PUBLIC TRUST BOARD OF DIRECTORS' MEETING

Wednesday 28 September 2022 in the Board Room, Westmorland General Hospital, Burton Road, Kendal LA9 7RG

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

Commencing at 9.30am

Agenda					
Item		**Lead**	**Action**	**Paper**	**Time**
Opening Administration					
110	Welcome and Introductions • Apologies for absence received from Bev Edgar (Lyn Hadwin to deputise), Sakthi Karunanithi, Bridget Lees (Lynne Wyre to deputise) and Sarah Rees • Declaration of conflicts of interest	Chair	To note	Verbal	9.30am-9.31am (1 Minute)
111	Minutes of the Board of Directors' Meeting held on 31 August 2022 *To approve the Minutes of the Meeting held on 31 August 2022.*	Chair	To approve	Attached	9.31am-9.33am (2 Minutes)
112	Action Sheet and Matters arising from the Minutes of the Public Meeting of the Board of Directors held on 31 August 2022 *To consider the action sheet and note the actions taken.*	Chair	To note	Attached	9.33am-9.35am (2 Minutes)
Matters for Consideration					
113	Patient Story *An account from a patient on their experience of recovering from a stroke.*	Chief Nursing Officer	To note	Attached	9.35am-9.50am (15 Minutes)
114	Chair's Report *An update presented by the Chair.*	Chair	To note	Attached	9.50am-9.55am (5 Minutes)
115	Chief Executive's Report *An update presented by the Chief Executive.*	Chief Executive	To note	Attached	9.55am-10.05am (10 Minutes)
116	Head Governor Update *An update presented by the Head Governor.*	Head Governor	To note	Attached	10.05am-10.10am (5

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					Minutes)
Patients					
117	Recovery Support Programme – UHMB Improvement Plan *A report to present the Trust's improvement plan in response to being placed in the NHSI/E Recovery Support Programme.*	Deputy Chief Executive / Intensive Support Director	To consider	Attached	10.10am-10.20am (10 Minutes)
118 i	Care Quality Commission (CQC) and Royal College of Surgeons (RCS) Improvement Plans *A report to summarise the current position and progress of the Improvement plans to address;* • *CQC Must Do and Should Do recommendations; and* • *Royal College of Surgeons Report recommendations.*	Director of Governance	For assurance	Attached	10.20am-10.30am (10 Minutes)
118 ii	Niche External Investigation Assurance *A report to present the current position, progress of and cross-cutting themes of the NICHE recommendations.*	Director of Governance	For assurance	Attached	10.30am-10.40am (10 Minutes)
119	Maternity Update *A report to provide an update of continuing monitoring and action taken on Quality, Performance and Service Delivery against national and local drivers within the Maternity and Neonatal Services.*	Chief Nursing Officer / Director of Midwifery	For assurance	Attached	10.40am-10.55am (15 Minutes)
	Break				10.55am-11.10am (15 Minutes)
Performance					
	The items in this section will be discussed with reference to the Integrated Performance Report and other specific reports				
120 i	Integrated Performance Dashboard and Report Month 4 incorporating matters raised by the Executive Team and through the Assurance Committees. *The Deputy Chief Executive will present this report covering quality and safety, operational, people and financial performance.*	Deputy Chief Executive	For assurance	Attached	11.10am-11.30am (20 Minutes)
120 ii	Minutes and 3A Reports from Assurance Committees	Chairs of the Assurance Committees	To note	Please refer to Board of	11.30am-11.40am (10

	a) Finance and Performance Committee from Minutes Meeting on 8 August 2022 and 3A Report from Meeting on 26 September 2022 b) Quality Committee Minutes from Meeting on 18 July 2022 and an Update from the Meeting on 26 September 2022 The 3A Reports from 26 September 2022 will be included in the next month's Board papers.			Directors' Reference Pack for copies of the Committee Minutes	Minutes)
121 i	Winter Plan *To provide a briefing on the approach UHMBT (and system partners) is taking to prepare for the forthcoming seasonal Winter period.*	Chief Operating Officer	To approve	Attached	11.40am-11.50am (10 Minutes)
121 ii	Emergency Preparedness, Resilience and Response (EPRR): Annual Assurance Return *A report to present the Emergency Preparedness, resilience and response annual return.*	Chief Operating Officer	For assurance	Attached	11.50am-11.55am (5 Minutes)
People					
122	Positive Difference Annual Report 2021/22 *To present the Positive Difference Annual Report. Alongside the Annual Report, the appendices include the annual submissions for the following national performance standards:* • *Workforce Race Equality Standard;* • *Workforce Disability Equality Standard;* • *Workforce Sexual Orientation Equality Standard;* • *Gender Pay Gap Reporting;* • *Equality Delivery System 2;* • *Workforce Monitoring Report; and* • *Service Monitoring Report.* *A colleague story will be presented to the Board of Directors.*	Interim Chief People Officer	To consider	Attached	11.55am-12.15pm (20 Minutes)
123	Cultural Transformation Programme Update *A report to provide an update on the Moving Forward culture change priorities and actions, all of which link to the Trust's Organisational Development and leadership plan which together form an integrated programme of transformation.*	Interim Chief People Officer	To consider	Attached	12.15pm-12.20pm (5 Minutes)

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Partnerships					
124	New Hospital Programme – Options *A report to provide an update on the Lancashire and South Cumbria New Hospitals Programme and to seek approval on the preferred and alternative options for the Royal Lancaster Infirmary.*	Chief Operating Officer	To approve	Attached	12.20pm-12.35pm (15 Minutes)
Governance and Assurance					
125	Trust-wide Risk Register (Corporate Risk Register) and Risk Management *A report to provide the Board of Directors with an overview of the Trust-wide Risk Register and the process for assigning risks to that.*	Director of Governance	To consider	Attached	12.35pm-12.40pm (5 Minutes)
126	Policy and Publications Report *A report to provide the Board of Directors with information on recent policy developments from the Department of Health, NHS England / Improvement, NHS Providers, NHS Confederation, Care Quality Commission (CQC) and Healthwatch.*	Chief Executive	To note	Attached	12.40pm-12.41pm (1 Minute)
Closing Administration					
127	Attendance Monitoring Register	Chair	To note	Attached	12.41pm-12.45pm (4 Minutes)
128	Schedule of Business	Chair	To note	Attached	
129	Urgent Business	Chair	To note	Verbal	
130	Date, Time and Venue of Next Meeting: Wednesday 26 October 2022 at 10am in the Board Room, Westmorland General Hospital, Kendal LA9 7RG and via Microsoft Teams.				
131	Exclusion of the Press and Members of the Public: To resolve that representatives of the press and other members of the public will be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted.				

Apologies to be given to Nicola Barnes by 26 September 2022.

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Board of Directors' Declarations of Interest

University Hospitals of Morecambe Bay NHS Foundation Trust is committed to openness and transparency in its work and decision making. As part of that commitment, we maintain and publish a Register of Interests which draws together Declarations of Interest made by members of the Board of Directors. In addition, at the commencement of each Board meeting, members of the Board are required to update the Register and declare any interests.

Date of Declaration	Name	Role	Nature of Interest	Do you envisage a conflict of interest between outside employment and your NHS employment?	Nil Declaration
13/04/2022	Chris Adcock	Director of Finance / Deputy Chief Executive			✓
14/04/2022	Aaron Cummins	Chief Executive	Trustee of South Cumbria Multi Academy Trust	A material conflict of interest does not exist. However, Aaron may wish to make a declaration and withdraw from any meetings where either Furness College or South Cumbria Multi Academy Trust is being discussed.	
04/04/2022	Bridget Lees	Executive Chief Nurse			✓
14/04/2022	Paul Jones	Company Secretary			✓
19/07/2022	Scott McLean	Chief Operating Officer			✓
05/04/2022	Jane McNicholas	Medical Director			✓
20/12/2021	Richard Sachs	Director of Governance	Trustee of Endeavour Learning Academy Trust (until 31/03/2022)	A material conflict of Interest does not exist as the Multi Academy Trust is based outside the catchment of the UHMB NHS Foundation Trust	
27/01/2022	Phil Woodford	Director of Corporate	1. Outside Employment -	It is not a management role	

		Affairs	Lancashire County Council as Paid volunteer Care support Worker 2. Outside Employment – ICS - Vaccination centre volunteer (unpaid)	and does not impact on his current role or working hours, to support the covid response efforts of regulated care. No conflict of interest; request for volunteers came from the Trust/NHS to help at vaccination centres, volunteered to help his local GP practice.	
23/04/2021	Adrian Leather	Non-Executive Director	Chief Executive Officer of Active Lancashire	Potentially a material conflict of interest may arise from his role as Chief Executive Officer of Active Lancashire. However Adrian would have to consider the circumstances; make a declaration and consider withdrawing from any meetings where Active Lancashire is being discussed.	
27/04/2022	Sarah Rees	Non-Executive Director	Outside Employment - Head of Stakeholder Relations at Lancaster University	Sarah is the University's appointed NED on the Board of UHMBT. Should any conflict of interest arise, such as a development involving both the Trust and the University, Sarah would declare accordingly and take advice on how best to proceed.	
22/05/2022	Hugh Reeve	Non-Executive Director	1. Director of HA Reeve Ltd - a company set up to provide consultancy and GP services to health care	Potentially a material conflict of interest may arise from the role with activities being undertaken by his consultancy and NHS	

			organisations. 2. GP Locum Employment - In NHS Highland which is a region of NHS Scotland - provision of GP services to various communities in the NHS Highland region. Also ad hoc locums in GP Practices in the Morecambe Bay area.	Highland. However, Hugh would have to consider the circumstances; make a declaration and consider withdrawing from any meetings where the matter being discussed relates to his consultancy or NHS Highland or activities, they are accountable for.	
16/06/2022	Elizabeth Sedgley	Non-Executive Director	1. A self-employed accountant. 2. Family Member employed as financial controller at Select Medical Ltd. 3. Governor of Nelson & Colne College Group	A material conflict does not exist. However Elizabeth may wish to make a declaration and consider withdrawing from any meeting where Select Medical is being discussed.	
11/04/2022	Jill Stannard	Non-Executive Director			✓
07/04/2022	Mike Thomas	Chair			✓
20/04/2022	Stephen Ward	Non-Executive Director			✓

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Minutes of the Trust Board of Directors' Meeting held on Wednesday 31 August 2022 in the Board Room, Westmorland General Hospital, Burton Road, Kendal LA9 7RG

The meeting also took place via Microsoft Teams.

This meeting was recorded to which all Board members verbally agreed.

Present:	Liz Sedgley (LS-NED)	Non-Executive Director (Chair)
	Aaron Cummins (AC)	Chief Executive
	Bev Edgar (BE)	Interim Chief People Officer
	Bridget Lees (BL)	Chief Nursing Officer
	Scott McLean (SM)	Chief Operating Officer
	Jane McNicholas (JM)	Chief Medical Officer
	Sarah Rees (SR-NED)	Non-Executive Director
	Liz Sedgley (LS-NED)	Non-Executive Director
	Jill Stannard (JS-NED)	Non-Executive Director
	Steve Ward (SW-NED)	Non-Executive Director
In attendance:	Nicola Barnes	Trust Board Administrator
	Olivia Caton	Deputy Company Secretary
	Lorraine Crossley-Close (LC)	Head Governor
	Heather Gallagher (HG)	Director of Midwifery (for item 99 only)
	Sarah Hauxwell (SH)	Associate Medical Director - Recovery Support Programme
	Caroline Howsley (CH)	General Manager – Cumbria Deaf Association (for item 22/93 only)
	Louise Jones (LJ)	Head of Communications
	Paul Jones (PJ)	Company Secretary
	Tim Povall (TP)	Operational Finance Director
	Barry Rigg	Head of Patient Experience
	Richard Sachs (RS)	Director of Governance

22/90 Welcome and Introductions

Apologies for Absence

Apologies for absence were received from Mike Thomas, Chris Adcock, Karen Deeny, Adrian Leather, Hugh Reeve and Phil Woodford.

Declarations of Conflicts of Interest

None.

22/91 Minutes of the Board of Directors' Meeting held on 27 July 2022

22/78i Integrated Performance Report
In relation to minute 22/78i referring to the work to address fractured neck of femur "*JM would present an update to the Quality Committee in September 2022,"* JM clarified the Care Group would present to the Quality Committee.

22/83i Chief Medical Officer Update: Appraisal and Revalidation Report
In relation to minute 22/83i "*SR-NED welcomed the report and sought assurance on the processes in place to test the impact of the policy. JM advised she would discuss this with SR-NED at the People Committee as they would continue to monitor this."*
SR-NED clarified that discussions had taken place outside the People Committee to seek assurance.

In relation to minute 22/83i *"JM advised the role of Regional Officer would stay with the Chief Medical Officer but the Deputy Medical Director would support this wor,"* JM advised the minute should read Responsible Officer.

Decision: That, subject to the above amendment, the Minutes of the meeting held on 27 July 2022 be agreed as an accurate record.

22/92 Action Sheet and Matters Arising from the Minutes of the Public Meeting of the Board of Directors held on 27 July 2022

79: Trust Wide Risk Register and Risk Management – RS provided the rationale for deferring the report to the Board of Directors' meeting on 28 September 2022.

Decision: The Board of Directors considered the action sheet and noted the actions taken.

22/93 Patient Story

BL introduced BR and CH.

BR delivered a presentation jointly with CH.

BR outlined how the Trust had complied with the Accessible Information Standard. The standard was built into five principles – identification of patient communication preference, record it, flag it in the care record and share this across other care providers. The fifth key principle was to meet the information and communication standards of people with a disability, impairment, or sensory loss. This scheme had been supported by Annette Shepherd (AS), Patient Experience Facilitator, which had enhanced the Trust's response to this.

CH commended the support of BR and AS in terms of the impact this had made for patients who were deaf.

There had been incidents in the Trust where people who were deaf and had arrived at the Trust after 5pm, could not access to the level of support they required.

JS-NED commended the presentation and commented that when people accessed the Trust's services, it was the duty of the Trust to provide the level of support they required. JS-NED sought assurance on the Trust's response to this.

BL outlined the progress made.

BR advised the patient experience team were working with the improvement team to monitor this. A training video was available for all clinical staff. Discussions had taken place with the Lorenzo team to ensure that accessible information was also included as

part of their Lorenzo training.

AC commended the and in terms of the development of the Trust's clinical strategy, AC requested JM work with BR team to ensure all needs were included to build in improvements through the design work of the strategy. JM agreed to involve BR and team.

CH recommended the Trust consider better accessibility to Team meetings for people who were hard of hearing. PJ agreed to follow this up outside of the meeting.

SR-NED commended the presentation and sought assurance on the process for training staff.

BL advised the newly appointed Deputy Chief Nurse would review this.

22/94 Chair's Report

LS-NED presented the Chair's report and updated the Board of Directors on his work.

LS-NED provided information on the number of meetings and walk rounds the Chair had attended at the Trust throughout August 2022. The report also included information on the meetings the Non-Executive Directors had chaired and attended in August 2022, recent Trust news and Mike's future engagements.

On behalf of the Chair, LS-NED paid tribute to all colleagues for their efforts as the Trust remained focused on the exit strategy from System Oversight Framework (SOF) level 4 and continued work with the recovery support programme. The Trust's aim was to progress to SOF2 and above.

Decision: That the report be noted.

22/95 Chief Executive's Report

AC presented the Chief Executive's report and updated the Board of Directors on recent activity in the Trust.

The following points were made in discussion:

1. AC paid tribute to colleagues as it was evident there had been no cessation of operational pressure from the winter period. Teams were working hard, particularly on patient flow and urgent care pressures which had been compounded by staff absence for COVID-19, high demand, high acuity, and significant issues with pressures external to the Trust, most notably in social care.
2. AC explained the context of the operational pressures was important to recognise when delivering the performance report.
3. Nationally, there were two priorities: structural reform and Integrated Care Systems. The dialogue to clarify and work through the operating model – this was still under development of which the Trust would contribute. When this had been developed, it would be presented to the Board of Directors for consideration. Elective recovery, urgent care, winter planning and financial improvement had driven the Trust's own priorities and was connected to the national message. AC advised of NHSI/E's approach to winter planning preparation and explained SM would provide a further update to the Board.
4. The Integrated Care Board continued to build its priorities of which the Trust was

contributing. There were decisions made around setting up the new place-based partnerships for Lancashire and Westmorland areas. Two place-based directors had been appointed and would commence post in autumn.

5. AC advised that Mark Hindle (MH) would retire from his position of Pathology Collaboration Managing Director in January 2023. Professor Anthony Rowbottom MBE, who had been closely involved in this project, would work with MH to pick up the day to day running of the Collaboration whilst the Board reviewed future leadership arrangements.
6. AC explained the Chair of the Trust had been appointed as the Chair of the Provider Collaborative Board.
7. BE had been appointed as the Interim Chief People Officer for a period of 3 to 6 months. Recruitment of a permanent Chief People Officer was underway.
8. Becky Higgs, Assistant Director for the Recovery Support Programme had joined the Trust from the Integrated Care System
9. Dave Sanderson has been appointed as the new Director of Estates and Facilities.
10. The recovery support programme continued to progress as and was the platform for continuous improvement to enable the Trust to move from System Oversight Framework (SOF) segment 4 to 3, 2 and beyond. The Trust's journey of improvement would not stop at the point of exiting SOF segment 4.
11. In this context, the report included an update on the most recent Care Quality Commission (CQC) inspection. AC was pleased to see reflection of the Trust's improvement work in the latest CQC report. The CQC highlighted the improvements and the care and compassion they witnessed at a point of being under pressure was commended. The CQC also highlighted areas for focus – the long waiting times for elective surgery and access to urgent care services, improvement in pharmacy support and medicines management, staffing levels and working arrangements when under pressure.

During deliberation of this item the following points were considered:

12. SR-NED sought assurance on the timeline for working arrangements on place-based partnerships (PBP) and how Bay Health and Care Partners would contribute to that. AC advised that the operating model for the leadership team would be finalised over the next 3 months. PBP directors would commence post in September 2022. Their levels of autonomy were still under discussion. AC advised he would provide further updates over the next two Board meetings and the forthcoming workshop.
13. LS-NED sought assurance on the mechanisms in place to communicate access to services during this transitional period. AC advised the current infrastructure remained in place until the transition was complete. LJ advised that a communications plan was in development with provider collaborative partners which would be shared across the system.

Decision: That the report be noted.

22/96 Head Governor Report

Consideration was given to a report presented by LC.

The following points were made in discussion:

1. Governor elections were ongoing.

2. The full Council met on 16 August 2022. The meeting took place from 5pm to

encourage attendance. The Governors received a financial update and a presentation on HoloLens.

3. The Director of Governance met governors on 2 August 2022 to give the latest updates on the recovery support programme, urology and Care Quality Commission recommendations and the next meeting will be held on 4 October 2022.
4. Governors undertook Making Data Count Training led by NHSI.
5. Governors also received a briefing on health literacy. This was an introduction to health literacy, what it was and why it was important. The session covered the impact of low health literacy on patients and the NHS. The session used several activities to highlight what low health literacy felt like and discussions on how the Trust could empower patients to ask questions and make decisions about their own health.
6. The Membership Strategy was approved by the Council of Governors (CoG) on 16 August 2022 and was an agenda item at today's meeting for the Board to approve. The Membership and Communications Group had established a working group to review, implement and embed the agreed objectives for 2022/24.
7. An amendment to the Trust Constitution was approved by the CoG on 16 August 2022. It was agreed to recommend to the Board that the 'Rest of England' Constituency be amended to a Public Constituency to allow Non-Executive Directors to be appointed from areas outside of the current three Public Constituencies.
8. Preparations for the Annual Members' Meeting were underway, and the provisional date was 28 September 2022. The Audit Committee was scheduled to receive the External Audit Value for Money Report and once approved the Annual Report and Accounts could be laid before Parliament. Following this, the provisional date for the Annual Members' Meeting would be confirmed.

Decision:

1. That the report be noted; and
2. An amendment to the Trust Constitution was approved by the CoG on 16 August 2022. It was agreed to recommend to the Board that the 'Rest of England' Constituency be amended to a Public Constituency to allow Non-Executive Directors to be appointed from areas outside of the current three Public Constituencies.

22/97 Recovery Support Programme – UHMB Improvement Plan

Consideration was given to a report presented by SH to provide an update on the Trust's improvement plan in response to being placed in the NHSI/E Recovery Support Programme.

The following points were made in discussion:

1. The work programmes were on track to deliver against the key milestones. SH outlined the timelines since the last Board update. The Trust was awaiting the official outcome of meeting with national team on 14 July 2022 but the team had been in discussions with the team since that time. It was envisaged a formal meeting with the national team would take place in December 2022 / January 2023. Preparations for that meeting had begun along with preparations for the meeting in quarter 1 of 2023/24 which was anticipated to be the meeting it was agreed the Trust exit SOF segment 4.

2. It was envisaged the maternity safety support programme would stay in place, but

the Trust would progress to a sustainability phase of the programme in January 2023 with exiting of the programme by June/July 2023. SH explained the rationale for this. This would not be a barrier to exiting System Oversight Framework (SOF) segment 4 if the Trust delivered the quality and safety and safe staffing issues. A formal review of the programme would be undertaken in September 2022.

3. SH outlined the criteria for exiting SOF segment 4; providing safe sustainable care and delivery against the exit criteria with a focus on continuous improvement was fundamental to the Trust's transition from SOF segment 4. The key enablers to providing assurance that the Trust was providing safe care to patients included the Performance and Accountability Framework, Quality Governance Accountability Framework, and Integrated Performance Reports to achieve improvement via business-as-usual structures.
4. Moving to a national patient safety incident response framework was a step-change for the Trust in terms of how the Trust investigated incidents to understand how the incidents occurred. This would support the Trust in becoming a learning organisation moving forward.
5. The clinical strategy would enable the Trust to unite multiple strands of the recovery support programme and improvement work to allow the Trust to sustainably move forward to become a continuously improving organisation.
6. SH advised the next phase of the programme would be embedded sustainably in the established organisation structures via the refreshed assurance and accountability enabling arrangements and progression to an outcome / impact focused reporting methodology aimed to increase Board awareness of the benefits realised because of the actions taken. A review of metrics would take place in line with the shift in approach to move them to outcome focus.
7. A focus on pace would be undertaken with wider engagement with staff to enable them to focus on improvement work and understand the barriers to staff engaging with this work.
8. There was a requirement to work with partners to achieve exit of SOF segment 4. The Trust was working with the newly established Integrated Care Board (ICB). The Chief Financial Officer had discussed with ICB colleagues to strengthen and co-ordinate the work being done moving forward.
9. The report demonstrated the progression against the requirement to meet the exit criteria for SOF segment 4. The Trust had submitted to the Care Quality Commission a request to remove the Section 31 Notice for stroke care; the Trust had not received the formal outcome of that. Agreement that had been reached for a close out report on the safe staffing workstream to be submitted to the Quality Assurance Committee and the System Improvement Board in September 2022. This was the first time a major piece of work had been delivered against the recovery support programme.

During deliberation of this item the following points were considered:

10. AC commended the approach of the leadership team as they focused on demonstrating sustainability to enable the Trust to be a continuous improving organisation.
11. BE sought assurance on inclusion of the freedom to speak up workstream within the culture work programme. BL advised freedom to speak up had been placed as a subset of this workstream and agreed to discuss further with BE outside the meeting.
12. JS-NED commended the report and was looking forward to working with the new Deputy Chief Nurse who would oversee the freedom to speak up element of the culture work programme.
13. SR-NED commended the update, particularly the emphasis on the shift towards

being outcome / impact focused.

14. LS-NED commended the report and welcomed the shift in approach as the Trust embedded the next phase of the programme.

Decision: That the report be noted.

22/98 Care Quality Commission (CQC), Niche and Royal College of Surgeons (RCS) Improvement Plan Progress Report

Consideration was given to a report to presented by RS providing the current position, progress of and cross-cutting themes of the CQC must and should do recommendations, NICHE recommendations and RCS recommendations.

The following points were made in discussion:

1. RS advised the recommendations following the inspection in March 2022 had been incorporated into the improvement plan.
2. Additional support had been secured in seeking, checking, and testing evidence for assurance purposes.
3. RS advised the report had not been presented to the Quality Committee as there was no meeting in August 2022.

During deliberation of this item the following points were considered:

4. JS-NED welcomed the additional support to test the evidence. JS-NED sought assurance on the Trust's response to the delay in progression of the Medicine Care Group to meet the recommendations. JS-NED sought clarity on the colour-code of dashboard which described the Niche recommendations by score. JS-NED would welcome the additional of detailed narrative on those recommendations not on track to understand the rationale for this and the mitigations in place in future reports.
5. RS advised discussions had taken place with the senior leadership team of the Medicine Care Group. Additional support had been provided to respond to the delay in progression. The check and challenge meetings with the Medicine Care Group had moved from monthly to fortnightly. Regarding the dashboard, RS clarified the colour-code and advised he would ensure the narrative was included in future reports.
6. SW-NED sought assurance that the recommendations overseen by the Finance and Performance Committee were included on the agenda for the Committee meeting in September 2022. RS agreed to oversee this.
7. SR-NED advised she was supporting RS and team by attending the support and review panels with the Care Groups to scrutinise and 'sign off' evidence upon completion of actions / recommendations.
8. LS-NED noted her concern at the delay in the progression of CQC Must and Should Do's the Medicine and Women and Children's Care Groups. RS advised on the actions taken to address this.
9. BL advised that the key priorities of the maternity safety support programme (MSSP) was the development of a clinical strategy for maternity, governance, and leadership. BL suggested the report was amended to reflect the work undertaken through the MSSP monitoring process for future reports.

Decision:

1. That the report be noted; and
2. That the recommendations overseen by the Finance and Performance Committee would be included on the Committee's agenda in September 2022.

22/99 Maternity Safety Update

Consideration was given to a report presented by HG to provide an update of continuing monitoring and action taken on Quality, Performance and Service Delivery against national and local drivers within the Maternity and Neonatal Services.

The following points were made in discussion:

1. There had been no perinatal mortality review tool (PMRT) cases this month. The report into the external PMRT review would be presented at the Board of Directors' private meeting on 28 September 2022.
2. There were no Healthcare Safety Investigation Bureau no new cases for July 2022.
3. There had been a further increase in the number of incidents graded moderate and above this month. This was in response to targeted work to improve the grading and reporting of harm, by assessing the harm occurred, not the harm caused (gaps in care). This was in alignment with the CQC Regulation 20. There had been one STEIS reported incident in month which was reported within the 72 hour time frame.
4. HG alerted the Board to an increase in the national perinatal stillbirth rate nationally from 3.8 per 1000 in 2019 to 4.2 per 1000 in 2021. The Trust continued to be below the national average PRSM and the increase in the rate was suspected to be due to the pandemic and accessing care.
5. Training compliance exceptions were outlined. There had been an increase in PROMPT training to 48%. PROMPT training had been escalated to with the Care Group as 90% was required by December 2022 in order to meet the requirements of CNST level 4. A revised plan had been requested from the Care Group to meet the 90% target by December 2022. HG advised this would be escalated to the Board of Directors if further improvement was not made. Obstetric staff compliance with training had decreased to 56% for PROMPT. The Care Group had been asked to oversee the improvement plan and trajectories to achieve compliance by December 2022.
6. The women and children's team met with anaesthetic colleagues to discuss the obstetric anaesthetic staffing requirements and the Ockenden (2022) final report's Chapter 11 Obstetric Anaesthesia. It had been agreed to collaborate on benchmarking the new obstetric anaesthetic standards and to present the gap analysis to the Quality Committee in October 2022. Staffing deficits were currently being mitigated.
7. Midwifery staffing fill rates for both the Royal Lancaster Infirmary (RLI) and Furness General Hospital (FGH) were above 85% with bank and agency usage for July 2022.
8. The women and children's workforce plan was in the process of being finalised with recruitment schemes were underway.
9. HG provided an update on obstetric leadership.
10. HG alerted the Board that maternity was experiencing its high activity period which would be expected until October. HG advised August to October were often the challenging months for staffing due to activity and high annual leave. The North West Escalation Policy for Maternity Services had been implemented which was having an impact on community midwives, as the policy required community midwives to be called to support the unit (often at night) if the escalation policy was to be enacted. However, this was having an impact on community service provision the following day due to the lack of staff availability. Following feedback, the North West Escalation policy was amended by the region and the Trust would re-launch. The impact of community midwives being called in as part of escalation would be

monitored via the Midwifery Professional Leads Group monthly, which was chaired by HG.

11. The Birthrate Plus intrapartum acuity tool was implemented in July 2022 at the RLI. The acuity tool at FGH required further bespoke amendments made by the provider due to the LDRP model of care delivery.
12. HG advised a 7-day week matron cover was being considered.
13. The Board Level Safety Champions meeting met monthly from August. HG thanked Hugh Reeve for his support and contribution as he stepped down from the role of the Non-Executive Director Board level safety champion for maternity services. Karen Deeny would commence this role from September 2022.
14. In relation to midwifery continuity of carer model, a national steer on the recommendations was awaited.
15. For Year 4 CNST incentive scheme for all safety actions, HG advised the Trust had met all current deadlines. As of August 2022, the Trust was compliant with 7/10 safety steps with actions in place to meet full compliance by the submission date for December 2022. Note the considerable improvement from CNST Year 3 when only 3/10 compliance was achieved. HG outlined the 3 actions not and assured the Board that all non-compliant safety actions were monitored via the Women and Children's Care Group Governance Assurance Group
16. The Ockenden assurance visit was undertaken by NHSE on 20/21 July 2022 across all sites with the regional chief midwife and LMNS key stakeholders. A full paper on the assurance visit feedback and revised action plan in light of the feedback would be presented to the Quality Committee in September 2022.
17. Expected publication of the immediate and essential actions for Ockenden the final report and East Kent's inquiry was expected in September 2022.
18. The Maternity Safety Self-assessment tool was undertaken as part of the MSSP visit with the Midwifery Maternity Improvement Advisor, Deputy Chief Midwife of NHSE, Maternity Improvement Obstetric Advisor and the maternity triumvirate. The progress is evident from a January 2022 position to July 2022 position.
19. A System Improvement Board deep dive into Maternity was due on 13 September 2022.
20. An improvement action plan for maternity governance following the mapping exercise had been developed and presented to the Executive Chief Nurse and Director of Governance and would now progress through internal governance processes for sign off and approval, and monitoring.

During deliberation of this item the following points were considered:

21. AC commended the report and noted the approach applied to incident reporting. AC sought assurance on the identified themes / improvement actions because of the reclassification of the incidents seen. HG advised there was more robust triangulation in terms of understanding the themes. Staff were able to identify more easily and judge whether the actions in place were robust and working. Triangulation of other organisations was important for sustainable improvement.
22. JS-NED commended the approach for incident reporting in a no-blame culture.

Decision: That the report be noted.

22/100i Integrated Performance Dashboard and Report Month 3

Consideration was given to a report presented by the Executive Directors to update the Board of Directors on the Trust's financial, quality and workforce performance against national and contractual standards.

The following points were made in discussion:

1. BL presented the quality and safety section and advised all the work progressed through the recovery support programme had enabled the correlation of the deep-dive of the safety measures, friends and family test and complaints. There was correlation between the long waits in Emergency Department attendances and an increase in pressure associated injuries. BL outlined the actions in place to response to this and explained a further update would be presented to the Quality Committee in September 2022.
2. JM advised following a clinical review and deep dive approval for new VTE metrics had been signed off and would be included in future reports. In terms of mortality, the Trust's position was middle of pack when compared with peers. JM advised the Board had previously been alerted to the fact that the Trust remained an outlier for hip fracture. Ongoing work continued to address this with a further update to the Quality Committee in September 2022. The Care Group had established a task and finish work stream to respond to this.
3. BE advised of the high vacancy rate for consultants with robust plans to recruit. The team continued to review the plans in place including a review of the way the Trust advertised and the creation of welcome packs. Attendance was a concern and the sickness absence rate had decreased to 6%. This was still relatively high for an NHS Foundation Trust. A review would take place to support staff. The COVID-19 guidelines relating to sickness absence had changed. There were currently 20 staff absent due to symptoms of long COVID-19. The teams were working with them to support their return to work. From now on any new occurrences of COVID-19 would be treated under the standard sickness absence guidelines. There was an increase in number of retirees returning to the organisation. The leadership programme, as part of the recovery support programme was on track. BE had requested the Deputy Director of OD and Improvement commence an evaluation of the programme to sustain the programme against a backdrop of winter pressures and adapt where necessary. Basic Life Support training (BLS) had declined for three months in a row. Whilst within statistical variation tolerances, contact had been made with the BLS delivery team to understand whether current levels of provision were adequate.
4. TP outlined the financial position. Processes were in place to identify excess inflation across the system. At end of month 3 the Trust was £0.85 million worse than planned. This related to agency spend in the first quarter and response on not meeting criteria to reside. A discussion would take place at the Finance and Performance Committee to review the wider system financial position as well as the Trust position. TP outlined the capital programme. TP provided an update on the energy position and the mitigations in place to manage this.
5. SM outlined the operational performance. Urgent care had shown sustained significant pressure; Emergency Department attendances were 12% higher than the pre-COVID-19 period. The Trust was not meeting criteria to reside – there were 138 patients not meeting the criteria to reside as at 27 September 2022 compared to less than 70 12 months ago. With number of patients not meeting criteria to reside, it had an impact on patient flow. Cancer performance was outlined. There had been a deterioration in diagnostic performance. Referral to treatment performance was outlined. Stroke data was presented. Unscheduled care was under pressure with improved performance in scheduled care. There was fragility in the Trusts estates which impacted theatres. The system and Trust response to not meeting criteria to reside was outlined. This was a significant issue for performance, quality and safety and urgent care. SM could not confidently assure the Board that this would be reduced and explained a number of meetings were taking place with colleagues across the partnership to review the response to

this.

During deliberation of this item the following points were considered:

6. JS-NED sought assurance on the response to the stroke data noting the improved trajectory for the next set of data. SM advised that in relation to stroke care provision, scanning and discharge processes were consistently positive and there were improvements in access to the stroke unit. Thrombolysis treatment had improved.
7. AC advised in terms of the Trust's financial position, energy was the most volatile area and was pleased to note the Trust had taken advice to manage this. AC articulated the response to the Trust's financial position. TP set out the procurement process being adopted for the provision of energy.
8. SR-NED sought assurance on the mortality report and the requirement to increase mortality reviewers. JM advised of the model which would be implemented.

Decision: That the report be noted and the approach to energy procurement be endorsed.

22/100 ii Assurance Committee Minutes and Chairperson's Report

An update on the following Assurance Committee was received and noted:

Audit Committee

LS-NED provided an update on the work of the Committee and advised the auditor's annual report had identified significant weaknesses in the Trust's financial position and governance.

Finance Committee

SW-NED provided an update from the Committee.

Oncology Business Case

SM presented the report and the Board approved the business case.

22/101 Cultural Transformation Programme

Consideration was given to a report presented by BE to present the Terms of Reference of the Cultural Programme Board together with a programme update.

The following points were made in discussion:

1. BE assured the Board of delivery of the programme with good progress made despite being in a transition phase with the departure of key leads.
2. BE presented the Terms of Reference for the Culture Programme Board.

Decision:

1. That the report be noted; and
2. The Board of Directors approved the terms of reference for the Culture Programme Board.

22/102 Integrated Care Board (ICB) Update / Provider Collaborative Board (PCB) Update

Consideration was given to a report presented by AC to provide an update from the ICS and PCB.

Decision: That the report be noted.

22/103 Quality Governance & Accountability Framework

Consideration was given to a report presented by RS to present the quality governance and accountability framework following a review by NHS England / Improvement.

The following points were made in discussion:
1. RS advised framework and structure built on the work of the Good Governance Institute to support and demonstrate the Trust was well-led.
2. The framework had been presented to the Trust Management Group in June and July 2022 for their consideration.

During deliberation of this item the following points were considered:
3. SR-NED commended the report and found the organogram of ward to Board helpful. SR-NED sought assurance on the template Chair's report in the context of the 3A report. RS advised that it suggested a return to the Chair's report and would adapt the 3A report, so there was one report.
4. AC reflected on the journey over the last 18 months and suggested it was included in the audit programme to provide assurance.
5. RS thanked Becky Southall, Quality Governance Lead at NHS England for her support in developing this framework.

Decision: The Board of Directors adopted and approved the Quality Governance & Accountability Framework following the PDSA cycle commenced in quarter 1 2022/23.

22/104 Membership Strategy

Consideration was given to a report presented by PJ.

The following points were made in discussion:
1. PJ advised that all Foundation Trusts were required to have a membership strategy.
2. A working group had been established to develop the strategy.
3. The Council of Governors had considered this and recommended approval by the Board of Directors.

During deliberation of this item the following points were considered:
4. SR-NED sought assurance on the criteria to monitor success and welcomed understanding what the criteria. PJ advised the working group would continue to meet to monitor this.

Decision: That the Board of Directors approved the Membership Strategy.

22/105 Attendance Monitoring Register

Noted.

22/106 Schedule of Business

Noted.

22/107 Urgent Business

None.

22/108 Date, Time and Venue of Next Meeting

It was noted that the next meeting of the Board of Directors would be held on Wednesday 28 September 2022 at 10am in the Board Room, Westmorland General Hospital, Kendal LA9 7RG

22/109 Exclusion of the Press and Members of the Public

Agreed: That the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted.

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Meeting Title	**Board of Directors' Meeting (Public) Action Tracker**
Meeting Chair	**Mike Thomas**
Previous Meeting Date	31/08/2022
Next Meeting Date	28/09/2022

Completion Status	
O	Overdue
SFM	Scheduled for meeting
SBM	Beyond date of meeting
ACP	Action completed

Meeting Date	Action No	Agenda Item	Action Point	Owner	Due Date	Original Due Date	Completed Date	Progress	RAG Rating
26/05/2021	29	Patient Story	The acute care team presented a service which was launched and piloted in January 2021 in relation to patients with acute kidney injuries and potential sepsis. It was agreed the team would return to a future Board meeting to provide an update on how this service had become business as usual.	Chief Nursing Officer	25/01/2023			This has been included as part of the schedule of patient and staff stories to be presented to Board. The acute care team had agreed to present an update to the Board of Directors at their meeting on 26 January 2022, but due to current pressures the team have been deployed to other areas in the Trust. A new date will be arranged (NOTE: The Executive Chief Nurse is developing a programme of patient stories for 2022/23).	**SBM**
29/09/2021	123	Lancashire and South Cumbria Pathology Collaboration	The pathology collaboration agreement would be presented to the Board of Directors at their meeting in November 2021.	Chief Operating Officer	30/11/2022			Further to the last meeting of the Board at which it was announced that the Pathology Collaboration Programme had been paused, a further report would be submitted when the Pathology Board have agreed next steps to be taken. The scheduling of this item will be kept under review.	**SBM**
30/03/2022	243	Patient Story	It was agreed to present an update on the improvements made in the provision of stroke care by inviting a patient to a future Board of Directors' meeting who had experienced the Trust's improved stroke care service.	Chief Nursing Officer	28/09/2022				**SFM**
25/05/2022	35	Mortality Update	A Board Development session would be included in the Board Development Programme for 2022/23 which focused on mortality, ulcers and urgent care.	Company Secretary	20/10/2022			This has been included in the Board Development Programme for 2022/23	**SBM**
29/06/2022	59	Freedom to Speak Up Report	It was agreed a report on raising concerns across the Trust would be presented at a future Board of Directors' meeting.	Chief Nursing Officer	27/10/2022				**SBM**

Meeting Date	Action No	Agenda Item	Action Point	Owner	Due Date	Original Due Date	Completed Date	Progress	RAG Rating
27/07/2022	71	Patient Story	The Board of Directors noted a new patient experience strategy was in development and would be reported to the Board of Directors at a future meeting.	Chief Nursing Officer	22/02/2023				SBM
27/07/2022	71	Patient Story	The Board of Directors noted that the patient experience team were in the process of reviewing the information pre-hospital admission to help inform citizens on how to access local services and this would be shared with the Board in spring 2023.	Chief Nursing Officer	29/03/2023				SBM
27/07/2022	78i	Integrated Performance Report	A workshop be arranged for the Non-Executive Directors to discuss the Trust's financial position in greater detail.	Chief Financial Officer				A workshop will be included in the Board Programme for 2022/23.	SBM
31/08/2022	93	Patient Story	It was agreed to review accessiblity to Team meetings for people who were hard of hearing.	Company Secretary	28/09/2022			Accessibility standards have been reviewed and improved communications have been agreed and published. A successful system test has been undertaken. Additional system analytical work is ongoing.	SFM

BOARD OF DIRECTORS

Date of Meeting	28 September 2022
Title	Chair's Report
Report of	Professor Mike Thomas
Prepared by and contact details	Maria Caparelli – Business Manager Maria.caparelli@mbht.nhs.uk

Confidentiality	Non-Confidential

Purpose of Report	**To Advise/Alert**	**To Assure**	**To Approve**	**To Update**
	x	x		x
	The content of this report outlines: – Introduction – An outline of the Chair's activities throughout September 2022; – An outline of the Non-Executive Directors' activities throughout September 2022 – Final Remarks			

Summary of Key Issues	A report providing key updates to the Trust Board on Chair and Non-Executive Directors' activities and their relation to governance and Trust objectives.

Prior Discussions	**Committee**	**Date**	**Recommendations/ Concerns**

Action to be recommended to the Committee/Board	The Trust Board are asked to receive and note the contents of this report.

Link to Key Priorities	Delivering outstanding care and experience	Create the culture and conditions for colleagues to be the very best they can be	Make the best use of our physical and financial resources	Working in partnership
	x	x	x	x

Impact on Board Assurance Framework or Corporate Risk Register				
Risk Impact Assessment	Is this required?	**N**	If Yes, Date Completed	
Equality Impact Assessment	Is this required?	**N**	If Yes, Date Completed	
Quality Impact Assessment	Is this required?	**N**	If Yes, Date Completed	
Environmental / Sustainability Impact Assessment	Is this required?	**N**	If Yes, Date Completed	

Acronyms	

UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST

Chair's Report

Introduction

1. I would like to begin by welcoming all to this month's meeting of the Trust Board of Directors.

2. This report provides a number of general updates in relation to both Chair and Non-executive Director activities.

3. It is with sadness I report on the passing of Her Majesty The Queen, on 8 September 2022. It has been a difficult period for many and as a Trust we have done our utmost to support colleagues at this time. Further operational detail and protocol guidance is contained within the Chief Executive's report on today's meeting agenda.

4. I reported last month on the establishment of the new Integrated Care Board (ICB). In support of the ICB establishment, there are a number of local partnership structures in place, one of which is our Provider Collaborative Board (PCB). Providers will work together to enable partnership working of acute, mental health and community providers across Lancashire and South Cumbria.

5. In this regard, I am delighted to take this opportunity to inform you that I have recently been appointed, and ratified, as the new Chair of the PCB. I take on this role from my predecessor, David Flory, Chair of the Lancashire and South Cumbria Integrated Care Board (ICB), who has stepped away from his PCB role now that the ICB has been established. I will of course continue in my role of UHMBT Chair and look forward to the future as we continue to work together.

6. Particularly so as we head into Winter, the Trust continues to experience service pressures and a number of challenges in our Emergency Departments and across our wards and departments. Further information is provided on today's Trust Board meeting agenda, and within the Chief Executive's Report.

7. Finally, and as always, I would like to offer my sincere thanks and gratitude to all colleagues for their continued efforts as we remain focused on our exit strategy from SOF4 (System Oversight Framework, NHSIE) and continued work with our Recovery Support Programme (RSP).

Chair's Activities

8. Meetings and events I attended in the month of September included, but not limited to, Provider Collaborative Board (PCB) meeting, and PCB Operational meeting, Race Equality Talent Management meeting, Chair, Head Governor and Deputy Head Governor meeting, New Hospitals Programme (NHP) Trust Engagement meeting, Clinical Integration Group meeting, Chair and Non-Executive's meeting, Chair and Chaplaincy meeting, MP meeting, and Trust Board Development session.

9. I also held my regular 'Meet the Chair' sessions with Trust colleagues, plus the regular board and assurance committee meetings, and meetings with the Governors and Non-Executive Directors.

10. I have also managed to take some annual leave which has given me time to rest and recharge.

Non-Executive Directors' Activities

11. Meetings Non-Executive Directors attended for September included, but not limited to, chairing and attending Board and Assurance Committees, participated in Council of Governor meetings and sub-groups, Care Group buddying, UHMBT and wider Bay Health and Care Partners' projects, as well as regular calls with the Chair and Executive Directors.

12. The Non-Executive Directors are carrying out clinical and ward visits and remain involved in commitments associated with buddying arrangements with Executives and Care Groups to provide ongoing support.

13. These are priority Non-Executive Director activities, and the planning and coordination of these are being carried out by the Trust Board Secretary's office, identified Executives and our office managers.

Final Remarks

14. On behalf of the Board, we are grateful and thankful to all colleagues for their commitment to our patients and our community, and for their continuous efforts to enhance the Trusts provision for the benefit of patients, carers, and families.

15. I look forward to the next meeting of the Trust Board in October 2022.

Professor Mike Thomas
Chair

28 September 2022

BOARD OF DIRECTORS

Date of Meeting	28 September 2022
Title	Chief Executive's Report
Report of	Aaron Cummins – Chief Executive
Prepared by and contact details	Maria Caparelli – Business Manager to Chief Executive maria.caparelli@mbht.nhs.uk

Confidentiality	Non-Confidential

Purpose of Report	**To Advise/Alert**	**To Assure**	**To Approve**	**To Update**
	x	x	x	x
	This report comprises the Chief Executive's overview of current matters and priorities for the Trust and wider System. It is produced to ensure the Trust Board, Governors, wider public and stakeholders are sighted on these matters and are provided with the opportunity to comment and seek further clarification if required. The report does not seek to duplicate business items on the Trust Board meeting agenda, but attention will be drawn to items of particular note.			

Summary of Key Issues	This report provides a range of key updates on a monthly basis to the Trust Board, under a number of current headings and themes which link to our organisational priorities. These items include but are not limited to: a general Introduction highlighting items of relevance to our current operating environment, the National and Regional Context, Lancashire and South Cumbria Integrated Care Board (ICB), Lancashire & South Cumbria Provider Collaborative Board (PCB), Morecambe Bay Place-Based Partnerships, General Trust Updates, Financial Sustainability, Service Transformation and Improvement, and Relationships and Partnerships. Additional items referenced in this month's report under the headings above include: • The Passing of Her Majesty The Queen Elizabeth II • New National Appointments • Annual Members Meeting • Interim Chief People Officer • Trauma & Orthopaedics Update

	• Care Quality Commission (CQC) Employment Tribunal A forward to look to the next meeting of the Trust Board in October is provided at the end of this report, together with a brief summary of the items scheduled.

Prior Discussions	Committee	Date	Recommendations/ Concerns
	Not applicable		

Action to be recommended to the Committee/Board	The Trust Board are asked to receive and note the contents of this report.

Link to Key Priorities	Delivering outstanding care and experience	Create the culture and conditions for colleagues to be the very best they can be	Make the best use of our physical and financial resources	Working in partnership
	x	x	x	x

Impact on Board Assurance Framework or Corporate Risk Register	Not applicable			
Risk Impact Assessment	Is this required?	**N**	If Yes, Date Completed	
Equality Impact Assessment	Is this required?	**N**	If Yes, Date Completed	
Quality Impact Assessment	Is this required?	**N**	If Yes, Date Completed	
Environmental / Sustainability Impact Assessment	Is this required?	**N**	If Yes, Date Completed	

Acronyms	
	Any acronyms explained in full in the main body of the report.

UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST

Chief Executive's Report

INTRODUCTION

1. This month's report provides an update on a number of key areas for the Trust as set out in the executive summary above.

2. Today's Board meeting agenda features a number of key areas and reports for discussion, including: Recovery Support Programme (RSP) – UHMBT Improvement Plan, Care Quality Commission (CQC), Niche Progress Report, Maternity Safety Update, Positive Difference Annual Report 2021/22, Cultural Transformation Programme Update, New Hospitals Programme, Trust-wide Risk Register (Corporate Risk Register) and Risk Management, Urgent Care and Winter Planning – plus the usual standing items for the Board to consider and receive.

3. I will not duplicate items on the agenda, but I will draw particular attention to a number of key items of note throughout this report.

4. Unfortunately, earlier this month, it was necessary for the Trust to escalate to OPEL 4 due to inordinate operational pressures, particularly at the Royal Lancaster Infirmary. There were a number of reasons for this escalation, including fewer beds available, longer ambulance waiting times, increased number of attendances, staffing challenges, and increasing numbers of patients in our hospitals who do not meet the criteria to reside (NMC2R) - i.e., they are medically fit to leave hospital but for a variety of reasons they are unable to do so.

5. Declaring OPEL allows us to be able to take additional steps to maintain safe services for our patients and help us cope with the growing pressures.

6. Escalation was stepped down on 9 September. This decision was made because the pressure on the site has reduced to a level which while still very significant, does not meet the OPEL 4 criteria.

7. Whilst de-escalation is positive news, it is important to note that our services do remain under extreme pressure, and particularly so as we head into winter. We will continue to work closely with our partners to take appropriate action where needed, particularly with supporting the discharge of patients who do not meet criteria to reside.

8. Item 121 on today's agenda provides an update on our Winter Plan, including an update on the funding position for the programme.

9. As always, our colleagues and teams continue to work extremely hard to ensure the safety of our patients across our hospitals and in the community. I would like to sincerely thank all colleagues who are going above and beyond to keep our patients safe in incredibly challenging circumstances.

NATIONAL AND REGIONAL UPDATES

The Passing of Her Majesty The Queen Elizabeth II

10. Her Majesty The Queen passed away peacefully at her Balmoral residence on 8 September 2022.

11. We join communities across the United Kingdom, the Commonwealth and the whole world in mourning the loss of The Queen and celebrating her life's commitment to our nation. We also send our condolences and best wishes to The Queen's family and loved ones.

12. In line with national mourning guidance, we took the decision to postpone some corporate events and visits we had planned during this period. Union Jack flags have continued to be flown at half-mast at each of our three main sites until the day after the funeral, as per the national guidance.

13. The funeral took place on Monday 19 September, which was designated as a Bank Holiday. Alongside our colleague Trusts in the region, UHMBT has sought to prioritise, where possible, continuing with our most urgent elective services, including those for patients with cancer. We have worked closely with teams to attempt to protect this activity for patients while respecting that this is an important bank holiday for colleagues. Routine outpatient and scheduled inpatient work were suspended for the day, and affected patients contacted.

14. The funeral marked a significant national event, and we appreciate that many staff wished to participate in the day in their own way.

15. I would like to take this opportunity to thank all colleagues for their assistance in working through the national guidance and protocols and taking the necessary actions.

New National Appointments

16. This month sees the commencement of a new Prime Minister, Liz Truss; and a new Secretary of State, Suella Braverman. These changes to national leadership will have implications for us as an NHS Trust, and the wider health and care system. We will continue to work with national, and regional, colleagues and teams in terms of developments around national mandates and planning requirements.

Lancashire and South Cumbria Integrated Care Board (ICB)

17. 1 July 2022 saw the formal establishment of the new Lancashire and South Cumbria Integrated Care Board. The eight Clinical Commissioning Groups across Lancashire and South Cumbria have been replaced by a single Integrated Care Board (ICB), which will be known publicly as NHS Lancashire and South Cumbria.

18. I plan to include the following section as a standing item in my report to the Trust Board each month as it serves as a useful reminder of the new structures.

19. The establishment of the new ICB signals a significant change to the way health services are planned, paid for and delivered in Lancashire and South Cumbria.

20. The new organisation will be responsible for NHS spending and the day-to-day running of the NHS in the area.

21. The change aims to ensure that services better meet the needs of local people. It will also see closer relationships between health and care partners, including local authorities and voluntary and community groups, who will work together to agree on local priorities.

22. This change to the structure of how local health services are managed is a positive step forward towards integrating care for our local communities. Regardless of where in the system you work, we all have the same aim - to offer the best possible services to local people with the best possible outcomes; and it is by working together in partnership that we will achieve this for all our communities.

23. We look forward to continuing to work with our local NHS provider colleagues as part of the Lancashire and South Cumbria Provider Collaborative to support the newly formed ICB as it builds on the hard work of all health and care organisations over the last few years.

24. In support of the ICB establishment and the wider Lancashire & South Cumbria Health & Care partnership that sits underneath the ICB structure outlined above, we have enabled a number of local partnership structures. An overview of these structures is provided below.

Lancashire & South Cumbria Provider Collaborative Board (PCB)

25. Service providers will work in collaboration to enable partnership working of acute, mental health and community providers across Lancashire and South Cumbria.

26. The PCB meets monthly, and the most recent meeting took place on 15 September 2022 where the agenda covered: current performance update; Urgent and Emergency care, Elective care, Mental Health and Learning Disabilities, Financial update, Corporate Collaboration update, Pathology Collaboration update, and Clinical Integration update.

27. In terms of a key update for the PCB this month, our Chair, Professor Mike Thomas, has been ratified as the new Chair of the Lancashire and South Cumbria Provider Collaborative Board (PCB). Mike takes over from David Flory, Chair of the Lancashire and South Cumbria Integrated Care Board (ICB), who has stepped away from his PCB role now that the ICB has been established as a statutory organisation. Mike will also continue in his role of UHMBT Chair, and together, we look forward to continuing to work with PCB colleagues.

Morecambe Bay Place-Based Partnerships

28. Planners and providers working together across health, local authority and the wider community, taking responsibility for improvement health and wellbeing of residents within a place. The five place-based partnerships that make up the Lancashire & South Cumbria Partnership are: Morecambe Bay, Pennine Lancashire, West Lancashire, Fylde Coast and Central Lancashire.

29. The most recent Place-Based Leadership Team meeting took place on 1 September 2022, and the agenda covered preparation for a subsequent BHCP Leaership meeting on 15 September 2022 regarding the outputs of the Place Based Boundary Review - and next steps for Morecambe Bay.

Primary Care Networks

30. Most day-to-day care is delivered here. Neighbourhoods will develop to bring together partners across health and social care to deliver integrated care.

TRUST UPDATES

Annual Members' Meeting

31. As a result of the Queen's passing and the national mourning guidance in place, we have reviewed our Annual Members' Meeting arrangements and agreed to postpone the meeting until later in the year. Further information and arrangements will be shared in due course.

Chief People Officer

32. I updated last month that the recruitment process for our substantive Chief People Officer was underway. Unfortunately, due to various reasons we did not appoint on this occasion. This is an important appointment for UHMBT so it is imperative that we get this right.

33. We are working with Odgers Recruitment to re-run the process and will keep you updated as this progresses. In the meantime, Bev Edgar is with us on an interim basis, and I would like to take this opportunity to thank Bev for her valuable contribution so far. The Trust Board and I are looking forward to continuing to work with Bev during this period.

Trauma & Orthopaedics Update

34. As part of the ongoing work around the raising of concerns in Trauma and Orthopaedics (T&O), the Trust commissioned an independent report by Investigation By Design Ltd (IBD) to look at how concerns were handled (not the clinical concerns raised). The final Draft Report was received by the Trust at the end of June 2022.

35. The Trust has previously stated its intention to publish the IBD report. In order to do this, the Trust must abide by Data Protection Laws (Data Protection Act 2018) particularly respecting the right of individuals not to have their personal data published without their consent.

36. While respecting and upholding the Data Protection Act, the Trust must ensure that patients and colleagues are kept safe in pursuant of the Trust's activities, to support the learning and understanding of the IBD report, the following actions have been or are being undertaken to assist the efficient and effective learning from the findings:

- Report shared in full (July 2022) as part of the July Part 2 Board meeting, enabling the Non-Executive Directors to scrutinise the report and hold the Executive to account, particularly for the delivery of the 'IBD Action Plan'.

- During October/November 2022, to hold a briefing with the Trust's Council of Governors, together with the IBD authors and Trust Board.
- During September/ October 2022 – all current and former Trust colleagues identified in the report to receive a confidential anonymised copy of the IBD report.
- Previous authors of recent investigation reports/review will also receive information related to this report.

37. Due to the large volume of personal information within the IBD Report, IBD have been commissioned to create an Executive Summary of the report, with less personal information to facilitate and support the response to Freedom of Information requests and further discussion by the Trust Board in public, this is expected to be presented to the Trust Board at its October 2022 meeting.

38. The purpose of this investigation report was to consider whether the Trust's relevant Medical Leaders acted appropriately upon receiving concerns raised by two medical Consultants (whistleblowers) regarding the clinical practice of a medical colleague, whether the Medical Leaders recognised and treated the two medics as whistle-blowers and whether they have experienced any detriment as a result of raising concerns.

39. Whilst we believe that we supported the two colleagues who raised concerns fairly, we accept that the situation could have been better managed – for which we sincerely apologise - and we have ensured we have identified key learning from this. We remain keen to work with the affected colleagues to ensure this is not repeated in the future. I would like to thank the two colleagues for their unwavering commitment to patient safety and raising the concerns in the first place.

Care Quality Commission (CQC) Employment Tribunal

40. Recently, a UHMBT colleague was successful in his Employment Tribunal against the Care Quality Commission. This case related to his employment with the CQC as a Specialist Advisor and was not related to his employment at UHMBT.

41. This led to significant media coverage, including a public statement made by a local MP relating to this Trust and their perception of the support our Trust offers to colleagues that raise concerns.

42. The Trust is keen to ensure an open dialogue with any colleagues who may be concerned or indeed have any queries regarding this matter.

RELATIONSHIPS AND PARTNERSHIPS

Engaging with colleagues across the Trust

43. My Chief Executive Tea and Talk sessions continue where colleagues from any area across the organisation can come and join me for a chat over tea and coffee - and raise any issues and feedback.

44. These sessions provide an informal but extremely valuable opportunity to discuss a wide range of concerns, areas of good practice and much more.

45. We have recently refreshed our approach to our monthly 'Team Talk' briefings with colleagues. Every month, the sessions will be held over Teams for any colleague to

attend. They will be recorded and shared via our leadership teams and corporate communications channels to allow those that cannot attend to catch up when convenient to them. This is a new format which we will be seeking feedback on in order we can make the necessary changes and improvements.

FINAL REMARKS

46. In-line with our revised Trust strategy for the period 2022-2027, our refreshed areas of focus for 2022/23 are as follows:

    - You're safe in our hands - Quality and safety of services
    - We're here for you - Colleague psychological and physical well-being
    - We're planning for success - Improved financial performance and transformation of services

47. As a result of this work, we have reaffirmed our vision for our Trust: "Creating a great place to be cared for and a great place to work".

48. In terms of forward planning, we continue to work on the content and format of our Trust Board meeting agendas and recognition of where we have placed emphasis during the past months; together with the priorities as we move forward.

49. The next meeting of the Trust Board will be held on 26 October 2022. Some of the items featuring on the agenda will be: Recovery Support Programme (RSP) – UHMBT Improvement Plan, Care Quality Commission (CQC), Niche and Royal College of Surgeons (RCS) Improvement Plan Progress Report, Maternity Safety Update, Avoiding Term Admissions into Neonatal Units (ATAIN) Report, Investigation By Design (IBD) regarding the Trust's Trauma & Orthopaedic service, Quarter 2 – Operational Plan Priorities and Board Assurance Framework Review – plus the usual standing items for the Board to consider.

50. May I conclude with offering my sincere and continued thanks and appreciation to all colleagues, patients and partner organisations for their continued commitment and support.

51. I look forward to the next meeting of the Trust Board in October.

Aaron Cummins
Chief Executive

September 2022

BOARD OF DIRECTORS

Date of Meeting	28 September 2022
Title	Head Governor Report
Report of	Lorraine Crossley-Close Head Governor
Prepared by and contact details	Lorraine Crossley-Close Head Governor

Confidentiality	Non-Confidential

Purpose of Report	**To Advise/Alert**	**To Assure**	**To Approve**	**To Update**
	x			x
	The purpose of this report is to present an update from the Head Governor, which provides an outline of activities undertaken by the Head Governor and her Governor colleagues since the last meeting of the Board.			

Summary of Key Issues	On behalf of the Council, I want to again give thanks to all staff for the tireless efforts to provide safe care to all our patients. There have been a number of governor meetings and activities: • Activities are taking place to improve member engagement and constituency meetings are scheduled for the late September/ early October 2022. The meeting will take place in Barrow, Kendal and Lancaster, providing members and the public with the opportunity to meet their Governors, learn more about the clinical strategy and participate in a Q&A • Governor elections have concluded and the results are available on the Trust website. I would like to give thanks to those governors who will be leaving the Council on 30 September and look forward to meeting and working closely with those newly elected. Looking ahead to October 2022: • Induction will take place for newly elected governors. • Preparations for the Annual Members' Meeting were suspended due to the sad passing of Her Majesty the Queen. A new date has been arranged for 22 November 2022 and the meeting will be held in public on a face to face basis.

	• During October/November 2022, a briefing with the Trust's Council of Governors on trauma and orthopaedics, together with the IBD authors and Trust Board will take place.

Prior Discussions	Committee	Date	Recommendations/ Concerns
	N/A		

Action to be recommended to the Committee/Board	The Board of Directors is asked to note the contents of this paper.

Link to Key Priorities	Delivering outstanding care and experience	Create the culture and conditions for colleagues to be the very best they can be	Make the best use of our physical and financial resources	Working in partnership
	x			

Impact on Board Assurance Framework or Corporate Risk Register				
Risk Impact Assessment	Is this required?	**N**	If Yes, Date Completed	
Equality Impact Assessment	Is this required?	**N**	If Yes, Date Completed	
Quality Impact Assessment	Is this required?	**N**	If Yes, Date Completed	
Environmental / Sustainability Impact Assessment	Is this required?	**N**	If Yes, Date Completed	

Acronyms	

BOARD OF DIRECTORS

Date of Meeting	28 September 2022
Title	An update on the progress of the Recovery Support Programme (RSP) – University Hospitals of Morecambe Bay's Improvement Plan
Report of	Chris Adcock, Director of Finance, Deputy Chief Executive and Executive Senior Responsible Officer for the RSP
Prepared by and contact details	Rebecca Higgs, Assistant Director for Recovery Support and Improvement- rebecca.higgs@mbht.nhs.uk

Confidentiality	Non-Confidential

Purpose of Report	**To Advise/Alert**	**To Assure**	**To Approve**	**To Update**
	x	x		x
	This report is intended to update the Board on the current position of the Trust's Recovery Support Improvement Plan and the progress made since the report provided in August 2022. The update provided in this paper on the exit criteria related to NICHE and the Care Quality Commission Should and Must Do recommendations should be considered in conjunction with the report on these issues from the Director of Governance to triangulate the progress position.			

Summary of Key Issues	This paper outlines how the Trust's approach and progress towards the achievement of the objectives of the RSP and the associated exit from System Oversight Framework (SOF) segmentation 4 via the delivery of a sustainable improvement programme. Key issues outlined in this paper include: - The receipt of a formal feedback letter following the national RSP review meeting on 14.07.2022. The areas identified within this letter align with the key areas of focus for the future and the associated action plan we identified following a post July review. These were outlined in our August Board paper, namely the need to embed the next phase of the programme sustainably within the organisation and to move to a more outcomes focused reporting methodology. - Progress achieved against the Trust's RSP exit criteria

	- An overview of the impact our improvement activity is having against the key domains the programme is intended to effect, and the risks to the overarching programme delivery due to the scale of the programme and the breadth of embedded and sustained improvement the Trust is required to deliver prior to the exit from RSP. - The deployment of the financial allocation received as a result of our inclusion in the RSP. - Workstream highlight report. Appendix 1: Letter dated 12.09.2022 from Sir Andrew Morris, Vice Chair of NHS England, following the July 2022 national RSP review meeting Appendix 2: RSP Metric Report Both appendices are included in the Board of Directors' Reference Pack.

Prior Discussions	Committee	Date	Recommendations/ Concerns

Action to be recommended to the Committee/Board	The Board of Directors is asked to note the contents of the report and endorse the actions proposed within the report to mitigate the risk to programme delivery.

Link to Key Priorities	Delivering outstanding care and experience	Create the culture and conditions for colleagues to be the very best they can be	Make the best use of our physical and financial resources	Working in partnership
	x	x	x	x

Impact on Board Assurance Framework or Corporate Risk Register	The Board Assurance Framework has been aligned to the RSP.			
Risk Impact Assessment	Is this required?	**N**	If Yes, Date Completed	

Equality Impact Assessment	Is this required?	**N**	If Yes, Date Completed	
Quality Impact Assessment	Is this required?	**N**	If Yes, Date Completed	
Environmental / Sustainability Impact Assessment	Is this required?	**N**	If Yes, Date Completed	

Acronyms	
RSP	Recovery Support Programme
PCB	Provider Collaborative Board
BAU	Business As Usual
IS	Intensive Support
NHSEI	NHS England and Improvement
SIB	System Improvement Board
SOF	System Oversight Framework
SSNAP	Sentinel Stroke National Audit Programme
MSSP	Maternity Safety and Support Programme
CQC	Care Quality Committee
FTSU	Freedom to Speak Up

UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST

An update on the progress of the Recovery Support Programme (RSP) – University Hospitals of Morecambe Bay's Improvement Plan

1. Introduction

1.1 This report is intended to update the Board on the progress made against the Trust's Improvement Plan, and the deliverables associated with the criteria for our exit from the RSP, since the report provided in August 2022.

2. Formal feedback from the July 2022 National Review Meeting

2.1 In our last Board report we indicated that we were still awaiting written correspondence following the national RSP review meeting the Trust Executive attended on 14.07.2022. Since that meeting the Chair and Chief Executive Officer have received a letter from Sir Andrew Morris, Vice Chair of NHS England, summarising the meeting events. This is attached as appendix 1.

2.2 The correspondence reflects the feedback received in the meeting, namely that the steps taken since the December 2021 entry meeting to develop solid improvement plans and the associated progress made were noted, but that the pace of delivery must increase during the next period, with continued support from the Integrated Care Board (ICB).

2.3 A further national review meeting will take place in January 2023.

3. Exit criteria progress

3.1 We have continued to make progress during September 2022 to deliver the component parts of the exit requirements of the RSP.

3.2 However, it is recognised that the breadth of the improvement activity the Trust must undertake to deliver the RSP requirements and the duration required between the implementation of change and sufficient data being available to demonstrate the desired impacts have been achieved and embedded constitutes a risk to our ability to demonstrate sufficient progress has been made on our improvement journey to enable our exit from the RSP. The forthcoming operational pressures that can be expected during the Winter period represent further complexity given that the timeline for our exit in quarter 1 of 2023/2024.

3.3 Work continues to take place between the Trust Executive Team, NHS England's Intensive Support Team and the Trust's RSP Leadership Team to ensure that the resource available to support the programme is prioritised in a way that most effectively mitigates this risk.

3.4 The activity which commenced during this reporting period, under the leadership of the new Associate Director for Recovery Support and Improvement, and is due to conclude imminently is intended to support the Trust to manage the mitigation of this risk. This activity has focused on ensuring that:

- the metrics used by the RSP Programme Board to assess whether improvement is being made at the pace required are aligned to reporting mechanisms utilised via the organisation's Business As Usual (BAU) forums.
- the reporting approach for the programme, which is delivered via the RSP Programme Board, increases the visibility of the impact our improvement activity is having, enabling us to ascertain more easily how performance, quality or safety metrics are changing as a consequence of the RSP workstream activity.
- where necessary, workstreams are increasing the prominence of relevant triangulated qualitative and quantitative data sources within BAU forums to ensure there is organisation wide awareness of our current position and desired state.
- increasing the visibility and awareness of the requirements of the exit criteria for the RSP and how they relate to the Trust's longer term improvement objectives.

3.5 The effective implementation of the new Quality Governance Accountability Framework will be a key enabler to this. Board members will play an active part in ensuring that the organisation demonstrates an increased focus on our progress against the exit criteria and our improvement journey via their roles as Chairs of the Board sub-committees.

3.6 Additionally we will continue to work with the new medical leadership structure to leverage the enhanced leadership capacity this provides to the quality, safety and clinical strategy areas of the programme, as well as the support it provides to the ongoing engagement of the clinical workforce.

3.7 It is however important to note that the improvements the programme is facilitating will take place at all levels of our organisation during day to day service delivery. The attainment of our ambition to exit the RSP in quarter 1 of 2023/2024 will therefore require a singular organisation wide focus on the prioritisation of improvement activity associated with the programme. This will be monitored via the quantitative and qualitative information flows reviewed by the RSP Programme Board to ensure achievement.

3.8 A summary of progress against the individual exit criteria for the programme and an associated RAG rating is provided in Table 1 below. More detailed insight into the progress made against the NICHE, Care Quality Committee (CQC) and Royal College of Surgeons (RCS) elements associated with our exit from the RSP during this period is contained in the progress report on these areas provided to the Board

by the Director of Governance. This reflects the oversight arrangements in place for those elements via the organisation's existing governance infrastructure.

3.9 The programme refresh activities identified that we need to increase the visibility of these elements via the RSP Programme Board to enable us to triangulate the assurance, given how critical it is in enabling us to fulfil the exit criteria. This arrangement will commence at the next Programme Board in October 2022, further assurance will therefore be provided in our next report.

Table 1 – Progress Against UHMBs RSP Exit Criteria

Criteria	Specific Evidence	Assurance Mechanism	Planned Delivery Date	Progress Update	RAG
1 No outstanding actions from historical review	-Trust to have demonstrated all actions from Kirkup review, Niche report, Royal College of Surgeons (RCS) report, Investigation by Design (IBD) report have been actioned and outcomes of these evidenced	SIB to receive Niche review report -SIB to receive closedown reports regarding RCS, IBD	March 2023	A retrospective review of randomised patient cases is currently in progress, following which the RCS close out report will be submitted. The IBD report had been received. The RSP Team will work with the Medical Director to identify the aspects of the report recommendations that will be addressed by improvement activity that is already underway, as well as any aspects that may require further improvement activity to remedy them. The NICHE review report is expected in March 2023. A more detailed update on progress with the NICHE review is included in the	
2 No outstanding actions arising from regulatory notices (Health Education England (HEE) , General Medical Council (GMC), CQC and Health and Safety Executive (HSE))	-Trust to have satisfied the requirements of Section 26 and Section 31 notices	- Ongoing Assurance demonstrated through Sentinel Stroke National Audit Programme (SSNAP) data	March 2023	No Section 26 notice was ever served on the Trust. The Trust made an application for removal of the Section 31 related to stroke services at Furness General Hospital (FGH) and Lancaster Royal Infirmary (RLI) in July 2022. A formal response has been received lifting the Section 31 notice for FGH. The notice remains in place for RLI the Trust was unable to demonstrate that sufficient	

				sustainable improvement had been achieved at this stage. A weekly task and finish group has been re-established led by the Chief Operating Officer. A root cause analysis of the basis for the performance reduction has been undertaken and a targeted improvement plan with an initial 6 week window has been agreed focusing on the domains that require additional improvement support, namely front door assessment, placement in and out of the stroke ward, thrombolysis and the deployment of therapies, has been developed. Visibility of consistent, sustained improvement in the performance data for RLI is required before we can be confident we are on track to deliver this exit criteria.	
		-A report to SIB on the outcomes delivered via CQC, HSE action plans. Trust demonstrates how Board assured these are embedded as business as Usual (BAU)	March 2023	The HSE has considered our action plans and confirmed their satisfaction with them. The retrospective review of compliance with the CQC Should and Must Do's that was reported to the Trust Board in August 2022 identified a number of actions which had been returned to "in progress", resulting in a "In progress-behind schedule, Completion by	

		October 2022" categorisation. Whilst those actions are off track against the October 2022 date, the Director of Governance and Deputy Director of Governance have indicated that mechanisms are in place, via the Support and Review panels led by the Governance Team to address the required actions ahead of the March 2023 assurance point for this exit criteria. Progress will continue to be monitored to ensure delivery.	
- Exit from the Maternity Safety and Support Programme (MSSP)	March 2023	A deep dive of progress against the MSSP was undertaken at the September SIB meeting. This highlighted that progress had been made against all domains of the MSSP (Leadership, Governance, Strategy & Vision), as well as the wider maternity improvement priorities of the Trust. In particular, it was noted the MSSP feedback scores received following the August visit showed a sustained rating of "Good" for the fourth month against the leadership domain, an improvement to a rating of "Good" for the first month for the strategy and vision domain and sustained delivery of "Good for the Governance and Safety domain for the second month.	

3 Demonstrable robust organisation wide governance structure in place	-Identification of risks and effective controls as evidenced in the Board Assurance Framework, Risk Management, Serious Incident process and triangulation via triple A reporting at subcommittee and Board level. -Evidence of learning/improvement -Third party audit for assurance.	-Well led self-assessment. -SIB to receive independent audit report based on well-led.	Quarter 4, 2022/ 2023	Work has commenced with the support from NHS England's Intensive Support Director to develop the approach for the Trust self-assessment, including a review of the impact of key enablers such as the Performance Accountability Framework, Risk Management Framework and Quality Governance Assurance Framework. The first cycle of business is being undertaken this month via the governance structures in the new Quality Governance Accountability Framework. Arrangements to commission the independent well led review have commenced. Whilst this criterion is currently rated as on track it is recognised that the outcome of the self-assessment may identify areas that require further enhancement if we are to achieve a positive outcome from the independent audit. This is representative of the review cycle required to achieve embedded improvement but may result in a risk to delivery being identified in future months because of the self-assessment.	

4 Demonstrable robust systems and process relating to safety & quality e.g., Safe staffing, Serious Incidents	-Improvement in hospital acquired infection, falls, pressure ulcer & other (Harm Free) benchmarks -Reset staffing establishments (Safer Nursing Care Tool) and safe staffing operational governance and metrics.	- Demonstrate sustained improvement via statistical process control charts against the following metrics: pressure ulcer, falls, infection prevention control, mortality, deteriorating patient. -Ward accreditation metrics: report to SIB demonstrating improved outcomes over time	TBC*	The development of the Nursing Quality Dashboard is scheduled for completion by the end of September 2022. This is a crucial tool to enable us to provide confidence to the SIB that there is a direct cause and effect relationship between the improvement action taken and the safety and quality of our care. As outlined in section 4 of the report above, the programme metrics do not yet demonstrate that widespread, consistent and sustainable improvement has been achieved across the range of domains the RSP is intended to target	
		-Safe staffing 'close out report' to be received by SIB. -Follow-up position to be reported to SIB demonstrating sustained performance and practice embedded as business as usual.	October 2022	The close out report, outlining the action taken to reset staffing establishments and refresh the governance to ensure it facilitates sustained adherence, is in the process of being approved via UHMBTs governance routes prior to its presentation to SIB in October 2022. It has been scheduled for approval at the People Committee on 03.10.2022. It has also been shared with the Quality Assurance Committee for assurance on 26.10.2022. Subject to any further requirements identified by the SIB in October 2022, it is our intention to provide a follow up report to SIB demonstrating sustained performance and practice to meet the	

				second part of this requirement following the receipt of the bi-annual staffing report by the Trust Board in January 2023.	
5 Agreement of a sustainable clinical strategy for Morecambe Bay, that contributes to the PCB and system financial plan and plan for sustainable services.	-Clinical strategy co-produced with partners – clinical leadership re model of care (triangulation of demand & activity/ workforce/safety & quality) -Strategy drives quality and financial sustainability at site and service level.	-Publication of clinical strategy -Evidence of clinical engagement and leadership for the implementation	March 2023	A deep dive of this workstream took place at the September SIB where progress to date was noted. A further clinical strategy workshop is scheduled to take place on 22.09.2022 to present and share the co-produced models of care, enabling further feedback prior to the submission of the strategy for approval via Trust governance structures. It is recognised that primary care capacity to engage with the development process has been challenged due to the impact of system reform on leadership arrangements. A Deputy Medical Director is currently leading dialogue with Primary Care colleagues to understand the degree to which this will influence implementation.	

				Work to ensure the 5-year service delivery plans that support the delivery of the strategy in practice is also underway. A meeting has taken place with the Lead Chief Executive Officer for the Provider Collaborative Board (PCB) during the week commencing 12.09.2022 following the national review meeting on 14.07.2022. This provided an opportunity for us to agree an approach that will enable us to demonstrate robustly at the January 2023 review meeting how the clinical strategy contributes to the PCB and system plans and vice versa.	
6 Evidence of UHMBT priorities in South Cumbria and Lancashire System Development Plan and alignment of Clinical strategy	-Alignment between Integrated Care System Submission and Trust Priorities -Shared Programmes of work e.g. urgent and emergency care, fragile services, ward accreditation programme	-Integrated Care Board (ICB) Strategy and Forward Plan -ICB Report to SIB confirming alignment	TBC	It is recognised that the ICB is in the process of establishing their clinical strategy and wider enablers associated with their delivery plan. The Trust will work closely with colleagues to ensure our priorities are reflected. It is however recognised that the difference in development timelines remain a challenge. This is not expected to be a rate limiting factor to our exit.	

7 Evidence of robust and embedded internal whistleblowing processes, that are utilised by staff, with appropriate and timely outcomes; evidence of sustained improvement in staff engagement	-Launch of Engagement Platform and Follow Up Priorities re Culture, Organisational and Leadership Development - Review of the Freedom to Speak Up (FTSU) approach and follow up Priorities	-Report to SIB on impact of organisational development year 1 Programme; to include Culture Dashboard Metrics at Divisional and Staff Group Level -FTSU: Independent Review of policy and processes - Staff pulse survey results to demonstrate improving metrics related to staff confidence in FTSU/ listening organisation	March 2023	A second Deputy Chief Nurse commenced in post in September 2022 to provide additional leadership capacity to the FTSU review. This will include oversight of the arrangements for the independent review. A further update on the progress and intended approach will be provided at the October Board. Following the commencement in post of the Interim Chief People Officer discussions are underway to ensure that the pulse survey configuration enables us to meet the needs of this exit criteria	

RAG rating key	
On track	
At risk	
Missed	
Complete	

*TBC- this timeline requires agreement with the regional team at the SIB following the completion of the Nursing Quality Dashboard.

4. Demonstrating the impact of our improvement programme

4.1 In the August Board paper we outlined our intention to review the reporting format for the programme to ensure it is able to more clearly articulate the impact it is having in the improvement of outcomes in a range of areas such as safety, quality and performance. We also recognised that the review offered us an opportunity to ensure that the metrics used represented the full range of areas that would be impacted by the improvement programme and its workstreams.

4.2 This activity has been undertaken throughout September and the refreshed reporting approach will be implemented universally at the October 2022 RSP Programme Board. As a result of the exercise several enhancements to the metrics have been identified, which will be incorporated in future Board reports.

4.3 However, given the proximity of the next national review meeting, which will take place in January 2023, this report sets out using statistical process control (SPC) methodology whether the current metrics indicate the improvement activity will sustainably achieve improvement going forward in the desired quality, safety, governance, people or performance areas.

4.4 The metric set that was shared with the September SIB is attached as appendix 2. In summary, whilst there are a small number of metrics that demonstrate pockets of sustained improvement as a consequence of the RSP, the data does not yet demonstrate that widespread, consistent and sustainable improvement has been achieved across the range of domains the RSP is intended to target.

4.5 For a number of the programme areas, in particular the Urgent and Emergency Care and mortality workstreams, this is because the outputs that needed to be delivered to enable improvement to be achieved are not yet fully delivered. This aligns with the workstream timelines and does not demonstrate programme slippage. The key milestones remain on track. The process metrics that we have been establishing as part of the programme refresh will provide us with further assurance mechanisms for the coming months until the delivery date is reached.

4.6 In two areas this is because the data demonstrates the actions taken to date have not been sufficient to create sustained improvement, most notably these areas are the stroke workstream and the project related to NMC2R. For stroke the task and finish group that has been re-established is mitigating this risk and a revised delivery timescale will be identified at the conclusion of the initial 6 week period. For the NMC2R project the outcome of the discussions between the ICB & Local Authority (LA) partners to identify additional mitigations is required before a revised delivery date can be confirmed.

4.7 The Board should also be aware that for some workstreams the length of time required to demonstrate impact means that we would not yet have expected to see material change. The RSP Team are working closely with Executive Senior Responsible

Officers (SROs) to ensure that achievable interim targets are in place that will enable us to demonstrate incremental progress in these areas in coming months.

4.8 Additionally, as outlined above, the amount of work required and the extent to which sustained improvement is required simultaneously across multiple areas means that should significant progress not be made in the next quarter, there is a clear risk that the Trust will be unable to demonstrate sustained improvement via SPC charts, a requirement of the fourth exit criteria of the RSP.

4.9 We have enhanced our programme support and governance arrangements to support the mitigation of this risk and are also reviewing the use of the programme budget to identify any additional areas that would benefit from increased support.

5. Programme budget utilisation: Month 4 update

5.1 As a result of the Trust's assignment to segment 4 of the System Oversight Framework (SOF) and our associated enrolment in the RSP the Trust receives an annual budget to support the delivery of our improvement plan and the actions required to meet the exit criteria. There are a number of principles that must be fulfilled to enable commitments to be made against this budget.

5.2 During 2022/2023 University Hospitals of Morecambe Bay Trust (UHMBT) was allocated £780,000 of funding to support the programme. An additional £279,108 of funds were carried forward for this purpose from the prior year, resulting in a total available budget of £1,059,108 during 2022/2023. Table 2 below outlines the commitments made against the programme budget this year, actual expenditure to date and forecasted full year expenditure.

Table 2: RSP budget commitments as of month 4 2022/2023

Description of expenditure area	Total funding commitment made	Actual expenditure at month 4	Forecasted full year expenditure
Programme set up costs (Business Intelligence, Clinical Leadership and Programme Management capacity)	£236,916	£84,945	£225,601
Urgent and Emergency Care (Pharmacy Technician, Transformation, Frailty and Ambulance Liaison capacity)	£148,710	£17,338	£131,279
Quality and Safety (Clinical and Nursing capacity)	£241,290	£24,408	£191,888
Support Services (Financial Leadership and Business Intelligence capacity)	£82,122	£0	£68,950
Leadership and Culture (Programme Delivery and Training)	£192,028	£0	£92,517

Total	**£901,066**	**£126,691**	**£710,235**

5.3 Based on the current forecasted full year expenditure there is £348,873 of programme budget remaining for commitment.

5.4 Activity is underway to ensure we are able to immediately deploy the arrangements associated with the funding commitments that have already been made. The RSP Leadership Team are also working the Intensive Support Director to identify any additional areas that require further funding support to consolidate our improvement achievements ahead of the January review meeting, recognising the programme challenges outlined above.

6. Workstream highlight reports

6.1 This highlight report focuses on progress made between August and September 2022. No change control requests were submitted during this period.

Regulatory Requirements: Maternity Safety and Support Programme (MSSP)

6.2 In addition to the information provided in the exit criteria progress table above it is noted that a further visit from the MSSP team took place during the week commencing 12.09.2022 to inform our September MSSP rating. A further Ockenden assurance visit is also scheduled to take place in October 2022.

6.3 The workstream continues to triangulate recommendations from Ockenden and Kirkup, alongside the MSSP. The Kirkup inquiry into East Kent and the Ockenden final report actions are expected to be published at the end of September 2022. Once available these will be considered alongside our existing improvement plan.

Regulatory Requirements: Strengthening of Patient Safety Investigations

6.4 Following the publication of the national Patient Safety and Incident Response Framework (PSIRF) in August 2022 a phased approach to implementation is being planned which will ensure the framework is implemented by September 2023, in line with national expectation.

Quality and Safety: Mortality

6.5 Following the appointment of the Deputy Medical Director with responsibility for this workstream activity during September has focused on ensuring a robust handover of the workstream, the effective implementation of the refreshed Quality Governance Assurance Framework via the Trust Mortality Group and engagement with the Better Tomorrow team to ensure our improvement plan will enable effective implementation of the report recommendations.

6.6 The workstream highlight report for the September Programme Board contained an alert which indicated that the Trust remains an outlier for hip fracture. Although improvements have been made, they are not yet reflected in the mortality figures and the time required to demonstrate an improvement in nationally collected data means that we are currently unable to achieve adequate assurance that the alert will have been categorised as amber or better during this quarter. Further engagement with the Fractured Neck of Femur Task and Finish Group to identify sources of data that can

provide increased assurance is underway to help inform our assessment of the level of risk posed.

Quality and Safety: Clinical Effectiveness and Deteriorating Patient

6.7 Following the appointment of the Deputy Medical Director with responsibility for this workstream activity during September has focused on ensuring a robust handover of the workstream and the effective implementation of the refreshed Quality Governance Assurance Framework, including the development of Terms of Reference and membership for the deteriorating patient group.

Quality and Safety: Fundamentals of Care

6.8 Activity this month has focused on nursing documentation, with the intention to rationalise and consolidate the number of nursing forms in use. There are currently 460 nursing forms, these are being reviewed to assess frequency of use and how they support the quality and safety agenda to ensure documentation supports effective delivery of care.

6.9 The quality improvement programme for ward managers has continued. There is evidence this is resulting in an improvement in the validation of data for falls and pressure ulcers, which in turn will enable a greater confidence in the data reported.

Quality and Safety: Safe Staffing

6.10 As outlined above, the safe staffing close out report has been produced and is progressing through the internal Trust governance processes prior to its submission to the SIB in October 2022.

Operations and Performance: Urgent and Emergency Care

6.11 The programme alerted that the no medical criteria to reside (NMC2R) workstream is off-track against our intended trajectory for the reduction in patients with NMC2R, which have now increased to over 150 patients (=25% of G&A beds). It is recognised that the root cause of the level of NMC2R is complex, multi-factorial and influenced by system factors. Discussions are therefore ongoing with ICB & Local Authority (LA) partners to identify additional mitigations however at this time the RSP has identified that current proposals are insufficient to assure delivery of overall target of 12% by December 2022.

6.12 The virtual ward workstream remains on track, with 20 virtual ward beds now live. Occupancy of the first 10 frailty virtual wards over the first 4 weeks has been 44%.

6.13 The design phase of the Royal Lancaster Infirmary Urgent Treatment Centre (UTC) has concluded and staffing models are being finalised. The workstream is on track to receive the first patient via the UTC during the first week of December.

Operations and Performance: Stroke

6.14 Key highlights for this workstream are outlined in Table 1 above.

Leadership and Culture

6.15 A number of projects within this workstream have made progress within this reporting period. Attendance at the core leadership development programme continues to increase with over two thirds of staff now having attended or booked to attend. Positive feedback has been received, over 90% of staff have fed back that the skills developed on the programme will be directly transferable to their day to day activity.

6.16 The Freedom to Speak Up (FTSU) workstream is receiving increased leadership and oversight following the commencement in post of the Deputy Director of Nursing and the identification of a lead from the HR &OD Team. We are reviewing how we ensure that the FTSU refresh interfaces effectively with wider processes for raising concerns for medical and clinical colleagues.

7. Conclusion

7.1 Activity undertaken during the most recent reporting period demonstrates the organisation continues to take action to meet the requirements of the exit criteria for the RSP.

7.2 Whilst there are areas of achievement, most notably the removal of the section 31 notice for Stroke at FGH and the submission to the People Committee of the close out report for the safe staffing workstream, progress continues to require increased pace and focus on the achievement of benefits realisation if we are to achieve our target exit date and embed sustainable improvement across the organisation.

8. Recommendations

8.1 The Board of Directors is asked to consider the contents of the report and note the indication provided that there are signs that the overarching delivery of embedded improvement at the scale desired to achieve the ambition of the RSP requires further focus and commitment if we are to be confident that material progress will have been achieved by March 2023.

BOARD OF DIRECTORS

Date of Meeting	28 September 2022
Title	Progress Report on Care Quality Commission (CQC) and Royal College of Surgeons (RCS) Improvement Plans
Report of	Richard Sachs, Director of Governance
Prepared by and contact details	Carl Foulkes, Deputy Head of Compliance, Assurance and Clinical Audit Carl.Foulkes@mbht.nhs.uk Angela Parfitt, Deputy Director of Governance Angela.parfitt@mbht.nhs.uk

Confidentiality	Non-Confidential

Purpose of Report	**To Advise/Alert**	**To Assure**	**To Approve**	**To Update**
	x	x		x

	• This report summarises the current position and progress of the Improvement plans to address;
	  ○ CQC Must Do and Should Do recommendations
	  ○ Royal College of Surgeons Report recommendations
	• This report combines both reviews into one report which has been designed to meet the reporting requirements of Trust Assurance Committees, Trust Board and Service Improvement Board (SIB).			

Summary of Key Issues	• The successful completion of the recommendations from the above reports will improve quality and safety, ensure better outcomes for patients and is SOF level 4 exit criteria for the Trust. • Work is progressing to enable information systems to integrate themes and commonalities between these plans and other sources of evidence (audits, service reviews, QI projects). • The process of 'Support & Review Panels' has been strengthened including the addition of a Non-executive Director and ICB Representative to scrutinise and 'sign off' evidence upon completion of actions / recommendations. • Support and Review Panels for Medicine Care Group and WACS Care Group, now take place on a twice monthly basis (previously monthly) • Support and Review Panels for SCC Care Group, Pharmacy Service and Corporate Functions will remain monthly. • A formal SOP has been developed to ensure recommendations and actions arising from inspections are managed in a consistent and robust manner. This is to be approved at the Procedural Documents meeting in September. • Approved evidence is continuously uploaded to AMaT, following approval at 'Support & Review Panels'. This will include further evidence from the amended governance model as it becomes available.

- Since the last report 3 Must Do Recommendation (2 in WACs, 1 in Medicine) and 1 Should Do Recommendation (In Medicine) have been completed.
- There are now 14 CQC Recommendations (6 Must Do and 8 Should Do) that are now 'Fully Completed Awaiting Approval', these are due to be reviewed at the Support and Review Panels scheduled in September.
- Following the addition of the recommendations from the July CQC Report, the number of CQC Recommendations allocated to each Care Group is as follows:

Care Group	Must Do	Should Do	Total
Medicine Care Group	37	32	69
WACS Care Group	14	10	24
SCC Care Group	1	6	7
Pharmacy Service	3	4	7
Corporate Functions	6	0	6

Prior Discussions	Committee	Date	Recommendations/ Concerns
	Quality Committee	26 September 2022	A verbal update will be given at the Board of Directors' meeting on 28 September 2022.

Action to be recommended to the Committee

The Board of Directors is requested to:

Note:

- Current progress of the recommendations from the CQC Inspection Report and RCS Review.
- 60% of all CQC recommendations and 60% of CQC Must Do recommendations are now allocated to Medicine Care Group.
- The implementation of twice monthly Support and Review Panels for Medicine Care Group and WACs Care Group.
- Evidence of the completion of recommendations/actions is approved at Support & Review Panels and stored in the Trust's AMaT Governance system.
- Progress against the NICHE Investigation Report will now be presented in a separate paper
- RCS Closure report will be finalised following completion of a retrospective review of randomised patient cases currently in progress and will be presented at the September Public Board Meeting.
- A wider review of culture and leadership in Trauma & Orthopaedics (T&O) has been completed (the IBD report). The draft report has recently been received and will be shared with Executives in due course.
- The Ockenden Review published its Final Report in May 2022. This has been reviewed and mapped into AMaT so WACS can develop an action plan to deliver the required improvements against each recommendation.
- The new CQC report has been received and recommendations recorded on AMaT. Actions to meet recommendations are currently

	with CQC for approval, though work has commenced on these already. • The retrospective review of evidence and actions as above, has resulted in further evidence being requested to bolster previously collated evidence and actions being amended / discontinued. • The Medicine Care Group has additional resource one day per week from an external compliance and assurance specialist. • There is no comments from QAC in the paper due to QAC being delayed this month **Comment:** • The Trust dashboard below shows current figures (September 2022) with previous months (August 2022) above. • There has been an improvement in the position, with 14 Recommendations now awaiting approval at Support and Review Panels • The Compliance and Assurance Team have identified a further 14 'Quick Win' recommendations, where only one piece of evidence is outstanding. These have been shared with the Care Groups. **Escalate**: • The potential impact of actual and expected operational pressures may have on the progress with CQC Must and Should Do's, particularly in the Medicine Care Group.

Link to Key Priorities	Delivering outstanding care and experience	Create the culture and conditions for colleagues to be the very best they can be	Make the best use of our physical and financial resources	Working in partnership
	x	x	x	x

Impact on Board Assurance Framework or Corporate Risk Register	• The combined action plan has been recognised in the refreshed BAF.			
Risk Impact Assessment	Is this required?	**N**	If Yes, Date Completed	
Equality Impact Assessment	Is this required?	**N**	If Yes, Date Completed	
Quality Impact Assessment	Is this required?	**N**	If Yes, Date Completed	
Environmental / Sustainability Impact Assessment	Is this required?	**N**	If Yes, Date Completed	

Acronyms	
AMAT	Audit Management and Tracking System
CQC	Care Quality Commission

ESP	Enhanced Support Programme
HSCA	Health and Social Care Act 2008
NICHE	Niche Healthcare Consulting Ltd
QAC	Quality Assurance Committee
RCS	Royal College of Surgeons
RSP	Recovery Support Programme
SCC	Surgery & Critical Care Group
SIB	System Improvement Board
SOF	System Oversight Framework
T&O	Trauma & Orthopaedics
WACS	Women and Children's Services

Improvement Plans - Combined Dashboard (August Position)				
Recommendation Status	**RCS Report[2]**	**CQC Must Do's**	**CQC Should Do's**	**Total**
Not Applicable	**0**	**0**	**0**	**0**
Unable to Complete	**0**	**0**	**0**	**0**
Not Started[6] (new recommendations, July 2022)	**0**	**19**	**7**	**26**
In Progress - Behind Schedule (Completion by Oct 2022)	**0**	**16**	**29**	**45**
In Progress - Behind Schedule (Completion After Oct 2022)	**0**	**1**	**2**	**3**
In Progress (Completion by Oct 2022)	**7**	**1**	**0**	**8**
In Progress (Completion after Oct 2022)	**0**	**1**	**8**	**9**
Fully Completed (awaiting approval)[3]	**0**	**2**	**9**	**11**
Fully Completed & Approved[4]	**0**	**12**	**5**	**17**
Total	**7**	**52**	**60**	**119**

Notes:

1. RCS: Timescale for completion for Trust Recommendations is still being assessed, Dashboard will be updated when reliable data is available.
2. Lead has confirmed actions completed, evidence to be scrutinised at Support & Review Panel
3. Completed and evidence scrutinised and approved at Support & Review Panel
4. Status Key:
   - **N/A - Not Applicable**
   - **UC – Unchanged**: No Change on figures in previous report
   - **B – Better** (Up to 10% Improvement)
   - **MB – Much Better** (Greater than 10% Improvement)
   - **W – Worse** (Up to 10% Deterioration)
   - **MW – Much Worse** (Greater than 10% Deterioration)

   The use of % measurements means that any changes in a Recommendation Status that contain less then 10 Recommendations can only be reported as 'Much Better' or 'Much Worse', please see section 2
5. Category retained - Following the most recent CQC inspections of Urgent Care Services and Medicine services.

Improvement Plans - Combined Dashboard (September Position)					
Recommendation Status	**RCS Report[2]**	**CQC Must Do's**	**CQC Should Do's**	**Total**	**Status[5]**
Not Applicable	0	0	0	**19**	**UC**
Unable to Complete	0	0	0	**0**	**UC**
Not Started[6] (New July 2022 recommendations)	0	0	0	**0**	**MB**
Behind Schedule (Completion by Oct 2022)	0	30	13	**43**	**B**
Behind Schedule (Completion By March 2023)	0	0	0	**0**	**UC**
Behind Schedule (Completion after March 2023)	0	2	1	**3**	**UC**
On Schedule (Completion by Oct 2022)	7	0	1	**8**	**UC**
On Schedule (Completion by March 2023)	0	14	19	**33**	**MW**
On Schedule (Completion after March 2023)	0	0	1	**1**	**UC**
Fully Completed (awaiting approval)[3]	0	8	6	**14**	**MB**
Fully Completed & Approved[4]	0	6	11	**17**	**UC**
Total	**7**	**60**	**52**	**119**	

*See key in first table (page 4) for footnote explanations

Due to the inclusion of the 26 new recommendations from the July 2021 CQC Report, the Dashboard has been reformatted to show whether recommendations are 'Behind Schedule' or 'On Schedule' and to also show when the Recommendation is expected to be completed; By October 2022, By March 2023, or After March 2023.

24 of the 26 new recommendations have moved from 'Not Started' to 'On Schedule Completion by March 2023'. This accounts for the significant change between these two categories.

CQC Dashboards by Care Group

(Inclusive of new Recommendations)

Medicine Care Group (September Position)				
Recommendation Status	**CQC Must Do's**	**CQC Should Do's**	**Total**	**Status[5]**
Not Applicable	0	0	**0**	**UC**
Unable to Complete	0	0	**0**	**UC**
Not Started[6] (New July 2022 recommendations)	0	0	**0**	**MB**
Behind Schedule (Completion by Oct 2022)	16	5	**21**	**B**
Behind Schedule (Completion By March 2023)	0	0	**0**	**UC**
Behind Schedule (Completion after March 2023)	0	0	**0**	**UC**
On Schedule (Completion by Oct 2022)	0	1	**1**	**W**
On Schedule (Completion by March 2023)	12	17	**29**	**MW**
On Schedule (Completion after March 2023)	0	1	**1**	**UC**
Fully Completed (awaiting approval)[3]	5	5	**10**	**B**
Fully Completed & Approved[4]	4	3	**7**	**UC**
Total	**37**	**32**	**69**	

*See key in first table (page 4) for footnote explanations

Following the July CQC Report the overall number of Recommendations has increased by 23. The majority of these are now scheduled for completion by March 2023. Two 'Behind Schedule' recommendations have been completed and are now awaiting approval at the next Support and Review Panel.

Women and Childrens Services Care Group (September Position)				
Recommendation Status	**CQC Must Do's**	**CQC Should Do's**	**Total**	**Status[5]**
Not Applicable	0	0	**0**	**UC**
Unable to Complete	0	0	**0**	**UC**
Not Started[6] (New July 2022 recommendations)	0	0	**0**	**UC**
Behind Schedule (Completion by Oct 2022)	10	4	**14**	**B**
Behind Schedule (Completion By March 2023)	0	0	**0**	**UC**
Behind Schedule (Completion after March 2023)	0	1	**1**	**UC**
On Schedule (Completion by Oct 2022)	0	0	**0**	**B**
On Schedule (Completion by March 2023)	0	1	**1**	**UC**
On Schedule (Completion after March 2023)	0	0	**0**	**UC**
Fully Completed (awaiting approval)[3]	3	1	**4**	**MB**
Fully Completed & Approved[4]	1	3	**4**	**UC**
Total	**14**	**10**	**24**	

*See key in first table (page 4) for footnote explanations

A ‘Behind Schedule’ recommendation and ‘On Schedule’ recommendation have been completed and are now awaiting approval at the next Support and Review Panel.

Surgery and Critical Care Group (September Position)				
Recommendation Status	**CQC Must Do's**	**CQC Should Do's**	**Total**	**Status[5]**
Not Applicable	0	0	**0**	**UC**
Unable to Complete	0	0	**0**	**UC**
Not Started[6] (New July 2022 recommendations)	0	0	**0**	**UC**
Behind Schedule (Completion by Oct 2022)	1	3	**4**	**UC**
Behind Schedule (Completion By March 2023)	0	0	**0**	**UC**
Behind Schedule (Completion after March 2023)	0	0	**0**	**UC**
On Schedule (Completion by Oct 2022)	0	0	**0**	**UC**
On Schedule (Completion by March 2023)	0	0	**0**	**UC**
On Schedule (Completion after March 2023)	0	0	**0**	**UC**
Fully Completed (awaiting approval)[3]	0	0	**0**	**UC**
Fully Completed & Approved[4]	0	3	**3**	**UC**
Total	**1**	**6**	**7**	

*See key in first table (page 4) for footnote explanations

There is no change in the Surgery and Critical Care Group Position.

Core Clinical Services Care Group (September Position) Only the Pharmacy Service have recommendations				
Recommendation Status	**CQC Must Do's**	**CQC Should Do's**	**Total**	**Status[5]**
Not Applicable	0	0	**0**	**UC**
Unable to Complete	0	0	**0**	**UC**
Not Started[6] (New July 2022 recommendations)	0	0	**0**	**MB**
Behind Schedule (Completion by Oct 2022)	0	1	**1**	**UC**
Behind Schedule (Completion By March 2023)	0	0	**0**	**UC**
Behind Schedule (Completion after March 2023)	0	0	**0**	**UC**
On Schedule (Completion by Oct 2022)	0	0	**0**	**UC**
On Schedule (Completion by March 2023)	2	1	**3**	**MW**
On Schedule (Completion after March 2023)	1	0	**1**	**UC**
Fully Completed (awaiting approval)[3]	0	0	**0**	**UC**
Fully Completed & Approved[4]	0	2	**2**	**UC**
Total	**3**	**4**	**7**	

*See key in first table (page 4) for footnote explanations

Following the July CQC Report the overall number of Recommendations has increased by 3. These new recommendations are now scheduled for completion by March 2023.

Corporate Functions (September Position) Governance, Operations and People & OD				
Recommendation Status	**CQC Must Do's**	**CQC Should Do's**	**Total**	**Status[5]**
Not Applicable	0	0	**0**	**UC**
Unable to Complete	0	0	**0**	**UC**
Not Started[6] (New July 2022 recommendations)	0	0	**0**	**UC**
Behind Schedule (Completion by Oct 2022)	3	0	**3**	**UC**
Behind Schedule (Completion By March 2023)	0	0	**0**	**UC**
Behind Schedule (Completion after March 2023)	2	0	**2**	**UC**
On Schedule (Completion by Oct 2022)	0	0	**0**	**UC**
On Schedule (Completion by March 2023)	0	0	**0**	**UC**
On Schedule (Completion after March 2023)	0	0	**0**	**UC**
Fully Completed (awaiting approval)[3]	0	0	**0**	**UC**
Fully Completed & Approved[4]	1	0	**1**	**UC**
Total	**6**	**0**	**6**	

*See key in first table (page 4) for footnote explanations

UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST

Progress Report on Care Quality Commission (CQC) and Royal College of Surgeons (RCS) Improvement Plans

Key Points

- 3 Must Do Recommendation (2 in WACs, 1 in Medicine) and 1 Should Recommendation (1 in Medicine) were completed in August.

- There are now 14 CQC Recommendations (6 Must Do and 8 Should Do) that are now 'Fully Completed Awaiting Approval', these are due to be reviewed at the Support and Review Panels scheduled in September.

- Medicine and WACS Care Groups now have twice monthly Support and Review Panels in place, this should improve the speed at which Recommendations are reviewed and then either approved or returned to the Care Group for further work.

- Sarah Rees (UHMBT Non-Executive Director) and Simon Bradley (Quality Improvement Lead NHS Lancashire and South Cumbria Integrated Care Board) have now been invented to all future Support and Review Panels.

- Following the addition of the 26 Recommendations from the CQC July Report, Medicine Care Group now have a total of 68 CQC Recommendations (this is 60% of the total Recommendations), 50 of these recommendations are for Emergency Medicine.

- Medicine also now have a total of 37 Must Do Recommendations (this is also 60% of the Must Do Recommendations), 25 of these Must Do recommendations are for Emergency Medicine.

- Helen Kelly, Compliance and Assurance Specialist, will now be supporting Medicine Care Group one day each week, to help improve delivery of CQC Recommendations.

- The Compliance and Assurance Team now has monthly CQC meetings with the local management teams (below the care group triumvirate) in Medicine Care Group (FGH ED, RLI ED, FGH Wards, RLI Wards). This is to improve delivery of CQC Recommendations.

- Analysis by the Compliance and Assurance Team has identified a further 14 'Quick Win' Recommendations that are currently 'Behind Schedule'. These only require a piece of supporting data/evidence to be provided for them to progress to 'Fully Completed Awaiting Approval'. All 14 Recommendations have been shared with the Care Groups and will also be reviewed at the Support and Review Panels scheduled in September.

- Progress on the NICHE recommendations will now be reported in separate paper.

- RCS Closure report will be finalised following completion of a retrospective review of randomised patient cases currently in progress and will be presented at the September Public Board Meeting

- This Paper was presented at the delayed QAC on 26/09/2022, this was after the paper submission date for Board, so no comment or feedback from QAC is included in this paper

Background/Context

1. There are 2 Improvement Plans that contain a combined total of 119 Recommendations (112 CQC, 7 RCS), that are being addressed through 200 Actions (193 CQC, 7 RCS). Some Recommendations are being addressed through multiple actions.

2. CQC Recommendations are from Inspection Reports published in August 2021, October 2021 and July 2022.

3. The RCS Recommendations are from an Inspection Report published in November 2021

4. The successful completion of the above recommendations is required to sustainably improve quality and safety within core services. The CQC Must Do's are also a SOF level 4 exit criteria for the Trust.

5. All actions / recommendations relating to improvements required in Stroke services / pathways are met through one extensive improvement plan.

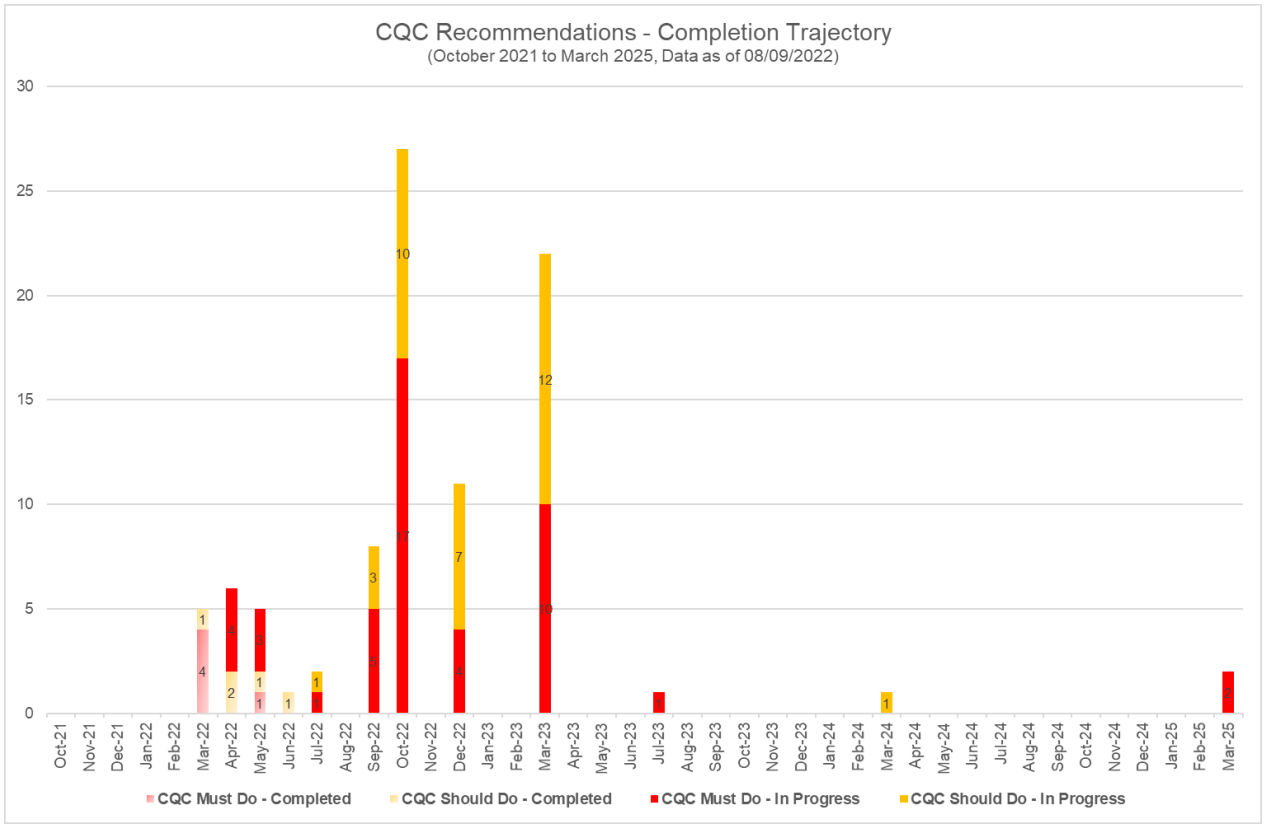
Advise: Improvement Plan Implementation Update

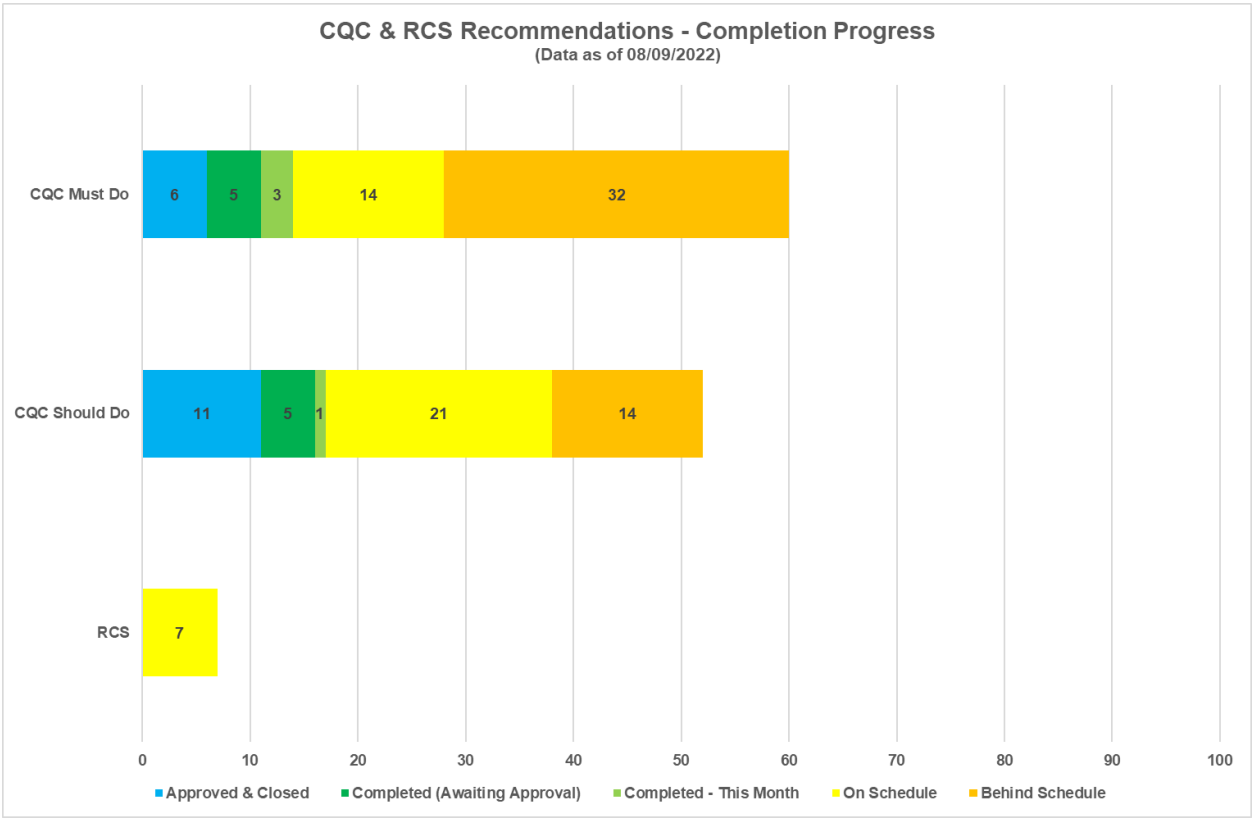
6. A summary of progress for the recommendations in the 2 plans provided in the dashboards above.

7. Support & Review Panels continue to be held, to oversee progress and review evidence presented by Care Group Senior Management Teams. The Compliance and Assurance Team is continuing to work with the Care Groups to ensure they are prepared for the panels and understand what information to provide and have themselves been assured of progress and evidence in advance.

8. An overview of 4 completed recommendations and the impact their progress and completion has had upon the Trust are detailed in Appendix 1.

9. The progress in completing recommendations and the trajectory for completion is detailed in the two below graphs. There are two significant clusters of target completion dates in October 2022 and March 2023.





10. **RCS**: RCS Closure report will be finalised following completion of a retrospective review of randomised patient cases currently in progress and will be presented at the September Public Board Meeting

11. A Standard Operating Protocol (SOP) has also been drafted (to be approved at September Procedural Documents Group) to clarify how recommendations and actions arising from inspections are to be managed, progressed and signed off in a consistent and systematic manner. This is included as an appendix.

12. The schedule for Support & Review Panels for 2022/23 is as follows:

Support and Review Panel Meeting Schedule for 2022-23							
Month	**Medicine S&R Dates** (Week 2)	**Medicine S&R Dates** (Week 4)	**WACS S&R Dates** (Week 2)	**WACS S&R Dates** (Week 4)	**SCC S&R Dates**	**Pharmacy S&R Dates**	**Corporate Functions S&R Dates**
May-22	N/A	31/08/2022	N/A	31/05/2022	04/05/2022		
Jun-22	N/A	22/06/2022	N/A	20/06/2022	02/07/2022		
Jul-22	N/A	21/07/2022	N/A		25/07/2022	07/07/2022	18/07/2022
Aug-22	03/08/2022	15/08/2022		15/08/2022		01/08/2022	
Sep-22	12/09/2022	23/09/2022	TBC	26/09/2022	19/09/2022	29/09/2022	TBC
Oct-22	05/10/2022	24/10/2022	06/10/2022	19/10/2022	17/10/2022	27/10/2022	TBC
Nov-22	07/11/2022	21/11/2022	10/11/2022	21/11/2022	21/11/2022	24/11/2022	TBC
Dec-22	07/12/2022	19/12/2022	08/12/2022	TBC	19/12/2022	29/12/2022	TBC
Jan-23	05/01/2023	20/01/2023	TBC	TBC	16/01/2022	26/01/2022	TBC
Feb-23	07/02/2023	28/02/2022	TBC	27/02/2023	20/02/2022	23/02/2022	TBC
Mar-23	TBC	TBC	TBC	TBC	20/03/2022	30/03/2022	TBC

Care Group Attendees:	Care Group Triumvirate/ Functional Directors/Managers
Governance Attendees:	Director of Governance, Deputy Director of Governance, Head of Library & Knowledge Services, RSP Programme Director
Independent Attendees:	UHMBT Non-Executive Director, Integrated Commissioning Board Representative
Support and Review Panel Meeting Standard Agenda Items:	Matters Arsing Review of completed actions for closure Review/Update of overdue actions Review/Update of actions due for completion by October 2022 Review/Update of actions due for completion after October 2022
Notes: 1) Twice Monthly S&R Panels initiated for Medicine Care Group and WACs Care Group in August 2022	

13. Future dates for Support and Review Panels are currently being scheduled to ensure closer alignment with Quality Assurance Committee and Board reporting schedules and deadlines. Medicine and WACS will also have 2 panels per month due to the number of actions and recommendations as of September 2022.

14. The Support and Review Panel for SCC Care Group scheduled for 19/09/2022 was cancelled at short notice due to the additional Bank Holiday, it is currently being rescheduled.

Alert

15. Concerns and Issues Log

No.	Concerns and Issues	Score	Mitigation
1	Competing Operational Priorities e.g. COVID, Recovery and Restoration	16	Twice monthly review meetings with Care Groups and Corporate function

	In particular in Medicine and WACS Care Group		to identify and escalate areas of concern
2	Completion of all NICHE Recommendations by SOF Level 4 target exit date of 31/03/2023.	12	Review recommendations to establish an accurate trajectory for completion. Escalation of concerns as required.
3	Compliance and Assurance staff resilience	12	Explore options for additional capacity / flex of wider establishment in event of long term absence
4	AMaT System Manager resilience	10	Cross training of other AMaT Super Users to provide resilience
5	Concentration of Recommendations with Target completion date of 31/03/22, are these dates 'year-end place markers'	8	Following Monthly Review Meetings with Care Group new/revised target dates have been requested, and are awaiting approval.
6	AMaT System Failure	5	AMaT is web based and cloud based, prolonged outage is unlikely

16. The Compliance and Assurance Team will continue to work with operational teams to ensure target dates are realistic and work is progressing to meet the target completion dates.

Quality Assurance

17. Current position with actions to deliver the recommendations, from data and information inputted into the AMaT system are provided in the CQC Improvement Plan Dashboard, which has been included as a supporting document. Work will continue to:

- Ensure any new or revised actions are SMART-er;
- Identify required evidence of impact / outcome and completion for each recommendation/action;
- NHS E/I Team have supported Urgent Care with a review of their actions and evidence to be provided to assure of completion;
- Stress test supporting evidence for 'completed' actions for robustness (through Support & Review Panels);
- Consolidate different RAG ratings for consistency, with reference to RSP reporting, with clearer criteria for each;
- More robust QA and scrutiny of status updates referring back the recommendations and outcomes in terms of quality and safety;
- Make clearer links / references to improvement projects and initiatives progressing through other plans / frameworks; and
- Understand mitigations or support needs in relation to those actions in progress but behind schedule.
- Establish interconnected reporting systems with support from I3 between plans and priorities
- Embed and strengthen the functioning of Support & Review Panels

Comments/Feedback from Quality Committe

18. There are no comments or feedback from Quality Committee on this paper. This is because QAC was delayed from 19/09/2022 to 26/09/2022, therefore QAC took place after the paper submission date for Trust Board Meeting had passed.

Recommendation

The Board is requested to:

Note:

- Current positive progress of the recommendations from the CQC Inspection Report and RCS Review.
- Progress against the NICHE Investigation Report will now be presented in separate Paper
- Evidence to support completion of all actions/recommendations continues to be populated within AMaT to allow for tolerance testing.
- Schedule of Support and Review Panel Meetings with Care Groups is in progress.
- The aim to achieve level three compliance with the Bruce standards of assurance.
- CQC report from March inspection has now been received, mapped to AMaT and actions to deliver the recommendations have been drafted for approval by CQC.
- The actions have now been activated in AMaT and are being addressed by the Care Groups.
- Recent review of progress and evidence led by the new DDoG and further assurances and evidence to be provided by Care Groups.
- There are no comments from QAC in the paper due to QAC being delayed this month

Comment:

- Comment on and make any suggestions for improvement in relation to progress reporting;
- Further comments in relation to progress towards completion of any recommendations

Escalate:

- The potential impact of actual and expected operational pressures may have on the progress with CQC Must and Should Do's, particularly in the Medicine Care Group

Appendix 1: Impact of Completed Recommendations and Actions

Risk Management

Recommendation MD2: The trust must ensure that risks in the organisation are correctly identified and appropriate mitigations put in place in a timely way

The Trust's Risk Strategy, Risk Policies and Standard Operating Procedures were reviewed and updated in July 2021. Three cycles of PDSA were implemented and a full review of current risks was completed in September 2021. Practical Risk Management workshops involving 86 Managers from across all Care Groups have been delivered, with a commitment to train 120 colleagues during 2022.

A new Trust Wide Risk Management Group was established and meets monthly and receives a Risk Escalation and Assurance Report which presents:

- any risks to be considered for the Corporate Risk Register,
- any high-value risks being managed by the Care Groups,
- any new risks; and
- any high-value risks which are pending acceptance by the Care Groups for information.

There is a heat map and risk profile which show changes on the previous month.

The number of risks on the Trust Risk Register has increased to 370 risks compared with 241 in September 2020 which indicates positive improvements in risk reporting and management. The Risk Management processes were audited by MIAA in May 2022 and no recommendations were issued by MIAA.

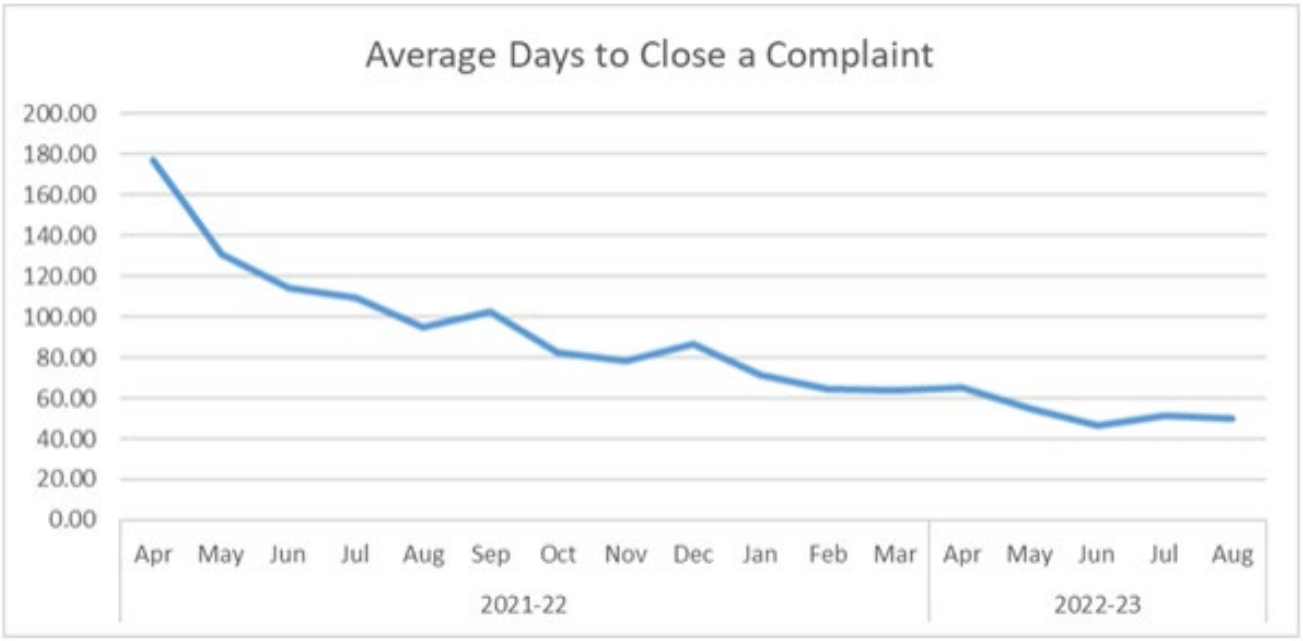
Complaints Management

Recommendation MD4: The trust must improve on the timeliness of responses to complaints.

At the time of the CQC inspection in April 2021 the Trust had a significant backlog of complaints and the Trust's average response time to complaints was over 175 Days.

The Complaints process was reviewed and aligned against the new Parliamentary standards for NHS Complaints. Additional resources were identified to address this backlog with plans to have no complaints over 6 months old by the end of October 2021. Training was developed and delivered to Care Group teams responsible for investigating and responding to complaints.

These actions resulted in a 52% reduction in the average response times during 2021 to 86 days in December 2021, this has been further reduced to 48 days in August 2022, response times are now below the regulatory standard/requirement. A review of complaints and revisits over a 12-month period will be presented at the September or October Quality and Safety Group, to ensure that progress has been embedded.

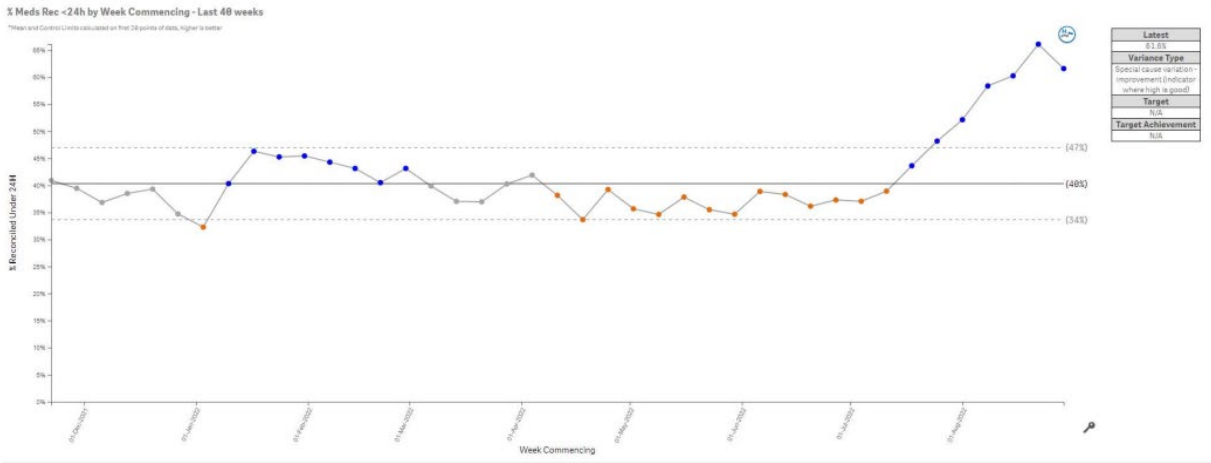


Medicines Reconciliation

Recommendation MD6: The trust must ensure that further development and investment in pharmacy resources should be prioritised to make sure medicines reconciliation rates and antimicrobial stewardship are improved across the trust.

A business case was developed and approved for increasing Pharmacy resources dedicated to Medicine Reconciliation, with a new Lead Pharmacist for Medicines Reconciliation and Medicines Reconciliation Pharmacy Technicians appointed in Summer 2022.

An internal target to achieve 60% of reconciliations with 24 hours of admission by December 2022 was set, with a stretch target to improve performance to 80%. The 60% target was achieved in September 2022 and will continue to be monitored to ensure the improvements are maintained.



Maternity EPR

Recommendation MD70: The service must ensure appropriate systems are used for maintaining accurate, complete and contemporaneous records for [Maternity] service users.

The Maternity Service has purchased and implemented the Badger Net Maternity EPR system to replace the maternity Module of Lorenzo. Badgernet is an ICS wide system and full complies with the requirements of Clinical Negligence Scheme for Trust, Digital Maternity Records Standard and the Maternity Services Data Set.

The System will enable the Trust to deliver more effective, person centred and safe maternity practice to Mothers and Babies, e.g. Cardio tachygraph records are reported directly into the patients record. As all maternity records are now centrally held it will also enable better review and audit of patient care and treatment. The system benefits include:

- Information to be shared directly from the maternity system
- Records can be easily updated at each maternity visit or appointment
- Midwives do not have to double enter data onto paper handheld notes
- Only those with the correct login details are able to access the notes

BOARD OF DIRECTORS

Date of Meeting	28 September 2022
Title	Niche External Investigation Assurance
Report of	Richard Sachs - Director of Governance Richard.sachs@mbht.nhs.uk
Prepared by and contact details	Claire Alexander - Associate Director Claire.alexander@mbht.nhs.uk

Confidentiality	Non-Confidential

Purpose of Report	**To Advise/Alert**	**To Assure**	**To Approve**	**To Update**
	x	x		x

Alert: The Niche assurance process is live and is an improving position week on week. All stakeholders are expected to maintain their contribution to this process.

Assurance: This paper describes the assurance process to check and test the evidence to support recommendations to a level 3 or above (NIAF (Niche Investigation Assurance Framework)) with gaps identified and action taken to address.

Summary of Key Issues	In November 2019 Niche Health and Social Care Consulting were commissioned by NHS England and NHS Improvement (NHSEI) to complete a five-phase investigation into Urology services at the University Hospitals of Morecambe Bay NHS Foundation Trust (the Trust). Phases One to Four are now complete, with the Trust supported during Phase Four to share the findings and recommendations across the Trust given the remit for wider applicability. Phase Five comprises of an assurance review commencing 6-12 months post the publication of the report which was published on 24 November 2021. Phase 5 will commence October 17th, 2022.

	This paper describes the background to the review, the detail of Phase 5 and the UHMB (University Hospitals of Morecambe Bay) processes in place to prepare for the Phase 5 review. The paper also describes our progress against the external evidence review.

Prior Discussions	Committee	Date	Recommendations/ Concerns
	Executive Directors' Group	23 August 2022	A paper to be submitted to EDG 30/08/22 with update on progress.
	Quality Committee	26 September 2022	A verbal update will be given at the Board of Directors' meeting on 28 September 2022.

Action to be recommended to the Committee/Board	The Board of Directors is asked to note the contents of the report.

Link to Key Priorities	Delivering outstanding care and experience	Create the culture and conditions for colleagues to be the very best they can be	Make the best use of our physical and financial resources	Working in partnership
	x	x	x	x

Impact on Board Assurance Framework or Corporate Risk Register				
Risk Impact Assessment	Is this required?	**Y/N**	If Yes, Date Completed	

Equality Impact Assessment	Is this required?	**Y/N**	If Yes, Date Completed	
Quality Impact Assessment	Is this required?	**Y/N**	If Yes, Date Completed	
Environmental / Sustainability Impact Assessment	Is this required?	**Y/N**	If Yes, Date Completed	

Acronyms	
EDG	Executive Directors Group
SJR	Structured Judgement Review
M&M	Mortality and Morbidity
MDT	Multi-disciplinary Team
VTE	Venous Thromboembolism
MUST	Malnutrition Universal Screening Tool
SOP	Standard Operating Procedure
GMC	General Medical Council
RCS	Royal College of Surgeons
CQC	Care Quality Commission
IBD	Investigation By Design
RSP	Recovery Support Programme
NIAF	Niche Investigation Assurance Framework
SGAG	Surgical Governance and Assurance Group
QGPS	Quality Governance and Patient experience Group

UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST Niche

External Investigation Assurance

Introduction and Context

1. In November 2019 Niche Health and Social Care Consulting were commissioned by NHS England and NHS Improvement (NHSEI) to complete a five-phase investigation into Urology services at the University Hospitals of Morecambe Bay NHS Foundation Trust (the Trust).

2. Phases One to Four are now complete, with the Trust supported during Phase Four to share the findings and recommendations across the Trust given the remit for wider applicability.

3. Phase Five comprises of an assurance review commencing 6-12 months post the publication of the report which was published on 24 November 2021.

4. There will be a repeat of the Current Case Review to commence on 17 October 2022 in advance of the wider assurance review. The review of current cases will provide evidence for the assurance process with individual patient assessment covering many recommendations.

5. This paper describes the approach to the Phase Five assurance review planned to commence in October 2022, the trust preparations for the review and the status of the recommendations in preparation for the review.

6. The key themes from the report were:

    - Clinical Governance
    - Corporate Governance
    - Culture and Leadership
    - Service design /delivery
    - Electronic patient Record (EPR) – documentation
    - Fundamental Care Standards

The Report

7. The 72 recommendations in the report are addressed to several stakeholders:

    - University Hospitals of Morecambe Bay NHS Foundation Trust (48) (plus three shared recommendations) = 51.
    - NHS England and NHS Improvement (12)
    - Care Quality Commission (1)
    - Royal College of Surgeons (1)
    - General Medical Council (1)
    - Clinical Commissioning Groups (now becoming Integrated Care Systems (ICS)) (6)
    - Shared national recommendations (2)

8. The recommendations within the report were based on 4 interim reports shared with the Trust between October 20 and November 21:

    - Current Controls Assurance Assessment Report (Oct 2020)
    - Current Care Review Report (March 2021 - review Oct/Nov 2020)
    - Index case recommendations (Jan 2021)
    - Trust recommendations (Nov 21)

9. From the dates above, it can be seen that some recommendations were made earlier than others and have had longer to deliver and embed. It is acknowledged that some recommendations will demonstrate greater progress than others.

Background

10. In October/November 2020, the Niche team undertook an independent review of 132 current Urology cases (38 outpatients and 94 inpatients) to assess if the service was safe (in conjunction with other activities). Some immediate concerns were escalated and managed while on site with a residual eight recommendations made to improve the safety and quality of care in the Urology department.

11. This included a need to repeat the case note review to assess if improvements made have been sustained and embedded in practice.

12. The current case review will feature the following activities:

    - Case note request – UHMB Business Intelligence team will generate c500 patients who are receiving care and treatment from the Urology service. This will be sent to Niche by the 1st of October and c100 patients will be selected randomly for review by the Niche team.
    - Site visit – the Niche team will attend the Trust for a five-day period to review the clinical care records selected (paper records and Lorenzo EpR)
    - The clinical record review will seek evidence to establish current practice as regards the following recommendations from previous reports and will inform the assurance review. Evidence gathered will be dependent on the sample cohort selected and will feature the following themes:
        - For any deaths within the cohort, the team will seek out the mortality reporting process - SJR quality, presentation to M&M, learning points etc. **Key REC - 10/15.** The data pull may not provide sufficient numbers, so we have agreed to add the last 10 deaths to the cohort (these are likely to have already been reviewed by Better Tomorrow team) and have been reviewed within the mortality team.
        - Models of care/pathways - Pooled patients, named consultant, bladder cancer diagnosis, nephrostomy service, follow-up pathways and surveillance procedures (stent management and cystoscopy) and the follow through to MDT - **Key REC 12/16/22/25/36/41**
        - Clinical guidance - fluid balance, capacity and best interests, suprapubic catheters audit, consent, clinical monitoring (VTE, MUST), SOPs (Standard Operating Procedures), emergency theatre access and patient handover - and the audit of these processes as described in R40. **Key RECS 14/17/18/23/24/40/43/44**
        - Admin/ records/ IT - results acknowledgement, Lorenzo documentation, stent register compliance and ethnicity - **Key RECS 19/20**

13. The key concerns arising from the 2020 care review are listed below and will be the focus for the specialty:

    - The need for named consultants for complex patients.
    - Fluid balance monitoring particularly given the specialty involved.
    - Mortality reviews recent practice and oversight.
    - Consent practice.
    - Capacity and best interest decision making and recording in line with the Mental Capacity Act 2005.
    - Use of Lorenzo to optimise its effectiveness (results acknowledgement) and
    - The recording of ethnicity (given the need to record ethnicity to support COVID research).

Interviews / engagement

14. The Niche team request that the following stakeholders engage in dialogue with them:

    - All Trust Board Executive members to discuss how they are securing robust assurance on the implementation of the recommendations and the quality of assurance in relation to the impact of the changes being made (appointments are being diarised).
    - Key individuals within the Trust and Urology services including current Urology Junior doctors and trainees.
    - Key individuals in other stakeholder groups including the GMC, RCS and CQC (Care Quality Commission).
    - NHS England and NHS Improvement in relation to the implementation of recommendations within their domain as well as Improvement Directors and the northwest regional team in respect of progress being made.

15. The Niche team will provide an information request (as for Phase 3) and mobilisation programme, setting out their expectations from each stakeholder involved (Trust, CQC, RCS, ICS, GMC and NHSEI) to plan for the provision of documentation and interviews. The Niche team will then carry out an assessment of the evidence provided by stakeholders in response to each of the recommendations and will be based on documentary evidence, a comparative quantitative analysis of key performance indicators and evidence drawn from the Urology current case review commencing 17 October 2022.

16. To deliver the project scope, Niche will undertake the following activities:

    - Review documentary evidence from each stakeholder: This may include the provision of recorded meetings held over the last year e.g., Audit and MDT meetings.
    - Undertake quantitative data analysis and re-run our original data analysis:

17. Data required from the Trust will include:

    - Updated activity data
    - Updated theatre activity and length of stay data

- Updated bed outliers
- NHS Cancer Waiting Times data
- Updated cancer breach data
- Updated Urology MDT attendance data
- Stent register compliance data
- Additional Activity Sessions data
- Workforce data
- Updated claims, Never Events, PHSO (Parliamentary Health Service Ombudsman), complaints data
- Learning from Deaths (Mortality)

18. This will provide comparative data to underpin the work supporting other evidence.

UHMB response

19. The Niche team have requested an initial understanding of the UHMB Recovery Support Programme (RSP) and governance processes in place within the Trust to understand how this is helping to implement the recommendations. This includes our response to other recommendations made by the CQC and RCS and the cross-over with these.

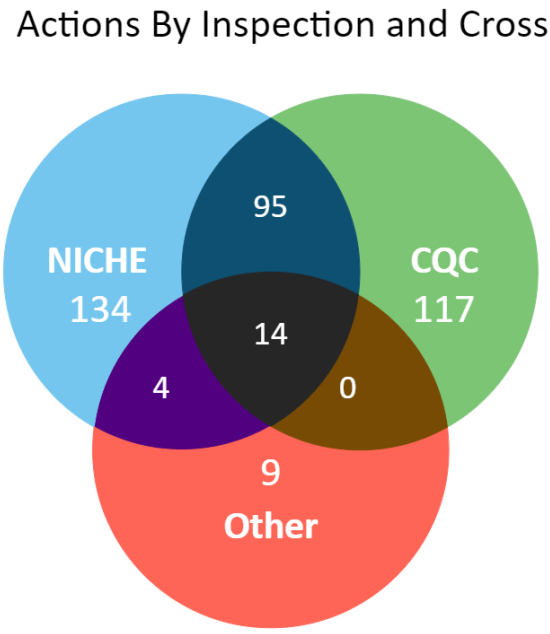
20. Our response to our various external reviews (RCS, Niche, Ockenden, IBD, CQC etc.) is complex and requires cross reference mapping, and cross-sectional compliance across challenging domains and functions. We also need to be efficient and smart with our evidence and ‘do the job once.’

21. The Trust response to the Niche report is therefore one, two and three dimensional.

22. **One-dimensional** - this captures those recommendations that are uniquely applicable to the UHMB Urology service

23. **Two-dimensional** - this captures those recommendations applicable to the UHMB Urology service and transferable to other services within the trust

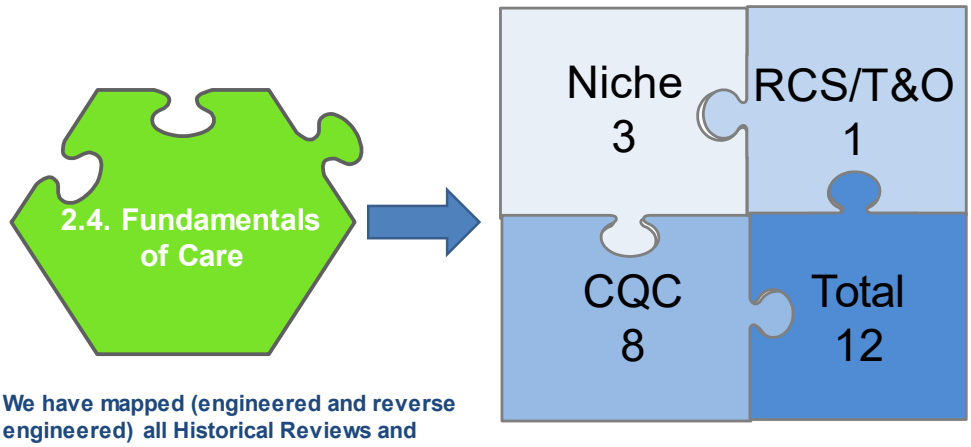
24. **Three-dimensional** - this captures the recommendations that see a wider response coming from trust and system wide programmes of work with ‘read through’ to RSP/RCS/CQC etc. and will pull from the 6 RSP workstreams, exit criteria, deep dives etc. All actions have been mapped across to identify the overlap.



Other - IBD*(actions to be agreed), Kirkup, Ockenden, RCS, regulatory actions

25. The RSP programmes of work will provide the opportunity to encompass trust wide improvements in response to some of the recommendations within the report.

2.4 Fundamentals of Care- example



We have mapped (engineered and reverse engineered) all Historical Reviews and Regulatory Notices by RSP workstream, by CQC action and by other external reviews.

Governance processes

26. A twice weekly Support and Review (S&R) meeting is now in place with the care group and specialty:

- To provide a documented narrative on how the recommendation will/is being delivered
- To present and consider existing evidence
- To use the collective knowledge to identify further evidence.
- An external compliance and assurance expert is reviewing the existing evidence 1 week ahead to offer a helpful challenge on the quality of the evidence and to rate (0-5) NIAF
- A workplan and revisit loop in place to revisit actions and work required
- TOR (Terms of Reference) and agenda in place
- Links in place to align all RSP relevant evidence for local and wider applicability
- Walkabouts to test assurance (one stop clinics/ward rounds/ theatres /Waiting List Office/ attendance at Urology business meetings, Audit, M&M, Clinical business meetings, SGAG and Surgical board.

27. A monthly task and finish group in place. This meeting has been established by the Senior Responsible Officer (Executive Chief Nurse) and Director of Governance to take all necessary actions as required to ensure demonstrable progress/completion of the recommendations within the review. The group will provide oversight, visibility, and tracking of planned actions to deliver the recommendations. Assurance reporting will be managed through updates to the Executive Directors Group, the Quality Assurance Committee, Trust Board, and appropriate Regulators over the next 6–9 months.

Engagement

- Weekly care group specialty preparation meeting
- Weekly Support & Review meetings (fully documented) with the care group and specialty with escalation and reporting to the SRO led T&F group
- Fortnightly working party for communication with the team
- Revised Audit meeting in place using revised agenda and structure
- Executive attendance at the Urology Audit meeting
- 2hr Urology business meeting to be actioned from August/September 2022
- Escalation from Audit and business meeting to SGAG and SMB (Surgery Management Board)
- Safe today paper at QGPS (Quality Governance & Patient Safety) monthly
- (Safe today paper under review from NHSI ‘Making Data Count’ and governance - changes already implemented with wider applicability)
- Safe today paper and update on recommendations tabled at SGAG
- Monthly update to QAC and Board as part of governance update
- New IPR (Integrated Performance Report) for Urology due Sept 2022

Progress

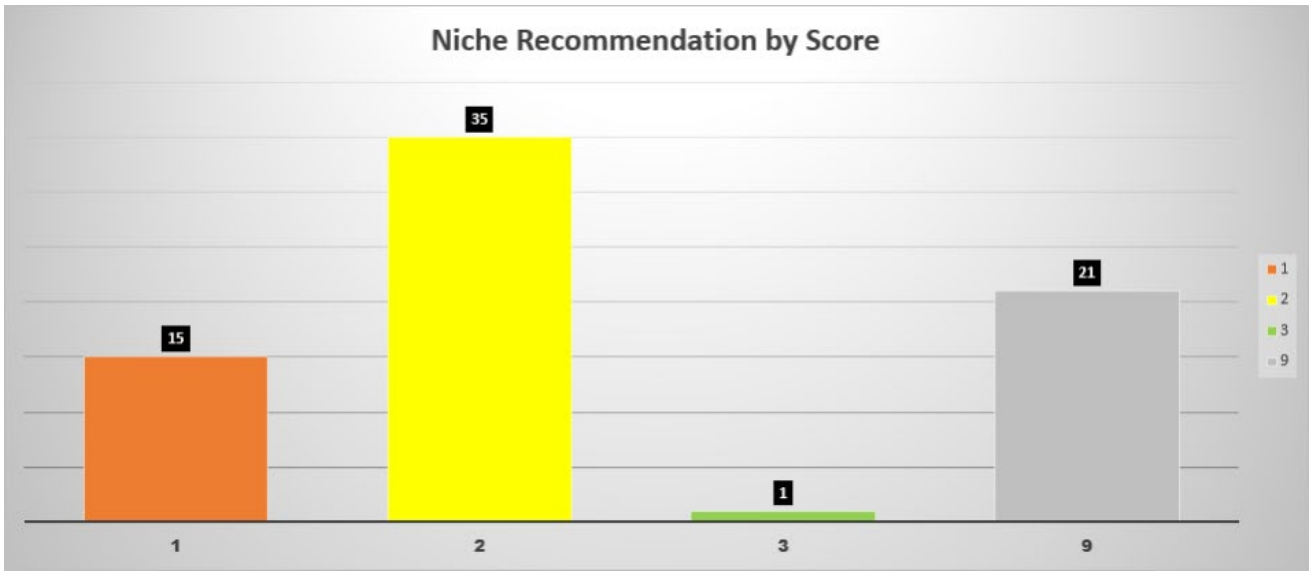
28. In previous Board reports, a status for the Niche recommendations has been provided through an extract from AMaT, with status based on an internal compliance and assurance review.

29. Since July 22 we have the support of an external compliance and assurance specialist and additional dedicated internal Associate Director and governance support to assist in seeking, checking, and testing this evidence for quality, based on the NIAF (Niche

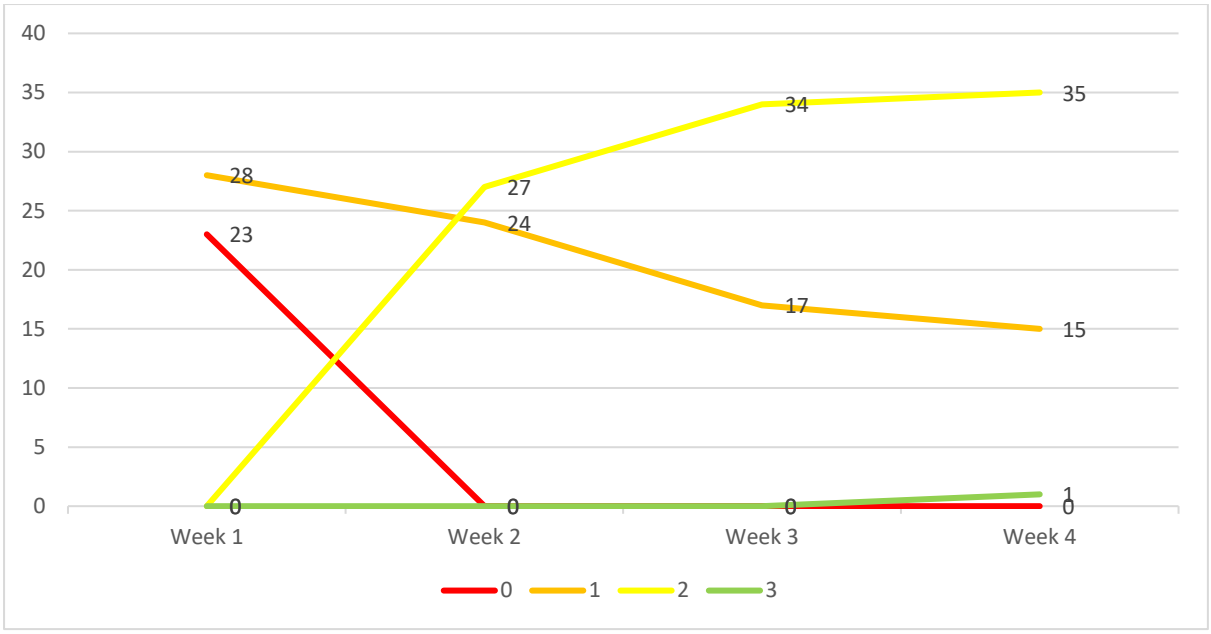
Investigation Assurance framework) with all recommendations assessed against the 0-5 score.

30. Following an initial review of all trust applicable recommendations, a decision has been taken to reopen recommendations previously thought to be complete based on testing and enriching the evidence in collaboration with the specialty, care group and executive corporate leads.

31. The dashboard below describes the current position on the quality of evidence provided. The evidence is pulled from the date of the recommendation alert:



32. The graph below shows weekly progress with a reduction in zero and 1 scores, and the increase in 2 and 3 scores.



	Date	0	1	2	3	Total
Week 1	16/08/2022	23	28	0	0	51
Week 2	23/08/2022	0	24	27	0	51
Week 3	30/08/2022	0	17	34	0	51
Week 4	07/09/2022	0	15	35	1	51

Wider applicability

33. There are 27 recommendations have been identified as having wider applicability with evidence triangulated with feedback to the national team on progress as part of the RSP assurance on the 14th of July 22 and have also been reviewed as part of the initial review with the help and support of exec leads.

Rec number	Niche Recommendation	Workstream/Work Programme
1	Oversight of Urology through Trust governance structures	RSP workstream 1
2	Quality and safety data in the Integrated Performance Report	Trust development of IPR with roll out to Care Groups and specialties Sept 2022
3	Performance framework for Urology	Trust framework
4	Urology audit	RSP workstream 3 - Clinical effectiveness
5	Safe Today Report	ESP (Enhanced Support Programme) teams
6	Meeting administration	RSP workstream 1
7	Risk registers at service, care group and Trust level	RSP workstream 1
10	Mortality review (Link to R15 and R26)	RSP workstream 3 - Mortality
12	Pooled model of patient care	S&CC service models
13	Monitoring of additional activity sessions (AASs)	Workstream 5 - SFIP (Sustainable Financial Improvement Programme) Trust performance framework
14	Fluid balance monitoring	RSP Workstream 2 - FOC
15	Mortality review (Link to R10 and R26)	RSP workstream 3 - Mortality
17	Capacity and best interests: applying the Mental Capacity Act 2005	RSP Workstream 2 - FOC
18	Consent	S&CC / medicine service models
19	Lorenzo	I3 - Results acknowledgement work programme
23	Clinical monitoring	RSP Workstream 2 - FOC
26	Mortality review (Link to R10 and R15)	RSP Workstream 3 - Mortality
28	Consultant relationships (Link to R65(E))	RSP Workstream 4 – cultural engagement
31	Clinical dispute resolution	RSP Workstream 4 – cultural engagement

37	Capacity and demand modelling in Urology	Clinical Operating Model (COM)
40	Implement clinical audit programme (Link to R4, R9, R14, R18, R25, R41, R47)	RSP workstream 3 - clinical effectiveness
41	104-day cancer breach root cause analysis	Performance / cancer operational board
45	Managing team dysfunction	RSP Workstream 4 – cultural engagement
46	Duty to monitor staff wellbeing	Trust vision and values
63E	Development of safe services and specialist interests	RSP Workstream 5 - Clinical strategy
66E	Whistleblowing	RSP Workstream 4 - FTSU (Freedom to Speak Up)
72	Testicular implant recall	Lessons learnt and national guidance on recall

Recommendation

34. The Board of Directors is asked to note the contents of the report.

BOARD OF DIRECTORS

Date of Meeting	28 September 2022
Title	Maternity Update
Report of	Bridget Lees, Chief Nursing Officer
Prepared by and contact details	Heather Gallagher, Director of Midwifery Heather.Gallagher@mbht.nhs.uk Donna Southam, Quality, Safety and Assurance Lead Midwife Donna.Southam@mbht.nhs.uk

Confidentiality	Non-Confidential

Purpose of Report	**To Advise/Alert**	**To Assure**	**To Approve**	**To Update**
	x	x		x
	One PMRT case in month. Continued increase in moderate harm and above incidents due to improvements in assessing harm grading. Training compliance for medical staff both Obstetricians and Anaesthetists continue to be a challenge due to workforce issues. FGH midwifery fill rates dipped under 80% for August, for the first time in the year, safe staffing maintained but challenging. Maternity and Neonatal frontline and Board Safety Champions active in seeking staff feedback and engagement. Governance improvement action plan has been developed in response to issues identified at the WACS governance mapping exercise held in July with MSSP and NHSE support. MSSP progress against exit criteria shows continued improvement for August.			

Summary of Key Issues	The Perinatal Quality Surveillance Data set out in this report seeks to provide a consistent and methodical oversight of maternity and neonatal services. It forms part of the long-term plan and revisions to the local, regional and national quality oversight model for the NHS. It is mandated that a monthly review of maternity and neonatal safety and quality metrics is undertaken by the Trust Board.

Prior Discussions	**Committee**	**Date**	**Recommendations/ Concerns**
	Quality Committee	19 September 2022	

Action to be recommended to the Committee/Board	The Board of Directors is asked to note the contents of the report.

Link to Key Priorities	Delivering outstanding care and experience	Create the culture and conditions for colleagues to be the very best they can be	Make the best use of our physical and financial resources	Working in partnership
	x	x	x	x
	This report has a direct impact on patient safety			

Impact on Board Assurance Framework or Corporate Risk Register				
Risk Impact Assessment	Is this required?	**N**	If Yes, Date Completed	
Equality Impact Assessment	Is this required?	**N**	If Yes, Date Completed	
Quality Impact Assessment	Is this required?	**N**	If Yes, Date Completed	
Environmental / Sustainability Impact Assessment	Is this required?	**N**	If Yes, Date Completed	

Acronyms	
LMNS	Local Maternity and Neonatal System
PMRT	Perinatal Mortality Review Tool
HSIB	Healthcare Safety Investigation Branch
STEIS	Transfer of Strategic Executive Information System
PPH	Postpartum Haemorrhage
ITU	Intensive Therapy Unit
NICU	Neonatal Intensive Care Unit
GAP/GROW	Grow Assessment Protocol
SBLCBV2	Saving Babies Lives Care Bundle Version 2
PROMPT	Practical Obstetric Multi-Professional Training
CQC	Care Quality Commission
CNST	Clinical Negligence Scheme for Trusts
IEAs	Immediate and essential actions
TC	Transitional Care
MSW	Midwifery Support Worker

UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST
MATERNITY UPDATE REPORT

INTRODUCTION

1. This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety, as outlined in the NHSE document 'Implementing a revised perinatal quality surveillance model' (December 2020). The purpose of the report is to inform UHMBT Trust Board and LMNS Board of present or emerging safety concerns or activity to ensure safety with a two-way reflection of 'ward to board' insight across the multi-disciplinary, multi-professional maternity and neonatal services team. The information within the report will reflect actions in line with Ockenden and progress made in response to any identified concerns at provider level. In line with the perinatal surveillance model, we are required to report the information outlined in the data measures proforma monthly to the Trust Board. Data is primarily for August 2022 in this report.

Perinatal Surveillance Model

2. Please refer to Appendix 1 for all data, which is included in the Board of Directors' Reference Pack.

Perinatal Mortality Review Tool (PMRT)

3. In August there has been one PMRT case and two PMRT case reports completed. The PMRT review report and action plan will be presented at private Board in September.

HSIB

4. No HSIB cases for August.

Maternity Serious Incidents

5. We have continued to see an increase in the number of incidents graded moderate and above since April, this is in response to targeted work to improve our grading and reporting of moderate harm and above. Ensuring that harm is graded on harm occurred, not on harm based on gaps in care. In August there was one incident of severe harm of a 26+5 Neonatal Death which has been STEIS reported. 13 Moderate harms; 5 of which were PPHs over >1500mls, two ITU admissions, two term babies admitted to NICU, one anaesthetic complication, one incorrect care, one shoulder dystocia, one safeguarding incident.

Training Compliance - exceptions

6. The current mandatory training offer is temporarily adapted due to the COVID-19 pandemic and associated sickness absence and staffing pressures. Day 2, 3, and 4 of mandatory training are currently being delivered virtually to aid attendance rates, this is to be reviewed in October.

   GAP/GROW; decrease in Obstetric staff compliance to below 77%
   SBLCBV2; decrease in Obstetric Staff compliance to 25% from 36.6% in July.
   Fetal Surveillance; decrease in Obstetric Staff compliance to below 65%

PROMPT; for Obstetricians remains at 56%, Anaesthetists remain at 48% as in July, the PROMPT training figures remain static in August as there is no scheduled PROMPT.

7. Obstetric staff training compliance and reasons for is currently undergoing a deep dive. The Clinical Director for Obstetrics and Gynaecology and Associate Director of WACS operations (ADOP) have been asked to oversee the improvement plan and trajectories to achieve compliance for Obstetric staff compliance with regards to role specific training.

8. Current compliance and estimated trajectories compliance based on bookings for Anaesthetists continues to be sent monthly to the surgical triumvirate for escalation and action.

Midwifery Staffing Exceptions

9. FGH fill rates dipped under 80% for August= 79.46 first time in year. High levels of levels of sickness absence – midwives 14.13% in August, peak annual leave period, reduced agency availability, evidenced by considerable decrease in agency usage, fill rate despite higher than usual bank usage in month. Daily safety huddles and staffing meetings continue to be held ensuring safety and responsive to areas of need. 1:1 care in labour maintained and support provided by ward manager(s) and matron(s) where required to maintain safety.

Maternity and Neonatal Safety Champions Feedback

- Feedback from frontline Safety Champions: clinical staff asking for increased communication – To implement new drop-in/update staff sessions. Full communication strategy to be progressed for the whole WACS care group by end of October by HOMs.
- Feedback (LRI) from Board Level Safety Champion: midwives concerned that there is no Band 2 MSW provision on maternity ward. WACS workforce planning in progress and MSW Band 2 provision will be explored.
- Feedback from frontline Safety Champion; that there are frequent occasions of no availability of TC nurses. Review of TC provision to be undertaken, incident reports to be completed if no TC nurse provision to increase visibility and to allow more robust monitoring. Staff to escalate to matrons/managers if concerned in real time. Neonatal workforce review being undertaken as part of WACS workforce planning.

CQC or other organisation with a concern or request for action made directly with Trust

10. One request made by the CQC for information on staffing levels, complaints, and incidents. Being treated as a whistleblowing case by CQC, from an employee.

Consultant Attendance (new addition)

11. Clinical situations in which a Consultant Obstetrician must attend (based on the RCOG Roles and Responsibilities document and as part of CNST Safety Action 4), unless the most senior Doctor has signed off evidence of clinical competency, is a new addition to the perinatal surveillance model. Audit shows full compliance with the standards for July.

NHSR action plan; see separate paper

Maternity Services Visiting

12. Maternity Services visiting has now reverted back to pre-pandemic arrangements.

Ockenden (2020/2022)

13. An Ockenden assurance visit was undertaken on 20/21st July across all sites with the regional chief midwife, **see separate paper** for detailed visit feedback and action plan. Expected publication of the IEAs and national steer for Ockenden the final report (2022) and East Kent's inquiry is expected 22nd September 2022.

CNST Incentive Scheme

14. **See separate CNST paper** for the update and assessment of CNST years 2-4 and associated refreshed action plan.

Maternity Governance

15. On the 4th July 2022 a governance mapping for WACS was undertaken by request of the Director of Midwifery, this was undertaken by the Quality, Safety and Assurance lead Midwife (before her substantive appointment), supported by NHSE and MSSP. An improvement action plan was developed in response to the issues identified through the mapping, some issues had already been identified previously within the service (i.e. PMRT). The maternity Improvement plan is in Appendix 2, which is included in the Board of Directors' Reference Pack.

Maternity Support Programme (MSSP) Visit

16. The monthly feedback from the MSSP for August shows continued progress against the exit criteria for the MSSP programme, see Appendix 3. The next MSSP visit is planned for 13-16th September.

System Improvement Board (SIB)

17. A System Improvement Board (SIB) deep dive into Maternity is due 13th September 2022.

18. Celebrations/Successes

- NICU at Lancaster achieved green status for Family Integrated Care (FI-care) by the North West Neonatal Network.
- Bereavement Midwife Celia Sykes has nominated for BBC Lancashire Make a Difference award in the key worker category, by a former employee of the trust who was recently a patient, who in December 2021 lost their daughter during pregnancy.

The patient nominated Celia as felt they were “treated with ultimate respect, compassion and professionalism during such a heart-breaking time”. Celia has made the final 4 shortlist and award ceremony is being held in September.

Recommendation

19. The Board of Directors is asked to note the contents of the report.

We are UHMBT

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

NHS
University Hospitals of Morecambe Bay
NHS Foundation Trust

Integrated Performance Report

July 2022 Performance- September Board

Contents

Key to KPI Variation and Assurance Icons

Variation			Assurance			
						
Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or higher pressure due to (H)igher or (L)ower values	Common cause - no significant change	'Pass' Variation indicates consistently - (P)assing of the target	'Hit and Miss' Variation indicated inconsistency - passing and failing the target	'Fail' Variation indicates consistently - (F)ailing of the target	Data Currently unavailable or insufficient data points to generate SPC

Special Cause Concern - this indicates that special cause variation is occurring in a metric, with the variation being in an adverse direction. Low(L) special cause concern indicates that variation is downward in a KPI where performance is ideally above a target or threshold e.g. ED or RTT Performance. (H) is where the variance is upwards for a metric that requires performance to be below a target or threshold e.g. Pressure Ulcers or Falls.

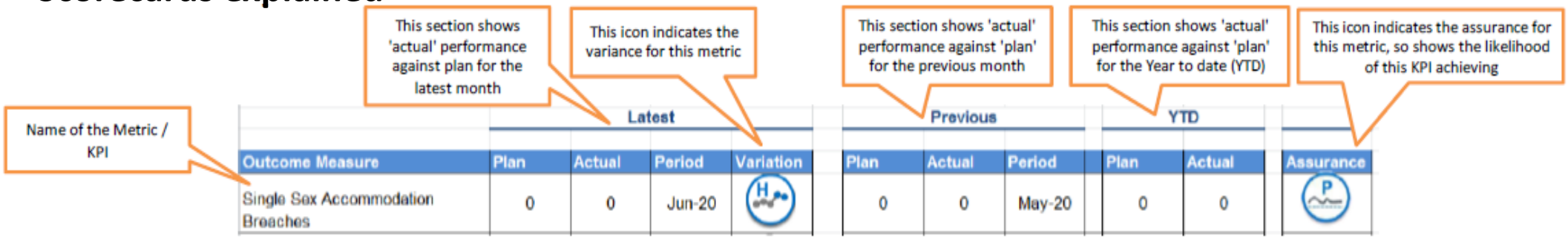
Special Cause Concern - this indicates that special cause variation is occurring in a metric, with the variation being in a favourable direction. Low (L) special cause concern indicates that variation is upward in a KPI where performance is ideally above a target or threshold e.g. ED or RTT Performance. (H) is where the variance is downwards for a metric that requires performance to be below a target or threshold e.g. Pressure Ulcers or Falls.

Escalation Rules:

Area are escalated for reporting if:

- They have special cause variation (positive or negative) in their performance
- They have a change in their assurance rating (positive or negative)

Scorecards explained



Further Reading / other resources

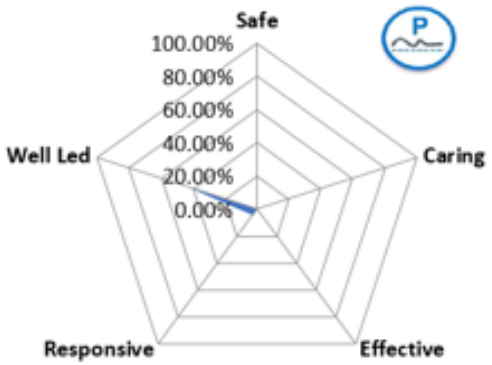
The NHS Improvement website has a range of resources to support Boards using the Making Data Count methodology. This includes are number of videos explaining the approach and a series of case studies – these can be accessed via the following link - https://www.england.nhs.uk/publication/making-data-count/

Executive Summary

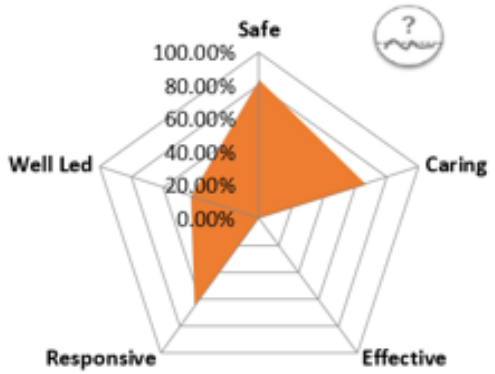
NHS
University Hospitals of Morecambe Bay
NHS Foundation Trust

Executive Summary

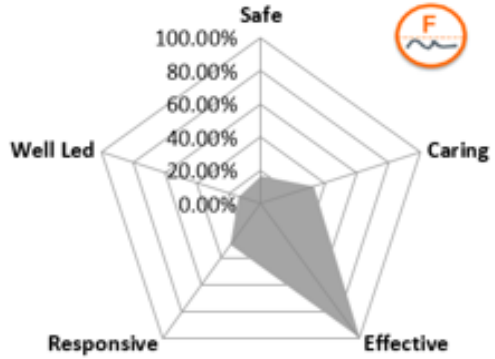
Consistently Passing



Hit and Miss



Consistently Failing



Consistently Passing
The following Key Performance Indicators are all consistently passing the target:

Safe:
Well Led:
- Vacancy %
- Registered Nurse Fill Rate
- Turnover %

Responsive:
- 2hr Community Crisis Response

Effective:
Caring:

Hit and Miss
The following Key Performance Indicators are experiencing inconsistency (passing or failing target):

Safe:
- Core Skills Framework, Hospital Falls per 1000 Bed Days – Moderate Harm or above, Total No. of MRSA Hospital Cases, Total No. of GNBIs, Total Number of c Diff Infections

Well Led:
- Absence FTE %, Average time to hire (advert close to booked start date), Bank & Agency Fill Rate

Responsive:
- % of ED attends > 12hrs, Ambulance Handovers over 60 mins (no.), Cancer 2WW (%), Cancer 28-Day FDS (%), Cancer 31-day(%), Cancer 31-day subsequent drug(%), Cancer 31-day subsequent Surgery(%), No. of patients on Cancer PTL over 62 days (no.), Cancer 62-day (%), Cancer 62-day screening(%), Cancer 62-day upgrade(%), Diagnostic waits >6weeks (%), RTT total waiting list size, RTT 52 weeks (no.), RTT 104 weeks (no.)

Effective:
Caring:
- A&E - % Rating the Service as Good or Very Good, Inpatients - % Rating the Service as Good or Very Good, Outpatients - % Rating the Service as Good or Very Good, Mixed Sex Accommodation Breaches

Consistently Failing
The following Key Performance Indicators are all consistently failing the target:

Safe:
- StEIS Incidents Reported to CCG

Well Led:
- Appraisal Compliance

Responsive:
- ED 4 Hrs (%)
- Ambulance Handovers within 15 mins(%)
- Ambulance Handovers within 30 mins(%)
- Ambulance Handovers within 60 mins(%)
- RTT <18 Weeks (%)
- RTT 78 weeks (no.)
- OP DNA Rate (%)

Effective:
- Overall % of Inpatients Receiving a VTE Assessment

Caring:
- Trust Overall (inc ED, OP & IP) - % Rating the Service as Good or Very Good
- Complaints per 1000 Bed Days

		Assurance		
		Pass	Hit and Miss	Fail
Variance	Special Cause – Improvement	- Vacancy - 2h Community Crisis Response	- RTT 52 weeks (no.) - No of Patients on Cancer PTL over 62 days (no.)	- RTT <18 weeks (%)
	Common Cause	- Registered Nurse Fill Rate - Turnover %	- Please see text box to RHS for metrics	- Ambulance Handovers within 15, 30 & 60 mins (%) – **3 metrics** - RTT 78 weeks (no.) - OP DNA Rate (%) - Complaints per 1000 Bed Days - StEIS Incidents reported to CCG
	Special Cause – Concern		- Core Skills Framework - % Of ED attends > 12hrs - Ambulance Handovers over 60 mins (no.) - Diagnostic waits > 6 weeks - RTT total waiting list size	- ED 4 hrs (%) - Appraisal Compliance - Trust Overall (inc ED, OP & IP) % Rating the Service as Good or Very Good - Overall % of Inpatients Receiving a VTE Assessment

Hit and Miss – Common Cause Metric List

Well Led
Absence FTE (%), Average time to hire, Bank & Agency Fill Rate,

Safe
Hospital Falls per 1000 Bed Days Resulting in Moderate Harm or Above, Total Number of MRSA Hospital Cases, Total Number of GNBIs, Total Number of c. Diff Infections

Caring
A&E - % Rating the Service as Good or Very Good, Inpatients - % Rating the Service as Good or Very Good, Outpatients - % Rating the Service as Good or Very Good, Mixed Sex Accommodation Breaches

Responsive
Cancer 2WW (%), Cancer 28 Day FDS, Cancer 31 day (%), Cancer 31-day subsequent drug (%), Cancer 31-day subsequent surgery (%), Cancer 62 day (%), Cancer 62-day screening (%), Cancer 62-day upgrade (%), RTT 104 weeks (no.)

Items for escalation based on those indicators that are failing the target or are unstable (Hit & Miss) and showing Special Cause for concern by CQC Domain are as follows:

Safe: Core Skills Framework
Caring: Trust Overall (inc ED, OP & IP) - % Rating the Service as Good or Very Good
Effective: Overall % of Inpatients Receiving a VTE Assessment
Responsive: % Of ED attends > 12hrs, Ambulance Handovers over 60 mins (no.), Diagnostic waits > 6 weeks, RTT total waiting list size
Well-Led: Appraisal Compliance

Executive Summary

The Integrated Performance Report sets out the key performance indicators to show which KPIs are currently achieving the standard and whether the KPIs will sustainably achieve the standard going forward using statistical process control methodology. Further detail i provided in the pack includes associated actions, outcomes, dates and assurance. The report for September Board (July performance) is now in the fourth month, with continued work to refine and improve the document, in partnership with the NHSI/E Improvement Team and the Recovery Support Programme (RSP).

Development work in August has included;

- The completion of targets where applicable for the Operational Performance Metrics and further progress against Quality and Safety Metrics.
- Completion of the Phase 1 metrics within the metric library to support the automation of KPIs at Trust, Care Group and Specialty level.

The work programme for September and October includes;

- The inclusion of a glossary of metrics and terms for Finance, Quality & Safety and People metrics for October Board, in response to feedback.
- Completion of the review of Phase 1 work with a recommendation to go to EDG for phases 2 and 3.

The Executive Summary includes 2 sections

1. An analysis of which metrics are consistently passing, hit or miss, or consistently failing the required targets, by CQC Domain.
2. A summary of highlighted themes and messages, grouped into Quality and Safety, People, Finance and Operational Performance.

Executive Summary

Operational Performance

Metrics achieving the target or standard and showing special cause improvement

- The 2 Hour Urgent Community Response standard has been achieved sustainably since April 2021.

Metrics which are failing the target or standard and showing special cause concern

- **Percentage of Emergency Department Attendances waiting >12 hours-** Performance has significantly declined from before the pandemic, with a shift of mean from 1% to 3% from Jan 2021.
- **Ambulance handover-** all 3 percentage handover standards >15, 30 and 60 minutes and the number of patients waiting >60 minutes are predicted to fail going forwards. The actions are set out within the document.
- **Percentage of patients waiting > 6 weeks for the first diagnostic test-** following 18 months of special cause- variation- improvement, the standard is now in special cause concern and unless achieved in August will predict a sustainable fail. The most challenged modalities by number of patients are; Ultrasound and DEXA. Actions to minimise the number of patients waiting and achieve the 1% UHMB stretch target (5% by March 2025 national standard) are included within the report.
- **Total Waiting List** -the waiting list has remained stable at between 28,000 and 29,000 between June and September. The actions to reduce the waiting list size to <26,623 by March 2023 are included within the report.

Stroke Performance- Quarter 1 SSNAP data- FGH declined from 80 to 77 and remained at level B. The RLI improved from 57 to 60 and improved from level D to level C in the SSNAP score.

Executive Summary

Quality and Safety

Clostridium Difficile infections – July saw the highest CDI rate this financial year. This spike has been reported consistently for the last 3 years. There is a focussed plan to increase medical engagement in CDI reviews and improvement work. This was an action in the NHSE/I IPC peer review.

VTE Assessment – Due to the timing of the report the compliance level remains low. The revised process has been signed off by the CMO. The revised compliance (currently approx. 85%) will be reflected in future IPR's.

FFT – patient satisfaction rates reported through the FFT remain low across all areas, but particularly in ED. A thematic analysis of feedback from FFT, PALS and complaints is planned to provide a rounded view of patient experience in ED and identify areas of focus for support and improvement.

Executive Summary- People

Vacancies: The overall vacancy rate continues to rise, although it remains under the Trust target. Recruitment plans are in place with regular review and re-adjustment where necessary. Success in several specialities for Consultants will positively contribute to the overall vacancy rate.

Sickness absence: Absence levels remain high and largely driven by non-COVID absences. The demand for psychological support continues to grow. The EASE service was successfully implemented in July which is intended to have a positive impact on absences due to mental health and MSK by provided early intervention (from day one).

Appraisals: Compliance with appraisals has been lower than planned due to COVID both nationally and at UHMB. At UHMB, the priority for recovery has been on the completion of Leadership appraisals which were to be completed by 31 July and signed off by 31st August 2022. This will ensure the timely cascade of objectives and priorities for the coming year.

Executive Summary

Finance

- The Trust is £1.1m worse than plan which includes income relating to ERF at planned levels. The National team has confirmed zero claw back ERF for months 1-4, regardless of system performance.
- The plan includes a £34.1m categorised as ICS stretch income as part of the system wide requirement to breakeven. This income is to be generated through system wide savings initiatives and other slippage and collaborative solutions. At month 4, 66% has been identified. Included in the position is £2.5m income against the stretch plan of £3.8m.

- **Pay controls –** Delays remain in providing appropriate documents to HB retinue delaying progress on recruitment to reduce high-cost agency and recruit substantively. This relates predominantly to Royal college approval. This requires clarification to allow care groups to progress.

- **Efficiencies** - There remains a significant element of the Trust efficiency programme that requires identification. Care Groups have been asked to consider the impact of expected benefits from RSP workstreams and to build these into the Care Group efficiency programme.

  The impact of NMC2R is impacting Care Group achievement of CIP, especially the Medicine Care Group. This pressure is outside of Care Group control and recognition of CIP will be made at Month 5, with funding being vired from Reserves to cover the costs of beds not able to be closed.

Quality and Safety

Metric Scorecards by CQC Domain

Caring

Outcome Measure	Target	Actual	Variation	Assurance
A&E - % Rating the Service as Good or Very Good	84%	80.80%		
Inpatients - % Rating the Service as Good or Very Good	94%	90.70%		
Outpatients - % Rating the Service as Good or Very Good	94%	93.10%		
Trust Overall (inc ED,OP & IP) - % Rating the Service as Good or Very Good	94%	90.80%		
Complaints per 1000 Bed Days	0.40	1.49		
Mixed Sex Accommodation Breaches	0	4		

Effective

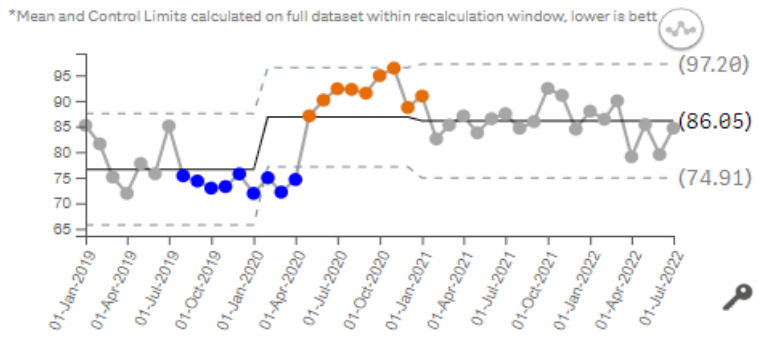
Outcome Measure	Target	Actual	Variation	Assurance
Overall % of Inpatients Receiving a VTE Assessment	95%	32%		

Safe

Outcome Measure	Target	Actual	Variation	Assurance
Patient Safety Incidents per 1000 Bed Days		84.66%		
StEIS Incidents Reported to CCG	0	9		
Never Events	---	0		
Moderate and Above Harm Patient Safety Incidents		108		
Hospital Falls per 1000 Bed Days Resulting in Moderate Harm or Above	0.13	0.15		
Inpatient Category 2, 3 & 4 Pressure Ulcers Per 1000 Bed Days		2.28		
Overall % of VTE's that are Hospital Aquired		1%		
Patient Safety Alerts by Date Received	---	1		
Total Number of MRSA Hospital Cases	0	0.00		
Total Number of MSSA Hospital Cases		2		
Total Number of GNBIs	11	3		
Total Number of c.Diff Infections	7	9		

Patient Safety

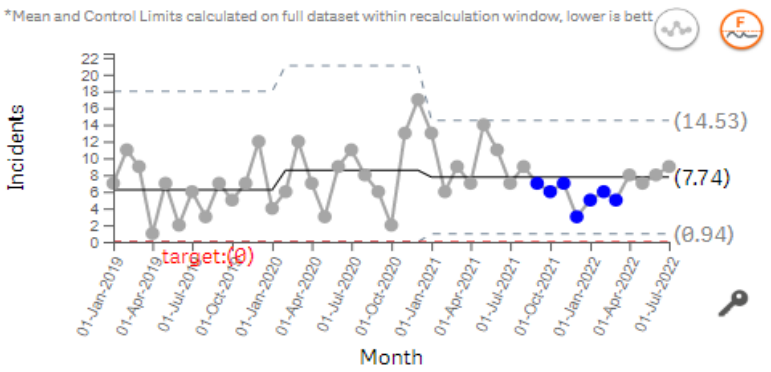
Patient Safety Incidents per 1000 Bed Days



Latest
84.66
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

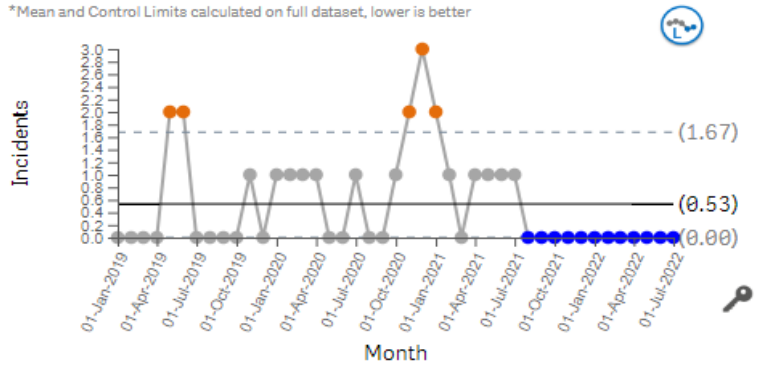
Awaiting revised national benchmarking before setting local target

StEIS Incidents by Month Reported to CCG



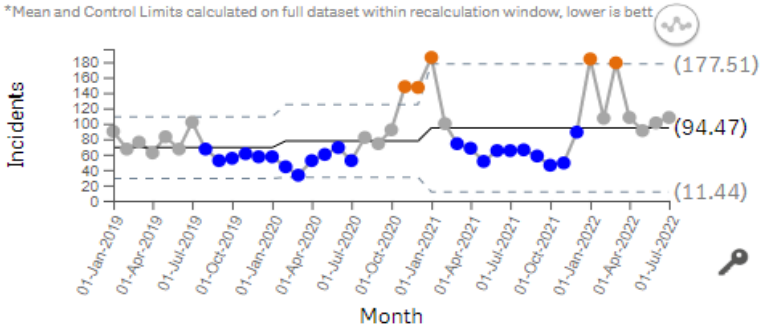
Latest
9
Variance Type
Common cause variation
Target
0
Target Achievement
The system is expected to consistently fail the target

Never Events



Latest
0
Variance Type
Special cause variation - improvement (indicator where low is good)
Target
N/A
Target Achievement
N/A

Moderate and Above Harm Patient Safety Incidents



Latest
108
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Awaiting revised national benchmarking before setting local target

Summary:

Patient Safety Incidents per 1000 Bed Days: On 01/06/2022, the Trust migrated from National Reporting and Learning System (NRLS) incident submissions to Learn from Patient Safety Events (LFPSE). This included the introduction of a number of additional sections within the incident reporting system. An identified risk associated with this was a potential for reporting rate to fall as incident reporting could be perceived as more time consuming or complex.
The chart shows an increase in the volume of reported Patient Safety Incidents in July 2022. The chart further suggests that reporting rates have remained stable despite the move to LFPSE.

StEIS Incidents by Month Reported to CCG: In July 2022, 9 incidents were reported on StEIS and declared serious incidents. 4 of these occurred within Women and Children's, 4 within Surgery and Critical Care and 1 within Medicine.
In the last 12 months, slips/trips/falls, pressure ulcers and diagnosis delays continue to be the most likely cause of a serious incident.

Moderate and Above Harm Patient Safety Incidents: Following a spike in COVID incidents in previous months the volume of moderate and above incidents appears to be returning to normal levels.

Actions:

Patient Safety Incidents per 1000 Bed Days: Audit to be undertaken to further understand the impact of migrating to LFPSE

Assurance:

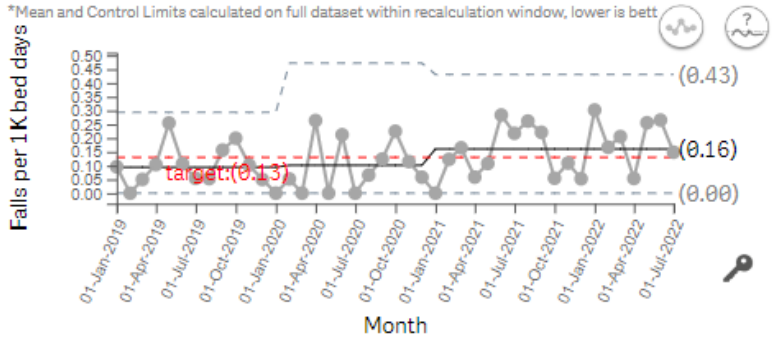
Patient Safety Incidents per 1000 Bed Days: The Trust will undertake an audit to further understand the impact of LFPSE.

Never Events: The Trust has had a sustained period without declaring a never event.

StEIS Incidents by Month Reported to CCG: Serious Incidents continue to be identified and investigated to avoid reoccurrence.

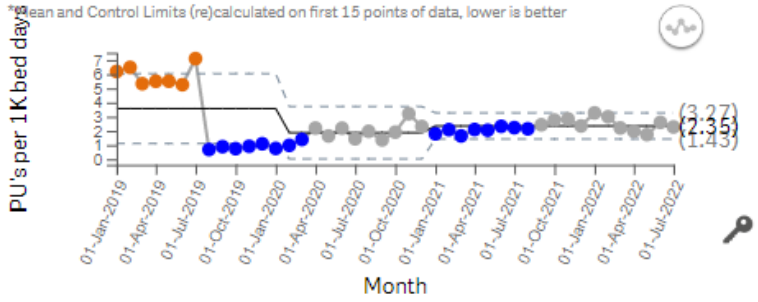
Patient Safety

Hospital Falls per 1,000 Bed Days Resulting in Moderate or Above Harm



Latest
0.15
Variance Type
Common cause variation
Target
0.13
Target Achievement
The system may achieve or fail the target subject to random variation

Inpatient Category 2, 3 & 4 Pressure Ulcers Per 1000 Bed Days



Latest
2.28
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Inpatient methodology: excluding PU incidents acquired in the community and non UHMB incidents

Summary:

Inpatient Category 2, 3 & 4 Pressure Ulcers per 1000 Bed Days: Validation of pressure ulcers is now widely understood and is monitored through the weekly Harm Free Care group and beginning to eliminate duplication of PU reporting. Education continues forward staff to ensure that the categorisation of the wound is correct. After category 2 pressure ulcers Deep Tissue Injuries are the second highest reported category.
Following a thematic review route causes have been identified as long trolley waits in ED, dressings/compression dressings not being taken down and the correct management of anti-embolism stocking.

Hospital Falls per 1000 Bed Days Resulting in Moderate or Above Harm: The QI programme to reduce falls continues with daily and weekly oversight of slips, trips and falls from the senior nursing team and matrons, including ongoing thematic analysis and focussed actions e.g. patients who fall multiple times.

Actions:

Inpatient Category 2, 3 & 4 Pressure Ulcers per 1000 Bed Days: Bed, mattress and pressure relieving equipment training was completed on the 3 main sites as drop in sessions. Review of trolley toppers in ED for corridor care. Educational posters have been shared regarding the importance of taking wound dressings down on admission to complete skin assessments. Anti-embolism stockings and the associated training is now under review

Hospital Falls per 1000 Bed Days Resulting in Moderate or Above Harm:
Additional support is offered to areas who care for patients that are at risk of recurrent falls
Awareness of falls and deconditioning of patients will be a focus for the month of September as part of International Falls Week.

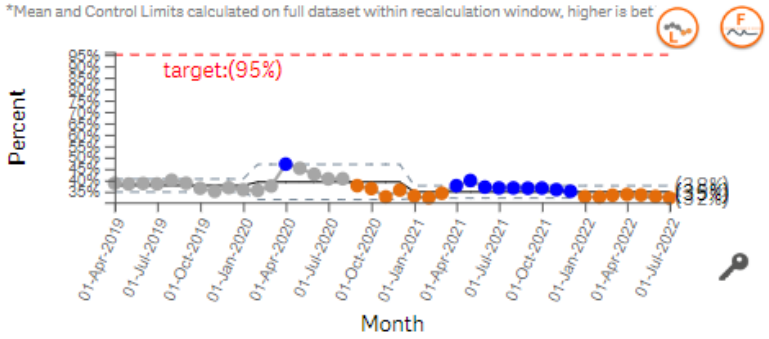
Assurance:

Inpatient Category 2, 3 & 4 Pressure Ulcers per 1000 Bed Days: The Pressure Ulcer Improvement forum is continuing to pick up actions from the Harm free care panel and drive improvements through the QI programme. National benchmarking is currently not available for pressure ulcers; but contacts have been sought to understand UHMB position against other Trusts. Wound Imaging is being used widely now, which is supporting validation and provides evidence for review and consistent monitoring.

Hospital Falls per 1000 Bed Days Resulting in Moderate or Above Harm:
The process of daily review and validation is now embedded with monitoring through the weekly harm free care group.
Identification of individual patients who recurrently fall has enabled the falls team to provide additional support and guidance to the ward staff by using a multidisciplinary approach.

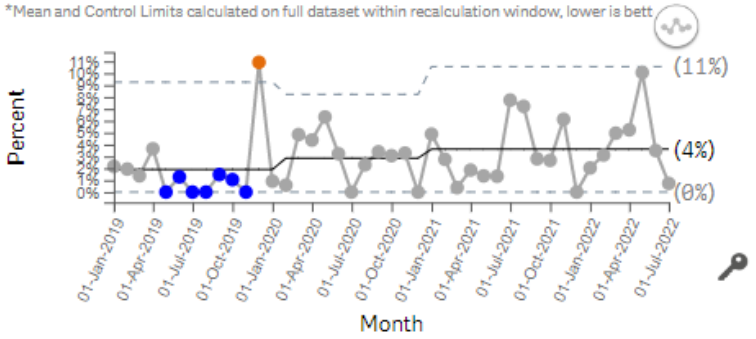
Patient Safety

Overall Percent of Inpatients Receiving a VTE Assessment



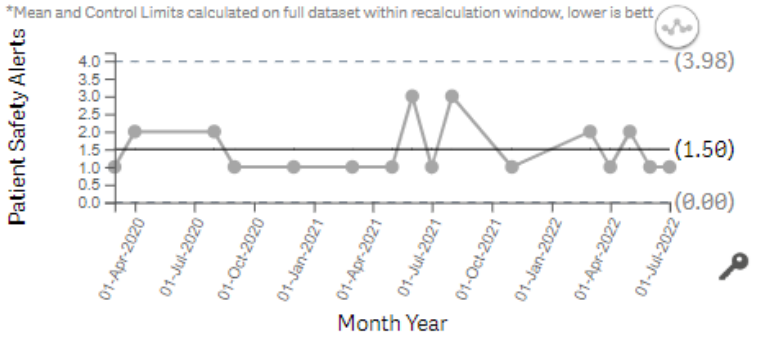
Latest
32%
Variance Type
Special cause variation - cause for concern (indicator where low is a concern)
Target
95%
Target Achievement
The system is expected to consistently fail the target

Overall Percent VTEs that are Hospital Acquired



Latest
1%
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Patient Safety Alerts by Date Received



Latest
1
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Summary:

Patient Safety Alerts: 1 National Patient Safety Alert was received in July22, which was an update to a previously received alert relating to the contamination of hygiene products with Pseudomonas aeruginosa. The Trust had a 1 week deadline to undertake an additional sweep of the organisation and withdraw any affected products. This was completed within the identified timeframe meaning the Trust complied with the Alert.
The Trust currently has no ongoing and overdue National Patient Safety Alerts.
VTE: Work has continued to identify the cohort of day care patients to be included in the data. Those DCU patients who carry very low VTE risk, as they're fully mobile will be excluded. Areas outside the Trust along with maternity wards have been excluded, maternity is not within NICE guidance. This revised process has been approved by the CMO and has improved compliance to around 85%. Future IPR's will reflect the correct data. An exception report has been submitted for the exclusion of the patients who are receiving local anaesthetic as the risk is extremely low.

Actions:

VTE Assessment and Hospital Acquired VTE
The ACN is working with the VTE Prophylaxis Lead doctor in further analysing data, to plan targeted actions to address improvements.

Hospital Acquired VTE
Training ongoing with FY Doctors. Working with BI to establish methodology for diagnosis of HAT within 90 days of discharge. As an internal audit mechanism, and a pathway for learning.

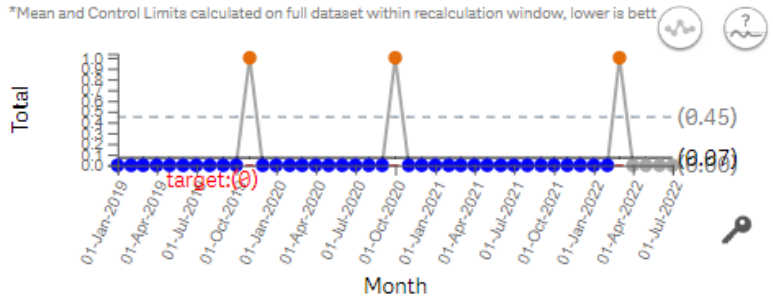
Assurance:

Patient Safety Alerts: The Trust has no ongoing and overdue National Patient Safety Alerts which suggests a robust process is in place.

VTE: An action plan has been agreed on the last VTE Prophylaxis meeting. An ongoing recruitment for VTE champions from nursing side is ongoing
A request for approval for the new metrics will be sought from Deputy CMO on our next meeting

Infection Prevention

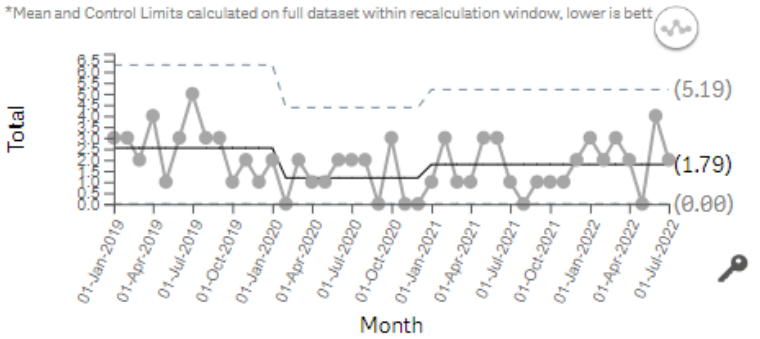
Total Number of MRSA Hospital Cases



Latest
0
Variance Type
Common cause variation
Target
0
Target Achievement
The system may achieve or fail the target subject to random variation

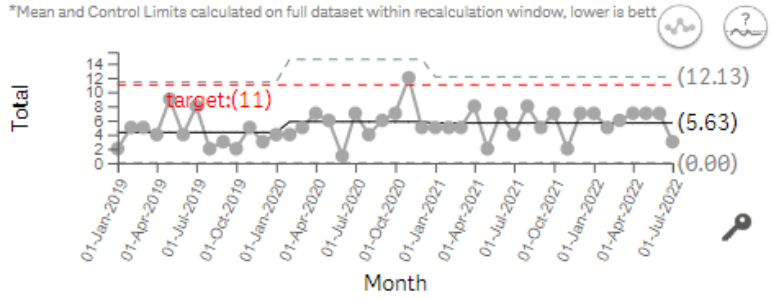
Target is nationally provided annual threshold (0)

Total Number of MSSA Hospital Cases



Latest
2
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

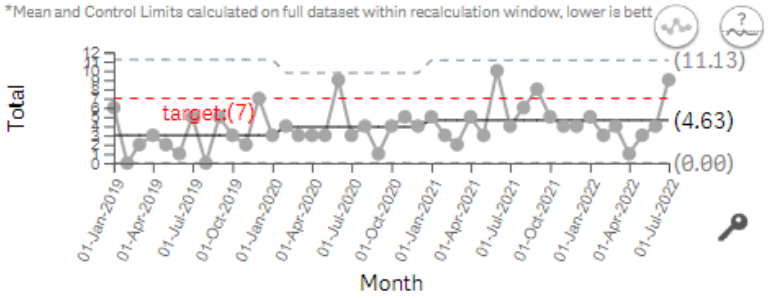
Total Number of GNBI's



Latest
3
Variance Type
Common cause variation
Target
11
Target Achievement
The system may achieve or fail the target subject to random variation

Target is nationally provided annual threshold (133) split across 12 months

Total Number of C.Diff Infections



Latest
9
Variance Type
Common cause variation
Target
7
Target Achievement
The system may achieve or fail the target subject to random variation

Target is nationally provided annual threshold (84) split across 12 months

Summary:
July had the highest monthly CDI rate this financial year; this has spike has been seen consistently in June/July for 3 years in a row.

This spike is well understood in Gram negative blood stream infections, due to hydration levels and associated UTIs through the summer, but not CDIs, which have been associated with the increase in antibiotic use through the winter.

An MSSA Q1 deep dive report has been completed and shared.

Actions:
CDI meetings will revert to being ward based to increase engagement.

Medical engagement is being picked up through CD meetings.

The Anti-Microbial Pharmacist team is becoming established with consistent anti-microbial reviews now taking place on FGH site.

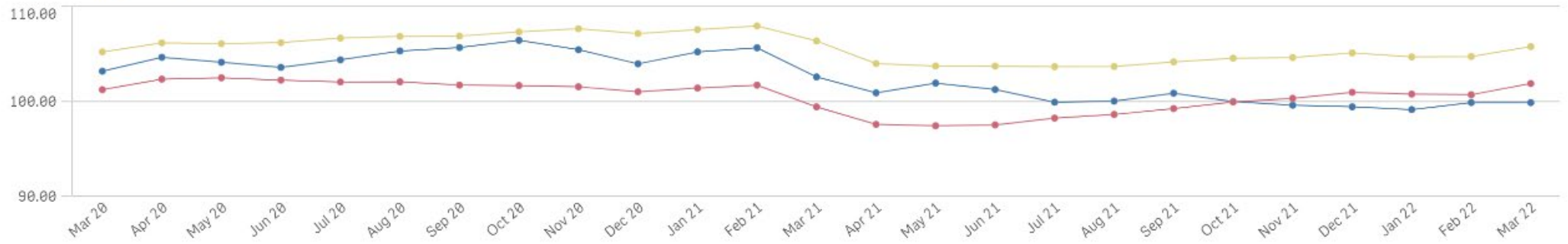
Themes of the MSSA Q1 deep dive are being shared with associated actions.

Assurance:
Engagement of CDI work is being escalated through all channels; included as an action from the NHSIE report.

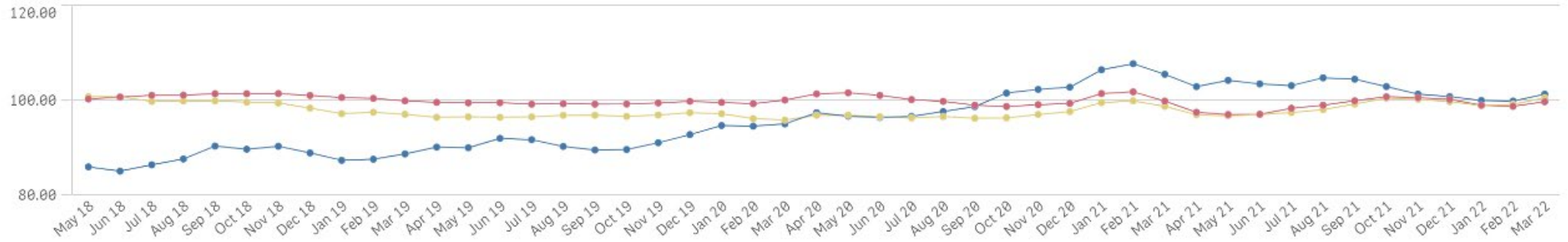
A Q1 deep dive of GNBSIs is being completed and will be shared with care groups and IPCC.

Mortality

SHMI - Rolling 12 Month Figures - latest data: March 2022



HSMR - Rolling 12 Month Figures - latest data: March 2022



Summary:
The rolling 12-Month SHMI score is 99.92 with 1680 observed deaths against 1681.31 expected.

The latest SHMI score for Fractured NoF is 169.01 with associated CI's of (129.80, 218.00) respectively. We continue to generate a red alert in SHMI for this diagnostic group.

Our rolling 12-month position for HSMR is 101.19, with lower and upper CI's of (95.18, 107.48).

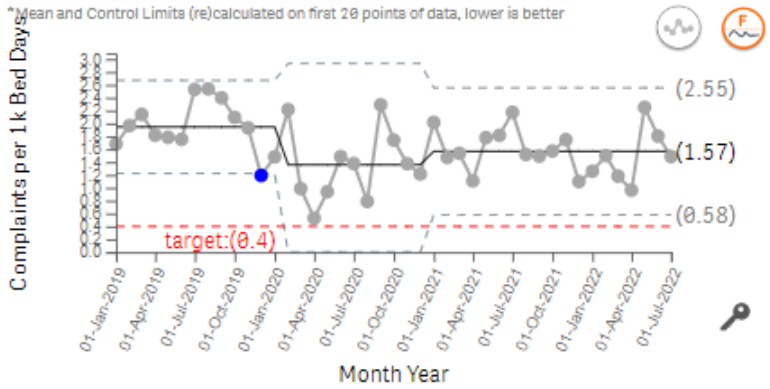
The latest HSMR score for FNoF is 165.91 with associated CI's of (121.89, 220.63).

Actions:
The Fractured Neck of Femur Steering group led by the ADOP and CSM for T&O are to provide an update to QAC in August with progress in our performance of FNoF.

Assurance:
The Fractured Neck of Femur Steering group and Mortality steering group will work together to ensure positive progress in the above 4 areas

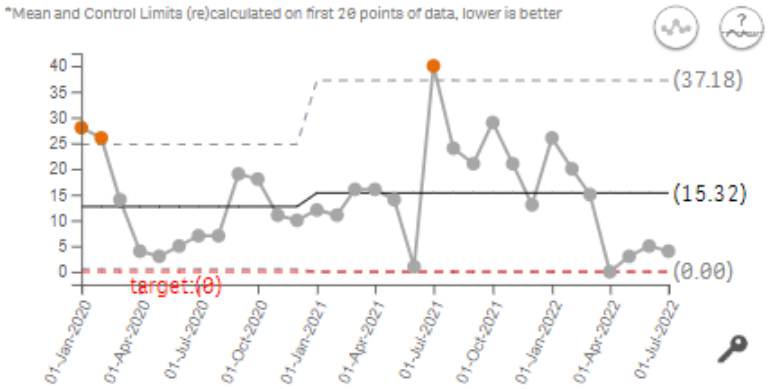
Patient Relations

Complaints per 1000 Bed Days



Latest
1.49
Variance Type
Common cause variation
Target
0.4
Target Achievement
The system is expected to consistently fail the target

Mixed Sex Accommodation Breaches



Latest
4
Variance Type
Common cause variation
Target
0
Target Achievement
The system may achieve or fail the target subject to random variation

Summary:

Complaints: 2 cases over 6 months. Case 1, meeting arranged for 31.8.2022.

Case 2 was drafted; however further information needed to be sought and is currently with care group to review.

MSB: After validation by the DCN 4 validated MSA breaches were reported. These were associated with delayed transfers from ICU.

Actions:

Complaints: Funding secured for WTE 1 band 5 member of staff for 4 months to assist with reduction in overall numbers

Top tips currently being drafted to support the team with providing the drafting response based on learning

MSB: Transfers out from ICU are prioritised at the Clinical Site Meeting.

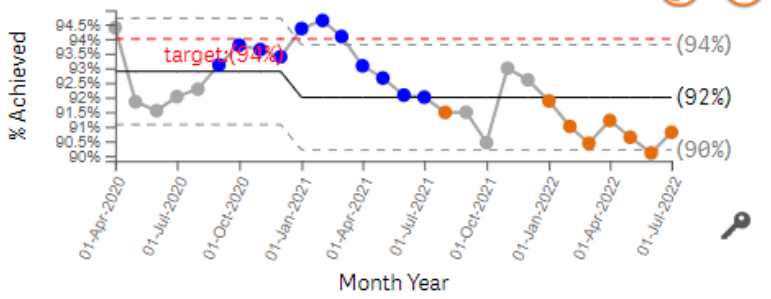
Assurance:

Complaints: Currently reviewing process with an emphasis on a patient centred approach

Friends & Family

Trust Overall (inc ED,OP & IP) - % Rating the Service as Good or Very Good

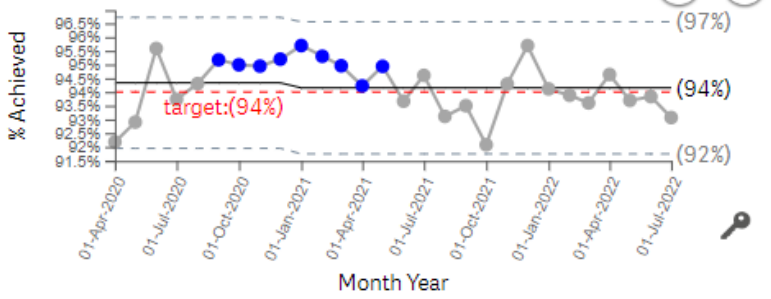
*Mean and Control Limits calculated on full dataset within recalculation window, higher is bet



Latest
90.8%
Variance Type
Special cause variation - cause for concern (indicator where low is a concern)
Target
94%
Target Achievement
The system is expected to consistently fail the target

Outpatients - % Rating the Service as Good or Very Good

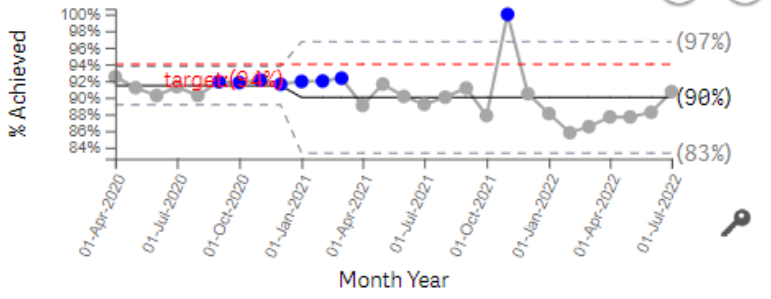
*Mean and Control Limits calculated on full dataset within recalculation window, higher is bet



Latest
93.1%
Variance Type
Common cause variation
Target
94%
Target Achievement
The system may achieve or fail the target subject to random variation

Inpatients - % Rating the Service as Good or Very Good

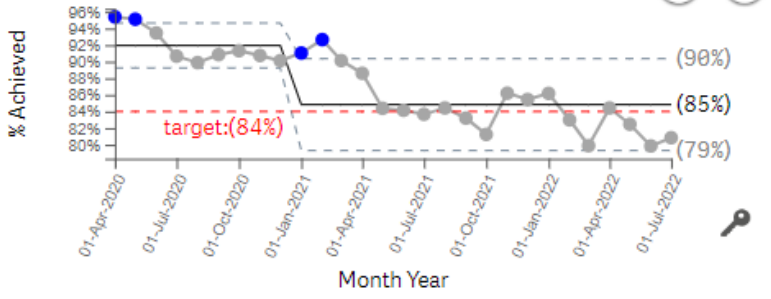
*Mean and Control Limits calculated on full dataset within recalculation window, higher is bet



Latest
90.7%
Variance Type
Common cause variation
Target
94%
Target Achievement
The system may achieve or fail the target subject to random variation

A&E - % Rating the Service as Good or Very Good

*Mean and Control Limits calculated on full dataset within recalculation window, higher is bet



Latest
80.8%
Variance Type
Common cause variation
Target
84%
Target Achievement
The system may achieve or fail the target subject to random variation

Summary:
FFT scores remain below agreed targets across all areas.

Care groups are focussing on understanding the feedback down to wards and dept. Improvements will be monitored through the care group performance meetings.

Care groups are encouraged to report different sources of patient feedback in addition to the FFT data.

Actions:
Following feedback from wards ad depts, the FFT external provider will deliver on site system training. This will help address several care groups' comments regarding the sampling methods and rationale.

The patient experience team are working with community and maternity colleagues to test QR codes and app-based collection methods, humanising data collection and empowering NHS staff to seek patient feedback directly.

The quality committee will receive a full patient satisfaction paper in Sept 2022 highlighting UHMBT benchmarks against four similar neighbouring trusts.

Assurance:
We increased the patient sample by 222 for July 2022, a total of 6565.

All patient comments are read and checked by the experience team to ensure the patient has correctly understood the scoring system (1 very good 5 very poor)

Patient relation colleagues are working with ED colleagues on a weekly basis to review the patients' compliments, comments, concerns, and complaints

Ward level patient experience developments are reported through the Patient Experience Group 22/08/2022 for monitoring.)

People

Metric Scorecards by CQC Domain

Well Led

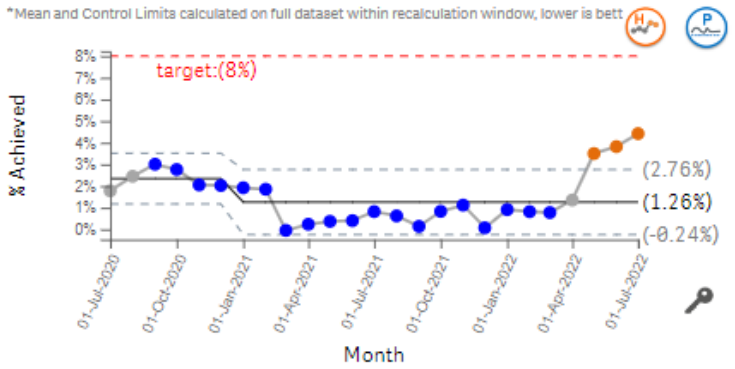
Outcome Measure	Target	Actual	Variation	Assurance
As of Month - Vacancy %	8.0%	4.4%	H	P
Turnover %	8.5%	0.8%		P
Average time to Hire (advert close to booked start date)	55	50.6		?
Bank & Agency Fill Rate	75%	68.0%		?
As of Month - Absence %	5.0%	7.2%		?
Registered Nurse Fill Rate	85.0%	92.6%		P
Appraisals	95%	76%	L	F

Safe

Outcome Measure	Target	Actual	Variation	Assurance
Core Skills Framework	95%	91%	L	?

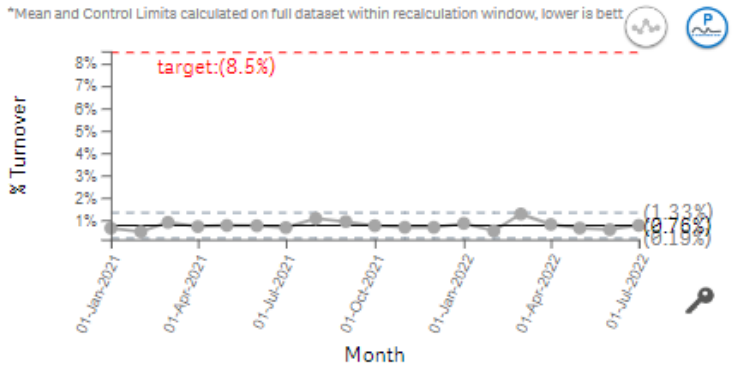
Workforce

Vacancy Rate %



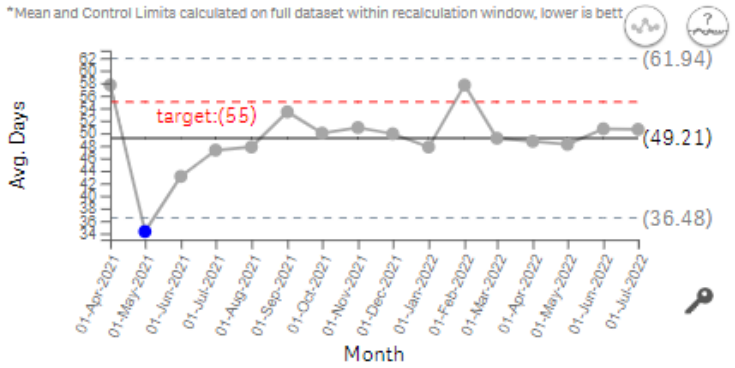
Latest
4.4%
Variance Type
Special cause variation - cause for concern (indicator where high is a concern)
Target
8%
Target Achievement
The system is expected to consistently pass the target

Turnover %



Latest
0.8%
Variance Type
Common cause variation
Target
8.5%
Target Achievement
The system is expected to consistently pass the target

Average time to hire (advert close to booked start date)



Latest
50.6
Variance Type
Common cause variation
Target
55
Target Achievement
The system may achieve or fail the target subject to random variation

Summary:

Vacancy: The overall vacancy rate continues to rise, although it remains under the Trust target. This is largely driven by Consultant vacancies (15.9%) and Midwifery vacancies (20.2%). A contributing factor to the increasing Midwifery vacancy is due to an increased establishment in response to recommendations.

Turnover: Turnover is being monitored in response to a slight increase. Rising turnover is largely driven by retirement which fits with the workforce profile. Whilst retirement remains the highest reason for leaving, it should be noted that there is a positive uptake of colleagues who retire and return after drawing their pension.

Time to Hire: This has remained elevated through June and July, and whilst lower than the target, its higher than pre-COVID levels.

Actions:

Vacancy: Recruitment plans are in place and are regularly reviewed to measure success, re-adjusting where necessary. Recovery of this metric is likely to be slow due the pressures experienced within Midwifery which is driven by national shortages and an increased establishment.

Turnover: Exit data to be analysed to further understand the reasons for leaving. Anecdotal evidence suggests that colleagues are making work life balance changes following the pandemic, including retirement.

Time to Hire: A recruitment mapping exercise has been undertaken in relation to medical and dental recruitment with the same approach to be applied to all other recruitment to identify improvements in the process with one of the expected outcomes being efficiencies in the process.

Assurance:

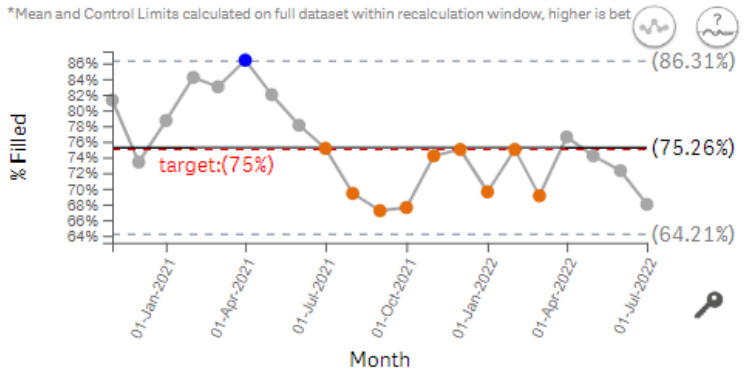
Vacancy: Consultant recruitment is proving successful, with appointments in several specialities which will contribute to the overall vacancy rate.

Turnover: Workforce plans are in development to ensure succession plans are in place and alternative models are considered where appropriate.

Time to Hire: Review of recruitment process to clarify roles and responsibilities which is anticipated to improve how effective the process is which may positively impact the time to hire.

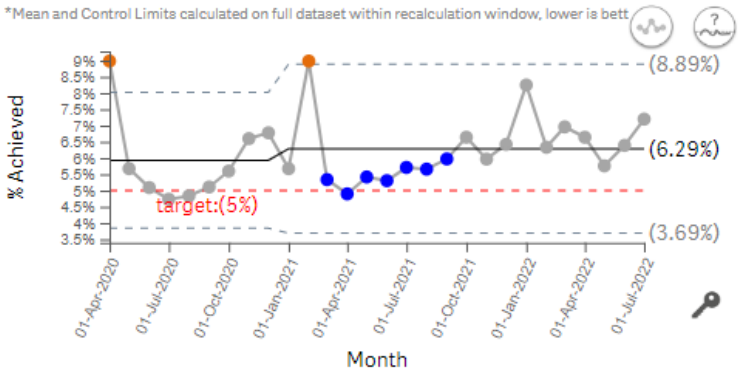
Workforce

Bank & Agency Fill Rate



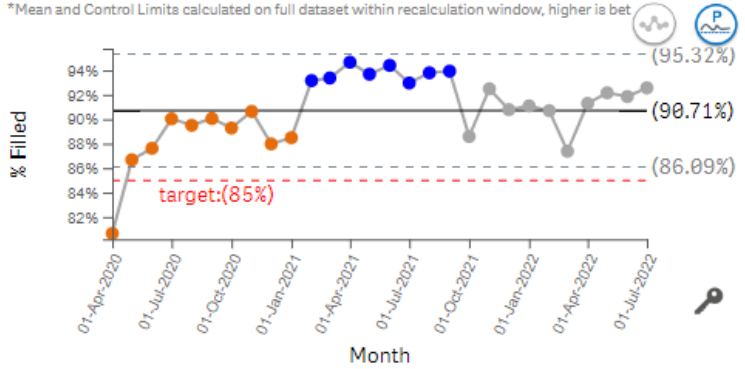
Latest
68.0%
Variance Type
Common cause variation
Target
75%
Target Achievement
The system may achieve or fail the target subject to random variation

Absence FTE %



Latest
7.2%
Variance Type
Common cause variation
Target
5%
Target Achievement
The system may achieve or fail the target subject to random variation

Registered Nurses Fill Rate



Latest
92.6%
Variance Type
Common cause variation
Target
85%
Target Achievement
The system is expected to consistently pass the target

Summary:

Bank & Agency Fill Rate: Fill rates continue to fall. The Trust continues to maintain rates within the ICS rate card and UHMB is the lowest in the area. Whilst this has a positive impact on agency spend, discretionary spend is high.

Nurse Fill Rate: The RN fill rate remains consistently above the 85% target at a trust level. However, individual ward level data indicates some departments below the 85% target. This data is used in the bi-annual staffing reviews and will influence the professional judgements of ward level staffing needs and will eventually sit in the wider quality dashboard view alongside nurse sensitive indicators to give a complete context to staffing, quality and safety.

Absence: Sickness Absence remains high and is largely driven by non-COVID absence with COVID showing continuing signs of improving. Overall absence is 75% attributed to non-COVID and 25% COVID related.

Actions:

Bank & Agency Fill Rate: Successful recruitment will mitigate the impact of low fill rates along with reducing levels of absence.

Nurse Fill Rate: A fill rate dashboard has been created with "manual" data feeds which allows review of ward level data over time to identify trends and themes of both RN and CSW rates. The data is used in the bi-annual staffing reviews and will influence the professional judgements of ward level staffing needs. This data will sit in the wider quality dashboard alongside nurse sensitive indicators to allow triangulation between staffing levels, quality and safety.

Absence: Demand for psychological support continues to grow with a total number of 291 consultations carried out in July 22. Management referrals received continues to be stable at around 45 per week with an increase in self-referrals.

Assurance:

Bank & Agency Fill Rate: UHMB are participating in a system approach to reducing bank and agency which is currently in the early stages.

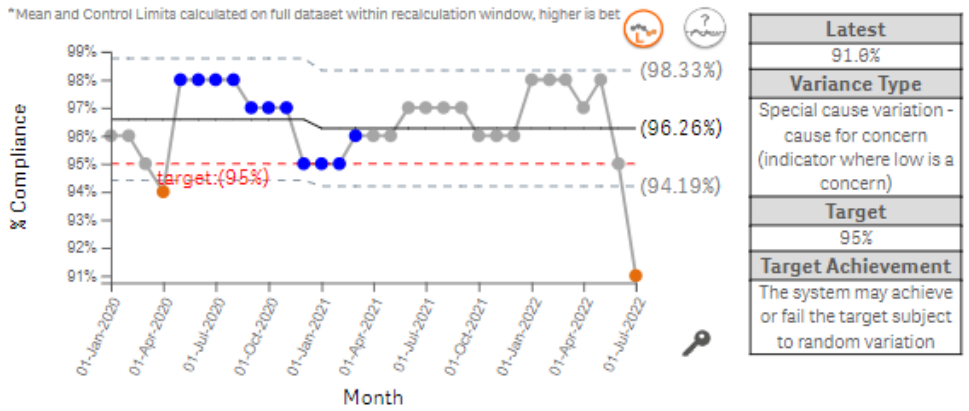
Nurse Fill Rate: i3 aim to deliver version 1 of the ward dashboard at the end of Sept.

Absence: EASE service has been successfully rolled out and the first 4 weeks completed, seeing 71 colleagues referred into the service, 25 mental health (MH) and 46 musculoskeletal (MSK).

Workforce

Core Skills Framework

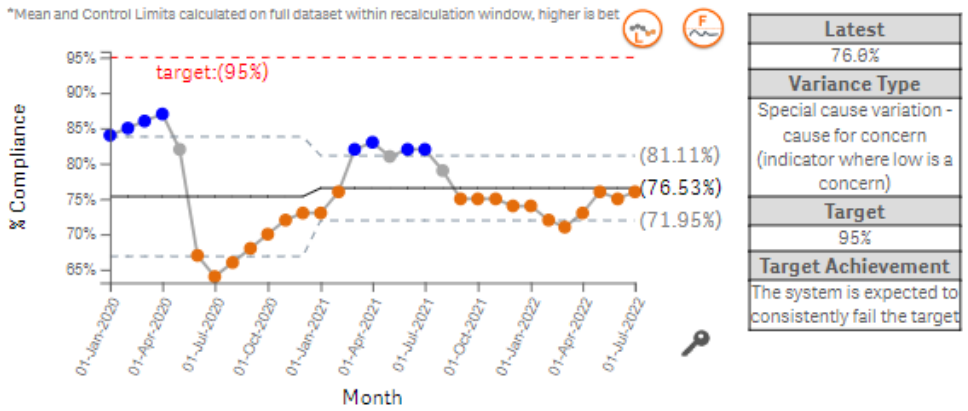
% of staff fully Compliant as start of month



Latest
91.6%
Variance Type
Special cause variation - cause for concern (indicator where low is a concern)
Target
95%
Target Achievement
The system may achieve or fail the target subject to random variation

Appraisal Compliance

% of staff compliant as start of month



Latest
76.6%
Variance Type
Special cause variation - cause for concern (indicator where low is a concern)
Target
95%
Target Achievement
The system is expected to consistently fail the target

Summary:

UHMBT CSF: Core skills has dropped to its lowest levels (since April 20) due to the removal of the 12month extension to the Information Governance and Data Security Awareness training.

Appraisal: Compliance with appraisals has been lower than planned due to COVID both nationally and at UHMB. At UHMB, the priority for recovery has been on the completion of Leadership appraisals which were to be completed by 31 July and signed off by 31st August 2022. This will ensure the timely cascade of objectives and priorities for the coming year.

Actions:

UHMBT CSF: Going forward Core Skills compliance reporting will focus on any areas where CQC have highlighted gaps and include interim targets for improvement toward the 95% mark. This will include training such as safeguarding level three and paediatric life support.

Appraisal: A recovery target of 80% by October 2022 for all other appraisals has been recommended. If this is achieved, this would be increased to 90% by the end of March 2023.

Assurance:

UHMBT CSF: A paper setting out 'Achieving Excellence' was presented to the People Committee in July 2022. This paper provided an update and clarity on the metric. It also notes that the Trust generally experiences positive levels of compliance in the region of 97%.

Appraisal: A paper setting out 'Achieving Excellence' was presented to the People Committee in July 2022. This paper provided an update and clarity on the metric. It also notes that the Trust generally experiences positive levels of compliance in the region of 97%.

Finance

Finance: Income & Expenditure

The table below summarises the financial position at Month 4, a deficit of £4.9m against a planned deficit of £3.8m, £1.1m worse than plan.

The plan includes a £34.1m categorised as ICS stretch income as part of the system wide requirement to breakeven. This income is to be generated through system wide savings initiatives and other slippage and collaborative solutions. At month 4, 66% has been identified. Included in the position is £2.5m income against the stretch plan of £3.8m.

Care groups have a year to date trading overspend of £5.4m of which £2.2m is unachieved CIP.

		Year To Date		
Table 1 - Income & expenditure	**Annual Plan £'000**	**Plan £'000**	**Actual £'000**	**Variance to Plan £'000**
Income from Patient Activities	491,586	164,262	162,824	(1,438)
Other Income	28,108	10,186	9,318	(867)
Subtotal income	**519,695**	**174,448**	**172,142**	**(2,306)**
Pay	(355,972)	(121,997)	(122,633)	(636)
Non Pay	(153,720)	(52,955)	(51,323)	1,632
Subtotal Expenditure	**(509,692)**	**(174,953)**	**(173,957)**	**996**
Operating Total	**10,002**	**(505)**	**(1,814)**	**(1,310)**
Finance Costs	(10,002)	(3,334)	(3,145)	189
Surplus / (deficit)	**0**	**(3,839)**	**(4,959)**	**(1,120)**

Finance: Income & Expenditure Risks

ERF income has been included in line with plan, with confirmation from National team of zero clawback of ERF funding for months 1-4, regardless of system performance.

Activity levels remain low and whilst income to date is not at risk, Care Groups must deliver against their remedial action plan at a service level to ensure activity levels increase to attain future ERF income.

The pay award is expected to be paid from September. The Trust is awaiting clarification of funding value. The estimated pressure to the Trust is between £0.7m and £2.05m.

A significant increase in electricity contract is expected to arise in October when a contract expires. This is estimated to be £1.5m above current levels, thereby requiring most of the additional inflation funding of £2.292m

The stretch income gap at month 4 is £11.4m and remains a high risk to the Trust delivering its financial obligations. The Trust continues to work with system partners to identify mitigations to deliver against this shortfall.

Finance:- Sustainable Financial Improvement Programme

The financial target for the ICS and Trust requires that the Trust achieves savings of 5%, £23.029m in 2022/23.

Care Group savings of £7.3m have been identified to date, see table below. with further opportunities of £9m being verified with meetings with Care group leadership and the SFIP team continuing to support further identification and delivery of savings.

Centrally identified savings of £9.8m are being validated resulting in a total £17.1m. This leaves a shortfall of £5.9m and we are developing the financial road map to target all viable options including non-recurrent areas to deliver the 22/23 target

The impact of NMC2R is impacting Care Group achievement of CIP, especially the Medicine Care Group. This pressure is outside of Care Group control and recognition of CIP will be made at Month 5, with funding being vired from Reserves to cover the costs of beds not able to be closed

CIP Forecast					
CG	Annual Plan £'000	Fcast Recurrent CYE £'000	Fcast Non Rec £'000	Total In Year £'000	in year Gap £'000
CCS	(2,476)	(1,041)	(295)	(1,336)	(1,140)
Community	(1,460)	(283)	(92)	(375)	(1,085)
E&F	(2,338)	(347)	(273)	(621)	(1,717)
Medicine	(6,769)	(1,352)	(899)	(2,251)	(4,518)
WACs	(2,977)	(596)	0	(596)	(2,381)
S&CC	(3,877)	(1,195)	(531)	(1,726)	(2,151)
Corp	(2,976)	(371)	(20)	(391)	(2,585)
Trust Central Turnaround	(156)	(6,447)	(3,355)	(9,802)	9,646
Total	(23,029)	(11,633)	(5,466)	(17,099)	(5,930)

Finance: Capital & Cash

UHMB has a capital programme of £31.3m for 2022/23 following a reduction of £1.3m in allocation for New Hospitals programme and a reduction of £0.5m relating to elective recovery. Spend to Month 4 is £2.4m behind the planned £6.1m.

Cash holdings remain significant with £42.2m at the end of July. The cash position remains favourable with high accrual levels from year end alongside changes to creditor and debtor balances.

The Trust receives its contract income on the 1st of the month, resulting in a high cash balance. This has a benefit to the revenue position in reducing the dividend payable, however the remaining Stretch income gap and the capital programme will mean risk management of the cash position as part of the overall financial risk monitoring

Operational Performance

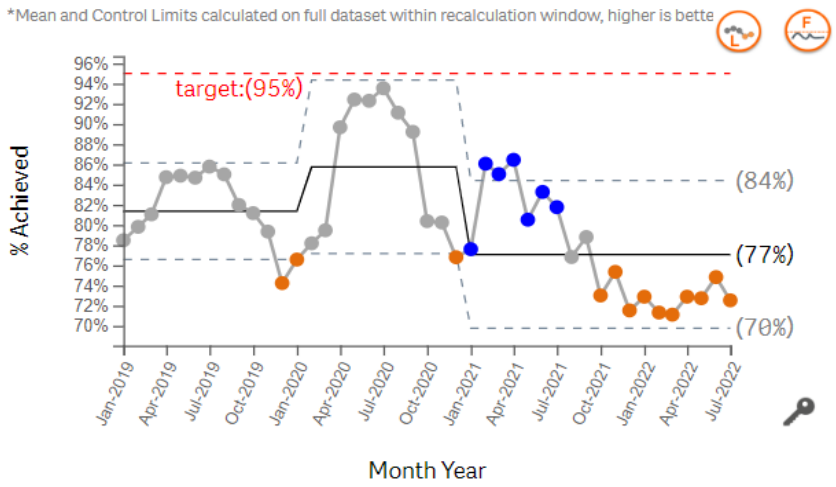
NHS
University Hospitals of Morecambe Bay
NHS Foundation Trust

Metrics Scorecard

Outcome Measure	Target	Actual	Period	Variation	Assurance
ED 4 Hours (%)	95%	72.5%	Jul-22	L	F
% of ED Attends >12 hrs	2%	4.9%	Jul-22	H	?
Ambulance Handovers within 15 mins (%)	65%	31.6%	Jul-22		F
Ambulance Handovers within 30 mins (%)	95%	63.2%	Jul-22		F
Ambulance Handovers within 60 mins (%)	100%	73.9%	Jul-22		F
Ambulance Handovers over 60 mins (no.)	0	161	Jul-22	H	?
Cancer 2WW (%)	93%	90.3%	Jul-22		?
Cancer 28 Day FDS (%)	75%	82.2%	Jul-22		?
Cancer 31 Day (%)	96%	96.9%	Jul-22		?
Cancer 31 Day Subsequent Drug (%)	98%	99.1%	Jul-22		?
Cancer 31 day Subsequent Surgery (%)	94%	83.3%	Jul-22		?
Number of Patients on Cancer PTL over 62 Days (no.)	71	74	Jul-22	L	?
Cancer 62 Day (%)	69%	58.9%	Jul-22		?
Cancer 62 Day Screening (%)	90%	50.0%	Jul-22		?
Cancer 62 Day Upgrade (%)	85%	83.5%	Jul-22		?
Cancer Treatments Beyond 62 Days (no.)	N/A	39.0	Jul-22		N/A
Cancer Treatments Beyond 104 Days (no.)	N/A	10.5	Jul-22		N/A
Diagnostic Waits > 6 weeks	1%	9.9%	Jul-22	H	?
RTT Total Waiting List Size	26623	29114	Jul-22	H	?
RTT <18 Weeks (%)	92%	70.6%	Jul-22	H	F
RTT 52 Weeks (no.)	965	931	Jul-22	L	?
RTT 78 Weeks (no.)	0	121	Jul-22		F
RTT 104 Weeks (no.)	0	1	Jul-22		?
OP DNA Rate (%)	N/A	7.7%	Jul-22		F
Follow-Ups Past IRD	27000	36183	Jul-22	H	F
2 Hour Urgent Community Response	70%	92.6%	Jul-22	H	P

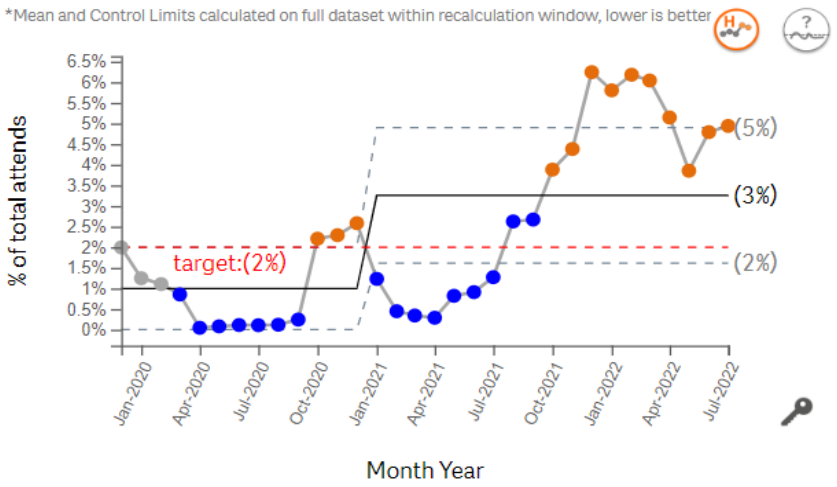
Urgent Care Performance

ED 4hr Performance



Latest
72.5%
Variance Type
Special cause variation - cause for concern (indicator where low is a concern)
Target
95%
Target Achievement
The system is expected to consistently fail the target

Percentage of ED attendances over 12 hours



Latest
4.9%
Variance Type
Special cause variation - cause for concern (indicator where high is a concern)
Target
2%
Target Achievement
The system may achieve or fail the target subject to random variation

Summary

Urgent care 4-hour performance has deteriorated since before the Covid 19 pandemic, with mean performance of 81% before the pandemic, 86% to December 2020 and 77% since January 2021. Since January 2021, variation between the upper and lower process limits has increased, with 10 points of special cause concern between October 2021 and July 2022. The standard will continue to fail.
% of attendances waiting >12 hours. Performance has significantly declined from before the pandemic, with a shift of mean from 1% to 3% since January 2021. The assurance icon is misleading in showing a hit or miss position due to the run of special cause improvement between January to October 2021. The lower control limit is very close to the target and when it moves slightly, to above the target the icon will display a consistent fail going forwards.

Both charts show a run of 10 points of special cause variation- concern in the most recent months.

Actions

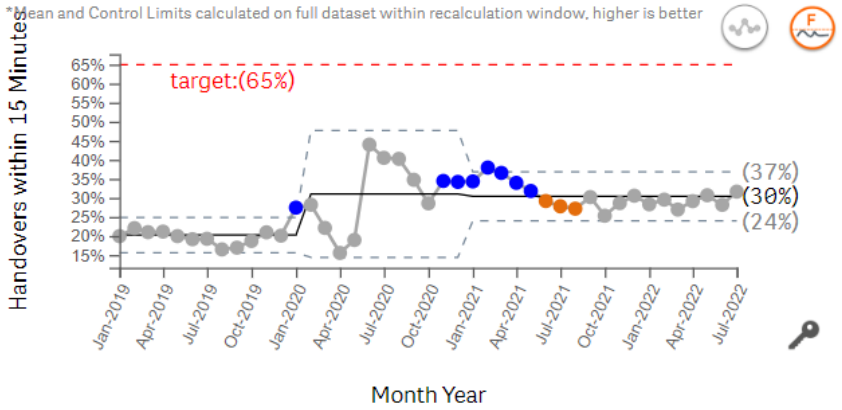
The 2022/23 B&HCP UEC (Urgent & Emergency Care) improvement plan was approved by the Board last month. The plan includes priority areas that build on the 21/22 plan, risks from NMC2R (not meeting criteria to reside), corridor care and asks from the 22/23 national planning guidance - specifically virtual wards and colocation of UTC (Urgent Treatment Centre) capacity.
SDEC – Service operational 5 days per week at RLI and 7 days at FGH with 43% 0-day LoS. Substantive recruitment key focus to further expand weekend provision at RLI.
Frailty and Virtual Wards – 10 Virtual frailty beds in place – current occupancy around 44%. Plus 10 Respiratory beds.
AFU RLI has converted 5 beds to FIT (SDEC) and is turning around 5 patients per day under the pathway.
RLI UTC – design phase completed with aim to open end November 2022; modular unit ordered; workshops/T&F groups in place for staff modelling and clinical pathways with primary care partners.
Reducing NMC2R – not meeting the agreed trajectory (currently at over 150 patients/25% of capacity). Discussions ongoing with ICB and LA partners – current proposals will not meet the target of 12% by Dec 22.
Transfer of care hub discharge support went live on 05/09/22.
Benchmarking exercise identified as a requirement of ED congestion, with 3 further audits in place to facilitate paediatric access and Mental Health access.

Assurance

- Benchmarking - ED 4 Hr (Type 1 performance)- 31st out of 109 national Trusts in July. Although not achieving the 95% standard, UHMB is 1st out of the 4 local Trusts within the ICB and actions within the UEC Improvement Programme are designed to improve on this position.

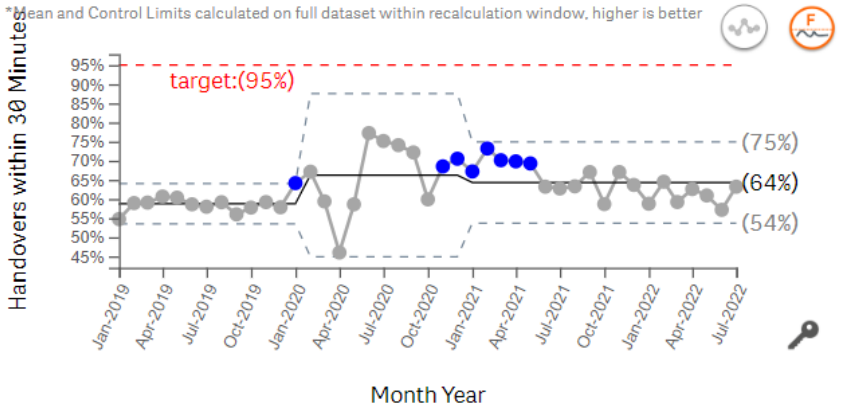
Urgent Care Performance Handover

Percentage of Ambulance Handovers within 15 Minutes



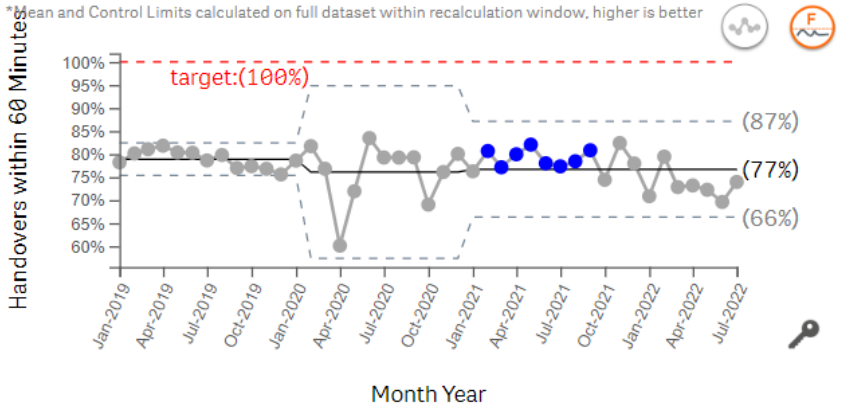
Latest
31.6%
Variance Type
Common cause variation
Target
65%
Target Achievement
The system is expected to consistently fail the target

Percentage of Ambulance Handovers within 30 Minutes



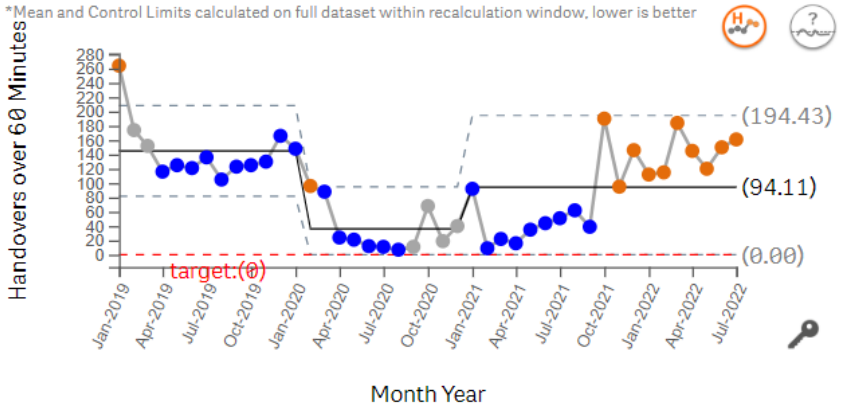
Latest
63.2%
Variance Type
Common cause variation
Target
95%
Target Achievement
The system is expected to consistently fail the target

Percentage of Ambulance Handovers within 60 Minutes



Latest
73.9%
Variance Type
Common cause variation
Target
100%
Target Achievement
The system is expected to consistently fail the target

Number of Ambulance Handovers over 60 Minutes

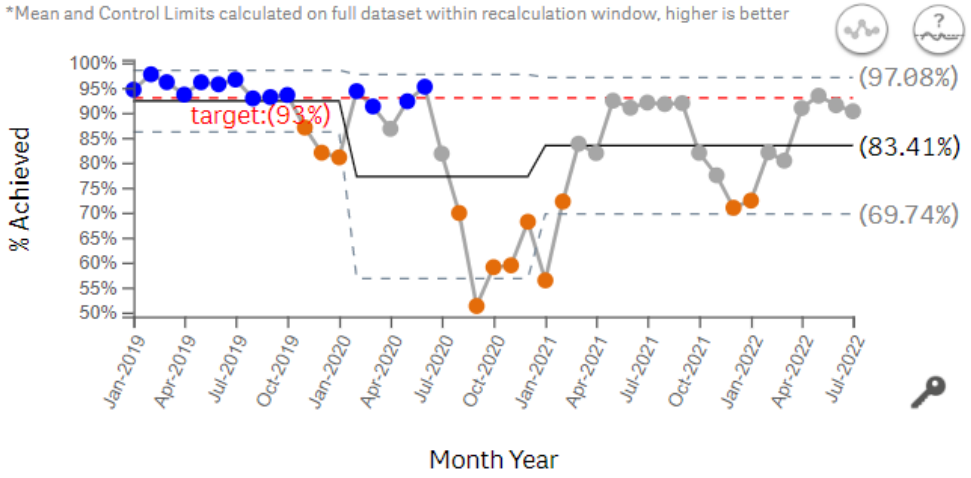


Latest
161
Variance Type
Special cause variation - cause for concern (indicator where high is a concern)
Target
0
Target Achievement
The system may achieve or fail the target subject to random variation

Summary	Actions	Assurance
% of Ambulance Handovers. **Within 15 mins**- the mean has improved from 20% before the pandemic, to 30% since January 2021. Variation has decreased however performance is significantly below the 65% target and the target will consistently fail without a step change. **Within 30 mins-** a slightly improved mean when compared to before pandemic but will consistently fail the 95% target. **Within 60 mins**- performance for the longest waiting patients has deteriorated. **Number of Ambulances >60 mins**- the assurance icon will move to a consistent fail, unless the target is achieved in August.	System wide UEC improvement programme in place to improve flow. Specific actions within the joint NWAS Ambulance Handover Collaborative, include; • Fit to sit / Handover criteria safety checklist; decongesting the corridor in ED. • One Ambulance Liaison Officer has been interviewed and offered with a further post back out to advert. • Escalation SOP being developed with teams identifying actions for times of pressure.	Actions completed include; ED corridor escalation SOP Safety Huddles part of daily business. Corridor staffing (1:3 ratio). Dashboard created to capture data/support surveillance.

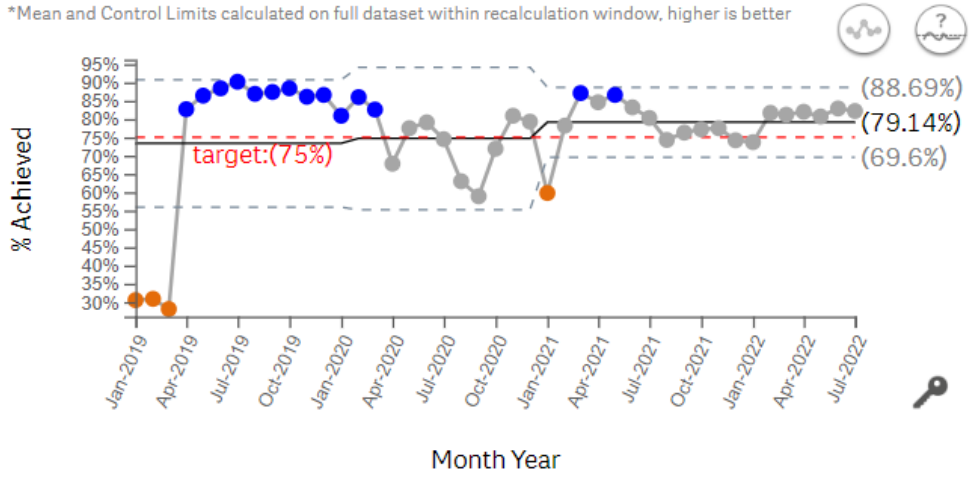
Cancer 2 Week Wait and 28 Day Faster Diagnosis Standard

Cancer 2ww



Latest
90.3%
Variance Type
Common cause variation
Target
93%
Target Achievement
The system may achieve or fail the target subject to random variation

Cancer 28 Day Faster Diagnosis Standard



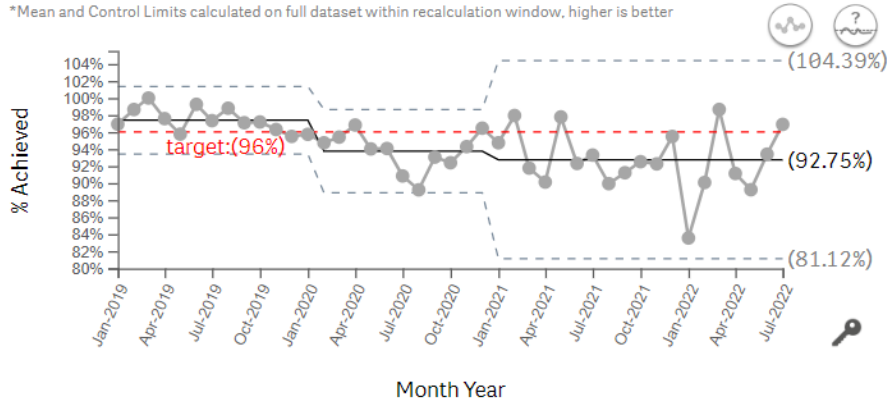
Latest
82.2%
Variance Type
Common cause variation
Target
75%
Target Achievement
The system may achieve or fail the target subject to random variation

Summary - June Performance	Actions	Assurance
• **Cancer 2 Week Wait (C2WW)** Pre-pandemic the target was achieved before a rapid decline. The recovery between May & Sept 2021 was stalled by a combination of factors within the Breast Service including severe medical staffing shortages, an increase in referrals of >100% and breast awareness month. In July performance was 90.3% (93%), not meeting the target. In July 2022, the highest number of breach patients and lowest %'s were in Upper GI (16 patients) and Gynaecology due to medical staff shortages (67 patients). • **Faster Diagnosis Standard (FDS)** –The data point of January 2021 adversely impacts upon the assurance icon. If the standard is achieved in coming months, as predicted, the icon will change to a consistent pass.	Specialty level Remedial Action Plan actions: • Upper GI: the Care Group plans to improve FDS to >75% by 31/01/23 and see 80% of suspected cancer referrals within 7 days by 31/03/23 via recruitment to vacancies, review of job plans and Locums/increased insourcing capacity in the short term. The 7 day business case for Endoscopy to be completed by 30/09/22. • Gynaecology: the Care Group plans to actions to see 85% of cancer referrals within 7 days by 28/02/23 via aligning required capacity over 52 weeks and recruitment. • Colorectal: clinic reconfiguration in line with theatre timetable re-write; provide clinics at all sites every week (minimise patient choice breaches); review of breach patients via the NHSE/I Pathway Analyser tool and appointment of a 3rd Colorectal surgeon at FGH.	• Breast - In July the C2WW standard was achieved at 93.4% (93% standard) with 255 patients accepting an appointment within 14 days and 18 at >14 days. • The FDS standard was achieved for the sixth consecutive month. • FDS- In June (last month with benchmarked performance) UHMB was 1st in L&SC ICB at 82.7%. In June, the number of patients seen in clinic was 41% higher than the same period in June 2019- an additional 631 patients seen.

Cancer 31 Day Performance

Cancer 31 Day First Treatment

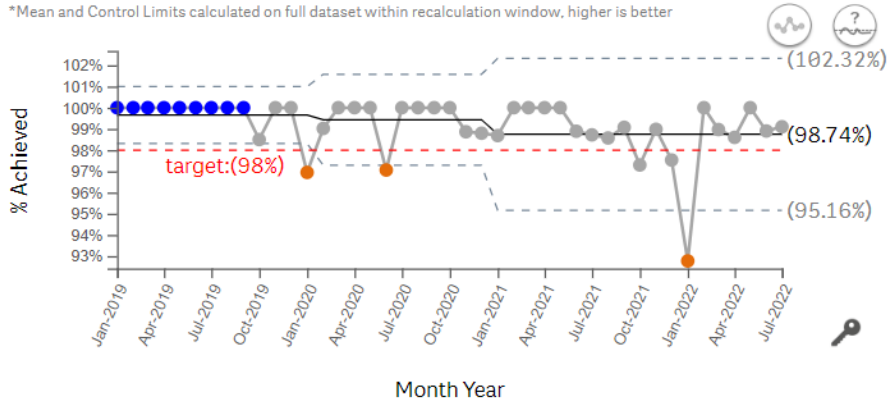
*Mean and Control Limits calculated on full dataset within recalculation window, higher is better



Latest
96.9%
Variance Type
Common cause variation
Target
96%
Target Achievement
The system may achieve or fail the target subject to random variation

Cancer 31 Day Subsequent Drugs

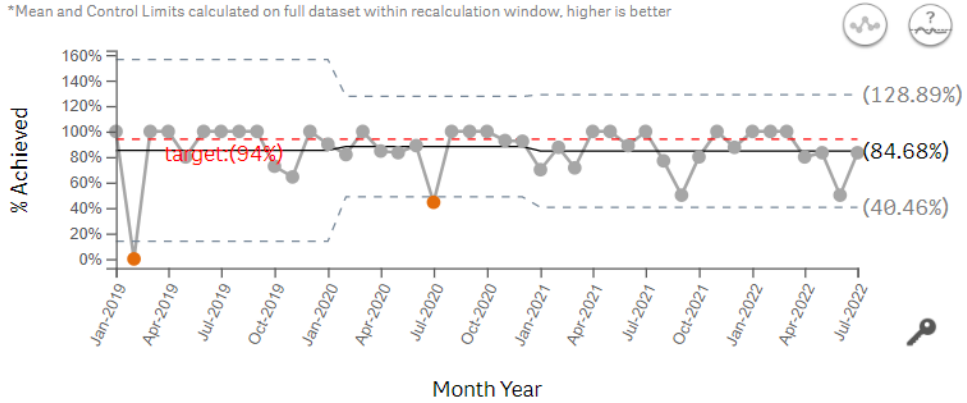
*Mean and Control Limits calculated on full dataset within recalculation window, higher is better



Latest
99.1%
Variance Type
Common cause variation
Target
98%
Target Achievement
The system may achieve or fail the target subject to random variation

Cancer 31 Day Subsequent Surgery

*Mean and Control Limits calculated on full dataset within recalculation window, higher is better



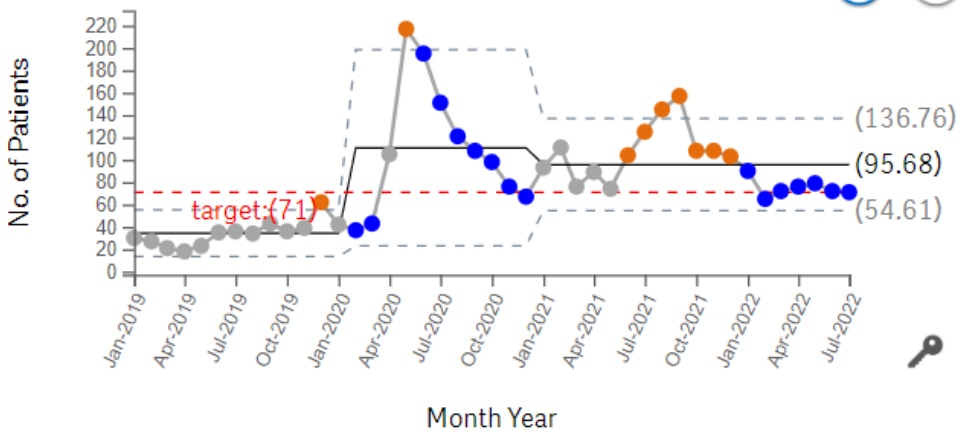
Latest
83.3%
Variance Type
Common cause variation
Target
94%
Target Achievement
The system may achieve or fail the target subject to random variation

Summary	Actions	Assurance
Cancer 31 Day 1st Treatment- variation in performance has increased since before the pandemic with a reduction in mean from 97.5% to 92.8%. The mean is below the target meaning that consistent achievement is highly unlikely, partly due to the small numbers involved (129 total treatments in July). In July 4 breaches occurred (Breast – 2, Head and Neck – 1, Skin - 1). **Cancer 31 Day Subsequent Drugs** standard was achieved in July. The standard may or may not be met due to the very small numbers (109 total treatments in July). **Cancer 31 Day Subsequent Surgery-** due to the very small numbers involved, the standard may or may not be achieved (12 total treatments in July).	**Skin**- 3 out of 4 planned additional biopsy sessions took place in June - 24 additional slots, plus 3 in July. Thursday a.m. clinic to run 52 weeks per year with prospective cover for annual leave. **Breast**- additional theatre capacity sought for July onwards with micro-management of each patient pathway.	• In June, UHMB C31 Day performance was ranked 1 out of 4 in L&SC ICB at 93.4% (England average 91.8%). The actions outlined are designed to achieve the 31- day standards.

Cancer 62 Day Performance

Number of Patients on Cancer PTL Over 62 Days

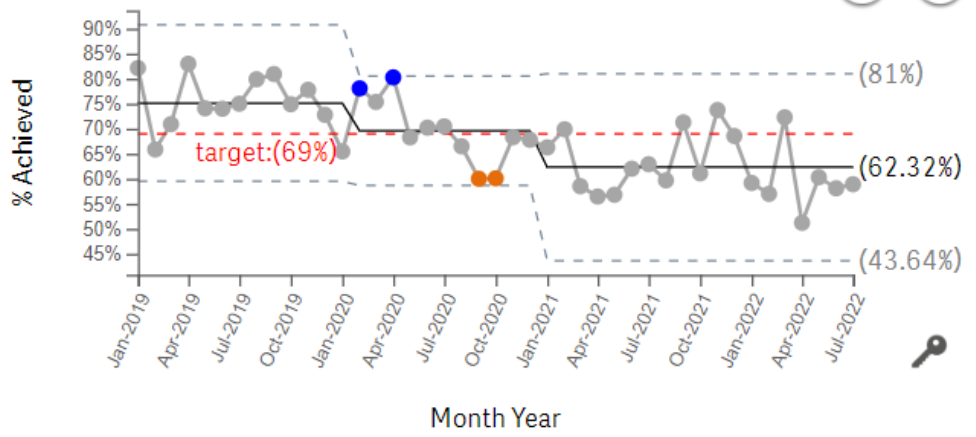
*Mean and Control Limits calculated on full dataset within recalculation window, lower is better



Latest
71
Variance Type
Special cause variation - improvement (indicator where low is good)
Target
71
Target Achievement
The system may achieve or fail the target subject to random variation

Cancer 62 Day

*Mean and Control Limits calculated on full dataset within recalculation window, higher is better



Latest
58.9%
Variance Type
Common cause variation
Target
69%
Target Achievement
The system may achieve or fail the target subject to random variation

Summary

Patients >62 days on the PTL- The trajectory for July of 78 patients waiting was achieved at 71. The most recent position on 30/08/22 shows an achieving position of 68 patients waiting >62 days (trajectory 71 for August). The number of patients is forecast to increase during August due to a seasonal reduction in capacity and patient choice, with recovery commencing in September.

C62 Day performance The mean before the pandemic was 75% (85% target). From Jan 2021 the mean has reduced to 62%, with an ICS target of 69% for March 2023. The confirmed position for July is 58.9%, with Breast, Urology and Colorectal sharing 63% of the breaches.

Top 3 reasons for delay: 1) insufficient outpatient/diagnostic capacity in Urology for cystoscopies and precision point biopsies; 2) Colonoscopy, Colorectal outpatient capacity 3) Breast capacity for first appointments in previous months.

Avoidable delays in EGFR tests continue to delay Colorectal pathways and restrict straight to test within 7 days, with recent NHSI/E analysis showing that 50% of patient pathways examined were delayed due to lack of EGFR testing.

Actions

- The delivery of the cancer 62-day standard is dependent upon the actions taken to deliver the Cancer 7-day, Faster Diagnosis and Cancer 31 Day standards, set out on previous slides.
- The Perfect Prostate pathway based on the definitive national best practice pathway was signed off on 08/09/22 and will be implemented at the RLI on 07/11/22 as part of the new medical rota roll out.

Additionally:

- Monthly thematic reviews are undertaken by tumour group to identify and minimize the cause of any delay along a patient pathway.
- Mutual aid from local Trusts sought, to provide additional breast surgeon capacity.

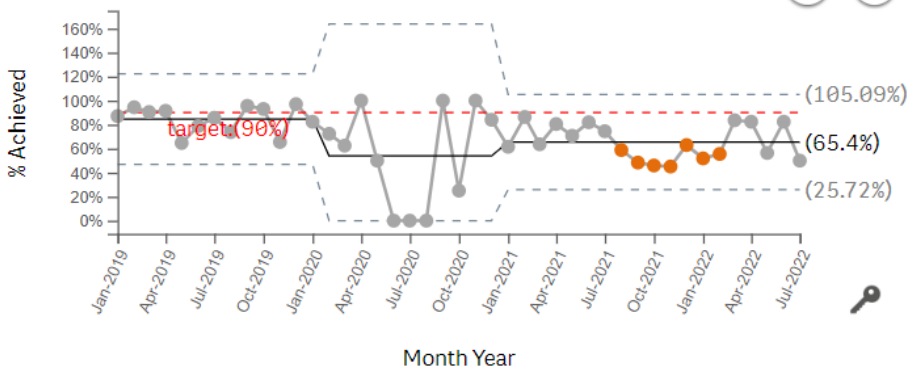
Assurance

- The July 2022 Cancer 62 Day PTL trajectory of 78 was achieved.
- Benchmarking - in June, UHMB's C62 day performance was 81st out of 140 Trusts nationally and 1st out of the local ICB Trusts. The actions within the RAP and overarching across tumour group actions are designed to improve this position.
- On 29/06/22, at 5.2% UHMB had the 3rd lowest % of patients on the PTL waiting > 62 days(out of 22 Trusts).

Cancer 62 Day Performance

Cancer 62 Day Screening

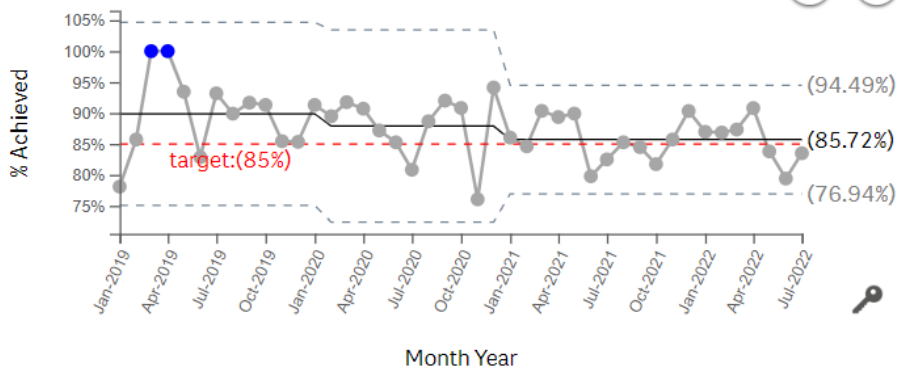
*Mean and Control Limits calculated on full dataset within recalculation window, higher is better



Latest
50.0%
Variance Type
Common cause variation
Target
90%
Target Achievement
The system may achieve or fail the target subject to random variation

Cancer 62 Day Upgrade

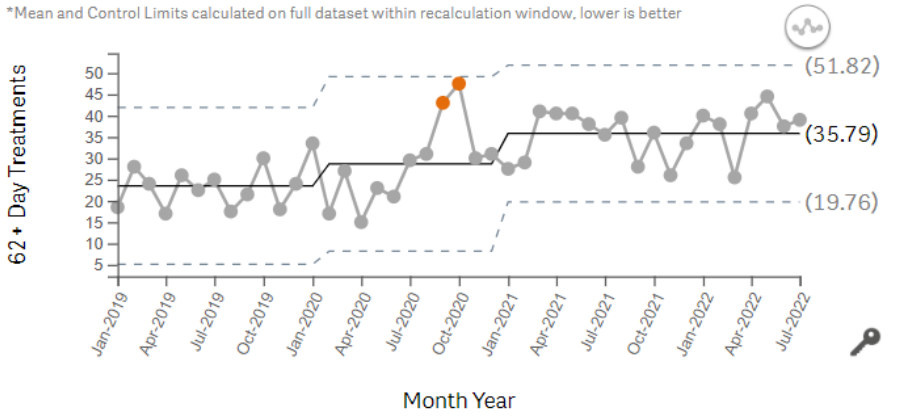
*Mean and Control Limits calculated on full dataset within recalculation window, higher is better



Latest
83.5%
Variance Type
Common cause variation
Target
85%
Target Achievement
The system may achieve or fail the target subject to random variation

Cancer Treatments Beyond 62 Days

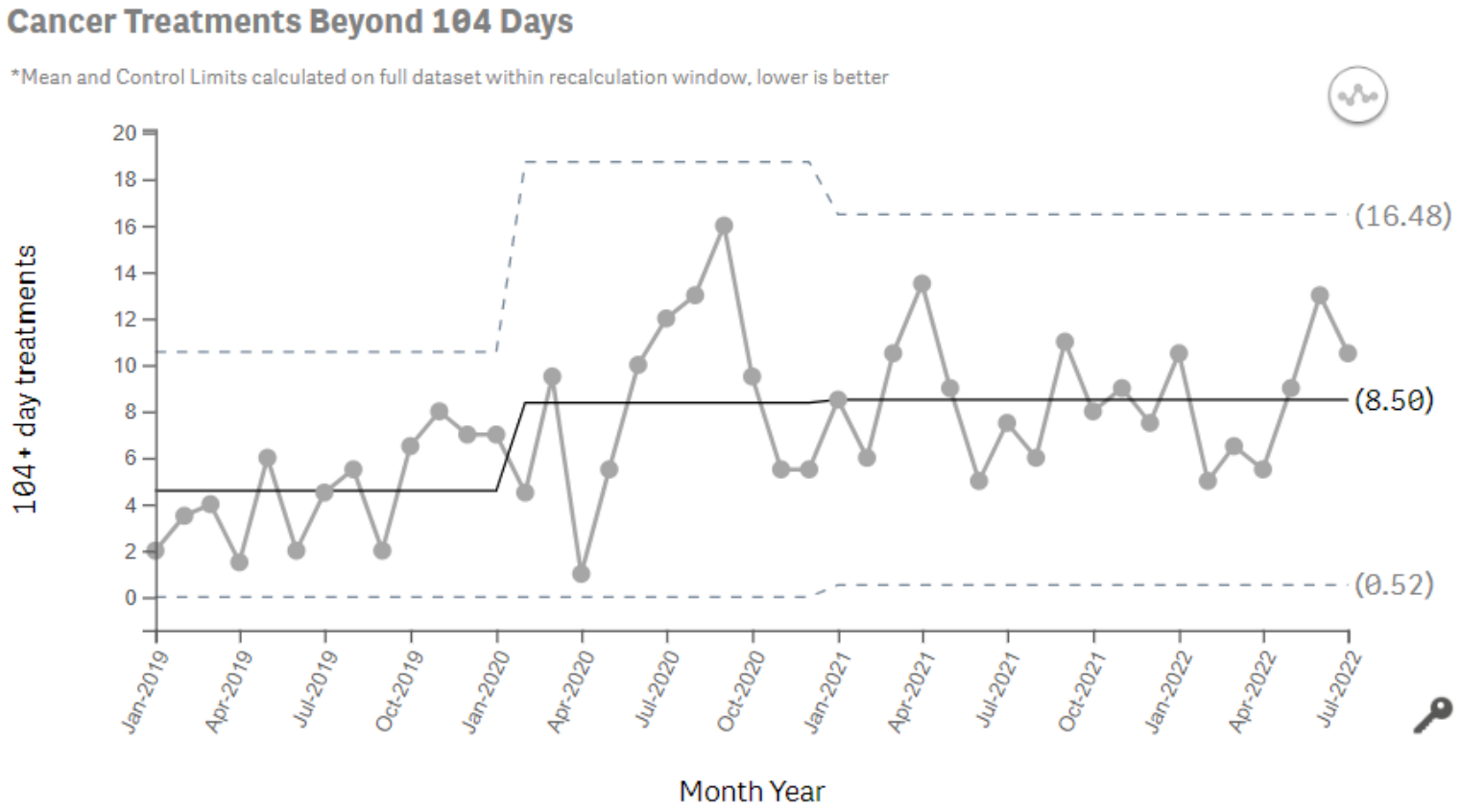
*Mean and Control Limits calculated on full dataset within recalculation window, lower is better



Latest
39
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Summary	Actions	Assurance
Cancer 62 Day Screening. The mean has fallen from 85% pre-pandemic to 65%. The standard is unlikely to be consistently achieved due to the small numbers involved (16 treatments in July). The assurance icon shows a misleading view of sustainability (may or may not achieve) due to the upper process limit position of >100% (which is not possible) from January 2021. In June 7 breast screening and 1 Lower GI patient pathways failed the standard. **Cancer 62 Day Upgrade.** The mean has declined from 90% to 86% since before the pandemic. The standard may or may not be achieved due to the small numbers involved (39.5 treatments in July). **Cancer Treatments >62 days**- performance directly mirrors the cancer 62 day % achievement chart on the previous slide.	• Focus on sufficient theatre capacity to treat within 62 days as part of the tumour level RAP actions. • Detailed pathway management to ensure that care is provided with no avoidable delays. • Breast screening- significant backlog with an improvement trajectory in place. 3 improvement scenarios in the process of agreement with commissioners. • Bowel screening- mapping and agreement of new pathway to be completed by 30/11/22	

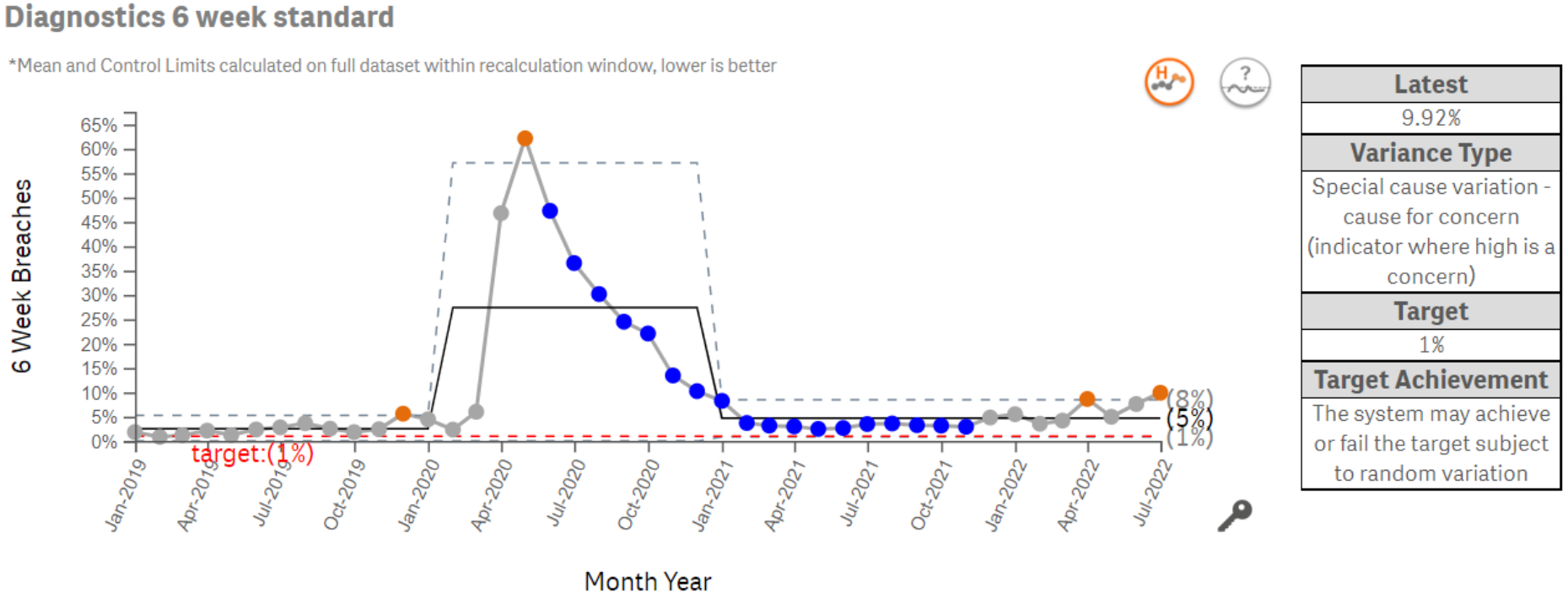
Cancer Treatments Beyond 104 Days



Latest
10.5
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Summary	Actions	Assurance
In June, 10.5 cancer patients were treated >104 days after referral. The chart shows the patients with confirmed cancer with treatment in June, more than 104 days after referral. The tumour groups with the most patients waiting over 104 days for treatment in June were: Urology (3.5 patients), Lung (2 patients), Lower GI (2 patients), Gynaecology (1.5 patients), Head and Neck (0.5 patients) and Haematology (0.5 patients). There is no target for the **treatment** of patients waiting > 104 days, however there should be 0 patients **waiting** >104 days.	• Joint work is ongoing to implement the NW Cancer Long Waits Policy for patients waiting >104 days on a C62 Day pathway and >73 days on a 31 Day pathway. The policy will be implemented by 30/10/22, led by the Lead Cancer Nurse. • Please see C62 Day and FDS actions for further detail.	• RCA's are completed for all 104 day breaches, in line with the Trust's standard operating procedure.

Diagnostic 6 Week Standard

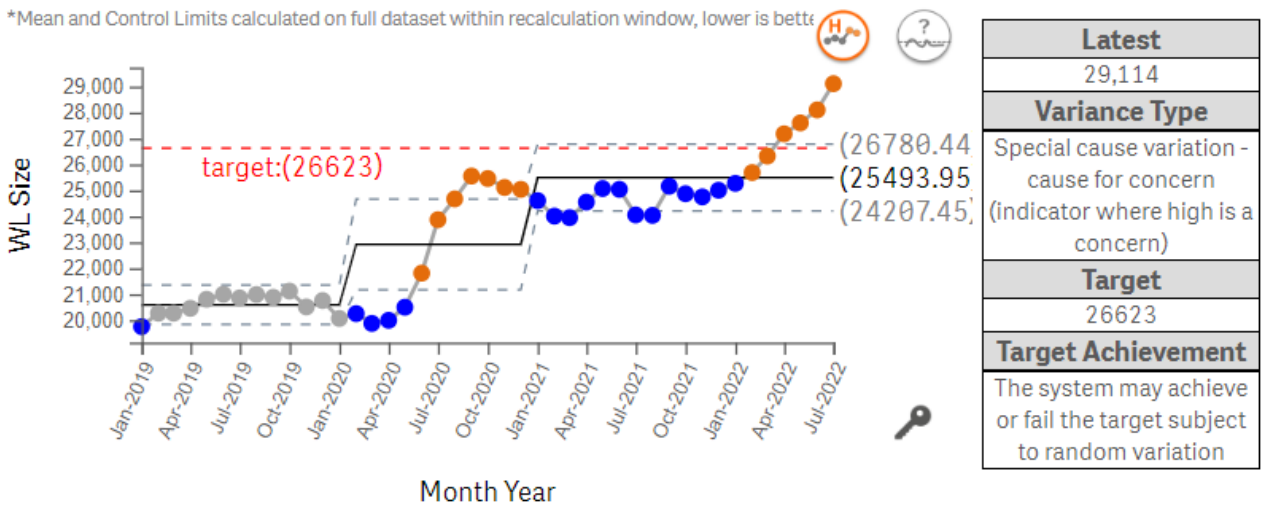


Latest
9.92%
Variance Type
Special cause variation - cause for concern (indicator where high is a concern)
Target
1%
Target Achievement
The system may achieve or fail the target subject to random variation

Summary	Actions	Assurance
Following 18 months of special cause- variation-improvement, the standard is now in special cause concern and unless achieved in August will predict a sustainable fail. The most challenged modalities by number of patients are; Imaging, with 521 breaches (10%), of which 494 of the patients were waiting for Ultrasound and DEXA with 215 breaches (32.3%).	• **DEXA** – At 22/08/22, the DEXA waiting list was 608 patients, against the plan of 375 for 01/09/22. The slippage was due to an increase in demand (1134 patients; expected 900 in Q1) and further sickness (162 lost slots in Q1). Mitigating actions are ongoing AAS sessions plus a locum starting on 15/09/22 with 5 sessions in September and further planned for October, homeworking for reporting to free up on site scanning capacity, FGH support from a Nuclear Medicine Radiographer and a new Radiographer at WGH recruited to provide cover for leave. In August 11 working days were lost due to AL and sickness (10 days and the BH (1day). The longest waiting patient is currently at 9 weeks. • **Ultrasound –** the plan to provide additional tests in May and June, to reach capacity and demand balance in July, has not been achieved due to losing capacity due to staff sickness/unavailability to do AAS (130 slots). Extra locum cover provided 150 and AAS delivered 117 additional slots in June. The waiting list as of 22/08/22 was 1575 against a trajectory of 1134 for 01/09/22. New actions - to continue to provide additional activity by: Medicare Locum started part time 13/06/22 (full time from mid July); Vascular Technologist started in June, freeing up Sonographers and expressions of interest out to train additional FGH staff. This will give an additional 700 slots in July and August, which would improve ultrasound performance to <5% (currently at 12.7%)	Benchmarking - In June (latest available NHSE data) UHMB's diagnostic performance was 131st out of 343 Trusts nationally and 1st out of the local 4 ICS Trusts. Actions within the Remedial Action Plans will further improve the position.

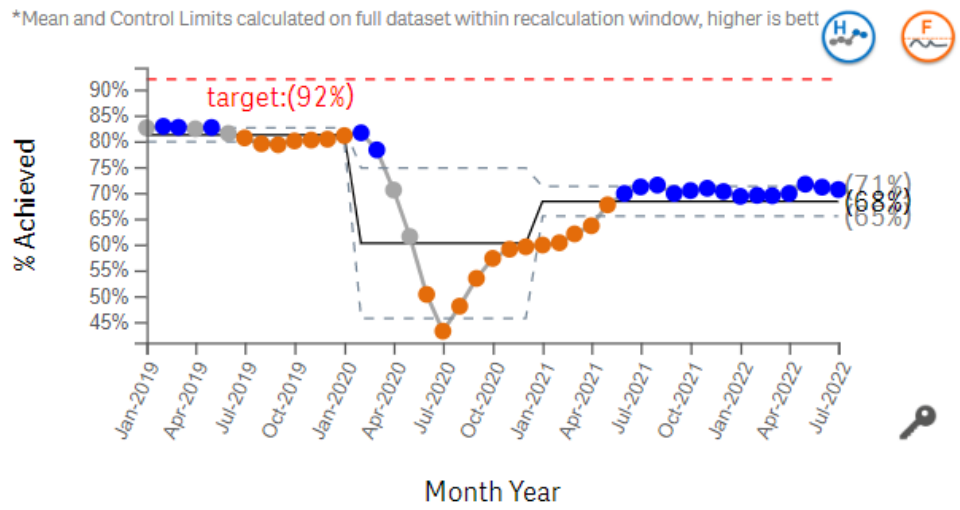
Referral to Treatment Time

RTT Total Waiting List Size



Latest
29,114
Variance Type
Special cause variation - cause for concern (indicator where high is a concern)
Target
26623
Target Achievement
The system may achieve or fail the target subject to random variation

RTT 18 Week Performance

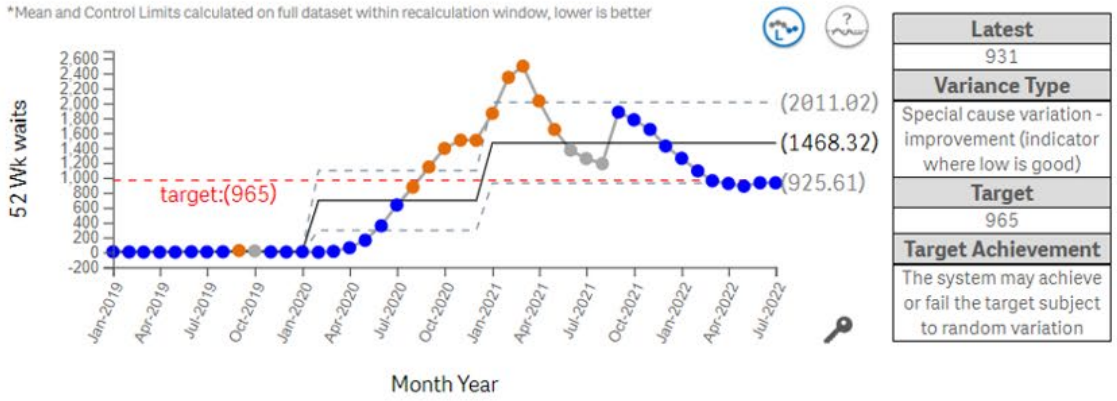


Latest
70.6%
Variance Type
Special cause variation - improvement (indicator where high is good)
Target
92%
Target Achievement
The system is expected to consistently fail the target

Summary	Actions	Assurance
Total waiting list size-Pre covid the mean was 20,500 with minimal variation, post covid the mean is 25,493 with a run of 6 points of special cause concern from February to July 2022. Although too early to display on the chart, the Insource Group clock stop validation (see actions) is forecast to assist in delivering the March 2023 position of 26,623. **RTT**- the mean has reduced from 83% pre pandemic to 68% from January 2022. Performance has been in special cause improvement for 14 months but is predicted to fail due to the distance to the 92% standard. **Risk**- the impact of the BMA rate card on (clinical willingness to) uptake of additional activity sessions. This is likely to have a significant negative impact upon the ability to treat the longest waiting patients and achieve trajectories.	Elective care actions across the board, as listed in the IPR, influence the waiting list size and RTT performance. 1)Implementation of the NHSI/E recommendation to develop specialty level recovery plans based on capacity and demand, including quantifiable improvement actions. 2) Outsourcing (T&O to IS and mutual aid) and insourcing of capacity (Endoscopy, ENT, Dermatology, Gastroenterology and proposal being developed for Colorectal). 3) Focus on outpatient, diagnostic imaging and endoscopy and theatre productivity. 4) Use of new innovation e.g. e-booking, and Chatbot, as discussed in previous reports. Insource Group to provide additional validation resource for a 6 month period from 25/07/22, to review the patients waiting and ensure that clock stops for treatments are not missed. The patients still require treatment but have received a treatment which stops their clock in the past. This is likely to reduce the waiting list size by 300 patients per month and achieve the ICB trajectory by December 2022. On the 31/07/22 the waiting list size was 28,940, by 15/09/22 this had reduced to 28,124. Since 25/07/22, 1585 patient records from a targeted areas on the waiting have been validated, with 1196 records updated with a clock stop in the past.	RTT- in June UHMB had the 55th highest performance out of all 156 Trusts and was 1st out of 3 local trusts (no data for ELHT).

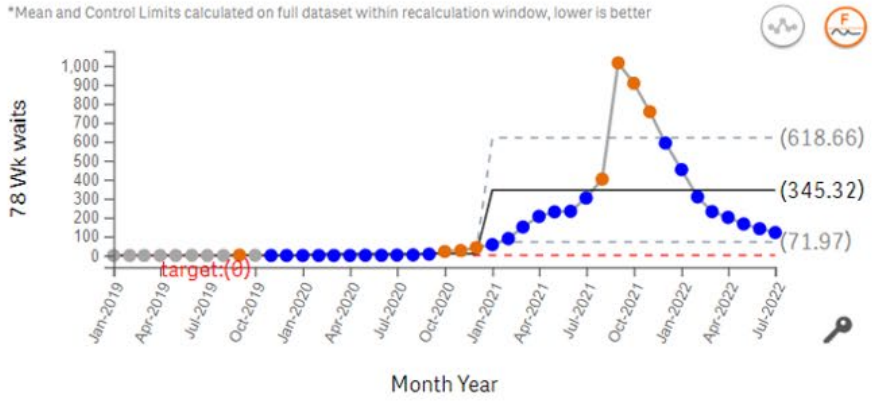
Referral to Treatment Time

RTT 52 Week Waits



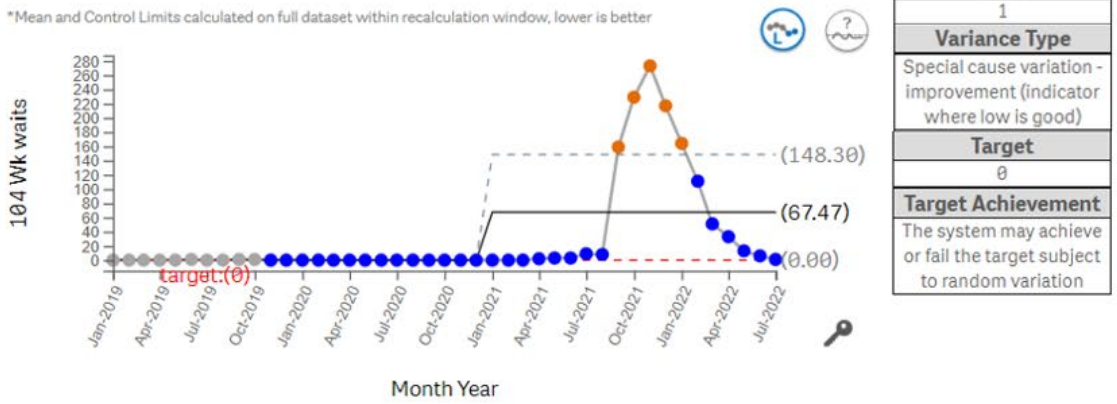
Latest
931
Variance Type
Special cause variation - improvement (indicator where low is good)
Target
965
Target Achievement
The system may achieve or fail the target subject to random variation

RTT 78 Week Waits



Latest
121
Variance Type
Common cause variation
Target
0
Target Achievement
The system is expected to consistently fail the target

RTT 104 Week Waits



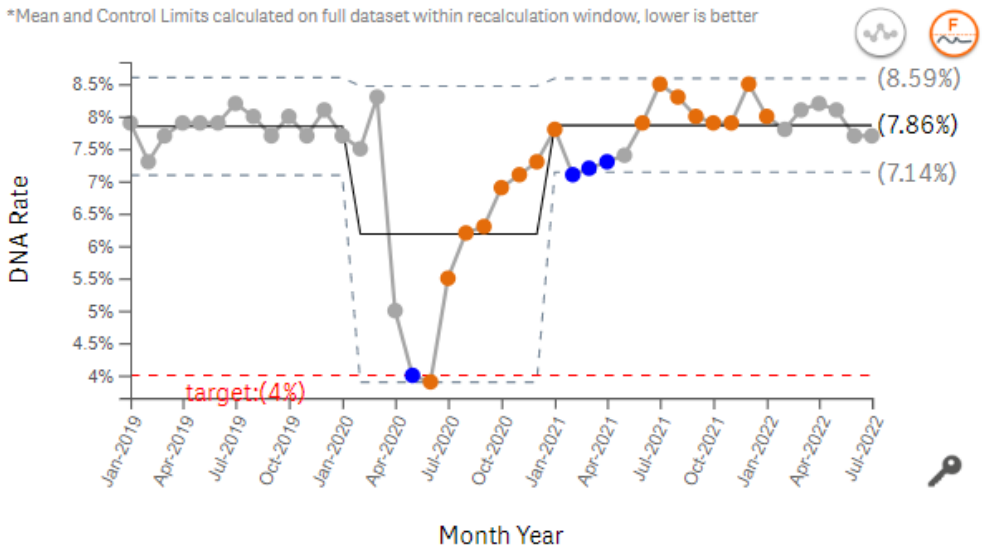
Latest
1
Variance Type
Special cause variation - improvement (indicator where low is good)
Target
0
Target Achievement
The system may achieve or fail the target subject to random variation

Summary	Actions	Assurance
52 Weeks- pre-pandemic the mean was 0 patients, which has increased to 1468 since Jan 2021. The last 11 months have been in special cause improvement. The target may or may not be achieved. August provisional figure of 919. **The 78 week target** mirrors the 52-week position but is predicted to fail as the lower process limit is above the target. August provisional- 89 with a trajectory to achieve 0 by December 2022. **104 week waits-** the standard is predicted to be achieved and sustained. August provisional- 0. Risks- medical staffing gaps and impact of the BMA rate card upon the availability of additional activity sessions.	Actions include • Trust-wide impact of the BMA rate card upon activity to be calculated by 10/09/22. • Mutual aid has been sought for T&O theatre capacity.	In August, UHMB was joint 1st out of the 4 local ICB Trusts for patients waiting over 104 weeks, and first for 1st for 78 and 52 weeks. The actions within the Remedial Action Plans are designed to achieve the trajectories.

Did Not Attend and Follow-Up Patients Past the Indicative Review Date

OP DNA Rate

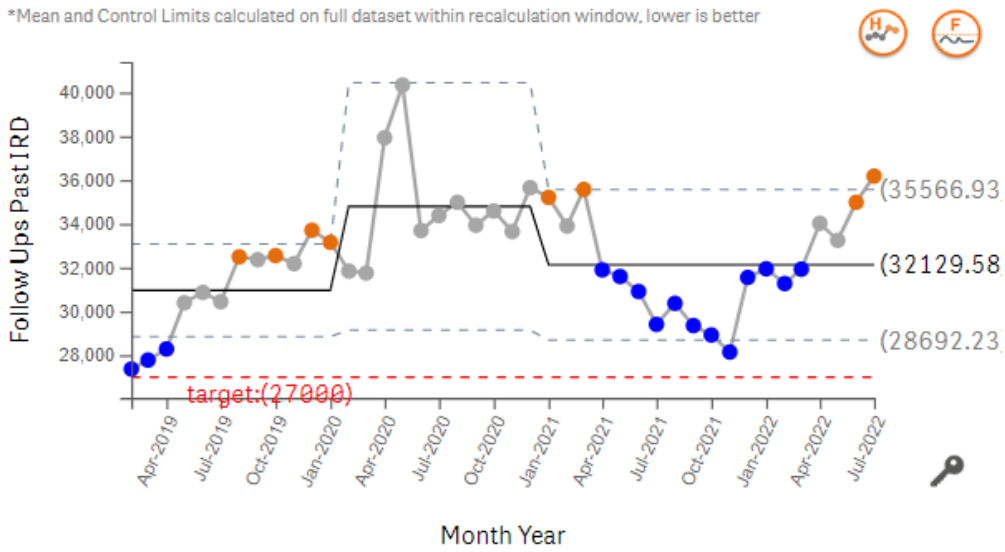
*Mean and Control Limits calculated on full dataset within recalculation window, lower is better



Latest
7.7%
Variance Type
Common cause variation
Target
4%
Target Achievement
The system is expected to consistently fail the target

Follow Ups Past IRD

*Mean and Control Limits calculated on full dataset within recalculation window, lower is better



Latest
36,183
Variance Type
Special cause variation - cause for concern (indicator where high is a concern)
Target
27000
Target Achievement
The system is expected to consistently fail the target

Summary	Actions	Assurance
Outpatient DNA rate: The mean has returned to the pre-pandemic position of 8%, following an artificial improvement during the pandemic due to the reduced number of face-to-face appointments. Performance in July was 7.7% against a best practice target of 4%. **Follow ups past IRD** are in a period of special cause concern, with an increase to 36,183. The mean has increased from 31,000 pre pandemic to 32,129 from January 2021 and the target is unlikely to be achieved	**DNA:** • Plan to roll out fully enabled Electronic Referral System (ERS) booking to 23 specialties. 12 specialties are live with 2 partially complete. This allows patients to choose their appointment dates at a time that suits them. In Q1, 45% of possible E-booked appointments were made by patients. • Use of virtual out-patient appointments to minimise the need for unnecessary patient time and travel. Non-face to face delivery in June was 19.7%, with trajectory of 25% for March 2023.	Follow-up patients that have previously been on a cancer pathway and those that are clinically urgent are prioritised for booking in available capacity.

Operational Performance: SSNAP Stroke Audit – Quarter 1 2022/23

Action-The focus remains on improving the Therapy Domains and ensuring sustainability in improvements through robust monitoring.

Performance- Quarter 1 SSNAP data- FGH has declined from 80 to 77 and remained at level B. The RLI has improved from 57 to 60 and improved from level D to level C in the SSNAP score.

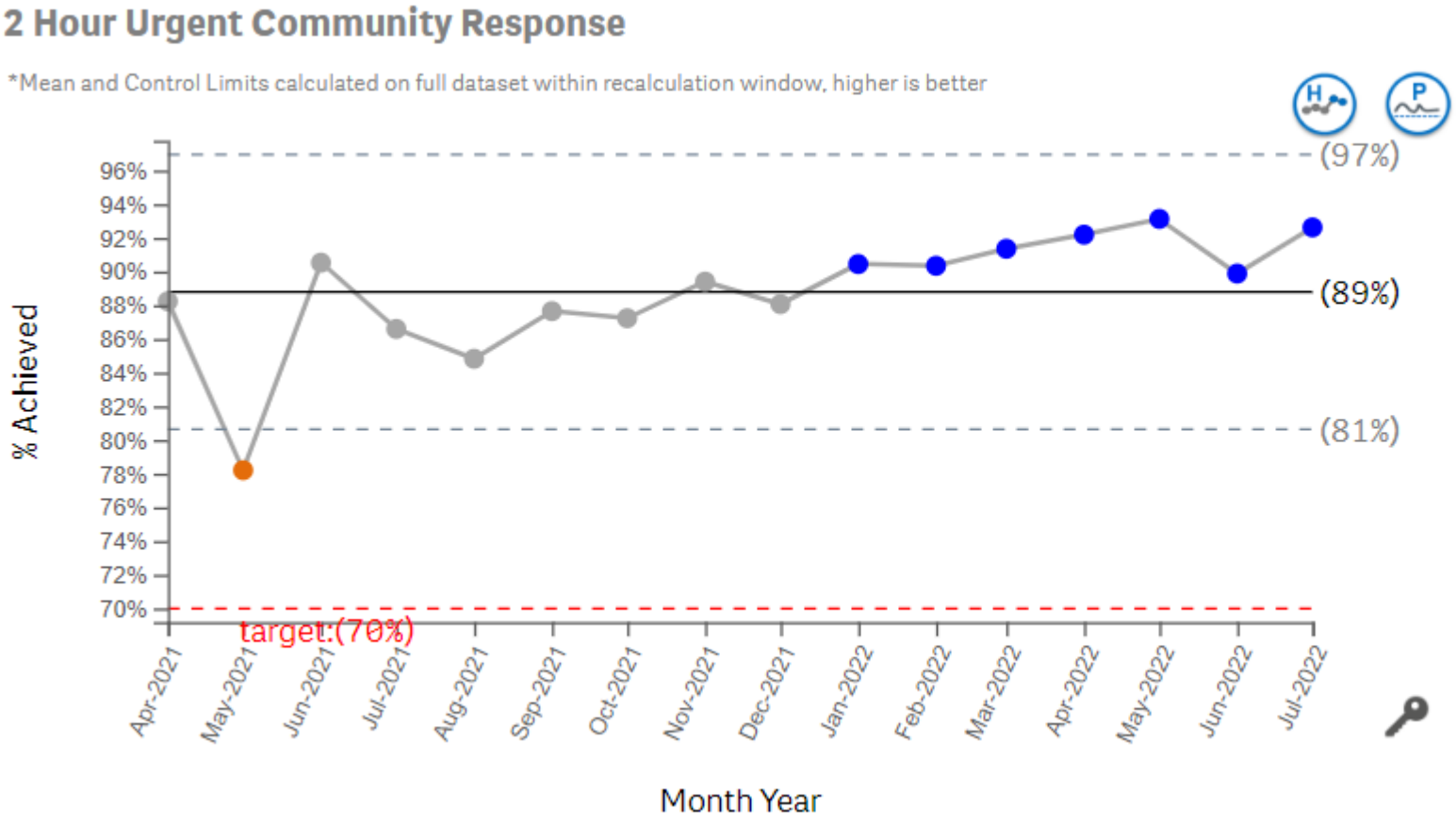
	FGH	Q2	Q3	Q4	Q1	
1	Scanning	A	A	A	A	1) Out of hours scan times remain a focus
2	Stroke Unit	B	B	C	B	2) Breach meetings continue cross bay
3	Thrombolysis	B	C	A	B	3) Improvements shown averaging 20%
4	Specialist Assessments	A	A	A	A	4) Remains good at FGH
5	Occupational Therapy	B	C	B	C	5) Improvements shown
6	Physiotherapy	C	C	B	C	6) Improved but staffing issues
7	Speech and Language Therapy	C	C	B	C	7) Additional staff recruitment in process
8	MDT Working	C	C	B	B	8) Focus for Q3
9	Standards by Discharge	B	C	B	B	9) Small changes required
10	Discharge Processes	B	B	C	A	10) Documentation changes on Lorenzo will improve this

	RLI	Q2	Q3	Q4	Q1	
1	Scanning	A	A	A	A	1) Good overall with continual monitoring
2	Stroke Unit	D	D	D	D	2) Ring fenced beds a key focus
3	Thrombolysis	D	D	E	E	3) Improving trajectory
4	Specialist Assessments	B	B	B	C	4) First line assessments improving weekly
5	Occupational Therapy	D	C	C	C	5) Staffing plans in place
6	Physiotherapy	D	D	D	C	6) Staffing plans in place - recruitment
7	Speech and Language Therapy	E	D	D	E	7) Additional recruitment continues
8	MDT Working	D	D	D	D	8) Improvements made in documentation
9	Standards by Discharge	C	B	C	B	9) improvements in process showing good outcomes
10	Discharge Processes	A	A	A	A	10) Documentation improved

Key to SSNAP Scoring

A = Over 80
B = Between 70 and <=80
C = Between 60 and <70
D = Between 40 and <60
E = Less than 40

2 Hour Urgent Community Response



Latest
92.6%
Variance Type
Special cause variation - improvement (indicator where high is good)
Target
70%
Target Achievement
The system is expected to consistently pass the target

Summary	Actions	Assurance
The target has been sustainably achieved since April 2021. The target is in special cause improvement with a run of 6 points above the mean. All pathways required for the 21/22 core standards have been in place since the end of March 2022.	Continue to attend the ICS-wide 2hUCR Delivery Group to engage in ICS-wide initiatives to develop the 2hUCR in accordance with 22/23 requirements. Use the maturity matrix self-assessment to consolidate Morecambe Bay action plan. Continue to monitor CSDS reports to improve data quality. Work with Care Group analyst to complete performance developments.	Reasons for the breaches of the 2 hour target are monitored and predominantly relate to unavailable capacity at the given time. The impact of work to increase referrals through 111/NWAS and Care Homes has not yet had an impact despite engagement and comms. Workforce/workflows will be monitored as/when referral rates do increase to maintain responsiveness.

Appendices

Mortality Appendices

Monitored Diagnosis Groups

Category	Data Model	Current Alert Level	CCS Group	Previous Rolling 12 Month Position -1	Previous Rolling 12 Month Position	Latest Rolling 12 Month Position
Overall Score	HSMR	Green	N/A	100.96	101.28	101.19
Ongoing HED Alert	HSMR	Amber	Fracture of neck of femur (hip)	160.92	161.21	165.91
Overall Score	SHMI	Green	N/A	99.73	99.89	99.92
Ongoing HED Alert	SHMI	Red	Fracture of neck of femur (hip)	168.70	175.03	169.71
Previous HED Alert	SHMI	Green	Peripheral and visceral atherosclerosis	207.35	185.88	194.56

Number of Patients who Waited More Than 104 Days for Treatment

Tumour Pathway	Column1	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
Brain	Number of Breaches		0.5										
Breast	Number of Breaches			1	1.5		1						
Gynaecology	Number of Breaches						0.5	0.5			1		1.5
Haematology	Number of Breaches			1						0.5	1.5	4	0.5
Head and Neck	Number of Breaches		1.5	1.5	0.5	0.5		0.5		0.5		1	0.5
Colorectal	Number of Breaches	0.5					1	2.5	2.5	1	1	3	2
Lung	Number of Breaches	2.5	1		2		1		1				2
Sarcoma	Number of Breaches												
Skin	Number of Breaches	1	3.5	2		1		0.5	0.5	1.5	1	0.5	
Upper GI	Number of Breaches	0.5	1.5	1		0	0.5				1.5	2	0.5
Urology	Number of Breaches	1.5	3	1.5	5	5	6.5	1	2	2	3	2.5	3.5
Other	Number of Breaches					1			0.5				
Trust	Number of Breaches	6	11	8	9	7.5	10.5	5	6.5	5.5	9	13	10.5

* 0.5 of a patient denotes a shared breach with a tertiary centre.

Cancer 62 Day Performance by Tumour Group:

Cancer 62 day performance: number of patients that received treatment over 62 days and % treated within 62 days, by tumour group:

Tumour Pathway	Number of Breaches	62 day %	SPC Icons
Breast	7	**65.0%**	
Gynaecology	2.5	**16.7%**	
Haematology	2.5	**72.2%**	
Head and Neck	0.5	**50.0%**	
Colorectal	9	**55.0%**	
Lung	4.5	**30.8%**	
Skin	2.5	**79.2%**	
Upper GI	3.5	**36.4%**	
Urology	6	**64.7%**	
Other	1	**0.0%**	
Trust	39	**58.9%**	

Operational Performance-Glossary of Metrics

Outcome Measure	Definition
ED 4 hrs (%)	% of patients who waited less than 4 hours in ED for discharge/transfer to ward
% of ED attends >12 hrs	% of patients who waited over 12 hours in ED for discharge/transfer to ward
Ambulance Handovers within 15 mins (%)	% of patients who waited less than 15 minutes for ambulance handover
Ambulance Handovers within 30 mins (%)	% of patients who waited less than 30 minutes for ambulance handover
Ambulance Handovers within 60 mins (%)	% of patients who waited less than 60 minutes for ambulance handover
Ambulance Handovers over 60 mins (no.)	Number of patients who waited more than 60 minutes for ambulance handover
Cancer 2WW (%)	% of patients referred from GPs with suspected cancer who had their first appointment within 2 weeks
Cancer 28 Day FDS (%)	% of patients referred from GPs with suspected cancer who were given their diagnosis within 28 days
Cancer 31 Day (%)	% of patients who received their first cancer treatment within 31 days from their decision to treat
Cancer 31 Day Subsequent Drug (%)	% of patients who received their subsequent drug cancer treatment within 31 days from their decision to treat
Cancer 31 Day Subsequent Surgery (%)	% of patients who received their subsequent surgery cancer treatment within 31 days from their decision to treat
Number of Patients on Cancer PTL over 62 Days	Number of patients referred from GPs with suspected or confirmed cancer who have not yet had treatment (they are still on the Patient Target List ,PTL) and who have waited over 62 days
Cancer 62 Day (%)	% of patients referred from GPs with suspected cancer who had their treatment within 62 days
Cancer 62 Day Screening (%)	% of patients referred from screening services who had their treatment within 62 days
Cancer 62 Day Upgrade (%)	% of patients that have been upgraded to a cancer pathway who had their treatment within 62 days
Cancer Treatments Beyond 62 Days (no.)	Patients who had cancer treatments last month and waited over 62 days
Cancer Treatments Beyond 104 Days (no.)	Patients who had cancer treatments last month and waited over 104 days
Diagnostic Waits >6weeks (%)	% of patients referred for a diagnostic test who had their test more than 6 weeks from referral
RTT Total Waiting List Size	All patients that are still waiting for their first treatment
RTT <18 Weeks (%)	% of patients who have not yet had treatment and are waiting less than 18 weeks
RTT 52 Weeks (no.)	Number of patients who have not yet had treatment and are waiting more than 52 weeks
RTT 78 Weeks (no.)	Number of patients who have not yet had treatment and are waiting more than 78 weeks
RTT 104 Weeks (no.)	Number of patients who have not yet had treatment and are waiting more than 104 weeks
OP DNA Rate (%)	% of patients who have not attended an appointment, without prior notice
Follow-Ups Past IRD	Patients waiting for follow-up appointments who have waited past their clinical review date (includes both with and without appointments)
2h Urgent Community Response	% of patients in crisis who were seen within 2 hours

Operational Performance-Glossary of Terminology

Terminology	Definition	Terminology	Definition
AAS	Additional Activity Session (over and above baseline capacity)	MDT	Multi-Disciplinary Team
B&HCP	Bay and Health Care Partners	NMC2R	Not Meeting Criteria to Reside
Chatbot	Electronic administrative validation tool	NWAS	North West Ambulance Service
CQC	Care Quality Commission	PIFU	Patient Initiated Follow Up
DEXA	Dual-Energy X-ray Absorptiometry, measures bone density.	Qliksense	Software to provide reports, dashboards and SPC charts
ED	Emergency Department	RAP	Remedial Action Plan
EGFR	Estimated Glomerular Filtration Rate	RCA	Root Cause Analysis
ERS	Electronic Referral System	RSP	Recovery Support Programme
FIT	Frailty Intervention Team	SDEC	Same Day Emergency Care
G&A	General & Acute beds	SPC	Statistical Process Control
ICB	Integrated Care Board	SSNAP	Sentinel Stroke National Audit Programme
IS	Independent Sector (non-NHS)	UEC	Urgent & Emergency Care
KPI	Key Performance Indicator	UTC	Urgent Treatment Centre
LSCFT	Lancashire and South Cumbria Foundation Trust		

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BOARD OF DIRECTORS

Date of Meeting	28 September 2022
Title	Winter Plan
Report of	Scott McLean Chief Operating Officer
Prepared by and contact details	Leanne Cooper Deputy Chief Operating Officer Leanne.cooper@mbht.nhs.uk

Confidentiality	Non-Confidential

Purpose of Report	**To Advise/Alert**	**To Assure**	**To Approve**	**To Update**
	x	x	x	x

The purpose of this report is to provide a briefing to the Trust Board on the approach UHMBT (and system partners) is taking to prepare for the forthcoming seasonal Winter period.

These plans are set in the context of the significant pressures our health and care system faces including the Trust declaring its highest level of operational escalation (OPEL 4) on a number of occasions over 2022.

The report will provide a brief summary of the approach UHMBT (and system partners) is taking to make general improvements to our urgent care system – a year-round process – in addition to the further, specific actions proposed to mitigate the pressures that generally increase over seasonal Winter.

The report will also summarise how these plans are resourced and overseen in respect of performance management and assurance.

Summary of Key Issues	The provision of 'High Quality, Safe Healthcare' leading to good patient experience is a key Trust priority, however, organisational pressures on clinical and operational workload can limit the ability of key areas to provide this effectively at all times. When this pressure inhibits normal daily functioning, it can significantly increase the risk of failure in care delivery and good patient outcome and experience. These pressures can escalate significantly over the

	seasonal Winter period – driven by increased demand for services, more acutely unwell patients, the prevalence of flu/COVID 19 and potential staffing shortages. To this end the Trust has 3 layers of approach to help mitigate the key issues we are likely to face: - The delivery of our "Managing Patient Flow, Surge & Escalation Plan". This is in place and utilised 24/7, 365 days of the year and is being refreshed for this seasonal Winter (by October 2022). - The implementation of the Urgent & Emergency Care Improvement Plan. This has been designed by the Trust in conjunction with system partners and with specialist input from NHSE/I teams. It is overseen by the Bay Health and Care Partners A&E Delivery Board and the System Improvement Board. - Our 2022/23 Winter plan – this is a specific set of actions designed to mitigate the specific risks that can feature over the seasonal Winter period. This plan includes the key actions required by NHSE/I that were detailed in their guidance issued on the 12th August 2022. The Trust has secured resources required for successful delivery of the preferred plans, however, two key points should be noted: (i) should additional financial resources be offered from the system/nationally we have plans in reserve which can be deployed or scaled-up, and (ii) should the preferred plans not be executed or delivered the Trust has contingency plans to deploy which are not financially resourced. There is a comprehensive performance and assurance framework in place – both within the Trust and the wider system – that will oversee our urgent care system performance, the delivery of these plans and the management/mitigation of escalating risks over this period.

Prior Discussions	Committee	Date	Recommendations/ Concerns
	Various committees have oversight of these issues: -Trust Management Group (TMG) -Quality Assurance Committee (QAC)	Various dates to scrutinise the design and approval of these plans and delivery oversight.	Plans have been approved and are mobilised for delivery

	- Finance & Performance Committee - A&E Delivery Board - Trust Board - System Improvement Board (SIB)		

Action to be recommended to the Committee/Board	The Board of Directors is asked: 1. To approve the seasonal Winter plan. 2. To note the resourcing issue associated with contingency plans.

Link to Key Priorities	Delivering outstanding care and experience	Create the culture and conditions for colleagues to be the very best they can be	Make the best use of our physical and financial resources	Working in partnership
	x	x	x	x

Impact on Board Assurance Framework or Corporate Risk Register	Urgent & Emergency Care performance.			
Risk Impact Assessment	Is this required?	**N**	If Yes, Date Completed	
Equality Impact Assessment	Is this required?	**N**	If Yes, Date Completed	
Quality Impact Assessment	Is this required?	**N**	If Yes, Date Completed	
Environmental / Sustainability Impact Assessment	Is this required?	**N**	If Yes, Date Completed	

Acronyms	
UEC	Urgent & Emergency Services
SDEC	Same Day Emergency Care
ED	Emergency Department
FIT	Frailty Intervention Team
ICS	Integrated Care System
NMC2R	Not Meeting the Criteria To Reside
UTC	Urgent Treatment Centre

UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST

UHMBT Winter Plans 2022/23

INTRODUCTION/BACKGROUND

1. Seasonal Winter plans are part of the normal cycle of business within the NHS, with the Trust working together with system partners to mitigate against seasonal Winter pressures. This year, Winter is expected to be particularly challenging given the starting position over Summer and Autumn, combined with the potential return of seasonal flu, norovirus and further COVID-19 variants. This is in addition to gaps in our staffing, financial sustainability, recovery of elective activity and the chronic issue of access to social care for North Lancashire and South Cumbria citizens in acute and community healthcare settings.

2. Resilience over this period will only be achieved through taking a system approach with plans created and delivered in a collaborative manner, leveraging the strengths of our Integrated Care System as well as our local partners across the health and social care system.

UHMBT approach to U&EC performance oversight and improvement

3. The daily management of patient flow, urgent care and escalation is managed 24h a day, 7 days a week, 365 days of the year. This comprehensive approach to managing Urgent and Emergency Care sits outside of the additional focus on seasonal Winter planning.

4. Sitting alongside this is the Urgent & Emergency Care Improvement Plan (U&ECIP) - a system wide plan developed to make our UEC system better, safer and more effective. This plan is overseen by the system A&E Delivery Board and System Improvement Board.

5. The U&ECIP focuses on a number of key projects delivered over a 6-18 month period and is summarised in the table below:

- Expanding same day emergency care (SDEC) for patients who would otherwise be admitted to hospital. Patients presenting at hospital with relevant conditions will be rapidly assessed, diagnosed and treated without being admitted to a ward, and if clinically safe to do so, will go home the same day their care is provided.
- Improvements in services for patients who are frail and/or elderly through a combination of virtual wards and a team of health and social care professionals who specialise in reviewing older patients with frailty, both pre-hospital to help avoid unnecessary admission, and within the Emergency Department and our frailty assessment units.
- The development of a co-located Urgent Treatment Centre (UTC) at the RLI site to help decompress our Emergency Department and reduce waiting times for those with minor injuries and illness.
- Reducing unnecessary delays for patients being discharged from hospital to ensure that once people no longer need hospital care, they can be discharged to the best place for them to continue recovery be that at home or into a community setting (such as a care home).

6. To support the above, the Trust has prioritised £9.61m in capital to support a new UTC and new Frailty Unit at the RLI, in addition to already expanding the cubicle capacity within both of our Emergency Departments, designing a new SDEC unit at FGH, and developing a Priority Assessment and Discharge Unit (PADU) and refurbishing old nightingale-style wards at RLI.

7. The Trust also invested £5.64m which equates to 95 additional staff for frailty pathways, increased staffing levels in our Emergency Departments and assessment areas, and expanding our Hospital Home Care team to support patients leaving hospital to go home.

8. Both the daily management of flow across our urgent care system and our U&ECIP are designed to ensure we are best placed to manage this seasonal Winter from a stronger baseline position.

Project	Goal	Planned Impact
SDEC	• 50% of unplanned admissions will not stay overnight in hospital	• 15-20 acute bed capacity across Trust by Q2 2023/24
Frailty	• 7-day pre-hospital Frailty service for admission avoidance, and • Develop 7-day in-hospital Frailty service and Intervention Team	• Average of 7 admissions avoided per day, equating to 34 acute bed capacity across Trust by Q2 2023/24
NMC2R	• Reduce the number of NMC2R patients (baseline 120 patients equating to 20% of general & acute (G&A) beds to: o Long-term: 30 patients (5%) o Medium-term: 72 patients (12%) by end December-22 o Short-term: 95 patients (16%) by end June-22	• Long-term (5%): 90 acute beds worth of capacity across Trust • Medium-term (12%): 48 acute beds worth of capacity across Trust • Short-term (16%): 25 acute beds worth of capacity across Trust
UTC	• 20-25% of RLI A&E attendances redirected to a new RLI Urgent Treatment Centre (UTC) by end November-22	• 30-45 patients per day diverted from RLI ED to RLI adjacent UTC • Long term plan (2024) is co-location with primary care teams as part of health estate review
Virtual wards	• Introduction of Virtual ward beds as an alternative to admission and to reduce delays to discharge from hospital: o Long-term: 150 patients by end December-23 o Medium-term: 53 patients by end November-22 o Short-term: 27 patients by end August-22	• Modelled net impact of 150 patients in virtual wards by end December-23 is ~50-80 acute hospital beds worth of capacity across Trust

Seasonal Winter Plan

9. Our Urgent and Emergency Care system is under significant pressure. Staff have faced one of their busiest summers ever with record numbers of ED attendances alongside another wave of COVID-19. To that end, on the 12th August 2022, NHS England set out 8 next steps in their plans to increase capacity and resilience ahead of winter. These include:

    1) **Prepare for variants of COVID-19,** including an integrated COVID-19 and flu vaccination programme.
    2) **Increase capacity outside acute trusts,** including the scaling up of additional roles in primary care and releasing annual funding to support mental health through the winter.
    3) **Increase resilience in NHS 111 and 999 services**, through increasing the number of call handlers to 4.8k in 111 and 2.5k in 999.
    4) **Target Category 2 response times** and ambulance handover delays.
    5) **Reduce crowding in A&E departments** and target the longest waits in ED, through improving use of the NHS directory of services, and increasing provision of SDEC and acute frailty services.
    6) **Reduce hospital occupancy**, through increasing general & acute bed capacity.
    7) **Ensure timely discharge,** across acute, mental health, and community settings, by working with social care partners and implementing the 10 best practice interventions through the '100-day challenge'.
    8) **Provide better support for people at home**, including the scaling up of virtual wards and additional support for High Intensity Users with complex needs.

10. Over the last 12-months, the Trust has worked with system partners to develop its U&ECIP that focuses on a number of priority areas which are believed to have the greatest impact in improving access to U&EC.

11. Whilst a number of these schemes are underway, the programme will not be delivered in its entirety in time for this seasonal Winter. We have therefore planned an additional response to this seasonal Winter.

12. Additional resources (some £250m nationally) are being allocated to NHSEI regions to support the return of U&EC performance to pre-Covid levels and to ensure sufficient bed capacity is in place to support systems through this seasonal Winter. The L&SC capitation share of this fund is ~£7.5m.

13. The remainder of this paper describes what we will do to maximise resilience in U&EC over seasonal Winter.

14. The plan focuses on increasing capacity outside hospital, ensuring timely discharges, increasing primary care and mental health access and reducing crowding in our EDs through the bringing forward a number of our U&ECIP schemes described earlier ahead of Christmas – such as UTC co-location at RLI, enhanced SDEC and the deployment of 40 virtual ward beds. A summary of the plan is provided in the table below:

Scheme Title	Description	Planned Impact
1. Positive Ageing and MH Wellbeing pilot	Trial of an intensive enhanced system MDT approach to MH physical health and wellbeing for older adults with a mental health need (including dementia) to reduce avoidable admissions, Length of stay & delayed discharge and to repatriate of out of area placements for this cohort of people. Placements will be up to 6-weeks based on need for those aged over 65 and above	• 8 beds in Morecambe Bay utilised for up to 6-weeks per person • Planned implementation: November 2022 to March 2023 • Delivered by LSCFT
2. Focussed MH support for 999	Increased focussed support for patients identified via 999 requiring MH support by deflecting from ED with the use of section 136	• Prevent ~200 ED deflections across ICS • Prevent ~170 S136 deflections across ICS • Implementation: October 2022 • Delivered by LSCFT
3. Reducing patients NMC2R	Alternative provision, above and beyond core Local Authority provision, to significantly reduce the volume of patients NMC2R in advance of and over the seasonal Winter. Chronic baseline of 60-80 patients has worsened acutely to be >135 (peaking at 162) over the last 2-3 months. This equates to 26-29% of general bed stock, versus a national ask of 5% (which would equate to 30 NMC2R patients occupying general inpatient beds).	• 80-95 domiciliary care packages providing an additional 1,100 hours of domiciliary care in South Cumbria • 15 residential packages in Kendal • Planned implementation: November 2022 • £1.51m supported by ICB
4. Support to Primary Care	Support to Primary care over the winter period to include; additional appointment capacity over winter period, virtually and face to face, pulse oximetry services to support to respiratory patient to remain in the community, and additional cover for Sundays and bank holidays.	• 440 additional appointment slots per week for in-day primary care provision • Planned implementation: October 2022 • £0.42m supported by ICB
5. Community support and admission avoidance	Integration of falls “lifting” service to prevent future falls and injury, and implementation of 'REACT' model at FGH to support admission avoidance.	• Falls “lifting”: supporting ~100 patients (equating to ~189 bed days saved for N Lancs and ~189 bed days for S Cumbria) • REACT function at FGH to support ~120 patients per month assessed for admission avoidance • £0.17m supported by ICB
6. Take home from Hospital & Support Voluntary Sector	Help for patients returning home from hospital. Red Cross to collect patients and make sure they have everything they need for your first 24 to 72 hours back at home. Provision of practical and emotional support, with up to 12 weeks of support to help patients recover as quickly as possible.	• 6 patients supported daily • £0.15m supported by ICB

15. In addition the autumn vaccination programme (COVID and Flu) began on the 5th September in Primary Care, with Primary Care Networks and identified community pharmacies administering vaccine to majority of the population. Provision will also include an outreach service and 'doorstep offer' for hard to reach groups including mobile pop-ups, vaccination at home and mobile vaccination units.

Key Risks and Issues & Mitigations

16. There are a number of key risks facing us this seasonal Winter – including the uncertainty of new COVID variants together with typical winter infection prevention issues associated with Flu and Norovirus, workforce pressures across acute, community, social care and primary care; balancing a financial position alongside the costs of funding UEC schemes and the costs and operational impact of elective recovery.

17. In addition, the is a specific risk associated with significantly high numbers of patients who do NMC2R in hospital due to social care fragility and access to domiciliary care.

18. The Board should be aware that colleagues in Cumbria County Council (CCC) have expressed concerns relating to scheme 3 in the table above (alternative provision, above and beyond core Local Authority provision, to significantly reduce the volume of patients NMC2R in advance of and over the seasonal Winter). The concern relates to the potential impact on the existing domiciliary care workforce in South Cumbria and that the alternative provider may source its workforce from the existing care market. The Trust is sympathetic to this and is working with colleagues at CCC to mitigate these concerns and ensure that the scheme safely provides the additionality required. Should an alternative scheme which delivers a similar impact be forthcoming this will be pursued.

19. In the event of system schemes not delivering the required impact, particularly scheme 3 referenced above at para 18., plans have been drawn up which would expand the inpatient bedbase at RLI and FGH. The Trust will be reluctant to pursue this given that, (i) this would result in keeping patients who do NMC2R in inpatient beds rather than at or close to home receiving care, (ii) it will deplete finite inpatient staffing resources, and (iii) they do not have a funding stream from UHMB core monies, ICB monies or any other monies. Equally the Trust must have contingency to surge into over the seasonal Winter period should the currently proposed schemes not deliver the expected impact.

RECOMMENDATIONS TO TRUST BOARD

1. To approve the seasonal Winter plan
2. To note the resourcing issue associated with contingency plans at para.20

Scott McLean
Chief Operating Officer

BOARD OF DIRECTORS

Date of Meeting	28 September 2022
Title	Emergency Preparedness, Resilience and Response (EPRR): Annual Assurance Return
Report of	Scott McLean Chief Operating Officer (COO), UHMBT
Prepared by and contact details	Andrew Crundell andrew.crundell@:mbht.nhs.uk EPRR Manager, UHMBT

Confidentiality	Non-Confidential

Purpose of Report	**To Advise/Alert**	**To Assure**	**To Approve**	**To Update**
		x		x

The purpose of the EPRR annual assurance process is to assess the preparedness of NHS organisations, both commissioners and providers.

The Trust has undertaken the self-assessment against the 2022 updated core standards relevant to the organisation.

The Chief Executive Officer ensures that the Accountable Emergency Officer (AEO) discharges their responsibilities to provide EPRR reports directly to the Board, no less than annually. UHMBTs AEO is the COO.

The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements.

This deep dive focuses on shelter and evacuation; following the publication of the updated evacuation and shelter guidance for the NHS in England, and recent work driven by the heightened risk associated with reinforced autoclaved aerated concrete (RAAC).

The outcome of this process is used to identify areas of good practice and further development for future guidance. It should also guide individual organisations in the further development of their shelter and evacuation arrangements.

Summary of Key Issues	1. Assurance is via self-assessment 2. 64 standards are applicable to acute Trusts ○ 21 standards are new or returning ○ 26 standards have been amended ○ 4 standards were removed or amalgamated 3. 57 of 64 standards self-rated as fully compliant

	4. 7 of 64 standards self-rated as partially compliant, ie - not compliant with the core standard, however with an EPRR work programme within the Trust which demonstrates sufficient evidence of progress and has an action plan to achieve full compliance within the next 12-months 5. 0 of 64 of the applicable standards are rated as non-compliant 6. Self-assessed as fully compliant in 89% of the applicable standards: **Substantially Complaint** (89-99%) 7. Deep Dive Topic: Shelter and Evacuation

Prior Discussions	Committee	Date	Recommendations/ Concerns
	EPRG	15 September 2022	None

Action to be recommended to the Committee/Board	The Board of Directors is asked to: 1. Note the UHMBT self-assessment (attached) 2. Note the self-assessed rating of substantially compliant 3. Note the EPRR core standards action plan and workplan 4. Note that by way of the AEO signing the statement of compliance the Trust is publicly stating its EPRR readiness and preparedness

Link to Key Priorities	Delivering outstanding care and experience	Create the culture and conditions for colleagues to be the very best they can be	Make the best use of our physical and financial resources	Working in partnership
	x	x	x	x

Impact on Board Assurance Framework or Corporate Risk Register	There remains a corporate risk to bariatric patients in relation to evacuation at the FGH site; risk management processes continue and are updated periodically.			
Risk Impact Assessment	Is this required?	**N**	If Yes, Date Completed	
Equality Impact Assessment	Is this required?	**N**	If Yes, Date Completed	
Quality Impact Assessment	Is this required?	**N**	If Yes, Date Completed	
Environmental / Sustainability Impact Assessment	Is this required?	**N**	If Yes, Date Completed	

Acronyms	
AEO	Accountable Emergency Officer
EPRG	Emergency Planning Resilience Group
EPRR	Emergency Planning Resilience and Response
ICB	Integrated Care Boards
LHRP	Local Health Resilience Partnership

UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST
EPRR ASSURANCE SELF ASSESMENT 2002 – 23

INTRODUCTION

1. As part of the NHS England EPRR framework, providers and commissioners of NHS funded services must show they can effectively respond to major, critical and business continuity incidents whilst maintaining services to patients.

2. The EPRR assurance process uses the NHS England core standards for EPRR. This year the standards, including the interoperable capabilities standards, have undergone a triannual review in advance of the assurance process.

3. 21 of the standards are new or returning standards; 4 of the previous standards have been removed or amalgamated; 26 of the standards have been amended.

4. Domain 10 (Chemical, Biological, Radiological and Nuclear (CBRN)) will be reviewed separately as part of the CBRN work programme. As such, for this year's assurance process, these specific standards remain unchanged.

5. The NHS core standards for EPRR are the basis of the assurance process. This year the standards, including the interoperable capabilities standards, having undergone a triannual review in advance of the assurance process.

6. With the introduction of the Health and Care Act 2022, this year's assurance process reflects the establishment of integrated care boards (ICBs) as Category 1 responders and their local NHS leadership role.

EPRR Annual Assurance Letter

EPRR Annual Assurance Guidance

Core Standards for EPRR (Amended)

RISKS AND MITIGATIONS

Stage One: Self-Assessment

7. Participating organisations are asked to rate their compliance (see table below) via a self-assessment against the relevant individual core standards.

Compliance Level	Compliance Definition
Not compliant	Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months.
Partially Compliant	Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months.

Fully Compliant	Fully compliant with core standard.

Overall Assurance Rating

8. An overall assurance rating is assigned based on the percentage of NHS Core Standards for EPRR which the organisation has assessed itself as being 'fully compliant' with.

Overall EPRR Assurance Rating	**Criteria**
Fully	The organisation is 100% compliant with all core standards they are required to achieve.
Substantial	The organisation is 89-99% compliant with the core standards they are required to achieve.
Partial	The organisation is 77-88% compliant with the core standards they are required to achieve.
Non-Compliant	The organisation compliant with 76% or less of the core standards they are required to achieve.

UHMB Self-Assessment 2022 – 23

Number of Applicable Standards	64
Fully Compliant	57
Partially Compliant	7
Non-complaint	0
Overall rating	**Substantial**

Deep Dive

9. Each year a deep dive review is conducted to gain additional assurance into a specific area. Previous years have covered the following topics:

Year	**Topic**
2015-2016	Pandemic Influenza
2016-2017	Business Continuity
2017-2018	Governance
2018-2019	Command and Control

2019-2020	Severe Weather and Climate Adaptation
2021 - 2022	Oxygen Supply and Medical Gases

10. The self-assessment against the deep dive standards does not contribute to the organisation's overall EPRR assurance rating, these should be reported separately.

2022 Deep Dive – Shelter and Evacuation

No.	Deep Dive Domain	Compliance
DD1	Up to date plans.	Fully Compliant
DD2	Activation	Fully Compliant
DD3	Incremental Planning	Fully Compliant
DD4	Patient Triage	Partially Compliant
DD5	Patient Movement	Fully Compliant
DD6	Patient Transport	Fully Compliant
DD7	Patient Dispersal and Tracking	Fully Compliant
DD8	Patient Receiving	Fully Compliant
DD9	Community Evacuation	Fully Compliant
DD10	Partnership Working	Fully Compliant
DD11	Communications – Warning and Informing	Partially Compliant
DD12	Equality and Health Inequalities	Fully Compliant
DD13	Exercising	Fully Compliant

Attachments included in the Board of Directors' Reference Pack

UHMB EPRR Assurance Summary including; 1. Applicable Core Standards Summary 2. EPRR Core Standards Action Plan 3. Statement of Compliance	file:///C:/Users/andrew.crundell/Desktop/EPRR Return/EPRR Return Summary.docx

RECOMMENDATION

11. The Board of Directors is asked to:
    1. Note the UHMBT self-assessment (attached)
    2. Note the self-assessed rating of substantially compliant
    3. Note the EPRR core standards action plan and workplan

4. Note that by way of the AEO signing the statement of compliance the Trust is publicly stating its EPRR readiness and preparedness

Scott McLean
Chief Operating Officer (& Accountable Emergency Officer)

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BOARD OF DIRECTORS

Date of Meeting	28 September 2022
Title	Positive Difference Annual Report 2022 - First Annual Update of the Five-year Strategy
Report of	Bev Edgar, Interim Chief People Officer
Prepared by and contact details	Hannah Chandisingh, Head of Inclusion and Engagement Hannah.chandisingh@mbht.nhs.uk Jessica Payne, Strategic Lead for Inclusion and Engagement Jessica.payne@mbht.nhs.uk Barry Rigg, Head of Patient Experience Barry.rigg@mbht.nhs.uk

Confidentiality	Non-Confidential

Purpose of Report	**To Advise/Alert**	**To Assure**	**To Approve**	**To Update**
	x	x		x
	The purpose of this report is to **update** the group of positive progress made and outcomes achieved over the past 12 months; to **advise** the actions set out in the Positive Difference action plan for 2022-23; and to **assure** the group of key areas now being delivered.			

Summary of Key Issues	*"We are an organisation where everybody feels that they belong, that takes action to tackle bullying and discrimination and empowers our people with the tools and confidence to take this action."* - The Morecambe Bay Promise. In September 2021, the Trust Board approved a five-year Inclusion and Diversity Strategy which was developed in partnership with the Trust's inclusion networks. This set of documents represents the first annual update against that strategy. After reaching #1 in the Top 50 Inclusive Companies List and the National Diversity Awards progress has continued, with the Anti-Racist Transformation Programme resulting in significant positive outcomes in the reduced proportion of ethnic minority colleagues experiencing bullying, harassment, abuse and discrimination from other colleagues; in some areas now equal to the experience of white colleagues.

	This report includes the annual submissions for the following national performance standards: - Workforce Race Equality Standard - Workforce Disability Equality Standard - Gender Pay Reporting - Equality Delivery System 2 stakeholder assessment - Workforce Monitoring In addition, the Trust's locally developed Sexual Orientation Workforce Equality Standard and Ethnicity Pay Reporting is included. Also highlighted in the report are the Trust's plans for 2022/23, against clear and measurable outcomes across the five areas of the strategy: - Just and Learning Culture - Inclusive Leadership and Behaviours - Inclusive and Representative Employment - Networks and Partnerships - Patients as Partners Though much progress has been made, these reports highlight that the experience of many continues to fall short of the standard we aim for. We must not become complacent but recommit to truly listening to and supporting our communities to make UHMB a great place to be cared for and a great place to work for every individual. A copy of the Annual Report and colleague experience is included in the Board of Directors' Reference Pack.

Prior Discussions	Committee	Date	Recommendations/ Concerns
	Inclusion and Diversity Steering Group People Committee	August 2022 July 2022	Approved Approved

Action to be recommended to the Committee/Board	The Board of Directors is asked to: 1. Note the contents of the annual report and supporting papers; 2. Support the action plans and national submission.

Link to Key Priorities	Delivering outstanding care and experience	Create the culture and conditions for colleagues to be the very best	Make the best use of our physical and financial resources	Working in partnership

		they can be		
	x	x	x	x
	Organisations who are able to provide a workplace and services which are genuinely inclusive, see benefits in performance, reputation, recruitment and staff motivation.			

Impact on Board Assurance Framework or Corporate Risk Register	Risk 2146 - Poorer experience of Black, Asian and Minority Ethnic colleagues at work resulting in lower engagement levels, impacting on recruitment and retention and ultimately patient care Risk 2445 - Unacceptable behaviour including bullying & harassment Risk 2835 - Organisational culture Risk 2873 - Failure to recruit and retain a competent, healthy, engaged and motivated workforce			
Risk Impact Assessment	Is this required?	**N**	If Yes, Date Completed	
Equality Impact Assessment	Is this required?	**N**	If Yes, Date Completed	
Quality Impact Assessment	Is this required?	**N**	If Yes, Date Completed	
Environmental / Sustainability Impact Assessment	Is this required?	**N**	If Yes, Date Completed	

Acronyms	
BAME	Black, Asian and Minority Ethnic

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BOARD OF DIRECTORS

Date of Meeting	28 September 2022
Title	Cultural Transformation Programme Update
Report of	Bev Edgar Interim Chief People Officer
Prepared by and contact details	Matthew France Assistant Director OD & Learning

Confidentiality	Non-Confidential

Purpose of Report	**To Advise/Alert**	**To Assure**	**To Approve**	**To Update**
			x	x
	This paper provides an update on the Moving Forward culture change priorities and actions, all of which link to the Trust's Organisational Development (OD) and leadership plan which together form an integrated programme of transformation.			

Summary of Key Issues	The most recent (September 2022) 3A's Culture and Leadership RSP programme report is appended to this report. **PROGRESS HIGHLIGHTS** - Over 500 leaders have attended the one-day leadership development workshop. Exit feedback has been positive and there have been 14.5k visits to the online materials. A further 500 colleagues are booked and the original cohort of 1500 is on track for completion by the end of the calendar year. Intelligence gathered through delivery has identified a further 325 colleagues for inclusion, with the aim that they participate before the end of March 2023. - Executive development programme has been contracted and is underway. - The revised Reward and Recognition strategy moved into delivery phase following contribution from the Culture Change Champions. - The Fair and inclusive recruitment programme has led to 100% of nursing and midwifery interview panels now having BAME and gender representation. - The Behavioural Standards Framework (BSF) review outcome: to transition from the BSF document to focussing on the new Trust Values and Behaviours. Agreed at Culture Transformation Board.

- Delivery of the just and learning workstream priorities for 21-22 underway with a deep dive presented to the Culture Programme Board in July.
- Dan West now leading FTSU review and improvement plan. Development of UHMBT app is near completion.
- The plan for Moving Forward Phase 2 (delivery) engagement was approved at the Culture Programme Board in July with the Culture Change Team at its core and developments for all colleague engagement / conversation
- Review of People and OD function is complete and will be with CEO initially prior to sharing and action planning as appropriate

PULSE SURVEY

Although the response rate to the Pulse Survey is low relative to the National Survey (c.400 responses), there are positive indicators as shown below. (The National Staff Survey will provide more robust data by Mid-December).

Question	July 2022	January 2022
My organisation is proactively supporting my health and wellbeing	64.5%	49.7%
In my team we support each other	78.1%	64.8%
I feel well informed about important changes taking place in my organisation	59.2%	52.8%
Overall, how anxious did you feel yesterday? (1-7)		
Anxious (1-3)	31.7%	40.7%
Middle (4)	18.6%	15.1%
Calm (5-7)	49.7%	44.2%

PROGRAMME RISKS

- SRO has left and Programme Lead leaves end of September. Now mitigated: Interim CPO in place & Head of Culture and OD starts January 3rd.
- People & OD resources are not fully aligned to the delivery of the cultural transformation and OD plan. Careful allocation of existing resources, linked to the externally supported HR and OD review is required.
- People & OD 18.5% CIP challenge - development of plans being supported by QIAs to understand impact and inform corporate-level decision-making.
- Resources and venue for 2023 leadership programme delivery not yet identified, options appraisal still underway.

Prior Discussions	Committee	Date	Recommendations/ Concerns
	Culture Programme Board	16 September 2022	Reward and recognition strategy approved

Action to be recommended to the Committee/Board	The Board of Directors is asked to: 1. Note the progress with the Culture Transformation Programme and priority workstreams.

Link to Key Priorities	Delivering outstanding care and experience	Create the culture and conditions for colleagues to be the very best they can be	Make the best use of our physical and financial resources	Working in partnership
	x	x	x	x

Impact on Board Assurance Framework or Corporate Risk Register				
Risk Impact Assessment	Is this required?	**N**	If Yes, Date Completed	
Equality Impact Assessment	Is this required?	**N**	If Yes, Date Completed	
Quality Impact Assessment	Is this required?	**N**	If Yes, Date Completed	
Environmental / Sustainability Impact Assessment	Is this required?	**N**	If Yes, Date Completed	

Acronyms	
ToR	Terms of Reference
CPB	Culture Programme Board
OD	Organisational Development
RSP	Recovery Support Programme
FTSU	Freedom to Speak Up
CIP	Cost Improvement Programme
QIAs	Quality Impact Assessments

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Cultural Programme Board Key Issues Report

Report Date: 20.09.2022		**Report of:** Cultural Programme Board
Date of last meeting: 16.09.2022		**Membership Numbers:** 20 including the Chair **Quoracy met** = Yes
1	**Agenda**	The Cultural Programme Board continues to meet bimonthly. The Cultural Programme Board considered an agenda which included the following: • Colleague Story • Programme update - RSP 3A's report • Behavioural Standards Framework Review • Recognition and Reward Proposal • Fair and Inclusive Recruitment - Workstream Update • Moving Forward Colleague Engagement Update
2a	**Alert**	The Cultural Programme Board wish to alert members of the Board of Directors that: • It was noted that there was a need to now be moving from status updates to more focus on completion rates, looking at difference, the change and improvement in the organisation. • Development of a sustainable ongoing engagement strategy is required within the RSP to include the funding to be revisited.
2b	**Assurance**	The Cultural Programme Board wish to assure members of the Board of Directors that: • There have been discussions and negotiations in relation to the delivery and resources for the Triumvirate Development programme and is likely to launch in November 2022. • The Board Development programme is underway, 65-75% complete. • The contract with ASK Europe, the provider for the Executive Director Development programme has been signed with a view to launch in early November 2022. • The Head if Culture and OD interviews took place with an offer being made and awaiting confirmation of acceptance of the position. • The staff side clinics were re-launched a few weeks ago and are deemed to be useful by colleagues, expressing that they feel they have a better understanding of the work being carried out.
2c	**Advise**	The Cultural Programme Board wish to advise members of the Board of Directors that: • Discussions will be taking place in relation to the role of the People Committee and the frequency, which may lead to a change in

		frequency of the Cultural Programme Board. • Reward and Recognition proposals were discussed with further conversations being required around criteria and terminology before returning back for sign off. • The new Trust Values and Behaviours was presented to the Board with agreement to bring back to the CPB post utlilisation to highlight how UHMB will measure effectiveness.
2d	**Review of Risks**	Continued risk of absence of permanent Chief People Officer. UHMB were unable to appoint although feedback has been issued to the company and the position has gone out to advert again. Bev Edgar will be here for the 6 month period. Matt France is carrying out an acting SRO role.

3	**Actions to be considered by the Board of Directors**			
4	**Report compiled by**	Matthew France	**Minutes available from:**	Jane Frill

BOARD OF DIRECTORS

Date of Meeting	28 September 2022
Title	New Hospitals Programme – Preferred and Alternative Options
Report of	Scott McLean Chief Operating Officer
Prepared by and contact details	Rebecca Malin New Hospitals Programme Director

Confidentiality	Non-Confidential

Purpose of Report	**To Advise/Alert**	**To Assure**	**To Approve**	**To Update**
			x	
	The purpose of this report is to provide an update on the Lancashire and South Cumbria New Hospitals Programme and to seek approval on the preferred and alternative options for the Royal Lancaster Infirmary.			

Summary of Key Issues	The Lancashire and South Cumbria New Hospitals Programme (NHP) has reached a significant milestone with work completed for the shortlisted options including their deliverability, affordability, value for money, and viability, considering feedback from patients, local people and staff. Over the last period the Programme has produced significant supporting documentation and presented this for review by the Morecambe Bay NHP Task and Finish Group and/or designated Programme oversight group. This has provided a structured “check and challenge” approach for each area. The approach and process used to develop a preferred and alternative option for the Royal Lancaster Infirmary (RLI) was presented to the Trust Board of Directors and NHP Strategic Oversight Group in July 2022. The Programme is now seeking approval from the Trust Board on the preferred and alternative options.

Prior Discussions	Committee	Date	Recommendations/ Concerns
	UHMB Board of Directors	27 July 2022	Endorsed
	NHP Strategic Oversight Group	28 July 2022	Approved

Action to be recommended to the Committee/Board	The Board of Directors is asked to approve the preferred and alternative options for inclusion in the developing business case and for continued discussion with the national New Hospital Programme team ahead of their submission of an updated programme business case to the Treasury in quarter 3 2022/23.

Link to Key Priorities	Delivering outstanding care and experience	Create the culture and conditions for colleagues to be the very best they can be	Make the best use of our physical and financial resources	Working in partnership
	x	x	x	x

Impact on Board Assurance Framework or Corporate Risk Register				
Risk Impact Assessment	Is this required?	**N**	If Yes, Date Completed	
Equality Impact Assessment	Is this required?	**N**	If Yes, Date Completed	
Quality Impact Assessment	Is this required?	**N**	If Yes, Date Completed	
Environmental / Sustainability Impact Assessment	Is this required?	**N**	If Yes, Date Completed	

Acronyms	
BCR	Benefit-Cost Ratio
DHSC	Department for Health and Social Care
FGH	Furness General Hospital
HBN	Health Building Notes
ICB	Integrated Care Board

NHP	New Hospitals Programme
RLI	Royal Lancaster Infirmary
RPH	Royal Preston Hospital
SOG	Strategic Oversight Group

Lancashire and South Cumbria New Hospitals Programme Royal Lancaster Infirmary options

1.0 Introduction

1.1 Lancashire Teaching Hospitals NHS Foundation Trust (Royal Preston Hospital - RPH) and University Hospitals of Morecambe Bay NHS Foundation Trust (Royal Lancaster Infirmary – RLI and Furness General Hospital - FGH) were both successful in becoming part of the national New Hospital Programme and have been placed in the "Full Adopter" phase, which is targeted at completion by 2030, with full (final) business case submission by 2025.

1.2 The Programme sits within our wider Integrated Care Board (ICB) strategy to drive reduced inequalities, improved clinical outcomes and address issues of wider system sustainability and is a key catalyst and enabler in the transformation of services across Lancashire and South Cumbria.

1.3 A robust Case for Change was published in Julye 2021, setting out the vision and ambition for the future, together with an assessment of our hospital estate focusing on significant backlog maintenance and dilapidation (£300m); inadequate compliance with existing and future building standards; poor clinical interdependencies and high operating costs. In March 2022, a final shortlist of options was approved by the Trusts and Commissioners. More detail on the Case for Change, options and approach taken can be found here https://newhospitals.info/

1.4 The NHP has since progressed from high level descriptions of each option to having completed a detailed and comprehensive assessment of the shortlisted options considering key elements including service configuration, Schedule of Accommodation and site options. This has enabled each option to be comprehensively assessed for deliverability, affordability, value for money and viability, considering feedback from patients, local people and staff. Completion of this work has now enabled both Trusts and system leaders to formally review the **preferred and alternative options** for Royal Lancaster Infirmary and Royal Preston Hospital. A summary of the preferred and alternative options for the Royal Lancaster Infirmary is set out overleaf.

1.5 Each of the shortlisted proposals for the new hospital facilities also includes investment in Furness General Hospital. Investment would mean better care and a better experience for patients and staff, particularly for patients who need critical or high dependency care and people receiving emergency care. Digital technologies would be brought in to support a network of care across Lancashire and South Cumbria linking up doctors, nurses and other healthcare professionals to work together on treatment for patients.

2.0 Preferred and Alternative Option – Royal Lancaster Infirmary

	High level descriptor	Key points
Preferred Option	New "state-of-the-art" hospital built on a new site delivering the full programme objectives and an opportunity to maximise significant quality and productivity gains	✓ A world class hospital facility delivering better care in a better environment for patients and our staff. ✓ Exceeds DHSC/Treasury Benefit-Cost Ratio (BCR) requirement ✓ Fully addresses the Case for Change ✓ 70% single rooms ✓ Fully meets Net Zero Carbon ✓ Designed and built to national Hospital 1.0 using modern methods of construction ✓ Education, training and research embedded as part of a Lancashire and South Cumbria networked model ✓ Opportunity to maximise partnerships ✓ Delivery of significant efficiency and productivity gains ✓ Potential to maximise opportunities with strategic partners
Alternative Option	Improved Royal Lancaster Infirmary to include an urgent and emergency care village would contain a range of departments focused on delivering urgent healthcare needs – for example, emergency department (A&E), assessment units, diagnostics and radiology, rapid assessment, same day treatment centre, paediatric care, and ambulance facilities.	✓ Prioritises buildings with the greatest need for investment ✓ Potential to significantly improve patient experience, performance and operational efficiencies. × Would not meet DHSC/Treasury BCR requirement × Partially addresses Case for Change × Limited steps towards Net Zero Carbon × Only partial delivery of the 70% single rooms × Does not resolve all backlog maintenance Significant operational and logistical issues to be overcome during the building phase.

See Appendix A for additional supporting information.

2.1 The preferred option of a new build hospital on a new site would bring significant system wide benefits, fully addressing the Case for Change and delivering on the programme's stated benefits of improving care for patients, the work environment for our staff, meeting our environmental commitments and maximising the wider socio-economic potential. This option would enable the programme to fully deliver all the national ambitions and enable us to maximise the benefits expected from Hospital 1.0 *(a standardised approach and centralised design creating clinically and operationally optimised hospitals)*. The clinical, operational, and cost efficiency benefits all help contribute to achieving a benefits realisation exceeding the Treasury requirement.

2.2 The alternative option would bring a range of improvements, particularly for patients with urgent and emergency care needs and people accessing maternity services along with improving clinical adjacencies. However, the option only partially addresses the

Case for Change and does not address all the required backlog maintenance or the ambitions of the national programme. The option would also limit the opportunity to maximise the benefits of service and quality improvements that should materialise from the Provider Collaborative clinical vision. Consequently, the benefits realisation is significantly below Treasury expectations.

2.3 In reaching these recommendations the Programme has undertaken extensive work in developing each a number of products e.g. Framework Model of Care, Clinical and Functional Brief, economic quantitative appraisal. These form the key building blocks behind each option and will continue to be developed and refined.

2.4 Significant supporting documentation covering such products has been produced and reviewed by the Morecambe Bay NHP Task and Finish Group and/or designated Programme oversight group. This has provided a structured “check and challenge” approach for each area.

2.5 The detail behind each option will continue to be expanded and refined as further work on the shortlist progresses and the required business cases are developed. Work is underway to assess the viability of potential locations for the preferred option – a new hospital built on a new site. Following an initial land search, the Programme is assessing the deliverability of each site, including environmental and planning considerations, capacity for utilities and high-level design, as well as undertaking travel and transport analysis to understand the accessibility of each site.

2.6 Our New Hospitals Programme is progressing at pace and we are excited by the scale of transformation the programme brings to our system and the people of Lancashire and South Cumbria.

3.0 Recommendations

3.1 Board members are asked to approve the preferred and alternative options for Royal Lancaster Infirmary for inclusion in the developing business case and for continued discussion with the national New Hospital team ahead of their submission of an updated programme business case to the Treasury in quarter 3 2022/23.

Appendix A - Supporting Information - Royal Lancaster Infirmary

Royal Lancaster Infirmary (RLI) is University Hospitals of Morecambe Bay NHS Foundation Trust's principal hospital, providing a range of general acute hospital services with an emergency department, critical coronary care units and various consultant-led services. Royal Lancaster Infirmary also provides a range of planned care, including outpatients; diagnostics; therapies; maternity; and day case and inpatient surgery.

The Royal Lancaster Infirmary site comprises of around 20 separate buildings of varying sizes and ages, some dating back to the 19th Century. Most, but not all the buildings are linked by long passages, with some buildings separated from the main complex by public highways. As a result, staff and patients must make longer journeys than is desirable, leading to poor experiences of care and operational inefficiencies.

Several services operate in temporary buildings offering poor quality accommodation and others are past their useful life. Most of the site is on a slope, which in some areas is too steep for patients to be safely moved except by ambulances. The hospital lacks an obvious main entrance, which can be confusing for patients and visitors.

Key information from the Case for Change:

- **50% of the Royal Lancaster Infirmary estate requires demolition** and the majority of the remaining site will require investment if it is retained in use.
- Backlog maintenance costs total £88m – predominantly due to the estate condition
- Running costs are double that of a new build at £442 per m2 due to the age of the site; running costs involve replacement i.e. lifecycle costs over maintenance.
- The site is configured over a challenging topography. Access is particularly challenging for people with a disability and transport to some parts of the hospital (separate ward blocks) is only possible by ambulance, at a cost of £500,000 a year to the Trust.
- Significant non-compliance with Health Building Notes (HBN):
    - 28% of beds are single rooms,
    - Many of the patient toilet facilities are inadequate
    - Operating suite floors are non-HBN compliant for all areas and are well below the HBN-recommended size of 55 m2.
    - Space requirements for an anaesthetic room, preparation room, scrub up and gown or dirty utility are not met.
    - Multi-bedded bays predominate, which exceed the current HBN standard of four beds as a maximum. Some bays range from six to ten beds.
    - Resus bay within the emergency department is 11m2 versus minimum standard of 20m2.
    - Sluice provision does not meet HBN standards of one sluice per 14 beds, often resulting in sewage leaks due to inadequate plumbing capacity.
- Delivery of high-quality care (National performance standards) is severely compromised by poor clinical adjacencies and lengthy circulation spaces.
- Energy consumption costs are 50% higher than peer hospitals and are heavily reliant on carbon-based energy sources.

- Car parking capacity is inadequate and consistently highlighted as a concern.

BOARD OF DIRECTORS

Title	Trust-wide Risk Register (Corporate RR) and Risk Management
Report of	Richard Sachs - Director of Governance
Prepared by and contact details	Anna Smith, Head of Health, Safety and Risk; anna.smith@mbht.nhs.uk. Mob 07787502293

Confidentiality	Non-Confidential

Purpose of Report	**To Advise/Alert**	**To Assure**	**To Approve**	**To Update**
		x		x
	To provide the Board with an overview of the Trust-wide Risk Register and the process for assigning risks to that.			

Summary of Key Issues	• There are currently 11 risks on the Trust-wide ("corporate") Risk Register (TRR) • Risks are allocated to the Trust-wide Risk Register following a robust process of escalation, check and challenge throughout which, the management strategies of Treat, Transfer, Tolerate, Terminate or Take the opportunity are applied. • Risks are assigned to the TRR because they are outside the capability, resources, authority etc. of the Care Group to manage. • Assurance Committees receive a quarterly report presenting the trust-wide risks relevant to that Committee and have the opportunity to discuss any of concern.

Prior Discussions	**Committee**	**Date**	**Recommendations/ Concerns**
	Trust Management Group	21 September 2022	A verbal update will be given at the Board of Directors' meeting on 28 September 2022

Action to be recommended to the Board	The Board of Directors is asked to: • note the report • Agree this report should be presented alongside the Board Assurance Framework in future on a quarterly basis to support connectivity.

Link to Key Priorities	Delivering outstanding care and experience	Create the culture and conditions for colleagues to be the very best they can be	Make the best use of our physical and financial resources	Working in partnership
	x	x	x	x

Impact on Board Assurance Framework or Corporate Risk Register	The Trust-wide Risk Register is presented in this report for oversight and connectivity with the Board Assurance Framework.			
Risk Impact Assessment	Is this required?	**N**	If Yes, Date Completed	
Equality Impact Assessment	Is this required?	**N**	If Yes, Date Completed	
Quality Impact Assessment	Is this required?	**N**	If Yes, Date Completed	
Environmental / Sustainability Impact Assessment	Is this required?	**N**	If Yes, Date Completed	

Acronyms	
TRR	Trust-wide risk Register (formerly Corporate Risk Register)
RMG	Risk Management Group
TMG	Trust Management Group
SPC chart	Statistical Process Control chart
MIAA	Mersey Internal Audit Authority

UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST
TRUST-WIDE RISK REGISTER (TRR) AND RISK MANAGEMENT

Definition

1.0 Trust-wide Risk Register means “Corporate Risk Register”. However to avoid confusion with the risk register held by the Corporate Care Group, the title of the Corporate Risk Register was discussed in February 2022 at Risk Management Group and it was agreed to use the term Trust-wide Risk Register (TRR).

Introduction

2.0 The high-level strategic risks identified on the Board Assurance Framework are underpinned and informed by risk registers overseen at the local operational level within Care Groups and Corporate Directorates. However, the TRR holds a small number of operational risks which may impact on the achievement of the strategic objectives of the Trust if not effectively managed.

3.0 The TRR holds risks which cannot be managed solely within the Care Group or Corporate Directorate. Assignment to the TRR is not dependent on risk score but on the impact on the trust’s operational objectives and the need for support outside of the Care Groups/Corporate Directorates. Consequently, not all risks on the TRR are of high value.

4.0 The process for assigning a risk to the TRR involves escalation from a Care Group/Corporate Directorate via the Risk Management Group (RMG) and is described in paragraphs 5.0 to 7.0 below

Risk management arrangements

5.0 Trust Risk Management Strategy (approved by the Board in July 2021) and the Risk Management Policy embed the concept that risks are managed at the point closest to where the risk is evident, and escalation occurs where it is not possible to manage the risk at that level. There is a clear escalation process, defined in a Standard Operating Procedure, from Departments through Specialities, Care Groups and to the Trust-wide Risk Register.

4.0 There is a check and challenge process at each escalation point at which the management strategies of Treat, Terminate, Tolerate, Transfer or Take the Opportunity are applied. The purpose is to consider and provide support at the relevant Department, Speciality or Care Group level to manage that risk, before escalation to the TRR via the Risk Management Group.

5.0 The RMG will apply the same considerations and may provide direction or support or may choose to escalate to Trust Management Group (TMG) for further direction or support and assignment to the TRR.

6.0 Therefore, the risks which are held on the TRR are those which are out-with the ability, capacity, resources or authority of the Care Groups to manage and require a (corporate) "trust-wide" approach.

7.0 To support the process above there is:

- A series of Standard Operating Procedures
- Standardised Terms of Reference for Care Group Governance Assurance Groups specifying the expectation with regards to risk management
- Standardised risk reports to Assurance Committees on a quarterly basis
- A Schedule of Business for the RMG which includes a 6-monthly full review of the risk register by Care Groups and Corporate Directorates and a series of thematic reviews
- A suite of KPIs represented through SPC Charts to track performance and identify deviations at an early stage
- Several training opportunities aligned with individual, and group needs e.g., Group workshops, coaching and an enhanced in-house Healthcare Risk Management training course.

8.0 Underpinning all of the above, a 12-month Phase 1 action plan has been completed and in May 2022, we assessed ourselves against the HM Treasury Risk Maturity Assessment Framework. The Phase 1 plan aimed to improve our position from;
Level 2: *Approaches for addressing risks are in place and action plans for implementation being developed* which is rated a Moderate to;
Level 3: *Risk management applied consistently and thoroughly across the organisation* which is rated as "Good".

Our self-assessment has identified we achieved our aim. The reference pack contains a one-page summary of this assessment.

9.0 MIAA reported on their Risk Management Review in May 2022 and stated *"Although the trust is not finished on its improvement journey for risk management, the direction of travel is clearly in the right direction".* A further audit is planned in Quarter 4.

10.0 A Phase 2 plan was approved at RMG in June 2022 for the next 12 months, which aims to achieve Level 4 against the assessment framework: *The organisation is proactive in driving and maintaining the embedding of risk management and integration in all areas of the organisation* which is rated as Very Good.

Key elements of this action plan will be to align operational risk management with the Board's risk appetite and to support engagement with other stakeholders on risks apparent and emerging within our partnership arrangements.

11.0 Audit Committee will continue to keep oversight of the risk management arrangements.

Current position

12.0 Within the reference pack, a suite of SPC Charts provide the current position against the measures agreed at Risk Management Group in June 2022.

- Since July 2021 there has been an increase in risk identification.
- There has been noticeable turnover of risks and a steady number of risks closed per month.
- Generally, the charts demonstrate significant improvement over Quarters 1 to 3 of 2021 which was generated through intensive workshops and training of staff.

Trust-wide Risk Register (TRR)

13.0 A summary of the TRR, each one aligned with the associated BAF Risk, is presented below.

14.0 Assurance Committees receive a quarterly report of risks relevant to that Committee and have the opportunity to discuss any risks of concern. Each Committee sees the relevant risks from the Trust-wide Risk Register and the high-value risks currently being managed within the Care Groups.

15.0 From this quarter, Assurance Committee reports will also feature the BAF risks, for line-of-sight and connectivity.

16.0 The reference pack also contains a summary of activity within the TRR and including operational risks escalated for consideration and those de-escalated as a result of management of the risk, over the last 12 months.

Trust-wide Risk Register

BAF Risk Descriptor

There is a risk to providing consistently safe, responsive, high quality care caused by:

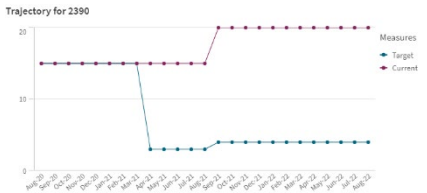
A) Availability of staff and ability to recruit and retain and reduce sickness levels

B) Occupancy levels in excess of 80%, impacted further by the presence of covid-19 pandemic and the requirement to configure services differently to accommodate infection status

C) Inability of the system to meet the health and social care requirements of the community. This results in delays in patients accessing or utilising secondary care more often and impacting on those that require elective and non-elective services. This also results in consistently high numbers of patients not meeting the criteria to reside

D) Fluctuating ability to consistently meet the constitutional and specialty standards

This may, alongside a fluctuating and uncertain regulatory environment, result in adverse patient outcomes and experiences leading to patient harm and the community losing confidence in services.

ID	Risk Title	Executive	Risk Score	Trajectory	Note
2390	Risk to delivery of commissioned services by Rapid Response and District Nurse Teams in South Cumbria due to pressures in the Home Care system impacting on capacity of the team.	Deputy COO	15 Almost Certain 5 x Moderate 3	**Treat** 	The ultimate solution to this risk lies with Adult Social Care however their risk impacts on UHMBT. The source of the risk cannot be addressed by UHMBT. UHMBT actions address the impact on the trust.

Current controls

- Attendance and data provision at system meetings – Cumbria ICAT, ISMB and Performance Report
- Where vulnerable people are identified in the community and have a lack of personal or social care there are established communication mechanisms to the Social Care colleagues with the aim of them taking over the provision of the care.
- Frailty Co-ordination hub created to co-ordinate the management the flow of patients and creates data and insights to identify opportunities to enhance pathways. April 2022- FCH has now evolved into Single Point of access for 2hUCR and further refinement of data collected to inform ongoing requirement for crisis and domiciliary care

Actions	Target date	Update	Progress
Create a Transfer of Care hub to support transition of patients into social care	21/12/2022	21/06/22	Transfer of Care Hub now operational. ICS funded use of agency staff from Mid Feb to end of May 2022 to support hospital discharge and patient flow.
Use of Bank staff on ad hoc basis to maintain responsiveness and keep caseloads open	01/10/2022		Standing agenda item on monthly A&E Delivery Board agenda as an element of the Urgent Care Recovery Plan

3001	Risk of significant patient harm associated with long waits in elective care due to the impact of Covid-19	Chief Operating Officer	12 Possible 3 x Major 4	**Treat** 	**Note** Planned care / activity may be displaced in order to manage the increased urgent care demand; causing increased delays to accessing elective care and treatment with the potential to cause patient harm. Score reduced in Aug, not yet reflected on trajectory

Current Controls

- Prioritisation of Cancer Pathways
- Clinical triage and prioritisation of waiting lists

- WGH Established as Elective Green Site
- Weekly tracking of cancer and RTT in place
- Working with IS – Insource / Outsource additional capacity
- Prehab Wellness Programme
- Monitor and ensure effective use of core capacity
- Urgent & Emergency Care Improvement Programme

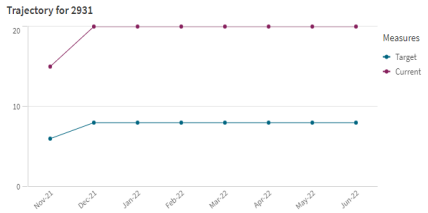
Actions	Target date	Update	Progress
Development of Urgent Elective Care Improvement programme	30/06/22	12/07/22	UEC plan developed with BHACP and approved at Trust Board in June 2022
Create new Integrated Performance report	23/05/22	19/05/22	New IPR completed and presented at the April 2022 Trust Board
Performance Accountability Framework & Revised Performance Meetings	22/07/22		Commenced July 22
Development of Care Group Integrated performance reports	30/09/22		In development; data library due to be completed end August 22; Care Group IPRs expected end Sept 22

3000	Risk of patient harm associated with capacity to effectively deliver the increasing urgent care demand	Chief Operating Officer	20 Almost Certain 5 x Major 4	**Treat** 	**Note** Impacted by: Increased urgent care demand Prolonged stays in ED Ambulance handover delays Bed occupancy levels at 95%+ Numbers of patients not meeting criteria to reside increasing Sickness levels in excess of 8%

Current Controls

- Real time monitoring of performance and access targets
- Daily patient flow meetings
- Urgent and Emergency Care Improvement Plan
- MADE Events – Multi-agency to discuss every patient on a weekly basis NMC2R chaired by Deputy COO (Community) with full representation from required system partners
- Daily Board Rounds
- Same Day Emergency Care Pathways in place
- Frailty Intervention Team
- Implementation of Escalation Policy
- Executive escalation response
- A&E Delivery Board
- Twice weekly system escalation meeting for those patients who do not meet the criteria to reside

Actions	Target date	Update	Progress
Refresh of current Urgent Elective Care Improvement Programme for BHACP	30/06/22	12/07/22	Board approved UEC plan in June 2022 following approval at June's A&E Delivery Board
Create new Integrated Performance report	23/05/22	18/05/22	New IPR completed and presented at the April Trust Board

2931	Risk of exceeding threshold level given for CDIFF positive patients for 2022/23 dependent upon timely sampling, antimicrobial stewardship, cleanliness and prompt isolation of patients	Executive Chief Nurse	12 Possible 3 x Major 4	**Treat** 	**Note** Impacted by: Meeting cleaning standards Antimicrobial stewardship/monitoring of antimicrobial prescribing in all clinical care groups Microbiology Consultant Capacity Management of cross infection through use of side rooms. Trajectory updates monthly therefore not yet showing the reduced score of 12.

Current Controls

- Trust Policy / Procedure – To ensure timely isolation of patient with diarrhoea and to ensure management as per the diarrhoea care pathway
- Estates and Capital teams contact Infection Prevention to ensure, and health building note risk assessment is completed for any Estates or Capital works to ensure all mitigation are in place
- Microguide - an electronic tool available to all prescribers, nursing and pharmacy for access to the current antimicrobial guidelines is implemented in the trust
- Business Continuity arrangements in place to provide senior pharmacist input to ensure essential antimicrobial changes are kept current on Microguide - the trust electronic antimicrobial formulary tool - this is additional support put in place until May 2022 when the return of the Antimicrobial Pharmacist from long term planned absence is expected.
- National Performance Standard / KPI - Measurement of C Difficile breaches, national indicators of infection
- EPMA in place and could be used for monitoring of agreed antimicrobials
- Clinical Pharmacist are required as part of their routine to check for antimicrobial formulary compliance and all other safe prescribing requirement when reviewing Patients prescriptions on EPMA (Lorenzo Electronic Prescribing and Medicines Administration)
- Medicines Management Drugs and Therapeutics Group agenda to have a regular agenda item to review Antimicrobial Stewardship
- Post infection review process in place which identifies any lapses in care and lessons to be learned

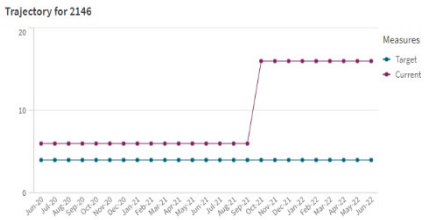
Actions	Target date	Update	Progress
Review antimicrobial stewardship and introduction of consultant Microbiologist-led ward round.	28/09/22	27/06/22	A team to support anti-microbial stewardship has been funded by the trust. Antimicrobial Management Group recently re-established for oversight.
Escalation of the need to improve engagement in Post Infection Reviews through Infection Prevention and Control Committee.	06/05/22	24/06/22	Agreed at IPCC 26th April 2022 to refresh the annual care group thresholds for C-Diff to be monitored at Infection Prevention Operational Group. Medicine and Surgery Care Group report C-Diff cases monthly against their agreed threshold.

BAF Risk Descriptor

There is a risk to the health and wellbeing of our workforce caused by:

- **Impacts of the pandemic (national staff shortages, early retirement and increased levels of staff sickness)**
- **Failure to offer a good working environment**
- **Failure to treat staff fairly and equitably**
- **Poor leadership**
- **Failure to support staff development**
- **Failure to transform our Human Resources and OD teams and practices**

This could lead to staff losing confidence in the Trust as an employer and result in poor staff satisfaction levels, impacting on the organisations reputation and culture subsequently affecting the ability to attract and retain staff, causing key workforce shortages, increasing the use of temporary staffing and poor patient care

2146	Risk of BAME colleagues having a poorer experience at work resulting in lower engagement levels, impacting on recruitment and retention and ultimately patient care	Director of People and OD	16 Likely 4 x Major 4	**Treat** 	**Note**

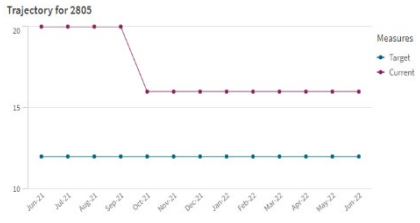
Current Controls

- National Performance Standard / KPI - Workforce Race Equality Standard (WRES)
- Annual WRES position and action plan developed in partnership with BME staff, presented to Trust Board every July.
- WRES Position and Action Plan Progress will be reported the Workforce Committee and Trust Board
- Five Task and Finish groups each led by an Exec Director, Non-Exec Director and an alumnus of the Ready Now positive action programme have been established to undertake focused work on priority areas for race equality as identified in the WRES. These are Bullying and Harassment; Recruitment and Selection; Clinical Incident Reporting; Talent Management and Succession Planning; and Conduct and Capability.
- Anti-Racism Influencers Group - allyship group chaired by the Chief Executive with leads from all Care Groups to help champion actively anti-racist positive behaviours and messaging in all areas of the Trust.

Action	Target date	Update	Progress
Anti-racist nursing leadership programme, designed and facilitated by Yvonne Coghill CBE, Vice President of the RCN and former Director of the WRES, and Dave Thornton, executive leadership coach. This programme will run from August 2022 to March 2023, for 24 senior nurses and midwives. The intention is to create an approach to anti-racism within nursing which is bespoke and sustainable for our organisation.	31/03/23	15/06/22	Initial session taking place 26th August 2022.
Cohort of 10-20 white senior leaders (including Board members) and ethnic minority aspiring leaders to be partnered in a reciprocal mentoring scheme for 2022.	31/03/23		Recruitment to this programme will run alongside full Board anti-racist development workshop in September 2022

Review of key Trust policies to ensure they do not support racist or unequal outcomes	31/10/22	29/06/22	Further review of disciplinary and MHPS policies to incorporate Mersey-care approach and reflecting just and learning culture work is underway
Race Equality Task & Finish Group established for Recruitment and Selection, led by an Executive Director, Non-Executive Director and supported by a senior BAME influencer to improve fairness in processes and provide better training to colleagues involved.	03/10/22		Diverse panels now mandated for nursing, midwifery and senior leadership roles. Bias Interrupters Group established
Race equality task & finish group established for disciplinary processes with a focus on conduct and capability, led by an Executive Director & Non-Executive Director and supported by a senior BAME influencer. Initial scope will be improving MHPS processes, including introduction of a decision tree, to first address the areas that are most clearly inequitable.	01/10/22	25/04/22 29/06/22	A review of previous and recent employee relations cases including process and outcome was undertaken, with gaps immediately acted upon, including ensuring that colleagues involved received appropriate support. This is being continued as a best practice approach through ongoing monthly case reviews. Employee Decision Tree is in use for all new cases to guide decision makers through seriousness, early intervention and non-formal processes review of MHPS and Disciplinary policies is underway to include a required process to consider restorative approaches before moving to formal process.
Race equality task & finish group formed for talent management led by an Executive Director & Non-Executive Director and supported by a senior BAME influencer, with a focus on positive action and a fundamental review of succession planning.	01/10/22		The Anti-Racist Programme was reset by the Board in October 2021, leading to smaller set of more focused action to ensure progress at pace. Due to this, actions set out in the WRES 2021 related to succession planning were put on hold for 2021 but should be revisited in 2022.

Post required - BAME Network Covid-19 Speak Up Ambassador	30/09/22	29/06/22	
Race equality task & finish group established for bullying and harassment, led by an Executive Director & Non-Executive Director and supported by a senior BAME influencer.	30/09/22		Board review to take place in September 22

					29/06/22 29/06/22	
2805	Risk of Patient harm associated with recruitment difficulties and under establishment of medical staff within ED RLI	Chief Medical Officer	16 Likely 4 x Major 4	**Treat** 	**Note** Currently 7 in post (plus 1 on sabbatical) against minimum requirement of 12.

Current Controls

- Use of Agency staff at Middle grade level. Bank Doctors used. Enhanced rates may be offered
- Medical staffing may not be optimal for the number of patients in the department. Incidents are reported to reflect the concerns

Actions	Target Date	Update	Progress
Recruitment efforts ongoing Agency staff in use	31/08/22	15/07/22	Recruitment for ED Consultants remains live. Potential internal candidates eligible in next 6 months.

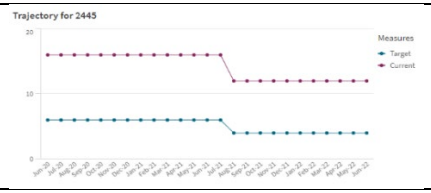
2945	Risk of patient harm associated with recruitment difficulties and under establishment of medical staff within ED FGH	Chief Medical Officer	12 Possible 3 x Major 4	**Treat** 	**Note** Some success with recruitment therefore score reduced.

Current Controls

- Use of Agency and Bank staff
- Medical staffing may not be optimal for the number of patients in the department, therefore incidents are reported to reflect concerns

Actions	Target Date	Update	Progress
Recruitment efforts ongoing Agency staff in use	31/01/23	05/05/22	New rota in place from April 2022

2445	Risk that colleagues may experience unacceptable behaviour including	Director of People and OD	12	**Treat**	**Note** 8-12% of colleagues are having a poorer experience - National Staff Survey 20/21.

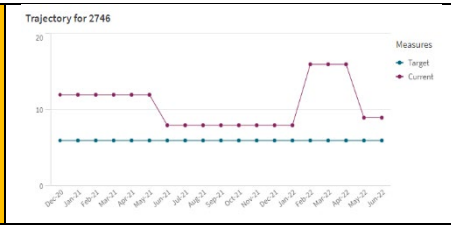
	bullying & harassment, affecting patient quality and safety		Possible 3 x Major 4		

Current Controls

- Bullying & Harassment Policy and Respect at Work policies in place
- Freedom To Speak Up Guardian - issues related to behaviour come through the FTSU route.
- Behavioural Standards framework in place
- E-learning package for Equality and Diversity, Behavioural Standard Framework and Inclusive, Compassionate Leadership, Assertiveness training and bespoke coaching
- Enhanced support programme and bespoke organisational development programmes for teams in difficulty

Actions	Target Date	Update	Progress
Comparative audit of Bullying and Harassment completed with support of NHSE/I and actions for 22/23 developed including • Race Equality Transformation • Review of Civility Toolkit Pilot • Refresh of Behavioural Standards Framework and review in line with publication of new Trust Vision and Values • Update of training and Leadership Programme content • Improved data collection and analysis (MIAA audit action) • Development of support and advisory skills (MIAA audit action) • Implementation of recommendations from Respect Champion review	30/03/23	10/06/22	Recommendations taken to POD Strategy Group and TMG - June 22. Implementation underway, as part of the Culture & Leadership RSP workstream

2746	Risk that Colleagues' resilience will be reduced due to sustained pressures from multiple sources increased due to Covid.	Director of People and OD	9 Possible 3 x Moderate 3	**Treat**	**Note** Discussed and agreed de-escalation at POD Strategy Group due to progress.

Current Controls

- Occupational Health Service well developed: Provision of TRIM, manage network of MH First Aiders, manage Resilience Hub, Psychological support, Physical support - Vaccinations, physio etc
- Numerous local support packages targeted at NHS i.e., Lancs and South Cumbria support, Macmillan Cancer, Samaritans
- Option to self-refer by colleagues or manager refer for support. Colleagues can be supported through either route.
- Implemented the EASE service which provides fast-track support for colleagues with MSK or psychological support needs on first day of absence

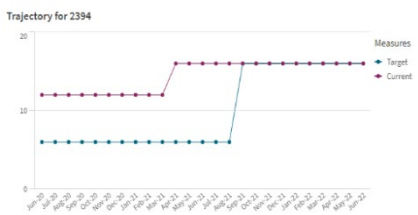
Actions	Target Date	Update	Progress
Wellbeing action plan in place with oversight by RSP: - Management support to ensure colleagues take breaks - 1)Management Support to ensure colleagues take breaks - 2) Review of IPC policies to support colleagues to be able to have water - 3) Identification of Clinical Leaders to own this priority - 4) Process to spot check and ensure colleagues have breaks - Clinical and Non-Clinical areas - 5) Identify a team/s within the trust that do this well and use this learning across the organisation Launch of new Flourish Strategy (aimed at meeting colleagues' basic needs) to be approved by People Committee/Board in September 2022 Re-introduction of a Colleague Recognition and Reward programme for all employees	31/03/22	01/08/22	3 clinical posts to be recruited EASE programme launched. Significant reduction in time to wait for support (8-10 weeks for psych support – now 2-4 weeks depending on service required). MSK support has been reduced from 16 weeks to 9 days. Leadership programme introduced to support wellbeing and resilience – Back to Basics for Leaders. All Colleague Support Programmes refreshed and re-launched and delivered both in person and on Teams.

BAF Risk Descriptor

There is a risk of the Trust's ambitions to achieve integrated care across the Bay area caused by:

- **Poorly defined shared vision and objectives and no strategic approach to issue of risk, costs and benefits**
- **Collaborative advantages for working together not defined and agreed**
- **Challenges arising from competing priorities from different partners**
- **Evolving system working and external constraints**
- **Strategic partners do not meet performance targets or deliver programmes of work**
- **Lack of effective and consistent well-resourced leadership**
- **Failure to engage stakeholders**

The effect of this of this is no improvement in services or outcomes for population served by UHMB

2394	Risk to the delivery of commissioned community nursing services due to a lack of clear process for Continuing Health Care impacting on capacity of teams	Executive Chief Nurse	16 Likely 4 x Major 4	**Tolerate** 	**Note** The ultimate solution to this risk lies with Adult Social Care however their risk impacts on UHMBT. The source of the risk cannot be addressed by UHMBT. UHMBT actions address the impact on the trust

Current Controls

- UHMB representation on IPA (CHC) steering group hosted and chaired by the ICS
- UHMB are sighted on the issues and concerns and have escalated through the trust and Bay Health & Care partners.
- Community Care Group is addressing the concerns through various mechanisms and are creating their own short term solutions whist awaiting guidance from the ICS
- Commissioner related risks are reported to the Quality Assurance Meeting which is joint meeting between the Commissioners and the Trust

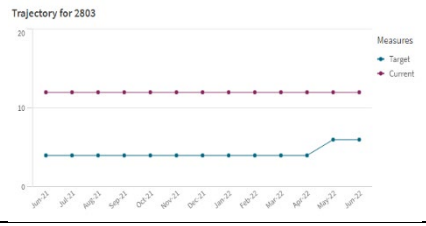
Actions	Target Date	Update	Progress
ICS/CCG workshops looking at whole system approach for end-to-end Continuing Health Care process	28/07/22	02/08/22	Deputy Chief Operating Officer, UHMB Executive Chief Nurse, CCG Executive Chief Nurse, and Transformation lead involved. Paper requesting an end-to-end service but with an interim solution taking CHC away from DNs submitted to ICB Designated Chief Nurse. This will either be through CSU or another provider to be funded by the ICB

BAF Risk Descriptor

There is a risk to the delivery of the Trust's priority to deliver financial sustainability through quality and safety improvement and transformation caused by:

- **Limited capacity and capability to deliver and implement key change programmes**
- **Challenges of workforce transformation and complexity of new models of care**
- **Evolving system working and external constraints;**
- **Limitations of aging estate and backlog maintenance**
- **Capital funding availability**
- **Limited investment and capability to utilise digital technologies**

The effect of this would be failure to deliver change in the required timescales and achieve our planned deficit reduction and financial recovery trajectories and may impact on quality and safety resulting in deterioration in outcomes for patients

2803	Risk of cross infection due to limited number of side rooms available in our hospitals cross bay	Executive Chief Nurse	12 Likely 4 x Moderate 3	**Treat** 	**Note** This risk is magnified during the COVID-19 pandemic when high number of infectious patients were present in our hospitals. This is resulting in the increased reliance on co-horting of patients and using a prioritisation tool for single use rooms

					There is currently a Single Room Provision Group who are meeting to review provision. This includes both long and short-term solutions.

Current Controls

- Trust 'Priority for single room' tool in use to support highest risk patients accessing very limited single room provision.
- The COVID-19 policy and the use of risk "colours" for patient cohorts support patients with a similar COVID risk profile having care in the same multi bedded area.
- Isolation room audit completed by the IP team at least weekly to rationalise the use of single rooms on the two main sites and ensure highest risk patients are prioritised in line with the Priority tool.
- New single room provision created at RLI site. This is due to a renovation and creation of W4 in MU1, which has 12 single rooms with en-suites. Lancaster Suite now has 8 single rooms due to remodelling.

Actions	Target date	Update	Progress
Increase single occupancy room provision to meet national benchmark, increase ensuite provision to meet national benchmark, reduce bed base numbers in multi-bedded bays to meet HTM standards and provide integral bathroom facilities	25/11/22	01/08/22	All new builds and refurbishments are being completed to current HBN spec in terms of isolation expectation Ventilation review undertaken for the whole Trust and is being scrutinised by the Ventilation Management Group with a view to improving Trust-wide ventilation capacity
Trial of Clinell Redi-rooms has taken place (not to be installed). Bioquell pods now to be investigated as a further option.	16/09/22		

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BOARD OF DIRECTORS

Date of Meeting	28 September 2022
Title	Policy & Publications Report
Report of	Aaron Cummins – Chief Executive
Prepared by and contact details	Maria Caparelli – Business Manager to Chief Executive maria.caparelli@mbht.nhs.uk

Confidentiality	Non-Confidential

Purpose of Report	**To Advise/Alert**	**To Assure**	**To Approve**	**To Update**
	x	x		x
	The purpose of this report is to provide the Board of Directors with information on recent policy developments and relevant information issued from the Department of Health, NHS England / Improvement, NHS Providers, NHS Confederation, Care Quality Commission (CQC) and Healthwatch. This report also provides a view as to any upcoming External Agency Visits, Inspections and Accreditations that are expected in month.			

Summary of Key Issues	This report highlights a number of current policies, guidance or publications, as follows: - Working in Partnership with People and Communities: Statutory Guidance for Integrated Care Boards, NHS Trusts, NHS Foundation Trusts and NHS England, 2022 - Update on COVID-19 public inquiry - Changes to universal mask wearing guidance - UHMBT - External Agency Visits, Inspections and Accreditations

Prior Discussions	**Committee**	**Date**	**Recommendations/ Concerns**

Action to be recommended to the Committee/Board	The Board of Directors is asked to note the contents of this paper.

Link to Key Priorities	Delivering outstanding care and experience	Create the culture and conditions for colleagues to be the very best they can be	Make the best use of our physical and financial resources	Working in partnership
	x	x	x	x

Impact on Board Assurance Framework or Corporate Risk Register				
Risk Impact Assessment	Is this required?	**N**	If Yes, Date Completed	
Equality Impact Assessment	Is this required?	**N**	If Yes, Date Completed	
Quality Impact Assessment	Is this required?	**N**	If Yes, Date Completed	
Environmental / Sustainability Impact Assessment	Is this required?	**N**	If Yes, Date Completed	

Acronyms	

UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST

Policy & Publications Report

Working in Partnership with People and Communities: Statutory Guidance for Integrated Care Boards, NHS Trusts, NHS Foundation Trusts and NHS England, 2022

1. Working in partnership with people and communities is new statutory guidance for Integrated Care Boards, NHS trusts and foundation trusts, published by NHS England. It supports the 'triple aim' of better health and wellbeing, improved quality of services and the sustainable use of resources.

2. The guidance sets out how working with people and communities supports the wider objectives of integration including population health management, personalisation of care and support, addressing health inequalities and improving quality. It supports building collaborative and meaningful partnerships that start with people and focus on what really matters to our communities.

3. There are clear benefits to working in partnership with people and communities. It means better decisions about service changes and how money is spent. It reduces risks of legal challenges and improves safety, experience and performance. It helps address health inequalities by understanding communities' needs and developing solutions with them. It is about shaping a sustainable future for the NHS that meets people's needs and aspirations.

4. Integrated care gives an opportunity for the NHS to collaborate with partners on working with communities. This is both within the NHS (for example, commissioners and providers coordinating their involvement activities so they do not duplicate), and between the NHS and other partners – including local authorities, social care providers, Healthwatch and voluntary, community and social enterprise (VCSE) sector organisations that already have links to and knowledge of communities.

5. You can access this guidance here: https://www.england.nhs.uk/publication/working-in-partnership-with-people-and-communities-statutory-guidance/

Update on COVID-19 public inquiry

6. NHS Providers have issued a helpful briefing and summary update on the COVID-19 public inquiry.

7. The government has set up the COVID-19 public inquiry to examine the UK's preparedness and response to the pandemic, and to learn lessons for the future. Its chair is Baroness Heather Hallett DBE.

8. The final terms of reference, following a six-week public consultation on the draft terms, have been accepted by the government. The inquiry was officially launched by Baroness Hallett on 21 July 2022. During the launch she set out her approach to the inquiry as well as the timetable, with the first procedural hearing due to take place this month.

9. The inquiry will be broken down into three modules with teams set up across the UK to investigate and report on each module, followed by public hearings chaired by Baroness Hallett. The third and final module will examine the impact on the health

sector including the impact of COVID-19 and of the governmental and societal responses to it, on healthcare systems and patients, hospital and other healthcare workers and staff. Among other issues, it will investigate healthcare systems and governance, hospitals, primary care, the impact on NHS backlogs and non-COVID treatment, the effects on healthcare provision of vaccination programmes, and long COVID diagnosis and support.

Changes to universal mask wearing guidance - UHMBT

10. I would like to start by thanking colleagues for their cooperation to the restrictions we have had in place since the start of the pandemic. We have been keeping our COVID-19 restrictions under continuous review; and our priority remains the safety of our colleagues, patients and community.

11. We have seen a significant decrease in COVID-19 cases and feel we are now in a position to move into the next stages of the 'living with COVID' guidance. With effect from 19 September 2022, we will no longer require universal mask use at our sites.

12. There will however, still be heightened restrictions in place in certain situations and colleagues will need to wear a mask when:

- Within 2 metres where the patient is an unknown risk; where the patient has attended to a high-risk area (such as ED where no triage has taken place).
- Within 2 metres or on entrance to a single room where the patient is symptomatic or confirmed for a respiratory communicable disease
- Within 2 metres or on entrance to a single room where the patient is immunocompromised
- Where there is the risk of contamination of blood, bodily fluid, excretions and secretions in line with standard precautions.
- Where there is a wide spread outbreak on a ward universal mask use to be requested in that clinical area

13. There is and should continue to be access to masks for those who are choosing to wear a mask for any healthcare interaction. This is a personal choice and UHMBT expects this choice to be supported and colleagues should feel confident to make this decision – It is vital however that masks are worn and changed in a timely manner with appropriate hand hygiene.

14. For our community teams: where our UHMBT Integrated Community care teams are going into Nursing and care homes, please follow local policy.

EXTERNAL AGENCY VISITS, INSPECTIONS AND ACCREDITATIONS

15. The Trust Compliance and Assurance team maintain a database of all external agency visits, inspections and accreditations.

16. This contains overview of any external visits, inspections or accreditations the Trust is expecting.

17. The Women & Children's Care Group have the following scheduled visits coming up:

    - 29 September 2022 – North West Operational Delivery Network Annual visit - Neonatal Unit, Royal Lancaster Infirmary (RLI)

- 17 October 2022 - NHSE/I Perinatal Pelvic Health project - South Lakes Birth Centre & Helme Chase Maternity Unit

18. There are no further external visits expected this month.

Aaron Cummins
Chief Executive

September 2022

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1 April 2022 – 31 March 2023
Trust Board Members' Attendance Monitoring

Public Board of Directors' Meetings

MEMBERS	27/04/2022	25/05/2022	29/06/2022	27/07/2022	31/08/2022	28/09/2022	26/10/2022	30/11/2022	21/12/2022	25/01/2023	22/02/2023	29/03/2023
Mike Thomas, Chair (Chair)												
Aaron Cummins, Chief Executive												
Chris Adcock, Director of Finance / Deputy Chief Executive												
Karen Deeny, Non-Executive Director (wef 25/07/2022)												
Bev Edgar, Interim Chief People Officer (wef 22/08/2022)												
Adrian Leather, Non-Executive Director												
Bridget Lees, Executive Chief Nurse												
Scott McLean, Chief Operating Officer (wef 01/07/2022)												
Jane McNicholas, Medical Director												
Sarah Rees, Non-Executive Director												
Hugh Reeve, Non-Executive Director												
Richard Sachs, Director of Governance												
Liz Sedgley, Non-Executive Director												
Jill Stannard, Non-Executive Director												
Stephen Ward, Non-Executive Director												
Members who have resigned / term of office ended during 2022/23												
Leanne Cooper, Interim Chief Operating Officer (01/03/2022-30/06/2022)												
David Wilkinson, Director of People and OD												

Attended	Apologies	Deputy	Not commenced


in post

University Hospitals of Morecambe Bay NHS Foundation Trust
Board of Directors' Forward Plan 2022/23

	Quarter 1 2022/23			Quarter 2 2022/23			Quarter 3 2022/23			Quarter 4 2022/23		
	27 April 2022	25 May 2022	29 June 2022	27 July 2022	31 August 2022	28 September 2022	26 October 2022	30 November 2022	22 December 2022	25 January 2023	22 February 2023	29 March 2023
Board Core Items	Minutes	Minutes	Minutes	Minutes	Minutes	Minutes	Minutes	Minutes	Minutes	Minutes	Minutes	Minutes
	Action Tracker	Action Tracker	Action Tracker	Action Tracker	Action Tracker	Action Tracker	Action Tracker	Action Tracker	Action Tracker	Action Tracker	Action Tracker	Action Tracker
	Patient Story	Patient Story	Patient Story	Patient Story	Patient Story	Patient Story	Staff Story	Patient Story	Patient Story	Patient Story	Patient Story	Patient Story
	Chair's Report	Chair's Report	Chair's Report	Chair's Report	Chair's Report	Chair's Report	Chair's Report	Chair's Report	Chair's Report	Chair's Report	Chair's Report	Chair's Report
	CEO Report	CEO Report	CEO Report	CEO Report	CEO Report	CEO Report	CEO Report	CEO Report	CEO Report	CEO Report	CEO Report	CEO Report
	Head Governor Update	Head Governor Update	Head Governor Update	Head Governor Update	Head Governor Update	Head Governor Update	Head Governor Update	Head Governor Update	Head Governor Update	Head Governor Update	Head Governor Update	Head Governor Update
	Recovery Support Programme	Recovery Support Programme	Recovery Support Programme	Recovery Support Programme	Recovery Support Programme	Recovery Support Programme	Recovery Support Programme	Recovery Support Programme	Recovery Support Programme	Recovery Support Programme	Recovery Support Programme	Recovery Support Programme
	CQC / Niche and Royal College of Surgeons Improvement Plan	CQC / Niche and Royal College of Surgeons Improvement Plan	CQC / Niche and Royal College of Surgeons Improvement Plan	CQC / Niche and Royal College of Surgeons Improvement Plan	CQC / Niche and Royal College of Surgeons Improvement Plan	CQC / Niche and Royal College of Surgeons Improvement Plan	CQC / Niche and Royal College of Surgeons Improvement Plan	CQC / Niche and Royal College of Surgeons Improvement Plan	CQC / Niche and Royal College of Surgeons Improvement Plan	CQC / Niche and Royal College of Surgeons Improvement Plan	CQC / Niche and Royal College of Surgeons Improvement Plan	CQC / Niche and Royal College of Surgeons Improvement Plan
	Maternity Services Update	Maternity Services Update	Maternity Services Update	Maternity Services Update including ATAIN update	Maternity Services Update	Maternity Services Update	Maternity Services Update including ATAIN update	Maternity Services Update	Maternity Services Update	Maternity Services Update including ATAIN update	Maternity Services Update	Maternity Services Update
			Maternity Serious Incidents Report (private)				Maternity Serious Incidents Report (private)			Maternity Serious Incidents Report (private)		
	Integrated Performance Report	Integrated Performance Report	Integrated Performance Report	Integrated Performance Report	Integrated Performance Report	Integrated Performance Report	Integrated Performance Report	Integrated Performance Report	Integrated Performance Report	Integrated Performance Report	Integrated Performance Report	Integrated Performance Report
	Assurance Committee 3A Report	Assurance Committee 3A Report	Assurance Committee 3A Report	Assurance Committee 3A Report	Assurance Committee 3A Report	Assurance Committee 3A Report inc Cultural Programme Board	Assurance Committee 3A Report	Assurance Committee 3A Report inc Cultural Programme Board	Assurance Committee 3A Report	Assurance Committee 3A Report inc Cultural Programme Board	Assurance Committee 3A Report	Assurance Committee 3A Report inc Cultural Programme Board

University Hospitals of Morecambe Bay NHS Foundation Trust
Board of Directors' Forward Plan 2022/23

		Mortality Review Update						Mortality Review Update				
	ICS/PCB Update	ICP Update	ICS/PCB Update	ICB/PCB Update	ICB/PCB Update	ICB/PCB Update	ICB/PCB Update	ICB/PCB Update	ICB/PCB Update	ICB/PCB Update	ICB/PCB Update	ICB/PCB Update
	Policy and Publications			Policy and Publications		Policy and Publications		Policy and Publications		Policy and Publications		Policy and Publications
	Employment, Patient Safety and Other Alerts	Employment, Patient Safety and Other Alerts / RO Update	Employment, Patient Safety and Other Alerts	Employment, Patient Safety and Other Alerts / RO Update	Employment, Patient Safety and Other Alerts	Employment, Patient Safety and Other Alerts	Employment, Patient Safety and Other Alerts / RO Update	Employment, Patient Safety and Other Alerts	Employment, Patient Safety and Other Alerts	Employment, Patient Safety and Other Alerts / RO Update	Employment, Patient Safety and Other Alerts	Employment, Patient Safety and Other Alerts
Board Quarterly Items		End of year Review of priorities		Q1 Quarterly Review of priorities including improvement work and Q1 finance review and Board Assurance Framework 2022/23/ Effectiveness Review of UHMB Strategy			Q2 Quarterly Review of priorities including improvement work and Board Assurance Framework 2022/23			Q3 Quarterly Review of priorities including improvement work and Board Assurance Framework 2022/23		Draft Board Assurance Framework 2023/24
	New Hospitals Programme Update Q4	BAF 2022/23		Chief Medical Officer Update			Chief Medical Officer Update: including Research & Guardian of Safe Working			Chief Medical Officer Update: including Research & Guardian of Safe Working		
			Freedom to Speak Up Annual Report	New Hospitals Programme Update Q1					Freedom to Speak Up Update	New Hospitals Programme Update Q3		
							New Hospitals Programme Update Q2					

University Hospitals of Morecambe Bay NHS Foundation Trust
Board of Directors' Forward Plan 2022/23

Board Annual / Statutory Items	Final Annual Plan 2022/23	Annual Report and Accounts 2022/23 (deadline 22/06/2022) (Audit Committee 17/06/2022)	Urgent Care Improvement Plan	*Chief Medical Officer Update including Guardian of Safe Working Annual Report, Annual Appraisal & Revalidation Report		Operational Resilience Plan including the Emergency Planning Resilience and Response (EPPR) Annual Assurance Return				Green Plan inc Carbon Energy Development		Draft Annual Plan 2023/24
	Final Trust Strategy / Purpose, Vision and Values	NHSI Submission of Annual Self-Declarations		Safe Staffing		Positive Difference Annual Report including Workforce Race Equality Standard / Workforce Disability Equality Standard / Gender Pay Gap Report / Equality Delivery System 2						NHS Staff Survey (public)
								Lancashire and South Cumbria Pathology Service Final Proposal		Safe Staffing		
												Annual Report from the Director of Infection Prevention and Control
	Board and Committee TORs		Board and Committee Effectiveness									

Strategies / other items reserved for Board for discussion – see below						Urgent Care Recovery Programme and Winter Planning						
Assurance Committee Items – for further discussion regarding items delegated to Committees		Cultural Transformation Programme			Cultural Transformation Programme			Cultural Transformation Programme		Cultural Transformation Programme		Cultural Transformation Programme
Extra Board Sessions												

Items for further discussion to be added to the Board Forward Plan:			
Other Items Reserved for Board	**Board Workshops**	**Strategies and Enabling Strategies Reserved for Board**	**Strategies delegated to Assurance Committees**
	• Review of Integrated Performance Report (March 2023) • Review of strategic risks and Board Assurance Framework 2023/24 (February / March 2023) See Board Development Programme 2022/23 for further details.	• Research and Development Strategy • Digital Strategy • Membership Strategy • Risk Management Strategy • ICP Strategy • ICS Strategy • Estate Strategy • Clinical Service Strategy • Financial Sustainability Strategy • Positive Difference trategy • People Strategy and Plan • Cultural and OD Improvement • Operational Plan • Operational Resilience Plan • Health and Safety Strategy • Freedom to Speak Up Policy	• Patient Experience Strategy (quarterly updates to Quality Committee) • Quality Improvement Strategy (Quality Committee) • Complaints Procedure (Quality Committee) • Communications and Engagement Strategy • Health and Wellbeing Flourish Strategy (People Committee) • Fit and Proper Person Policy (Audit Committee) • Standards of Business Conduct (Audit Committee) • Governance and Assurance Strategy (Audit Committee)