis

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Response rate</strong></td>
<td>Trust</td>
<td>National Average</td>
</tr>
<tr>
<td></td>
<td>64%</td>
<td>54%</td>
</tr>
</tbody>
</table>

The Trust was in the top 20% of trusts for its survey return rate in 2010. Although this has dropped by 1% for the 2011 survey, it remains in the top 20%.

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Top 4 Ranking Scores</strong> (KF Key Finding)</td>
<td>Trust</td>
<td>National Average</td>
</tr>
<tr>
<td>KF29 Percentage of staff feeling pressure in last 3 months to attend work when feeling unwell*</td>
<td>20%</td>
<td>26%</td>
</tr>
<tr>
<td>KF38 Percentage of staff experiencing discrimination at work in last 12 months*</td>
<td>9%</td>
<td>13%</td>
</tr>
<tr>
<td>KF28 Impact of health and wellbeing on ability to perform work or daily activities*</td>
<td>1.49</td>
<td>1.57</td>
</tr>
<tr>
<td>KF3 Percentage of staff feeling valued by their work colleagues</td>
<td>80%</td>
<td>76%</td>
</tr>
</tbody>
</table>

* The lower the score the better

<table>
<thead>
<tr>
<th>Bottom 4 Ranking Scores (KF Key Finding)</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust</td>
<td>National Average</td>
<td>Trust</td>
</tr>
<tr>
<td>KF17 Percentage of staff suffering work related injury in last 12 months*</td>
<td>21%</td>
<td>16%</td>
</tr>
<tr>
<td>KF30 Percentage of staff reporting good communication between senior management and staff</td>
<td>17%</td>
<td>26%</td>
</tr>
<tr>
<td>KF1 Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver</td>
<td>70%</td>
<td>74%</td>
</tr>
<tr>
<td>KF35 Staff motivation at work</td>
<td>3.75</td>
<td>3.83</td>
</tr>
</tbody>
</table>
* The lower the score the better

The tables above show the top and worse ranking areas in the annual NHS Staff Surveys 2010 and 2011.

The 2010 survey highlighted several positive areas for the Trust including:

- Feeling valued by work colleagues
- Helping to achieve a good work/life balance
- Receiving relevant training, learning or development
- Fairness and effectiveness of incident reporting procedures
- Staff job satisfaction
- Providing equal opportunities for career progression
- Having hand washing materials available

The Trust develops an annual action plan to address the findings from the staff survey. This is monitored via the Hospital Management Team on a quarterly basis. Priorities for the outcomes of the 2010 survey included:

- improving communications between staff and senior managers,
- improving the uptake and quality of appraisals
- improving our health and safety performance

From the 2011 results, for 75% of the questions asked, the Trust was in the best 20 per cent, above average or average categories. These results highlighted several key areas where the Trust was viewed positively including:

- Feeling valued by work colleagues
- Helping to achieve a good work/life balance
- Numbers of staff being appraised and having a personal development plan
- Numbers of staff receiving health and safety training
- Numbers of staff reporting good communications between senior managers and staff
- Staff job satisfaction
- Providing equal opportunities for career progression

The Trust has developed an action plan to address the outcomes of the 2011 survey.
7.2 Sickness absence management

Sickness Absence Management
The Trust has taken a pro-active approach to managing absence. A new policy was introduced in 2009 and this has resulted in a reduction in absence rates. The Trust target for 2011/12 was 4% and this has been achieved. The Trust provides a monthly update to the Board on trends and a detailed quarterly report providing reasons for absence, the cost of this and action taken under the Trust’s sickness absence policy.

The Human Resources, Occupational Health and Health and Safety team work together to support staff to return to work.

Trust wide cumulative sickness absence rate comparison:

Sickness absence rates by division:
HR / Workforce Information
A detailed quarterly report is provided via the Integrated Performance Report. This provides Board level information about sickness absence rates, reasons and costs for absence, mandatory training, appraisals and induction. Information on the application of policies (sickness absence, grievance, disciplinary) is also provided.

Policy Development
All employment related policies are reviewed in line with the Policy Review Framework using the agreed process for policy review. Policies are consulted on with a range of staff, managers and staff side representatives. HR policies are supported with training and rollout programmes including toolkits to support managers.
8. Quality Account 2011 / 2012

[Quality account and annexes to be inserted here]
**Glossary of terms and abbreviations used within the Quality Report.**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bundle</td>
<td>A number of measures/interventions to be implemented together as part of the care package for patients</td>
</tr>
<tr>
<td>CHKS</td>
<td>A commercial company providing a clinical performance data analysis system.</td>
</tr>
<tr>
<td>CQC</td>
<td>Care Quality Commission</td>
</tr>
<tr>
<td>CQUIN</td>
<td>Commissioning for quality and innovation</td>
</tr>
<tr>
<td>DNA</td>
<td>Did not attend</td>
</tr>
<tr>
<td>EMSA</td>
<td>Eliminating mixed sex accommodation</td>
</tr>
<tr>
<td>EQIP</td>
<td>Efficiency and Quality Improvement Programme</td>
</tr>
<tr>
<td>EWS</td>
<td>Early warning system</td>
</tr>
<tr>
<td>GSF</td>
<td>Gold standard framework</td>
</tr>
<tr>
<td>GURU</td>
<td>An online database named GURU. The GURU database provides a simple overview of performance at ward level against a range of indicators.</td>
</tr>
<tr>
<td>HSC</td>
<td>Local authority – Health Scrutiny Committee</td>
</tr>
<tr>
<td>LINKs</td>
<td>Local involvement networks</td>
</tr>
<tr>
<td>Lorenzo</td>
<td>A software programme. The electronic patient management system</td>
</tr>
<tr>
<td>LPC</td>
<td>Liverpool care pathway</td>
</tr>
<tr>
<td>MQUAT</td>
<td>Midwifery quality assessment tool</td>
</tr>
<tr>
<td>MRSA</td>
<td>Methicillin resistant staphylococcus aureus (superbug)</td>
</tr>
<tr>
<td>MUST</td>
<td>Malnutrition universal screening tool</td>
</tr>
<tr>
<td>NQUAT</td>
<td>Nursing quality assessment tool</td>
</tr>
<tr>
<td>OSC</td>
<td>Local authority – Overview and Scrutiny Committee</td>
</tr>
<tr>
<td>PBC</td>
<td>Practice based commissioners</td>
</tr>
<tr>
<td>PCT</td>
<td>Primary care Trust</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Definition</td>
</tr>
<tr>
<td>--------------</td>
<td>------------------------------------</td>
</tr>
<tr>
<td>PEMs</td>
<td>Patient experience measures</td>
</tr>
<tr>
<td>PMB</td>
<td>Programme management board</td>
</tr>
<tr>
<td>PMO</td>
<td>Programme management office</td>
</tr>
<tr>
<td>POTTS</td>
<td>Physiological track and trigger system</td>
</tr>
<tr>
<td>PROMs</td>
<td>Patient recorded outcome measures</td>
</tr>
</tbody>
</table>
8.1 Part 1: Statement on quality from the Chief Executive

Quality Reports are annual reports from organisations which provide NHS services. They are intended to give patients, the wider public and others with an interest in our services, information about the quality of the services which we deliver.

This has been a difficult year for the Trust and at times we have let patients, staff and our partners down and in some areas we have not provided our patients with the safety and quality of care that they rightly expect and deserve, for this we are truly sorry.

We have failed to meet some of the standards required by the Care Quality Commission, Monitor and the Nursing and Midwifery Council.

The Trust received four Warning Notices from the Care Quality Commission in the period from September 2011 to February 2012. The Trust was found in significant breach of its’ authorisation under section 52 of the Health and Social Care Act 2008 on 11 October 2011 following declaration of a major incident following the identification of an issue that resulted in a significant number of patients not receiving their outpatient appointments within the required timescale. The Trust was found in significant breach for a second time on 6 February 2012.

The Trust has engaged with the Care Quality Commission, Monitor, Commissioners, NHS specialists and other expert resources to review the issues and develop a recovery plan.

Detailed reports were initially received in three areas:

- PriceWaterhouseCoopers Governance Review
- Central Manchester Diagnostic Review – Maternity Services
- Outpatient Review

In addition subject matter experts were consulted to provide review and recommendations for action and improvement in a number of areas including Unscheduled Care and Mortality. Ofsted and CQC undertook a Joint review of Safeguarding Children across Lancashire County Council and the local Health Economy in February 2012 and identified a number of areas for improvement for the Trust and across the economy. A similar review is currently taking place in Cumbria. The CQC also launched an inspection into the Emergency pathway at Furness General Hospital and the Royal Lancaster Infirmary in February 2012. The Trust anticipates that the draft report will be published in May 2012. Any recommendations from the report will be incorporated into the Trusts improvement plans.
These significant internal control issues have also been reported in the Annual Governance Statement and the Annual report.

The Trusts proposals for quality improvement are based on saving lives by reducing hospital mortality rates, preventing harmful events, reducing variations in fundamental aspects of basic care and continuously improving patient satisfaction and outcomes. The Trust aims for provide an exemplary patient experience in a safe and effective manner.

In selecting the priorities for 2012/2013 the Trust has considered the regulatory reviews undertaken in 2011/2012 and the issues these reviews identified. The priorities have been set in line with the recovery plan and the work streams developed in the Programme Management Office.

Monitoring of performance and progress will be through Programme Management Office (PMO), Programme Management Board (PMB), CQUIN (Commissioning for quality and innovation), national teams and the Trust committee structure.

The recovery plan implementation programme is now in place. Regular updates on progress will be published and shared with the public, our staff and stakeholders.

The Care Quality Commission and Monitor will continue to review the quality and safety of services delivered to our patients.

I confirm that to the best of my knowledge the information in this document is accurate.

ERIC MORTON
INTERIM CHIEF EXECUTIVE

DATE: 30 May 2012
8.2 Part 1a: Summary of Regulator Reviews

To be added
8.3 Part 2:

Priorities for improvement and statements of assurance from the Board

The Trust’s proposals for quality improvement 2012 onwards are based on saving lives by reducing hospital mortality rates, preventing harmful events, reducing variations in fundamental aspects of basic care, and continuously improving patient satisfaction and outcomes.

The Trust aims to provide an exemplary patient experience in a safe and effective manner. In the quality report for 2010/2011 the Trust identified the 2011/2012 priorities for improvement in relation to Safety, Clinical Effectiveness and Patient Experience. This section provides information on how we have progressed against the identified priorities in each of these areas.
Review of quality improvement priorities 2011/2012

Safety
Continued implementation of “Rapid Spread” and “Patient Safety Express” safety bundles. These two initiatives have been combined into a single programme.

“Improving Safety, Reducing Harm”

- Improved patient experience
- Reduce length of inpatient stay
- Reduce 30 day readmissions

Pressure ulcers, urinary tract infections, falls and venous thromboembolisms are all largely preventable events or conditions, which could extend the length of stay in hospital, adversely affect the outcome of the primary reason for admission, detract from the patient experience and possibly lead to readmission.

Malnutrition screening helps to ensure that patients receive adequate nutrition and support to aid faster recovery and minimise delays in discharge.

See Part 3 for further details.

The table below summarises the priorities we identified in relation to providing safe care.

<table>
<thead>
<tr>
<th>Priority</th>
<th>Anticipated Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduction of Hospital Acquired pressure Ulcers</td>
<td>- No more than 13 Grade 3 and 4 Hospital Acquired pressure ulcers. All Hospital Acquired pressure ulcers reduced by 30%</td>
</tr>
<tr>
<td>Reduction of catheter acquired urinary tract infections</td>
<td>- Catheter acquired urinary tract infections reduced by 50%</td>
</tr>
</tbody>
</table>
| Reducing inpatient falls | - Raise awareness amongst staff  
- Increase reporting  
- Reduce number of inpatient falls by 35% overall and 50% in pilot areas  
- Established pan Cumbria collaboration to learn and share best practice |
| Reduction of Venous Thromboembolism (VTE) | - Reduce Venous Thromboembolism (VTE) by 50% within 2 years |
| Continued implementation of malnutrition screening and improved nutrition. | - Comprehensive utilisation of the Malnutrition Universal Screening Tool (MUST) |
Reduction of Hospital Acquired pressure Ulcers

**What:** Reduction of all hospital acquired pressure ulcers, particularly the most serious grade 3 and 4 ulcers.

The overall indicator is to reduce all pressure ulcers acquired in hospital by 80% by March 2013. For 2011-12 a 30% reduction in all pressure ulcers and to have no more than 13 Grade 3 & 4 pressure ulcers.

**How much:** Reduce the overall total of hospital acquired pressure ulcers by 30% from the 2010-2011 baseline figure of 256 with no more than 13 grade 3 or 4.

**By when:** 31 March 2013

**Outcome:** The target for a reduction in grade 3 and 4 pressure ulcers has been met.

A total of 263 hospital acquired pressure ulcers have been reported, 9 of these being grade 3 and 4. The overall 30% reduction target has not been met, there has been an increase of 3% in all reported pressure ulcers.

**Progress:** The level and quality of reporting has continued to improve. An ongoing process of validation for all reports of hospital acquired pressure ulcers is in place.

**Improvements achieved:**

A number of measures have been introduced to continue to prevent and manage pressure ulcers.

- The Tissue Viability Link Nurse role has been strengthened by the introduction of a new role of Skin and Safety Advisors (SAS advisors)
- Introduction of Risk Assessment Bundle and Skin and Safety (SAS) Form
- Introduction of mattress and chair audits
- More effective management of specialist mattresses
- Introduction of an improved Wound Care Formulary
- Improved audit programme to monitor prevalence of tissue damage
- Improved incident reporting and follow up
Reduction of catheter acquired urinary tract infections

What: Reduction of all hospital acquired urinary tract infections in catheterised patients.

How much: A target of 50% reduction against a baseline established in 2010-2011 was agreed with commissioners.

By when: 31st March 2012

Outcome: The target has been achieved.
As part of the Cumbria collaborative group a series of audits was undertaken to determine the prevalence of catheter acquired urinary tract infections. The prevalence was found to be extremely low, much less than 1%.

It was acknowledged that the Trust had already reduced numbers significantly by adopting the Saving Lives guidance of 2007.

Improvements achieved:
New joint guidelines on testing and definitions issued. Prevalence will continue to be monitored.

Reducing inpatient falls

What: Reduce the overall number of inpatient falls and particularly those resulting in significant injury.

How much: A target of 25% reduction in the number of falls compared to 2010/2011 level of 2174 was agreed. Target reduction to 1631 falls.

By when: 31 March 2012

Outcome: The number of reported falls is 1947, this is a reduction of 10% compared with 2010/2011. The target has not been achieved.
The number of falls causing moderate or major harm was 32. This is the same as in 2010/2011.
The remainder of falls caused no injury or minor (requiring first aid) harm.

Progress: The reporting of falls remains consistently at a high level.
**Improvements achieved:**
Introduction of the Skin and Safety Bundle and intentional rounding continues to ensure that patients at risk of falling are assessed and monitored to ensure that common falling risks are minimised. Measures introduced include checks on:

- uncluttered bed space
- walking aids availability
- drinks, call button etc within easy reach
- improved guidance and additional training on the use of bedrails
- reinstatement of “Falls Group”

These measures will be maintained in 2012-2013 and will be part of the national “Safety Thermometer” programme and CQUIN.
Reduction of Venous Thromboembolism (VTE)

What: Reduce the number patients who develop a VTE

How much: 90% of all admitted inpatients to have a VTE risk assessment

By when: 31 March 2012

Outcome: The target has been met.

Progress: Consistently achieving above 90% in completed risk assessments for VTE prevention.

Continued implementation of malnutrition screening and improved nutrition

What: Improve the usage of the Malnutrition Universal Screening Tool (MUST)

How much: Increase usage by 50% in the cohort wards. Baseline usage 44%, target 66% usage.

By when: 31 March 2012

Outcome: Consistently achieving in excess of 90% usage. Target met.

Progress: Introduction of the MUST tool in conjunction with the Skin and Safety Bundle has maintained a high level of implementation.

Improvements achieved
A programme of audits is in place to monitor quality of implementation of the MUST tool. It is important to note that MUST is a tool not a rule. It is designed to identify and support those who are at high risk or would benefit most from nutritional support. Where clinical judgement indicates the process can be terminated or accelerated at any stage.

Audit Comments:

- Excellent number of patients had a MUST tool in place (97%) and of these 81% had it completed within 24 hours. Where further intervention or support was required:
  - 72% had a weight recorded.
  - 68% had BMI correctly calculated.
• 73% had a care plan completed and followed

Areas for further improvement:

• Aim to complete all MUST assessments within 24 hours of admission
• Need to modify the MUST form to accommodate a comments column and how weights are obtained.
• Ensure usual weight is recorded or document reason why not available
• Weight loss needs to be calculated from usual weight or admission weight not the previous week
• Always question discrepancies in weights or large changes over a week reweigh if necessary
• Remember to sign the appropriate care plan to say that it is has been completed.
• All patients should be rescreened and weighed weekly and reassessed thoroughly
Clinical Effectiveness

The table below summarises the priorities we identified in relation to improving clinical effectiveness.

<table>
<thead>
<tr>
<th>Priority</th>
<th>Anticipated Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care of stroke patients</td>
<td>The clinical outcomes will improve for all stroke patients.</td>
</tr>
<tr>
<td>Readmissions</td>
<td>Number of readmissions will reduce</td>
</tr>
<tr>
<td>Outpatient improvements</td>
<td>Reduction in cancelled appointments</td>
</tr>
</tbody>
</table>

Care of stroke patients

What: To improve the quality of care provided to stroke patients in line with national standards through Advancing Quality and CQUIN.

How much: 90% of stroke patients should receive the following measures

- 80% of stroke patients to spend 90% of time in hospital on stroke unit
- Direct admission within 4 hours
- Brain scan within 24 hours
- Aspirin given - if patients suitable for Aspirin
- Target 100% of patients weighed
- All patients to be assessed by Physiotherapist within 72 hours of admission
- Occupational Therapy assessment within 4 working days
- Swallowing screening by Dysphagia trained staff within 24 hours
- Assessment of mood completed on discharge

By when: 31 March 2012
Outcome:
The table below illustrates the levels of compliance achieved against each of the measures:

<table>
<thead>
<tr>
<th>Measure</th>
<th>RLI</th>
<th>FGH</th>
<th>Trust</th>
<th>Target level</th>
</tr>
</thead>
<tbody>
<tr>
<td>80% of stroke patients to spend 90% of time in hospital on stroke unit</td>
<td>35%</td>
<td>69%</td>
<td>49%</td>
<td>80%</td>
</tr>
<tr>
<td>Direct admission with in 4 hour</td>
<td>15%</td>
<td>52%</td>
<td>29%</td>
<td>100%</td>
</tr>
<tr>
<td>Brain scan within 24 hours</td>
<td>80%</td>
<td>86%</td>
<td>82%</td>
<td>100%</td>
</tr>
<tr>
<td>Aspirin given - if patients suitable for Aspirin</td>
<td>70%</td>
<td>74%</td>
<td>72%</td>
<td>93%</td>
</tr>
<tr>
<td>Patient weighed during admission</td>
<td>94%</td>
<td>94%</td>
<td>94%</td>
<td>85%</td>
</tr>
<tr>
<td>All patients to be assessed by Physiotherapist within 72 hours of admission</td>
<td>70%</td>
<td>82%</td>
<td>75%</td>
<td>91%</td>
</tr>
<tr>
<td>Occupational Therapy assessment within 4 working days</td>
<td>77%</td>
<td>84%</td>
<td>80%</td>
<td>83%</td>
</tr>
<tr>
<td>Swallowing screening by Dysphagia trained staff within 24 hours</td>
<td>73%</td>
<td>80%</td>
<td>75%</td>
<td>83%</td>
</tr>
<tr>
<td>Assessment of mood completed on discharge</td>
<td>88%</td>
<td>67%</td>
<td>81%</td>
<td>80%</td>
</tr>
</tbody>
</table>

The Trust has only met 2 of the 9 targets.

Progress:
The Trust has established a project dedicated to improving care for stroke patients. The project is monitored by the Programme Management Office as a component of the Turnaround Plan. The Key areas of improvement are:

1 - Stroke Acute Care Pathway
   - Embed 72 hour pathway / initial presentation process
   - Establish Acute Stroke beds on Emergency floor in Centenary building
   - Operating procedures and workforce arrangements for stroke beds
   - Transient Ischemic Attack Process

2 - Stroke rehab and discharge process
   - Improve transfer and discharge process
   - Stroke 'Rehabilitation' Unit

3 - Stroke Strategy and Organisational Structure
   - Governance, Leadership, Steering Group, Network
   - Develop and Implement Patient-Centred Stroke Strategy
   - Data Collection and Performance Targets
Readmissions

What: Reduce the number of readmissions following an episode of inpatient care.

How much: Baseline to be established. The baseline will be established utilising the CHKS clinical performance database. Performance will be benchmarked against a group of similar Trusts.

By when: 31 March 2012

Outcome: There were a total of 2699 readmissions within 7 days of discharge giving a readmission rate of 3.0%. Our peer group average rate of readmission is 3.4%

There were a total of 6520 readmissions within 30 days of discharge giving a readmission rate of 6.5%. Our peer group average rate of readmission is 7.1%

Progress:
The Trust readmission rates are slightly lower than those of similar Trusts.

This indicator will be included in the mandatory national set of core indicators for 2012-2013.

The measure will be; Emergency readmissions to hospital within 28 days of discharge.

To reduce the number of cancelled or re-arranged outpatient clinic appointments

What: To reduce the number of cancelled appointments by the patient and hospital.

How much: To achieve a reduction in cancelled appointments.

By when: 31 March 2012

Outcome: The Trust has reduced the number of cancelled appointments when measured against 2010/2011.
The graph below shows the percentage of appointment cancellations by patients and the Trust:

![Appointment Cancellations](image)

**Source:** Trust Board reports

This shows an increase of approximately 2.5% in patient cancellations and a reduction of approximately 1.5% in hospital cancellations.

A number of issues have arisen during the year which have had a serious impact on the provision of outpatient services. Appointments have been missed or delayed, which in some cases has resulted in patients suffering harm.

**Progress:**
The Trust has established a team to analyse the problems, develop and implement action plans to resolve this issue.

This issue is now being taken forward via the Programme Management Office. A recovery plan has been implemented. There is a dedicated work stream and implementation team in place to develop a safe, effective and sustainable outpatient service.

This project is in place to lead and manage the implementation and roll out of HUBs within UHMBFT. HUBs will be the model in which all outpatient capacity and demand will be monitored, measured and managed. The initial phase of this project is to implement booking HUBs for all consultant led specialities by May 2012.
Patient Experience

The table below summarises the priorities we identified in relation to improving the patient experience.

<table>
<thead>
<tr>
<th>Priority</th>
<th>Anticipated Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elderly service review</td>
<td>100 patient stories obtained to inform a service improvement plan</td>
</tr>
<tr>
<td>Emergency department patient experience</td>
<td>Improve the overall patient experience in Emergency Department</td>
</tr>
<tr>
<td>End of life care</td>
<td>In line with the national End of Life Care Strategy, promote high quality care for all adult patients at the end of life.</td>
</tr>
</tbody>
</table>

**Elderly service review**

**What:** Elderly Care Review - Comprehensive service review of clinical services delivered to older people focussed on patient stories. Agreed service improvement plan arising from service review

**How much:** 100 patient stories to be obtained

**By when:** 31 March 2012

**Outcome:** 111 patient stories obtained. An independent external organisation was engaged to collect the patient stories.

**Progress:** Target achieved

**Improvements achieved**

Patient stories currently being analysed to develop a service improvement plan.

Themes have been identified and action plans are being developed to address the issues raised.
Emergency department patient experience

What: To improve the overall patient experience within the Emergency department at Royal Lancaster infirmary.

In partnership with Lancashire LINk a detailed patient experience survey was undertaken to establish areas of concern within the department. The survey established patient’s views on the following issues:

- Privacy
- Communication
- Environment
- Satisfaction

Overall the responses to the survey were positive, but there was room for improvement in all areas.

How much: To achieve an overall improvement in the patient experience

By when: 31 March 2012

Outcome: A series of measures have been implemented by the department to improve the overall patient experience.

These include:

- Reorganisation of triage system
- Clarification of staff roles
- Improved shift coordination
- Introduction of triage/comments cards
- Welcome and information boards
- You said we did board
- Monitoring of complaints and compliments

Progress:
Monitoring of triage/comments cards began earlier in the year and is now embedded and providing good on-going feedback on patients’ views. The chart below summarises the overall patient experience measures for the final six months of the year.
Improvements achieved
Changes to the way ‘General Practitioner referred patients’ are managed have recently been introduced involving some re-organisation of assessment services including the introduction of ‘Short Stay’ services. This has already led to significant improvements for this group of patients and as a result has enabled the Emergency Department team to care for Emergency Department patients more effectively. Staffing levels improved.

New build commenced (extension to enable separate stream of ‘ambulatory’ patients (completion August 2012).

The CQC has raised a number of issues in relation to provision of emergency care. A dedicated work stream has been set up within the Project Management Office to rectify these issues and improve the emergency care pathway.

An internal follow up survey was conducted in March 2012 using the same questions and methodology to the joint survey undertaken with Lancashire LINk. In summary, the response to the question “Overall, how would you rate the care you received in the A & E department, the responses were:
<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
<td>40%</td>
<td>67%</td>
</tr>
<tr>
<td>Very good</td>
<td>35%</td>
<td>21%</td>
</tr>
<tr>
<td>Good</td>
<td>16%</td>
<td>8%</td>
</tr>
<tr>
<td>Fair</td>
<td>3%</td>
<td>4%</td>
</tr>
<tr>
<td>Poor</td>
<td>5%</td>
<td>0%</td>
</tr>
<tr>
<td>Very poor</td>
<td>1%</td>
<td>0%</td>
</tr>
</tbody>
</table>

The results are beginning to demonstrate a more positive experience for patients accessing the emergency department.

**End of life care**

**What:** In line with the national End of Life Care Strategy, promote high quality care for all adult patients at the end of life. Increase the percentage of all adult patients, who are identified as on the end of life pathway.

**How much:**

1a Establish a baseline of the number of adult patients who are identified as on the end of life pathway (July - Sept 2011)

1b Using the Gold Standards Framework (GSF) prognostic indicators, identify the number of adult patients who should be on the end of life pathway (September 2011)

1c Agree % increase of inpatient, who are identified as on the end of life pathway.

1d Increase the percentage of patients, who on admission are identified as being on the end of life care pathway, who are provided with an opportunity to review their Preferred Priority of Care (PPC)

1e 90% adult inpatient deaths will have a care after death form completed from January 2012

**By when:** 31 March 2012

**Outcome:** The Trust has achieved 2 of the targets, made good progress against 2 of the targets and failed to meet 1 of the targets.
Progress:

1a - Establish a baseline of the number of adult patients who are identified as on the end of life pathway (July - Sept 2011).

**Status report:** 69 patients were identified on the end of life pathway.

**Improvement actions:** Improve identification of patients and recording on Lorenzo.

1b - Using the GSF prognostic indicators, identify the number of adult patients who should be on the end of life pathway (September 2011).

**Status report:** Trust audit work has concurred that in line with the National average between 30 & 40% of inpatients at any one time would trigger against the End of Life prognostic indicators which would support their inclusion on an End of Life care register, as being potentially in the last 6-12 months of life.

**Improvement actions:** A pilot has been commenced on wards at FGH to support the identification and recording of patients (utilising a prognostic indicator guide) who meet the EoL criteria.

1c - Agree % increase of inpatient, who are identified as on the end of life pathway.

**Status report:** No agreement was made in relation to the % increase, however from the baseline of 69 patients in September 2011 there are now 306 patients with an EoL alert on Lorenzo. Where appropriate these patients are offered advanced care planning (PPC) and if in the dying phase the Liverpool Care Pathway is introduced.

**Improvement actions:** Table below shows improvements in numbers recorded:

<table>
<thead>
<tr>
<th>Year</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010-11</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>2011-12</td>
<td>7</td>
<td>1</td>
<td>6</td>
<td>10</td>
<td>29</td>
<td>30</td>
<td>41</td>
<td>49</td>
<td>42</td>
<td>31</td>
<td>25</td>
<td>9</td>
</tr>
</tbody>
</table>

1d - Increase the percentage of patients, who on admission are identified as being on the end of life care pathway, who are provided with an opportunity to review their Preferred Priority of Care (PPC)

**Status report:** There is no communication from primary care informing the admitting team if a patient has a PPC in place or is on an EoL care register this compromises the review of this documentation during an acute event.

**Improvement actions:** Improve EoL communications across the care boundaries to support the appropriate EoL discussion by health and social care professionals across all care boundaries.

1e - 90% adult inpatient deaths will have a care after death form completed from January 2012

**Status report:** A form was developed for use instead of the GP notification used when a patient died. Introduction of this was postponed. GP notification following the death of a patient is now communicated via Lorenzo utilising the patient discharge notification. Use of the form has been compromised by the lack of a centralised area for managing documentation following the death of a
patient on RLI site. Audit of recorded care following a patient’s death continues in line with on-going End of Life care audit.

**Improvement actions:** Review documentation requirement in view of the changes to GP communication.

An audit of care after death form is being undertaken at FGH this shows significant variance.

**Quality improvement priorities 2012/2013**

In selecting the priorities for 2012/2013 the Trust has considered the regulatory reviews undertaken in 2011/2012 and the issues these reviews identified. The priorities have been set in line with the recovery plan and the work streams developed in the Programme Management Office. Other key influences include the objectives set out in the Quality Report 2011/2012, Quality Improvement Strategy 2010/2013, the NHS Outcomes Framework and feedback from Trust activity and monitoring. The Trust has also considered the following:

- Staff and patients via NHS surveys
- Governors via meetings and workshops (lead by Chair, Director of Service and Commercial Development and Specialist Advisers)
- NHS Choices , Patient reported outcomes , Matrons’ questionnaires
- Primary Care Trusts, Practice Based Commissioners and partner organisations
- Customer care for complaints, concerns and compliments
- LINks - local involvement networks (community groups)
- Health Overview Scrutiny Committees
- Care Quality Commission

Monitoring of performance and progress will be through Programme Management Office (PMO), Programme Management Board (PMB), CQUIN (Commissioning for quality and innovation), national teams and the Trust committee structure.
## Safety

<table>
<thead>
<tr>
<th>Priority</th>
<th>Outpatients – harms assessment and reporting and development of Outpatient Booking Hubs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rationale</strong></td>
<td>Implementation of Harms measurement will provide assurance to the Board and the public that our services are provided in a safe manner.</td>
</tr>
<tr>
<td><strong>What will be measured</strong></td>
<td>Assessment of harms using NPSA tool and to openly communicate with patients the findings of the review in to their care. Outpatients booking hubs are being established to provide a robust mechanism for ensuring patients receive appointments at the correct time and are not ‘missed’. Hubs in all areas will be established by May 2012.</td>
</tr>
<tr>
<td><strong>When</strong></td>
<td>Start May 2012 – Complete July 2012</td>
</tr>
<tr>
<td><strong>Outcome</strong></td>
<td>Establish baseline level of harms experienced during outpatient episodes.</td>
</tr>
<tr>
<td><strong>Lead</strong></td>
<td>Medical Director</td>
</tr>
<tr>
<td><strong>Monitoring</strong></td>
<td>PMO to monitor implementation and progress – report to PMB and committees(to be confirmed)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Priority</th>
<th>Enhanced Risk Management</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rationale</strong></td>
<td>The CQC and Monitor reviews of Maternity services in 2011/12 identified a shortfall in incident management processes. A number of issues have arisen during the year which have confirmed the issue requires addressing throughout the Trust. Monitoring of this indicator will provide assurances that robust systems are in place to manage and learn from all serious untoward incidents (SUls).</td>
</tr>
<tr>
<td><strong>What will be measured</strong></td>
<td>Time taken for the completion of all action arising from SUls (including feedback to the team).</td>
</tr>
<tr>
<td><strong>When</strong></td>
<td>Start April 2012 – Complete March 2013</td>
</tr>
<tr>
<td><strong>Outcome</strong></td>
<td>To be measured against Trust policy (45 days normally – 60 days for external investigation). Measured every month. Aim for 100% compliance.</td>
</tr>
<tr>
<td><strong>Lead</strong></td>
<td>Director of Nursing</td>
</tr>
<tr>
<td><strong>Monitoring</strong></td>
<td>PMO to monitor implementation and progress – report to PMB and committees(to be confirmed)</td>
</tr>
</tbody>
</table>
### Priority “Harm Free Care” – Falls

**Rationale**
Part of national Patient Safety Express/Safety Thermometer initiative.

Reduce incidence of falls causing moderate or significant harm to patients using enhancing monitoring and interventions including learning lessons from previous incidents.

This work is an on-going project and needs to maintain a high profile to continue making improvements.

**What will be measured**
A target of 25% reduction in the number of falls compared to the baseline in 2010/2011 level of 2174.32 resulted in moderate or major harm.

In 2011/2012 falls reduced to 1947.32 resulted in moderate or major harm.

**When**
Start April 2012 – Complete March 2013

**Outcome**
Target reduction to 1631 falls.

**Lead**
Director of Nursing

**Monitoring**
To be monitored via safeguard incident reporting system. Reports be monitored via – Falls Group and Trust Committee structure.

### Priority “Harm Free Care” – Pressure Ulcers

**Rationale**
Part of national Patient Safety Express initiative.

Hospital acquired pressure ulcers can cause significant harm to patients. The Trust is aiming to build on the work undertaken in 2011/12 and reduce all grades of pressures ulcers and particularly the most significant grade 3 and 4 pressure ulcers. This work is an on-going project and needs to maintain a high profile to continue making improvements.

**What will be measured**
Reduction of all hospital acquired pressure ulcers, particularly the most serious grade 3 and 4 ulcers.

The overall indicator is to reduce all pressure ulcers acquired in hospital by 80% by March 2013 from the 2010-2011 baseline figures of 256.
For 2011-12 the Trust recorded 263 pressure ulcers with 9 of these being grade 3 or 4.

<table>
<thead>
<tr>
<th>Priority</th>
<th>“Harm Free Care” – Patient Monitoring “Early Warning Scores” (EWS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rationale</td>
<td>Part of national Patient Safety Express initiative.</td>
</tr>
</tbody>
</table>

The Care Quality Commission issued the Trust with a Warning Notice in February 2012 with regard to non-compliance with the Trust’s procedures in relation to physiological observations and early warning signs. The Trust has escalated surveillance and monitoring across the emergency pathway to provide assurance on compliance and address issues where non-compliance with procedures is identified. Additional training and support has been given to staff.

This work is an on-going project and needs to maintain a high profile to continue making improvements.

<table>
<thead>
<tr>
<th>What will be measured</th>
<th>Compliance with Patient Safety Express initiative measures.</th>
</tr>
</thead>
<tbody>
<tr>
<td>When</td>
<td>Start April 2012 – Complete March 2013</td>
</tr>
<tr>
<td>Outcome</td>
<td>100% compliance</td>
</tr>
<tr>
<td>Lead</td>
<td>Director of Nursing</td>
</tr>
<tr>
<td>Monitoring</td>
<td>Monitoring will be via a series of audits. The outcome will be reported via the Trust Committee structure.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Priority</th>
<th>Safeguarding Review (Adults)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rationale</td>
<td>The Trust recognises a need to improve safeguarding and governance arrangements and to enhance safeguarding capacity and capability at operational and Board level. This includes multi-agency relationships.</td>
</tr>
</tbody>
</table>

The level of care for vulnerable patients will be enhanced.

| What will be measured | • Monthly number of potential instances of safeguarding identified for investigation increases.  
|                       | • Training – Number of staff trained per quarter. Indicated as |

| Outcome | Original target – 51. Final target values to be confirmed with commissioners. Grade 3 and 4 pressure ulcers to be less than 9. |

<table>
<thead>
<tr>
<th>Lead</th>
<th>Director of Nursing</th>
</tr>
</thead>
</table>
| Monitoring | To be monitored via safeguard incident reporting system  
| Reports to be monitored via –Trust Committee structure. |
- Uniformity/Evidence - reporting package (outputs TBC) of statistics on all safeguarding and MCA DoLS cases reviewed by Trust safeguarding lead.

<table>
<thead>
<tr>
<th>When</th>
<th>April 2012-March 2013</th>
</tr>
</thead>
</table>
| Outcome    | Number of investigations will increase.  
Number of staff trained will increase.  
Quality of reporting will increase |
| Lead       | Director of Nursing   |
| Monitoring | The outcome will be reported via the Trust Committee structure. |

<table>
<thead>
<tr>
<th>Priority</th>
<th>Safeguarding Review (Children)</th>
</tr>
</thead>
</table>
| Rationale| The Trust recognises a need to improve safeguarding and governance arrangements and to enhance safeguarding capacity and capability at operational and Board level. This includes multi-agency relationships.  
The level of care for vulnerable children will be enhanced. |
| What will be measured | Final measures to be determined on receipt and evaluation of CQC report |
| When | April 2012-March 2013 |
| Outcome | Final measures to be determined on receipt and evaluation of CQC report |
| Lead | Director of Nursing |
| Monitoring | The outcome will be reported via the Trust Committee structure. |
### Effectiveness

<table>
<thead>
<tr>
<th>Priority</th>
<th>Stroke Pathways Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rationale</td>
<td>This is a national priority and the Trust acknowledges that the service to stroke patients must be improved. Following the Stroke Network Peer review, a number of concerns were raised regarding care for acutely ill stroke patients. The Trust has initiated a programme to improve the quality of care provided to stroke patients in line with national standards including an interim plan to identify dedicated beds for acutely ill stroke patients at the Royal Lancaster Infirmary.</td>
</tr>
</tbody>
</table>
| What will be measured | Continue to improve the quality of care provided to stroke patients in line with national standards. Key performance indicators (KPI) are:  
- 80% of stroke patients to spend 90% of time in hospital on stroke unit  
- Direct admission within 4 hours  
- Brain scan within 24 hours  
- Aspirin given - if patients suitable for Aspirin  
- Target 100% of patients weighed  
- All patients to be assessed by Physiotherapist within 72 hours of admission  
- Occupational Therapy assessment within 4 working days  
- Swallowing screening by Dysphagia trained staff within 24 hours  
- Assessment of mood completed on discharge |
| When       | Start April 2012 – Complete March 2013                                                      |
| Outcome    | PMO to monitor implementation and progress against KPIs on a monthly basis – report to PMB |
| Lead       | Medical Director                                                                            |
| Monitoring | Reports to be monitored via –Trust Committee structure.                                     |

### Readmissions

<table>
<thead>
<tr>
<th>Priority</th>
<th>Readmissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rationale</td>
<td>This is a national priority. The readmission rate provides an overall indicator on the quality and efficacy of services provided Patient care should be optimised throughout their stay to ensure that the need to emergency readmission is minimised. The readmission rate provides an overall indicator on the quality and efficacy of services provided.</td>
</tr>
<tr>
<td>What will be measured</td>
<td>In line with Domain 3 of the NHS Outcomes Framework for 2012/13.</td>
</tr>
<tr>
<td><strong>Emergency readmissions to hospital within 28 days of discharge.</strong></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td></td>
</tr>
<tr>
<td><strong>When</strong></td>
<td>Start April 2012 – Complete March 2013</td>
</tr>
<tr>
<td><strong>Outcome</strong></td>
<td>The percentage of patients of all ages and genders who were readmitted to hospital within 28 days of being discharged. This is to be compared against the national average.</td>
</tr>
<tr>
<td><strong>Lead</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Monitoring</strong></td>
<td>Data collection is to be via existing Hospital Episode Statistics mechanisms. Reporting on progress will be via the Trust committee structure</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Priority</strong></th>
<th><strong>Mortality</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rationale</strong></td>
<td>The Trust performed poorly against the target indices. An on-going project is in place to improve mortality ratings. Achieving levels of the best performing Trusts will restore public confidence in the Trust whilst also providing assurance to the Board. An improvement project has been set up within the Trust with detailed action plans and measures in place.</td>
</tr>
<tr>
<td><strong>What will be measured</strong></td>
<td>The aim is to improve performance against all published indices. Hospital mortality rates and risk-adjusted rates are dependent upon clinical information, clinical care and arrangements for end of life care in a primary care setting.</td>
</tr>
<tr>
<td><strong>When</strong></td>
<td>Start April 2012 – Complete March 2013</td>
</tr>
<tr>
<td><strong>Outcome</strong></td>
<td>Monthly monitoring statistics will be produced via the CHKS clinical performance database. Target is to achieve performance in line with our peer group average.</td>
</tr>
<tr>
<td><strong>Lead</strong></td>
<td>Medical Director</td>
</tr>
<tr>
<td><strong>Monitoring</strong></td>
<td>PMO to monitor implementation and progress – report to PMB Reports to be monitored via –Trust Committee structure</td>
</tr>
</tbody>
</table>
### Experience

<table>
<thead>
<tr>
<th>Priority</th>
<th>Transforming Unscheduled Care</th>
</tr>
</thead>
</table>
| **Rationale**    | The CQC review of the emergency department identified a number of issues relating to the provision of emergency care.  
This indicator will provide assurance to the public and Board that the current and planned changes to the whole emergency care pathway are improving the quality and effectiveness of service provision. |
| What will be measured | Improvement in the overall experience for patients requiring urgent unscheduled care.  
An improvement project has been set up within the Trust with detailed action plans and measures in place |
| When             | Start April 2012 – Complete March 2013 |
| Outcome          | Key indicator to be monitored is the time spent in the Emergency department should be less than 4 hours for 95% of patients |
| Lead             | Medical Director |
| Monitoring       | PMO to monitor implementation and progress – report to PMB  
Reports to be monitored via –Trust Committee structure |

<table>
<thead>
<tr>
<th>Priority</th>
<th>End of life care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rationale</strong></td>
<td>This project was begun in 2011/12 and actions have been implemented. The Trust has not yet met the standards required. In line with the national End of Life Care Strategy, promote high quality care for all adult patients at the end of life.</td>
</tr>
<tr>
<td>What will be measured</td>
<td>Increase the percentage of all adult patients, who are identified as on the end of life care instances and receive the appropriate care pathway</td>
</tr>
<tr>
<td>When</td>
<td>Start April 2012 – Complete March 2013</td>
</tr>
<tr>
<td>Outcome</td>
<td>An improvement project has been set up within the Trust with detailed action plans and measures in place</td>
</tr>
<tr>
<td>Lead</td>
<td>Medical Director</td>
</tr>
</tbody>
</table>
| Monitoring       | PMO to monitor implementation and progress – report to PMB  
Reports to be monitored via –Trust Committee structure |
<table>
<thead>
<tr>
<th>Priority</th>
<th>Maternity Patient Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rationale</td>
<td>The CQC and Monitor’s reviews of Maternity services in 2011/12 identified a shortfall in patient engagement and feedback. A number of issues have arisen during the year which has confirmed the issue. Monitoring of this indicator will provide assurances that robust systems are in place to engage with women and develop robust feedback/communication mechanisms relating to maternity services. There is a need to restore confidence to women using the service. The trust needs to provide assurance to regulators that services have improved.</td>
</tr>
<tr>
<td>What will be measured</td>
<td>Ensure the quality of patient experience is measured and monitored on a regular basis. Ensure patient feedback is registered and used to influence practice and service development. Liaise with external groups/individuals to ensure opportunities for external validation of services and changes planned Consult stakeholders in proposals for change to enable service users views to influence models of care</td>
</tr>
<tr>
<td>When</td>
<td>Start April 2012 – Complete March 2013</td>
</tr>
<tr>
<td>Outcome</td>
<td>An improvement project has been set up within the Trust with detailed action plans and measures in place.</td>
</tr>
<tr>
<td>Lead</td>
<td>Director of Nursing</td>
</tr>
<tr>
<td>Monitoring</td>
<td>PMO to monitor implementation and progress – report to PMB Reports to be monitored via –Trust Committee structure</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Priority</th>
<th>Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rationale</td>
<td>The Trust has recognised that discharge procedures need to be improved. The discharge process and procedures remain a concern to patients. The issue requires to be addressed to improve the whole process and experience for patients at discharge. A number of issues need to be addressed to improve care and the safe and effective discharge of patients. Key issues identified are:</td>
</tr>
<tr>
<td></td>
<td>- Delayed transfers of care to a more appropriate care</td>
</tr>
</tbody>
</table>
| Environment | Ensuring care is provided in the most appropriate environment and reducing outliers  
Improving information and communication relative to the whole discharge process. |
|---|---|
| What will be measured | Ensure that the discharge processes and procedures meet patient’s needs and expectations.  
The Trust has consistently failed to provide a high standard of discharge experience. This is reflected in the National In-Patient Survey where a number of discharge related indicators are significantly worse than the average for other Trusts |
| When | Start April 2012 – Complete March 2013 |
| Outcome | An improvement project is being set up within the Trust with detailed action plans and measures in place. |
| Lead | Chief Operating Officer. |
| Monitoring | PMO to monitor implementation and progress – report to PMB  
Reports to be monitored via –Trust Committee structure |

<table>
<thead>
<tr>
<th>Priority</th>
<th>Dementia Care</th>
</tr>
</thead>
</table>
| Rationale | The demographics within the Trust catchment areas are showing an increase in the elderly population and linked to this is an increase in the incidence of dementia amount the population. There has been a national strategy for dementia and the momentum to improve area has increased and the Trust needs to respond to and enhance care given to this group of patients.  
Improve awareness and diagnosis of dementia, using risk assessment, in an acute hospital setting. |
| What will be measured | % of all patients aged 75 and over who have been screened following admission to hospital, using the dementia screening question.  
% of all patients aged 75 and over, who have been screened as at risk of dementia, who have had a dementia risk assessment within 72 hours of admission to hospital, using the hospital dementia risk assessment tool.  
% of all patients aged 75 and over, identified as at risk of having dementia who are referred for specialist diagnosis. |
<table>
<thead>
<tr>
<th>When</th>
<th>Start May 2012 – Complete July 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome</td>
<td>Key indicators (National CQUIN) 90% of all patients in the 3 separate indicators over 3 consecutive months in the first year. An improvement project has been set up within the Trust with detailed action plans and measures in place</td>
</tr>
<tr>
<td>Lead</td>
<td>Director of Nursing</td>
</tr>
<tr>
<td>Monitoring</td>
<td>PMO to monitor implementation and progress – report to PMB and committees(to be confirmed).</td>
</tr>
</tbody>
</table>
Statements of assurance from the board

Information on the review of services.

During 2011/12 the University Hospitals of Morecambe Bay NHS Foundation Trust provided and/or sub-contracted 45 NHS services. These services are provided under the following regulated activities:

- Maternity & Midwifery Services
- Surgical Procedures
- Termination of Pregnancy,
- Treatment of Disease, Disorder and Injury
- Diagnostic and Screening Procedures

The University Hospitals of Morecambe Bay NHS Foundation Trust has reviewed all the data available to them on the quality of care in 45 of these NHS services.

The income generated by the NHS services reviewed in 2011/12 represents 99 per cent of the total income generated from the provision of NHS services by the University Hospitals of Morecambe Bay NHS Foundation Trust for 2011/12.

The data reviewed covers the three dimensions of quality – patient safety, clinical effectiveness and patient experience. During the year there were problems with data completeness which contributed to the problems experienced in outpatients.

Clinical audits and national confidential enquiries

During 2011/12 there were a total of 51 national clinical audits and 2 national confidential enquiries covered NHS services, of which 41 national audits and 1 NCEPOD that University Hospitals of Morecambe Bay NHS Foundation Trust were eligible to participate in.

During 2011/12 University Hospitals of Morecambe Bay NHS Foundation Trust participated in 78% of national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that University Hospitals of Morecambe Bay NHS Foundation Trust was eligible to participate in during 2011/12 are as follows:
<table>
<thead>
<tr>
<th>Name of audit</th>
<th>Peri-and Neo-natal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perinatal mortality (MBRRACE-UK)</td>
<td></td>
</tr>
<tr>
<td>Neonatal intensive and special care (NNAP)</td>
<td></td>
</tr>
<tr>
<td>Children</td>
<td></td>
</tr>
<tr>
<td>Paediatric pneumonia (British Thoracic Society)</td>
<td></td>
</tr>
<tr>
<td>Paediatric asthma (British Thoracic Society)</td>
<td></td>
</tr>
<tr>
<td>Pain management (College of Emergency Medicine)</td>
<td></td>
</tr>
<tr>
<td>Childhood epilepsy (RCPH National Childhood Epilepsy Audit)</td>
<td></td>
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<tr>
<td>Diabetes (RCPH National Paediatric Diabetes Audit)</td>
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<tr>
<td>Acute care</td>
<td></td>
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<tr>
<td>Emergency use of oxygen (British Thoracic Society)</td>
<td></td>
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<tr>
<td>Adult community acquired pneumonia (British Thoracic Society)</td>
<td></td>
</tr>
<tr>
<td>Non-invasive ventilation - adults (British Thoracic Society)</td>
<td></td>
</tr>
<tr>
<td>Pleural procedures (British Thoracic Society)</td>
<td></td>
</tr>
<tr>
<td>Cardiac arrest (National Cardiac Arrest Audit)</td>
<td></td>
</tr>
<tr>
<td>Severe sepsis &amp; septic shock (College of Emergency Medicine)</td>
<td></td>
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<tr>
<td>Adult critical care (ICNARC CMPD)</td>
<td></td>
</tr>
<tr>
<td>Potential donor audit (NHS Blood &amp; Transplant)</td>
<td></td>
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<tr>
<td>Seizure management (National Audit of Seizure Management)</td>
<td></td>
</tr>
<tr>
<td>Long term conditions</td>
<td></td>
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<tr>
<td>Diabetes (National Adult Diabetes Audit)</td>
<td></td>
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<tr>
<td>Heavy menstrual bleeding (RCOG National Audit of HMB)</td>
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<tr>
<td>Chronic pain (National Pain Audit)</td>
<td></td>
</tr>
<tr>
<td>Ulcerative colitis &amp; Crohn's disease (UK IBD Audit)</td>
<td></td>
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<tr>
<td>Parkinson's disease (National Parkinson's Audit)</td>
<td></td>
</tr>
<tr>
<td>Adult asthma (British Thoracic Society)</td>
<td></td>
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<tr>
<td>Bronchiectasis (British Thoracic Society)</td>
<td></td>
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<tr>
<td>Elective procedures</td>
<td></td>
</tr>
<tr>
<td>Hip, knee and ankle replacements (National Joint Registry)</td>
<td></td>
</tr>
<tr>
<td>Elective surgery (National PROMs Programme)</td>
<td></td>
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<tr>
<td>Peripheral vascular surgery (VSGBI Vascular Surgery Database)</td>
<td></td>
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<tr>
<td>Carotid interventions (Carotid Intervention Audit)</td>
<td></td>
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<tr>
<td>Cardiovascular disease</td>
<td></td>
</tr>
<tr>
<td>Acute Myocardial Infarction &amp; other ACS (MINAP)</td>
<td></td>
</tr>
<tr>
<td>Heart failure (Heart Failure Audit)</td>
<td></td>
</tr>
<tr>
<td>Acute stroke (SINAP)</td>
<td></td>
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<tr>
<td>Cardiac arrhythmia (Cardiac Rhythm Management Audit)</td>
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<tr>
<td>Cancer</td>
<td></td>
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<tr>
<td>Lung cancer (National Lung Cancer Audit)</td>
<td></td>
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<tr>
<td>Bowel cancer (National Bowel Cancer Audit Programme)</td>
<td></td>
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<tr>
<td>Head &amp; neck cancer (DAHNO)</td>
<td></td>
</tr>
</tbody>
</table>
Oesophago-gastric cancer (National O-G Cancer Audit)

**Trauma**
- Hip fracture (National Hip Fracture Database)
- Severe trauma (Trauma Audit & Research Network)

**Blood transfusion**
- Bedside transfusion (National Comparative Audit of Blood Transfusion)
- Medical use of blood (National Comparative Audit of Blood Transfusion)

**Health promotion**
- Risk factors (National Health Promotion in Hospitals Audit)

**End of life**
- Care of dying in hospital (NCDAH)

**NCEPOD**
- Cardiac arrest procedures
- Total: 42

The national clinical audits and national confidential enquiries that University Hospitals of Morecambe Bay NHS Foundation Trust participated in during 2011/12 are as follows:

<table>
<thead>
<tr>
<th>Name of audit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peri-and Neo-natal</td>
</tr>
<tr>
<td>Perinatal mortality (MBRRACE-UK)</td>
</tr>
<tr>
<td>Neonatal intensive and special care (NNAP)</td>
</tr>
<tr>
<td><strong>Children</strong></td>
</tr>
<tr>
<td>Paediatric pneumonia (British Thoracic Society)</td>
</tr>
<tr>
<td>Paediatric asthma (British Thoracic Society)</td>
</tr>
<tr>
<td>Childhood epilepsy (RCPH National Childhood Epilepsy Audit)</td>
</tr>
<tr>
<td>Diabetes (RCPH National Paediatric Diabetes Audit)</td>
</tr>
<tr>
<td><strong>Acute care</strong></td>
</tr>
<tr>
<td>Adult community acquired pneumonia (British Thoracic Society)</td>
</tr>
<tr>
<td>Severe sepsis &amp; septic shock (College of Emergency Medicine)</td>
</tr>
<tr>
<td>Adult critical care (ICNARC CMPD)</td>
</tr>
<tr>
<td>Potential donor audit (NHS Blood &amp; Transplant)</td>
</tr>
<tr>
<td>Seizure management (National Audit of Seizure Management)</td>
</tr>
<tr>
<td><strong>Long term conditions</strong></td>
</tr>
<tr>
<td>Heavy menstrual bleeding (RCOG National Audit of HMB)</td>
</tr>
<tr>
<td>Chronic pain (National Pain Audit)</td>
</tr>
<tr>
<td>Ulcerative colitis &amp; Crohn's disease (UK IBD Audit)</td>
</tr>
<tr>
<td>Adult asthma (British Thoracic Society)</td>
</tr>
<tr>
<td>Bronchiectasis (British Thoracic Society)</td>
</tr>
<tr>
<td><strong>Elective procedures</strong></td>
</tr>
<tr>
<td>Hip, knee and ankle replacements (National Joint Registry)</td>
</tr>
<tr>
<td>Category</td>
</tr>
<tr>
<td>----------------------------------</td>
</tr>
<tr>
<td>Elective surgery</td>
</tr>
<tr>
<td>Peripheral vascular surgery</td>
</tr>
<tr>
<td>Carotid interventions</td>
</tr>
<tr>
<td>Cardiovascular disease</td>
</tr>
<tr>
<td>Acute Myocardial Infarction &amp;</td>
</tr>
<tr>
<td>other ACS</td>
</tr>
<tr>
<td>Acute stroke</td>
</tr>
<tr>
<td>Cancer</td>
</tr>
<tr>
<td>Lung cancer</td>
</tr>
<tr>
<td>Bowel cancer</td>
</tr>
<tr>
<td>Head &amp; neck cancer</td>
</tr>
<tr>
<td>Oesophago-gastric cancer</td>
</tr>
<tr>
<td>Trauma</td>
</tr>
<tr>
<td>Hip fracture</td>
</tr>
<tr>
<td>Severe trauma</td>
</tr>
<tr>
<td>Blood transfusion</td>
</tr>
<tr>
<td>Bedside transfusion</td>
</tr>
<tr>
<td>Medical use of blood</td>
</tr>
<tr>
<td>Health promotion</td>
</tr>
<tr>
<td>Risk factors</td>
</tr>
<tr>
<td>End of life</td>
</tr>
<tr>
<td>Care of dying in hospital</td>
</tr>
<tr>
<td>NCEPOD</td>
</tr>
<tr>
<td>Cardiac arrest procedures</td>
</tr>
<tr>
<td>Total: 33</td>
</tr>
</tbody>
</table>
The national clinical audits and national confidential enquiries that University Hospitals of Morecambe Bay NHS Foundation Trust participated in, and for which data collection was completed during 2011/12, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

<table>
<thead>
<tr>
<th>Name of audit</th>
<th>No. of cases required by Audit &amp; %</th>
<th>No. of cases submitted to Audit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Peri-and Neo-natal</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Perinatal mortality (MBRRACE-UK)</td>
<td>FGH 9 (100%)</td>
<td>FGH 9 RLI awaiting</td>
</tr>
<tr>
<td>2 Neonatal intensive and special care (NNAP)</td>
<td>On-going</td>
<td></td>
</tr>
<tr>
<td><strong>Children</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Paediatric pneumonia (British Thoracic Society)</td>
<td>FGH 5 (100%)</td>
<td>FGH 5 RLI 12</td>
</tr>
<tr>
<td>4 Paediatric asthma (British Thoracic Society)</td>
<td>FGH 8 (100%)</td>
<td>FGH 8 RLI 25</td>
</tr>
<tr>
<td>5 Childhood epilepsy (RCPH National Childhood Epilepsy Audit)</td>
<td>1 FGH (100%)</td>
<td>1 FGH</td>
</tr>
<tr>
<td>6 Diabetes (RCPH National Paediatric Diabetes Audit)</td>
<td>140 Trust wide no breakdown</td>
<td></td>
</tr>
<tr>
<td><strong>Acute care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 Adult community acquired pneumonia (British Thoracic Society)</td>
<td>RLI 85 (100%)</td>
<td>RLI 85</td>
</tr>
<tr>
<td>8 Severe sepsis &amp; septic shock (College of Emergency Medicine)</td>
<td>30 (67%) 30 (100%)</td>
<td>FGH 20 RLI 30</td>
</tr>
<tr>
<td>9 Adult critical care (ICNARC CMPD)</td>
<td>FGH 341 (100%) RLI 469 (100%)</td>
<td>FGH 341 RLI 469</td>
</tr>
<tr>
<td>10 Potential donor audit (NHS Blood &amp; Transplant)</td>
<td>Unable to access data</td>
<td></td>
</tr>
<tr>
<td>11 Seizure management (National Audit of Seizure Management)</td>
<td>30 (93%) 30 (80%)</td>
<td>FGH 28 RLI 24</td>
</tr>
</tbody>
</table>
### Long term conditions

<table>
<thead>
<tr>
<th></th>
<th>Condition</th>
<th>On-going</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>Heavy menstrual bleeding (RCOG National Audit of HMB)*</td>
<td>17</td>
</tr>
<tr>
<td>13</td>
<td>Chronic pain (National Pain Audit)</td>
<td>On-going</td>
</tr>
<tr>
<td>14</td>
<td>Ulcerative colitis &amp; Crohn's disease (UK IBD Audit)</td>
<td>UC 20 (60%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CD 20 (60%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>UC 20 (50%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CD 20 (70%)</td>
</tr>
<tr>
<td>15</td>
<td>Adult asthma (British Thoracic Society)</td>
<td>10 RLI (100%)</td>
</tr>
<tr>
<td>16</td>
<td>Bronchiectasis (British Thoracic Society)</td>
<td>21 RLI (100%)</td>
</tr>
</tbody>
</table>

### Elective procedures

<table>
<thead>
<tr>
<th></th>
<th>Procedure</th>
<th>On-going</th>
</tr>
</thead>
<tbody>
<tr>
<td>17</td>
<td>Hip, knee and ankle replacements (National Joint Registry)</td>
<td>On-going</td>
</tr>
<tr>
<td>18</td>
<td>Elective surgery (National PROMs Programme)</td>
<td>On-going</td>
</tr>
<tr>
<td>19</td>
<td>Peripheral vascular surgery (VSGBI Vascular Surgery Database)</td>
<td>27 (100%)</td>
</tr>
<tr>
<td>20</td>
<td>Carotid interventions (Carotid Intervention Audit)*</td>
<td>44 (100%)</td>
</tr>
</tbody>
</table>

### Cardiovascular disease

<table>
<thead>
<tr>
<th></th>
<th>Condition</th>
<th>On-going</th>
</tr>
</thead>
<tbody>
<tr>
<td>21</td>
<td>Acute Myocardial Infarction &amp; other ACS (MINAP)</td>
<td>On-going</td>
</tr>
<tr>
<td>22</td>
<td>Acute stroke (SINAP)</td>
<td>On-going</td>
</tr>
</tbody>
</table>

### Cancer

<table>
<thead>
<tr>
<th></th>
<th>Condition</th>
<th>On-going</th>
</tr>
</thead>
<tbody>
<tr>
<td>23</td>
<td>Lung cancer (National Lung Cancer Audit)</td>
<td>On-going</td>
</tr>
<tr>
<td>24</td>
<td>Bowel cancer (National Bowel Cancer Audit Programme)</td>
<td>On-going</td>
</tr>
<tr>
<td>25</td>
<td>Head &amp; neck cancer (DAHNO)</td>
<td>On-going</td>
</tr>
<tr>
<td>26</td>
<td>Oesophago-gastric cancer (National O-G Cancer Audit)</td>
<td>cancer services stated that audit did not take place</td>
</tr>
</tbody>
</table>

### Trauma

<table>
<thead>
<tr>
<th></th>
<th>Condition</th>
<th>On-going</th>
</tr>
</thead>
<tbody>
<tr>
<td>27</td>
<td>Hip fracture (National Hip Fracture Database)</td>
<td>On-going</td>
</tr>
<tr>
<td></td>
<td>Severe trauma (Trauma Audit &amp; Research Network)</td>
<td>On-going</td>
</tr>
<tr>
<td>---</td>
<td>-----------------------------------------------</td>
<td>---------</td>
</tr>
</tbody>
</table>

**Blood transfusion**

<table>
<thead>
<tr>
<th></th>
<th>Bedside transfusion (National Comparative Audit of Blood Transfusion)</th>
<th>All cases (100%)</th>
<th>FGH 13 RLI 13 WGH 5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Medical use of blood (National Comparative Audit of Blood Transfusion)</td>
<td>Still current</td>
<td>FGH 8 RLI 27</td>
</tr>
</tbody>
</table>

**Health promotion**

<table>
<thead>
<tr>
<th></th>
<th>Risk factors (National Health Promotion in Hospitals Audit)</th>
<th>100 (100%)</th>
<th>100 (100%)</th>
<th>100 (80%)</th>
<th>FGH 100 RLI 100 WGH 80</th>
</tr>
</thead>
</table>

**End of life**

<table>
<thead>
<tr>
<th></th>
<th>Care of dying in hospital (NCDAH)</th>
<th>30 (100%)</th>
<th>30</th>
</tr>
</thead>
</table>

**NCEPOD**

<table>
<thead>
<tr>
<th></th>
<th>Cardiac arrest procedures</th>
<th>1/1 FGH (100%)</th>
<th>3/4 RLI (75%)</th>
</tr>
</thead>
</table>

**Total: 33**

The reports of all national clinical audits were reviewed by the provider in 2011/12 and University Hospitals of Morecambe Bay NHS Foundation Trust intends to take the actions to improve the quality of healthcare provided.

The reports of national clinical audits were reviewed in detail by the clinical teams involved.

The reports of 87 local clinical audits were reviewed by the provider in 2011/12 and University Hospitals of Morecambe Bay NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

- Reports will continue to be presented to Clinical Audit and Effectiveness Sub-Committee & Divisional Governance Groups.
- Any recommendations are taken forward by the relevant clinical team supported by the Associate Medical Directors and discussed within the Division where relevant action plans are developed.
Improvements may include a change to the patient pathway, a change in a policy or procedure and any necessary education and training as required.

Local Audits are vital in measuring and benchmarking clinical practice against agreed national and local standards. The Trust Clinical Audit Department ensures that the full cycle of clinical audit is maintained.

**Information on participation in clinical research**

The number of patients receiving NHS services provided or sub-contracted by University Hospitals of Morecambe Bay NHS Foundation Trust that were recruited during that period to participate in research approved by a research ethics committee was 678.

**Information on the use of the CQUIN framework**

A proportion of University Hospitals of Morecambe Bay NHS Foundation Trust income in 2011/12 was conditional upon achieving quality improvement and innovation goals agreed between University Hospitals of Morecambe Bay NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2011/12 and for the following 12 month period are available online at: [http://www.institute.nhs.uk/commissioning/pct_portal/2011%1012_cquin_schemes_in_north_west.html](http://www.institute.nhs.uk/commissioning/pct_portal/2011%1012_cquin_schemes_in_north_west.html)

An income of £3.2 million was conditional upon University Hospitals of Morecambe Bay NHS Foundation Trust achieving quality and innovation goals. University Hospitals of Morecambe Bay NHS Foundation Trust received an income of £1.7 million from the goals achieved.
Information relating to registration with the Care Quality Commission and periodic/ special reviews

University Hospitals of Morecambe Bay NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is full registration without any conditions.

The Care Quality Commission has taken enforcement action against University Hospitals of Morecambe Bay NHS Foundation Trust during 2011/12.

University Hospitals of Morecambe Bay NHS Foundation Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas:

1. Responsive review in July 2011 against the regulated activity for Maternity and Midwifery Services. Maternity care is provided at all three hospital locations. This review was initiated in response to several concerns that were brought to the attention of the Care Quality Commission in relation to the provision of maternity care at the Trust. These concerns included the findings of the Coroner’s inquest relating to a serious incident in 2008 and the subsequent rule 43 letter issued to the Trust in June 2011. A rule 43 letter is issued when a coroner believes that action should be taken to prevent the recurrence of fatalities similar to that in respect of the inquest being held.

The findings of the review were:

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Compliant</th>
</tr>
</thead>
<tbody>
<tr>
<td>1: Respecting and involving people who use services</td>
<td>No</td>
</tr>
<tr>
<td>4: Care and welfare of people who use services</td>
<td>Yes</td>
</tr>
<tr>
<td>6: Cooperating with other providers</td>
<td>Yes</td>
</tr>
<tr>
<td>8: Cleanliness and infection control</td>
<td>No</td>
</tr>
<tr>
<td>10: Safety and suitability of premises</td>
<td>No</td>
</tr>
<tr>
<td>11: People should be safe from harm from unsafe or unsuitable equipment.</td>
<td>Yes</td>
</tr>
<tr>
<td>13: Staffing</td>
<td>No</td>
</tr>
<tr>
<td>14: Supporting workers</td>
<td>Yes</td>
</tr>
<tr>
<td>16: Assessing and monitoring the quality of service provision</td>
<td>No</td>
</tr>
<tr>
<td>21: Records</td>
<td>No</td>
</tr>
</tbody>
</table>
2. Responsive review in December 2011 against the provision of accident and emergency services at Royal Lancaster Infirmary. The CQC carried out this review because concerns were identified in relation to:

- Respecting and involving people who use services
- Care and welfare of people who use services
- Staffing
- Supporting workers

The findings of the review were:

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Compliant</th>
</tr>
</thead>
<tbody>
<tr>
<td>1: Respecting and involving people who use services</td>
<td>Yes</td>
</tr>
<tr>
<td>4: Care and welfare of people who use services</td>
<td>No</td>
</tr>
<tr>
<td>13: Staffing</td>
<td>No</td>
</tr>
<tr>
<td>14: Supporting workers</td>
<td>No</td>
</tr>
</tbody>
</table>

3. Planned review in April 2011 against the provision of services at Royal Lancaster infirmary.

The findings of the review were:

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Compliant</th>
</tr>
</thead>
<tbody>
<tr>
<td>2: Consent to care and treatment.</td>
<td>No</td>
</tr>
<tr>
<td>4: Care and welfare of people who use services</td>
<td>No</td>
</tr>
<tr>
<td>5: Meeting nutritional needs</td>
<td>No</td>
</tr>
<tr>
<td>6: Cooperating with other providers</td>
<td>No</td>
</tr>
<tr>
<td>7: Safeguarding people who use services from abuse</td>
<td>Yes</td>
</tr>
<tr>
<td>8: Cleanliness and infection control</td>
<td>No</td>
</tr>
<tr>
<td>9: Management of medicines</td>
<td>Yes</td>
</tr>
<tr>
<td>10: Safety and suitability of premises</td>
<td>Yes</td>
</tr>
<tr>
<td>11: People should be safe from harm from unsafe or unsuitable equipment</td>
<td>Yes</td>
</tr>
<tr>
<td>12: Requirements relating to workers</td>
<td>Yes</td>
</tr>
<tr>
<td>13: Staffing</td>
<td>No</td>
</tr>
<tr>
<td>14: Supporting workers</td>
<td>Yes</td>
</tr>
<tr>
<td>16: Assessing and monitoring the quality of service provision</td>
<td>No</td>
</tr>
<tr>
<td>17: Complaints</td>
<td>No</td>
</tr>
<tr>
<td>21: Records</td>
<td>No</td>
</tr>
</tbody>
</table>
Two further reviews have been undertaken:

- OFSTED Joint Review Safeguarding Children
- Termination of Pregnancy

The trust is awaiting the official reports on these reviews.

University Hospitals of Morecambe Bay NHS Foundation intends to take the following action to address the conclusions or requirements reported by the Care Quality Commission.

Detailed plans have been developed and agreed with the CQC to address the concerns and non-compliances identified at the reviews. The main points for each review are summarised below.

<table>
<thead>
<tr>
<th>Planned review in April 2011 against the provision of services at Royal Lancaster infirmary</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outcome 5</strong></td>
</tr>
<tr>
<td>Ensure that the standard of nutritional risk assessment and recording of nutrition and hydration is of a consistently good standard.</td>
</tr>
<tr>
<td>Ensure patients are always well supported individually to have adequate nutrition and hydration.</td>
</tr>
<tr>
<td>Ensure that patients are confident that they would be supported to eat their meals according to their ability and to maintain their dignity and independence and that their nutritional intake is monitored.</td>
</tr>
<tr>
<td><strong>Outcome 13</strong></td>
</tr>
<tr>
<td>Ensure that staffing levels are constantly monitored and there are plans in place to deal realistically with unexpected changes in staffing circumstances.</td>
</tr>
<tr>
<td>Ensure there are sufficient staff to meet the individualised and holistic needs of people using the service at all times.</td>
</tr>
<tr>
<td>Review the present structures to ensure staffing levels are constantly monitored.</td>
</tr>
<tr>
<td><strong>Outcome 17</strong></td>
</tr>
<tr>
<td>Ensure the Trust always acts promptly to co-ordinate a response to an escalated complaint.</td>
</tr>
<tr>
<td><strong>Outcome 2</strong></td>
</tr>
<tr>
<td>Ensure that where a patient was not in the correct care environment for their condition they get the kind of specialised support they need to make an informed decision about future care.</td>
</tr>
<tr>
<td>Ensure a multi-disciplinary approach has been taken in assessing the</td>
</tr>
<tr>
<td>Outcome 4</td>
</tr>
<tr>
<td>---------</td>
</tr>
<tr>
<td>Outcome 8</td>
</tr>
<tr>
<td>Outcome 16</td>
</tr>
<tr>
<td>Outcome 21</td>
</tr>
</tbody>
</table>

### Responsive review in July 2011 against the regulated activity for Maternity and Midwifery Services

<table>
<thead>
<tr>
<th>Outcome 1</th>
<th>Ensure that the privacy, dignity and safety of women are maintained during transfers to theatres. Ensure that women are fully informed of the arrangement and are able to make an informed choice or provide their views on these arrangements.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome 8</td>
<td>Ensure that standards of cleanliness are maintained in all areas. Ensure that staff follow the correct procedures for single person use items.</td>
</tr>
<tr>
<td>Outcome 10</td>
<td>Improve the care environment and arrangements for people to access facilities.</td>
</tr>
<tr>
<td>Outcome 13</td>
<td>Ensure sufficient staff are available to cover out of hours requirements in theatres.</td>
</tr>
<tr>
<td>Outcome 16</td>
<td>Ensure that risks are identified and managed through a robust risk register system. Ensure that all incidents and near misses are reported and acted on. Ensure that clinical leadership and integrated working achieve consistent approaches, particularly in developing and delivering evidence based guidelines consistently across all three hospitals. Ensure that senior medical staff work together to ensure nationally recognised care pathways are met.</td>
</tr>
<tr>
<td>Outcome 21</td>
<td>Ensure records are stored securely and managed in people’s best interests. Ensure that robust measures are in place to meet the current legislation protecting confidential information and also the codes of practice in relation to...</td>
</tr>
</tbody>
</table>
Responsive review in December 2011 against the provision of accident and emergency services at Royal Lancaster Infirmary.

**Outcome 4**
Ensure effective coordination and bed management within the hospital to reduce the impact on the effective working of the emergency department and the flow of patients through their care pathway.

**Outcome 13**
Ensure that adequate staffing levels are maintained at all times to provide high quality, safe and effective emergency care to patients.

**Outcome 14**
Ensure that robust systems are in place to consistently monitor staff training. Ensure that robust systems are in place to provide all relevant staff with the training they require to deliver high quality, safe and effective emergency care to patients.

University Hospitals of Morecambe Bay NHS Foundation has made the following progress by 31 March 2012 in taking such action.

**Planned review in April 2011 against the provision of services at Royal Lancaster infirmary**
All actions completed

**Responsive review in July 2011 against the regulated activity for Maternity and Midwifery Services**
Outcome 1 - All actions completed
Outcome 8 - All actions completed
Outcome 10 – All interim actions completed. Longer term site redevelopment project in planning stages.
Outcome 13 - All actions completed
Outcome 21
Storage and security measures completed. Mandatory and additional information governance training in progress.

**Responsive review in December 2011 against the provision of accident and emergency services at Royal Lancaster Infirmary.**
Outcome 4 - All short term measures completed – creation of additional beds, modified admission procedures, increased ward rounds etc.
Longer term site development in progress – on track.

Outcome 13 - All actions completed. Continue to monitor adequacy of staffing levels.

Outcome 14 – Systems in place to monitor training. Detailed training programme developed and delivery commenced.

Information on the quality of data

University Hospitals of Morecambe Bay NHS Foundation Trust submitted records during 2011/12 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- which included the patient's valid NHS Number was: 99.6% for admitted patient care; 99.7% for outpatient care; and 98.2% for accident and emergency care.

- which included the patient's valid General Practitioner Registration Code was:
  - 100% for admitted patient care; 100% for outpatient care; and 100% for accident and emergency care.

University Hospitals of Morecambe Bay NHS Foundation Trust Information Governance Assessment Report overall score for 2011/12 was 75% and was graded Green.

University Hospitals of Morecambe Bay NHS Foundation Trust run data quality checks against key data items on all data streams for all 3 activity types. This is used to spot any anomalous data and correct before submission wherever possible. Coverage of NHS, Number & GP Practice code is much higher than National average in all instances.

Data completeness can be checked at Ward and outpatient department level using the locally developed GURU tool which means that departments can self-manage data quality levels. We also use the Spine demographics system which links back to GP Practice held data. Trust data is up to date with Patient Demographic Service.

University Hospitals of Morecambe Bay NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission. University Hospitals of Morecambe Bay NHS Foundation Trust was assessed by the Audit Commission as being “low risk” based on the outcome of previous audits in 2009/2010.
8.4 Part 3:

This section provides an overview of the quality of care offered by the NHS Foundation Trust based on performance in 2011/12 against indicators selected by the board in consultation with stakeholders. The indicators include measures on patient safety, clinical effectiveness and patient experience. The indicators selected are to promote quality improvement and are based on saving lives by reducing hospital mortality rates, preventing harmful events, reducing variations in fundamental aspects of basic care and continuously improving patient satisfaction and outcomes. The Trust aims for provide an exemplary patient experience in a safe and effective manner.

Additional information is also included on projects started within the year.
Patient Safety Indicators

The Trust monitors an extensive range of data to provide an indication of the level of safety in the care delivered by the Trust. This section provides an overview of performance against some of the key indicators.

Overview of Incident Indicators

The Trust continues to develop an effective incident reporting system. This system is supported by an improving reporting culture within the Trust.

The trend for incidents in the Trust remains at a consistent level with no statistically significant variations over the reported period. The most significant types of incidents in the Trust are:

- Slips, trips and falls – patients, staff, visitors and contractors
- Medication
- Violence and verbal abuse on staff by both patients and visitors
- Manual handling

It is worth noting that the proportion of high and moderate impact incidents has risen over the year from over 4% of all incidents to 6%. This increase is mainly due to reclassification of some incident types and a greater level of sensitivity to all incidents being adopted.

The table and graphs below illustrate the number and type of incidents reported.

<table>
<thead>
<tr>
<th>Incident Type</th>
<th>2010/11</th>
<th>2011/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient safety incidents</td>
<td>5472</td>
<td>6675</td>
</tr>
<tr>
<td>Serious Untoward Incidents (SUIs)</td>
<td>18</td>
<td>42</td>
</tr>
<tr>
<td>Patient accidents (slips, trips or falls)</td>
<td>2980</td>
<td>2535</td>
</tr>
<tr>
<td>Staff, visitor or contractor incidents (health and safety)</td>
<td>932</td>
<td>991</td>
</tr>
<tr>
<td>Other incidents (e.g. security, fire, theft)</td>
<td>297</td>
<td>217</td>
</tr>
<tr>
<td>Percentage which caused no harm, required simple first aid or were near misses.</td>
<td>94%</td>
<td>91%</td>
</tr>
</tbody>
</table>

Source: Emergency department report
Keeping patients safe while in our care is the top priority for the Trust. We encourage staff to report any unintended or unexpected incidents and also near misses. High volumes of incident reporting is thought (by the National Patient Safety Agency) to be good because it shows staff are aware of safety and it allows lessons to be learned from incidents even if no harm was caused.

**Serious Incidents**

Serious patient safety incidents are formally reported to a national system.

A Serious Untoward Incident Panel has been established to ensure all serious incidents are effectively investigated and managed. The Trust has introduced more rigorous standardised processes and procedures for the investigation and root cause analysis for incidents. Our commissioning Primary Care Trusts (PCTs) oversee this
process and scrutinise the outcomes of all investigations and monitor the changes made. Since the major incident was declared in October 2011 the Trust has agreed to lower the threshold for classifying incidents as “Serious Untoward Incidents”. This recategorisation has led to an increase in the number of serious incidents reported.

There have been 42 Serious Untoward Incidents reported during the year, there were 18 reported last year. The table below summarises the serious incidents.

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRSA and other infections</td>
<td>5</td>
<td>Additional staff education &amp; training. Equipment storage facilities improved.</td>
</tr>
<tr>
<td>Hospital Acquired Pressure Ulcers Grade 3 &amp; 4</td>
<td>9</td>
<td>Complex cases managed jointly with partners. Introduction of safety bundle.</td>
</tr>
<tr>
<td>Clinical practice issues</td>
<td>6</td>
<td>Staff supervision and training implemented. Equipment procedures standardised and equipment clearly labelled. Correct procedures reinforced and further training introduced.</td>
</tr>
<tr>
<td>Appointment issues</td>
<td>1</td>
<td>Project implemented to identify and rectify all appointment issues to ensure all patients receive appropriate follow up.</td>
</tr>
<tr>
<td>Patient accident</td>
<td>1</td>
<td>Distressed patient ran from hospital and was involved in a traffic accident. Patient sustained fracture injuries. Need to provide a place of safety to prevent further occurrences.</td>
</tr>
<tr>
<td>Falls related</td>
<td>5</td>
<td>Falls led to serious injury or contributed to death. All vulnerable patients with mobility issues. Introduction of skin and safety bundle. Increased vigilance and use of bedrails where appropriate.</td>
</tr>
<tr>
<td>Documentation error</td>
<td>1</td>
<td>Wrong identity number allocated. System rectified. No harm occurred.</td>
</tr>
<tr>
<td>Maternity related incidents</td>
<td>14</td>
<td>Implementation of action plans to address all concerns related to provision of maternity services across the Trust.</td>
</tr>
</tbody>
</table>

*Source: Safeguard risk system*
MRSA or Methicillin Resistant Staphylococcus Aureus

MRSA is a bacterium which is particularly resistant to normal antibiotic treatment. It is commonly known as a superbug. This superbug is very widespread in the environment and many people carry traces on their bodies. MRSA can become very dangerous when they infect the bloodstream and infections can lead to serious injury or death.

The Trust has implemented a range of measures to prevent bloodstream infections. The graph and information below illustrate the high standards achieved by the Trust. In all cases of infection, a very thorough investigation is undertaken to establish all the factors which have contributed to the infection.

**Total number of MRSA bloodstream infections**

There were 4 cases which the Trust was responsible for in 2011/12. This performance was over the target of 3 cases set by the Department of Health.

During April the Trust reported no cases, but 2 cases were reported in May. There was a further case during November and a 4th case was reported during January. Staff involved in these cases have been provided with additional education and training to reduce the possibility of further infections. Equipment storage and decontamination procedures in endoscopy have also been improved to reduce the risk of infection.

The graph below illustrates the reduction in hospital acquired blood stream infections over the last six years:

![Yearly Total of MRSA Bloodstream Infections](graph)

*Source: Trust Board reports*
**MRSA Screening**

All admitted patients are now screened to determine if they are carrying MRSA bacteria. Where a positive result is obtained, measures can be implemented to reduce the risks of passing it on or contracting a bloodstream infection.

Data from lab sampling figures continues to show the Trust screening rates at more than 100%. The Department of Health guidance on screening is to count the number of screening samples received in the laboratory compared to the number of admissions, however this fails to take into account that some patients have more than one screen, and others may have been missed. This methodology does not provide any assurance that 100% of the admissions have been screened; therefore the Trust introduced a more rigorous method in order to gain assurance. Each month an audit of 200 elective and 200 emergency admissions is carried out to establish our screening compliance rates to provide assurance to the PCT. This approach provides a better understanding of the situation and where improvements are required. Action plans are monitored at the monthly Infection Prevention Committee meetings.

**Clostridium Difficile Infections (CD)**

The Trust has responsibility for Clostridium Difficile cases which occur at least 48 hours after admission.

Clostridium Difficile is a bacterium which can typically cause diarrhoea or other intestinal disease when allowed to proliferate. This can occur when competing bacteria are wiped out by antibiotics. The elderly or vulnerable patients are most commonly affected.

The Trust has implemented antibiotic protocols to help reduce the occurrence of Clostridium Difficile infections.
Improving Safety, Reducing Harm

Continued implementation of “Rapid Spread” and “Patient Safety Express” safety bundles. These two initiatives have been combined into a single programme. “Improving Safety, Reducing Harm”.

University Hospitals of Morecambe Foundation Trust was one of three Northwest Trusts to test the Rapid Spread methodology in February 2011. The Trust launched the ‘Improving Safety, Reducing Harm’ initiative.

The areas for improvement:

- Reduce falls that cause harm 50%
- Reduce Hospital acquired pressure ulcers (grades 3&4) by 80%
- Improve compliance with nutritional screening in 95% of all inpatients

The initiative was introduced and maintained in 36 ward/departments across 3 hospitals (included GP wards).

- An influential component of Rapid spread has been the standardised risk documentation across the whole Trust
- Putting the patient at the forefront of care by being highly visible
- Driven by the fundamentals of nursing
- The bundle ensures that progress is made that will lead to:-
- Increased direct patient contact through intentional rounding.
- Full risk assessment of all potential harms alongside general, mental and physical condition
• Greater and more accurate reporting of falls and pressure ulcers
• Steady increase in number of days between development of pressure ulcers
• Reduction in falls
• Reduction in cost of falls
• Increased confidence that risk assessments are followed up with robust care plans
• Increased collaborative working and teamwork amongst staff

Rapid Spread is about improving patient safety and experience using a systematic methodology to implement a proven change that does not need to be piloted or refined at a local level for local circumstances.

Rapid Spread involves the adoption and application of evidence-based bundles of care known to improve safety.

• In February 2011 there was an immersion event for clinical leaders (ward managers, matrons, allied health professions leaders and topic experts) aimed at harnessing the enthusiasm, expertise and motivation of these influential leaders.
• Nurses and allied health professional designed the bundle. Standardised documentation across all 3 sites reduces the incidence of miscommunication and potential harm to patients.
• This essential safety improvement work is seen as part of everything we do every day in the Trust. It will help to reduce variations in care which still exist across the Trust and clarify the standards expected in all clinical areas.

A system and data set for measuring the reduction in avoidable harms is in place. Results will be reported via the Integrated Risk Sub-Committee to Clinical Quality and Safety Committee.

Summary
• The human and financial benefits of reducing harm and meeting these objectives will be measured
• Expert knowledge and learning is on hand from other organisations in the region and nationally.
• Data sets have been established to monitor progress and for reporting purposes
• Progress with these safety programmes will assist the Trust in meeting CQUIN targets (commissioning for quality and innovation)
• The Trust is leading this work across the integrated health care system
• Opportunities for patient and public involvement have been designed into the plans for these programmes

135
- Ownership from design to implementation driven by nurses on the ward.
- Integrated risk assessments and care plans - standardised documentation.
- Preparation – Electronic Profiling Beds, introduction of wound formulary, hotel services
- Aligned to quality monitoring systems i.e. GURU
- Aligned to Performance Management Framework – holding to account.
- Linking the SAS / Bundle to increased patient satisfaction and experience.
- Communication strategy and plan.
- Actively involves patients/relatives and carers from admission to discharge.
Clinical Effectiveness Indicators

This section provides an overview of how effectively clinical care is delivered within the Trust against a number of national indicators.

Mortality

It is recognised that a proportion of patients admitted to hospital will die due to their illness or condition. However to ensure the Trust is providing safe and effective care, the Trust monitors the number of deaths of patients (mortality) in our care. This is done in line with national guidance and statistics. The guidance takes into account clinical conditions and local factors such as age and social conditions. This enables the Trust to determine if the number of deaths is in the expected range for our local population by producing a mortality index. An index of 100 is the expected value, values above 100 indicate a higher or worse than expected rate.

The Trust also monitors mortality rates against a group of similar Trusts (peer group).

Mortality indicators

The graphs below illustrate that mortality rates have generally shown a reduction compared to last year. The trend for mortality rates is now becoming more in line with the peer group for most of the year. The index for March 2012 shows a significant rise whilst our peer group average has fallen considerably. An analysis will be undertaken to determine the cause of this variance.
Mortality Review

The Trust invited the Advancing Quality Alliance (AQuA) to work with them to conduct an initial independent review of mortality rates at the Trust. AQuA is the North West of England's health care quality improvement organisation.

It was planned that the work would be undertaken in three phases. This summary covers the first phase of the work which looked at understanding the reasons behind the Trust's relatively high levels of mortality.

The report concludes that the characteristics of the local population, deprivation, data quality and co-morbidities do not appear significant drivers of high rates of mortality at UHMB. In addition whilst, the historic low level of palliative coding is likely to have had an adverse impact this by itself does not entirely explain the Trust’s high mortality rates.

Key elements of the first phase of the review were;

- Analysis of key indicators
- Assessment of how clinical care is provided, evidenced and documented including care bundles and patient pathways
- Assessment of the provision of End of Life Care provided by and associated with the Trust
- Assessment of the quality and accuracy of coding and documentation, and quality systems in the organisation to support this
- Assessment of how the organisation's leadership manages quality and safety; information and systems for receiving and acting upon issues, strategic linkages of projects and programmes in the organisation, whether the Trust has due regard to quality
Recommendations:

The Trust should:

- Pay greater attention to the recording of diagnoses as this will significantly influence the calculation of expected mortality rates
- Strengthen its arrangements in relation to mortality including the development of a mortality reduction strategy and action plan
- Ensure high levels of clinical engagement and ownership
- Investigate the level of clinical quality and staffing levels in areas with high levels of expected and actual mortality and consider a care bundle approach to tackling these

In the second phase AQuA will work with the Trust to support the development of a mortality reduction strategy. In the third phase AQUA will support the Trust in the implementation of the strategy and action plan that will accompany it.

Advancing Quality

Delivering reliable care for patients

The Trust has participated in a regional programme known as Advancing Quality. The aim is to record and report the level of compliance to a set of evidence-based measures that all patients should receive. Five conditions have been selected with the third year of this programme running from April 2011 to March 2012.

The AQ programme concentrates on improvements in five clinical areas. These are:

- Acute myocardial infarction (heart attack) (AMI)
- Heart failure (HF)
- Community acquired pneumonia (CAP)
- Hip and Knee replacement (H&KR)
- Stroke
- Patient experience

Results for the year are available approximately 6 months after the year end, therefore, only interim results are available at this time based on the first 6 months of the year.
Results:

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMI</td>
<td>96.34%</td>
<td>97.86%</td>
<td></td>
<td>Met 95% target level</td>
</tr>
<tr>
<td>HF</td>
<td>63.33%</td>
<td>51.83%</td>
<td>Q3 reports not due until 29th May 2012</td>
<td>Below 75% target level</td>
</tr>
<tr>
<td>CAP</td>
<td>71.75%</td>
<td>74.76%</td>
<td></td>
<td>Improving but below threshold of 86%</td>
</tr>
<tr>
<td>H&amp;KR</td>
<td>91.40%</td>
<td>94.07%</td>
<td></td>
<td>Just below 95% target level</td>
</tr>
<tr>
<td>Stroke</td>
<td>71.09%</td>
<td>68.74%</td>
<td></td>
<td>Below target level</td>
</tr>
<tr>
<td>Patient experience</td>
<td>21.6% to January 2012</td>
<td></td>
<td></td>
<td>Target 25%</td>
</tr>
</tbody>
</table>

Source: Trust Board reports

Accident and Emergency (A&E) Wait Times

The Trust has not met the statutory 95% target for a 4 hour maximum wait in A&E with a year end performance of 93.95%.

Work with the Primary Care Trusts / Local Authorities/ LINks and ongoing to support the emergency care agenda, in addition to support from the Emergency Care Intensive Support Team.

A project is underway to extend the facilities at RLI. Additional staffing resource has also been provided. As part of the Trust Recovery Plan a detailed project has been commissioned by the Trust to improve the Emergency Care pathway.

![A&E 4 Hour Maximum Waits](source: Trust Board reports)
Delayed Transfers of Care

A delayed transfer of care is simply defined as a patient remaining within a hospital longer than is necessary. This may mean a patient going home, transferring to intermediate care, a specialist unit or other care setting. Some reasons for delay are; lack of available places in other care settings, unavailability of transport, delays in hospital procedures, constraints on partner organisations, family issues etc.

The Care Quality Commission set a target that the total number of delays should not exceed 7.5% of the occupied beds in the hospital.

The Trust has achieved a delay rate of only 2.49% which meets the target level.

Source: Trust Board reports

Outpatient Appointments

Following serious failings in the system for booking outpatients appointments, a Trust wide project to look in detail at the front end of the patient journey has been established. A number of actions have been identified and are currently being implemented to:-

- Provide additional capacity.
- Investigate any instances where the patient may have suffered harm as a result of delayed or missed appointments.
- Ensure all referred and follow up patients have received appointments.
- Review and amend all outpatient clinic templates to assess capacity and demand.
- Ensure that all patients will receive a “Guaranteed Appointment date” within the appropriate timescale.
Patient Experience Indicators

The Trust continues to actively seek the views of patients on the quality of their care through a range of approaches, during 2011/2012 these have included;

- Matrons Questionnaires
- Advancing Quality Patient Experience Measures
- Compliments and Complaints
- NHS Choices
- Patient Experience Questionnaires-Maternity Services
- Real time patient feedback - Paediatrics
- Hand held feedback devices - Adult Services
- Patient stories
- Listen with mother initiatives - Maternity Services
- Emotional touch-points

Complaints Summary for 2011/2012

<table>
<thead>
<tr>
<th></th>
<th>2009/10</th>
<th>2010/11</th>
<th>2011/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Patient Contacts</td>
<td>682673</td>
<td>731878</td>
<td>741208</td>
</tr>
<tr>
<td>Number of Complaints</td>
<td>473</td>
<td>555</td>
<td>600</td>
</tr>
<tr>
<td>Number of complaints per 100 care contacts</td>
<td>0.069</td>
<td>0.075</td>
<td>0.081</td>
</tr>
</tbody>
</table>

Complaints reports

In addition to formal complaints, a total of 704 concerns and 1129 PALS enquiries were received.

The main themes of complaints, concerns and PALS generally are related to “inadequate treatment /care”, “outpatient issues and “communication / information issues”.

Eliminating mixed-sex accommodation (EMSA)

Every patient has the right to receive high quality care that is safe and effective and which respects their privacy and dignity. Men and women should not normally have to share accommodation, bathrooms or toilet facilities but there may be exceptions, in agreed cases of clinical need, when patients require emergency, highly specialised or ‘high-tech’ care.
Progress to date
The table below illustrates the number of breaches in compliance which have occurred.

<table>
<thead>
<tr>
<th>Quarter</th>
<th>RLI</th>
<th>FGH</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr-11</td>
<td>15</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>May-11</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Jun-11</td>
<td>10</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Jul-11</td>
<td>15</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Aug-11</td>
<td>20</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>Sep-11</td>
<td>25</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>Oct-11</td>
<td>25</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>Nov-11</td>
<td>25</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>Dec-11</td>
<td>30</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>Jan-12</td>
<td>25</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>Feb-12</td>
<td>35</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td>Mar-12</td>
<td>30</td>
<td>25</td>
<td>25</td>
</tr>
</tbody>
</table>

Source: Trust Board reports

The Trust has developed and implemented an “Eliminating mixed sex accommodation - Delivery plan”. The plan aims to eliminate contraventions by addressing the following areas:

- Patient Experience Feedback
- Breach Escalation, Reporting and Monitoring
- Communication and information
- Education and training
- Contract
- Strategic Estates Development / Plans

The Strategic Health Authority and Cumbria PCT have undertaken joint visits to review the action plans and progress being made to address concerns.

In December 2011 the CQC identified a contravention in the Clinical Decision Unit (CDU) at the Royal Lancaster Infirmary. The CDU was used to accommodate patients when there was a high demand for emergency care. This arrangement caused a problem when day patients arrived for treatment. The practice has now ceased and alternative provision has been arranged.
Matrons’ questionnaires-

Matrons’ questionnaires are completed each month by all matrons across the Trust (with the exception of maternity, gynaecology and paediatric services). Each matron oversees the completion of 10 questionnaires meaning that every month we collect the views of around 100 people who are inpatients at one of our hospitals. Overall a total 1183 surveys were undertaken during 2011/2012.

The questionnaire asks patients ten questions about their experience during their stay as an inpatient. These questions include:

- Overall, how do you rate your stay in hospital?
- When you were first admitted to a bed on a ward did you share a ward or sleeping area with someone of the opposite sex?
- Were you treated with dignity and respect during your stay in hospital?
- Did nurses and midwives explain things to you in an understandable way?
- Was the hospital clean?
- How would you rate the hospital food?
- Were you involved in decisions about your care and treatment?
- Did you find someone on the hospital staff to discuss any worries or concerns with?

What our patients told us:
Listed below is a selection of comments from the matrons’ questionnaire

Experience
- Very friendly hospital. Staff very kind and understanding.
- Excellent, wonderful and thoughtful nurses. Nothing is ever too much trouble for them.
- The nurses were attentive and friendly without exception.
- Since moving to ward x on 8th Feb, I have received the upmost courtesy and help from all your staff.
- To the moronic morons who criticise the NHS, I have been treated with the upmost respect and the information given is well meaning and thoughtful.
- Every time I am admitted to hospital it is re-affirmed to me that nurses are very special people. Truly a vocation for them not just a job.
- While I am having my stay here, the love and care that I have had from everyone is excellent, it could not be better anywhere else
- My first time in hospital. I've had the most wonderful treatment from the most dedicated nurses you could imagine. Thank you
- Prefers to have care delivered by a female carer. This has been accommodated by the staff.
- I have been 3 days without seeing a doctor to bring me up to date re treatment
and length of stay. As a single person, it is essential I can get home or contact neighbours.

- Meals were average. Was given advice on becoming mobile. I found some nurses didn’t listen to you enough but overall my stay has been very good
- Not all staff displaying their ID badges.

Food and environment

- Staff are 100% excellent. Meals need upgrading - food is sloppy. Would prefer breakfast, sandwiches and then a "proper meal".
- Food is rubbish.
- The nurses do very good considering the shortage of them on the wards. Should get the toaster mended as the white bread is very poor quality.
- Lavatory facilities on ward x are inadequate. Find the food rather stodgy, more fruit and fruit juices would be welcomed. Staff seem very stretched.
- There is a good ethos on this ward between staff and patients. Shower room got flooded with 2 inches of water - slippers and other items got wet, was a bit of a fiasco. Drain left too long before being cleared. During admission there was an abrupt doctor which was very upsetting but the staff are so loving and show concern.

Progress

The Trust has been using Matrons’ questionnaires as a way of gathering feedback on patient experience for approximately three years and we will continue to review and improve.

We also collect feedback on patient experience from a range of other sources including: electronic hand held devices which we have used to collect information in a range of wards and areas across the bay during 2011/2012. These have included measuring experience of protected mealtimes cross bay, experiences of older people during their inpatient stay on Medical Unit 2, experience of Orthoptic services and experience of Outpatient services.

We also routinely collect patient experience as part of the Advancing Quality initiative; this involves gathering feedback from patients with one of the following conditions: pneumonia, heart failure, acute myocardial infarction and hip or knee replacement. In addition, as part of the Advancing Quality programme we collect Patient Recorded Outcome Measures (PROMs) which seek to find out the effectiveness of an operation or procedure after a person has left hospital.

We introduced an electronic, real-time patient experience feedback system for the collection of paediatric and parent/carer information during the year and this has been used in a range of areas throughout the year. The real-time nature of the
system means that appropriate staff can be alerted and address issues soon after they are reported to us.

A patient questionnaire has also been launched in maternity services in January 2012. These questionnaires will be given to every woman accessing the service to collect feedback on their experience.

A quarterly Integrated Patient Experience report is compiled and reported through the Trust committee structure and Governors.

**National Patient Surveys**

The Trust is required to take part in the range of National Patient Surveys scheduled annually by Care Quality Commission. For the year 2011/2012 these surveys were around Outpatient experience and Inpatient experience.

**National Outpatient Survey**

The Outpatient survey looked at the experiences of patients attending Trust Outpatient services in March 2011, a total of 437 completed questionnaires were received giving a response rate of 52%.

The CQC do not provide a single rating for each Trust because the survey assesses a number of different aspects of patient experience and Trust performance varies across these aspects which means it is not possible to compare the Trusts overall.

However, the CQC do provide a comparison with other Trusts across the nine categories of patient experience in the survey.

Compared with other Trusts our performance was;

- Before the appointment - about the same
- Waiting in the hospital - about the same
- Hospital environment and facilities - about the same
- Tests and treatments – about the same
- Seeing a doctor - about the same
- Seeing other professionals - about the same
- Overall about the department - about the same
- Leaving the outpatients department - about the same
- Overall impression - about the same

Drilling down into the individual aspects of patient experience, it should be noted that our performance was worse than other Trusts when patients were asked to comment...
on the information they received before an outpatient appointment enabling them to know what to expect during the appointment.

**National Inpatient Survey**

The Trust took part in the National Inpatient Survey with 850 of our patients who had experienced an Inpatient stay during July 2011 receiving a questionnaire. 836 patients were eligible for the survey of which 457 patients returned the completed questionnaire giving a response rate of 55%. The average response rate from other Trusts was 50%.

<table>
<thead>
<tr>
<th>Section</th>
<th>Number of indicators in worst 20%</th>
<th>Number of indicators in middle 60%</th>
<th>Number of indicators in best 20%</th>
<th>Total number of indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency department</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Admission to hospital</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Waiting to get a bed on a ward</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>The hospital and ward</td>
<td>0</td>
<td>13</td>
<td>0</td>
<td>13</td>
</tr>
<tr>
<td>Doctors</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Nurses</td>
<td>0</td>
<td>5</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Your care and treatment</td>
<td>0</td>
<td>10</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>Operations &amp; Procedures</td>
<td>0</td>
<td>6</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Leaving Hospital</td>
<td>1</td>
<td>12</td>
<td>0</td>
<td>13</td>
</tr>
<tr>
<td>Overall experience</td>
<td>0</td>
<td>5</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>1</td>
<td>63</td>
<td>0</td>
<td>64</td>
</tr>
</tbody>
</table>

The only indicator in the worst 20% was: - Discharge: not given any written/printed information about what they should or should not do after leaving hospital.
Have we improved since the 2010 survey?
A total of 87 questions were used in both the 2010 and 2011 surveys.
Compared to the 2010 survey, the Trust is:
Significantly BETTER on 2 questions
Significantly WORSE on 11 questions
The scores show no significant difference on 74 questions.

How do we compare to other Trusts?
The survey showed that your Trust is:
Significantly BETTER than average on 4 questions
Significantly WORSE than average on 6 questions
The scores were average on 87 questions

The Trust has improved significantly on the following questions:
Surgery: not enough time to discuss operation or procedure with consultant
Discharge: did not receive copies of letters sent between hospital doctors and GP

The Trust has worsened significantly on the following questions:
Planned admission: not offered a choice of hospitals
Admission: had to wait long time to get to bed on ward
Hospital: bothered by noise at night from other patients
Nurses: talked in front of patients as if they weren't there
Nurses: some/none knew enough about condition/treatment
Care: could not always find staff member to discuss concerns with
Care: not always enough privacy when discussing condition or treatment
Care: did not always get help in getting to the bathroom when needed
Care: more than 5 minutes to answer call button
Discharge: not given any written/printed information about what they should or should not do after leaving hospital
Overall: worried about security of personal information held by the hospital

The Trust will develop and implement action plans to address areas of concern.

Listening to Older People / Patient Stories
In May 2011, staff from UHMB NHS Foundation Trust took part in a listening event for older people from the South Lakeland area facilitated by Age UK South Lakeland. This event was attended by over 70 people and provided our patients, their families and carers with the opportunity to tell us how we could improve their experience of services in our hospitals. An action plan picking up the recommendations which came out of this event is being delivered through the Nursing and Midwifery strategy group.

In addition, during 2011/2012 we have collected the detailed stories of over 100 older people who have used our services during 2010 and 2011. These stories are
being used as part of a review of elderly services and the themes which have been identified drawn up into an improvement action plan to be taken forward across the range of clinical divisions during 2012/2013.

A group of eleven staff have been working with Lancaster University to support them in developing skills to collect stories from patients about their experiences of our hospitals going forward into 2012/2013. The collection and use of patient stories in filmed, audio or written format for service improvement and staff learning and development is a powerful tool for change, and each public meeting of the Trust board during 2011/2012 has started with a patient story.

**Spiritual Support**

The Interfaith Chaplaincy Service provides an essential and very important role in patient care across the Trust. The service is committed to providing spiritual support to all patients of all beliefs or none. The spiritual care which is provided by our Chaplains makes a big contribution to a patient's wellbeing and recovery. The Chaplains provide much needed support to patients at the time of death, to those who are critically ill, those involved in major incidents, and also to patient's family and friends. They provide liaison with other health care professionals. Dedicated areas are provided within our hospitals for worship, quiet reflection and personal advice, and contemplation.
Performance against key national priorities

This section gives an overview of performance in 2011/12 against the key national priorities

<table>
<thead>
<tr>
<th>Target</th>
<th>2008/9 Details</th>
<th>2009/10 Details</th>
<th>2010/11 Details</th>
<th>2011/12 Details</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incidence of MRSA bloodstream infections</td>
<td>Target 12 cases, 20 cases reported. Target not achieved.</td>
<td>Target 12 cases, 12 cases reported. Target achieved.</td>
<td>Target 6 cases, 4 cases reported. Target achieved.</td>
<td>Target 3 cases, 4 cases reported. Target not achieved.</td>
<td></td>
</tr>
<tr>
<td>MRSA screening</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>Achieved</td>
<td>Achieved</td>
<td>Achieved DH Target. Did not achieve internal target. Elective admissions (from audit) 97% Emergency admissions (from audit) 88% Against a target of 100% Target unchanged for 2011-12</td>
</tr>
<tr>
<td>18 weeks referral to treatment</td>
<td>Achieved June 2008 onwards for admitted patients, July 2008 onwards for non-admitted patients*</td>
<td>Achieved</td>
<td>Achieved non-admitted patients. Achieved admitted patients until September 2010**</td>
<td>Achieved non-admitted patients. Not achieved admitted patients</td>
<td>The 95th percentile for admitted patients in March is 23.7 weeks and therefore not achieved due to</td>
</tr>
<tr>
<td>Two weeks from urgent GP referral to first appointment for all urgent suspected cancers referrals</td>
<td>Q1-Q3 achieved</td>
<td>Q4 achieved***</td>
<td>Achieved</td>
<td>Achieved</td>
<td>Achieved (YTD)</td>
</tr>
<tr>
<td>31 days from decision to treat to start of first treatment: All Cancers</td>
<td>Q1-Q3 achieved</td>
<td>Q4 achieved***</td>
<td>Achieved</td>
<td>Achieved</td>
<td>Achieved (YTD)</td>
</tr>
<tr>
<td>Target</td>
<td>Q1-Q3 achieved Q4 achieved***</td>
<td>Achieved quarterly</td>
<td>Achieved YTD</td>
<td>Consistently achieved targets throughout the year.</td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------------------------------</td>
<td>--------------------------------</td>
<td>--------------------</td>
<td>--------------</td>
<td>---------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>31 days from decision to treat to start of subsequent treatment: All Cancers</td>
<td>N/A until Q4 which achieved***</td>
<td>Achieved</td>
<td>Achieved (YTD)</td>
<td>Consistently achieved above the 94% target for surgery, 94% for radiotherapy and 98% for drug treatment.</td>
<td></td>
</tr>
<tr>
<td>62 days from referral to treatment for all urgent suspected cancers referrals. Includes referrals from screening service and Consultant upgrades</td>
<td>Q1-Q3 achieved Q4 achieved***</td>
<td>Achieved quarterly</td>
<td>Achieved YTD</td>
<td>Consistently achieved targets throughout the year.</td>
<td></td>
</tr>
<tr>
<td>A&amp;E waiting times</td>
<td>Achieved</td>
<td>Achieved</td>
<td>Achieved</td>
<td>Not achieved</td>
<td></td>
</tr>
<tr>
<td>Self certification against compliance with</td>
<td>Achieved</td>
<td>Achieved</td>
<td>Achieved</td>
<td>Achieved</td>
<td></td>
</tr>
</tbody>
</table>

From 2011, A&E Clinical Quality-Total Time in A&E <4hours 95%. N/A Q1, Achieved Q2, Not Achieved Q3 & Q4. Full Year performance 93.95%
| requirements regarding access to healthcare for people with a disability |

Source: Trust Board reports
8.5 Annex 1:

Statements from Primary Care Trusts, Local Involvement Networks (LINKs) and Overview and Scrutiny Committees.

Comments from NHS North Lancashire
Final commentary to be added

Comments from NHS Cumbria
Final commentary to be added
Comments from Cumbria Health Scrutiny Committee and Cumbria LINk

‘The representatives of the Cumbria Health Scrutiny Committee and Cumbria LINk welcome the opportunity to make comments on the draft Quality Account for 2012/13. The group recognises the improvements that have taken place in the Trust's Quality Account over the last two years and that you have taken on board comments previously made. As a result, the Quality Account is a more realistic statement acknowledging when targets have not been met but with a clear determination to persist where targets remain appropriate. The targets being set for 2012/13 are rightly challenging but appropriate. The group appreciate the use of a glossary right at the start of the document.

The main concern that we have shared is that it is not always clear what whole figures and percentages are telling us and that data in the text should be closely linked to appropriate tables. Where targets have been set it might help if it was clarified why they have been set. Where comparisons can be given either on previous years or with peer group, these would be welcomed. We have also been hampered by the lack of end year data at the draft stage which is linked to the unrealistic deadlines set by national government. We also believe that the prescribed structure and content of the document is not always public friendly and that it might help to publicise some of the achievements and aspirations contained in the document in other ways. We acknowledge the improvements in quality provision that have been achieved during a challenging period for the Trust and believe that these should rightly be highlighted but maintain that more can and should be done.

Overall, we appreciate the co-operation received and look forward to continuing to work with the Trust during the coming year to help drive up quality.’

Health Scrutiny Manager
Comments from Lancashire Health Scrutiny Committee

Until recent months engagement with the Trust over the previous year was limited and ineffectual.

Following the inspection and subsequent recommendations made by CQC and Monitor on a range of services delivered by the Trust the Lancashire Health Scrutiny Committee became extremely concerned about how the Trust intended to address the serious shortcomings expressed in the reports.

Representatives from the Lancashire HSC attended a meeting held by Cumbria HSC which highlighted issues that specifically affected local residents accessing services at Royal Lancaster Infirmary. The culmination of the involvement of the Lancashire Health Scrutiny Committee resulted in the attendance of the Interim Chair of the Board, the Interim Chief Executive and other senior officers at the Committee meeting held on 10 April 2012.

The outcome of this meeting provided members with assurances from the Trust as to how they will demonstrate and evidence that real progress is being made in the delivery of services and patient care.

As improving services for the people of Lancashire and holding the providers of those services to account is a key responsibility of the Health Scrutiny Committee, members will continue to have an overview on the progress and impact of the recovery plan.

Chair of the Lancashire Health Scrutiny Committee
Comments from Lancashire LINk

Final commentary to be added
8.6 Annex 2:

Statement of directors’ responsibilities in respect of the quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Reports for each financial year.

Monitor has issued guidance to NHS foundation Trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that foundation Trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2011-12;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2011 to May 2012
  - Papers relating to Quality reported to the Board over the period April 2011 to May 2012
  - Feedback from the commissioners dated 11/05/2012
  - Feedback from governors dated May 2012
  - Feedback from LINks dated 11/05/2012
  - The Trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2011 and May 2012
  - The national patient survey February 2012
  - The national staff survey March 2012
  - The Head of Internal Audits annual opinion over the Trust's control environment dated May 2012
  - CQC quality and risk profiles dated April 2011 - March 2012
- the Quality Report presents a balanced picture of the NHS Foundation Trusts performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor’s annual reporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

........................................Date........................................................ Interim Chair

........................................Date........................................................ Interim Chief Executive
8.7 Annex 3:

Independent Auditor’s Report to the Board of Governors of NHS Foundation Trust on the Annual Quality Report

I have been engaged by the Board of Governors of University Hospitals of Morecambe Bay NHS Foundation Trust to perform an independent assurance engagement in respect of University Hospitals of Morecambe Bay NHS Foundation Trust’s Quality Report for the year ended 31 March 2012 (the “Quality Report”) and certain performance indicators contained therein.

Scope and subject matter
The indicators for the year ended 31 March 2012 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- Methicillin Resistant Staphylococcus Aureus (MRSA)
- Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.

I refer to these national priority indicators collectively as the “indicators”.

Respective responsibilities of the Directors and auditors
The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual issued by the Independent Regulator of NHS Foundation Trusts (“Monitor”).

My responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to my attention that causes me to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Report is not consistent in all material respects with the sources specified in section 2.1 of Monitor's Detailed Guidance for External Assurance on Quality Reports 2011-12; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Detailed Guidance for External Assurance on Quality Reports.
I read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual, and considered the implications for my report if I became aware of any material omissions.

I read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes for the period April 2011 to May 2012;
- Papers relating to quality reported to the Board over the period April 2011 to May 2012;
- Feedback from the Commissioners dated 23/05/2012;
- Feedback from LINKs dated 11/05/2012;
- Feedback from Governors dated May 2012;
- The Trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2011 to May 2012;
- The national patient survey dated February 2012;
- The national staff survey March 2012;
- Care Quality Commission quality and risk profiles dated April 2011 to March 2012;
- The Head of Internal Audit’s annual opinion over the Trust’s control environment dated 18/04/2012; and
- Any other information included in our review.

I consider the implications for my report if I become aware of any apparent misstatements or material inconsistencies with those documents (collectively the “documents”). My responsibilities do not extend to any other information.

I am in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. My team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Board of Governors of University Hospitals of Morecambe Bay NHS Foundation Trust as a body, to assist the Board of Governors in reporting University Hospitals of Morecambe Bay NHS Foundation Trust’s quality agenda, performance and activities. I permit the disclosure of this report within the Annual Report for the year ended 31 March 2012, to enable the Board of Governors to demonstrate that it has discharged its governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the Board of Governors as a body and University Hospitals of Morecambe Bay NHS Foundation Trust for my work or this report save where terms are expressly agreed and with my prior consent in writing.
Assurance work performed
I conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – ‘Assurance Engagements other than Audits or Reviews of Historical Financial Information’ issued by the International Auditing and Assurance Standards Board (‘ISAE 3000’). My limited assurance procedures included:

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- Making enquiries of management;
- Testing key management controls;
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation; and
- Comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report.

A limited assurance engagement is less in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations
Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

The nature, form and content required of Quality Reports are determined by Monitor. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts.

In addition, the scope of my assurance work has not included governance over quality or non-mandated indicators which have been determined locally by University Hospitals of Morecambe Bay NHS Foundation Trust.
Conclusion
Based on the results of my procedures, nothing has come to my attention that causes me to believe that, for the year ended 31 March 2012:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*;

- the Quality Report is not consistent in all material respects with the sources specified in section 2.1 of Monitor’s Detailed Guidance for External Assurance on Quality Reports 2011-12; and

- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual* and the six dimensions of data quality set out in the *Detailed Guidance for External Assurance on Quality Reports*.

Jackie Bellard
Officer of the Audit Commission
Audit Commission,
2nd Floor Aspinall House,
Aspinall Close,
Middlebrook, Horwich
Bolton, BL6 6QQ

30 May 2012
9. Governors and membership

9.1 Membership and attendance 2011/12

The Council of Governors comprises of seven staff governors, 17 public governors from across Morecambe Bay and seven partner governors. The Governors provide a vital link between the communities and groups they serve and the Trust Board, which has the statutory responsibility for the management of the organisation.

The Council of Governors have a number of statutory roles, including providing their view on our forward planning, appointing and deciding the terms of office of the Chair and other Non-Executive Directors of the Board, approving the appointment of the Chief Executive, appointing or removing our auditors and receiving our annual accounts, auditor's reports and annual report.

The Trust Chair chairs the Council of Governors and is supported by the Deputy Chair who is a Non-Executive Director of the Board of Directors.

The details below show the members of the Council of Governors during 2011/12, and their attendances at the five formal meetings. It is important to note that this does not reflect the significant amount of time that many Governors have committed outside these meetings through Council of Governors Sub Groups and many other ways to benefit the patients and the local community.

<table>
<thead>
<tr>
<th>Chair</th>
<th>Name</th>
<th>Title</th>
<th>Appointment Period</th>
<th>26/07/11</th>
<th>31/10/11</th>
<th>04/01/12</th>
<th>02/02/12</th>
<th>13/03/12</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Professor Eddie Kane</td>
<td>Chair</td>
<td>01/10/10 – 12/12/11</td>
<td>✓</td>
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<td></td>
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<tr>
<td></td>
<td>Ian Tomlinson</td>
<td>Acting Chair</td>
<td>13/12/11 – 05/02/12</td>
<td>✓</td>
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<tr>
<td></td>
<td>Sir David Henshaw</td>
<td>Chair</td>
<td>06/02/12 –</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
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### Elected Governors

Public and staff Governors are elected by members within their constituency. The following Governors were in post during 2011/12:

<table>
<thead>
<tr>
<th>Name</th>
<th>Public Gov representing</th>
<th>Appointment Period</th>
<th>26/07/11</th>
<th>31/10/11</th>
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<th>13/03/12</th>
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<tr>
<td>Derek Lyon</td>
<td>Barrow</td>
<td>01/10/10</td>
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<tr>
<td>Shahnaz Asghar</td>
<td>Barrow</td>
<td>01/10/10</td>
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<tr>
<td>Ray Short</td>
<td>Barrow</td>
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<td>30/09/12</td>
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<tr>
<td>Kathleen Knipe</td>
<td>Lancaster</td>
<td>01/10/10</td>
<td>30/09/13</td>
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<tr>
<td>Jim Wood</td>
<td>Lancaster</td>
<td>01/10/10</td>
<td>30/09/13</td>
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<tr>
<td>Lynne Stafford</td>
<td>Lancaster</td>
<td>01/10/10</td>
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<tr>
<td>Alan Hutchings</td>
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<tr>
<td>Peter Gee</td>
<td>Lancaster</td>
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<tr>
<td>John Hunter</td>
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<td>01/10/10</td>
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<tr>
<td>Natalie Tidy</td>
<td>Lancaster</td>
<td>01/10/10</td>
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<tr>
<td>David Earnshaw</td>
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<tr>
<td>Maria Radice</td>
<td>South Lakes</td>
<td>01/10/10</td>
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<tr>
<td>Paul Brown</td>
<td>South Lakes</td>
<td>01/10/10</td>
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<tr>
<td>John Kaye</td>
<td>South Lakes</td>
<td>01/10/10</td>
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<tr>
<td>Roy Slack</td>
<td>South Lakes</td>
<td>01/10/10</td>
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<tr>
<td>Richard Boddy</td>
<td>South Lakes</td>
<td>01/10/10</td>
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<td>Bernadette Adams</td>
<td>South Lakes</td>
<td>30/09/11</td>
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<td>Janet Hamid</td>
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<td>Michael Porter</td>
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</table>
Key to the above table:

Barrow = Barrow and Copeland Public Constituency
Lancaster = Lancaster, Craven and Wyre Public Constituency
South Lakes = South Lakeland and Eden Public Constituency

<table>
<thead>
<tr>
<th>Name</th>
<th>Staff Representing</th>
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<td>Lindsey Biggs</td>
<td>A</td>
<td>01/10/10 Resigned 10/05/11</td>
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<tr>
<td>Graeme Nicholson</td>
<td>B</td>
<td>01/10/10 30/09/13</td>
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</tr>
<tr>
<td>Kay Hyland</td>
<td>C</td>
<td>01/10/10 30/09/12</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Glyn Davies</td>
<td>D</td>
<td>01/10/10 30/09/13</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Gill Ryder</td>
<td>E</td>
<td>01/10/10 30/09/13</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gilbert Ozuzu</td>
<td>F</td>
<td>01/10/10 30/09/14</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Sharon Granville</td>
<td>G</td>
<td>30/09/11 30/09/14</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Karen Halbert</td>
<td>H</td>
<td>30/09/11 30/09/13</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Key to the above table:

A - Registered Nurses, Midwives and Operating Department Practitioners
B - Registered Nurses, Midwives and Operating Department Practitioners
C - Allied Health Professionals
D - Estates and Ancillary
E - Management and Administration
F - Registered Medical and Dental Practitioners
G - Management and Administration
H - Registered Nurses, Midwives and Operating Department Practitioners
9.2 Appointed Governors
All appointed posts on the Council of Governors were nominated by partner organisations as follows:

<table>
<thead>
<tr>
<th>Name</th>
<th>Organisation</th>
<th>Appointment Period</th>
<th>26/07/11</th>
<th>31/10/11</th>
<th>04/01/12</th>
<th>02/02/12</th>
<th>13/03/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Michael Holder</td>
<td>NHS North Lancashire</td>
<td>01/10/10</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Peter Clarke</td>
<td>NHS Cumbria</td>
<td>01/10/10</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Anne Burns</td>
<td>Cumbria County Council</td>
<td>01/10/10</td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Sarah Fishwick</td>
<td>Lancashire County Council</td>
<td>01/10/10</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Ian Soane</td>
<td>Voluntary Sector, Cumbria</td>
<td>01/10/10</td>
<td></td>
<td></td>
<td></td>
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<td>✓</td>
</tr>
<tr>
<td>Denise Partington</td>
<td>Voluntary Sector, Lancashire</td>
<td>01/10/10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>John Goodacre</td>
<td>Liverpool University</td>
<td>01/10/10</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

9.3 Council of Governors meetings
The Council of Governors held five meetings in public during the year (July, October, January, February and March). The individual attendance by Governors is detailed on pages 81-84.

Declaration of Interests
All members of the Council of Governors have a responsibility to declare relevant interests, as defined in the Trust Constitution. These declarations are made known to the Company Secretary, reported formally to the Council of Governors and entered into a register, held by the Company Secretary, which must be available to the public. Declarations are available for viewing at Trust Headquarters, Westmorland General Hospital, Burton Road, Kendal, Cumbria, LA9 7RG or by contacting the Company Secretary at trustHQ@mbht.nhs.uk or 01539 716684.
9.4 Committee Support

Council of Governors’ Nominations Committee

The Council of Governors Nominations Committee is a formal committee of the Council of Governors. The Committee’s function is to deal with recruitment and appointment, and terms and conditions of the Chair and the Non-Executive Directors. The Lead Governor, Director of Human Resources and Organisational Development and Company Secretary provide support to the Committee as appropriate.

Its membership during 2011/12 was:

Eddie Kane, Chair of the Trust (Chair)
Gilbert Ozuzu, Elected Governor
Richard Boddy, Elected Governor
Peter Clarke, Appointed Governor

During 2011/12, the Nominations Committee met 4 times on 19 December 2011, 16 January 2012, 22 February 2012 and 13 March 2012 to discuss the appointment process for a Non-Executive Director Vacancy and Remuneration of the Chair and Non-Executive Directors. Recommendations following these discussions were presented to formal Council of Governors meetings for approval.

The Non-Executive Director vacancy application process was managed by our Employment Services Department, with support from an executive recruitment agency. The posts were openly advertised in local and national newspapers and on the NHS jobs website.

Council of Governors Sub-Groups

In addition to the Council of Governors’ Nominations Committee, three working groups are in place to address the following areas in more detail than is possible at formal Council of Governors meetings:

- Strategy
- Patient Experience
- FT Membership and Communications

All the groups have terms of reference and report their activities to the formal Council of Governors meetings.
9.5 Board and Council of Governors communications

The Chair of the Board of Directors, who also chairs the Council of Governors, is an important link between the two bodies. In addition, there are a range of mechanisms for sharing of information and views both formally and informally between Governors and Directors, including written and ‘face to face’ communications, workshops and meetings. A Non-Executive Director of the Board has a responsibility to act as a key link with the Governors. Each of the Council of Governors sub groups benefits from the attendance of an Executive Director or appropriate senior managers at their meetings.

The Lead Governor, Gilbert Ozuzu, has regular contact with the Chair, Monitor and the Chief Executive’s office in relation to on-going issues.

Governors are routinely encouraged to access Board reports. This allows them to keep up to date in addition to the feedback presented at Council of Governors formal meetings. Regular briefings are also sent to Governors on topical issues, as well as other communications such as press releases.

Efforts continue to strengthen the mechanisms for discussions between the Board and Council of Governors. In relation to our future strategy, the input of Governors is an important element in the preparation of our forward plans. Relevant discussions have been incorporated into the agendas of formal Strategy Group meetings and workshops.

In the coming year, it is vital that relationships and roles are developed for our Council of Governors. The Board of Directors and Council of Governors will strive to continue to develop their relationship so that they can deliver their respective statutory roles and responsibilities in the most effective way possible.
9.6 Membership

Our membership is designed to allow eligible members of the public and staff to become involved with the Trust in a variety of ways, depending on their preferences.

We operate a public and staff membership scheme. Members of the public can apply to become a member via our website (http://www.uhmb.nhs.uk/trust/how-to-become-a-member/), by email or by completing an application form and handing it to a member of staff or mailing it to our membership office.

Public constituency
Patients, carers and the wider public are combined to form a single public constituency. Membership is on an opt in basis and open to any eligible person aged 16 years and over residing in the areas that make up the public constituency.

As a hospital Trust providing a service to a large and diverse population, we acknowledge the challenges that having three main hospital sites brings, particularly in relation to the distinctive characteristics of the communities across South Cumbria and North Lancashire.

We are striving to ensure that we have adequate membership of such a large and diverse population. Each of the three sub constituencies have elected a number of governors according to the size of the population served.

In 2012, the public constituency area was expanded to cover the whole of Lancashire, Cumbria and North Yorkshire. This process was approved by Monitor following a public meeting where members voted in favour of the change. A key reason for proposing the amendment was to ensure that the area fully represented the catchment area of the Trust and to allow a wider area for the recruitment of Non-Executive Directors.

Staff scheme
Individuals working for, or providing services for the Trust have been brought together in the staff constituency. Membership is automatic unless staff stipulate otherwise by default.

The staff constituency has five classes, each of which has elected one governor, with the exception of the Nurses and Midwives category which has two governors, to represent them on the Council of Governors:

- Registered Medical and Dental Practitioners
- Registered Nurses and Midwives
- Allied Health Professions
- Estates and ancillary
- Management and administration
Our area
Our constituency areas are currently established in line with local council boundaries:

- Lancashire
- Cumbria
- North Yorkshire

Membership strategy – summary
The FT Membership and Communication Sub-group are currently reviewing the membership strategy and producing an action plan to ensure they maximise the opportunity for members of the public to join our Trust.

In summary, we plan to:

- Maximise opportunities to recruit members at Trust events across the network and public constituency communities
- Target potential members on a more direct face to face basis at the three hospital sites, particularly within out-patient departments and ward areas. Permanent Display stands will also be established in main entrances
- Target volunteers to become members and explore the option of volunteers actively engaging with patients to promote membership by their presence in waiting areas and general reception
- Continue to encourage staff and existing members to sign up family and friends from their communities through established communication methods
- Continue to enclose membership application forms with letters to new patients
- Target local organisations, e.g., major businesses, voluntary groups, education establishments etc
- Pursue joint working opportunities with healthcare colleagues to maximise membership and to facilitate effective use of resources
- Target fundraisers/donors to Morecambe Bay Hospitals Charity
- Raise awareness of the membership via media briefings, press releases, hospital radio and our website
Our Governors can be contacted in a number of ways. We publicise their contact details in our member's newsletter, New Horizons, together with a dedicated section on our website. The website also contains a dedicated email address for the majority of our Governors. Where they don’t have access to email, we provide an alternative method.

We have provided all of our Governors, who are able to have suitable internet access from home, a secure portal to collect emails and exchange documents with the Trust.

**Membership statistics**
As of 25 April 2012, our public membership consisted of 6,280 members and our staff membership consisted of 4,990 members, a total of 11,270 members.

<table>
<thead>
<tr>
<th>As of 25 April 2012</th>
<th>Barrow and Copeland</th>
<th>South Lakeland and Eden</th>
<th>Lancaster Craven and Wyre</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public membership</td>
<td>1,554</td>
<td>2,037</td>
<td>2,595</td>
<td>6,280</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>As of April 2012</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff membership</td>
<td>4,990</td>
</tr>
</tbody>
</table>
10. Other disclosures in the public interest

The NHS Foundation Trust’s policies in relation to disabled employees and equal opportunities:

We are an equal opportunities employer with the following policies in relation to disabled employees and equal opportunities:

- Dignity and Respect at Work Policy and the RESPECT charter
- Equality and Human Rights Policy
- Recruitment and Selection Policy

Further information regarding our staff can be found on page 72.

Information on health and safety performance and occupational health:

We continue to achieve our target of reducing the number of accidents to staff by at least 3% every year on the base year.

The chart below shows our progress.
However, overall our incidence rate has remained relatively stable from 109:1000 employees in 2010/11 to 110:1000 employees in 2011/12.

Our main types of accidents continue to be manual handling, slips, trips and falls and impacts/collisions with objects however in impacts/collisions and slips/trips/falls there has been a reduction with as much as 12 % fewer slips, trips and falls. The number of manual handling incidents has remained the same on the previous year’s figures; however, the impact of introducing of Electronic Profiling Beds is not yet fully evident and should improve manual handling for staff.

We also have a reporting culture for near miss incidents involving needles, (those with potential to cause injury but haven’t) and this ensures that action can be taken to prevent injuries from occurring. In total 27% of reported needle sticks or sharps were near misses. Although the actual number of needle stick injuries reported has risen by 2%, 19% of these have involved clean, uncontaminated needles or sharps therefore the infection risk is low. Higher risk needle stick injuries have risen slightly, this includes a significant increase in incidents involving insulin pens. Devices have been introduced this year to all wards to increase the safety of insulin pens which are one of the most frequent causes of injury to staff. It is expected that there will be a noticeable reduction in injuries from insulin pens over the next few months. There is other work underway to improve training for staff and to investigate other safe devices.

This year we have seen a 2% decrease in reported Violent and Aggressive and Anti-social incidents. This is made up of:

- A 10% increase in reported violent and aggressive incidents, which includes both physical and verbal abuse.
- However, physically violent incidents have only increased by 7% where verbal abuse incidents have increased by 15%.
- Anti-social behaviour has decreased by 55%.

We believe that the shift from physical to verbal abuse is positive and is due to our continued trust-wide Conflict Resolution Training (CRT) programme.

We receive excellent responses to incidents from our local police forces and it is felt that this contributes in part to the reduction of incidents involving anti-social behaviour. However we are working closely with police to continue to tackle the level of abuse our staff receive.

Furthermore, the overall decrease can be seen as a deterrent effect, resulting from the Trust and local agencies working more effectively together to ensure that crimes
against our staff are strongly dealt with, something that we aimed to do this past year.

During this period we have seen a greater number of sanctions made against the perpetrators many of which are stronger than seen in previous years, such as a 12 month custodial sentence.

The Staff Health and Wellbeing Strategy is now embedded and we have developed an identity for all health and wellbeing work which has introduced the “Change tomorrow, today” concept. Key areas of focus for 2011/12 have been to encourage staff to increase levels of physical activity, reduce alcohol intake and reduce the amount they smoke.

Our physical activity promotion campaign supporting the NHS 2012 Challenge, has been awarded the Inspire Mark as part of the London Olympic Games 2012 Inspire Programme which recognises the efforts of employers in promoting and fostering a physical activity culture.

A consistent campaign has been underway to reinforce the smoke-free message on our sites culminating with the launch of staff and patient information leaflets on No-Smoking day in March 2012. This campaign aims to encourage staff, visitors and patients to reduce their consumption of cigarettes.

Our plan for the coming months for improving staff resilience and managing stress consists of a calendar of events based around the national “5 ways to mental wellbeing” campaign which underpins the Year of Health and Wellbeing.

**Information on policies and procedures with respect to countering fraud and corruption:**

We are absolutely committed to maintaining an honest, open and well-intentioned atmosphere within the organisation.

It is, therefore, also committed to the elimination of any fraud within the Trust by employees, patients, contractors and others, and to the rigorous investigation and punishment of any such cases.

We wish to encourage anyone having reasonable suspicions of fraud to report them.

It is our policy, as covered by the Whistle Blowing (Concerns at Work) Policy, that matters of concern raised by staff are treated in the strictest confidence.

This policy, which will be rigorously enforced, ensures that no employee should suffer in any way as a result of reporting reasonably held suspicions.
The combination of the public service values, the complexity of the NHS as a business and the intricacy of its organisational structure makes both the rules of conduct and clear operational guidance essential.

Examples of guidance published within the Trust are:

- Standing Orders
- Standing Financial Instructions
- Standards of Business Conduct for NHS Staff
- Internal Codes of Conduct and Procedures

We have a Fraud and Corruption Policy in place, work closely with our local Counter Fraud specialist together and publicise the details of the NHS Counter Fraud Corruption reporting telephone line.

**Consultations**

There have been no formal consultations in the previous year and there are no formal plans for consultations to report for the next financial year. The Trust are developing a comprehensive recovery plan, should the outcome of this plan require a formal consultation process, the appropriate regulations will be followed which includes thorough, open and transparent engagement with all of our stakeholders.
11. Remuneration Report
University Hospitals of Morecambe Bay NHS Foundation Trust

The membership of the Remuneration and Nominations Committee comprises of the Chair and Non-Executive Directors of the Trust. The Chief Executive and Trust Secretary are in attendance, except when their positions are being discussed. Its role is to:

- determine and review, as appropriate, remuneration and terms of service for the Chief Executive Director and other Executive directors including:
  (i) all aspect of salary (including any performance related elements/bonuses)
  (ii) provisions for other benefits, including pensions and cars
  (iii) arrangements for termination of employment and other contractual terms
- The Committee is also authorised to determine and review remuneration for senior managers on locally determined pay conditions
- ensure that levels of remuneration are sufficient to attract, retain and motivate directors of the quality to run the organisation successfully but to avoid paying more than is necessary

All staff, who come within the remit of the Committee, are on permanent contracts, with six month notice periods. Determination of annual uplifts in salary is based on performance, although account is also taken of relevant benchmarking information.

The Chief Executive and Executive Directors voluntarily sacrificed their annual inflationary uplift in 2010/2011, and in line with Agenda for Change terms and conditions, they will not be receiving an annual inflationary increase for three years. In addition, other than for one Executive Director, they have sacrificed the additional annual incremental payment for three years, commencing in 2010/2011. The exclusion of one Executive Director was to ensure pay parity for the year 2010/2011.

During 2011/12, no compensation payments were made to senior staff. For details of salary, benefits in kind, pension entitlements and disclosures for Senior Managers, see Notes 6.6 to 6.9 in the Annual Accounts which have been audited.

ERIC MORTON
INTERIM CHIEF EXECUTIVE       DATE: 30 May 2012
12. Annual Governance Statement

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of University Hospitals of Morecambe Bay NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in University Hospitals of Morecambe Bay NHS Foundation Trust for the year ended 31 March 2012 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

I have overall accountability and responsibility for risk management across all organisational, financial and clinical activities of the Trust.

The Trust Board recognises that risk management is an integral part of good management practice and is responsible for reviewing the effectiveness of internal controls.

The Risk Management Strategy provides a framework for managing risks across the organisation and is based on current guidance and legislation. The Strategy provides details of the approach to the management of risk adopted by the Trust and sets out details of the risk management structure, groups and key risk manager roles. The role of the Board and Standing Committees is detailed, together with the individual responsibilities of the Chief Executive, Executive Directors and all staff in managing risk. In particular, the Clinical Quality and Safety Committee, the Hospital Management Team and the Finance Sub-Committee provide the mechanisms for
managing and monitoring clinical, operational, financial and information governance risks throughout the Trust and report through to the Board. The Audit Committee oversees the systems of internal control and overall assurance process associated with managing risk.

The Board of Directors routinely receives the minutes of all Standing Committees outlined above and also receives reports on all serious untoward incidents as well as integrated reports on complaints, claims and incidents, which it receives twice a year. Other reports are received from the Integrated Risk Sub-Committee, the Clinical Audit and Effectiveness Sub-Committee and the Patient Service and Experience Sub-Committee via the Clinical Quality and Safety Committee. These groups are underpinned by Divisional Governance Groups and Ward and Department Governance Groups.

Risk management training is provided to staff at all levels. New employees are trained through an induction programme and specific training is targeted for individual roles appropriate to their responsibilities. The Trust’s mandatory training programme reflects essential training needs and includes risk management processes such as health and safety, clinical risk management, fire safety, conflict resolution, resuscitation, moving and handling, safeguarding patients, infection prevention, information governance and equality and diversity. Each of these is included within an e-learning programme available to staff.

Additional training is provided to staff members who have direct responsibility for risk management within their area of work. Lessons learned when things go wrong are shared through Divisional governance systems which enables staff to share experiences and to learn from good practice either from within other Divisions and/or other organisations.

**The risk and control framework**

Risk management requires participation and commitment from staff at all levels. The Risk Management Strategy applies to all employees and requires managers to take an active lead to ensure that risk management is a fundamental part of the total approach to quality, safety, corporate and clinical governance, performance management and assurance.

The process starts with the identification of risks throughout the organisation via structured risk assessments. Identified risks are recorded on risk registers and are graded using a risk scoring matrix. Low scoring risks are managed within the individual wards or departments whilst higher scoring risks are referred upwards to the next tier of management and will appear on Divisional risk registers in additional to the departmental risk register. Significant Divisional issues are identified and culminate in a corporate risk register. Risk control measures are also identified at all levels and used to formulate treatment plans and reduce the potential for harm. The
corporate risk register is used to inform the Trust Board of the significant corporate risk issues.

An electronic system ‘Safeguard’ was introduced during the year 2011/12 which provides an online risk register accessible throughout the Trust. Appropriate staff training has been provided to support staff in accessing, inputting and managing risks on the system. An ongoing process of moderation is in place to ensure consistency in the quality, completeness and rating of risks.

Incident Reporting is openly encouraged by employees, contractors and agency staff and this is embedded by the Trust’s adoption of a fair blame culture. Objective investigations or reviews are carried out to continually learn from incidents which do arise.

Stakeholders, including the public are actively involved in all areas of the Trust’s activities which includes informing and consulting on the management of any significant risk. A wide range of communication and consultation mechanisms exist with relevant stakeholders, both internal and external. The Patient Service and Experience Sub-Committee leads on patient and public involvement and the Council of Governors provide significant representation of stakeholder interest. All Trust policies and procedures are subject to an equality impact assessment and the Trust has developed and implemented a Single Equality Scheme.

The Trust has a Risk Assurance Framework which is based on the following key elements:

- Clearly defined corporate objectives with clear lines of responsibility and accountability;
- Clearly defined principal risks to the achievement of these objectives together with assessment of their potential impact and likelihood;
- Key controls by which the risks can be managed, including involvement of stakeholders in agreeing controls where risks impact on them;
- Management and independent assurances that risks are being managed effectively;
- Board reports identifying gaps in controls or assurances;

Board action plans which ensure the delivery of objectives, control of risk and improvements in assurances.

The Trust is measured against the Risk Assurance Framework components by internal and external audit and the framework provides evidence to support the statements contained within this Annual Governance Statement. The Trust Board
has been actively engaged in a development programme to further enhance the quality and understanding of the Risk Assurance Framework.

Information governance risks are managed as part of the processes described above and information governance, confidentiality and data protection are key elements of the Trust’s mandatory training. The Information Governance Toolkit is used to assess current standards and identify gaps in control and assurance relating to information. The Trust has faced challenges with compliance in respect of mandatory training and measures are in place to address this and improve compliance levels.

The Trust has an Information Governance Group that implements actions to maintain and improve Information Governance standards and to collate evidence to support the self-assessments carried out.

Data quality and data security risks are managed and controlled via the risk management system. Any risks are identified and added to the risk registers. In addition, independent assurance is provided by the Audit Commission’s PbR (Payments by Results) Data Assurance Framework and the Information Governance Toolkit self-assessment review process.

Monitor’s Quality Governance Framework sets out a definition of quality governance as being “a combination of structures and processes at and below Board level to lead on Trust-wide quality performance including:

- Ensuring required standards are achieved
- Investigating and taking action on sub-standard performance
- Planning and driving continuous improvement
- Identifying, sharing and ensuring delivery of best practice
- Identifying and managing risks to quality of care”.

The Trust strives to incorporate the principles of this framework in it’s Risk Management Strategy, however, improvements are required to ensure that quality governance throughout the organisation is of the highest standard expected by Monitor and stakeholders.

The Board approved Quality Improvement Strategy includes specific objectives for the improvement of quality throughout the Trust. Processes have been identified to improve clinical standards, patient experience, staff knowledge and sustainability and assurance is obtained through the Clinical Quality and Safety Committee. Executive responsibility for this area was assigned to the Medical Director for the majority of the year but has now been transferred to the Director of Nursing and
Modernisation. In order to strengthen the Trust’s risk and governance arrangements, an Interim Associate Director of Quality Governance and an Interim Risk and Governance Manager have also been appointed. The Quality Report, within this Annual Report and Accounts, describes the quality improvements and quality governance in more detail.

The Trust is registered with the Care Quality Commission and is required to comply with their Essential Standards of Quality and Safety. A process of self assessment is in place following the prompts within the CQC Essential Standards of Quality and Safety judgement framework. Results of the assessments are considered by the Clinical Quality and Safety Committee and reported to the Board on a regular basis.

During 2011/12, the Trust’s key organisational risks were identified as:

- Significant failure to deliver financial plans
- Sustainability of clinical staff recruitment
- Failure to deliver key national targets
- Failure to manage workforce implications of the Integrated Business Plan
- Failure to demonstrate compliance with CQC standards
- Failure to develop a whole economy approach to service delivery
- Viability of clinical service provision across three sites.

These risks presented significant challenges, the results of which are contained within the section Review of Effectiveness and further detailed in the Quality Report. In respect of the financial challenges, these are documented in the Annual Accounts and in the Financial Review section of the Annual Report and Accounts.

For 2012/13 the Trust is in the process of establishing and implementing an interim recovery plan to address the immediate issues affecting the quality and safety of services outlined in the Review of Effectiveness section. A Programme Management Office has been established to manage significant project areas and to assist with development of a longer term recovery plan. The Programme Management Office will be responsible for monitoring all the action plans to resolve the clinical issues that regulators have identified.

The Foundation Trust is not fully compliant with the registration requirements of the Care Quality Commission.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer’s contributions and payments into the Scheme are in accordance
with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation’s obligations under equality, diversity and human rights legislation are complied with.

The foundation trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation’s obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Review of economy, efficiency and effectiveness of the use of resources

The Trust has an annual financial plan which is approved by the Board and submitted to Monitor. Performance against the plan is monitored by the Finance Sub-Committee and the Trust Board. A monthly Integrated Performance Report is produced which contains performance indicators and Monitor metrics for finance, activity and workforce information. The Trust’s resources are managed within the framework set by the Corporate Governance Manual, which includes Standing Financial Instructions. Financial governance arrangements are supported by internal and external audit to ensure economic, efficient and effective use of resources.

Divisional and corporate departments are responsible for the delivery of financial and other performance targets via a performance management framework incorporating service reviews with the Executive Team for key areas and compliance with the Trust’s Financial Accountability Framework.

Divisions play an active role in ongoing reviews of financial performance including Cost Improvement Requirements/Quality Innovation, Productivity and Prevention (QIPP) delivery. Weekly reports are considered by the Executive Team on key influences on the Trust’s financial position, including activity and workforce indicators.

Assurance is provided by the Trust’s internal and external auditors.

Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

The annual Quality Report for 2011/12 has been developed in line with national guidance and is supported internally by the Risk Assurance Framework. Scrutiny of the information in the report has been undertaken by the Board of Directors and sub
committees of the Board including the Clinical Quality and Safety Committee and the Integrated Risk Sub-Committee.

The Board has directed the Director of Nursing and Modernisation to produce the Quality Report and the contents have been consulted upon with local stakeholders to ensure balance and accuracy. Comments received from stakeholders are included in Annex 1 of the Quality Report within the Annual Report and Accounts.

The Trust validates data and carries out data quality checks against key items across all areas of activity. Regular audit checks on processes in respect of data quality are carried out and action plans are put in place to mitigate any risks identified. All operational policies are version controlled and reviewed when necessary and are available via the Trust’s intranet site.

In respect of patient activity data, the Trust uses reports from SUS (Secondary User System) to improve the quality of the Commissioning Data Set (CDS) submission and acts on queries raised by Commissioners as part of the contractual framework. Activity and income data is reported to the Board within the monthly Integrated Performance Report.

**Review of effectiveness**

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Report attached to this Annual Report and Accounts and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and the Clinical Quality and Safety Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

For the year 2011/12 I am unable to provide assurance that the system of internal control has been fully effective throughout the Trust.

Significant failings have been identified during the year by the Care Quality Commission and by Monitor in respect of four key areas:

- Maternity services
- Outpatients appointments
- Emergency care pathways
Governance and risk

Maternity Services

Maternity and midwifery services were found to be inadequate in that they failed to meet CQC standards. Reviews were initiated following concerns raised by the Coroner related to a serious incident which took place in 2008. The CQC found that the Trust was not compliant with 6 of the expected outcomes out of a total of 10. This included failings in; respecting and involving people who use services; cleanliness and infection control; safety and suitability of premises; staffing; assessing and monitoring the quality of service provision; and, records. The CQC issued a report in September 2011 and Monitor subsequently issued the Trust with a Section 52 Notice which indicates "significant breech" of the Trust’s terms of authorisation.

Immediate action was taken to address the concerns raised where this was possible and the Trust sought professional advice from expert consultants and practitioners to assist with the situation. A plan to return the service to full compliance with all standards was agreed with the CQC and Monitor and actions continue to be taken to ensure that the service provided is sustainable at the appropriate standard and that management of risks is fully embedded into all operational activity.

Outpatient Appointments

A number of issues have arisen during the year which had a serious impact on the provision of outpatient services. This resulted in follow-up appointments being missed or delayed at the risk of causing potential harm to patients and the Trust failed to meet the required standards for delivery of treatment within specified timescales.

A substantial review was undertaken to re-assess the case notes of all patients who may have been affected by the shortcomings identified. Where necessary patients were seen as a matter of urgency and additional clinical resources were engaged for this purpose. Future sustainability of services was reviewed to prevent a recurrence of the problems encountered and this resulted in fundamental changes to the operational arrangements for outpatients. A hub system was introduced with responsibility for the booking and tracking of patients and this has been rolled out across the Trust. Implementation reviews undertaken to date have indicated that these new arrangements have significantly improved the service to patients and therefore greater assurance can be obtained in this area.

Emergency Care Pathways

The CQC undertook some unannounced visits to the Emergency Department at the Royal Lancaster Infirmary in December 2011 and they concluded that the Trust was not compliant with the following expected outcomes; care and welfare of people who use services; staffing; and supporting workers. A further review was initiated as a
result of these visits, into the emergency care pathways. The purpose of this review is to ensure that patients attending the Trust as an emergency are provided with appropriate medical care, by suitably qualified staff and within reasonable timescales and that the level of care is sustained as they progress their patient journey through the organisation.

The Trust has again acted upon the immediate concerns raised where possible and is fully co-operating with the review of emergency care. External professional advice has been secured from a former Government National Clinical Director for Emergency Access who will be supporting the Trust in work to improve the emergency care pathway across the organisation. This work is due to commence in May 2012.

**Governance and Risk**

As a result of the serious failings identified, Monitor raised concerns about the Trust’s management and governance arrangements and intervened to redress the situation. They commissioned a review of risk management and governance arrangements which has been undertaken by PricewaterhouseCoopers. The review focused on the Board’s capability and effectiveness; the effectiveness of the Trust’s governance arrangements, systems and processes, including quality governance; and risk management and risk escalation.

The review found the Trust to be inadequate in many areas with the overall result that risk management and governance is lacking the emphasis required across the organisation and risk management processes and protocols are not sufficiently embedded to be effective. There are some areas of good practice but overall the risk management culture requires significant improvement.

In addition to the PWC report, the Audit Commission undertook a Governance and Risk Management review commissioned by the Trust. Their findings indicated similar concerns and recommended; enhancing the risk management culture; a full review of governance arrangements; improved data quality and challenge of information provided; better integrated risk management; and a more fully developed role for the Audit Committee in overseeing the assurance process.

The Trust has accepted the findings in these reports and is currently working towards an integrated action plan to address the issues.

In addition, in response to the issues identified in the Trust, NHS Lancashire, NHS Cumbria and NHS North established Gold Command to ensure the immediate safety and longer term sustainability of services at the Trust. This is a group which leads and coordinates internal communications and communicates with the public about the safety of services. They meet regularly and update the Department of Health. They have established sub groups specifically to oversee action plans and progress in respect of maternity and paediatric services and outpatients.
Further Monitor intervention has been instigated at the Trust and this includes:

- Appointment of a new interim Chair to drive the recovery agenda.
- The requirement to appoint a Turnaround Director to develop and deliver the recovery plan.
- Creation of a Programme Management Office to support the delivery of the recovery plan.
- Appointment of an interim Chief Operating Officer to manage operational activity across the Trust.

Assurances are provided to me by the Trust’s internal and external auditors. For the year 2011/12, the assurances provided are consistent with the findings and issues documented above.

The Head of Internal Audit opinion is that: Limited assurance can be given as weaknesses in the design and/or inconsistent application of controls, put the achievement of the organisation’s objectives at risk in a number of areas reviewed.

The external auditor has issued a qualified certificate in respect of the Value for Money conclusion for 2011/12. The auditor has a duty to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in the use of resources. As a result of the matters raised in the Section 52 notices issued by Monitor, the auditor is not satisfied that the Trust made proper arrangements in this respect.

During 2011/12 the Trust delivered a proportion of savings through non recurrent cost improvement schemes. The Trust recognises that savings schemes should be embedded in the recovery plan with clear ownership from financial and clinical managers and that recurrent savings are required to ensure future financial sustainability.

The Trust is currently undergoing a period of organisational restructure to address the concerns about leadership, risk management and quality governance. Consultation with staff is taking place on a proposed new management structure with increased levels of clinical engagement and accountability. The Board committee structure and the Risk Management Framework are also being reviewed. The financial impact of proposed changes is also being addressed.

The action plan can be summarised as below:

- The Trust is working with the interim Chair, Chief Executive and Chief Operating Officer to assess the extent of change required to provide sustainable delivery of high quality care.
- A process is ongoing to appoint to these posts on a permanent basis.
• An annual plan is to be produced by 31 May 2012 in line with the annual planning process required by Monitor, for the year 2012/13.

• A longer term recovery plan covering the following four years is being compiled for Monitor and is due to be submitted by the beginning of October 2012. This will address the long term financial viability of the Trust.

• A clinical strategy is being developed and will be an integral part of the recovery plan.

• Governance is a specific area of work within the Programme Management Office work plan and quality governance underpins all work streams associated with addressing the issues raised.

The Care Quality Commission and Monitor will continue to scrutinise the quality and safety of services delivered to our patients.

**Conclusion**

The significant internal control issues which have been identified have resulted in the Trust delivering a quality and safety of care which is below expectations to some of our patients.

The Trust is committed to turning this situation around and to producing and implementing a recovery plan to provide sustainable high class healthcare for the population of Morecambe Bay.

ERIC MORTON  
INTERIM CHIEF EXECUTIVE  
DATE: 30 May 2012
13. Statement of the Chief Executive’s responsibilities as the accounting officer of University Hospitals of Morecambe bay NHS Foundation Trust

The NHS Act 2006 states that the Chief Executive is the Accounting Officer of the NHS Foundation Trust. The relevant responsibilities of the Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by the Independent Regulator of NHS Foundation Trusts (Monitor).

Under the NHS Act 2006, Monitor has directed University Hospitals of Morecambe Bay NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of University Hospitals of Morecambe Bay NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Annual Reporting Manual and in particular to:

- observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual have been followed, and disclose and explain any material departures in the financial statements; and
- prepare the financial statements on a going concern basis.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.
To the best of my knowledge and belief, I have properly discharged the responsibilities set out in Monitor’s NHS Foundation Trust Accounting Officer Memorandum.

ERIC MORTON
INTERIM CHIEF EXECUTIVE

DATE: 30 May 2012
INDEPENDENT AUDITOR’S REPORT TO THE BOARD OF GOVERNORS OF UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST

I have audited the financial statements of University Hospitals of Morecambe Bay NHS Foundation Trust NHS Foundation Trust for the year ended 31 March 2012 under the National Health Service Act 2006. The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers’ Equity, the Statement of Cash Flows and the related notes. These financial statements have been prepared under the accounting policies set out in the Statement of Accounting Policies.

This report is made solely to the Board of Governors of University Hospitals of Morecambe Bay NHS Foundation Trust in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. My audit work has been undertaken so that I might state to the Board of Governors those matters I am required to state to it in an auditor’s report and for no other purpose. To the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the Foundation Trust as a body, for my audit work, for this report or for the opinions I have formed.

Respective responsibilities of the Accounting Officer and auditor

As explained more fully in the Statement of Accounting Officer’s Responsibilities, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view.

My responsibility is to audit the financial statements in accordance with applicable law, the Audit Code for NHS Foundation Trusts and International Standards on Auditing (UK and Ireland). Those standards require me to comply with the Auditing Practice’s Board’s Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Trust’s circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Trust;
and the overall presentation of the financial statements. In addition, I read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my report.

**Opinion on financial statements**

**In my opinion the financial statements:**

give a true and fair view of the state of affairs of University Hospitals of Morecambe Bay NHS Foundation Trust’s affairs as at 31 March 2012 and of its income and expenditure for the year then ended; and have been properly prepared in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts.

**Opinion on other matters**

In my opinion the information given in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

**Matters on which I report by exception**

I report to you if, in my opinion the Annual Governance Statement does not reflect compliance with Monitor's requirements. I have nothing to report in this respect.

**Qualified certificate**

Under Schedule 10 1(d) of the National Health Service Act 2006 I have a duty to satisfy myself that the Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

On 11 October 2011 and 6 February 2012 Monitor issued notices of exercise of intervention of powers under section 52 of the National Health Service Act 2006 to the Board of Directors and the Board of Governors of the Trust. These notices stated that Monitor was satisfied that the Foundation Trust had contravened and was failing to comply with the following conditions of its Term of Authorisation:

Condition 2 to exercise its functions 'effectively, efficiently and economically';
Condition 5 its governance duty; and
Condition 6 its healthcare targets and other standards duty.
Monitor was satisfied that the contraventions and failures were significant under section 52(1) of the Act.

As a result of the matters discussed in the two notices issued by Monitor, I am not satisfied that University Hospitals of Morecambe Bay NHS Foundation Trust made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2012.

I certify that I have completed the audit of the accounts of University Hospitals of Morecambe Bay NHS Foundation Trust in accordance with the requirements of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.

Jackie Bellard
Officer of the Audit Commission

Audit Commission,
2nd Floor Aspinall House,
Aspinall Close,
Middlebrook, Horwich
Bolton,
BL6 6QQ

30 May 2012
Annual accounts

ANNUAL ACCOUNTS 2011/2012

Foreword to the accounts

UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST

These accounts for the twelve months ending 31 March 2012, have been prepared by the University Hospitals of Morecambe Bay NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006.

These accounts are the second published accounts of the Foundation Trust which was authorised with effect from 1 October 2010.

ERIC MORTON
INTERIM CHIEF EXECUTIVE

X XXXX 2012