PUBLIC TRUST BOARD OF DIRECTORS' MEETING

Wednesday 26 October 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					
132	Welcome and Introductions • Apologies for absence received from Scott McLean (Leanne Cooper to attend) • Declaration of conflicts of interest	Chair	To note	Verbal	9.30am-9.31am (1 Minute)
133	Minutes of the Board of Directors' Meeting held on 28 September 2022 *To approve the Minutes of the Meeting held on 28 September 2022.*	Chair	To approve	Attached	9.31am-9.33am (2 Minutes)
134	Action Sheet and Matters arising from the Minutes of the Public Meeting of the Board of Directors held on 28 September 2022 *To consider the action sheet and note the actions taken.*	Chair	To note	Attached	9.33am-9.35am (2 Minutes)
Matters for Consideration					
135	Patient Story: Organ Donation family experience case study *A presentation by the Organ Donation Services team. This year's Organ Donation campaign took place from 26 September 2022 to 2 October 2022. Everyday people of all ages and backgrounds become recipients and donors of organs, eyes, and tissues. Matt Collis, a Specialist Nurse in Organ Donation and Dr Vera Gotz Consultant in Acute & Intensive Care Medicine will share a donor family experience case study.*	Chief Nursing Officer	To note	Verbal	9.35am-9.50am (15 Minutes)
136	Chair's Report	Chair	To	Attached	9.50am-

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

	An update presented by the Chair.		approve		9.55am (5 Minutes)
137	Chief Executive's Report *An update presented by the Chief Executive.*	Chief Executive	To note	Attached	9.55am-10.05am (10 Minutes)
138	Head Governor Update *An update presented by the Head Governor.*	Head Governor	To note	Attached	10.05am-10.10am (5 Minutes)
People and organisational development: ***Create the culture and conditions for colleagues to be the very best they can be***					
139	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	10.10am-10.30am (20 Minutes)
Quality and safety: ***Delivering outstanding care and experience***					
140 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	10.30am-10.40am (10 Minutes)
140	Niche External Investigation Assurance	Director of	For	Attached	10.40am-

ii	*A report to present the current position, progress of and cross-cutting themes of the NICHE recommendations.*	Governance	assurance		10.45am (5 Minutes)
141 i	Maternity Safety 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	10.45am-10.50am (5 Minutes)
141 ii	Avoiding Term Admissions into Neonatal Units (ATAIN) Report *A report to provide an overview on the progress with safety action three from the Maternity Incentive Scheme Year 4.*	Executive Chief Nurse / Director of Midwifery	To approve	Attached	10.50am-10.55am (5 Minutes)
141 iii	Safety Champion Report *A report to provide an update from the maternity safety champion.*	Chief Nursing Officer / Director of Midwifery	For assurance	Attached	10.55am-11am (5 Minutes)
	Mid-morning break				11am-11.10am (10 Minutes)
142	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	To consider	Attached	11.10am-11.20am (10 Minutes)
Performance and resources: Make the best use of our physical and financial resources					
	The items in this section will be discussed with reference to the Integrated Performance Report and other specific reports				
143 i	Integrated Performance Dashboard and Report Month 5 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	11.20am-11.40am (20 Minutes)

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

143 ii	Minutes and 3A Reports from Assurance Committees a) People Committee Minutes from Meeting on 18 July 2022 and 3A Report from Meeting on 3 October 2022 b) Audit Committee Minutes from Meeting on 25 and 31 August 2022 and 3A Report from Meeting on 20 October 2022 c) Finance and Performance Committee Minutes and 3A Report from Meeting on 26 September 2022 and Update from Meeting on 24 October 2022 d) Quality Committee Minutes from Meeting on 26 September 2022 and 3A Report from Meeting on 17 October 2022 The 3A Reports are included as appendices to the Integrated Performance Report.	Chairs of the Assurance Committees	To note	Please refer to Board of Directors' Reference Pack for copies of the Committee Minutes	11.40am-11.50am (10 Minutes)
144	Quarter 2 Review 2022/23 *A report to provide assurance on progress during Quarter 2 against the Trust's portfolio priorities aligned to the 2022/23 Trust Priorities:* • *Deliver outstanding care and experience;* • *Create the culture and conditions for our colleagues to be the very best they can be;* • *Make the best use of our physical and financial resources; and* • *Working in partnership.* *As part of this item, the Board will review the Board Assurance Framework.*	Chief Executive Company Secretary	For discussion	Attached	11.50am-12.10pm (20 Minutes)
Working in partnership ***Working together as one with a culture of continuous improvement***					
145	Integrated Care Board Update / Provider Collaborative Update *A report to present an update from the Integrated Care Board and Provider Collaborative.*	Chief Executive	To note	Attached	12.10pm-12.15pm (5 Minutes)
146	New Hospitals Programme Quarter 2 Report *A report to provide an update on the New*	Chief Operating Officer	To consider	Attached	12.15pm-12.20pm (5

	Hospitals Programme for the quarter 2 period.				Minutes)
Governance and Assurance					
147	Chief Medical Officer Update *A report to provide an update on the following areas of the Chief Medical Officer's portfolio:* i. *Research and Development; and* ii. *Guardian of Safe Working Hours Quarterly Update.*	Chief Medical Officer	To consider	Attached	12.20pm-12.30pm (10 Minutes)
Closing Administration					
148	Attendance Monitoring Register	Chair	To note	Attached	12.30pm-12.35pm (5 Minutes)
149	Schedule of Business	Chair	To note	Attached	
150	Urgent Business	Chair	To note	Verbal	
151	Date, Time and Venue of Next Meeting: Wednesday 30 November 2022 at 10am in the Board Room, Westmorland General Hospital, Kendal LA9 7RG and also via Microsoft Teams.				
152	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 24 October 2022.

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

THIS PAGE IS INTENTIONALLY BLANK

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

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.	
16/09/2022	Bev Edgar	Interim Chief People Officer	1. Trustee at BHS Trust Fund since 8 February 2021 2. Trustee on two charity Boards, John Taylor and Birmingham St Marys Hospices since June 2019	A material conflict of Interest does not exist as Trust Fund and hospices are based outside the catchment of the UHMB NHS Foundation Trust	

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			✓
20/09/2022	Richard Sachs	Director of Governance	Trustee of Endeavour Learning Academy Trust	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 Affairs	1. Outside Employment - Lancashire County Council as Paid volunteer Care support Worker 2. Outside Employment – ICS - Vaccination centre volunteer (unpaid)	It is not a management role 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.	
6/10/2022	Karen Deeny	Non-Executive Director	1. Director of Deeny Consulting Ltd 2. Co-Vice Chair and Senior Independent Trustee for Transforming Futures Multi-Academy Trust	Potentially a material conflict of interest may arise from the role with activities being undertaken by her consultancy. However, Karen would consider the circumstances; make a declaration and consider withdrawing from any meetings where the matter being discussed relates to her consultancy.	

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. Active Lancashire holds contracts with the Integrated Care Board (ICB) and going forward, Active Lancashire could be contacted through the ICB to provide home-care services in Morecambe Bay. No direct contracts are held with UHMB. 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	Potentially a material conflict of interest may arise from the role with activities being undertaken by his consultancy	

			GP services to health care 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.	and NHS 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			✓

Minutes of the Trust Board of Directors' Meeting held on
Wednesday 28 September 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:	Mike Thomas (MT)	Chair
	Aaron Cummins (AC)	Chief Executive
	Chris Adcock (CA)	Chief Financial Officer / Deputy Chief Executive
	Karen Deeny (KD-NED)	Non-Executive Director
	Adrian Leather (AL-NED)	Non-Executive Director
	Scott McLean (SM)	Chief Operating Officer
	Jane McNicholas (JM)	Chief Medical Officer
	Hugh Reeve (HR-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
	Megan Fowler (MF)	Team Lead – Occupational Therapy (for item 113)
	Lyn Hadwin (LH)	Deputy Director of People and OD
	Yvonne Hastings (YH)	Clinical Service Manager (for item 113 only)
	Louise Jones (LJ)	Head of Communications
	Paul Jones (PJ)	Company Secretary
	Ben Maden (BM)	Staff Side Chair
	Joanne McGuire (JMcG)	Matron – Urgent and Emergency Care (for item 113 only)
	Barry Rigg (BR)	Head of Patient Experience (for item 113 only)
	Richard Sachs (RS)	Director of Governance
	Donna Southern (DS)	Quality, Safety and Assurance Lead – Midwife (for item 119 only)
	Lynne Wyre (LW)	Deputy Chief Nurse

22/110 Welcome and Introductions

Apologies for Absence

Apologies for absence were received from Bev Edgar, Sakthi Karunanithi, Bridget Lees and Sarah Rees.

Declarations of Conflicts of Interest

PJ advised KD-NED declarations were Director of Deeny Consulting Ltd and Trustee and Senior Independent Trustee for Transforming Futures Multi-Academy Trust. PJ explained these were not available when the declarations of Board members were extracted from the register.

22/111 Minutes of the Board of Directors' Meeting held on 31 August 2022

Decision: That the Minutes of the meeting held on 31 August 2022 be agreed as an accurate record.

22/112 Action Sheet and Matters Arising from the Minutes of the Public Meeting of the Board of Directors held on 31 August 2022

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

22/113 Patient Story

LW introduced BR.

BR introduced the patient story explaining David had suffered a stroke. BR played a video to share David's recovery from a stroke and the support he had received from the integrated community stroke team every working weekday with a combination of physiotherapy and occupational therapy.

LW thanked the patient and family and all the team for sharing the story which demonstrated how teamwork had a positive impact on patient experience, outcomes and their quality of life.

AC thanked David and his wife Pamela for sharing their story with the Board. The Trust had invested in improving the stroke care provision. AC commented that it was a privilege to hear how the teams had responded to make the improvements to stroke care provision through David's story.

MT thanked David and Pamela.

22/114 Chair's Report

Mike Thomas presented the Chair's report and updated the Board of Directors on his work.

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

KD-NED provided an update on her role as the Non-Executive Director (NED) maternity safety champion. It was agreed the Chair's report would like an update from the NED maternity safety champion each month.

Decision:
1. That the report be noted; and
2. It was agreed an update from the Non-Executive Director maternity safety champion be included in future reports.

22/115 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 advised there were several items which the report referred to and would be presented in further detail at the meeting today, such as winter planning and urgent care.
2. AC thanked all colleagues working in the Trust and wider partnership in Morecambe Bay. September had been another challenging month in terms of pressure, particularly in urgent care. The Trust escalated to OPEL level 4 due to operational pressures. Escalation was stepped down a couple of days later. AC commended the efforts of colleagues continuing to make improvements against a backdrop of challenging pressures across the organisation.
3. Her Majesty The Queen passed away peacefully at her Balmoral residence on 8 September 2022. On behalf of the Trust, AC extended his condolences and best wishes to The Queen's family. AC thanked colleagues for their actions within the period of mourning and for ensuring services were delivered during this period and bank holiday.
4. Nationally, there had been significant changes with the appointment of a new Prime Minister and new Secretary of State for Health. AC corrected the error in the report which stated Suella Braverman was the Secretary of State for Health; Therese Coffey had been appointed as Secretary of State for Health.
5. AC set out the impact of these changes and it was pleasing to note the guidance/direction on specific focus for the NHS was aligned to Trust strategy and objectives, which included health and wellbeing of colleagues, elective recovery, reducing waiting times and improving access and improving urgent care with particular focus on ambulance performance and handovers. These were the Trust's key priorities.
6. Mobilisation of the new Integrated Care Board system had been in operation from 1 July 2022 and also aligned to the national objectives, such as elective recovery, urgent care improvement and financial performance improvement. Confirmation and details of the appointment of Place-based Partnership had been included in the report.
7. AC advised that unfortunately the Trust's Annual Members' Meeting was postponed this month due to the period of mourning. A revised date had been arranged and the team were exploring options to improve accessibility for communities to attend the event. Further details of the event would be communicated in due course.
8. AC advised the Trust did not appoint to the role of Chief People Officer. In the interim, Bev Edgar would continue to work with the Trust for 6 months. The post had been advertised with interviews taking place on 12 October 2022; an early review of interested candidates was positive.
9. Referring to the trauma and orthopaedic service, AC thanked the two consultant surgeons who had raised the concerns and apologised for the continued period taken to work through that. The final report would be presented to the Board of Directors at their meeting on 30 November 2022. The report was an independent external review on the impact on colleagues raising concerns in the way that progressed through the trauma and orthopaedic service. A joint meeting with the Board and Council of

Governors would be arranged to review the report and the actions delivered, remaining actions to be delivered and any themes to include as part of the Trust's continued improvement work. This would conclude the work in relation to the trauma and orthopaedic service. AC explained this work was connected to the recovery support programme particularly under the Chief Nursing Officer's leadership of Freedom to Speak Up, whistling blowing and raising concerns. It was pleasing to note improvements in that area and feedback from Pulse survey had demonstrated that colleagues were recognising the improvements in this area. This would form part of the review check and challenge the Board would oversee to enable the Trust to exit System Oversight Framework (SOF) level 4; the improvement work would continue as the Trust progressed and moved to SOF level 2.

During deliberation of this item the following points were considered:

10. KD-NED advised she had joined a Team Talk session in September 2022 and was encouraged by staff engagement. KD-NED sought assurance on understanding how those sessions were accessed to enable all colleagues and Care Groups to triangulate with other areas where there were improvements. LJ advised on the communication around the Team Talk sessions and tracked how and who attended the sessions. A survey was sent out to provide feedback. The communications team were engaging with the Care Groups to receive direct feedback from them which would inform future Tea Talk sessions.
11. AC recommended presenting a colleague engagement report that demonstrated all the various programmes for Board assurance. AC would work with LJ on this.

Decision:

1. That the report be noted; and
2. It was agreed that a colleague engagement report would be presented to a future Board meeting.

22/116 Head Governor Update

Consideration was given to a report presented by LC.

The following points were made in discussion:

1. Activities had taken place improve member engagement and constituency meetings had been scheduled for the late September/ early October 2022. The meetings would 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 question-and-answer session.
2. Governor elections had concluded, and the results were available on the Trust website. Inductions would take place for newly elected governors in October 2022.
3. Preparations for the Annual Members' Meeting were suspended due to the sad passing of Her Majesty the Queen. A new date had been arranged for 22 November 2022 and the meeting would be held in public on a face-to-face basis.
4. 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 would take place.
5. LC commended all staff, on behalf of the Council of Governors, for their contribution and hard work given the extreme pressures.
6. LC thanked all the retiring Governors for their contribution and welcomed the new Governors.

Decision: That the report be noted.

22/117 Recovery Support Programme – UHMB Improvement Plan

Consideration was given to a report presented by CA 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. CA advised that following the meeting with the national team on 14 July 2022, a review of the learning from the first half of the year to inform the requirements to achieve the objectives overall had been undertaken. This formed part of the assurance processes. The narrative of the report focused on risks associated with the achievement of the required outcome and the mechanisms for providing assurance that systems and processes had embedded sustained improvements.
2. The Trust had received the formal feedback letter from the national team following a meeting with the national team on 14 July 2022. The letter was consistent with previous updates to the Board. The pace of improvement was the main theme consistent with the programme objectives.
3. Relating to the safe staffing review, CA advised there had been significant achievement in the development of this work. A close out report, outlining the action taken to reset staffing establishments and refreshed the governance to ensure it facilitated sustained adherence would be presented to the System Improvement Board in October 2022.
4. The report set out the risks associated with the scale of activity and delivery required over the next 6 months. The potential impact of operational pressures and challenges during winter had been included. The approach to support mitigation of risks included the refresh of the programme management processes. The report highlighted the critical role of the quality governance and accountability framework. The impact of the newly formed medical leadership structures was critical to the plan during the second part of the year. These formed the critical components of the programme to achieve the exit criteria.
5. Workstream progress against the exit criteria was set out in the report; these had been RAG rated and reflected the work to be completed or the complexity and challenge associated with the workstream.
6. The report articulated the challenge of using statistical methods for assurance on outcomes and embeddedness. The challenge related to the actions to be completed and the amount of time available to demonstrated embeddedness. In that instance, the team were working to identify other triangulation points to provide assurance with the intensive support team and regional office.
7. The information set out in the report described the challenge of demonstrating improved outcomes in respect of urgent and emergency care due to the challenging context the Trust was operating in, particularly with the specific challenge of the number of patients in hospital that predominately did not meet the medical criteria to reside which had offset the impact of the plans and actions in the programme of work. The team continued to drive the improvements and explore opportunities to supplement this and would discuss at the System Improvement Board.

During deliberation of this item the following points were considered:

8. JS-NED commended the removal of the Care Quality Commission Section 31 Notice from Furness General Hospital which was great to triangulate this with the patient story which demonstrated the improvements made in provision of stroke care. JS-NED commended the action plan and establishment of the task and finish group at the Royal Lancaster Infirmary (RLI) to achieve removal of the Section 31 Notice. JS-NED

sought assurance on the process and pace to achieve removal of the Section 31 Notice at the RLI.

9. SM advised that the Sentinel Stroke National Audit Programme (SSNAP) score at the RLI had increased from D to C. Unvalidated data suggested the Trust had sustained which showed evidence of improvement. The weekly task and finish group had been assured by the evidence in terms of scanning, thrombolysis and access to the ward that there was sustained improvements. SM was assured that the RLI would sustain the C score and work continued to drive improvements to achieve a B score.
10. AL-NED commended the report and sought assurance on the nature of the embedded and sustained direction of travel particularly considering the winter pressures. AL-NED also sought assurance on criteria to reside and the resilience to maintain the direction of travel and commitment to achieving the embedded and sustained improvements required to exit SOF level 4 whilst balancing this with the winter pressures.
11. SM advised he would respond to the question on not meeting to criteria to reside in presentation of the winter plan later on the agenda.
12. CA advised that other routes were being explored to ensure the actions taken had the correct impact. The Trust had lot of independent support into this aspect of the programme.
13. MT advised the Non-Executive Directors would explore the evidence to look for signs of embeddedness.
14. AC advised that with CA leadership and Caroline Griffiths' input, the check and challenge was important. The structure set up with NHSI/E was the right one to articulate the required improvements and inform Board assurance. Keeping connected with partners for their contribution. CA and AC discussed with Kevin McGee to strengthen connectivity with the Provider Collaborative Board.
15. AL-NED noted the risks which were critical to exiting SOF 4.
16. HR-NED commented that a good example of showing improvements was around mortality. The Quality Committee reviewed a detailed mortality report and were assured by the actions taken relating to the fractured neck of femur workstream. A dashboard had been developed for fractured neck of femur similar to that of the stroke dashboard which would be able to demonstrate and provide evidence of improvements. The challenge would be to embedded improvements within the available time as referred by CA. The Quality Committee would continue to monitor the fractured neck of femur workstream and had requested a detailed report on stroke provision at the RLI. The Quality Committee would also continue to monitor not meeting criteria to reside due to the impact this had on patients.
17. LW advised triangulation of data of not meeting criteria to reside and the level of harm for those patients would be undertaken. CG team had offered support to develop matrices to review this.
18. LS-NED commended the report and the impact of the recovery support programme was evident when hearing the patient story; the fact that two years the support the patient received was not in place was a living testament to the work of the programme and the impact it had on patients and their families.
19. LC commented that people who stay in hospital longer became less likely to be discharged home. It was important to review the provision for patients who were staying in hospital for no medical reason and suggested exploring the use of rehabilitation wards nurse led for patients who did not require medical care. This would enable nursing care for rehabilitation for home and not rehabilitation in hospital.
20. KD-NED sought assurance on leadership engagement with the wider workforce, noting the importance of medical leadership due to the pace and breadth of the improvement programme as they were critical to sustain and embed the required improvements.

21. CA advised the workstream on culture and had moved forward in particularly with the leadership programme. SM was leading discussions with the Care Groups regarding capacity to lead on change and identify any gaps which required additional resource; support arrangements were in place.
22. LH advised the leadership programme was on target. Additional bespoke programmes around medical leadership were under development with opportunities being explored about how to deliver training to the teams given the operational pressures. Progress with this workstream would be presented to the People Committee.
23. AC encouraged Board colleagues to discuss with Care Group, service managers / clinical managers to triangulate with areas of improvement.
24. MT advised PJ was working on a programme of visits for the Non-Executive Directors to visit Care Groups and wards to engage with colleagues.
25. LC questioned whether the Trust could explore opportunities of enhancing the step up / step down facilities for those patients who were medically fit for discharge.
26. AC advised the work SM led on with partners all featured as areas being addressed as part of the improvement work in the medium to long term future. LC suggested an update was presented to the Council of Governors to provide assurance in this area.
27. BM advised that in relation to LC comment regarding rehabilitation wards, the Langdale Unit provided this service until its closure. BM sought assurance on engagement with the programme. As part of the programme, BM advised that Staff Side had been informed by NHSI/E that there were certain policies the Trust were required to review and adapt the just and learning culture approach to the policies in order for the other workstreams to succeed. Given that the programme had been running for 12 months, BM was concerned that Staff Side were being requested to arrange extra-ordinary policy group meetings when struggling with the release of representatives to discuss policies such as grievance, recruitment disciplinary, attendance management, Freedom to Speak Up, bullying and harassment. BM advised there was pressure on Staff Side colleagues to review these policies at pace and was very concerned that at the last policy group it was perceived that Staff Side colleagues would be blamed if the policies were not reviewed in a timely manner. BM alerted the Board to share a reflection of the work to progress the culture and OD workstream of the programme.
28. LH thanked BM and his Staff Side colleagues for their support when reviewing policies. LH explained there were several policies to review regarding restorative and cultural changes which required prioritising. LH explained the focus was not on blame but on working in partnership with Staff Side colleagues to review policies and ensure they were fit for future use. There were policies where a review of the terminology and processes would be undertaken to ensure the just and restorative approach had been applied. LH agreed to review the timelines and support release of representatives to review the policies and processes as the Trust progressed the culture and OD workstream. To support colleagues through a difficult winter period, it was important to ensure the right support was available for colleagues and a review of policies and adapting the just and restorative approach would support. LH advised a detailed report regarding this would be presented to the next People Committee and suggested discussing with AL-NED on how collectively work through prioritising the policies. It was agreed LH and AL-NED discuss further and the matter be referred to the People Committee for resolution.
29. CA confirmed there was no pressure or blame from the Recovery Support Programme (RSP) Board. CA advised the RSP Board would review the issues and the potential solutions to this.
30. MT noted the importance of ensuring changes were embedded. The People Committee would continue to monitor this.

31. BM appreciated the action taken and explained the policy group functioned well when working in partnership. BM remained concern about the timeframe to review the policies.
32. AC thanked BM from raising this, apologised for the timeframe and agreed to work together on reviewing the policies. AC requested LH and CA review this under their leadership of the RSP Board and People Committee to work through the detail to ensure the policies were of a good quality agreeable to all parties.

Decision:
1. That the report be noted;
2. That the Board of Directors endorsed the actions proposed within the report to mitigate the risk to programme delivery; and
3. It was agreed to present the winter plan, with particular focus on criteria to reside to the Council of Governors to provide assurance in this area.

22/118i Care Quality Commission (CQC) 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 and RCS recommendations.

The following points were made in discussion:
1. RS advised the report was shared with the Quality Committee on 26 September 2022. An update on actions of the Niche recommendations had been presented in a separate report.
2. RS explained Sarah Rees (Non-Executive Director) and Simon Bradley (Quality Improvement Lead NHS Lancashire and South Cumbria Integrated Care Board) had now been invited to all future Support and Review Panels. RS clarified their contribution at these meetings.
3. Appendix 1 outlined the progress made with the complaints management process which was an improving picture. A complaints management mapping exercise continued.
4. RS explained that the quality governance structure approved by the Board last month had been used as example, in the report, of an action that was partially compliant working towards full compliance. RS set out the process to demonstrate full compliance.

During deliberation of this item the following points were considered:
5. KD-NED commended the report as it articulated the actions completed and approved and those actions subject to ongoing work. KS-NED sought assurance on the balance between focus on completing outstanding actions and ensuring that those completed remain embedded. RS confident that through the quality governance framework, the structure would ensure actions completed remained embedded.
6. HR-NED sought assurance on the confidence of reducing recommendations. RS assured the Board he was confident that these would be reduced due to the input from the Care Groups.
7. JS-NED sought assurance on the risks, particularly in the Medicine Care Group, which RS had addressed. JS-NED assured RS continued to monitor this to see some real evidence of catch up.
8. LS-NED sought assurance on how improvements in the culture of the organisation be demonstrated. RS advised there were methods that were used as evidence such as the Trust's relationship with the CQC; this was a valuable indicator. The work being

done by Dan West to improve raising of concerns processes would also provide evidence.

9. AC advised there were methods for the Board to consider as evidence such as the outcome and results of staff survey and Pulse surveys; the level of incidents reported and how incidents were reported to the Quality Committee and SIRI Panel; feedback from patients through the Friends and Family test and the recruitment and retention figures and whether this indicated a positive culture in terms of retaining colleagues. Ultimately the new values developed with colleagues

Decision: That the report be noted.

22/118ii Niche External Investigation Assurance

Consideration was given to a report to presented by RS providing the current position, progress of and cross-cutting themes of the Niche recommendations.

The following points were made in discussion:

1. RS outlined the current position of the 51 Niche recommendations owned by the Trust and clarified the level of the recommendations. These described the level of assurance and robustness of arrangements in place. Level 3 demonstrated that processes were in place albeit to be tolerance tested.

During deliberation of this item the following points were considered:

2. KD-NED sought assurance on the confidence of balancing resource to drive the improvements to be made and keeping oversight and scrutiny of embedded changes. RS advised that the 51 recommendations were the responsibility of the Trust to action. The aim was that 51 recommendations would be at level 3 over the course of the next few months. This process would be tested by Niche during phase 6 of their investigation to tolerance test that evidence provided to demonstrate the actions had been implemented.
3. AC advised that he had discussed with the executive team how to articulate impact to demonstrate the difference delivery of actions had made to patient. AC commented that whilst the Board should focus on delivery of actions, it would be helpful for the Board to see the difference completed and embedded actions were making to patients.
4. MT echoed AC comments and advised the Non-Executive Directors would continue to seek assurance on the impact and difference this had made to patient care following delivery of actions.
5. HR-NED advised this report had been discussed at Quality Committee. It was agreed to consider the appropriate time to invite clinicians to provide feedback to the Quality Committee to provide evidence that completed actions were being sustained. HR-NED sought assurance on the process following the informal external review prior to Niche returning to the Trust as this had reopened a number of actions that were closed. RS advised this was a valuable process ahead of the Niche returning to the Trust as it had enabled a review of the quality of evidence to demonstrate completed actions. RS confirmed the informal review had not delayed implementation of the 51 recommendations.
6. To support AC comments, JS-NED noted that whilst the progress had been demonstrated in the report, it would be helpful to reflect on the themes in the Niche report to and how these had been addressed.
7. MT advised this connected to the triangulation point AC alluded to and would follow this up.

Decision:
1. That the report be noted; and
2. It was agreed to review the themes of the Niche Report and include as part of the Board Development Programme.

22/119 Maternity Safety Update

Consideration was given to a report presented by DS 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. DS advised there had been one PMRT case and two PMRT case reports completed in August 2022. The PMRT review report and action plan would be presented at private Board of Directors' meeting later on today.
2. There were no HSIB cases reported in August 2022.
3. There continued to be an increase in the number of incidents graded moderate and above since April 2022. DS reassured the Board that this was in response to targeted work to improve grading and reporting of moderate harm and above in keeping with CQC regulation 20 guidance. In August 2022 there was one incident of severe harm and 13 moderate harms, which had been reviewed and closed with no care or service issues identified. There were two serious incident declared.
4. There had been a static compliance rate for obstetrics and anaesthetics in July and August 2022. Having worked with the Care Groups, a trajectory had been set in place to ensure compliance for obstetrics and anaesthetics to achieve 90% by December 2022. It was a requirement of the CNST submission that all speciality groups be above 90% before submission to CNST.
5. There had been a dip in the midwifery fill rate in August. This was not uncommon in maternity units due to a peak in annual leave and it was also the peak period for an increase in birth rates. DS assured the Board that daily safety huddles and staffing meetings continued to be held to ensure safety and response to areas of need.
6. Feedback from frontline Safety Champions was set out in the report.
7. In relation to Ockenden, DS advised the Trust submitted partial compliance with all the immediate actions in June 2022 and following external validation the Trust was awarded full compliance with immediate action 2 and 7. This was shared in the public domain in May 2022. The Trust received a regional Insight visit in July 2022, as part of the ongoing assurance of compliance and sustainability of improvement, supported by the Regional Chief Midwife. The Trust has received a report with recommendations. The Insights team provided a summary of the Ockenden IAEs status. The Trust was found to be partially compliant with all the seven IEAs. The Trust was working towards full compliance. The Insight team would return to the Trust mid October 2022. The report detailed the actions taken and monitoring process going forward.
8. DS provided a Maternity Incentive Scheme update.

During deliberation of this item the following points were considered:

9. AL-NED sought assurance on training compliance, noting a timeline of recovery, and the impact this would have on service provision to keep services safe. DS advised this was being monitored fortnightly. Working with Care Groups to meet that timeframe. The midwife compliance level had maintained a high standard due to forward planning which had not taken place within obstetrics and anaesthetics. This was now in placed to ensure that the quality of services was safe. Partnership working

continued to ensure these services were forward planning to avoid a repeat of this situation again.

10. KD-NED commended the training that had been booked to deliver against compliance, particularly in obstetrics and anaesthetics. KD-NED sought assurance that those bookings would continue to be monitored so they translated to training. KD-NED advised that building on the section in the report regarding safety champions, it had been agreed to present a specific safety champions report to the Quality Committee and Board on a quarterly basis to ensure the Board were sighted on this work. KD-NED sought clarity that in relation to when harm had occurred rather than caused by gaps in care and where there was potential for recurrence of that harm related to other agencies / system partners in support of women, was there a process in placed to share with other agencies / partners if the investigation raised concerns about their support. DS advised there was a monthly report monitored at the Governance Care Group meetings for training compliance of all specialty groups. A Women and Children's education faculty would be established to feed into a governance forum as an MDT approach. The Trust was working collaboratively with other agencies where harm had occurred in a woman's pregnancy. There was shared learning with other hospitals and agencies. KD-NED suggested that specific themes and learning related to that be presented in future reports. DS advised this would be presented through the PMRT reports going forward.
11. HR-NED assured the Board that the Quality Committee had discussed the Maternity Incentive scheme report, the Ockenden report and the NHS resolution thematic review report and actions agreed including the action plans. The Committee noted the amount of work being undertaken in maternity relating to the Ockenden initial review as well as the CQC report. It was recognised the maternity incentive scheme was challenging in terms of the actions along with publication of the final Ockenden report and the Kirkup Report. The Committee noted recruitment was improving and a full leadership team was in place along with support by KD-NED as the NED maternity safety champion would support this work to drive forward the improvements.
12. MT recognised and appreciated the pressure this team was under and efforts to drive forward the improvements and ensure they were embedded.
13. AC advised he met with the maternity leadership team recently and discussed the levels of pressure, work, and scrutiny. AC thanked the team for their professionalism as they worked through the actions. Discussions included the capacity and stretch within that team and additional support was being explored. A lot of leadership resource had been implemented in the Women and Children's Care Group, particularly maternity. The trajectory for reporting in this service area nationally would highlight the improvements to be implemented across maternity services nationally. It was envisaged that the work done with the maternity safety support team over the 12 months would support the recommendations in those final reports.
14. MT advised the Board would seek assurance on the impact and difference this had made to patient care following delivery of actions.
15. Supporting MT comments, KD-NED commented that it was important for the Board to support this work and encouraged the team to request Board support, through the maternity safety champion report, should it be required.

Decision:

1. That the report be noted; and
2. A maternity safety champions report would be presented to the Board on a quarterly basis.
3. That the action plans for the Maternity Incentive scheme report, the Ockenden

report and the NHS resolution thematic review report be supported.

22/120i Integrated Performance Dashboard and Report Month 4

Consideration was given to a report 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. LW advised the Trust was above the threshold for the number of *clostridium difficile* cases; this was a nationally recognised problem. Cumbria were experiencing a high number of *clostridium difficile* cases. The challenge was around the use of certain medication. Following the successful business case for anti-microbial pharmacists, the team were in place and were overseeing the use of medications which had a known impact on *clostridium difficile*. It was envisaged that with the arrival of the anti-microbial pharmacists, improvements would be made in this area. CA agreed to work with LW and team to articulate improvements in this area in future reports.
2. Regarding the Family and Friends test, LW advised patient satisfaction rated remained low across all areas, particularly in the Emergency Departments. LW explained the Care Groups were being encouraged to review the qualitative data of the patient engagement feedback to drive forward improvements. In response to MT question regarding the long waiting times in ED, LW set out the response to that.
3. JM presented an updated on VTE assessment; the compliance rate remained low which would improve over the next few months as the methodology had changed in line with national practice. JM provided assurance to the Board on the Trust processes in place for VTE assessment.
4. JM provided an update on mortality data and confirmed the Trust was where it was expected to be. There was a particular concern regarding the fractured neck of femur pathway; a lot of work was ongoing to address this but was a complex area due to the whole pathway problems. A dashboard had been created and the Trust had linked with a regional piece of work as there were issues with the fractured neck of femur pathway across the region.
5. LH highlighted the vacancy rate; there were a couple of focused areas - one being consultant and the other midwifery. It was envisaged that the vacancy rates for both these staff groups would reduce over the coming months due to the number of colleagues progressing through pre-employment checks. Agency use had reduced but given the workforce pressures, further work around the agency use was required. Absence and health and well-being of colleagues were the main areas of concern. There was a continued escalation of absence. There were a number of support packages in pace for colleagues and it was positive to see the number of colleagues accessing these, particularly for mental health and musculoskeletal conditions. Psychological support offered by the occupational health team had improved access to this service. Weekly monitoring of absence and health and well-being of colleagues would continue. The People Committee would continue to monitor this particularly through the winter period.
6. SM provided an update on operational performance. In terms of the percentage of Emergency Department attendances, performance had significantly declined from before the pandemic. Ambulance handover times were not meeting standards. The cancer standards were presented, and it was noted there was variation across the metrics. Regarding diagnostic tests, the most challenged areas were the number of patients waiting for a DEXA or ultrasound scan. The report set out the Trust's response to this. Referral to treatment standards were stable. In terms of stroke care provision, the quarter 1 SSNAP data had demonstrated that the Furness General Hospital remained at level B and the Royal Lancaster Infirmary had improved from

level D to level C in the SSNAP score.

7. CA provided an update on the financial position to the end of July 2022. The Trust was £1.1 million worse than planned which included income relating to ERF at planned levels. CA advised that the financial position included £2.5m income against the stretch plan of £3.8m. The impact of savings achieved was required to increase each month to enable the balance of the year-to-date position. CA alerted the Board that services continued to experience associated with the number of patients not meeting criteria to reside which was reflected in the year-to-date position. Emergency and urgent care activity had increased, particularly Emergency Department attendances. There had been some slippage against the saving plan delivery. Working with Care Groups and corporate departments continued to respond to this. CA would undertake a month 6 review and would present to the Board at the appropriate time. Agency use was challenging; the work to address vacancy levels continued. CA was working with all executive colleagues to ensure the mechanisms to address the escalating risk were supporting the actions to mitigate and recover the position. In terms of the ERF income, CA was working with system colleagues on this. The Trust had accrued income in respect of the system stretch target in line with that agreed at a system level. This would be formalised in next few weeks and would be reported to the Finance Committee at the end of the month. The impact of the pressures had been mitigated through management of financial risk, mitigation of cost pressures and additional savings opportunities.

During deliberation of this item the following points were considered:

8. HR-NED confirmed the Quality Committee was assured on the work undertaken regarding VTE assessment. The Quality Committee would receive a detailed report in November 2022 on the improvements made in VTE assessment. CA advised improvements in this area would be tracked through this report. The Trust had established a control mechanism for changes in presenting data.
9. MT explained the Non-Executive Directors would seek assurance by triangulating the data through qualitative measures.
10. AL-NED sought assurance on the necessary support packages in place to response to the health and well-being of colleagues, particularly the psychological support. LH advised that psychological support had been provided through the occupational health team. OH reviewing this and contributed the health and well-being review across the ICS; it is a focus but remained an area of concern. AL-NED to discuss at PC. AL-NED sought assurance on the recovery targets for appraisals and core skills framework in the context of the Trust's major focus on cultural development focusing on behaviours. LH advised this was an area to be addressed; 100% was not achievable but agreed to review the targets to ensure they were realistic as it was important all colleagues undertook an appraisal. Regarding core skills framework, LH advised that the extensions granted during the pandemic had since ceased. Core skills framework and appraisals, particularly leadership appraisals would continue to be monitored as they remained areas of concern.
11. LS-NED commended the recruitment of 17 midwives and sought assurance on applying the learning of this to other areas. In terms of health and well-being of colleagues, LS-NED sought assurance on the support and advice available to colleagues to support their anxieties, particularly financial anxiety. LS-NED sought clarity on the mechanisms in place to ensure colleagues were not taking on too many additional hours of work to supplement their income. LH advised a financial well-being group had been set up. There was a detailed report to be presented to the People Committee on the Trust's response to support colleagues having listened to them.
12. AL-NED advised the Bay Hospitals Charity had also discussed this and were reviewing the support in place for colleagues, particularly those in financial challenging

positions.

13. KD-NED noted the nurse-fill rates would be part of the forthcoming of the ward-board dashboard and highlighted the importance of the dashboard. KD-NED sought assurance on whether this would be up and running at the end of September 2022. LH advised the Trust had received support from NHSI/E to be up and running in October 2022 to triangulate the qualitative metrics and data.
14. AL-NED noted the DNA rate and was pleased to see the increased use of electronic booking system and increased use of virtual outpatient appointments. Building on LS-NED comments, AL-NED recognised it would be difficult for some people to attend appointments in the context of the cost-of-living crisis. AL-NED sought assurance on support to address this and communicate the use of the electronic booking system. SM agreed to monitor this and take forward for those patients who could not attend.
15. KD-NED sought assurance on the learning of other organisations with similar demographic challenges in the context of the references to national and local benchmarking. SM advised the process for selecting organisations to benchmark against and would explore the learning from Cornwall, Devon and Exeter due to the demographic similarities. MT suggested a dataset was included in future reports setting out the Trust's position against comparator hospitals. SM suggested presenting a paper to a future Board meeting provided an update on the Getting-it-Right-First-Time programme which set out the Trust's position compared to other organisations.
16. CA advised this was referred to in the financial sustainability report and a lot of the detail was referenced in the coastal communities' report by Sir Chris Whitty. CA and team had contacted financial colleagues in coastal organisations to establish this network and agreed to include operational colleagues. This was also being addressed through the recovery support programme.
17. HR-NED commented the improvement of this report was very noticeable and suggested further amendments which would demonstrate improvements. CA advised this area would be discussed at the Board workshop later on today. HR-NED commended inclusion of a glossary at the end of the report.
18. MT noted the performance data had demonstrated significant improvement in a lot of areas whilst the financial performance was deteriorating. MT sought assurance on whether those improvements were being financed. CA advised that provisions had been allocated for the improvements; these had been reported to the System Improvement Board. Cost pressures had been mitigated and some schemes / improvements had been implemented at a lower level than anticipated in the plan. CA advised there were areas, particularly the CQC must do and should do recommendations that had incurred costs.
19. SW-NED alerted the Board that the ICS stretch income which CA was working on with ICS colleagues in the context of uncertainty was a risk that the Board be alerted to.
20. AC alerted the Board that one of the areas highlighted by CA; premium spend areas of bank / agency use was a piece of work the Provider Collaborative Board (PCB) was undertaking to explore ways of managing this level of spend. There was significant pressure in managing that level of spend across the PCB. UHMB were supporting the procurement process and piece of work. AC advised it was unlikely to be at the level of which the Board would need to make separate approvals and would form part of the executive business of contracts. An update would be presented to Board as this progressed so it was clear as to what engagement UHMB would be entering into. The value of this piece of work would enable access to staffing to address the gaps and the financial recovery position.
21. MT acknowledged the work being done and understood the balance of driving embedded improvements whilst responding to the financial challenges.
22. AL-NED sought assurance on the connection between the high-level financial plan and

team behaviours. CA advised the financial position was validated with the Care Groups and would engage colleagues further on this.

Decision:
1. That the report be noted; and
2. That the Board be kept updated on the work of the Provider Collaborative Board to address premium spend areas.

22/120ii Assurance Committee Minutes and Chairperson's Report

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

Finance Committee

SW-NED provided an update from the Committee.

Quality Committee

HR-NED provided an update from the Committee.

22/121i Winter Plan

Consideration was given to a report presented by SM to provide a briefing on the approach the Trust (and system partners) were taking to prepare for the winter period.

The following points were made in discussion:
1. SM presented the Trust and system partners' approach to prepare for the winter period. The plans set the context of the significant pressures the 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 summarised the approach the Trust and system partners would take to make general improvements to the urgent care system – a year-round process – in addition to the further, specific actions proposed to mitigate the pressures that generally increase over winter. The report also summarised how these plans were resourced and overseen in respect of performance management and assurance.
2. SM alerted the Board that Cumbria County Council (CCC) had expressed concerns relating to scheme 3 (as referred to in the report) to significantly reduce the volume of patients not meeting criteria to reside. The concern related 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 was with colleagues at CCC to mitigate these concerns and ensure that the scheme safely provides the additionality required. There were plans for open additional inpatient capacity should domiciliary provision not be secured.

During deliberation of this item the following points were considered:
3. In response to MT challenge, SM advised a procurement exercise was underway in parallel with the local authority and there was a plan to open additional capacity of 50 beds that could be used if required.
4. JS-NED noted the perennial problem of recruiting domiciliary care in Cumbria and sought assurance on exploring ways to address this.
5. SM advised recruitment featured in discussions with the local authority.
6. JS-NED sought assurance on resourcing extra provision. SM advised on the actions in place should additional domiciliary care provision be insufficient.

7. CA advised the Trust would need to work with the ICB on funding arrangements.
8. HR-NED sought clarity that of the 159 people, a significant proportion were from Cumbria. SM advised it was over 100. HR-NED echoed JS-NED comments regarding the long-term issues with domiciliary care workers in Cumbria.
9. MT suggested that the risk presented to the Trust arising from continuing excessive numbers of patients not meeting criteria be considered further at forthcoming meetings of the Board
10. AL-NED noted that this was a perennial issue and would like a proposal to the Board about how the Trust would respond to this.
11. In response to HR-NED, SM advised an update on the virtual ward be presented to the Quality Committee. SM provided an update on the same day emergency clinic model.

Decision:
1. That the Board of Directors approved the seasonal Winter plan;
2. That the Board of Directors noted the resourcing issue associated with contingency plans; and
3. That the risk presented to the Trust arising from continuing excessive numbers of patients not meeting criteria be considered further at forthcoming meetings of the Board through the Integrated Performance Report.

22/121ii Emergency Preparedness, Resilience and Response (EPRR) Annual Assurance Return

Consideration was given to a report presented by SM to provide assurance on the EPRR annual process.

The following points were made in discussion:
1. SM advised the Trust had undertaken the self-assessment against the 2022 updated core standards relevant to the organisation.
2. LS-NED suggested triangulating with the MIAA report relating to business continuity.

Decision:
1. That the report be noted; and
2. That the Board of Directors noted that the Accountable Emergency Officer would sign the statement of compliance and the Trust was publicly stating its EPRR readiness and preparedness.

22/122 Positive Difference Annual Report 2021/22

As the Board meeting was running over time, it was agreed to defer this report to the Board of Directors' meeting on 26 October 2022.

22/123 Cultural Transformation Programme Update

Consideration was given to a report presented by LH to provide an update on the Moving Forward culture change priorities and actions, all of which linked to the Trust's Organisational Development and leadership plan which formed an integrated programme of transformation.

During deliberation of this item the following points were considered:
1. KD-NED commended the number of colleagues who had attended the leadership development workshop. KD-NED sought clarity on whether it was possible to demonstrate participation across the organisation to triangulate this with leadership

development in the Care Groups and the improvement plans. LH agreed to provide this.

Decision: That the report be noted.

22/124 New Hospital Programme – Preferred and Alternative Options

Consideration was given to a report presented by SM 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.

The following points were made in discussion:
1. The report set out the preferred and alternative options.

Decision: That the Board of Directors approved 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.

22/125 Trust-wide Risk Register (Corporate Risk Register) and Risk Management

Consideration was given to a report presented by RS to provide an overview of the Trust-wide Risk Register and the process for assigning risks to that.

The following points were made in discussion:
1. There were 11 risks on the Trust-wide corporate Risk Register (TRR)
2. Risks were 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.
3. Risks were assigned to the TRR because they are outside the capability, resources, authority etc. of the Care Group to manage.
4. Assurance Committees received a quarterly report presenting the Trust-wide risks relevant to that Committee and have the opportunity to discuss any of concern.
5. RS advised of the training colleagues had undertaken.

Decision:
1. That the report be noted; and
2. That the Board of Directors agreed this report be presented alongside the Board Assurance Framework in future on a quarterly basis to support connectivity.

22/126 Policy and Publications Report

Consideration was given to a report presented by Aaron Cummins (AC) to provide the Board with information on recent policy developments from the Department of Health, NHS England / Improvement, NHS Providers, NHS Confederation, Care Quality Commission and Health Watch.

22/127 Attendance Monitoring Register

Noted.

22/128 Schedule of Business

Noted.

22/129 Urgent Business

MT thanked SW-NED for his contribution to the Trust and chairing of the Finance Committee and his constant call for us to be financially disciplined. SW-NED thanked all colleagues and had been a privilege to get involved.

22/130 Date, Time and Venue of Next Meeting

It was noted that the next meeting of the Board of Directors would be held on Wednesday 26 October 2022 at 10am in the Board Room, Westmorland General Hospital, Kendal LA9 7RG and also via Microsoft Teams.

22/131 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.

Meeting Title	**Board of Directors' Meeting (Public) Action Tracker**
Meeting Chair	**Mike Thomas**
Previous Meeting Date	28/09/2022
Next Meeting Date	26/10/2022

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**
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	19/01/2023			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	30/11/2022			This has been scheduled for November 2022.	**SBM**
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**

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 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	09/11/2022			A workshop has been arranged for 9 November 2022.	SBM
28/09/2022	114	Chair's Report	It was agreed an upate from the Non-Executive Director maternity safety champion be presented to the Board on a quarterly basis.	Director of Midwifery	26/10/2022			A report has been included on the agenda and schedule of business has been updated.	SFM
28/09/2022	115	CEO Report	It was agreed a colleague engagement report would be presented to a future Board meeting.	Chief Executive	22/12/2022				SBM
28/09/2022	117	Recovery Support Programme	It was agreed to present the winter plan to the Council of Governors	Chief Operating Offficer	14/11/2022			This has been scheduled for presentation at the Council of Governors' meeting on 14 November 2022.	SBM
28/09/2022	118ii	Niche External Investigation Assurance	It was agreed to review the themes of the Niche Report.	Director of Governance	20/10/2022			This has been included as part of the Board Development Programme 2022/23. An initial session was held on 20 October 2022 and it was agreed a further session would be held.	SBM

BOARD OF DIRECTORS

Date of Meeting	26 October 2022
Title	Chair's Report
Report of	Professor Mike Thomas Chair
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	x
	The content of this report outlines: – Introduction – An outline of the Chair's activities throughout October 2022; – An outline of the Non-Executive Directors' activities throughout October 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 Board of Directors is asked to: 1. Receive and note the contents of this report; and 2. Approve inclusion of the Non-Executive Director, who holds who the maternity safety champion role, to the membership of the

	Quality Committee.

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, plus any other key updates related to the Trust, our Provider Collaborative, or the wider Integrated Care Board (ICB).

3. The Trust continues to experience a number of pressures across our hospitals, particularly so within our Emergency Departments. Colleagues continue to work very hard in treating patients safely and compassionately.

4. I would like to offer my sincere thanks and gratitude to all colleagues for their sustained efforts as we remain focused on our improvement journey.

Lancashire and South Cumbria NHS Foundation Trust (LSCFT) Update

5. On 10 October 2022, LSCFT announced that David Fillingham CBE has been appointed to the role of Chair.

6. LSCFT provide a range of services including inpatient mental health, learning disability and autism services across Lancashire and South Cumbria.

7. David's previous roles include Chair of Healthier Wigan Partnership, Chief Executive at the Advancing Quality Alliance, CEO at Royal Bolton Hospital and Deputy Chair at Aintree University Hospital, Liverpool.

8. David will be taking over from David Eva, who has held the position of Chair at LSCFT since 2016. David will work closely with Chris Oliver as their interim Chief Executive.

9. I wish David well in his new role and look forward to working together as part of the Provider Collaborative.

Chair's Activities

10. Meetings and events I attended in the month of October included, but not limited to, Lancaster University and UHMBT Health Partnership meeting, Provider Chairs meeting, new Governor Induction, Provider Collaborative Board (PCB) meeting, and PCB Development Session, Health Inequalities meeting, Chair, Head Governor and Deputy Head Governor meeting, New Hospitals Programme (NHP) Trust Engagement meeting, Chair and Non-Executive's meeting, Chair and Chaplaincy meeting, and a series of MP Quarterly meetings.

11. I 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.

12. I also sat on the final interview panel for the UHMBT Chief People Officer post, further details of which can be found in the Chief Executive's report on today's meeting agenda.

Non-Executive Directors' Activities

13. Meetings Non-Executive Directors attended for October 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.

14. 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.

15. 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.

16. I would like the support of the Board to include the Non-Executive Director who holds who the maternity champion role to be added to the membership of the Quality Committee. This will take the total membership of Non-Executive Directors to 3, but the quorum will remain at 2 Non-Executive Directors.

Final Remarks

17. 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.

18. I look forward to the next meeting of the Trust Board in November 2022.

Professor Mike Thomas
Chair

26 October 2022

BOARD OF DIRECTORS

Date of Meeting	26 October 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

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: • ICB Board to Board Session • Publication of report following independent investigation into maternity and neonatal services provided by East Kent

	University NHS Foundation Trust • Chief People Officer • Director of Finance • New Hospitals Programme • Trauma & Orthopaedics Update A forward to look to the next meeting of the Trust Board in November 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 report provides an update on current matters and priority 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: Positive Difference Annual Report 2021/22, Recovery Support Programme (RSP) – UHMBT Improvement Plan, Care Quality Commission (CQC), and Royal College of Surgeons (RCS) improvement Plans, Niche External Investigation Assurance, Maternity Safety Update, Avoiding Term Admissions into Neonatal Units (ATAIN) Report, Quarter 2 – Operational Plan Priorities and Board Assurance Framework Review, New Hospitals Programme Quarter 2 Report, – 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. UHMBT had its first Board to Board meeting with the newly established Integrated Care Board (ICB) on 20 October. These are a series of sessions with each of the provider Trusts within the system.

5. This meeting was an invaluable opportunity to come together to enable a joint discussion around the opportunities and risks and gain a mutual understanding of any significant challenges we face within our organisations and the wider system.

6. Operationally, our hospitals remain under pressure as we continue to experience an increase in Emergency Department attendances, patients with high acuity and a number of patients who do not meet criteria to reside.

7. Colleagues and teams continue to work incredibly hard to ensure the safety of our patients across our hospitals and in the community. As always, your sustained efforts are appreciated, and I would like to convey my sincere thanks to all.

NATIONAL AND REGIONAL UPDATES

Lancashire and South Cumbria Integrated Care Board (ICB)

8. 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.

9. 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.

10. 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.

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

12. 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.

13. 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.

14. 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.

15. 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)

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

17. The PCB meets monthly, and the most recent meeting took place on 20 October 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, Clinical Integration update and the PCB Annual Conference.

18. A further, more detailed update, on the work of the ICB and PCB can be found at Agenda Item 145 on today's meeting agenda.

Morecambe Bay Place-Based Partnerships

19. 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.

20. The Bay Health & Care Partners (BHCP) Place-Based Leadership Team meet bi-monthly and the most recent meeting took place on 20 October 2022, and the agenda covered outputs from the September workshop, next steps place development, operational issues / decision making, Primary Care Collaborative Update, and Partnership update on pressures.

Primary Care Networks

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

Publication of report following independent investigation into maternity and neonatal services provided by East Kent University NHS Foundation Trust

22. On 19 October 2022, Dr Bill Kirkup published his report following the independent investigation into maternity and neonatal services provided by East Kent University NHS Foundation Trust.

23. The investigation was commissioned by NHS England and Improvement to examine maternity and neonatal services in East Kent, in the period since 2009, by looking at the following four layers in particular:

    - What happened at the time, in individual cases, independently assessed by the investigation?
    - In any medical setting, as elsewhere, from time to time, things do go wrong. How, in the individual cases, did the Trust respond and seek to learn lessons?
    - How did the Trust respond to signals that there were problems with maternity services more generally, including in external reports?
    - The Trust's engagement with regulators including the CQC. How did the Trust engage with the bodies involved and seek to apply the relevant messages? And what were the actions and responses of the regulators and commissioners?

24. The investigation found that between 2009 and 2020, 'those responsible for the services too often provided clinical care that was suboptimal and led to significant harm, failed to listen to the families involved, and acted in ways which made the experience of families unacceptably and distressingly poor'.

25. The panel identified four broad areas for action based on the findings but with much wider applicability. They are:

    - Monitoring safe performance - finding signals among noise
    - Standards of clinical behaviour - technical care is not enough
    - Flawed teamworking - pulling in different directions
    - Organisational behaviour - looking good while doing badly

26. The report is heart breaking to read; and our sincere condolences go out to all the families involved.

27. We are absolutely committed to learning all we can from the investigation into East Kent's maternity services; and implementing any actions that will further improve the services we offer to women and families across Morecambe Bay.

28. Our teams now need to take the time to review the report in full in order to respond fully about any actions we may take as a result of Dr Kirkup's findings and areas for actions.

29. We are aware that the publication of this report - although not about UHMBT - may lead to media interest for our Trust.

30. We will also ensure that any women and families (current or previous users of the service) or colleagues affected are offered the relevant support they need.

TRUST UPDATES

Chief People Officer

31. I reported last month that we were re-running our recruitment process for our new Chief People Officer position.

32. Final panel interviews took place on 10 October 2022, and I am delighted to advise that we have made a successful appointment. Further details will be shared once the appropriate HR processes are complete.

Director of Finance

33. Following a recent recruitment process, Helen Cobb has been appointed as our new Director of Finance and joined us on 14 October 2022. Helen will be supporting Chris Adcock in his role as Chief Financial Officer (CFO) and Deputy CEO by leading all of the day-to-day activities and operations of the Finance function, the provision of support and advice to Care groups, Corporate Departments and to the Trust Management Group, and will deputise in the CFO role supporting our work to drive better financial collaboration and performance across the wider system.

34. As well as her extensive financial leadership experience, Helen has a strong track record in leading transformational programmes and we will draw on these skills in the development and implementation of our financial strategy and sustainability plans. Helen is a Fellow of the Association of Certified Chartered Accountants and has a huge passion for finance skills development.

35. Helen's most recent role was as Director of Finance for Wythenshawe, Trafford, Withington and Altrincham Hospitals at Manchester University NHS Foundation Trust. Originally from Keighley in West Yorkshire, Helen started her career at Airedale General Hospital in 1985 and generated good experience within the financial services teams before securing a role in the management accounts function.

36. On behalf of the Trust Board, I would like to take this opportunity to welcome Helen to UHMBT.

New Hospitals Programme (NHP)

37. The NHS in Lancashire and South Cumbria has stated its preference for new hospitals on new sites for both Royal Preston Hospital and Royal Lancaster Infirmary as part of the New Hospitals Programme, which plans to develop cutting-edge facilities, offering the best in modern healthcare and addressing significant problems with the current ageing hospital buildings.

38. Following on from the announcement of the shortlist of proposals for new hospital facilities in March 2022, the Lancashire and South Cumbria NHP team has carried out a detailed assessment of the shortlisted options. Each shortlisted proposal has been comprehensively assessed for deliverability, affordability, value for money, and viability, considering feedback from patients, local people and staff:

- A new Royal Lancaster Infirmary on a new site, with partial rebuild / refurbishment of Royal Preston Hospital
- A new Royal Preston Hospital on a new site, with partial rebuild / refurbishment of Royal Lancaster Infirmary
- Investment at both Royal Lancaster Infirmary and Royal Preston Hospital, allowing partial rebuilding work on both existing sites
- Two new hospitals to replace Royal Lancaster Infirmary and Royal Preston Hospital (new sites).

39. This work has resulted in recommendations for preferred options and alternative options for both Royal Preston Hospital and Royal Lancaster Infirmary, subject to endorsement from UHMBT Board, Lancashire Teaching Hospitals NHS Foundation Trust and NHS Lancashire and South Cumbria Integrated Care Board.

40. A more detailed update can be found at Agenda Item 146 on today's agenda.

Trauma & Orthopaedics Update

41. I reported last month that 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).

42. The draft report was received by the Trust at the end of June 2022 and the final report will be presented to the Trust Board at its November 2022 meeting.

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. Sessions are being held monthly via Teams for any colleague to attend. They will be recorded and shared through our leadership teams and corporate communications channels to allow those that cannot attend to catch up when convenient to them.

46. This is a new format which we will be seeking feedback on in order we can make the necessary changes and improvements.

FINAL REMARKS

47. 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

48. 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".

49. 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.

50. The next meeting of the Trust Board will be held on 30 November 2022. Some of the items featuring on the agenda will be: Investigation By Design (IBD): to present the Investigation by Design report regarding the Trust's trauma and orthopaedic service, Recovery Support Programme (RSP) – UHMBT Improvement Plan, Maternity Safety Update, Niche External Investigation Assurance, Mortality Update, Draft UHMBT Clinical Strategy, Cultural Transformation Programme Update, CQC Single Assessment Framework, Care Quality Commission (CQC) and Royal College of Surgeons (RCS) Improvement Plans, – plus the usual standing items for the Board to consider.

51. 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.

52. I look forward to the next meeting of the Trust Board in November.

Aaron Cummins
Chief Executive

October 2022

THIS PAGE IS INTENTIONALLY BLANK

BOARD OF DIRECTORS

Date of Meeting	26 October 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: • Governors received a briefing on Urology, T&O and CQC • Constituency meetings took 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. The meetings were well attended and more will take place in the future. • Governor election results were announced at the end of September and newly elected governors commenced in post on 1 October 2022. • Governor induction took place on 18 October 2022. • Further Staff Governor elections are being held to fill vacancies within Nursing and Midwifery and Estates and Facilities • Non-Executive Director recruitment commenced Looking ahead to November 2022: • Preparations for the Annual Members' Meeting are ongoing. The meeting will be held 22 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 following the Board of Directors meeting in November 2022.

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	26 October 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 they can be	Make the best use of our physical and financial resources	Working in partnership
	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

THIS PAGE IS INTENTIONALLY BLANK

BOARD OF DIRECTORS

Date of Meeting	26 October 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	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 a ICB Representative to scrutinise and 'sign off' evidence upon completion of actions / recommendations. A Non-executive Director is also invited to attend panels to enable them to obtain impartial assurance around the process. • Support and Review Panels for Medicine Care Group, now take place on a weekly basis (previously twice monthly) to support the pace of completion of actions. • Support and Review Panels for 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 October. • 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 4 Must Do recommendations (2 in Medicine, 2 in WACs,) and 4 Should Do recommendations (all in Medicine) have been completed. • There are now 2 CQC recommendations (1 Must Do and 1 Should Do) that are now 'Fully Completed Awaiting Approval'. • 18 Recommendations (14 Must Do and 4 Should Do) are expected to be completed in October. • 35 overdue recommendations (23 Must Do and 12 Should Do) are expected to continue beyond October 2022. Plans are in place with targeted completion for these recommendations by December 2022. Further to conversation at the Quality Assurance Committee, these will be prioritised based on regulatory and patient safety risks. • A RCS closure report for the 7 outstanding actions was approved at Quality Assurance Committee and is addressed under a separate item to this Board Meeting.

Prior Discussions	Committee	Date	Recommendations/ Concerns
	Quality Committee	17 October 2022	An alert was raised to the Board in relation to the progress against action completion. A paper is going to the November 2022 QAC meeting to outline how risks have been mitigated regarding regulatory breaches. Further assurance will also be provided regarding progression of actions.

Action to be recommended to the Committee	The Board is requested to: **Note:** • A RCS closure report for the 7 outstanding actions was approved at Quality Assurance Committee and is addressed under a separate item to this Board Meeting. • Current progress of the recommendations from the CQC Inspection Report. • The implementation of weekly Support and Review Panels for Medicine Care Group. • The Compliance & Assurance Lead for Medicine Care Group is undertaking a focussed piece of work on all recommendations related to achieving the RCPCH 'Facing the Future Standards' in Emergency Medicine. • Progress against the NICHE Investigation Report will now be presented in a separate paper.

	• The potential impact of actual and expected operational pressures are having on the progress with CQC Must and Should Do's, particularly in the Medicine Care Group. **Comment:** • The Trust dashboard below shows current figures (October 2022) with previous month's (September 2022) above. • There has been an improvement in the position, with 8 recommendations approved for closure at Support and Review Panels. • A further 18 recommendations are expected to be completed in October. These have been shared with the Care Groups.

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

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

- 4 Must Do Recommendations (2 in Medicine, 2 in WACs,) and 4 Should Do Recommendations (all in Medicine) were completed in September.
- There are 2 CQC Recommendations (1 Must Do and 1 Should Do) that are now 'Fully Completed Awaiting Approval'. These are due to be reviewed at the Support and Review Panels scheduled in October.
- Plans are in place for a further 18 recommendations (14 Must Do and 4 Should Do) to be completed in October.
- Current information received indicates that 35 overdue recommendations (23 Must Do and 12 Should Do) will continue beyond October 2022. These have been reviewed with the Care Groups and specifics actions have been outlined. Plans are in place so that these recommendations are targeted to be completed by December 2022. A more detailed analysis of these recommendations will be presented in the November Paper.
- 17 of the 35 overdue recommendations are with Medicine Care Group (11 Must Do and 6 Should Do) and a further 10 are with WACS Care Group (8 Must Do and 2 Should Do). These recommendations will be prioritised at October Support and Review Panels.
- To support timely and comprehensive completion of actions, following Support and Review Panel meetings an outcomes and actions required summary is shared with each Care Group. This assists them in resolving actions and providing appropriate evidence to progress the completion of recommendations.
- A RCS closure report for the 7 outstanding actions was approved at Quality Assurance Committee and is addressed under a separate item to this Board Meeting.

Background/Context

1. There are 2 Improvement Plans that contain a combined total of 119 recommendations (112 CQC, 7 RCS).

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

3. 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.

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

Improvement Plan Implementation Update

5. A summary of progress for the recommendations in the 2 plans is provided in the dashboards below. It is important to note that recommendations can have multiple actions in place. Each action has to be completed to enable a recommendation to be deemed as closed.

Improvement Plans - Combined Dashboard (October Position)									
Recommendation Status	**RCS Report[2]**		**CQC Must Do's**		**CQC Should Do's**		**Total**		**Status[5]**
Month	**Sep**	**Oct**	**Sep**	**Oct**	**Sep**	**Oct**	**Sep**	**Oct**	**N/A**
Not Started[6] (new recommendations)	0	0	0	0	0	0	0	0	UC
Behind Schedule (Completion by Oct 2022)	0	0	30	33	13	16	43	49	MW
Behind Schedule (Completion by March 2023)	0	0	0	0	0	0	0	0	UC
Behind Schedule (Completion after March 2023)	0	0	2	2	1	1	3	3	UC
On Schedule (Completion by Oct 2022)	7	7	0	0	1	0	8	8	B
On Schedule (Completion by March 2023)	0	0	14	14	19	18	33	32	B
On Schedule (Completion after March 2023)	0	0	1	1	0	0	1	1	UC
Fully Completed (awaiting approval)[3]	0	0	8	1	6	1	14	2	MB
Fully Completed & Approved[4]	0	0	6	10	11	15	17	25	MB
Total	7		51		61		119		

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

The number of overdue recommendations has increased as some of them that were due in September and October have now passed deadline. Plans have been agreed with the Care Groups to complete these recommendations by December 2022.

8 recommendations (4 Must Do and 4 Should Do) were completed in September. This has reduced the Complete – Awaiting Approval and has increased the Fully Completed and Approved.

Medicine Care Group (October 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)	19	7	**26**	**W**
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**	**B**
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]	0	1	**1**	**MW**
Fully Completed & Approved[4]	6	7	**13**	**MB**
Total	**37**	**31**	**68**	

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

Weekly meetings are being undertaken with Medicine Care Group to facilitate the completion of the 26 recommendations that are now overdue, with a focus on the 19 Must Do recommendations. It is currently expected that 9 recommendations (8 Must Do and 1 Should Do) will be completed in October.

6 recommendations (2 Must Do, 4 Should Do) were completed in September.

Women and Children's Services Care Group (October 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	5	**15**	**MW**
Behind Schedule (Completion By March 2023)	0	1	**1**	**UC**
Behind Schedule (Completion after March 2023)	0	1	**1**	**UC**
On Schedule (Completion by Oct 2022)	0	0	**0**	**UC**
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]	1	0	**1**	**MW**
Fully Completed & Approved[4]	3	3	**6**	**MB**
Total	**14**	**10**	**24**	

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

Bi-Weekly meetings have been scheduled with WACs Care Group to facilitate the completion of the 15 Recommendations that are now overdue, with a focus on the 10 Must Do recommendations. It is currently expected that 5 recommendations (2 Must Do and 3 Should Do) will be completed in October.

A Support and Review Panel was cancelled in September due to an MSSP visit and operational challenges.

2 Must Do recommendations were approved for closure at the Support and Review Panel in September.

Surgery and Critical Care Group (October 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. A meeting has been scheduled with the Care Group and Estates to progress one recommendation.

Core Clinical Services Care Group (October 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**	**UC**
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**	**UC**
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

The Overdue Should Do recommendation relates to Medicine Management E-Learning. Overall Trust Wide training compliance is now above target. There are small number of 'Hot Spots' of poor compliance that are still being addressed by Pharmacy using a targeted trajectory to address this.

Corporate Functions (October 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)	2	0	**2**	**MB**
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]	1	0	**1**	**MB**
Fully Completed & Approved[4]	1	0	**1**	**UC**
Total	**6**	**0**	**6**	

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

The Corporate Support and Review Panel is scheduled for 31 October 2022. Two recommendations are scheduled for that panel with plans in plans so that a further Must Do recommendation will be completed in October and will also be reviewed for closure.

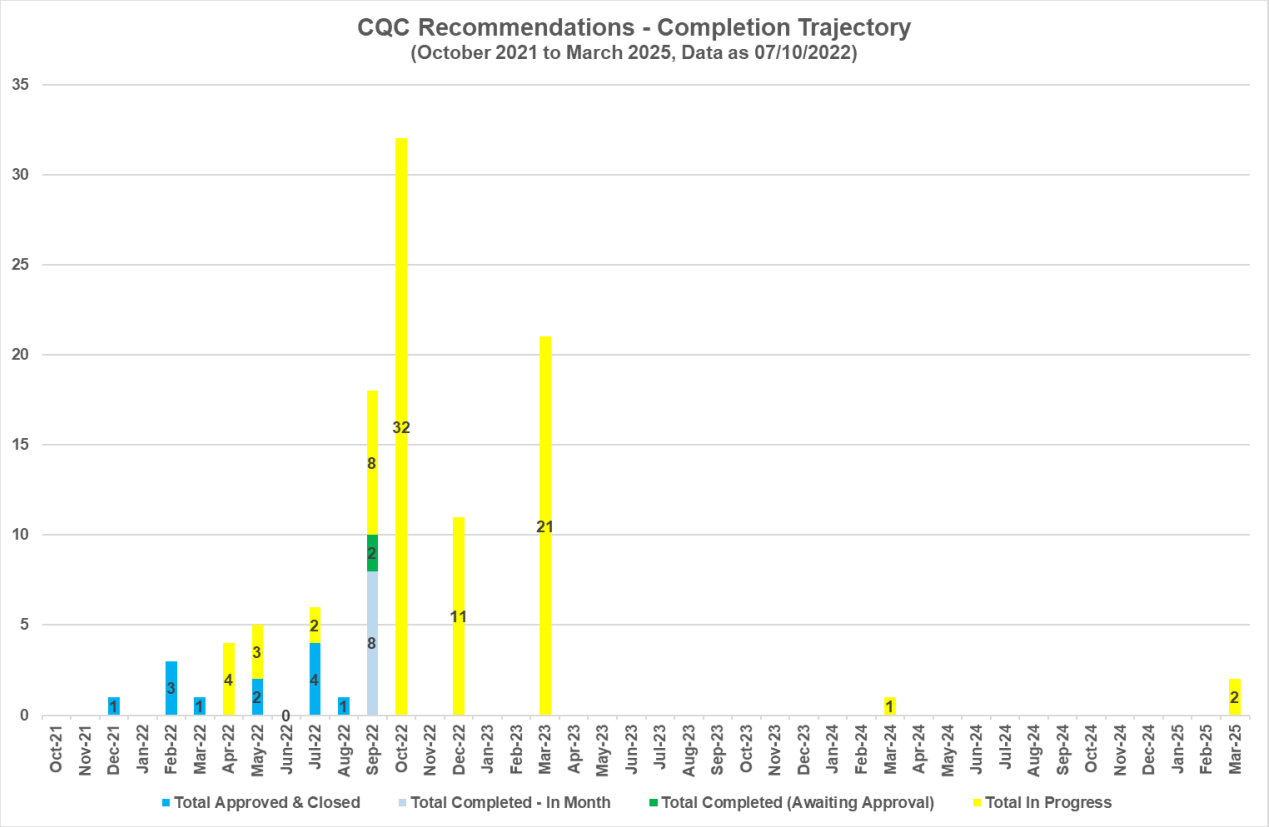
The Three remaining Must Do recommendations relate to:

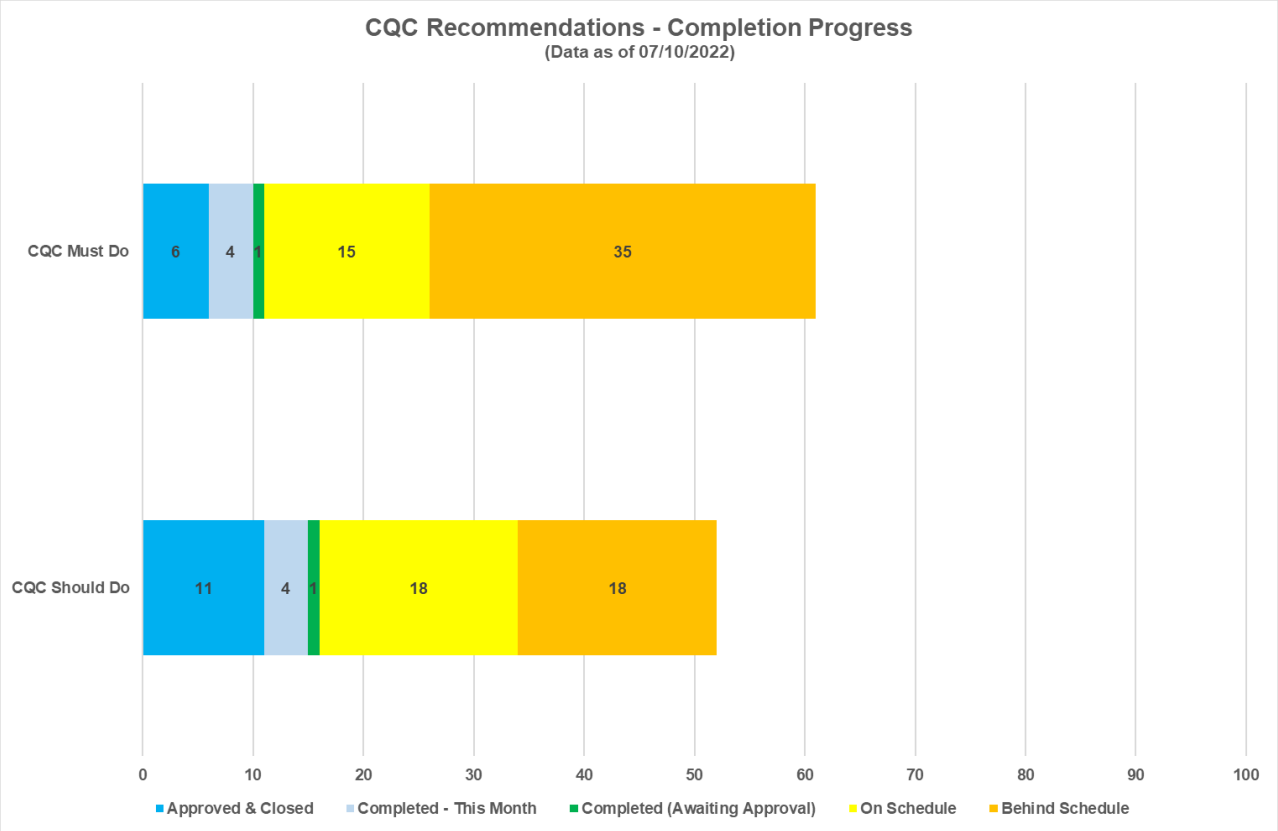
- Delivery of the Cultural Transformation Plan - Scheduled from April 2022 to March 2025
- Delivery of the RTT Recovery Plan - Scheduled from April 2022 to March 2025
- Improvement in the timeliness of Patient Safety Incident Investigations – Performance has been steadily improving April 2021 (3400 Open Incidents) to September 2022 (1400 Overview and Open Incidents). An improvement trajectory is in place to achieve the target of 0 overdue incidents by the end of October 2022.

6. 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.

7. An overview of 3 recommendations completed in September and the impact their progress and completion has had upon the Trust are detailed in Appendix 1.

8. 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.





9. Future dates for Support and Review Panels have been scheduled to ensure closer alignment with Quality Assurance Committee and Board reporting schedules and deadlines. Medicine have now moved to weekly panel meetings due to the number of actions and recommendations these meetings are currently being scheduled.

Alert

10. Concerns and Issues Log

No.	Concerns and Issues	Score	Mitigation
1	Competing Operational Priorities e.g. COVID, Recovery and Restoration In particular in Medicine and WACS Care Group	16	Regular review meetings with Care Groups and Corporate functions to identify and escalate areas of concern
2	Compliance and Assurance staff resilience	12	Explore options for additional capacity / flex of wider establishment in event of long term absence
3	AMaT System Manager resilience	10	Cross training of other AMaT Super Users to provide resilience
4	AMaT System Failure	5	AMaT is web based and cloud based, prolonged outage is unlikely

11. 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.

Recommendation

The Board is requested to:

Note:

- Current progress of the recommendations from the CQC Inspection Report.
- The implementation of weekly Support and Review Panels for Medicine Care Group.
- The Compliance & Assurance Lead for Medicine Care group is undertaking a focussed piece of work on all recommendations related to achieving the RCPCH 'Facing the Future Standards' in Emergency Medicine.
- Progress against the NICHE Investigation Report will now be presented in a separate paper.
- A RCS closure report for the 7 outstanding actions was approved at Quality Assurance Committee and is addressed under a separate item to this Board Meeting.

Comment:

- There has been an improvement in the position, with 8 recommendations approved for closure at Support and Review Panels.
- A further 18 recommendations are expected to be completed in October. These have been shared with the Care Groups.

Escalate:

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

Appendix 1: Impact of Recommendations completed in September 2022

MD68: The maternity service must ensure risk assessments are completed and are actions taken to minimise any risks identified

Following the introduction of the new Badgernet maternity EPR System, the completion and review of maternal risk assessments is now mandatory and is monitored. Maternity are currently undertaking a monthly audit of 30 patient records to check the quality of the assessment undertaken.

Badgernet risk assessments are compliant with all national standards, including NHS Resolution Clinical Negligence Scheme for Trusts (CNST)

Increasing the frequency and quality of maternal risk assessments will deliver improved, safety, care and treatment of mothers and babies.

SD83: The Trust should ensure that privacy and confidentiality is maintained for patients at WGH UTC when sharing personal information

Information Governance Training at WGH UTC is at 100%. Regular monitoring takes place via Matron audits.

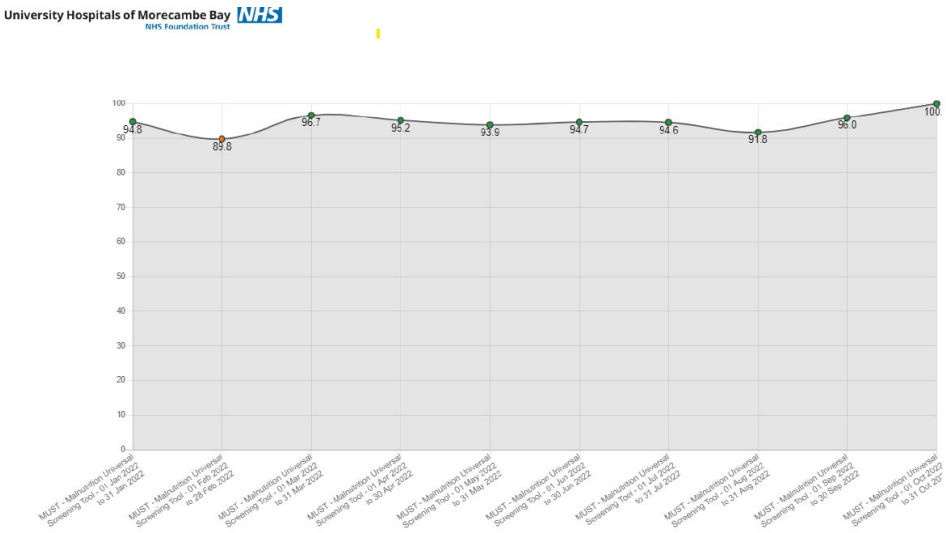
Analysis of Clinical Incident data shows one reported incident of 'accidental disclosure' between September 2020 and August 2022, in this time ~40k patients have been treated at WGH UTC.

SD104: The Medical Care service at RLI should ensure they complete Malnutrition Universal Screening Tool (MUST) documentation

'MUST' is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. The total scores indicate recommended management guidelines for patients.

This was addressed through the Trust Wide fundamentals of care workstream on managing a deteriorating patient. This is monitored through monthly Trust Wide MUST audits and ad-hoc Matron audits of individual Depts/Units/Wards.

MUST Audit Data in AMaT shows that the Medical Wards at RLI are now achieving the Trust target of 90% completion.



Lancashire and South Cumbria Provider Collaborative

Bay Health & Care Partners delivering bettercare together

NHS University Hospitals of Morecambe Bay NHS Foundation Trust

BOARD OF DIRECTORS

Date of Meeting	26 October 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 describes our progress against the external evidence review.

Prior Discussions	Committee	Date	Recommendations/ Concerns
	Quality Assurance Committee	17 October 2022	Paper received

Action to be recommended to the Committee/Board	Review and challenge the content of the paper and seek assurance against trust preparation for Phase 5 and progress against the recommendation in the Niche 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	
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 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 preparation and planning for the Phase Five assurance review to commence in October 2022, the paper also describes the status of the recommendations in preparation for the review.

The Report

6. 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)

7. The recommendations within the report were based on 4 interim reports shared with the trust between October 20 and November 21:
   1. Current Controls Assurance Assessment Report (Oct 2020)
   2. Current Care Review Report (March 2021 - review Oct/Nov 2020)
   3. Index case recommendations (Jan 2021)
   4. Trust recommendations (Nov 21)

8. From the dates above, some recommendations were made earlier than others and have had longer to deliver and embed. It is acknowledged by the external investigators that some recommendations will demonstrate greater progress than others.
9. The graphic below described the datelines for each recommendation and will dictate the timescales for the assurance review.

No	Subject	Recommendations	Date of recommendation
1	Corporate Governance	1, 7	Oct-20
		31	Nov-21(March 21)
		48, 49, 50, 51, 52	Nov-21
2	Performance and financial management	2, 3, 5, 13	Oct-20
		39	Nov-21
3	Investigation management	8, 9	Oct-20
		29	Nov-21(March 21)
		35	Nov-21
4	Mortality processes	10	Oct-20
		15	Jan-21
		26	Nov-21(March 21)
5	Complaint management	27	Nov-21(March 21)
6	Raising concerns processes	38	Nov-21(March 21)
7	Models of care and pathways	12	Oct-20
		16	Jan-21
		22, 25	Nov-21(March 21)
		36, 37, 41, 42	Nov-21
8	Clinical care/guidelines and audit	4	Oct-20
		14, 17, 18	Jan-21
		23, 24	Nov-21(March 21)
		40, 43, 44	Nov-21
9	Medical management and leadership	45, 47	Nov-21
10	Administration/record management and IT	6	Oct-20
		19, 20	Jan-21
		30	Nov-21(March 21)
11	Staff wellbeing/HR and Culture	28	Nov-21(March 21)
		46	Nov-21
	No follow up recuired	11	Oct-20
	Case review (separate activity)	See Clinical care/guidelines and audit recommendations and 19, 21	Jan-21

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:
    a) Case note request – a UHMB Business Intelligence generated patient list. This has been sent to Niche by the deadline of the 1st of October and c100 patients have been selected randomly for review by the Niche team.

    b) 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 (Electronic Patient Record))

    c) The clinical record review will seek evidence to establish current practice as regards the key recommendations as previously shared.

d) the Niche team will also undertake quantitative data analysis and from a re-run of our original data analysis.

Interviews / engagement

13. The Niche team have requested 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.

UHMB response

14. The Niche team will request 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.

15. This includes our response to other recommendations made by the CQC and RCS and the cross-over with these.

16. The trust process of evidence collection is one, two and three dimensional.

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

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

19. **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.

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

21. 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. Executive briefing packs have been shared with colleagues and supported by 1:1 meetings to agree actions to close gaps in assurance and actions required.

Governance processes

22. A twice weekly Support and Review (S&R) meeting continues with the Surgery and Critical care group and Urology specialty:
23. 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

24. Walkabouts are underway to test assurance (one stop clinics/ward rounds/ theatres /Waiting List Office/ attendance at Urology business meetings, Audit, Mortality and Morbidity, Clinical business meetings, Surgical Governance and Assurance Group (SGAG) and Surgery and Critical Care Board).

25. A weekly task and finish group 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.

26. Progress with CQC 'Must do' and 'Should do' actions are now reported through a standardised process to the Performance Review Meetings monthly and it is proposed that the Niche recommendations are reported by the care group through this forum going forward.

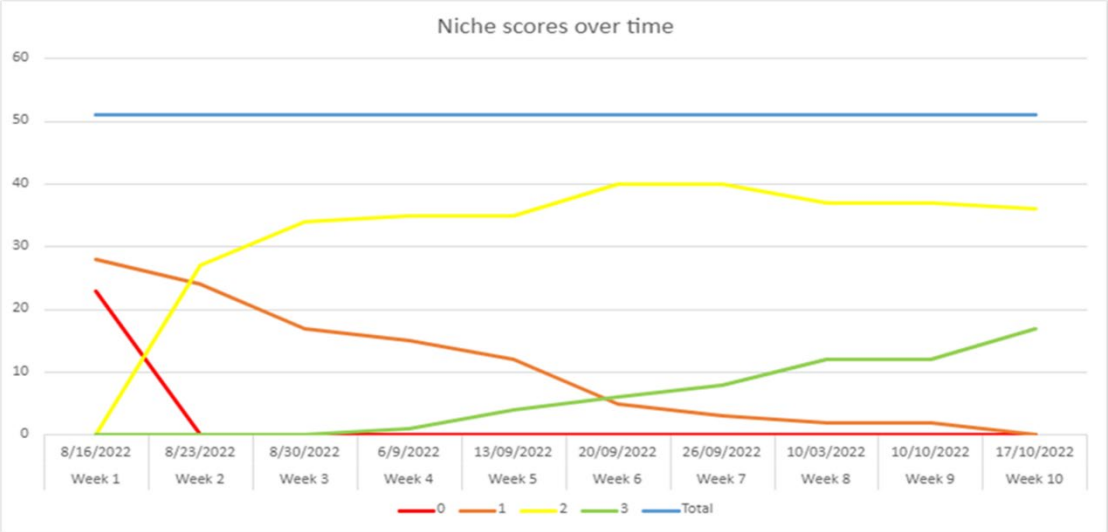
Progress

27. In previous board reports, a status for the Niche recommendations has been provided through an extract from AMaT (Audit Management and Tracking), with status based on an internal compliance and assurance review.

28. 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.

29. Following an initial review of all trust applicable recommendations, a decision was made 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.

30. The graph below shows weekly progress with a reduction in zero and 1 scores, and the increase in 2 and 3 scores. The Director of Governance informs the weekly Executive Directors Group of progress. Following rapid movement from scores of zero to two, the movement has slowed whilst final documents/evidence are updated, revised, and approved in line with trust governance processes. It is anticipated that further progress will occur during week commencing 17th October 22.


Niche scores over time
60
50
40
30
20
10
0
8/16/2022
Week 1
8/23/2022
Week 2
8/30/2022
Week 3
6/9/2022
Week 4
13/09/2022
Week 5
20/09/2022
Week 6
26/09/2022
Week 7
10/03/2022
Week 8
10/10/2022
Week 9
17/10/2022
Week 10
0
1
2
3
Total

Executive Director / Care Group	No. of recommendations	NIAF (0-5) Status		
		1	2	3
Care group/specialty *	8	0	3	5
Chief Executive Officer	1	0	0	1
Chief Operating Officer	2	0	1	1
Executive Chief Nurse **	12	0	10	2
Chief Medical Officer	12	0	8	4
Chief Financial Officer	2	0	2	0
Chief People Officer	2	0	2	0
Company Secretary	2	0	2	0
Director of Governance **	10	0	8	2
Collaborative recommendation with NHSEI/ICB (UHMB contributary evidence)	2	0	0	2

**There is overlap in the delivery of care group recommendations and Executive director responsibility*
*** there is overlap in the delivery of these recommendations as the ECN has overall executive responsibility for Governance*

Timelines

The following describes the timescales where known:

Date	Action	Responsible	
6th October 22	Distribution of Exec Director briefing packs	CA	
10th October 22	Start-up meeting - UHMBT (University Hospitals Morecambe Bay Trust) Urology Assurance Review	RS/CA - purpose to define and agree timescales for the assurance and evidence review, preparation and timescales for the sharing of the report	
W/B 10th October 22	1:1 with execs to discuss briefing pack content	CA/HK	
17th October 22	Current case note review	Niche investigation team on site (RLI (Royal Lancaster Infirmary) Education Centre) Key colleagues diarised to meet the team	
20th October 22	Board development session (Niche Update)	RS/CA/HK	

1st November 22 onwards	Assurance and evidence review Evidence submission to support the review: • Quantitative data set • Recommendation evidence folders	All relevant stakeholders and the board of directors to accommodate a series of interviews 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. The assurance and evidence review will consider findings from the current case review.	
1st November 22 onwards	Timescale/date for submission of evidence to Niche 2-way agreement to additional evidence submission and requests	Library services/CA /exec sign off	
To be confirmed - 20th Jan 22	Timescale for Niche to review the evidence, requests for points of clarity and questions	Key contact – Richard Sachs / Claire Alexander / Tracey Roberts-Cuffin	
To be confirmed - Early Feb 22	Timescale for preparing the first draft report	Niche	
To be confirmed – late Feb 22	Opportunities for factual accuracy checks, feedback, and submission of any additional evidence	UHMBT	

To be confirmed	Draft report submission to NHSE and process following NHS England receipt of first draft	Niche /NHSE	
To be confirmed	Report to UHMBT	NHSE	
29th March 23	Report submission to UHMBT Board	UHMBT	

End of report

BOARD OF DIRECTORS

Date of Meeting	26 October 2022
Title	Maternity Update Report
Report of	Bridget Lees, Chief Nursing Officer
Prepared by and contact details	Heather Gallagher, Director of Midwifery Heather.gallagher@mbht.nhs.uk

Confidentiality	Non-Confidential

Purpose of Report	**To Advise/Alert**	**To Assure**	**To Approve**	**To Update**
	x	x		x
	The report is to advise/alert, to assure and to update. 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. (CQC S.28 i-iv in the report refers to the Trusts S.28 conditions and indicative content)			

Summary of Key Issues	One PMRT case in month, no HSIB cases. Continued ongoing improvements in the reporting of moderate harm and above incidents. Quarterly Maternity Serious Incident Report. The NHSR action plan following our thematic review of EN cases has been closed by NHSR. Training compliance for medical staff both Obstetricians and Anaesthetists is slowly improving but continue to be a challenge due to workforce issues. Compliance for Anaesthetists still projected to be under 90% by December. CNST Year 1 evidence is being submitted, CNST Year 4 is being refreshed and re-published soon with potential revised deadlines. FGH midwifery fill rates continued to be under 80% for September, safe staffing maintained but challenging. Awaiting new starters. Workforce plan developed for maternity, including retention and recruitment.

	MCOC targets removed by NHSE, to focus on retention and recruitment. RCM is balloting members for industrial action. Reduced uptake in bank and agency, midwives reportedly joining agencies with enhanced pay. New quarterly Maternity and Neonatal Safety Champions paper. RCOG issues guidance on short term Locums in Maternity services in response to poor outcomes nationally. Maternity Digital Strategy developed. MSSP progress against exit criteria shows sustained improvement for September. New ICS Community Pharmacy led vaccination service for Flu, Pertussis and COVID-19 New Maternity Dashboard with SPC. Clinical strategy development for Maternity ongoing.

Prior Discussions	Committee	Date	Recommendations/ Concerns
	Quality Committee	17 October 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
	Direct link to Patient Safety			

Impact on Board Assurance Framework or Corporate Risk Register	N/a			
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
QRM	Quality review meeting
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
NHSR	NHS Resolution
MCOC	Midwifery Continuity of Carer
RCOG	Royal College of Obstetricians and Gynaecologists
RCM	Royal College of Midwives
ATAIN	Avoidance of term admissions into Neonatal Unit
MSSP	Maternity Safety Support Programme
SPC	Statistical Process Control
MVP	Maternity Voices Partnership

UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST

Maternity Update Report

Introduction

Perinatal Surveillance Model – See Appendix 1 for data. (CQC: S.28 i)

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 September 2022, except for where exceptions are highlighted.

Perinatal Mortality Review Tool (PMRT) (CQC S.28 i)

2. September saw three PMRT reports complete, there was one new PMRT case reported, one of which had a 72 hour review completed, which was deemed not StEIS reportable.

HSIB (CQC S.28 i)

3. There were no HSIB cases for September. The QRM continue.

Maternity Serious Incidents (CQC S.28 i & ii)

4. We have continued to see a higher number of incidents graded moderate and above since April, this is in response to continued targeted work to ensure all clinical incidents are reported and to improve our grading of harms moderate and above. Ensuring that harm is graded on harm occurred, not on harm based on gaps in care.

5. In September there was one incident of neonatal death at 28+1 weeks gestation, 4 incidents of 4 x Arterial Gas <7.05 Or Base Excess Of >10, 2 incidents of PPH/Blood loss over 1500mls, 1 readmission of mother, 1 baby born outside of NICU at 27 weeks gestation and 1 neonatal transfer. See Maternity Serious Incidents report for further detail.

Role specific Training Compliance – September exceptions (CQC S.28 iii)

- **SBLCBV2**: Obstetric compliance increased from 59% to 67%.
- **GAP/GROW**: Obstetric compliance increase by 7% to nearly the compliance target of 90%.
- **Neonatal Resus**: 4% increase in compliance across all professionals to 96%.

- **PROMPT** (Obstetric Emergency skills) Obstetric compliance increased by nearly 7% to 62.8%, Anaesthetics compliance from 48% to 57%. Total compliance for PROMPT across all professionals now at 83% from 72%, showing an improvement in compliance trajectories, but still work in progress as specific professionals' compliance are holding up other professional groups. CNST requires 90% compliance of all maternity professionals by role.
- **Fetal Surveillance:** Obstetric compliance decreased to 61.7% from 64.3%.

Staffing; Exceptions

6. Midwifery fill rates for FGH have been under 80% again for September at 79.51% mitigations undertaken. September also showing a marked reduction in both bank and agency uptake. Midwifery staff verbalising that they are joining regional midwifery agencies with higher payment per hour than UHMBT (up to £50 per hour). The HOMs are working with wider corporate team on incentives and enhanced pay offer to help mitigate. New starters and international recruits are hopefully starting in the next few months.

NHS Resolution (CQC S.28 i)

7. Following the action plan submitted to NHSR in response to their thematic review into UHMBT's Early Notification cases, we have received a letter from NHSR thanking us and considering the issue now closed, the NHSR action plan is to be monitored to completion locally via the usual governance processes.

8. NHSR published in September 'The second report: The evolution of the Early Notification Scheme' which provides an overview of progress of the Early Notification scheme since 2019. The report updates on the progress made against the key recommendations which were made in the first report and provides an analysis of the main clinical themes and makes recommendations to further improve outcomes for families affected serious harm. The key clinical themes being.

    - Delayed delivery with problems arising from delays in escalation
    - Problems with fetal heart rate monitoring
    - Uterine rupture in women opting for vaginal birth after caesarean

9. Recommendations include:

    - improve antenatal counselling before trial of vaginal birth after caesarean section
    - improve awareness in relation to response to harm for families and staff

10. The maternity team will benchmark the report's recommendations and add to the NHSR action plan any further required actions.

CNST Maternity Incentive Scheme Year One /Year Four (CQC S.28 i)

11. The lookback exercise for CNST Year One has been completed and submitted to NHSR. Evidence was found for 9/10 standards for Year One, evidence for Anaesthetic compliance with MDT Training was not able to be located. NHSR has asked for all the available evidence for Year One to be re-submitted allow an assessment to be undertaken, with a deadline of the 17th October 22.

12. CNST Year Four 10 safety actions are reported to being refreshed, in addition to the extended deadline for evidence submission being pushed back until early February 23.

Maternity and Neonatal Safety Champions

13. Please refer to separate new Maternity Safety Champions paper for detail. (CQC S.28 i & ii)

CQC or other organisation with a concern or request for action made directly with Trust (CQC S.28 i)

14. One approach was made by an MP following a whistleblowing from an employee of the Trust raising concerns with regard to staffing levels, senior visibility of leaders and a culture preventing speaking out. A response has been sent.

Consultant Attendance (CQC S.28 i)

15. 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 August.

Other Updates

RCOG Guidance on the engagement of short-term locums in maternity care (2022)

16. The RCOG have developed new guidance on the engagement of short term locums in maternity care. This guidance outlines the roles and responsibilities for healthcare providers, health care organisations and individual doctors undertaking locum positions within the NHS.

17. A number of Coroner's Regulation 28 reports have highlighted the need for adequate support and supervision of obstetric locums. These individuals face the challenge of providing excellent clinical care but without the knowledge of the organisation or familiarity with the staff with whom they will work. The recruitment of locums is necessary to maintain safe staffing levels. There is a higher risk of variation in care, particularly for short-term locums. Locum doctors, particularly short-term external agency locums, are exposed to highly complex situations within a relatively short space of time. This can occur before they have time to acclimatise to the unit's team members, environment and guidelines. While it is often the case that new team members will meet for the first time on their shifts, the introduction of short-term locums escalates the potential for variation in care because:

    - The curriculum and capabilities framework and educational supervision for deanery trainees and longer term locally employed doctors is circumvented
    - The usual trust/hospital induction process and unit acclimatisation is circumvented
    - Team members have limited information on the locum doctor's ability or level of experience prior to them starting their shift

18. As such it would not be an uncommon scenario for there to be a novel team with a middle grade lead clinician functioning for the first time within an alien environment. This can create variation in care that will be further exposed if demands on the team escalate. A good unit will have systems, team working and clinical leadership in place to reduce the risk of these problems arising. There is a need to standardise the level of supervision and support for locum clinicians, a need to ensure their skillset is a good fit for the service at recruitment and a need to establish the lines of support, performance evaluation and pastoral care, to reflect that which in-house clinicians receive. This should be in place before clinicians start to work independently. The measures are suggested to help to reduce the risk of problems with the quality of care. The WACS Clinical Directors will ensure that the RCOG guidance is reviewed, benchmarked, and implemented.

RCM

19. The RCM is currently balloting midwifery members on industrial action.

Maternity Workforce Funding bid

20. An NHSE maternity workforce funding bid has been submitted:
    - £9,500 for additional PAs to support Obstetric Leadership capacity
    - £4,750 for bereavement training (Post Mortem consent)
    - £30,000 for additional non-midwifery bereavement post

21. We are awaiting to hear about the funding allocation.

22. We have also been offered financial support from the LMNS (spending plan for 2022/2023) for reimbursement of any shortfall costs associated with international midwifery recruitment. £7,000 per international midwife is funded nationally but often this is not sufficient to cover all costs. This offer is in place until the end of March 2023.

Maternity Communication Strategy and Staff Engagement

23. A maternity communication strategy has been written, including the following activities that have been undertaken in September:

    - Launch of a weekly core brief on key topics for staff.
    - Sessions with the Safety, Quality and Assurance Midwife for Consultant Obstetricians to update on current safety and quality workstreams across both Obstetric Lead sites.
    - Launch of weekly ‘Here to Hear and Safe to Say’ sessions with the Director of Midwifery for all staff across all sites.
    - Board level Safety Champion walkabouts continue, further development of sharing the feedback and actions via ‘You said, We did’.

24. Planned activities:

    - Joint Director of Midwifery and Freedom to Speak Up Guardians sessions/walk about, as part of October’s ‘Speak up month’.
    - Launch of the newly designed Maternity online Padlets for Quality and Safety and Better Births information for staff.
    - Joint RCM and Director of Midwifery virtual drop-in session.
    - Half day Quality, Safety and Assurance time out with Consultant Obstetricians.

- Time out/team development day for senior midwifery team Band 7 managers and above.

ATAIN-

25. Please refer to separate ATAIN paper. (CQC S.28 i & ii)

Maternity Safety Support Programme (MSSP) (CQC S.28 i)

26. The monthly feedback from the MSSP for September shows continued sustained progress against the exit criteria of Leadership, Governance and Vision and Strategy for the programme, see Appendix 3. The exit trajectory is circa July/August 2023.

CQC

27. All maternity services in the UK are being inspected by the CQC as part of a new maternity inspection programme, as almost all maternity services across the UK are facing significant challenges. All NHS acute hospital maternity services will be inspected if they have not been inspected and rated since April 2021.

Maternity Digital Strategy (CQC S.28 i)

28. We have developed a maternity digital strategy in alignment with the wider trust digital strategy dedicated leadership it will be signed off by the LMNS and ICB CNST standard Safety Action 2 (MSDS).

Midwifery Continuity of Carer (MCOC)

29. A letter was received by NHSE on 21st September 22 detailing that all targets related to MCOC are removed, in recognition of the current midwifery workforce challenges. Trusts are asked to focus their attention on the retention and recruitment of midwifery staff, as a building block to achieving MCOC when able. The CNST Year Four Safety Actions are expected to be amended due to this change in policy position.

Kirkup (East Kent) Report /Ockenden Reports (CQC S.28 i)

30. Kickup's East Kent's inquiry publication was delayed from an expected date of 22nd September 2022, this was due to the Queens passing. The new publication date is the 19th October 2022.

31. The Chief Nursing Officer (CNO) for NHSE has indicated that a new national plan for Maternity will be published shortly. This is expected to contain the national steer for the Ockenden (2022) IEAs detailed in the final report and Kickup's East Kent actions.

Maternity Clinical Strategy

32. The maternity team have been engaged with the wider Trust team in developing the clinical strategy. Work has commenced on understanding our population demographic with help from the public health data and input from the local Public Health Consultants to aid developing priority areas of need within the strategy. Work is ongoing with the

MVP chair in terms of engaging women from areas of priority need to allow co-production in developing sustainable models of care.

Maternity Dashboard

33. Please refer to Appendix 2 (CQC S.28 iv)

34. The newly developed dashboard for maternity is detailed in Appendix 3. This sees the development and implementation of SPC charts for exception reporting. The dashboard removes the metric for Elective and Emergency Caesarean Sections (CS) as per NHSE guidance issued in February 2022 requesting that these should not be used as quality measure. The dashboard uses the Robson criteria for the assessment of and focus of any quality improvements around CS.

35. The dashboard is presented at CGGAG and QGPS and included in WACS Care Group IPR. Due to the timings the dashboard will always be a month behind. There is further work to develop G charts for the small data points and separate SPC charts for the individual sites. The maternity dashboard has been presented to MVP.

Vaccination service for Influenza, Pertussis and COVID-19

36. New service being rolled out for the provision of Influenza, Pertussis and Covid-19 immunisation/vaccination during pregnancy. The new service is ICS lead, and the service is to be delivered in Antenatal Clinic's by community pharmacy, until 31st March 2023.

MatNeoSIP

37. The maternity team including the Non-Executive Safety Champion attended a MatNeoSIP event, aiming to further build on work as a Maternity and Neonatal Patient Safety Network to share learning and drive improvement across the North West Coast.

38. The aim of MatNeo SIP is to:

- Contribute to the national ambition set out in Better Births to reduce the rates of maternal and neonatal deaths, stillbirths and brain injuries that occur during or soon after birth by 50% by 2025.
- Contribute to the national ambition, set out in Safer Maternity Care to reduce the national rate of preterm births from 8% to 6%.
- Improve the safety and outcomes of maternal and neonatal care by reducing unwarranted variation and provide a high-quality healthcare experience for all women, babies, and families across maternity and neonatal care setting in England.

Perinatal Quality Surveillance Model

CQC Maternity Rating	Overall	Safe	Effective	Caring	Well-Led	Responsive
RLI	Requires Improvement	Good	Requires Improvement	Good	Requires Improvement	Good
FGH	Inadequate	Requires Improvement	Inadequate	Good	Inadequate	Good
WGH	Inadequate	Inadequate	Requires Improvement	Not rated	Inadequate	Requires Improvement

Maternity Safety Support Programme Yes	Yes

	January	February	March	April	May	June	July	August	September	October	November	December	January	February	March
Findings of review of all perinatal deaths using the real time data monitoring tool	None - meeting cancelled due to staff shortages/ sickness	1 Review completed - IUD. Issues identified - no CO monitoring performed, maternal pulse not recorded when ausculatating fetal heart, missed opportunities to refer for a growth scan from GROW chart.	2 Reviews completed: 1 NND - Issue identified with mums psychological care in the postnatal period. NND due to fatal abnormality not detectable in the ante-natal period. 1 IUD - review identified 'No issues with care identified'	0 Reviews completed due to annual leave and half term giving limited availability for midwifery and clinical staff to support with the reviews	1 review completed IUD - review identified no issues with care	1 twin Stillbirth 35/40_ PMRT outstanding, been to ERG no identified care delivery issues	0 reviews completed	2 PMRT reports completed. 1 New PMRT case reported, 72 hour review identified learning. Case has been StEIS reported for SI	3 PMRT reports complete. External PMRT report has been shared at Private Board. 1 New PMRT case reported 72 hour review completed. Deemed Not StEIS reportable						
Findings of the review of all cases eligible for referral to HSIB	0	0	0	1 Neonatal Death. HSIB awaiting parents consent to progress with the investigation.	0	0	0	0	0						
The number of incidents logged graded as moderate or above	1 Moderate Harm	4 Moderate Harm	6 Moderate Harm	4 Moderate Harm (3 PPH's >2000mls & 1 Term baby admission to NNU), 1 Neonatal Death	6 Moderate Harm including: 3 PPH's >2000mls 2 Term admissions to NNU 1 Thrombectomy	10 Moderate Harm including: 3 PPH's 2 Poor clinician documentation 1 Shoulder Dystocia 1 unsuccesful forceps 1 low cord gas 1 neonatal seizure 1 term admission to NNU	1 Severe Harm: Maternal Blood loss 10 Moderate Harm: 3 x Maternal - Blood Loss >1500mls 6 x Neonatal - Term Baby Admitted To NNU 1 x Fetal - Stillbirth	1 x Neonatal Death - 26+5 weeks gestation. 1 x Severe Harm - externally reported: Birth Trauma (already linked to PSI 275993 which has had an RCA, and steis reported). 13 x Moderate Harms: 5 x Blood Loss >1500mls, 2 x Intensive Care Admission, 2 x Term Baby Admitted To NNU, 1 x Anaesthetic Complications, 1 x Care - Incorrect Care, 1 x Shoulder Dystocia, 1 x Safeguarding Referral Made	1 x Neonatal Death 28+1 weeks gestation. 4 x Arterial Gas <7.05 Or Base ExcessOf >10 2 x Blood Loss >1500mls 2 x Term Baby Admitted To NNU 1 x Readmission Of Mother 1 x Baby Born Less Than 27 Weeks Outside NICU 1 x Neonatal Transfer						
Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training															
SBLCBv2	61%	72.80%	Midwives 79.7% Doctors 33.3% Total 75.3%	Midwives 74.7% Doctors 56.5% Total 72.9%	Midwives 66% Doctors 37.8% Total: 66%	Midwives 65% Doctors 38.9% Total: 60.4%	Midwives 69% Doctors 36.6% Total: 64%	Midwives 69% Doctors 25% Total 59%	Midwives: 73.4% Doctors: 40% Total: 67%						
GAP and GROW Training			Midwives 83%% Doctors 75% Total 82.3%	Midwives 78.8%% Doctors 76.5% Total 78.5%	Midwives 74.7% Doctors 76.5% Total 74.9%	Midwives 75.4% Doctors 84% Total 76.6%	Midwives 86.5% Doctors 80.8% Total: 85.7%	Midwives 90.3% Doctors 76.9% Total 88.5%	Midwives: 90.1% Doctors: 84% Total: 89.3%						
Fetal Surveillance in Labour	63%	75.90%	K2 Competency assessment Midwives 87.7% Doctors 73.9%	K2 Competency assessment Midwives 87.7% Doctors 73.9%	K2 Compliance assessment: 88.6% Midwives - 88% Doctors - 72.2%	K2 Competency assessment: 90.9% Midwives - 92.5% Doctors - 80.8% Total inc.Face to face training - 86%	K2 Competency Assessment: 84.9% Midwives: 89.4% Doctors: 68.6% Total inc face to face:86%	K2 competency assessment: 84.7% Midwives: 88.2% Doctors: 64.3%	Midwives: 91.7% Doctors: 61.7% Total: 87%						
Maternity Emergencies and Multiprofessional training	47%	70.70%	Midwives/MSW's 79.9% Doctors 65.2% Total 78.3%	Midwives 77% MSW's 80% Doctors 61% Anaesthetists 32% Total 69%	Midwives 77.2% MSWs 83.3 Doctors 57.6% Anaesthetists 45.5% Total 69.6%	Midwives 81% MSWs 71.4% Drs 61.8% Anaesthetists 35.6% Total 70.9%	Midwives 90.1% MSWs 87.2% Doctors 56% Anaesthetists 48% Total 72.6%	Midwives 90.1% MSWs 87.2% Doctors 56% Anaesthetists 48% Total 72.6%	Midwives 93% MSWs 93.5% Doctors 62.8% Anaesthetists 57% Total 83.1%						
Personalised Care	64%	73.40%	Midwives # MSW's 83.9% Doctors 52.2% Total 80.9%	Midwives 74.7% MSWs # Doctors 56.5% Total 72.9%	Midwives 73.5% MSW's 78.2% Doctors 58.1% Total 72.7%	Midwives 74.9% MSWs 80% Doctors 62.5% Total 74.5%	Midwives 82.2% MSWs 83% Doctors 69.7% Total 76.1%	Midwives 82.2% MSWs 83% Doctors 69.7% Total 76.1%	Midwives 89% MSWs 96% Doctors 57% Total 85.4%						
Care during Labour and the Immediate Postnatal Period	61%	72.80%	Midwives/MSW's 79.7% Doctors 33.3% Total 75.3%	Midwives/MSW's 78.7% Doctors 37.5% Total 74.7%	Midwives 75.3% MSWs 85.5% Doctors 58.8% Total 75.3%	Midwives 79.8% MSWs 85.5% Doctors 65.7% Total 79.2%	Midwives 84.4% MSWs 92.5% Doctors 65.6% Total 83.3%	Midwives 84.4% MSWs 92.5% Doctors 65.6% Total 83.3%	Midwives 89% MSWs 98% Doctors 54.2% Total 86.1%						
Newborn Life Support	80%	92.70%	Midwives 93.2% Doctors 90.5% Total 92.9%	Midwives 94% Doctors 90.5% Total 93.7%	Midwives 94.6% Doctors 92.3% Total 93.9%	Midwives 94.7% Doctors 92.3% Total 94.4%	Midwives 93% MSWs 96% Doctors 91.3% Total 93.4%	Midwives 94.6% MSWs 95.8% Doctors 88% Total :94.1%	Midwives 96% MSWs 98% Doctors 91.7% Total 96%						
Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite, gaps in rotas	100%	100%	100%	100%	100%	100%	100%	100%	100%						
Minimum midwife safe staffing															
Midwifery Staff average fill rate	RLI 93.21% FGH 83.27%	RLI 86.46% FGH 88.4%	RLI 87.22% FGH 85.49%	RLI 88.22% FGH 87.09%	RLI 87.2% FGH 84.63%	RLI 89.09% FGH 87.97%	RLI 91.25% FGH 85.39%	RLI 88.83 % FGH 79.46 %	RLI 85.39% FGH 79.51%						
Midwifery bank usage	RLI 1152.58 hrs FGH 161 hrs	RLI 1264.52 hrs FGH 267.42 hrs	RLI 1144.58 hrs FGH 266.91 hrs	RLI 1092.66 hrs FGH 286.92 hrs	RLI 1359.5 hrs FGH 340.42 hrs	RLI 881.25 hrs FGH 254.92 hrs	RLI 1034 hrs FGH 247.5 hrs	RLI 1621.33 hrs FGH 548.83 hrs	RLI 770.67 hrs FGH 272.75 hrs						
Midwifery agency usage	RLI 187 hours FGH 725.5 hrs	RLI 221.5 hours FGH 710.08 hrs	RLI 88 hours FGH 892.17 hrs	RLI 119 hrs FGH 996.5 hrs	RLI 250.75 hrs FGH 1064 hrs	RLI 427.58 hrs FGH 987.25 hrs	RLI 385.42 hrs FGH 1088.5 hrs	RLI 235.33 hrs FGH 826.25 hrs	RLI 86.17 hrs FGH 729 hrs						
Service User Voice Feedback	Midwife led unit provision, decorative order Choice available continuity of antenatal care Reliability of provision	Request to extend the dashboard information for public view, Agreement to provide this on the website	Infant Feeding support Antenatal Education (face to face and publicity of provision).	An online antenatal education package is being introduced across the LMNS with MVP support,	MVP 15 steps undertaken at RLI- positive feedback from service users. Parts of environment praised (art work), concern raised about estates ie LW flooring/visitors toliet and	Visiting arrangements have been reviewed in line with trust and national guidance and the introduction of sibling visiting now available. With a plan to review further in July.	Themes around not being listended to and not receiving individualised care.	Feedback from a younger mum in relation to poor staff communication. Next MVP face to face meeting to be arranged at a Young Mum's Group.	Concerns raised regarding availability of homebirth service across sites - Consultant midwife addressing concerns with users and midwifery teams						
Staff feedback from frontline champions and walk abouts	Homebirth bags heavy and not standardised	12 Homebirth Bags ordered	MSSP Engagement event with doctors. Clinicians highlighted issues with mandatory fields within BadgerNet, digital support offered.	Speciality specific training commenced with junior obstetricians and being developed for other staff groups.	MVP 15 steps undertaken at RLI (with NED)- staff discussed the reduced availability of support for women throughout the pandemic. Visiting provision currently under review. Awaiting written	Staff have escalated the environmental conditions on ward 17 at RLI (extreme heat). Estates team adding reflective film to windows w/c 18.7.22. Arranging for twice daily temperature monitoring. On risk register.	Walk about by DOM, WGH staff raised concerns about night shifts at Helme Chase. Listening event to be arranged with HOM and Consultant Midwife.	Clinical Staff asking for increased communication - HOM's to implement new drop-in/update staff sessions. Communication strategy in progress. Feedback on Ward that no Band 2 MSW. No TC nurses. Delays in IOL	Need for triage service at RLI to ensure safe and timely assessment of women on arrival. New area identified, however capital works required - costings requested.						
HSIB/ NHSR/ CQC or other organisation with a concern or request for action made directly with Trust	0	Each baby Counts Thematic review received from NHS Resolution	0	0	0	1 action plan requested from a thematic review	0	1 CQC	0						
Coroner Regulation 28 made directly Trust	0	0	0	0	0	0	0	0	0						

Progress in Achievement of CNST			Evidence requested for year 2 submission	Scheme restarted	Year 4 on-going assessment against new criteria.	Benchmarking taking place of year 2, 3 and 4 criteria. Currently 3/10	Evidence requested for year 1 submission	CNST Year 1 declaration submitted. 5/10 compliance with Year 4 to date	CNST year 1 evidence to be uploaded to NHSR. 5/10 complaince with year 4 to date - awaiting revised guidance						
Situations in which a Consultant MUST ATTEND								15 out of 15	15 out of 15						
Unless the most senior doctor present has documented evidence as being signed off as competent								11 out of 11	11 out of 11						

Proportion of Midwives responding with 'Agree or Strongly Agree' on whether they would recommend their Trust as a place to work or receive treatment	67%
Proportion of speciality trainees in Obstetrics and Gynaecology responding with 'excellent or good' on how they would rate the quality of clinical supervision out of hours (National 79.3%, 2019)	RLI 90.91% FGH 91.25%

Latest available annual figures used	**UHMBT**	**National**
Stillbirth Rate	2.87 per 1000 2021/22	3.8 per 1000 (2020)
Neonatal Death Rate	1.2 per 1000 2021/22	1.3 per 1000 (2019)
Perinatal Mortality Rate	3.88 per 1000 (2019)	4.96 per 1000 (2018)

Stillbirths after 24 weeks gestation and excluding termination of pregnancy
Neonatal deaths after 24 weeks gestation

University Hospitals of Morecambe Bay
NHS Foundation Trust

Maternity Dashboard

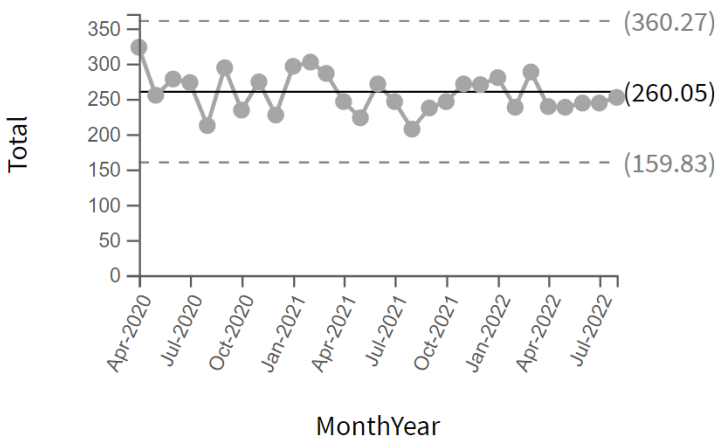
August 2022

Karen Bridgeman

Bookings

Total Number of Bookings

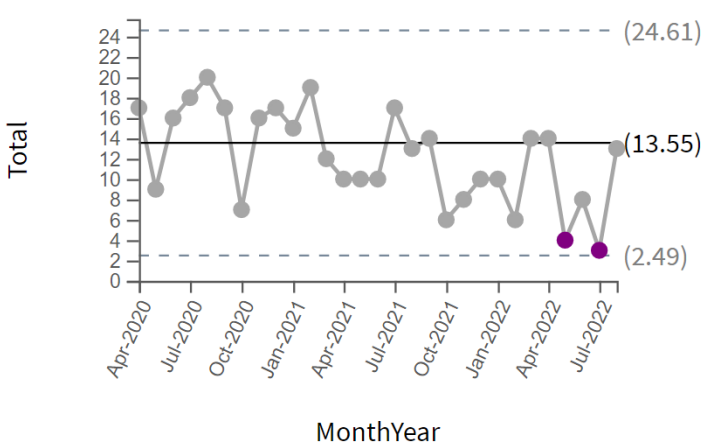
*Mean and Control Limits (re)calculated on first 20 points of data, neither higher or lower is



Latest
252
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Number of Bookings Transferred In

*Mean and Control Limits (re)calculated on first 20 points of data, neither higher or lower is



Latest
13
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

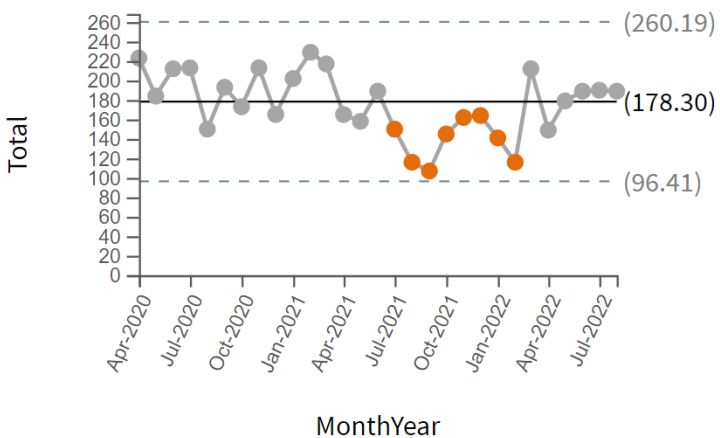
Summary:

The decrease in number of booking transferred in is due to the shared system, and a change in processes for border bookings. The women are not technically transfers but shared care therefore no longer get included/identified as true transfers in.

Bookings

Number of Bookings by 9 Weeks + 6 Days

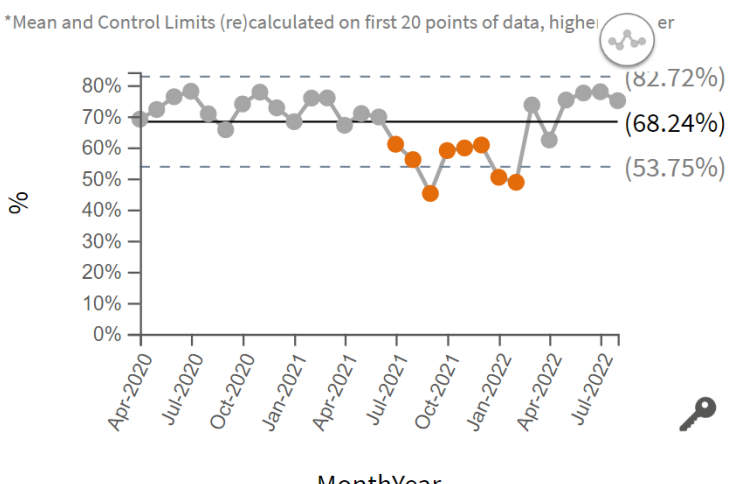
*Mean and Control Limits (re)calculated on first 20 points of data, higher is better



Latest
189
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Percentage of Bookings by 9 Weeks + 6 Days

*Mean and Control Limits (re)calculated on first 20 points of data, higher



Latest
75.00%
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

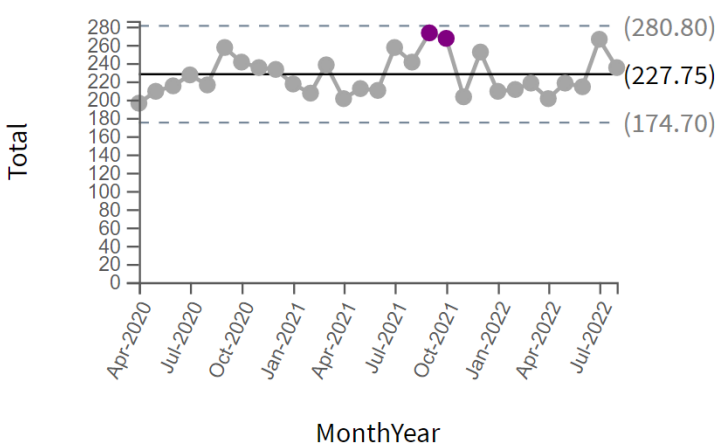
Summary:

There was a significant decrease in booking's undertaken by 9+6 weeks during the COVID-19 pandemic however since February 2022 bookings have maintained above improved to 74%

Births / Birth Location

Number of Women Delivered

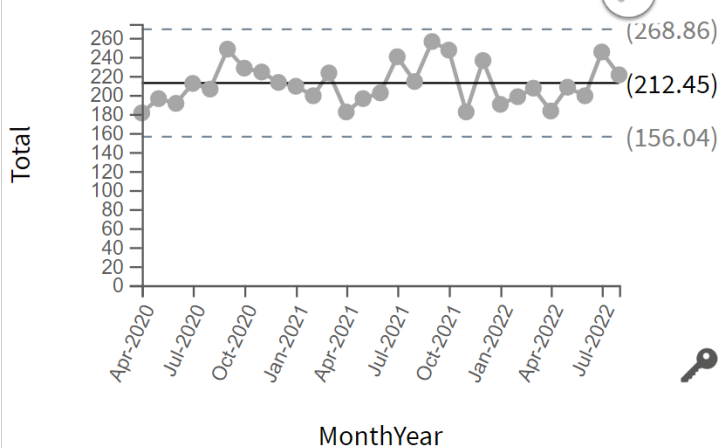
*Mean and Control Limits (re)calculated on first 20 points of data, neither higher or lower is



Latest
235
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Number of Women Delivered ≥ 37 Weeks

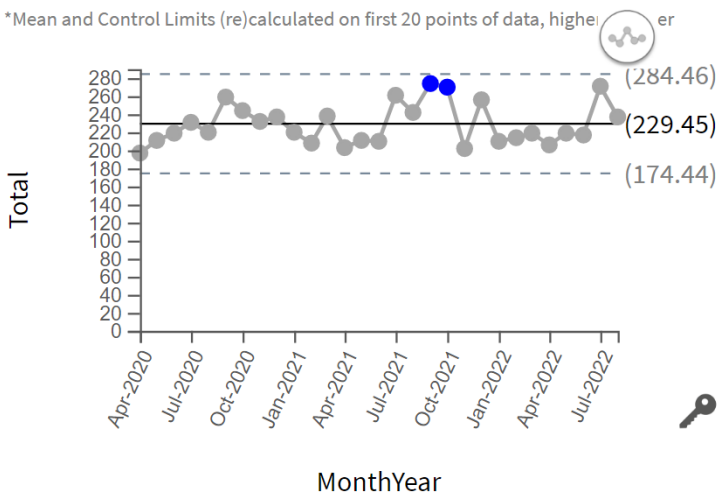
*Mean and Control Limits (re)calculated on first 20 points of data, highe er



Latest
221
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Number of Live Births

*Mean and Control Limits (re)calculated on first 20 points of data, highe er



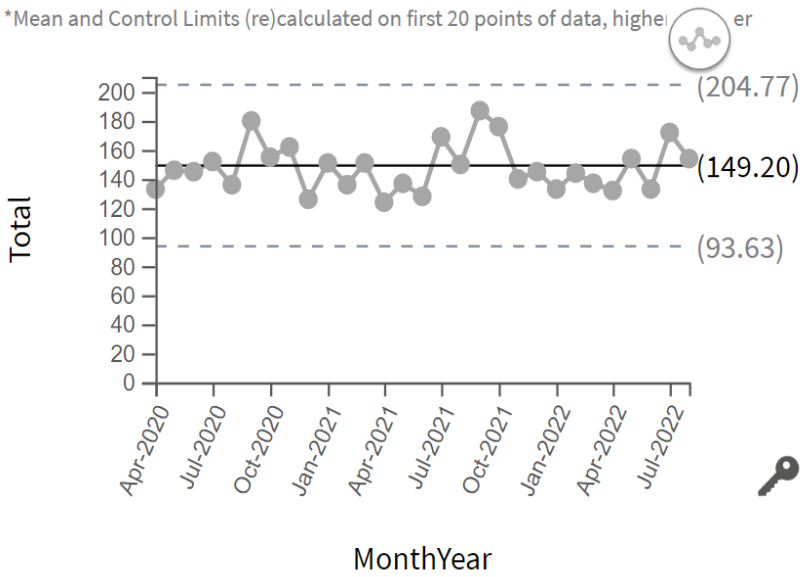
Latest
237
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Summary:

The birth rate demonstrates normal variation with an increase seen in July which us in keeping with this time of year. Based on booking numbers and estimated due dates this is expected to settle in October and November 2022.

Number of Vaginal Births

*Mean and Control Limits (re)calculated on first 20 points of data, highe er



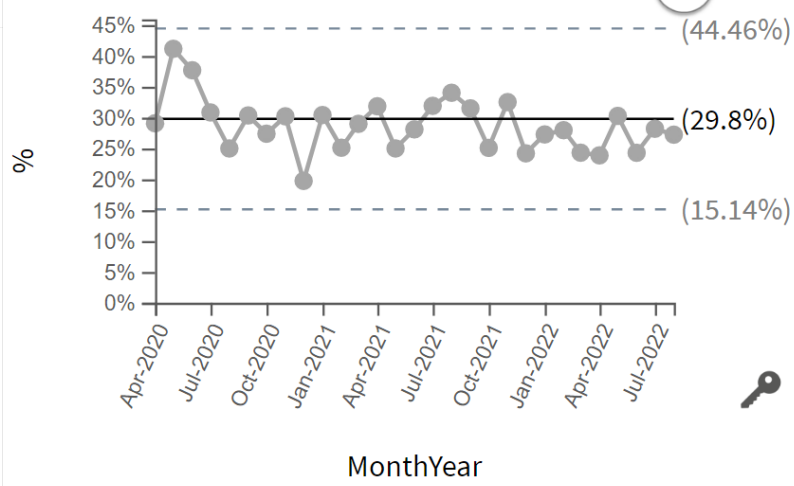
Latest
154
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Summary:

Vaginal births and spontaneous vaginal births demonstrate normal variation

Percentage of Spontaneous Vaginal Births

*Mean and Control Limits (re)calculated on first 20 points of data, highe er

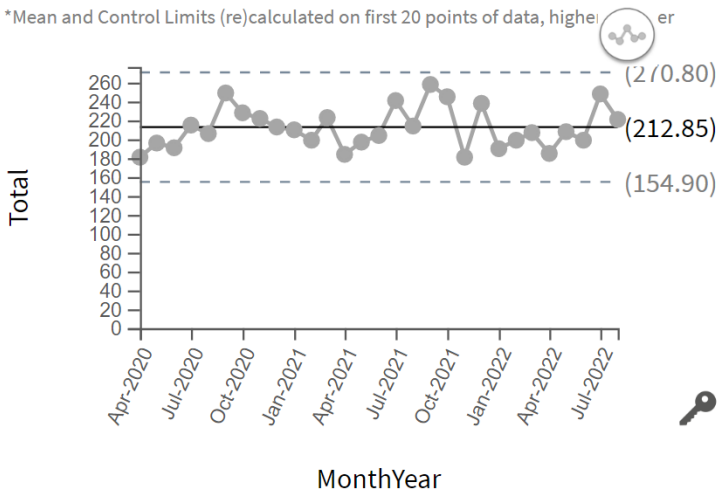


Latest
27.23%
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Births / Birth Location

Number of Live Births ≥ 37 Weeks

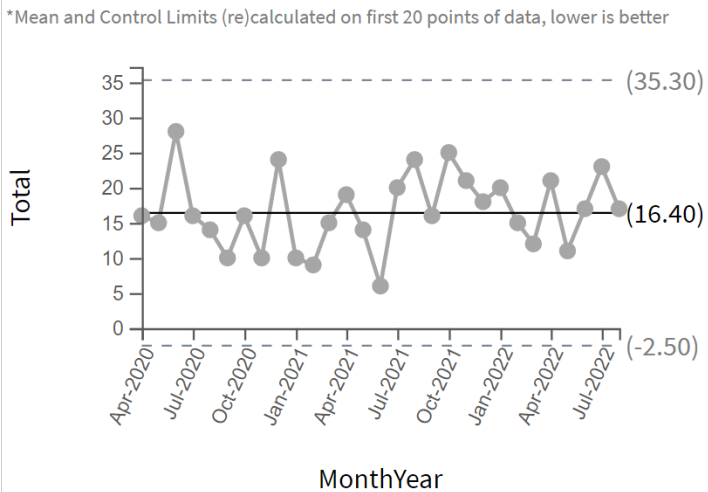
*Mean and Control Limits (re)calculated on first 20 points of data, highe er



Latest
221
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Number of Pre-term Live Births < 37 Weeks

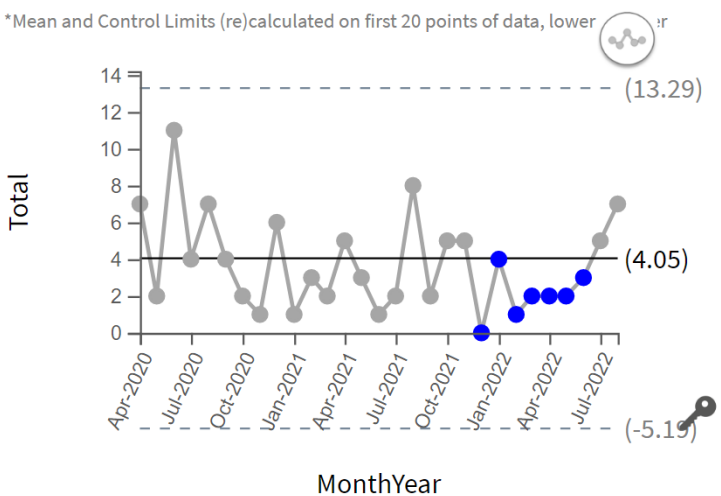
*Mean and Control Limits (re)calculated on first 20 points of data, lower is better



Latest
17
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Number of Pre-term Live Births < 34 Weeks

*Mean and Control Limits (re)calculated on first 20 points of data, lower r



Latest
7
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

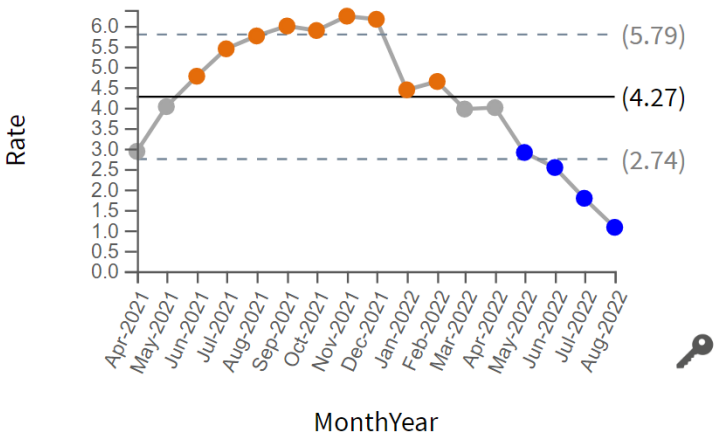
Summary:

The rate of preterm births <34weeks in 2022, highlighted a significant decrease. It is not known what contributed to this decrease.

Births / Birth Location

Total Stillbirth Rate (≥ 24 weeks)

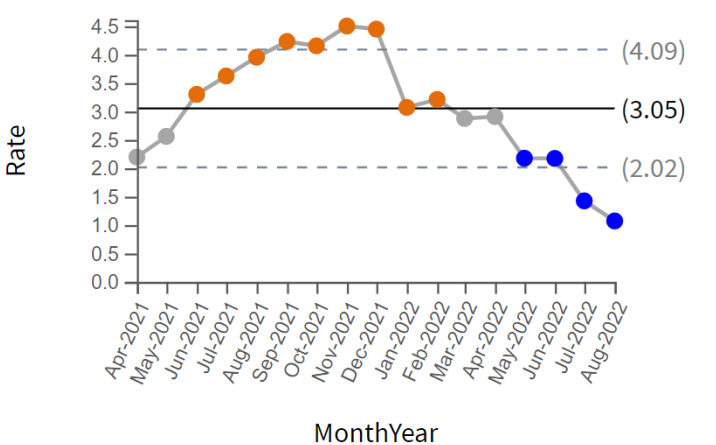
*Mean and Control Limits calculated on full dataset within recalculation window, lower is b



Latest
1
Variance Type
Special cause variation - improvement (indicator where low is good)
Target
N/A
Target Achievement
N/A

Stillbirth Rate excluding TOPFA & declined TOPFA

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



Latest
1
Variance Type
Special cause variation - improvement (indicator where low is good)
Target
N/A
Target Achievement
N/A

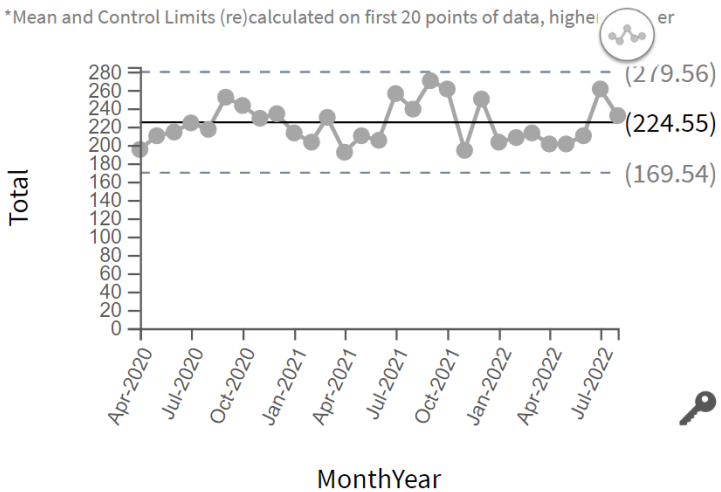
Summary:

The stillbirth rate has been calculated based on 12 month rolling data. A special cause for improvement has been highlighted. During the COVID-19 pandemic there was a noted national increase in stillbirths. This data may represent this increase and the decrease maybe be associated with the move to return back to face to face appointments and the normal care pathway in 2022.

All stillbirths are reviewed at PMRT to identify any themes and trends.

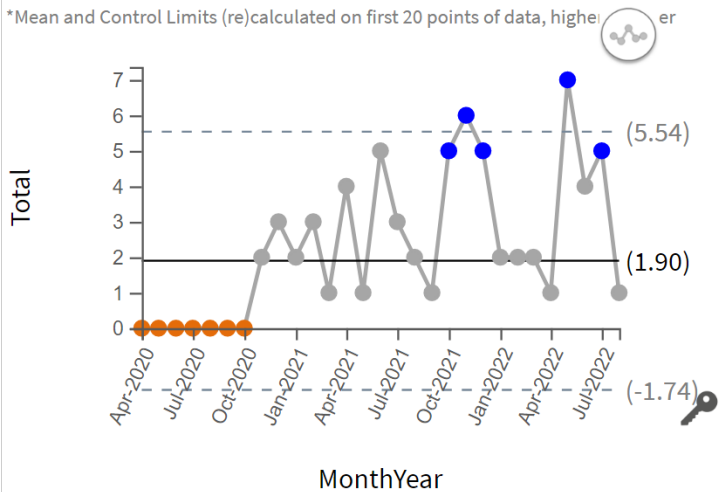
Births / Birth Location

Number of Babies Born in a CLU / Labour Ward



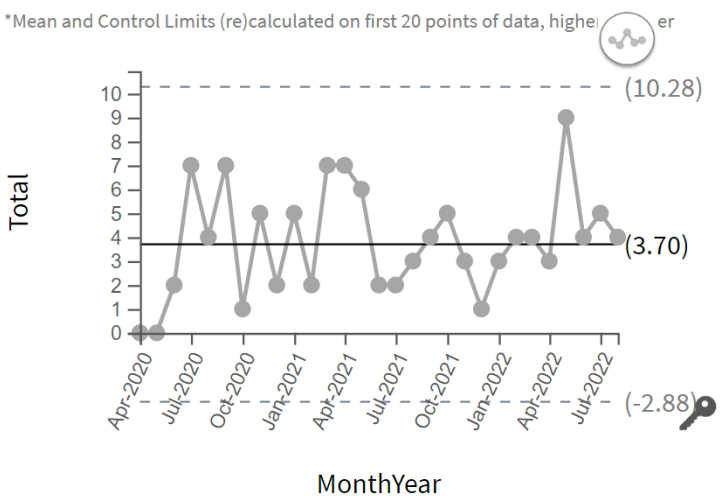
Latest
232
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Number of Babies Born in a Free-standing MLU



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

Number of Homebirths



Latest
4
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

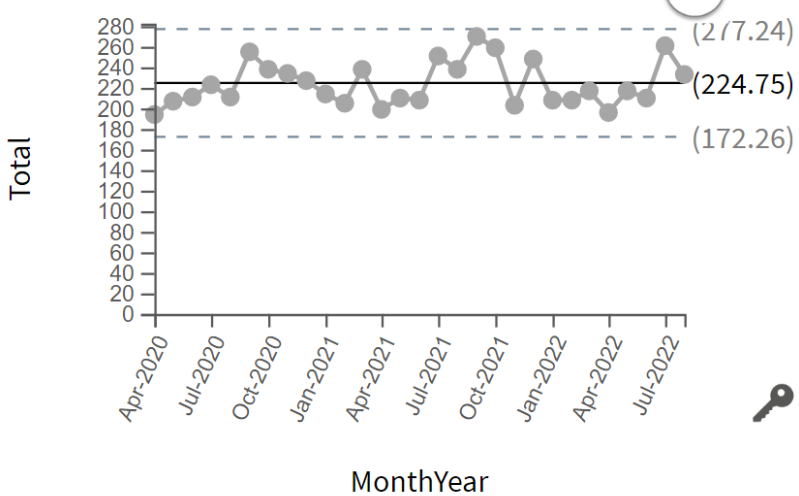
Summary:

Common cause variation is seen in all birth settings.

Births / Birth Location

Number of Singleton Babies Born (Registrable Births)

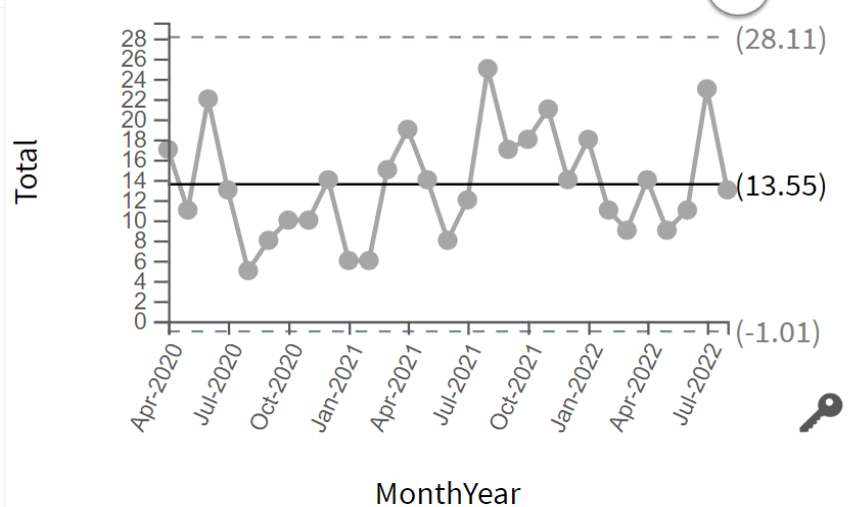
*Mean and Control Limits (re)calculated on first 20 points of data, neithe r or lower is



Latest
233
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Number of Singleton Births ≥ 24 Weeks & < 37 Weeks

*Mean and Control Limits (re)calculated on first 20 points of data, lower r

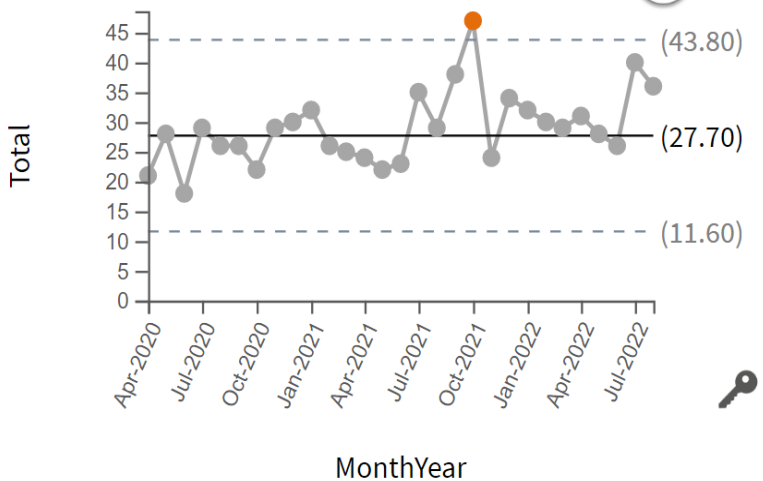


Latest
13
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Assisted Vaginal Births

Number of Women Instrumental Births

*Mean and Control Limits (re)calculated on first 20 points of data, lower



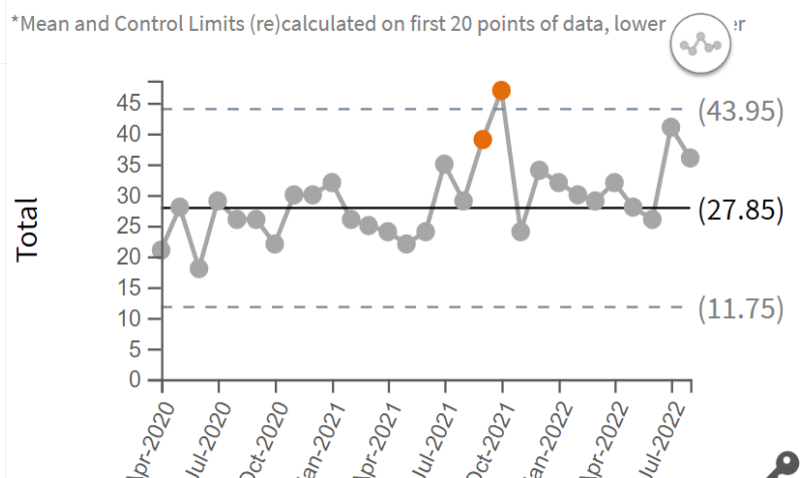
Latest
36
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Summary:

Common cause variation is observed with instrumental births

Number of Babies Instrumental Births

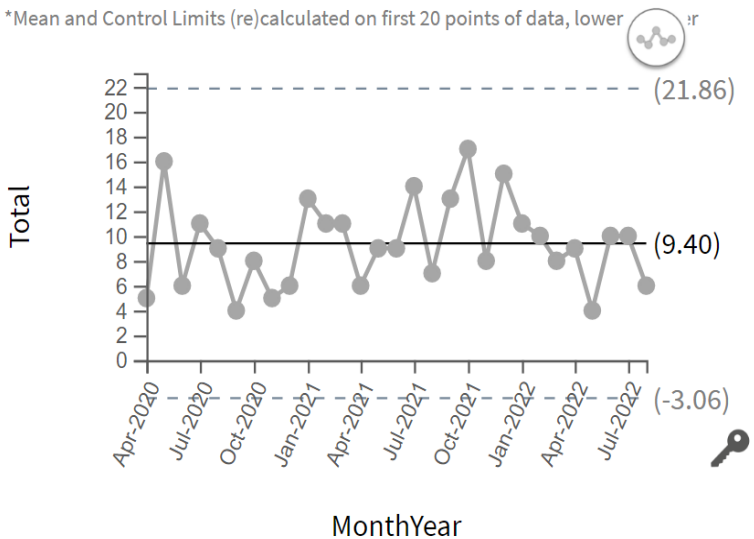
*Mean and Control Limits (re)calculated on first 20 points of data, lower



Latest
36
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Assisted Vaginal Births

Number of Women Ventouse Births

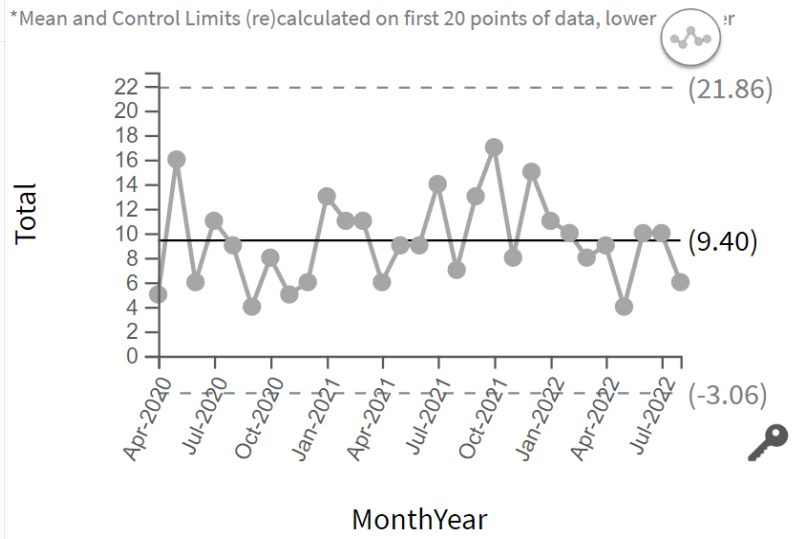


Latest
6
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Summary:

Common cause variation is observed with ventouse births

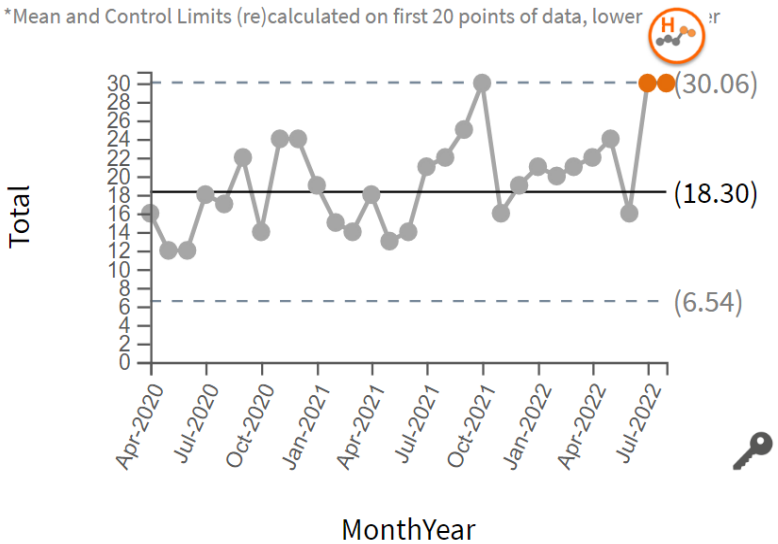
Number of Babies Ventouse Births



Latest
6
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Assisted Vaginal Births

Number of Women Forceps Births



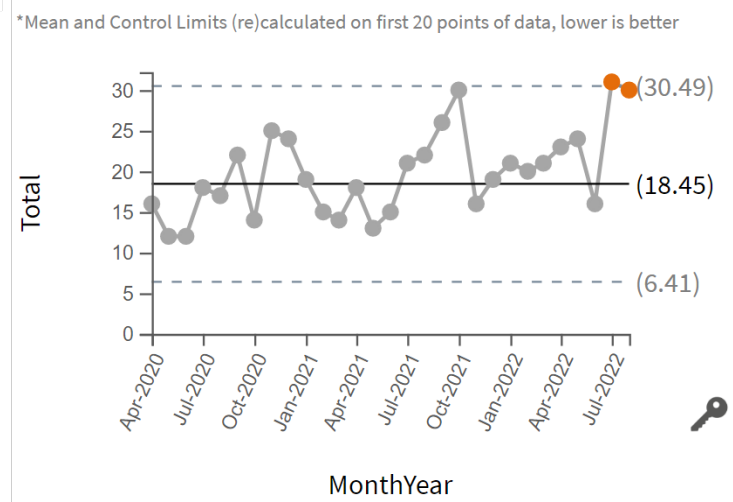
Latest
30
Variance Type
Special cause variation - cause for concern (indicator where high is a concern)
Target
N/A
Target Achievement
N/A

Recent increase of instrumental births for monitoring, although does follow birth numbers, awaiting percentage chart.

Summary:

Common cause variation is observed with forceps births

Number of Babies Forceps Births

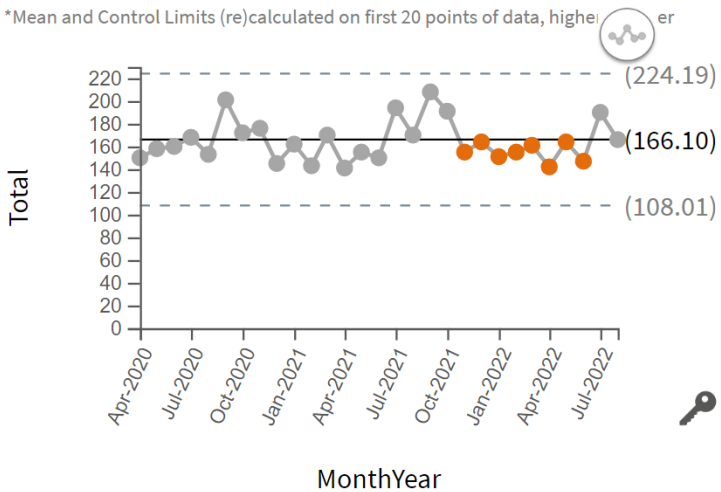


Latest
30
Variance Type
Special cause variation - cause for concern (indicator where high is a concern)
Target
N/A
Target Achievement
N/A

Care in Labour

Number of Women Receiving 1:1 Care in Labour

*Mean and Control Limits (re)calculated on first 20 points of data, highe er



Latest
166
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

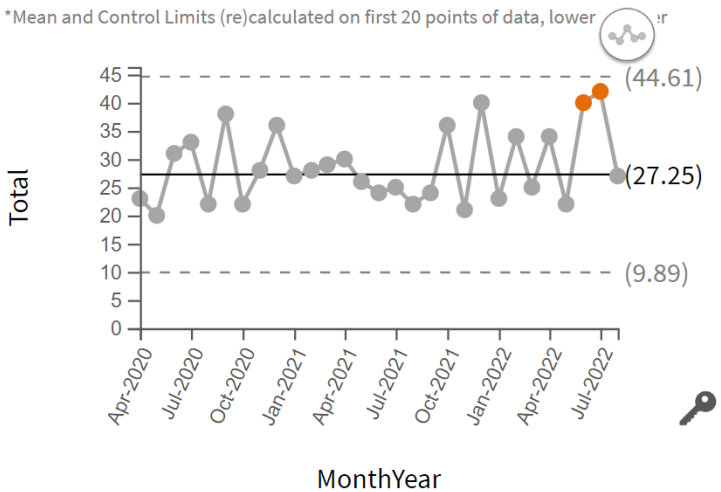
Summary:

1:1 care in labour is maintaining at 100%

Low Birth Weight (Grow)

Number of Live Born Babies ≤ 10th Centile

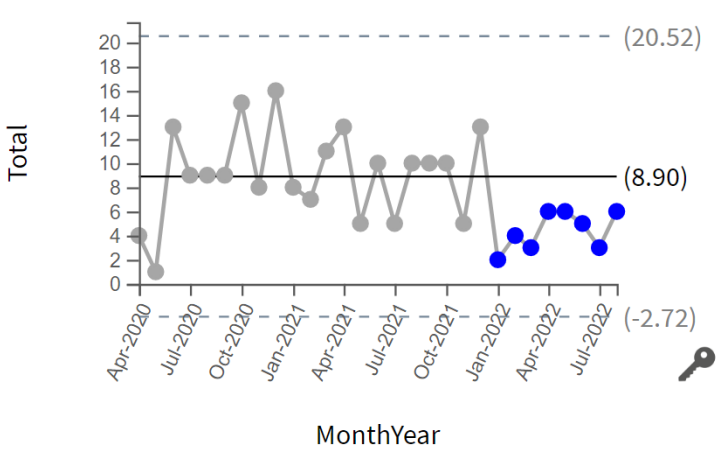
*Mean and Control Limits (re)calculated on first 20 points of data, lower



Latest
27
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Number of Live Born Babies ≤ 3rd Centile

*Mean and Control Limits (re)calculated on first 20 points of data, lower is better



Latest
6
Variance Type
Special cause variation - improvement (indicator where low is good)
Target
N/A
Target Achievement
N/A

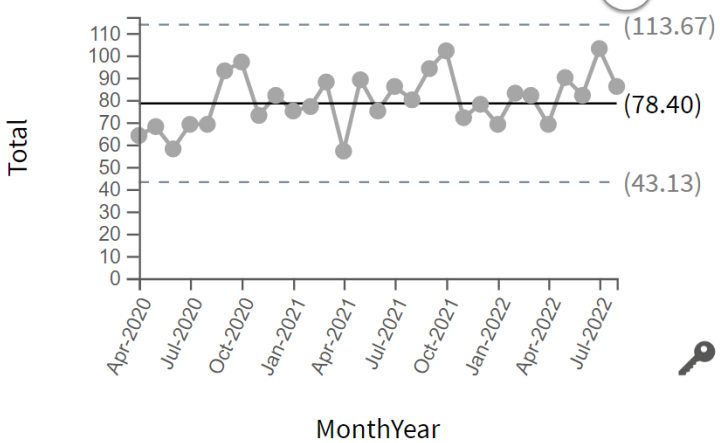
Summary:

There is a change in the data collection, after it was identified that the North West dashboard was incorrectly using the wrong gestation which accounts for the special cause for improvement.

Inductions of Labour

Total Number of Women Successfully Induced

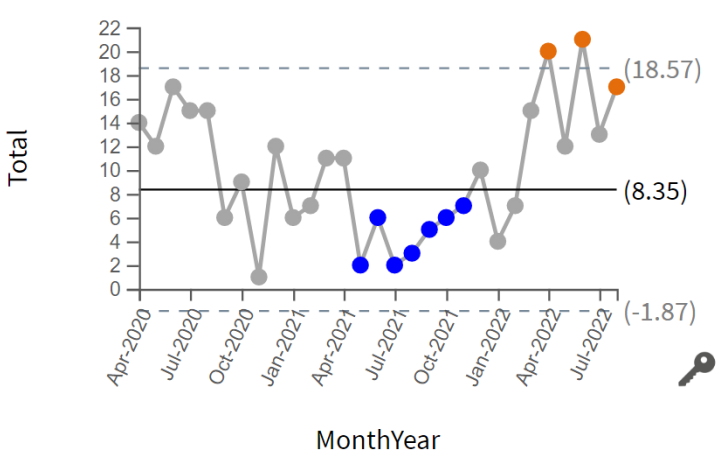
*Mean and Control Limits (re)calculated on first 20 points of data, highe er



Latest
86
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Number of Women Unsuccessfully Induced

*Mean and Control Limits (re)calculated on first 20 points of data, lower is better



Latest
17
Variance Type
Special cause variation - cause for concern (indicator where high is a concern)
Target
N/A
Target Achievement
N/A

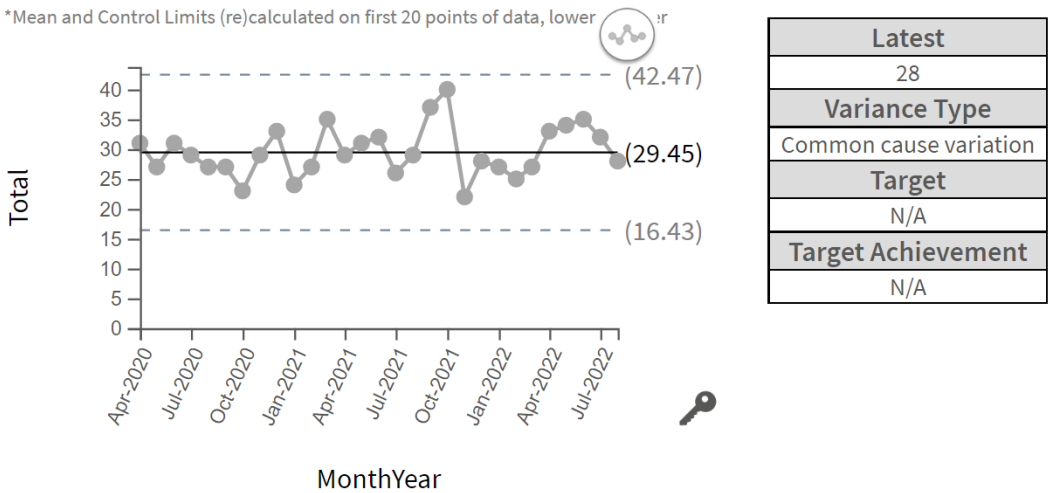
Summary:

There are have been more women who have had an unsuccessful induction of labour. This maybe attributed to the amount of women who are commenced on an induction of labour pathway and then paused due to staffing issues. An induction of labour escalation pathway has been implemented.

A review of the induction of labour's will be undertaken

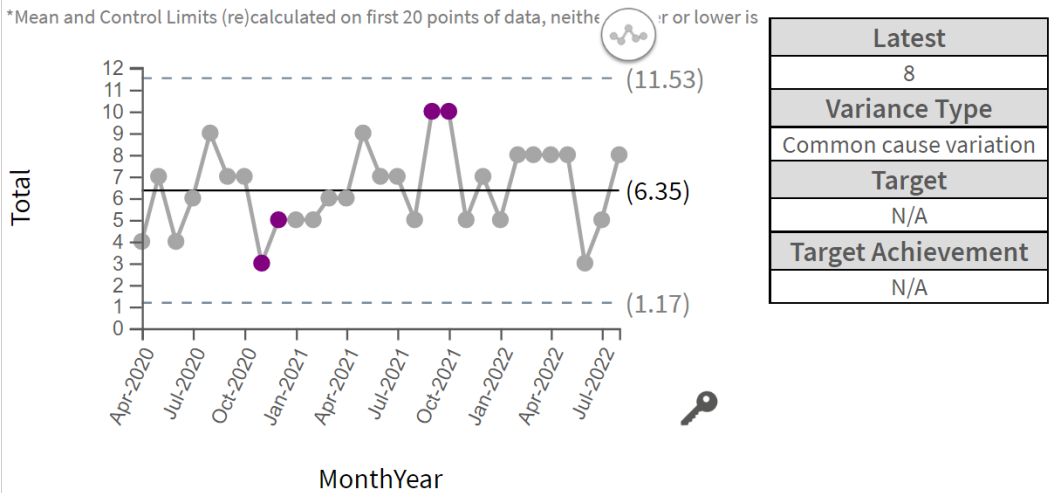
Inductions of Labour

Number of Women Induced <39 weeks



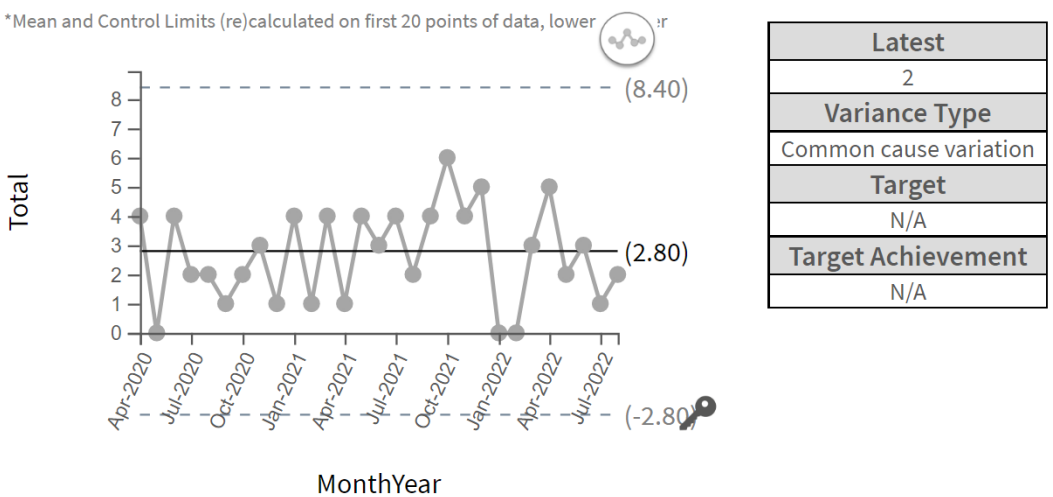
Latest
28
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Number of Women Induced >41+5 weeks



Latest
8
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Number of Women Induced for RFM only before 39+0 weeks



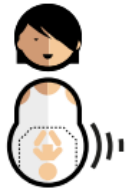
Latest
2
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Summary:

Common cause variation is observed with all categories of induction of labour

3.1 The 10 groups of the Robson Classification

GROUP 1

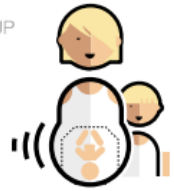


Nulliparous women with a single cephalic pregnancy, ≥37 weeks gestation in spontaneous labour

GROUP 2

Nulliparous women with a single cephalic pregnancy, ≥37 weeks gestation who either had labour induced or were delivered by caesarean section before labour

GROUP 3



Multiparous women without a previous uterine scar, with a single cephalic pregnancy, ≥37 weeks gestation in spontaneous labour

GROUP 4

Multiparous women without a previous uterine scar, with a single cephalic pregnancy, ≥37 weeks gestation who either had labour induced or were delivered by caesarean section before labour

GROUP 5

All multiparous women with at least one previous uterine scar, with a single cephalic pregnancy, ≥37 weeks gestation

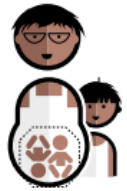
GROUP 6

All nulliparous women with a single breech pregnancy

GROUP 7

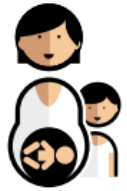
All multiparous women with a single breech pregnancy, including women with previous uterine scars

GROUP 8



All women with multiple pregnancies, including women with previous uterine scars

GROUP 9



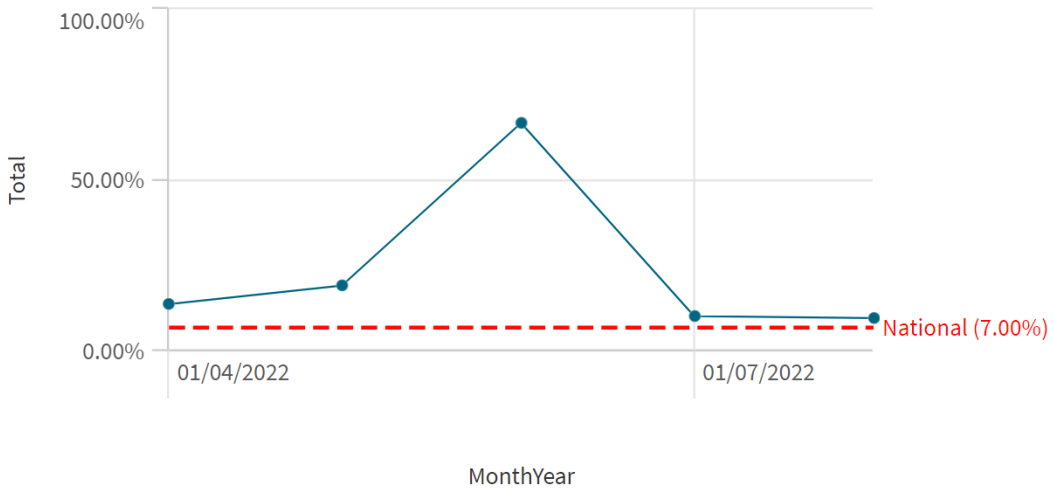
All women with a single pregnancy with a transverse or oblique lie, including women with previous uterine scars

GROUP 10

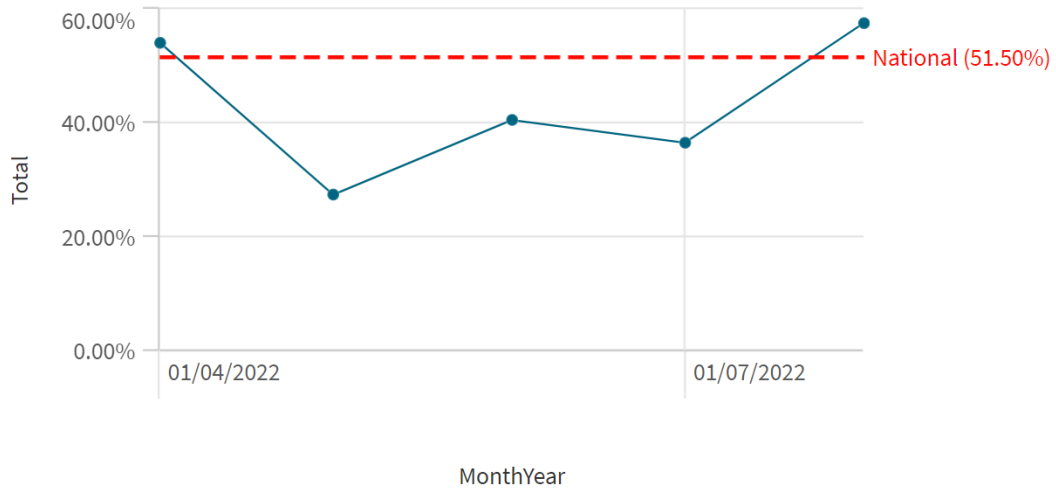
All women with a single cephalic pregnancy <37weeks gestation, including women with previous scars

Robson Groups

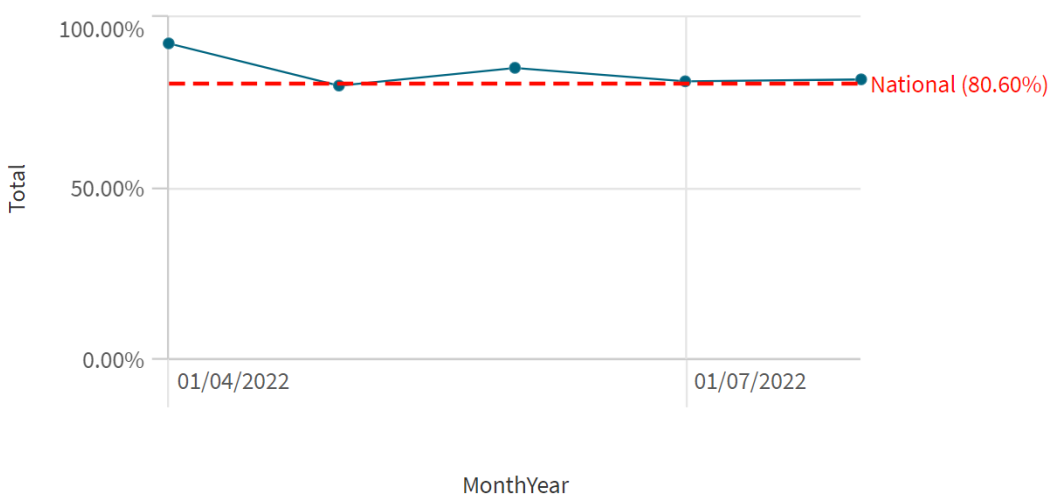
Percentage of Women Experiencing a C-Section in Robson Group 1



Percentage of Women Experiencing a C-Section in Robson Group 2



Percentage of Women Experiencing a C-Section (Robson Group 5)



Summary:

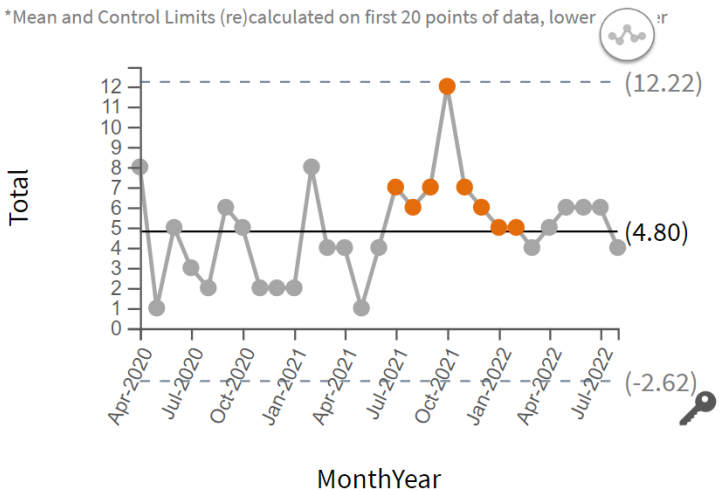
Robson criteria can not be shown on an SPC chart due to the change in EPR system over to Badgernet in 2022. The information is not obtainable prior to the move to Badgernet. Run charts will be used until there are enough data points to move to SPC charts.

The data is not highlighting an immediate concerns.

3rd / 4th Degree Tears

Number of 3rd/4th Degree Tears

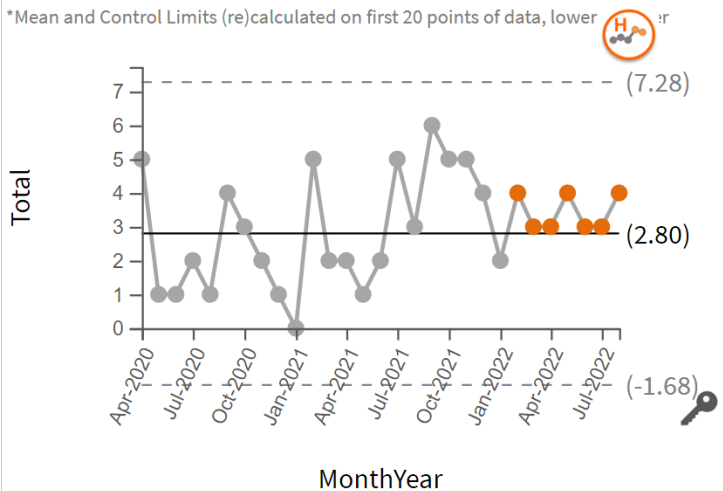
*Mean and Control Limits (re)calculated on first 20 points of data, lower



Latest
4
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Number of 3rd/4th Degree Tears in Vaginal Births

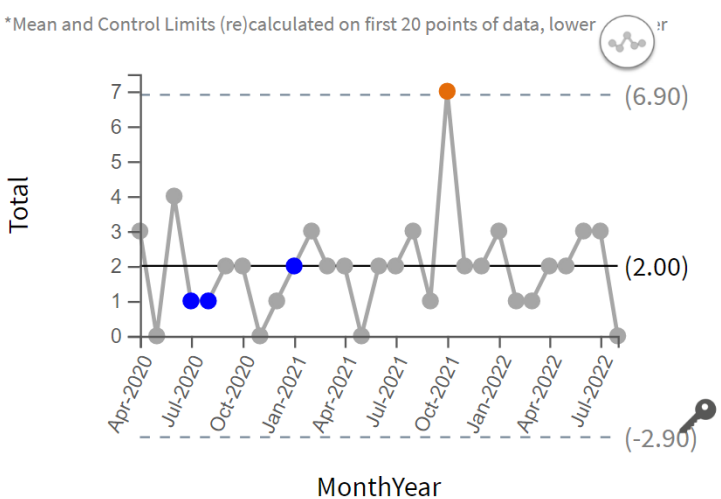
*Mean and Control Limits (re)calculated on first 20 points of data, lower



Latest
4
Variance Type
Special cause variation - cause for concern (indicator where high is a concern)
Target
N/A
Target Achievement
N/A

Number of 3rd/4th Degree Tears in Instrumental/Unsuccessful Instru…

*Mean and Control Limits (re)calculated on first 20 points of data, lower



Latest
0
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

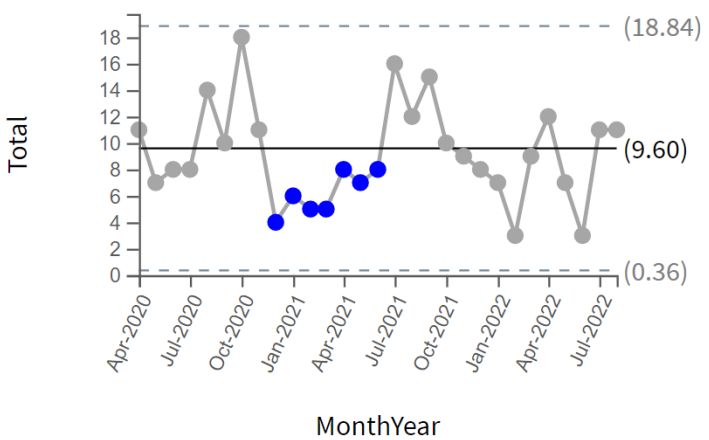
Summary:

There is a special cause for concern with 3rd/4th degree tears associated with vaginal births. OASI is currently in the early stages of implementation.

Haemorrhages

Number of Haemorrhages ≥1500 ml

*Mean and Control Limits (re)calculated on first 20 points of data, lower is better



Latest
11
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

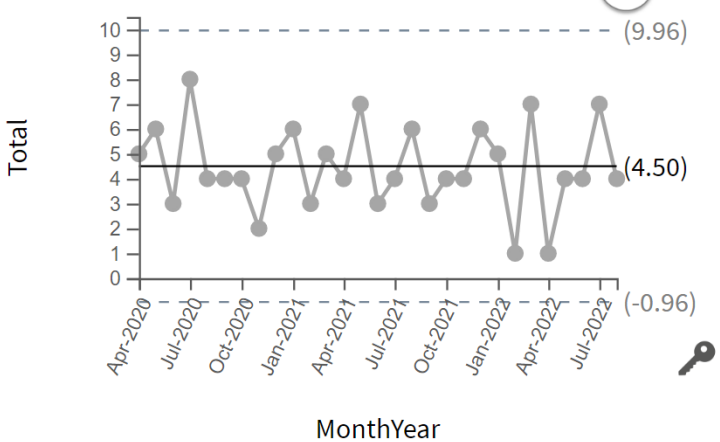
Summary:
Common cause variation is observed with PPH. A thematical review remains in progress. Tranexamic acid will be implemented for all high risk caesarean sections.

In October the chart will be broken down by site specific.

VBAC

Number of women having a vaginal birth, after a previous caesarean ...

*Mean and Control Limits (re)calculated on first 20 points of data, highe er



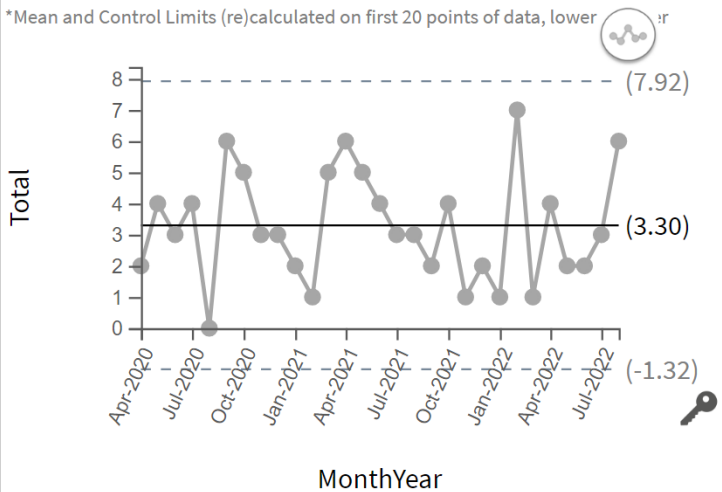
Latest
4
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Summary:

Common cause variation is observed

Shoulder Dystocia

Number of Shoulder Dystocia Events



Latest
6
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

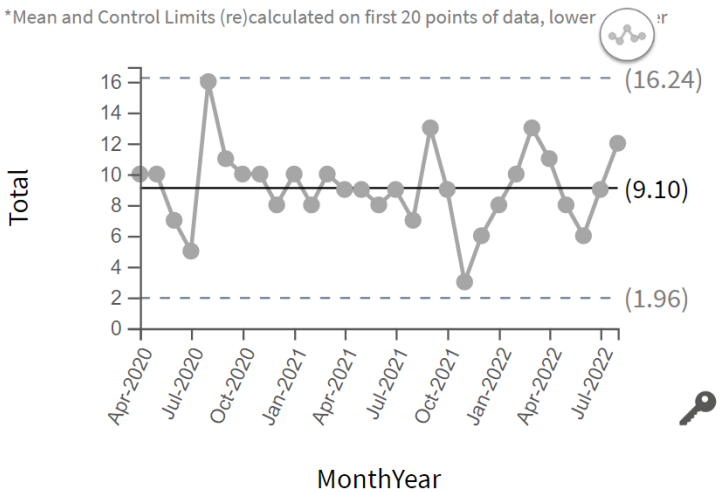
Summary:

Common cause variation is observed. All shoulder dystocia's are incident reported and reviewed.

Neonatal Admissions

Number of Neonatal Admissions - Term Babies

*Mean and Control Limits (re)calculated on first 20 points of data, lower



Latest
12
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

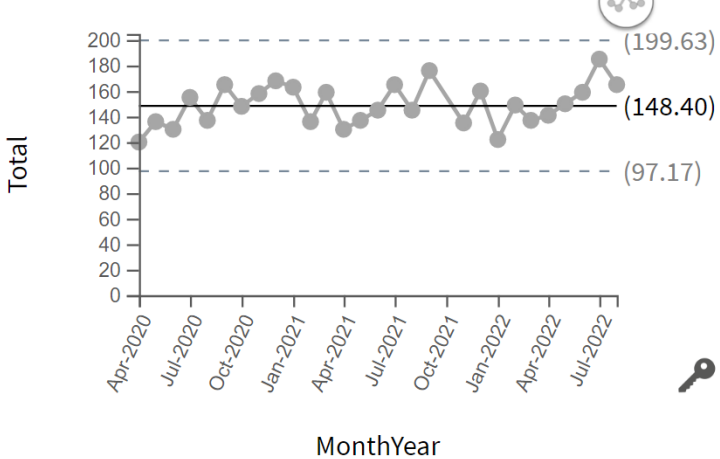
Summary:

Common cause variation is observed. All term admissions are reviewed at the weekly ATAIN meeting. UHMBT term admission rate is below the 5% target.

Breast Feeding

Number of infants receiving any breastmilk in the first 48hours (Inclu...

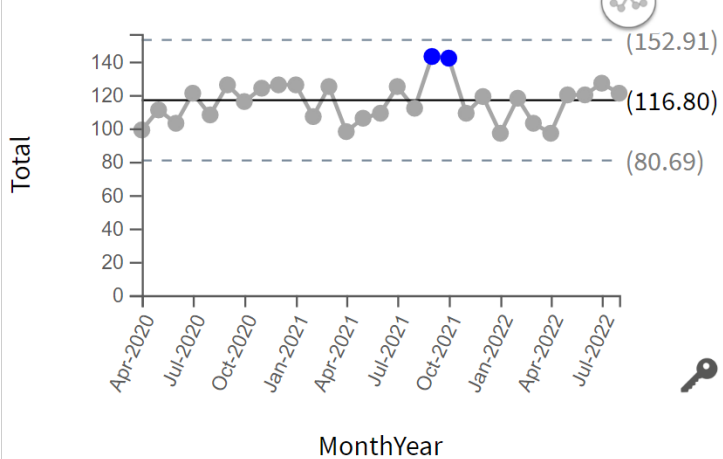
*Mean and Control Limits (re)calculated on first 20 points of data, highe er



Latest
165
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

No of babies totally breastfed at transfer from hospital care to home c...

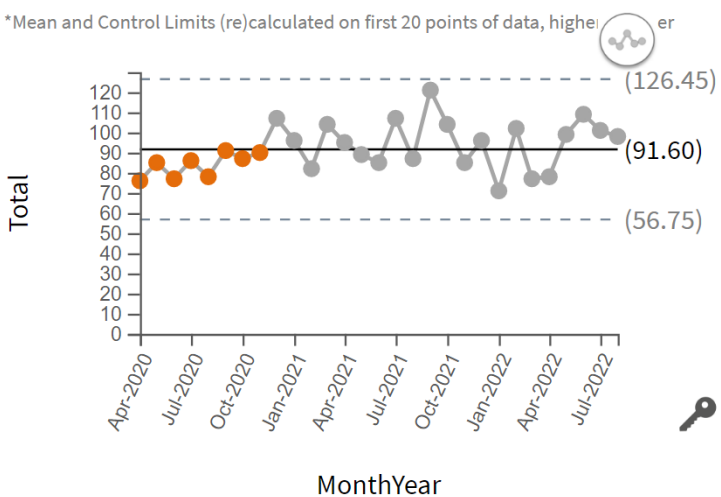
*Mean and Control Limits (re)calculated on first 20 points of data, highe er



Latest
121
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Number of infants totally breastfed/breastmilk on day 5

*Mean and Control Limits (re)calculated on first 20 points of data, highe er



Latest
98
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

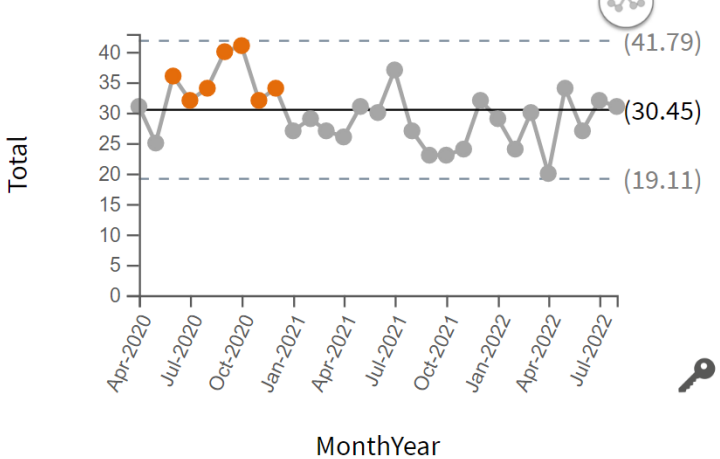
Summary:

Common cause variation observed for all categories of breastfed babies.

Smoking in Pregnancy

Number of Women Smoking at Booking

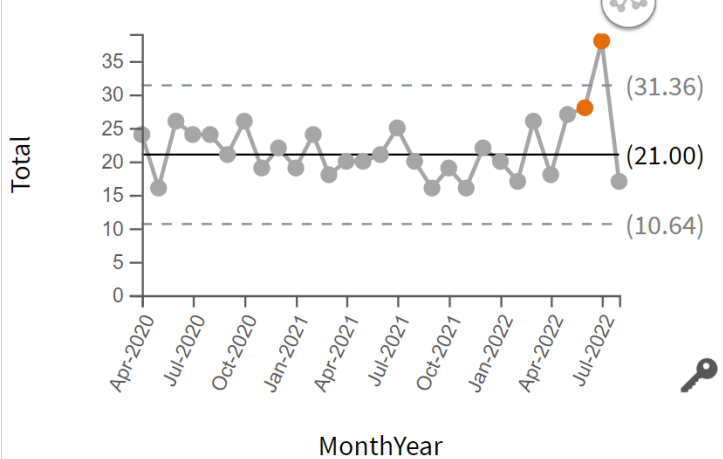
*Mean and Control Limits (re)calculated on first 20 points of data, lower



Latest
31
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Number of Women Smoking at Delivery

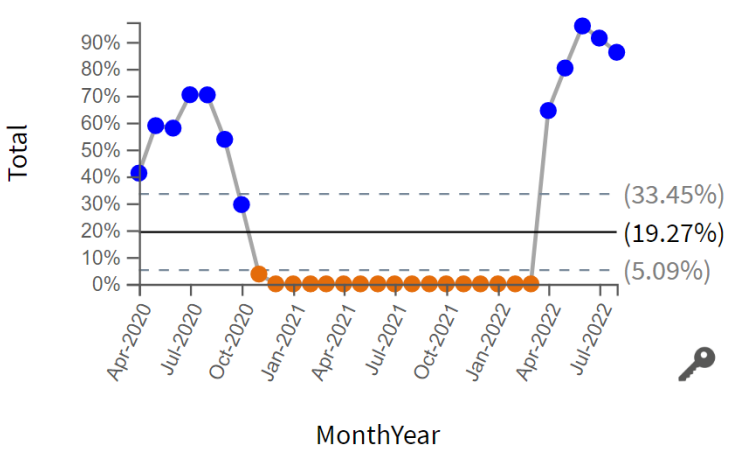
*Mean and Control Limits (re)calculated on first 20 points of data, lower



Latest
17
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Percentage of women where CO measurement at booking is recorded

*Mean and Control Limits (re)calculated on first 20 points of data, higher is better



Latest
86.11%
Variance Type
Special cause variation - improvement (indicator where high is good)
Target
N/A
Target Achievement
N/A

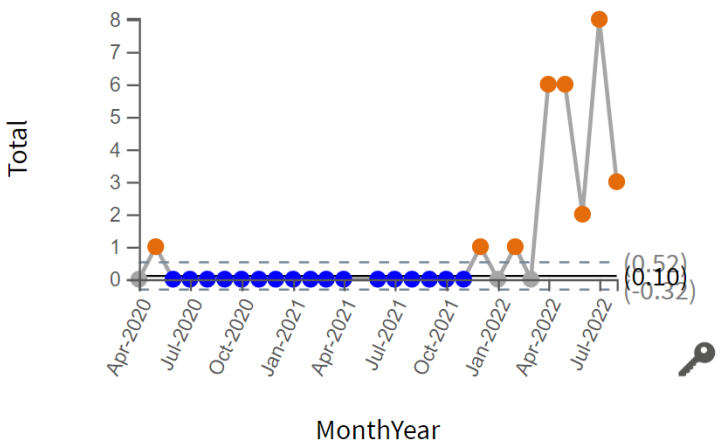
Summary:

In 2020 there was a pause in CO monitoring due to the COVID-19 pandemic. Following Public Health Guidance published in 2022 reinstating CO monitoring, CO monitoring was reinstated.

Service Closures

Obstetric Unit - number of days the service has diverted on in reporti...

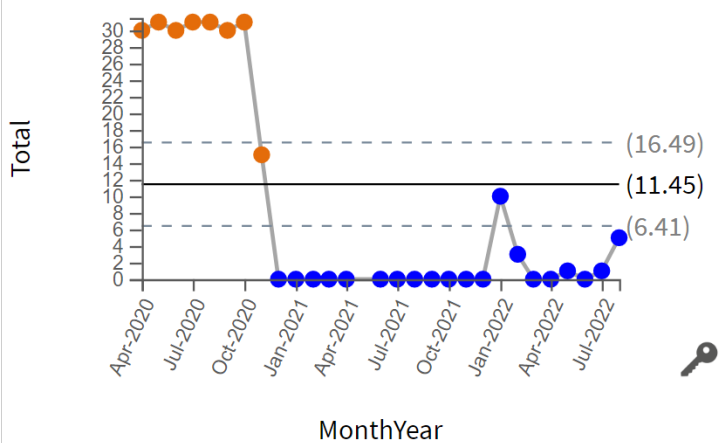
*Mean and Control Limits (re)calculated on first 20 points of data, lower is better



Latest
3
Variance Type
Special cause variation - cause for concern (indicator where high is a concern)
Target
N/A
Target Achievement
N/A

FMU - number of days the service has diverted on in reporting period

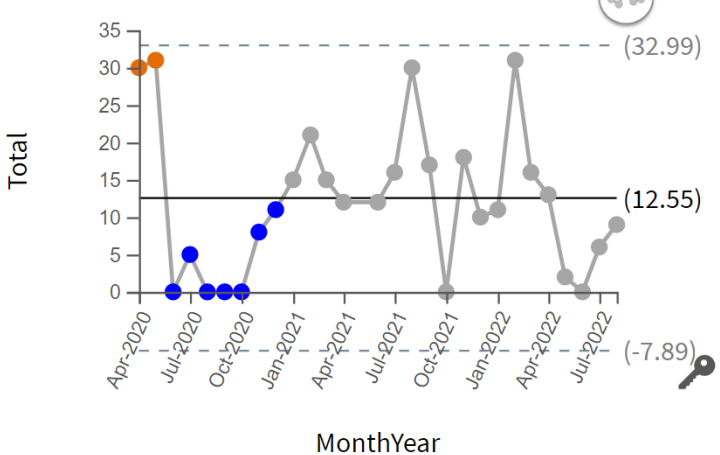
*Mean and Control Limits (re)calculated on first 20 points of data, lower is better



Latest
5
Variance Type
Special cause variation - improvement (indicator where low is good)
Target
N/A
Target Achievement
N/A

Homebirth - number of days the service has diverted on in reporting ...

*Mean and Control Limits (re)calculated on first 20 points of data, lower



Latest
9
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Summary:

There is a cause for concern noted with the number of days the Obstetric unit has been diverted. This is in response to staffing levels and acuity. There has been a reduction in the number of occasions the FMU has been placed on divert.

Summary

- A review of the induction of labour to explore the rationale behind why unsuccessful IOL have increased

Next steps with the dashboard

- Embed further percentage charts
- Include new charts for small numbers, such as G charts
- Filter these charts to site

Appendix 3 Maternity Safety Support Programme (MSSP)

KEY ISSUE 1 (Leadership)												
Month/Year	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 22	Feb 22	Mar 22	Apr 22
Rating	GOOD	GOOD	Good	Good	Good							

KEY ISSUE 2 (Strategy and Vision)												
Month/Year	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 22	Feb 22	Mar 22	Apr 22
Rating	NONE	NONE	Little	Good	Good							

KEY ISSUE 3 (Governance and Safety)												
Month/Year	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 22	Feb 22	Mar 22	Apr 22
Rating	LITTLE	LITTLE	Good	Good	Good							

THIS PAGE IS INTENTIONALLY BLANK

BOARD OF DIRECTORS

Date of Meeting	26 October 2022
Title	Avoiding Term Admissions into Neonatal Units (ATAIN) Report
Report of	Bridget Lees, Chief Nursing Officer and Board Level Safety Champion
Prepared by and contact details	Donna Southam, Quality, Safety and Assurance lead midwife Donna.southam@mhbt.nhs.uk Heather Gallagher, Director of Midwifery heather.gallagher@mhbt.nhs.uk

Confidentiality	Non-Confidential

Purpose of Report	**To Advise/Alert**	**To Assure**	**To Approve**	**To Update**
	x	x	x	x
	To advise, alert, assure and approve. This report provides an overview on the progress with safety action three from the Maternity Incentive Scheme Year 4. Trusts will need to report compliance with the Maternity Incentive Scheme by the 2 February 2023.			

Summary of Key Issues	The Avoiding Term Admission to NICU programme is a national initiative that provides the framework for best practice to reduce potential avoidable harm from separating mums and babies. Learning themes will inform changes to practice so that term admissions could be reduced resulting in better family experience. Newborn respiratory distress is the leading reason for admission at UHMBT and consequent mother infant separation. The ATAIN multidisciplinary meetings have been reconvened in September 2022. They are held weekly and chaired by an Obstetric Consultant and a Consultant Paediatrician, with a Midwife and Neonatal Nurse in attendance to ensure the reviews have a well-rounded perinatal collaborative. The action plan in Appendix one provides an update on the progress made in establishing the ATAIN multidisciplinary team. The ATAIN multidisciplinary team have identified some trends which have been incorporated into an action plan (Appendix two) to ensure care pathways are reviewed with aim to reduce mother and baby separation. This includes identification and management of maternal infection/ sepsis, management of jaundice, management of hypoglycaemia and respiratory distress. In addition, a review of the

	transitional care service will be undertaken. A thematical review is currently being undertaken of babies readmitted with jaundice. To reduce readmission of jaundice babies the maternity services will be implementing a screening test for all babies prior to discharge home for jaundice and again at the first home visit. In addition, a change in guidance for the which babies require blood glucose monitoring has been highlighted which will result in a reduction of babies require invasive testing. In summary the Trust term admission rate is below nationally average (Appendix three). Furness General Hospital had 6% unexpected term admission rate between August 2021 to August 2022. This will continue to be monitored to by the ATAIN team to identify any variations in practice and themes. The action plan from local reviews going forward will be reviewed by the ward and Board level champions, LMNS, commissioner and Integrated Care System (ICS) quality surveillance meeting each quarter

Prior Discussions	**Committee**	**Date**	**Recommendations/ Concerns**
	WACS Care Group Management Board	12th October 2022	Approved
	Quality Assurance Committee	17th October 2022	Approved

Action to be recommended to the Committee/Board	The Board of Directors is asked to note the content of this report and agree the recommendations.

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
	Directly Linked to Patient safety			

Impact on Board Assurance	

Framework or Corporate Risk Register				
Risk Impact Assessment	Is this required?	**Y**	If Yes, Date Completed	06/11/2022
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	
CTG	Cardiotocograph
CGGAG	Care group governance and assurance group
TC	Transitional Care
NICU	Neonatal Intensive Care Unit
SCBU	Special Care Baby Unit
MIS	Maternity Incentive Scheme
LMNS	Local Maternity and Neonatal System
ATAIN	Avoiding Term Admissions in Neonatal Intensive Care Unit

UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST

Avoiding Term Admissions into Neonatal units (ATAIN) report

PURPOSE

1. This report provides a review of the avoiding term admissions to NICU/ SCBU.

BACKGROUND

2. Welcoming a new-born baby to one's family is an important life event. It is joyous, enjoyable experience for most women and families. Babies born at full term gestation are expected to stay with their mothers, establish feeding of parental choice and go home at the earliest opportunity. Nevertheless, a proportion of term babies have potentially preventable medical conditions that require admission to the Neonatal Unit. In certain instances, term admission to the neonatal unit could be an indicator of avoidable harm due to modifiable factors upstream in the antenatal/intrapartum/postnatal pathway.

3. Evidence suggests that separation of baby from his/her mother soon after birth adversely impacts bonding, breastfeeding and has long term consequence on infant/maternal physical and mental health. Term admissions to the Neonatal unit are seen as avoidable harm (NHS Outcomes Framework 5.5).
4. The Maternity Incentive Scheme was launched in 2017 by NHS Resolution. There are ten safety actions and avoiding term admissions forms part of safety action 3.

5. Evidence of an action plan being agreed with the maternity and neonatal safety champions and Board level champion and signed off by the Board no later than 29 July 2022 is required as part of the Maternity Incentive Scheme Year 4. A report and action plan were submitted to Quality Assurance Committee and Trust board in July 2022 to address the refresh of the ATAIN meetings, dedicated Consultant leadership to ensure thorough reviews were undertaken of all term admissions to identity themes and trends.

6. Nationally recommended target is to reduce term admissions to under <6 % of live births. The term admission rate for Furness General Hospital retrospectively in 2018/19 2.3%, 2019/2020 3% and 2021/2022 was 4.1%. The Royal Lancaster Infirmary Hospital in 2018/19 was 4.2%, 2019/2020 4.1% and 2020/2021 was 4.7%.

Analysis/Discussion

7. The Avoiding Term Admission in NICU programme is a national initiative that provides the framework for best practice to reduce avoidable harm by term admissions. Learning themes will inform changes to practice so that term admissions could be reduced resulting in better family experience.

8. New-born respiratory distress is the leading reason for admission at UHMBT and consequent mother infant separation.

9. Regular, multidisciplinary local reviews provide a useful starting point for understanding why a term baby has been admitted to the neonatal unit and for identifying service improvements. For all unplanned admissions to a neonatal unit for medical care at

term a thorough and joint clinical review by the maternity and neonatal services should identify learning points to improve care provision, consider the impact service re-design might have on reducing admissions and identify avoidable harm. Clinical reviews undertaken jointly by both maternity and neonatal services should optimise understanding of potential areas of suboptimal care so that the learning and impact can be fully addressed. This should include considering whether the baby was admitted as a 'safety net' strategy because of concern for infant wellbeing on the delivery unit or the postnatal ward, or because of lack of availability of transitional care.

10. The ATAIN multidisciplinary meetings have been reconvened in September 2022. They are held weekly and chaired by an Obstetric Consultant and a Consultant Paediatrician, Midwife and Neonatal Nurse are in attendance to ensure the reviews have a perinatal collaborative. The action plan in Appendix One provides an update on the progress made in establishing an ATAIN multidisciplinary team.

11. The ATAIN multidisciplinary team have identified some trends which have been incorporated into an action plan (Appendix Two) to ensure care pathways are reviewed with aim to reduce mother and baby separation. This includes identification and management of maternal infection/ sepsis, management of jaundice, management of hypoglycaemia and respiratory distress. In addition, a review of the transitional care service will be undertaken.

12. A thematical review is currently being undertaken of babies readmitted with jaundice. To reduce readmission of jaundice babies the maternity services will be implementing a screening test for all babies prior to discharge for jaundice and again at the first home visit. In addition, a change in guidance for the which babies require blood glucose monitoring has been highlighted which will result in a reduction of babies require invasive testing.

13. In summary the Trust term admission rate is below nationally average (Appendix Three). Furness General Hospital had a 6% term admission rate from August 2021 to August 2022. This will continue to be monitored to by the ATAIN team to identify any variations in practice and themes.

14. The action plan from local reviews going forward will be reviewed by the ward and Board level champions, LMNS, commissioner and Integrated Care System (ICS) quality surveillance meeting each quarter.

Risks

15. Higher rates of term admissions result in poor patient experience, adverse impact of maternal well-being, anxiety, poor breast-feeding rates.

16. Inappropriate increases in staff workload, diversion of resources from essential neonatal care.

17. Financial risk of not achieving the safety action 3 will result in the Trust not being awarded the incentive contributions payable for the Trust.

Recommendations

18. The term admission rate to NICU at the Trust is below the target of 6%. There is an uptrend of term admissions in Furness General Hospital, which needs to be further explored by the ATAIN group.

19. The Board of Directors is asked to receive this report for discussion and assurance of the progress with ATAIN and safety action 3 in the maternity NHS resolution scheme for year 4.

Appendix One: ATAIN Action Plan

Action	Key Tasks to Deliver Action	Designation of Responsible Officer	Target Date	Evidence of Progress and Completion	Monitoring and Evaluation group	Date Action Completed
1. Develop a Terms of Reference for the ATAIN group	Terms of Reference	Donna Southam Quality, Safety and Assurance Lead Midwife	25/10/2022	Terms of Reference agreed at Governance meeting	Governance meeting, Safety Champion meeting and Quality Committee	
2. Sessional hours for dedicated Obstetric and Paediatric Consultants to lead on ATAIN	PA's allocated for Obstetric and Neonatal Consultants	Mark Davies Clinical Director of Obstetrics and Gynecology	30/7/2022	Email notification with allocated Consultant names and dates/ times to undertake ATAIN meetings	Governance meeting, Safety Champion meeting and Quality Committee	1/9/2022

3. Multidisciplinary to include wider team members such as the Fetal Monitoring Lead Midwife and Obstetrician, Infant feeding Midwife, QI Midwife, Consultant Midwife	Include wider team in the Terms of Reference	Donna Southam Quality, Safety and Assurance Lead Midwife	25/10/2022	Terms of Reference agreed at Governance meeting	Governance meeting, Safety Champion meeting and Quality Committee	
4. Fortnightly multidisciplinary ATAIN meeting	Fortnightly agreed dates agreed with Consultant leads	Mark Davies Clinical Director of Obstetrics and Gynecology Donna Southam Quality, Safety and Assurance Lead Midwife	30/7/2022	Meeting dates agreed and invites to the wider ATAIN team	Governance meeting, Safety Champion meeting and Quality Committee	1/9/2022

5. Revised Maternity Incentive Scheme Proforma to be used for all reviews	Maternity incentive scheme proforma used for all ATAIN reviews and uploaded to incidents	Donna Southam Quality, Safety and Assurance Lead Midwife	30/8/2022	ATAIN reviews uploaded on to Ulysses	Governance meeting, Safety Champion meeting and Quality Committee	1/9/2022
6. The ATAIN meeting to be minuted and action plan from the ATAIN reviews	Minutes of meeting and action plan from the ATAIN meeting	Donna Southam Quality, Safety and Assurance Lead Midwife	30/8/2022	Minutes of meeting and action plan	Governance meeting, Safety Champion meeting and Quality Committee	30/9/2022
7. Action plan to be shared with neonatal, midwifery, obstetric frontline staff, presented at perinatal meetings, clinical governance and safety champion	ATAIN Newsletter shared with staff on a monthly basis. Action plan shared at governance and safety champion meeting	Donna Southam Quality, Safety and Assurance Lead Midwife Donna Southam Quality, Safety and Assurance Lead	1. 30/10/2022 2. 30/7/2022	ATAIN Newsletter ATAIN action plan shared at governance and safety champion	Governance meeting, Safety Champion meeting and Quality Committee	2. 30/7/2022

meetings.		Midwife		meeting		
8. Reviews should include all neonatal unit transfers or admissions regardless of their length of stay and/or admission to BadgerNet. In addition, reviews should report on the number of transfers to the neonatal unit that would have met current TC admissions criteria but were transferred or admitted to the neonatal unit due to capacity	Weekly report from BadgerNet to identify term admissions. Include babies who were admitted with a nasogastric tube admitted to NICU in the ATAIN review	Donna Southam Quality, Safety and Assurance Lead Midwife	30/10/2022	BadgerNet report ATAIN action plan	Governance meeting, Safety Champion meeting and Quality Committee	

or staffing issues. The review should also record the number of babies that were transferred or admitted or remained on Neonatal Units because of their need for nasogastric tube feeding but could have been cared for on a TC if nasogastric feeding was supported there.						
9. Transitional care to be included in the audit report.	Transitional care included in the report.	Donna Southam Quality, Safety and Assurance Lead Midwife	30/10/2022	ATAIN report action plan	Governance meeting, Safety Champion meeting and Quality Committee	

10. Report and action plan to be presented with the ward and Board level maternity and neonatal safety champions aware of progress and challenges in this area on a quarterly basis.	ATAIN report and action plan added to the forward schedule for the maternity safety champion meeting quarterly	Donna Southam Quality, Safety and Assurance Lead Midwife	30/7/2022	ATAIN report and action plan presented at the maternity safety meeting. Evidence in minutes	Governance meeting, Safety Champion meeting and Quality Committee	30/7/2022
11. Audit findings are shared with the LMNS, commissioner and Integrated Care System (ICS) quality surveillance meeting each quarter.	Action plan and report shared with the LMNS, ICS and quality surveillance meeting	Donna Southam Quality, Safety and Assurance Lead Midwife	30/10/2022	Reports sent to LMNS, ICS and commissioner	Governance meeting, Safety Champion meeting and Quality Committee	

Appendix Two: Action plan on workstreams to reduce term admission

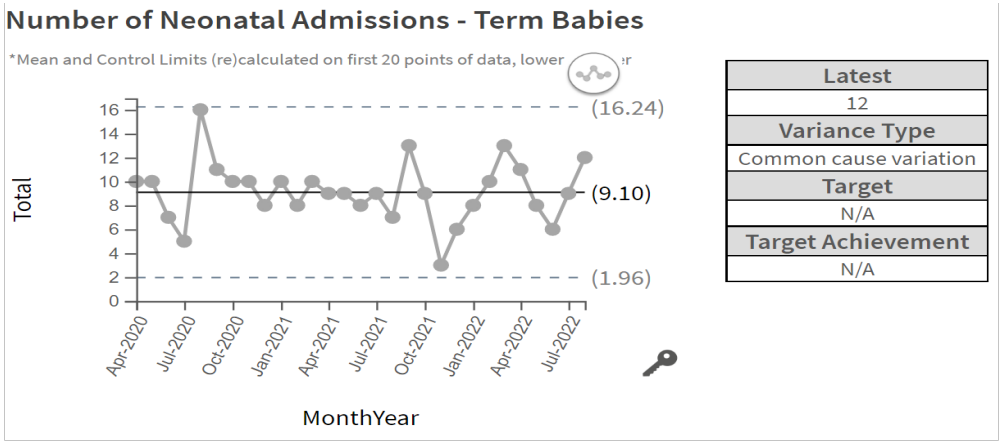
Action	Key Tasks to Deliver Action	Designation of Responsible Officer	Target Date	Evidence of Progress and Completion	Monitoring and Evaluation group	Date Action Completed

Workstream 1: Reduce term admissions due to respiratory distress						
Identify further contributory factors for term respiratory distress by doing a 'deep dive' analysis of perinatal history	Review prelabour caesarean section at early term gestation and examine opportunities for improvement (if any)	ATAIN group	30/12/2022	Maternity Dashboard Caesarean section audits	ATAIN Group/ CGGAG/ Maternity Safety Champion meeting	
Workstream 2: Neonatal Jaundice						
Improve at risk infant identification before discharge	Implement transcutaneous bilirubin screening prior to discharge	Quality, Safety and Assurance Lead Midwife	30/11/2022	Jaundice guideline updated	ATAIN Group/ CGGAG/ Maternity Safety Champion meeting	
Workstream 3: Improve episodes of hypothermia/hypoglycaemia (co-morbidities that increase risk of respiratory distress)						
Update the Hypoglycaemia guideline	Amend the hypoglycaemia guideline to reflect babies born under the 2nd centile based on the World Health Organisation charts receive blood glucose monitoring	Quality, Safety and Assurance Lead Midwife	30/11/2022	Neonatal Hypoglycaemia guideline updated	ATAIN Group/ CGGAG/ Maternity Safety Champion meeting	
Workstream 4: Maternal sepsis						

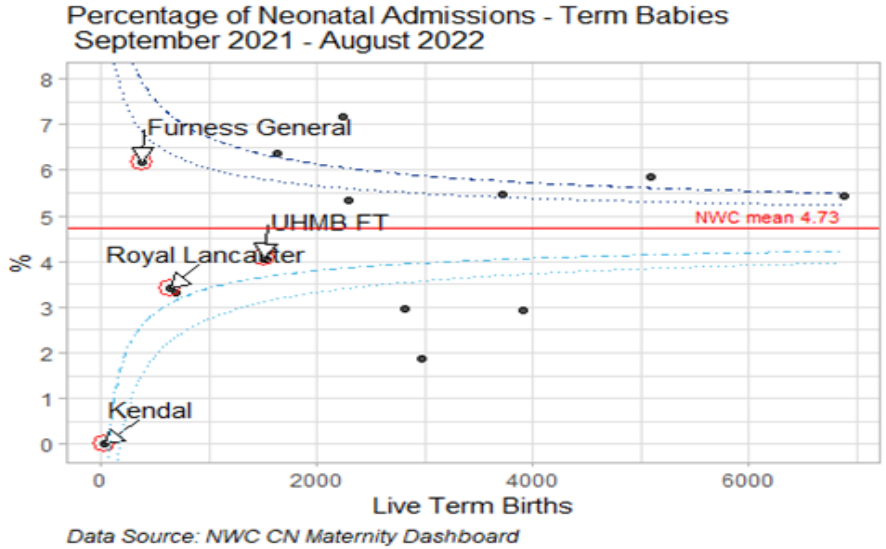
Identification of maternal sepsis/ infection	Amend the maternal sepsis guideline	Consultant Obstetrician	30/11/2022	Maternal sepsis guideline updated	ATAIN Group/ CGGAG/ Maternity Safety Champion meeting	
	Dedicated sepsis training by the education team	Education team	30/11/2022	Registers/ Training materials	ATAIN Group/ CGGAG/ Maternity Safety Champion meeting	
	Implement physiological CTG interpretation	Fetal Monitoring Lead Consultant and Midwives	20/1/2023	Fetal monitoring guidelines and tools updated	ATAIN Group/ CGGAG/ Maternity Safety Champion meeting	
Workstream 5: Transitional Care						
Review the Transitional care service	Lead person to be allocated the lead of the review	Associate Director of Nursing for CYP	5/10/2022	Allocated named person	ATAIN Group/ CGGAG/ Maternity Safety Champion meeting	5/10/2022
	Transitional care service to be benchmarked against BAPM	Transitional Care Lead	30/10/2022	Report	ATAIN Group/ CGGAG/ Maternity Safety Champion meeting	

	Review the neonatal nursing workforce set up for transitional care	Transitional Care Lead	30/10/2022	Report	ATAIN Group/ CGGAG/ Maternity Safety Champion meeting	

Appendix Three: Term Admission Rates



Latest
12
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A



Data Source: NWC CN Maternity Dashboard

BOARD OF DIRECTORS

Date of Meeting	26 October 2022
Title	Maternity Safety Champion's Report (July to September 2022)
Report of	Bridget Lees, Chief Nursing Officer Heather Gallagher, Director of Midwifery
Prepared by and contact details	Head of Midwifery tamsin.cripps@mbht.nhs.uk

Confidentiality	Non-Confidential

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

Summary of Key Issues	This paper provides update on Safety Action Nine relating to the Maternity Safety Champions as part of the ten maternity safety actions included in the NHS Resolution Maternity Incentive Scheme Year 4 (Relaunched in May 2022). There is a requirement for safety champions to meet on a bi-monthly basis. From August 2022, the UHMBT safety champions agreed to increase this to meet monthly. This is to support rapid improvement work ongoing in the maternity service. Membership consists of maternity, obstetric and neonatal frontline safety champions as well as Bridget Lees as Board level Executive champion. Karen Deeny joined the team in August 2022 as Non-Executive champion replacing Hugh Reeve. The June 2022 meeting included a full refresh of terms of reference presented by the Director of Midwifery. The maternity service continues to submit monthly Board reports including updates from PMRT and HSIB as well as a Perinatal Surveillance Model dashboard. The reports are presented monthly to support rapid improvement work. The Executive and Non-Executive safety champion attend these meetings The NHS scorecard claims, and litigation (2020/21) report was presented at the Care Group Governance and Assurance Group in August 2022 and was discussed at the safety champions meeting in August 2022. The report helps identify areas of focus for quality improvement within the Maternity service.

	The Non-Executive safety champion and maternity safety champion attended a launch event for the Maternity and Neonatal Safety Improvement Programme (MatNeoSIP) on the September 20th 2022. The maternity clinical strategy will be co-produced, utilising population health data to improve care for families living in areas of deprivation. This was discussed at the September 26th, 2022, MVP meeting and support requested from the wider attendance group for service user volunteers with lived experience to be involved in this work. Following the move of the CCG to the ICB, the MVP chair has not been receiving payment or expenses. This has led to a pause in MVP work until this has been addressed. There is a risk that this could affect the progress of maternity improvements and co-production. Mitigation is in place to continue connecting with service users for the strategy development. This is being escalated to the Executive and Non-Executive safety champions at the Maternity Safety Champion meeting on the 7th of October 2022. **Recommendations** To relaunch the joint walk arounds with all safety champions and raise the profile of the Maternity Safety Champions through different forms of communications. Strengthen the collaboration with the Non-Executive safety champion and the MVP to ensure all women's and families voices across the Trust are represented at Board level. Escalation of concerns to the ICB regarding the no payment of the payment MVP chair.

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 content of this report and agree the recommendations.

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	
CNST	Clinical Negligence Scheme for Trusts
SLBC	South Lakes Birth Centre
NHSR	National Health Service Resolution
MVP	Maternity Voices Partnership
MIS	Maternity Incentive Scheme
LMNS	Local Maternity and Neonatal System
PMRT	Perinatal Mortality Review Tool
HSIB	Healthcare Safety Investigation Branch
NED	Non-Executive Director
RLI	Royal Lancaster Infirmary
TC	Transitional Care
WACS	Women and Children's Services
ATAIN	Avoiding Term Admissions into Neonatal units

UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST

Safety Champions' Quarterly Assurance Report October 2022

Purpose

1. This paper provides update on Safety Action Nine relating to the Maternity Safety Champions as part of the ten maternity safety actions included in the NHS Resolution Maternity Incentive Scheme Year 4 (Relaunched in May 2022).

Background

2. Maternity safety champions work at every level – trust, regional and national and across regional, organisational, and service boundaries. They develop strong partnerships, promote the professional cultures needed to deliver better care and play a central role in ensuring that mothers and babies continue to receive the safest care possible by adopting best practice.

3. The maternity incentive scheme (MIS) safety action nine requires the Trust to demonstrate that the safety champions (obstetrician, midwife, neonatal) are meeting bi-monthly with Board level champions to escalate locally identified issues.

4. The Ockenden (2020) review highlighted the importance of identifying a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and their family's voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.

5. Following Ockenden a key responsibility is to oversee the implementation of the Revised perinatal quality surveillance model (December 2020) in collaboration with the LMNS lead and Regional Chief Midwife, formalising how Trust – level intelligence will be shared to ensure early action and support for areas of concern.

6. The role of the Maternity Safety Champions is the golden thread that underpins the ten maternity safety actions, through the development of strong partnerships, promotion of the professional cultures needed to deliver better care and playing a central role in ensuring that mothers and babies continue to receive the safest care possible by adopting best practice.

Analysis and Discussion

7. There is a requirement for safety champions to meet on a bi-monthly basis. From August 2022, the UHMBT safety champions agreed to increase this to meet monthly. This is to support rapid improvement work ongoing in the maternity service.

8. Membership consists of maternity, obstetric and neonatal frontline safety champions as well as Bridget Lees as Board level Executive champion. Karen Deeny joined the team in August 2022 as Non-Executive champion replacing Hugh Reeve.

9. The June 2022 meeting included a full refresh of terms of reference presented by the Director of Midwifery.

10. Board level Safety Champions are required to present a locally agreed dashboard to the Board quarterly which includes the number of incidents reported as serious harm, themes

identified, and actions taken to address any issues, staff feedback from frontline champions and walk abouts, minimum staffing in maternity and training compliance. The maternity service continues to submit monthly Board reports including updates from PMRT and HSIB as well as a Perinatal Surveillance Model dashboard. The reports are presented monthly to support rapid improvement work. The Executive and Non-Executive safety champion attend these meetings.

11. There is a requirement quarterly reports have been submitted to the Trust Board from 6 May 2022 onwards that include details of all deaths in maternity reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions. PMRT reports are now submitted to the Quality Assurance Committee and Trust Board as a standalone item. The first report was presented in September 2022. In addition, a summary is provided within the Perinatal Surveillance Model which is presented at Trust Board monthly.

12. The NHS scorecard claims and litigation (2020/21) report was presented at the Care Group Governance and Assurance Group in August 2022 and was discussed at the safety champions meeting in August 2022. The report helps identify areas of focus for quality improvement within the Maternity service.

13. The Trust received a thematic review of maternity cases from NHS Resolution at the beginning of 2022. An action plan was developed from the findings by the senior leadership team which included the maternity safety champions. The report and action plan was shared with the Safety Champions at the August 2022 meeting and Trust Board in September 2022.

14. Currently the Maternity Incentive Scheme technical guidance requires an action plan to implement continuity of carer as the default model by March 2024. In September 2022 a letter was released by Ruth May Chief Nurse, Matthew Jolly and Jacqueline Dunkley Bent National Safety Champions removing the March 2024 target. Further guidance will be published in the next ten days with an update on this standard with removal of targets for continuity of care.

15. The UHMBT continuity of care implementation plan has been reviewed and the decision to delay implementation considering staffing levels was approved at safety champions and Trust Board level during the month of August 2022

16. The maternity service shared an ATAIN report and action plan at trust Board on 27th July 2022. The plan was brought to the August 2022 safety champions meeting for discussion. There will be a quarterly ATAIN, and transitional care report presented and discussed with the Executive and Non-Executive safety champion.

17. The Non-Executive safety champion and maternity safety champion attended a launch event for the Maternity and Neonatal Safety Improvement Programme (MatNeoSIP) on the September 20th, 2022.

18. A forward schedule of Board level walk arounds commenced in May 2022 with 15 steps visit conducted by the chair of Maternity Voices Partnership (MVP) and the Non-Executive safety champion.

19. The joint 15 steps review conducted between the Maternity Voices Partnership (MVP) and Non-Executive safety champion highlighted issues with the estates at RLI. Following this visit, a new floor has been laid on Central Delivery Suite. Positive feedback was received including the room decorations/illustrations on Delivery Suite. Staff highlighted the

pressure they have been under as feedback due to current staffing levels and recruitment challenges.

20. An MVP work plan has been produced and was signed off by the LMNS. This was presented by the MVP chair at the July 12th MVP meeting. Opportunities identified in the work plan for co-production are the production of information about personalised care and birth choices and shaping the provision of care at Helme Chase Birth Centre.

21. The maternity clinical strategy will be co-produced, utilising population health data to improve care for families living in areas of deprivation. This was discussed at the September 26th, 2022, MVP meeting and support requested from the wider attendance group for service user volunteers with lived experience to be involved in this work. Following the move of the CCG to the ICB, the MVP chair did not receive payment or expenses. This led to a pause in MVP work until this has been addressed. There was a risk that this could affect the progress of maternity improvements and co-production. The MVP chair notified the Maternity safety champions this was addressed on the 6th October 2022.

22. The safety champions undertake monthly walkarounds on all sites. Appendix one highlights the issues raised by staff and actions taken. The feedback is displayed and shared with staff.

Recommendations

23. To relaunch the joint walk arounds with all safety champions and raise the profile of the Maternity Safety Champions through different forms of communications.

24. Strengthen the collaboration with the Non-Executive safety champion and the MVP to ensure all women's and families voices across the Trust are represented at Board level.

Appendix One Actions arising from the Maternity Safety Champion walkarounds

Key for RAGBW rating of Actions:

White = Not yet started	Green = On Track	Amber = In progress	Red = Due but not complete	Blue = completed

Month	Safety concern	Action	Responsible	Due date	Progress	Status
June 2022	Ward 17 at RLI is too hot both patients and comfortable working conditions	Reflective film to be added to windows	Estates team		Complete	
		Temperature Checks 2x daily to be commenced	Ward Manager		Checks commenced	
		Issue added to the risk register	Head of Midwifery (RLI)		Complete	
July 2022	Some of the midwives at Helme Chase are finding the night shift model is tiring and making it difficult to manage their workload during the day.	Evaluation of night shifts survey	Community Midwifery Matron	31/08/2022	Completed August 2022 with positive feedback but some staff voiced that they had not reported and had concerns	
		Series of listening events (minimum 3)	Ward manager and Professional Midwifery Advocate	01/11/2022	1st event 9/9/2022, 2nd event 05/10/2022 3rd event TBA to ensure everyone has had the opportunity to attend	
August 2022	Staff at South Lakes Birth Centre felt they did not	Drop in sessions with Director of Midwifery to begin	Director of Midwifery		Sessions commenced 03/10/2022	

	have enough communication from the leadership team.					
		Weekly Brief to share news and updates to commence	Heads of Midwifery	26/09/2022	First Brief issued	
		Head of Midwifery to attend Band 7 meeting	Head of Midwifery (SLBC)	28/09/2022		
		Teams channel for 2 way communication between midwives and Head of Midwifery	Head of Midwifery (SLBC)	14/10/2022		
		Communication strategy to be written	Heads of Midwifery	31/10/2022		
	There are frequent occasions when no transitional care nurse is available at RLI	Review of transitional care provision	Associate Director of Nursing	30/11/2022		
		Staff asked to escalate concerns to matron/ward manager when they occur and complete incident reports	Heads of Midwifery/ Associate Director of Nursing	30/9/2022		

		Neonatal workforce review to be completed and represented at Quality Assurance Committee	Associate Director of Nursing	30/11/2022		

BOARD OF DIRECTORS

Date of Meeting	26 October 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, Chief Finance Officer, Deputy Chief Executive and Executive Senior Responsible Officer for the RSP
Prepared by and contact details	Rebecca Hogan, Assistant Director for Recovery Support and Improvement- rebecca.hogan2@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 September 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 and acceptance of the report related to the first part of the exit criteria related to safe staffing by the System Improvement Board (SIB) - 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. - The increased insight the use of data is providing to our ability to identify variation in the impact experienced as a result of our improvement activity and the associated action being taken. - The ongoing mitigations in place via the programme to address the risk posed by the scale of improvement activity that must be delivered prior to March 2023 if we are to meet our current planned timeline for exit from RSP. Appendix 1: RSP Metric Report is 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 the intention to provide a further update on the outcome of the gateway review meeting at the next Trust Board 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
SNCT	Safer Nursing Care Tool

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. Exit criteria progress

2.1 A significant amount of activity remains underway to support the delivery of the requirements of the exit criteria of the RSP and the Trust's ongoing improvement journey. A summary of progress against the individual exit criteria for the programme and an associated RAG rating is provided in Table 1 below.

2.2 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.

2.3 Most notably a key programme milestone has been achieved during this reporting period, namely the submission of a report to the System Improvement Board (SIB) regarding the first part of the exit criteria aimed at ensuring the organisation has safe staffing levels in line with National Quality Board requirements and Developing Workforce Safeguard recommendations.

2.4 A close out report was provided to the October System Improvement Board (SIB) outlining the activity that has been undertaken to re-set the Trust's staffing establishment in line with the Safer Nursing Care Tool (SNCT) and to refresh our operational governance, ensuring the practice is embedded as part of our routine oversight activities. The SIB confirmed receipt of the report and acknowledged that it represented the provision of evidence related to how the organisation is working to meet the requirements of the fourth exit criteria.

2.5 Whilst the assurance this achievement represents against our progress in exiting segment 4 of the System Oversight Framework (SOF) should be recognised it is important that we also acknowledge the benefit the improvement activity was intended to derive, namely the improved quality, safety and financial sustainability of the care delivered by ensuring that:

i. the staffing levels in place are sufficient to meet the acuity/dependency rates of patients.
ii. there is increased oversight of planned versus actual staffing rates, to enable a greater understanding of the correlation between staffing levels and the quality and safety of patient care.
iii. appropriate arrangements are in place to enable suitable scrutiny, oversight and challenge via the Trust Board and associated governance processes.
iv. roster management is undertaken in a fair and efficient manner that enables additional capacity to be created where necessary, in way that supports financial control.

2.6 The provision of the report related to this exit criteria to the SIB enables us to assure the Board that the staff skill mix in all Care Groups has been aligned to the acuity & dependency data available and the increased oversight of data and intelligence has provided a deeper insight into variation in fill rate, supporting us to identify at ward level areas which are not consistently achieving the 85% RN fill rate target, which is being consistently met at an aggregate Trust level.

2.7 It is recognised that, in assessing the impact the realignment of staffing levels has had on quality and safety metrics it will be difficult to assume any direct correlation between this undertaking and any improvements seen in the immediate period, given the wider quality and safety improvement work that is ongoing via the Fundamentals of Care workstream. As a result of this confounding factor scrutiny of the impact will therefore be undertaken over coming months via the care group performance meetings, via the use of the care group level IPR in development which will allow further triangulation at a granular ward level of workforce metrics, quality metric and fill rates. Further focused work is also required to understand how the increased governance arrangements regarding roster management are supporting financial sustainability.

3. Key areas of risk

3.1 In the last Board report we highlighted that the time required to demonstrate statistical change in quality and safety metrics has occurred and been sustained posed a risk to our ability to demonstrate sufficient progress has been made in our improvement journey given the time available between now and our planned March 2023 exit date. We also highlighted the pressure the competing demand of ongoing operational service delivery represents given the breadth of the improvement activity underway. These risks to the programme remain present and are reflected by the fact that six of the eleven exit criteria delivery requirements in table 1 below are currently RAG rated as “at risk” due to the complexity and scale of activity required.

3.2 We continue to work closely with workstream Senior Responsible Officers (SROs) and the Trust’s Intensive Support Director to mitigate the risk as fully as possible. In the period since the last Board report additional financial resource has been allocated via the programme budget to three workstreams to provide additional capacity and focus to support delivery. Interim support has been provided via the realignment of the

Intensive Support and core RSP Team capacity to these workstream areas whilst recruitment is undertaken.

3.3 It is however recognised that despite the challenge we continue to face in relation to the time required to demonstrate sustained improvement, the increased use of data across the organisation, facilitated via the work done to date on the Integrated Performance Report (IPR), metric library and programme metrics, is resulting in a much greater insight into our position in areas such as Fundamentals of Care, where targeted activity is occurring earlier in the pathway, and mortality where additional capacity is being recruited to support timely mortality reviews. Not only is this supporting our ability to identify variation in the impact our improvement activity is having, enabling us to take necessary action, but it will also support us to demonstrate the positive steps being taken to create a learning culture organisationally.

3.4 We are also working with regional NHS England colleagues to continue to understand the level of assurance that will be accepted via qualitative measures to help mitigate this risk. A meeting is scheduled for 19.10.2022 to gain a fuller understanding of this element of the gateway process that will be applied to the consideration of our exit from segment 4 of the SOF. Further information about our approach to this during the last reporting period is provided in section 3 of the 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	RCS report: Arrangements are underway for the close out report related to the retrospective review of randomised cases to be considered by the Quality Assurance Committee in November 2022, following which a report will be shared with SIB. An update on the action taken in response to this report is scheduled for the January SIB. IBD Report : The RSP Team continue to work with the Medical Director to identify the aspects of the report recommendations that may require increased focus via our ongoing improvement activity to remedy them, in particular where there are areas of the FTSU workstream that can support us to evidence remedial action has been undertaken. Once the report has completed the internal Trust governance process for consideration a closeout report will be shared with SIB. An update on the action taken in response to this report is scheduled for the January SIB.	

				A more detailed update on the activity underway in preparation for the NICHE case note review and their subsequent visit to the Trust is provided in the paper from the Director of Governance. The RSP Team are working with the Director of Governance and Trust colleagues who are facilitating this activity to ensure that the NICHE team are furnished with an understanding of the wider improvement activity that is underway via the RSP.	
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	The Section 31 notice for stroke services remains in place for Royal Lancaster Infirmary. Unvalidated SSNAP scores in the domains requiring improvement (front door assessment, placement in & out of the stroke ward, therapies) suggest there are early reasons for confidence that the initial 6 week targeted improvement plan, developed in response to receipt of confirmation that the S31 had not been lifted, has been impactful with an improvement seen in Q2 to a SSNAP-C from a Q1 SSNAP-D. The formal SSNAP position for Q2 will be reviewed in November 2022 before any timeline is established for the re-	⇨

				submission of a request to lift the notice at RLI.	
		-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. A more detailed update on the activity underway to meet the asks related to the CQC Should and Must Do's is provided in the paper from the Director of Governance. The RSP Programme is aware of the additional mitigations the Governance Team have put in place to support the Medicine Care Group given the significant proportion of recommendations that are aligned to their services and will continue to work with Governance colleagues to jointly support assurance.	
		- Exit from the Maternity Safety and Support Programme (MSSP)	March 2023	It is recognised that exit from the MSSP is unlikely to have been achieved by March 2023 due to the different approaches to oversight used nationally for the MSSP and Recovery Support Programmes.	

				The variation in timelines is known to the Regional Team and has been discussed with the Trust's Intensive Support Director extensively. The ongoing inclusion of the Trust in the MSSP is not expected to be a rate limiting factor in our exit from RSP, provided the Trust is able to show ongoing progress against all domains of the MSSP (Leadership, Governance, Strategy & Vision), as well as the wider maternity improvement priorities of the Trust. Discussions are planned with the Regional Team and the Trust's Intensive Support Director for October 2022 to clarify the deliverables they expect to have been achieved to demonstrate sufficient progress to support exit from the RSP. The change in RAG rating is therefore reflective of the complexity of this criteria and the need for further clarity of the objective test that will be applied as part of our exit, rather than a deterioration in progress or service outcomes. Clarity is also being sought from the MSSP Team at their October visit to the Trust, with an expected conclusion by the end of October 2022.	

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	Activity associated with the well-led self-assessment has commenced during October 2022. This includes the collation of relevant assurance documentation related to Trust Board and sub-committee meetings. Observations of Trust Board and sub-committees will take place during October and November 2022, with focus groups and Executive interviews planned for November 2022. The outcome of the self-assessment will be shared with the December 2022 Trust Board, key headlines will be shared with SIB the same month. The independent review will take place during the first part of Q4 with the report shared with SIB in March 2023. The action plan produced as a result of the findings of our internal self-assessment will be used to demonstrate our ongoing development approach. Work is ongoing to support the embeddedness of the new Quality Governance Accountability Framework, with a planned review cycle to take place once two cycles of business have been completed to ensure effectiveness. The first review cycle of the Performance Meetings took place in September 2022,	⇨

				with recommendations made to support consistency across Care Groups in areas such as risk management.	
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.	TBC*	Whilst the SPC charts do not yet show widespread, consistent and sustained improvement against the breadth of these metrics the improvements we have made to our reporting and data quality, and the training we have undertaken to improve the organisation's ability to interpret and act on data, means we are able to demonstrate a more objective understanding the impact of the activities we've undertaken, of areas where our metrics indicate improvement and areas where further work is required. Further information on the action underway to reduce the harms associated with these metrics are outlined in section 4 of the report. A deep dive on the Fundamentals of Care workstream was presented to the October SIB outlining the activity undertaken to date, the impact seen on our metrics via our SPC charts and the additional areas of improvement focus we are undertaking to address the emergent issues contributing to the stubborn performance in these	⇨

		-Ward accreditation metrics: report to SIB demonstrating improved outcomes over time		areas. The SIB was supportive of our approach and acknowledged the assurance provided by our data led approach. The deep dive at the October SIB showed the following improvement in ward accreditation scores on re-assessment: -10 wards moving from Bronze (overall score of 0-79%) to Gold (overall score of 90-100%) - 18 wards moving from Bronze (overall score of 0-79%) to Silver (overall score of 80-89.9%) A further update will be provided to SIB at the deep dive in January 2023 to demonstrate full compliance with this element of the criteria.	
		-Safe staffing 'close out report' to be received by SIB.	October 2022	The October SIB received the formal close out report outlining the action taken to reset staffing establishments and refresh the governance.	
		Follow-up position to be reported to SIB demonstrating sustained performance and practice	February 2023	The October SIB also agreed our proposed timeline for the submission of the follow up report on safe staffing, which will take place in February 2023 following the provision of the bi-annual report to Trust Board in January 2023.	

		embedded as business as usual			
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		
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 difference in development timelines is recognised and we are proactively engaging with ICB colleagues to ensure that, whilst the variation is acknowledged in any report the ICB provides to the SIB, it does not impede our ability to demonstrate collaborative working and alignment in our priorities.	⇨

				A meeting took place with the ICB Medical Director on 30.09.2022 to discuss early priorities that have emerged during the first 3 month's operation of the ICB and further opportunities for engagement.	
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	March 2023	The impact of the year 1 OD programme is starting to be realised. A 14% improvement in the Health and Well Being question on the pulse survey has been seen between January and June 2022. Data related to the Leadership programme demonstrates that immediate feedback received from those who have attended the course thus far is almost wholly positive, with 97% rating it as directly transferable to their day to day activity. More detailed activity is underway to consider how, given its phased rollout we will be able to triangulate pulse and staff survey metrics in a way that supports a deeper understanding of how embedded the learning has been in reality and the associated impact on staff who work with those leaders who have attended the course to date. Agreement has been reached with the workstream lead at the National Guardian's Office framework will be used	⇨

		-FTSU: Independent Review of policy and processes - Staff pulse survey results to demonstrate improving metrics related to staff confidence in FTSU/ listening organisation		to facilitate the review of our policy and processes. Whilst a number of external reports have identified the need to increase staff confidence and awareness of FTSU historically data has not been captured to provide a baseline position. Activity is underway to facilitate the inclusion of this via staff pulse surveys. In the interim additional focus on FTSU is taking place during the national Freedom to Speak Up Month given that the staff survey is currently open.	

RAG rating key	
On track	
At risk	
Missed	
Complete	
Sustained	→
Improved	↑
Deteriorated	↓

*TBC- this timeline requires agreement with the regional team during the discussion planned for mid-October regarding the gateway process for exit from RSP.

4. Demonstrating the impact of our improvement programme

4.1 The programme continues to use statistical process control (SPC) methodology to assess whether the current metrics indicate the improvement activity underway will sustainably achieve improvement going forward in the desired quality, safety, governance, people or performance areas. Where appropriate, workstreams will also triangulate this data set with intelligence from other sources including complaints, serious incident reports, workforce reporting and the IPR to enable a rich understanding of our progress.

4.2 The metric set that was shared with the September SIB is attached as appendix 1. In summary, whilst there continues to be 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 at a Trust level across the range of domains the RSP is intended to target.

4.3 However, what we can demonstrate is that in several areas the increased understanding we have at a more granular level of the root cause of our lack of progress, and the associated approach the programme is taking to ensuring increased targeted activity is undertaken, is deriving benefit. We are working to roll out this out across all workstreams as part of our enhanced programme support and oversight arrangements.

4.4 An example of this is the pressure ulcer project within the Fundamentals of Care workstream. The SPC run rate indicated that, instead of the Trust level reduction in hospital acquired category 2 pressure ulcers the improvement activity was intended to achieve, there had been an unexpected rise in the aggregate position. On further examination of the data at ward level via the Harm Free Care Panel it was identified that the rise was primarily isolated to the Acute Medical Unit (AMU). Further work is therefore underway to address the potential impact of long trolley waits in ED on the development of pressure damage later in the patients stay.

4.5 Additionally, it should be noted that for the Urgent and Emergency Care workstream the programme metrics relate to the Trust's overarching performance position, which it is recognised remains challenged. Whilst significant progress has been made in this workstream the totality of the planned activity we have committed to deliver to enable improvement to be achieved has not yet been completed, it should be recognised that this aligns with the planned workstream timelines, which expect activity to be ongoing throughout Q3 and 4.

4.6 However, the process metrics do demonstrate progress against the intended outcomes, for example via a 66% increase in referrals to the Same Day Emergency Care (SDEC) unit at Royal Lancaster Infirmary between July and August 2022 and a corresponding special cause variation in improvement related to 0 day length of stay (LOS) and the treatment of 40 patients via the 27 open virtual ward beds, with an average LOS of 4.5 days. Both these process metrics represent positive indicators of

the likely impact of the U&EC improvement plan both in terms of flow, as these patients would previously have represented a demand for inpatient beds, and for safety outcomes as it is recognised the safest place for patients, particularly frail patients managed via the virtual wards, is at home, to ensure we prevent avoidable harm or de-conditioning following an inpatient stay.

4.7 In two areas the data demonstrates the actions taken to date have not been sufficient to create sustained improvement, these areas are the stroke workstream and the project related to NMC2R. For stroke it is recognised that the number of data points required for the production of the SPC charts means that it will take some time before sustained improvement is demonstrated however unvalidated SSNAP scores in the domains requiring improvement (namely front door assessment, placement in & out of the stroke ward, therapies) suggest early reasons for confidence, building on the improvement in Q2 to a Sentinal Stroke National Audit Programme (SSNAP) C from a Q1 SSNAP-D. Further work is taking place with the team in the next month whilst the formal SSNAP data for Q2 is awaited to consolidate this position, with a particular focus on ensuring the care group and organisational governance enable us to manage our response to any operational pressures experienced in coming weeks in a way that doesn't pose a risk to the ongoing achievement of the stroke improvement work. The formal SSNAP position for Q2 will be reviewed before any timeline is established for the re-submission of a request to lift the notice at RLI.

4.8 For the No Medical Criteria to Reside (NMC2R) project work continues to identify additional mitigations to bring the delivery of the intended reduction in patients with NMC2R back on track with the planned programme trajectories. An independent provider has been successfully appointed through a procurement process to deliver 85-90 domiciliary care packages in South Cumbria. Work continues with Cumbria County Council to mitigate any potential consequence on core domiciliary care, including the option of contract breaks. The ward "health check" which looks in detail at ward processes was completed in early October 2022, with the outputs of that review developing actions that can be taken at individual ward level to support flow. It is however recognised that that further system support will continue to be required to address the primary drivers of our high level of NMC2R patients, namely the fragility of the social care market. Dialogue with system colleagues on this area continues.

4.9 It is recognised that 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 statistical methods. We continue to mitigate this risk via the ongoing work we are doing to identify alternative qualitative means of demonstrating improvement, along with the activity planned with NHS England colleagues to understand more fully the gateway process that will be applied to the consideration of our exit from segment 4 of the SOF.

5. Conclusion

5.1 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.

5.2 Whilst there are areas of achievement, most notably receipt and acceptance of the safe staffing close out report by the SIB, 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.

6. Recommendations

6.1 The Board of Directors is asked to consider the contents of the report and note the progress update report provided. An update on the output of the gateway review meeting will be provided to the next meeting of the Trust Board, along with any associated recommendations on the activity required in the coming months as we progress towards exit from segment 4 of the SOF.

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

August 2022 Performance- October 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.

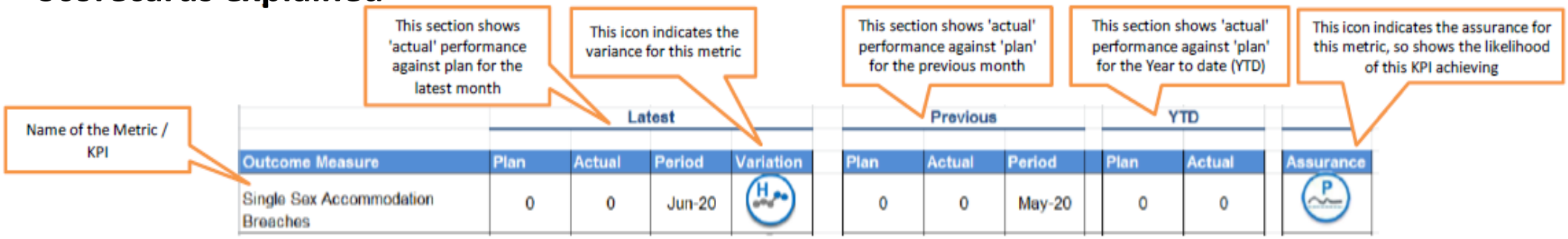
Special Cause Concern - this indicates that special cause variation is occurring in a metric, with the variation being in a favourable direction. Low (L) special cause concern indicates that variation is upward in a KPI where performance is ideally above a target or threshold e.g. ED or RTT Performance. (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

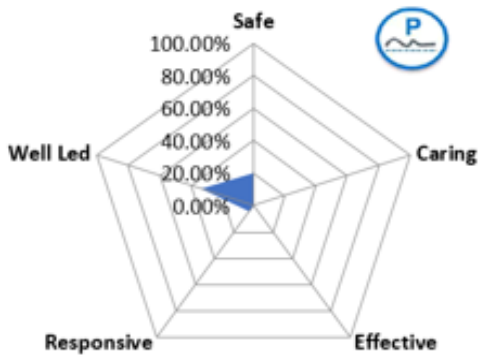
The NHS Improvement website has a range of resources to support Boards using the Making Data Count methodology. This includes are number of videos explaining the approach and a series of case studies – these can be accessed via the following link - https://www.england.nhs.uk/publication/making-data-count/

Executive Summary

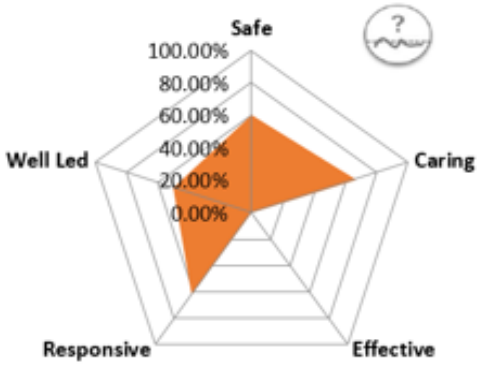
NHS
University Hospitals of Morecambe Bay
NHS Foundation Trust

Executive Summary

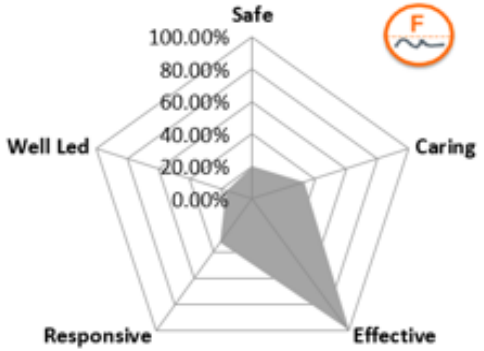
Consistently Passing



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

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 (%)
- Follow-Ups Past IRD

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

Executive Summary

Variance	Assurance: Pass	Assurance: Hit and Miss	Assurance: Fail
Special Cause – Improvement	- 2h Community Crisis Response	- RTT 52 weeks (no.) - No of Patients on Cancer PTL over 62 days (no.) - RTT 104 weeks (no.)	- RTT <18 weeks (%) - RTT 78 weeks (no.)
Common Cause	- Registered Nurse Fill Rate - Turnover %	- Please see text box to RHS for metrics	- Ambulance Handovers within 15, 30 & 60 mins (%) – 3 **metrics** - OP DNA Rate (%) - Complaints per 1000 Bed Days - StEIS Incidents reported to CCG - Overall % of Inpatients Receiving a VTE Assessment
Special Cause – Concern	- Vacancy	- Core Skills Framework - % Of ED attends > 12hrs - Ambulance Handovers over 60 mins (no.) - Diagnostic waits > 6 weeks - RTT total waiting list size - A&E % Rating the Service as Good or Very Good	- ED 4 hrs (%) - Appraisal Compliance - Trust Overall (inc ED, OP & IP) % Rating the Service as Good or Very Good - Follow-Ups Past IRD

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
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 (%)

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, A&E - % Rating the Service as Good or Very Good
Effective:
Responsive: ED 4 hrs (%), % Of ED attends > 12hrs, Ambulance Handovers over 60 mins (no.), Diagnostic waits > 6 weeks, RTT total waiting list size, Follow-Ups Past IRD
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 provided in the pack includes associated actions, outcomes, dates and assurance. The report for October Board (August performance) is now in the fifth month, with continued work to refine and improve the document, in partnership with the NHSI/E Improvement Team.

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.

Operational Performance

- **Metrics achieving the target or standard and predicted to achieve going forward.**
  - The 2 Hour Urgent Community Response standard which has been achieved sustainably since April 2021.

- **Metrics which are failing the target or standard and predicted to fail going forward.**
  - Urgent Care 4 Hour Standard
  - Ambulance handover- within 15, 30 and 60 minutes.
  - RTT 18 Week standard
  - Number of patients waiting >78 weeks against trajectory
  - Outpatient Did Not Attend rate.
  - Number of patients awaiting follow-up past their Indicative Review date

Executive Summary

Quality and Safety

- **Clostridium Difficile infections –** YTD there are 5 cases above threshold. None of the cases are connected in time or place. A thematic review has highlighted issues with antimicrobial prescribing, which will now be mitigated with the introduction of the antimicrobial pharmacy team, and PPI (proton pump inhibitors) review. Clinician (Dr) engagement in post infection reviews has improved.

- **VTE Assessment –** This month the VTE assessment compliance data accurately reflects the position at 84.4% against a target of 95.5%. This reflects the recent improvement work to clarify inclusion criteria for VTE assessment. Monthly review of VTE risk assessment compliance at care group level including actions for improvement is in place led by the DCMO.

- **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 has indicated feedback related to long waits in ED and long waits for planned surgery. Care groups are being encouraged to review a wider range of metrics, including qualitative feedback to give a wider perspective. This will be supported by the Patient Experience and patient relations steam.

Executive Summary

People

- **Vacancies:** The overall vacancy rate continues to rise, although it remains under the Trust target. Consultant (16.4%), Midwifery, (21.1%) Additional Prof Scientific and Technical services (11.7%) remain a concern for the Trust. 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 and will be seen to reduce this figure over the coming months

- **Sickness absence:** Absence levels have decreased and this largely driven by non-COVID absences reduction of 1.1%. The demand for psychological support continues to grow, although the average waiting time has now been reduced further to 12 days. 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), this has seen 68 colleagues referred, with a 66% Return to Work (RTW) rate for MSK referrals and a 14% RTW rate for Mental Health..

- **Appraisals:** Compliance with appraisals has been lower than planned. Performance can be expected to range from 72% - 81% against a target of 95%. Targeted action is necessary if the target is to be achieved. At UHMB, the priority for recovery has been on the completion of Leadership appraisals. This will ensure the timely cascade of objectives and priorities for the coming year. Leadership programme is also providing the support to managers to understand why appraisals must be completed in a timely manner every reporting period.

Executive Summary

Finance

- The Trust is £0.1m worse than plan which includes income relating to ERF at planned levels. The National team has confirmed zero claw back ERF from ICB systems for months 1-5, regardless of system performance.

- The plan includes a £34.1m categorised as ICS stretch income as part of the system wide requirement to break even. This income is to be generated through system wide savings initiatives and other slippage and collaborative solutions. At month 5, 66% has been identified. Included in the position is £5.1m income against the stretch plan of £7.6m.

- Pay controls – The Pay control Board has yet to meet and substantive and agency pay is exceeding plan and putting pressure on the delivery of the financial obligations of the Trust. Agency forecast is above the nationally set cap which is being flagged by the national team as a major concern

- 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 was made at Month 5, with funding vired from Reserves to cover the costs of beds not able to be closed at this point.

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%	82.1%		
Inpatients - % Rating the Service as Good or Very Good	94%	86.8%		
Outpatients - % Rating the Service as Good or Very Good	94%	94.2%		
Trust Overall (inc ED,OP & IP) - % Rating the Service as Good or Very Good	94%	91.1%		
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%	85%		

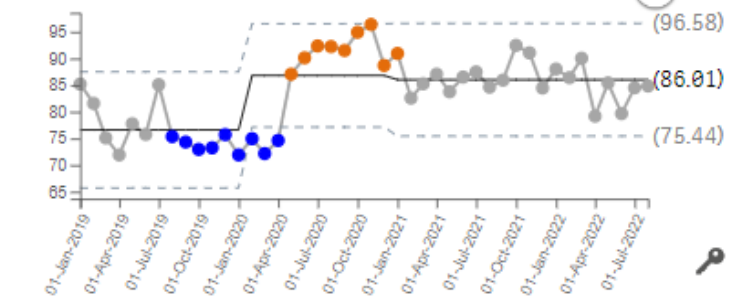
Safe

Outcome Measure	Target	Actual	Variation	Assurance
Patient Safety Incidents per 1000 Bed Days	---	84.84%		
StEIS Incidents Reported to CCG	0	15		
Never Events	---	0		
Moderate and Above Harm Patient Safety Incidents	---	67		
Hospital Falls per 1000 Bed Days Resulting in Moderate Harm or Above	0.13	0.25		
Inpatient Category 2, 3 & 4 Pressure Ulcers Per 1000 Bed Days	---	2.61		
Overall % of VTE's that are Hospital Aquired	---	2%		
Patient Safety Alerts by Date Received	---	2		
Total Number of MRSA Hospital Cases	0	0.00		
Total Number of MSSA Hospital Cases	---	4		
Total Number of GNBIs	---	10		
Total Number of c.Diff Infections	---	7		

Patient Safety

Patient Safety Incidents per 1000 Bed Days

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

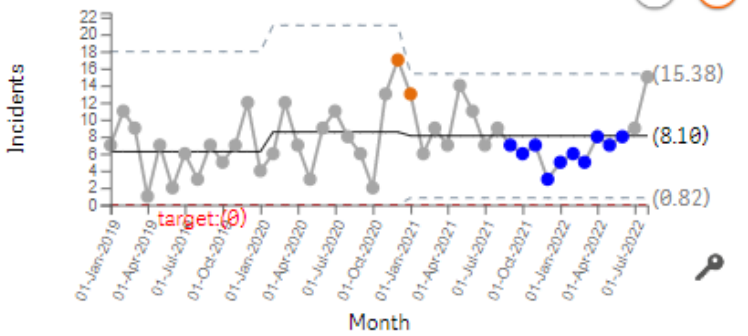


Latest
84.84
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Awaiting revised national benchmarking before setting local target

StEIS Incidents by Month Reported to CCG

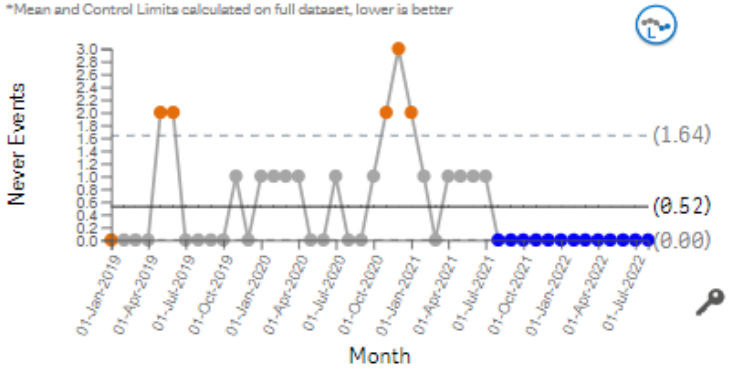
*Mean and Control Limits calculated on full dataset within recalculation window, lower is bett



Latest
15
Variance Type
Common cause variation
Target
0
Target Achievement
The system is expected to consistently fail the target

Never Events

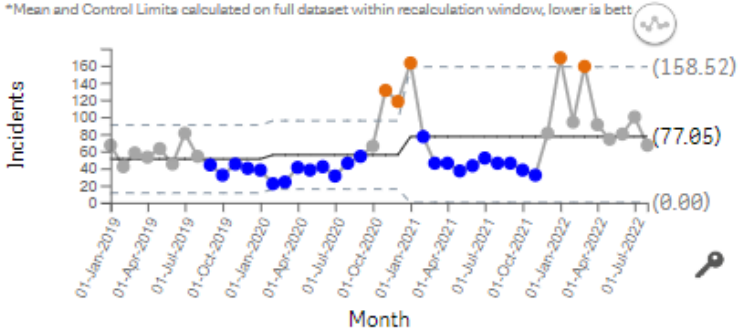
*Mean and Control Limits calculated on full dataset, lower is better



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

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



Latest
67
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: The Trust continues to report a high volume of incidents. The Trust recently migrated the submission of Patient Safety Incidents from the NRLS to LFPSE which is a key element of the Patient Safety Strategy. As a result a number of additional mandated sections were introduced and a risk was added to the Trust's Risk Register regarding a potential in under reporting. However, this has not transpired and reporting levels remain stable.

StEIS Incidents by Month Reported to CCG: In August 2022, 15 incidents were declared as a serious incident and subsequently reported on StEIS. 7 of these occurred within Medicine, 4 within Surgery, 2 within Women and Children's and 2 in Core Clinical Services. Themes identified include tissue viability (4 incidents) and falls (3 incident)

Moderate and Above Harm Patient Safety Incidents: In August 2022, 80 incidents were graded as moderate or above. 33.75% of these related to Infection Prevention incidents.

Actions:

StEIS Incidents by Month Reported to CCG: Ongoing review is in place to monitor the rise in the volume of incidents reported on StEIS.

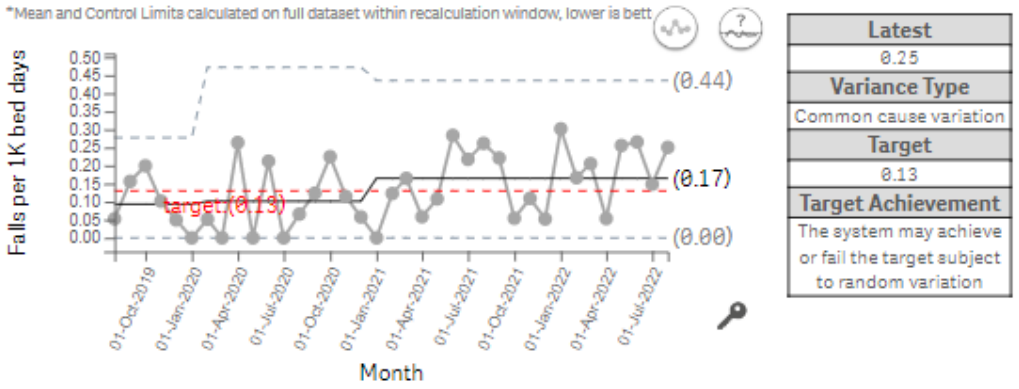
Assurance:

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

Moderate and Above Harm Patient Safety Incidents: Despite an increase in the number of incidents reported through STEiS, the number of moderate and above harm incidents has not increased.

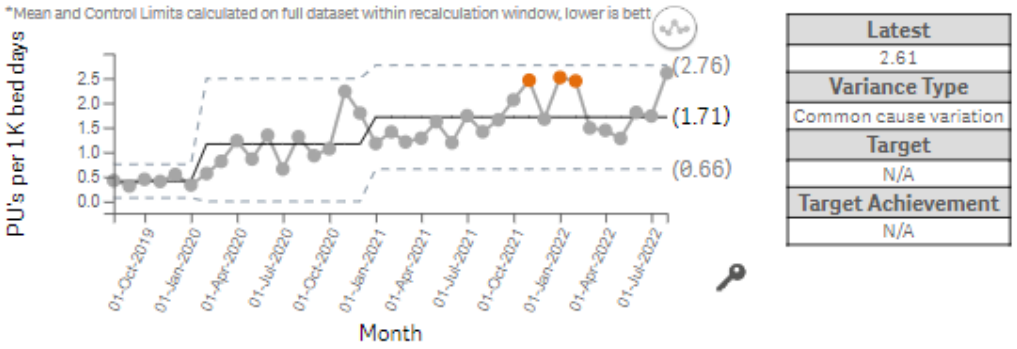
Patient Safety

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



Latest
0.25
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
2.61
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: Although the SPC run rate is at an early stage the data has led us to investigate the marked rise in grade 2 pressure ulcers, which was unexpected.

Hospital Falls per 1000 Bed Days Resulting in Moderate or Above Harm: There were 5 moderate harm falls reported during the month of August. Two of the patients had a history of recurrent falls. One patient did not meet the criteria to reside and was awaiting a Pathway 2 discharge home.

Actions:

Inpatient Category 2, 3 & 4 Pressure Ulcers per 1000 Bed Days: Work is planned with the HIVE to explore the potential impact/triangulation of staffing in ward areas, increased length of stay due to patients no longer meeting the criteria to reside and long trolley waits in ED on the development of pressure damage later in the patients stay.
The aim of the QI work will be to understand causation, mitigation of risk and a sustained reduction in grade 2 pressure ulcers and DTI's.

Hospital Falls per 1000 Bed Days Resulting in Moderate or Above Harm: RSP FOC Practitioner now in post. The expected outputs from this post are:
1) Monitor adherence to National Falls standards. 2) Focus on improving the pathway for those patients who are of high risk of falls e.g. patients who have frequent falls prior to admission. 3) Falls Link Nurse Training November 2022 to provide every ward with a key trainer.

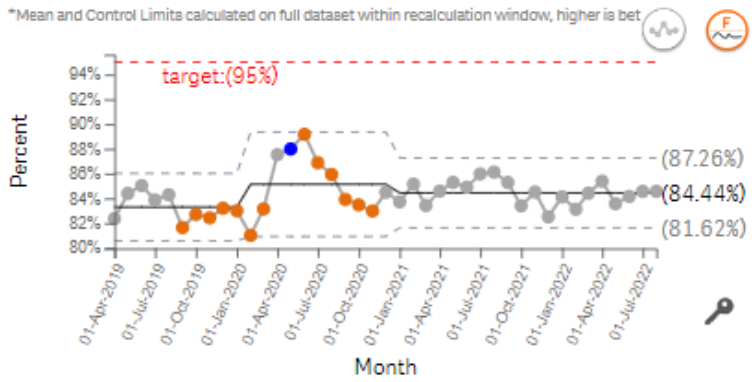
Assurance:

Inpatient Category 2, 3 & 4 Pressure Ulcers per 1000 Bed Days: The validation of pressure ulcers is well established and is consistently completed across all care groups – achieving greater than 95% compliance. This is being monitored via the harm free care panel and the Tissue viability dashboard.
There is currently no national benchmark for pressure ulcers. The IPC Lead Nurse has engaged with Model Hospital and the National Wound Care Strategy Team reviewing development of a national benchmark. UHMBT to become a fast follower.

Hospital Falls per 1000 Bed Days Resulting in Moderate or Above Harm:
Thematic review of falls for the last 3 months with harm to QAC.
A Falls e-learning module is now in place for clinical staff to enhance staff awareness on the mechanisms associated with falls.
Compliance with validation of falls is above 95% compliance.
The Trust participated in the National Falls Awareness week in September with a focus on "Get up & Keep Moving"

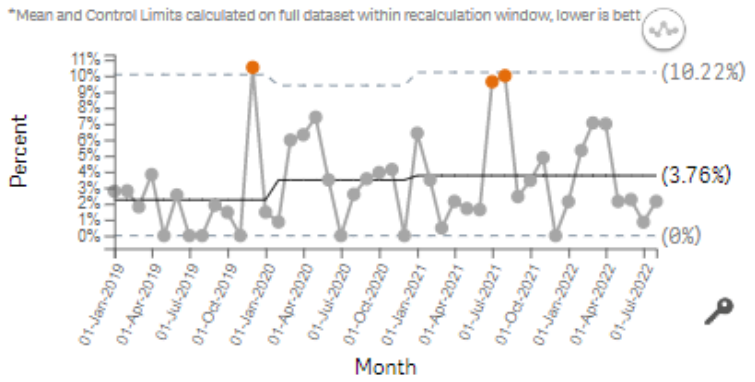
Patient Safety

Overall Percent of Inpatients Receiving a VTE Assessment



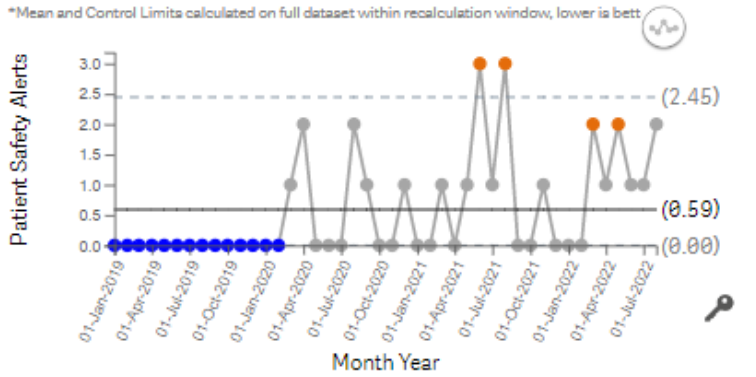
Latest
85%
Variance Type
Common cause variation
Target
95%
Target Achievement
The system is expected to consistently fail the target

Overall Percent VTEs that are Hospital Acquired



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

Patient Safety Alerts by Date Received



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

Summary:

VTE: VTE risk assessment (RA) currently is at 84.44% against a target of 95.5%. A deep dive into the metrics shows that there is a considerable improvement in Day Case VTE assessment rates (RLI 84.1%, WGH 77.7%, FGH 74.8%). The in-patient VTE RA shows FGH 93%, RLI 88.3%, WGH 78.0%. For IP the bottom 5 performing specialities are obstetrics, gynaecology, ENT, urology, and neurology.
By Care-group, overall IP VTE assessment: Medicine 94.1, Surgery 87.5% and WACS 60.5% and DC VTE assessment: Surgery 81.0%, WACS 77.3% and Medicine 40.3%

Actions:

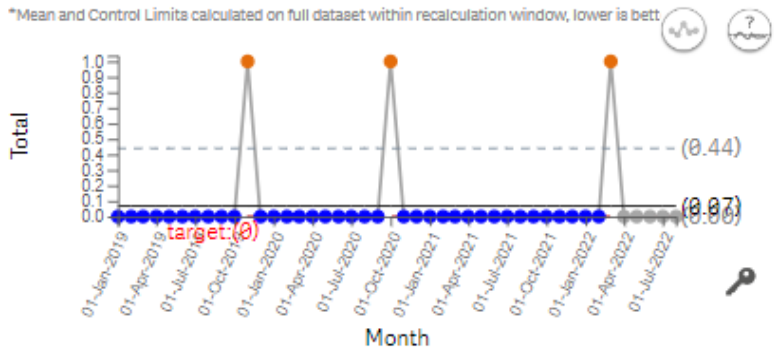
VTE: Care-groups have their granular details and are expected to drive improvements. The VTE Medical Champions (FY2s) have undertaken an audit of VTE cross-bay and will be attending Care Group GAG to discuss their findings and drive improvement.
Nurse VTE champions are to be recruited to. Encourage teams to utilise white board to identify patients who have not had a VTE risk assessment and for Senior Decision makers to mandate that pre-WR, VTE RA assurance is obtained from JDrs.
Nursing teams will provide prompting as part of MDT responsibility.
VTE Clinical Lead still out to advert, Ameeta Joshi and Emma Fitton pushing VTE improvements

Assurance:

VTE: Monthly performance review of VTE RA at each group and action plans must show improvement

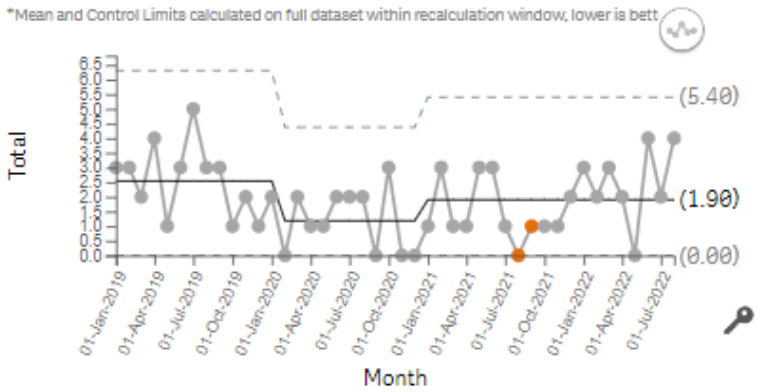
Infection Prevention

Total Number of MRSA Hospital Cases



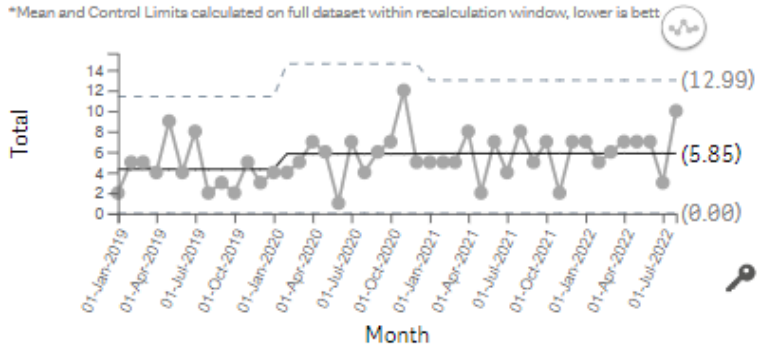
Latest
0
Variance Type
Common cause variation
Target
0
Target Achievement
The system may achieve or fail the target subject to random variation

Total Number of MSSA Hospital Cases



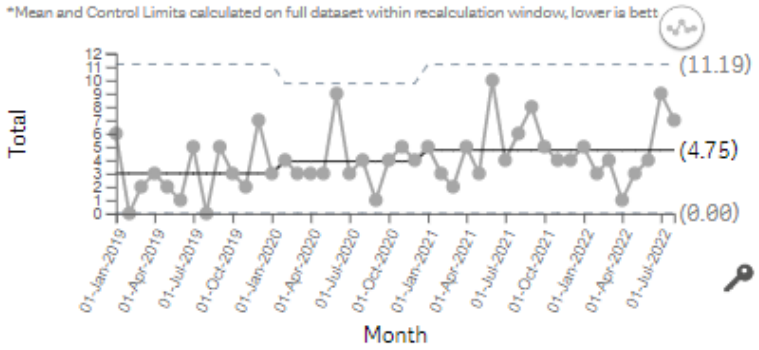
Latest
4
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Total Number of GNBI's



Latest
10
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Total Number of C.Diff Infections



Latest
7
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Summary:
YTD to end July 2022 C.Diff infections (HOHA/ COHA) 33 against a YTD threshold of 28 placing us over the YTD trajectory following a spike in incidence in July. None of the cases are connected in time or place.
The total threshold for 2022-23 is 84.
Thematic reviews continue to identify common trends around antimicrobial prescribing and PPI review

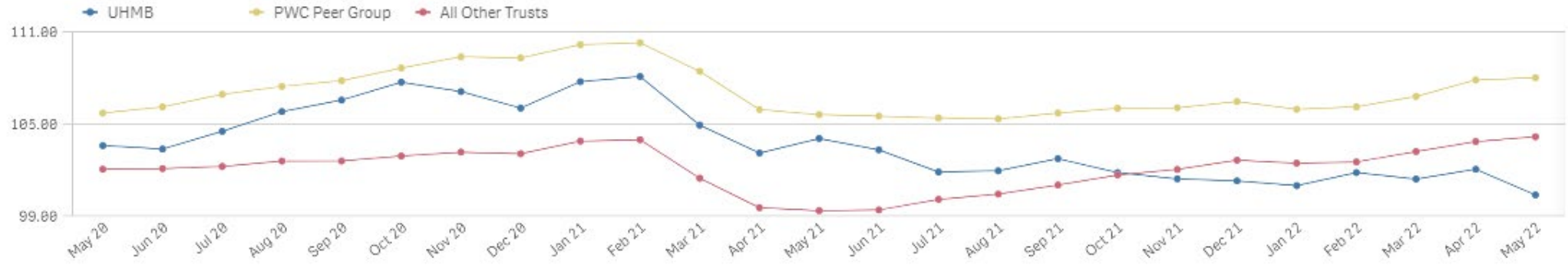
Actions:
CDI meetings now completed on the ward, clinical engagement at ward level improving.

ICB workstreams have been created to support CDI reduction plans.

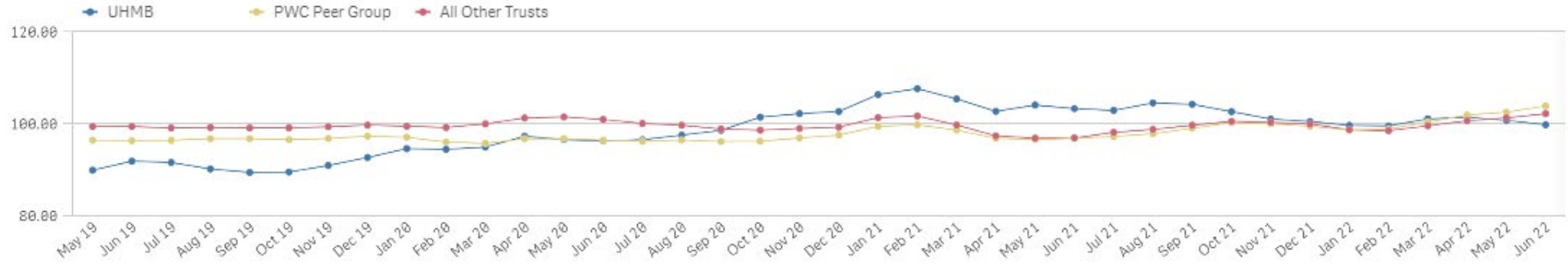
Assurance:
Antimicrobial pharmacy team now fully in place and reviewing adherence to antimicrobial prescribing pathways/ formulary across both sites.
Outputs/ assurances will be reported via IPCC.

Mortality

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



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



Summary:

latest rolling 12-Month SHMI (June 2021- May 2022) score is 100.4 with 1645 observed deaths against 1638.42 expected. This is in the green alert level

The latest SHMI score for Fractured NoF is 178.85 with associated CI's of (137.43, 228.84) respectively. We continue to generate a red alert in SHMI for this diagnostic group. Our crude mortality rate has increased to 13.10% when compared with August.

We are also alerting red for peripheral and vascular atherosclerosis with SHMI at 233.25.

Our rolling 12-month position for HSMR (July 2021-June 2022) is 99.88, with lower and upper CI's of (94.01, 106.01). This is in the green alert level

The latest HSMR score for FNoF is 167.05 with associated CI's of (123.58, 200.68). This is in the amber alert level

Actions:

The Fractured Neck of Femur Steering group led by the ADOP and CSM for T &O are continuing to progress with improvements in our performance of FNoF.

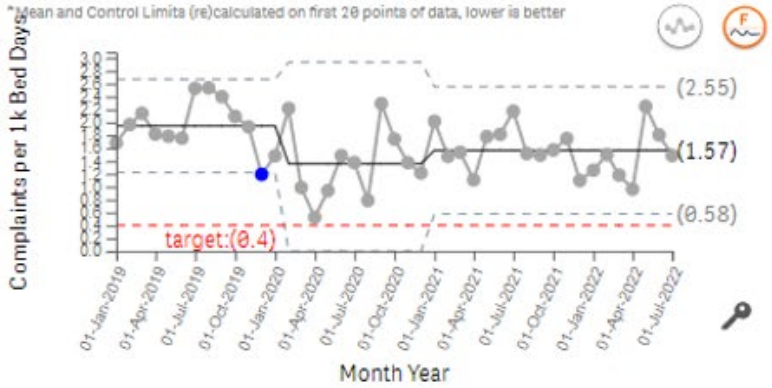
The data and coding for peripheral and vascular atherosclerosis is being examined by the CD for S & CC as well mortality lead.

Assurance:

The Fractured Neck of Femur Steering group and Mortality steering group will work together to ensure positive progress in the above 4 areas. An improvement in fractured neck of femur metrics will hopefully occur in early 2023 - at least 6 months time.

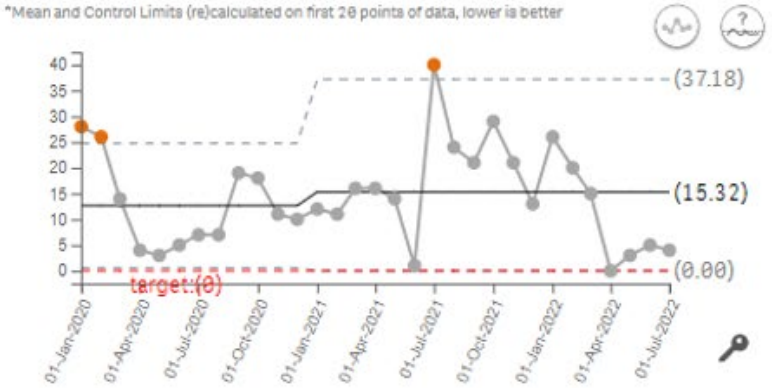
Patient Relations

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: Number of complaints per 1000 bed days remains in common cause variation.
There are 3 cases in the approval process which are over the 6 months regulatory time frame.

MSB: There are 4 reported MSA breaches. 3 relating to delayed transfer out of ICU to the ward and 1 patient who was placed in the acute stroke bay due to clinical need.

Actions:

Complaints: Urgent action is being taken to progress the 6 month cases through the approval stage.

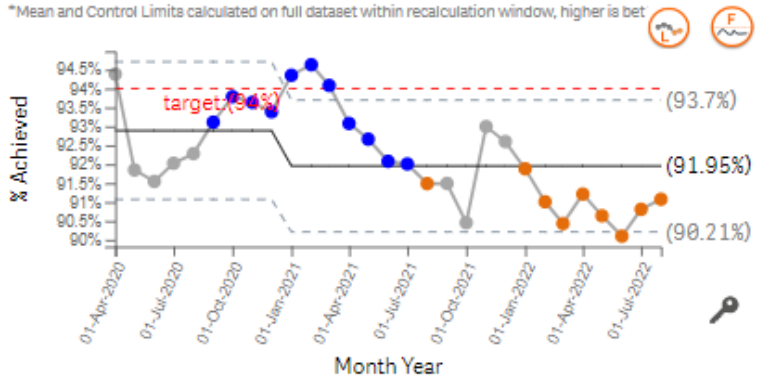
Assurance:

Complaints: A review of the complaints procedure is underway to address delays in the process and strengthen the learning.

MSA: MSA continues to be a red line breach and is monitored by the DCN.

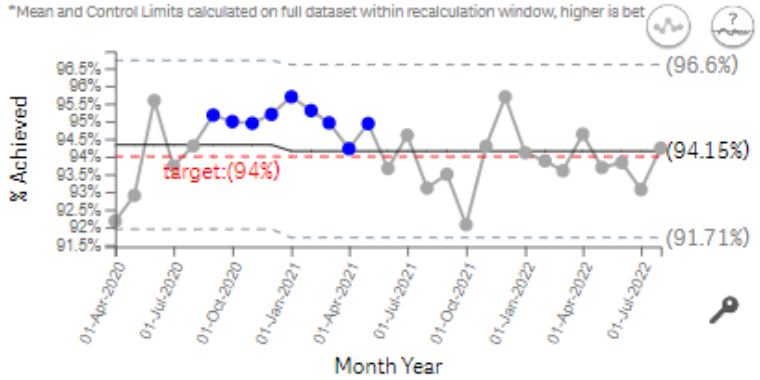
Friends and Family

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



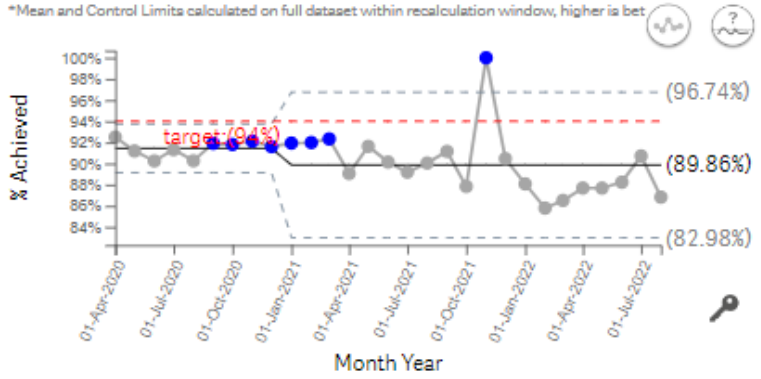
Latest
91.1%
Variance Type
Special cause variation - cause for concern (indicator where low is a concern)
Target
94%
Target Achievement
The system is expected to consistently fail the target

Outpatients - % Rating the Service as Good or Very Good



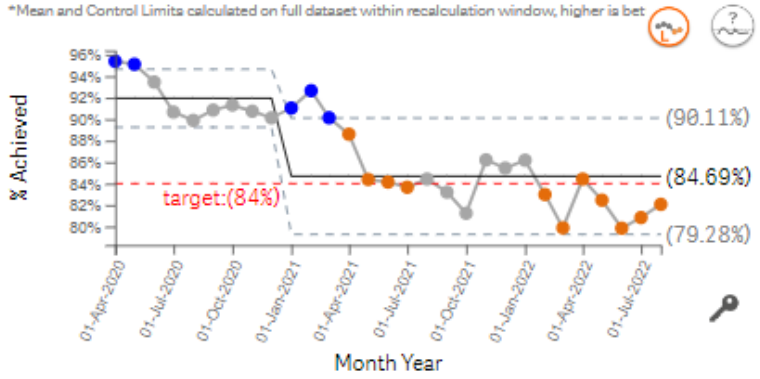
Latest
94.2%
Variance Type
Common cause variation
Target
94%
Target Achievement
The system may achieve or fail the target subject to random variation

Inpatients - % Rating the Service as Good or Very Good



Latest
86.8%
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



Latest
82.1%
Variance Type
Special cause variation - cause for concern (indicator where low is a concern)
Target
84%
Target Achievement
The system may achieve or fail the target subject to random variation

Summary:

Inpatient and Emergency departments continue to report low patient satisfaction scores.

The trust FFT has remained below 94% over last 12 months. The themes are mainly related to long waits for planned, emergency and outpatient health and care service.

The FFT results must be read conjunction with our organisational performance measures.

- Operational pressures are having an impact on patient satisfaction.

Actions:

The patient experience team to continue to offer a local check point five survey service.

The patient experience team to continue to review all FFT comments and ensure the patient has used the correct scoring rules.

The patient experience team to continue the roll out of QR codes for colleagues to promote the FFT survey with the patient / carer ongoing during the care / treatment and on discharge.

Assurance:

We have benchmarked our FFT with other comparable NHS Trusts.

Emergency Dept national average 75%, UHMBT 82.1%

Inpatient national average 94%, UHMBT 86.6%

Outpatients national average 93%, UHMBT 94.2%

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%	1.2%		P
Average time to Hire (advert close to booked start date)	55	50.6		?
Bank & Agency Fill Rate	75%	72.6%		?
As of Month - Absence %	5.0%	5.7%		?
Registered Nurse Fill Rate	85.0%	92.6%		P
Appraisals	95%	77%		F

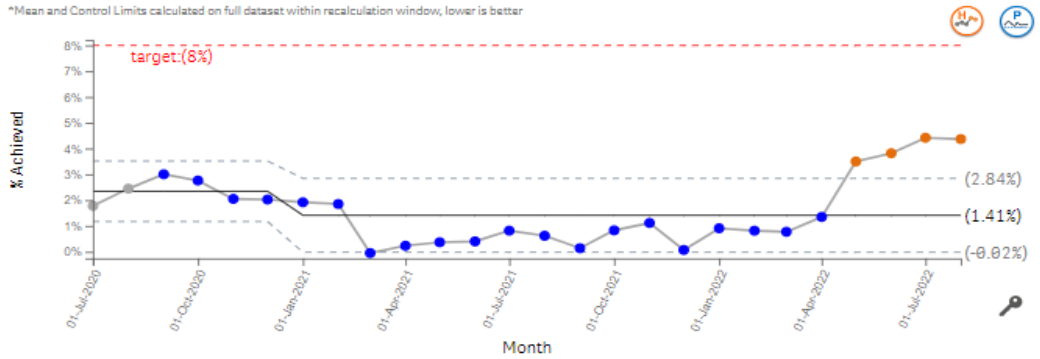
Safe

Outcome Measure	Target	Actual	Variation	Assurance
Core Skills Framework	95%	93%	L	?

Workforce

Vacancy Rate %

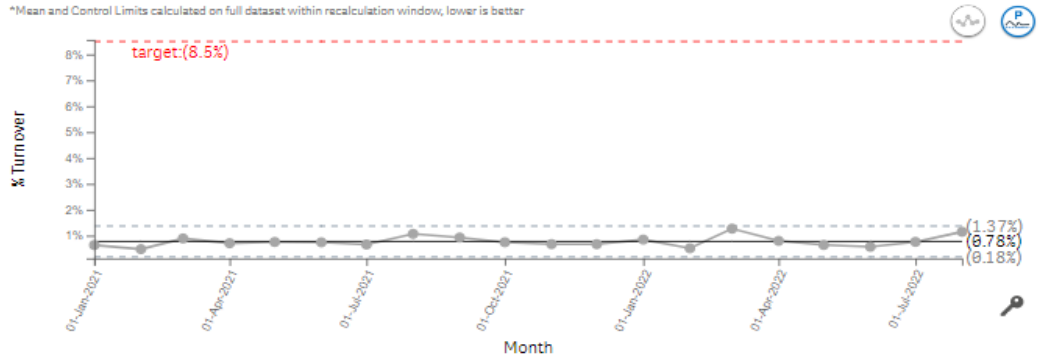
*Mean and Control Limits calculated on full dataset within recalculation window, lower is better



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 %

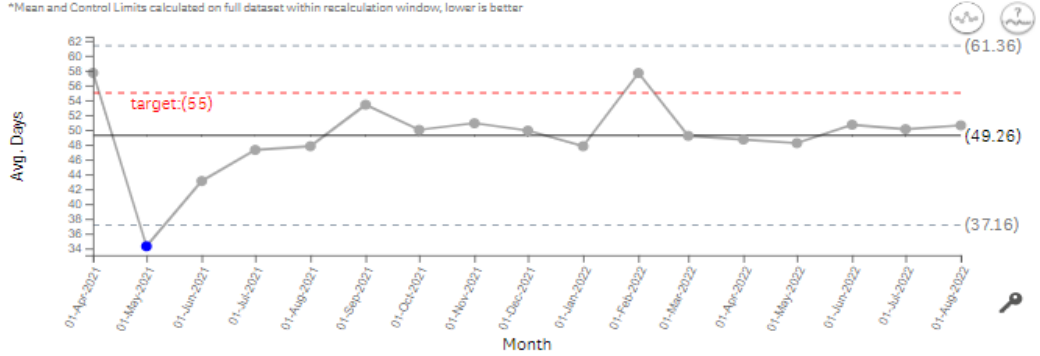
*Mean and Control Limits calculated on full dataset within recalculation window, lower is better



Latest
1.2%
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)

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



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 Rate has deviated outside of process upper limit, this is due to the Midwives vacancy rate increasing to 21.1% and the Consultant vacancy rate increasing to 16.4%. Both areas remain a concern for the Trust even if overall vacancy rate is below trust target.

Turnover: The rolling trust turnover rate increased to 10.0%, which is what the Trust target is based upon. This remains within statistical variation and process limits.

Ave Time to Hire: This remains within statistical variation and process limits, exceeding the requirements for the trust target.

Actions:

Vacancy Rate: Several the areas for concern have directed actions that are addressing the pockets of high vacancy rate. This includes taking strategic actions to address long term issues by using apprenticeships and new exploring new ways of delivering care as part of service transformation.

Turnover: The way that Turnover is reported will be reviewed by People and OD as part of the ongoing work to ensure that data provides a clearer picture. This will mean looking at resetting targets and the way in which it is reported.

Ave Time to Hire: Analysis is being undertaken to understand the variation in the length of each stage of recruitment and to look at further ways to improve performance.

Assurance:

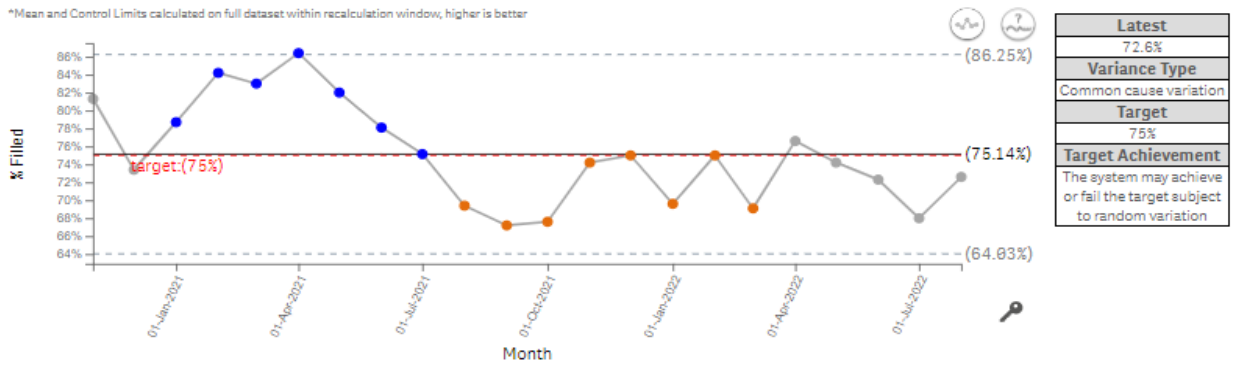
Vacancy Rate: limited assurance as we have a number of pockets that have a high level of vacancy, even if the overall vacancy rate is below trust target.

Turnover: moderate assurance can be taken from the current performance, but will need to be reviewed further once changes to process and reporting have been affected.

Ave Time to Hire: High assurance can be taken on performance remaining positive and is exceeding the Trust target that is current set.

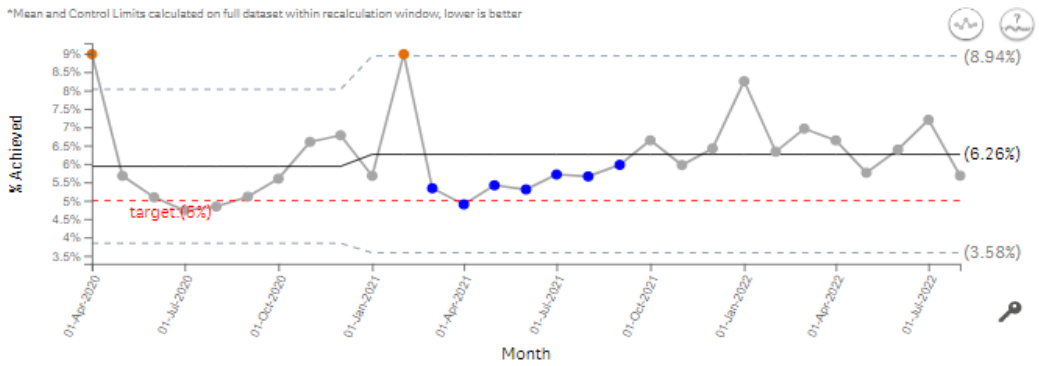
Workforce

Bank & Agency Fill Rate



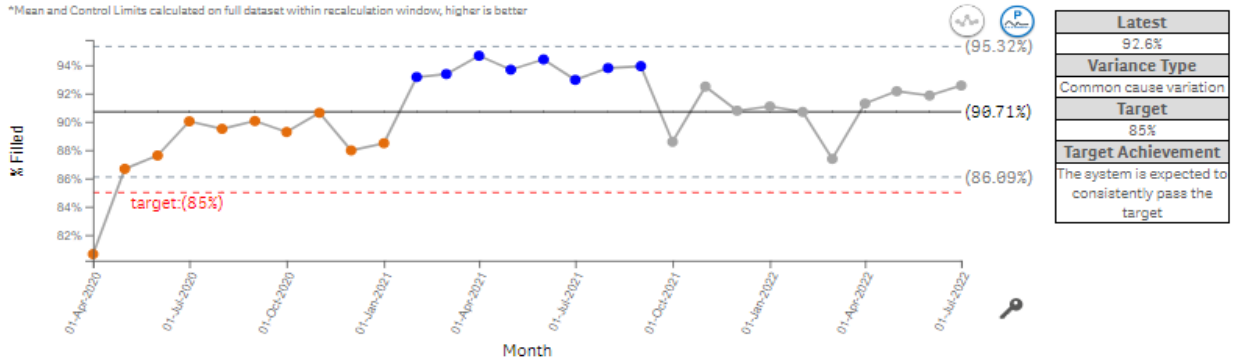
Latest
72.6%
Variance Type
Common cause variation
Target
75%
Target Achievement
The system may achieve or fail the target subject to random variation

Absence FTE %



Latest
5.7%
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 and agency fill rates continue to fluctuate with common cause variation and do not consistently achieve the 75% target.

Absence remains above trust target; although currently within process limits this has been consistently above target for considerable time.

The registered nurse fill rate at a trust level continues to remain consistently above the 85% target with the average rate above 90%. However, at a granular level we do see some wards and departments failing to meet the 85% fill rate consistently.

Actions:
Bank and agency policy is under review and proposals for winter usage and pay rates are being developed and presented this week with an aim to improve shift fill rates.

EASE service has been successfully rolled out and a performance dashboard is available to measure the impact of EASE referrals, this will be fed back to People Committee once sufficient data has been collected and analysed.

The nursing quality dashboard currently in development will support scrutiny on nursing fill rates alongside nurse sensitive indicators at a department, care group and trust level. This will allow a greater understanding of staffing issues and help focus improvement activity.

Assurance:
Absence: Covid related absence is down to 0.8%, which is decrease in month of 1.1% (Special cause variation), Non-Covid has seen a slight decline, but within statistical variation tolerances.

Fill rates are subject to a robust sign off process with care group and senior nurse sign off prior to publication and NHSE/I submission.

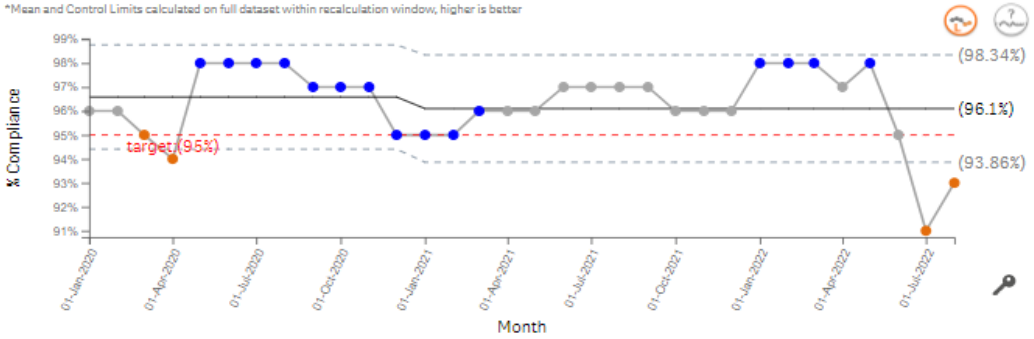
The workforce cell and SAG meetings have been re-established to support rapid review and escalation of staffing concerns and issues.

Workforce

Core Skills Framework

% of staff fully Compliant as start of month

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

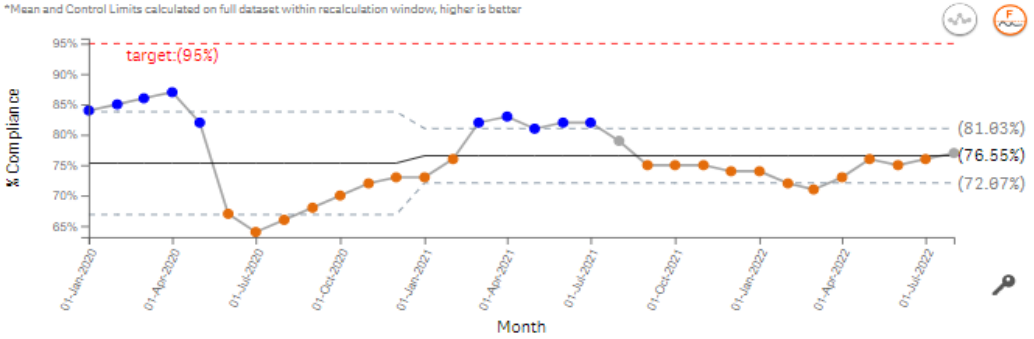


Latest
93.0%
Variance Type
Special cause variation - cause for concern (indicator where low is a concern)
Target
95%
Target Achievement
The system may achieve or fail the target subject to random variation

Appraisal Compliance

% of staff compliant as start of month

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



Latest
77.0%
Variance Type
Common cause variation
Target
95%
Target Achievement
The system is expected to consistently fail the target

Summary:

Core Skills Framework: The removal of the 12 month extension to Data Security Awareness Training and Information Governance has seen CSF compliance drop below target and out side of the lower process limit.

Appraisal: Performance can be expected to range from 72% - 81% against a target of 95%. Targeted action is necessary if the target is to be achieved.

Actions:

Core Skills Framework: Work is underway to understand the better performing care groups with a view to spreading the learning to others.

Appraisal: Analysis is being undertaken to understand the variation by care group and corporate teams and what can be done to drive quality and performance upwards.

Assurance:

Core Skills Framework: The current performance dip is due to a special cause occurrence and performance to target should have no long term effect and moderate assurance should be taken from the bounce back on performance to date.

Appraisal: No assurance can be provided that the target will be achieved, based on current performance.

Finance

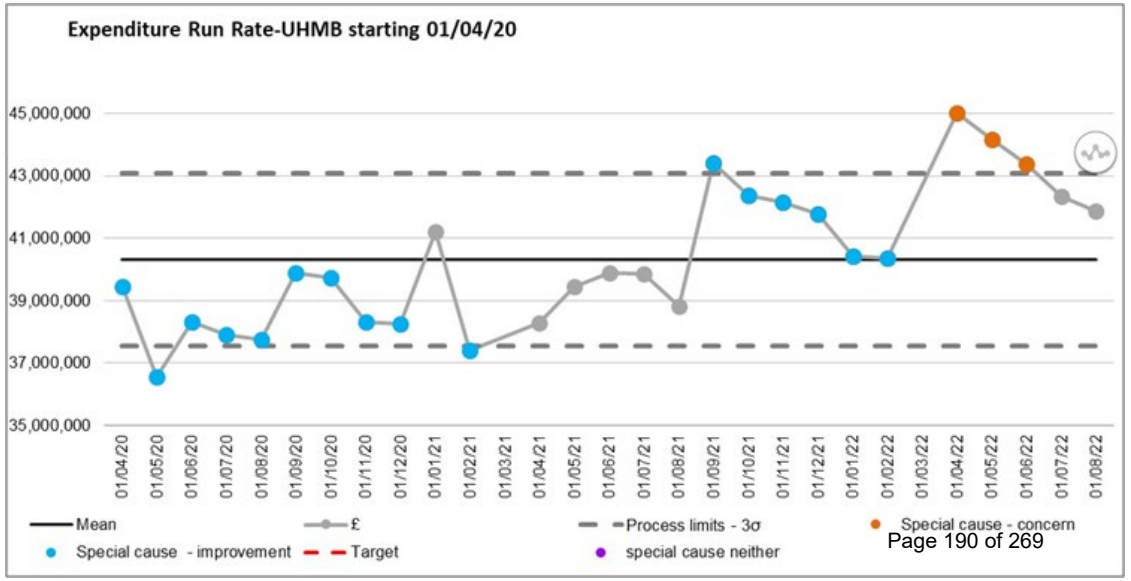
Finance: Income & Expenditure

The table below summarises the financial position at Month 5, a deficit of £4.4m against a planned deficit of £4.3m, £0.1m worse than plan.

The position includes coverage for the £2.5m system stretch gap, worsening position on pay and agency spend as well as the the financial impact of the Trust's response to significant operational pressures associated with the high numbers of patients in hospital which do not meet the medical criteria to reside. This has been mitigated by release of reserves and technical adjustments.

Care groups have a year to date trading overspend of £6.7m of which £2.8m is unachieved CIP. The reduction in run rate seen in the chart below is due to release of risk accruals made in the first quarter, which show as the special cause variation below.

		Year To Date		
Table 1 - Income & expenditure	Annual Plan £'000	Plan £'000	Actual £'000	Variance to Plan £'000
Income from Patient Activities	490,910	205,033	203,159	(1,874)
Other Income	28,042	12,802	12,173	(629)
Subtotal income	**518,952**	**217,835**	**215,332**	**(2,503)**
Pay	(357,100)	(152,153)	(151,619)	534
Non Pay	(155,478)	(67,320)	(65,499)	1,821
Subtotal Expenditure	**(512,578)**	**(219,473)**	**(217,118)**	**2,355**
Operating Total	**6,375**	**(1,638)**	**(1,786)**	**(148)**
Finance Costs	(6,375)	(2,656)	(2,635)	21
Surplus / (deficit)	**0**	**(4,294)**	**(4,421)**	**(127)**



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 1-5.

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 was paid in September including back pay from April 2022. UHMB does not have a pressure from this pay award agreement following increases seen in the contract income due to inflation uplift. This has nullified the risk reported last month.

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 target at month 5 is £7.6m with £2.5m being reported as unachieved. This 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.

Agency costs are putting severe pressure on the Trust ability to deliver its financial obligations. The forecast spend for agency is above the nationally set cap. The Pay control board established via TMG will need to prioritise reduction of spend in this area

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 £8.2m have been identified to date, see table below. with further opportunities of £6.5m 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 result in a total £18m. This leaves a shortfall of £5m and we are developing the financial road map to target all viable options including non-recurrent areas to deliver the 22/23 target

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 was be made at Month 5, with funding being vired from Reserves to cover the costs of those beds not able to be closed at this point.

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)	(900)	(437)	(1,336)	(1,140)
Community	(1,460)	(275)	(112)	(387)	(1,073)
E&F	(2,338)	(270)	(223)	(494)	(1,844)
Medicine	(6,769)	(2,338)	(1,010)	(3,348)	(3,421)
WACs	(2,977)	(530)	0	(530)	(2,447)
S&CC	(3,877)	(1,178)	(517)	(1,694)	(2,183)
Corp	(2,976)	(390)	(20)	(410)	(2,566)
Trust Central Turnaround	(156)	(6,447)	(3,355)	(9,802)	9,646
Total	**(23,029)**	**(12,328)**	**(5,673)**	**(18,002)**	**(5,027)**

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 5 is £2.8m behind the planned £8.26m.

Cash holdings remain significant with £42.8m at the end of August. 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

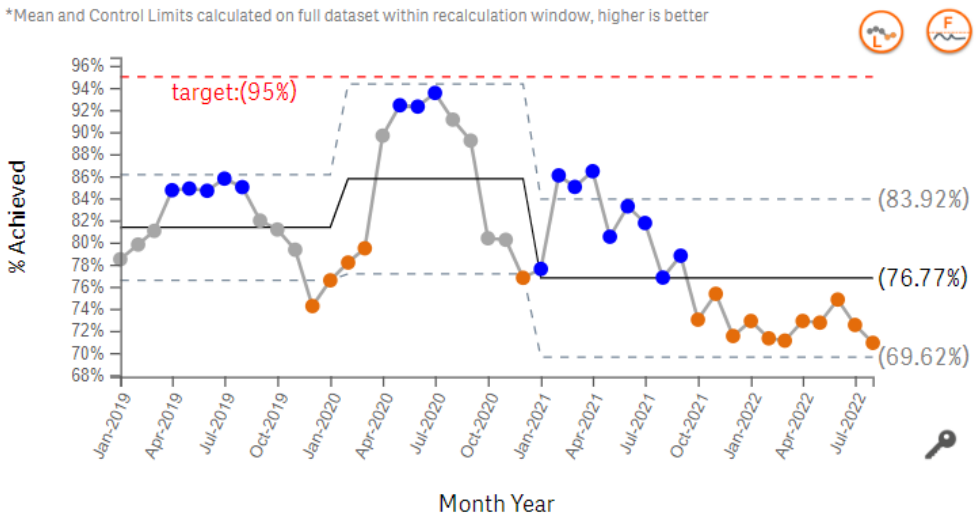
Metrics Scorecard

	Latest				
Outcome Measure	Target	Actual	Period	Variation	Assurance
ED 4 Hours (%)	95%	70.9%	Aug-22		
% of ED Attends >12 hrs	2%	6.6%	Aug-22		
Ambulance Handovers within 15 mins (%)	65%	27.4%	Aug-22		
Ambulance Handovers within 30 mins (%)	95%	57.1%	Aug-22		
Ambulance Handovers within 60 mins (%)	100%	68.4%	Aug-22		
Ambulance Handovers over 60 mins (no.)	0	229	Aug-22		
Cancer 2WW (%)	93%	83.5%	Aug-22		
Cancer 28 Day FDS (%)	75%	81.0%	Aug-22		
Cancer 31 Day (%)	96%	93.3%	Aug-22		
Cancer 31 Day Subsequent Drug (%)	98%	100.0%	Aug-22		
Cancer 31 day Subsequent Surgery (%)	94%	66.7%	Aug-22		
Number of Patients on Cancer PTL over 62 Days (no.)	71	75	Aug-22		
Cancer 62 Day (%)	69%	57.0%	Aug-22		
Cancer 62 Day Screening (%)	90%	48.5%	Aug-22		
Cancer 62 Day Upgrade (%)	85%	81.3%	Aug-22		
Cancer Treatments Beyond 62 Days (no.)	N/A	32.5	Aug-22		N/A
Cancer Treatments Beyond 104 Days (no.)	N/A	8.0	Aug-22		N/A
Diagnostic Waits > 6 weeks	1%	15.5%	Aug-22		
RTT Total Waiting List Size	26623	28982	Aug-22		
RTT <18 Weeks (%)	92%	69.5%	Aug-22		
RTT 52 Weeks (no.)	965	908	Aug-22		
RTT 78 Weeks (no.)	0	89	Aug-22		
RTT 104 Weeks (no.)	0	0	Aug-22		
OP DNA Rate (%)	4%	7.9%	Aug-22		
Follow-Ups Past IRD	27000	37417	Aug-22		
2 Hour Urgent Community Response	70%	94.9%	Aug-22		

Urgent Care Performance

ED 4hr Performance

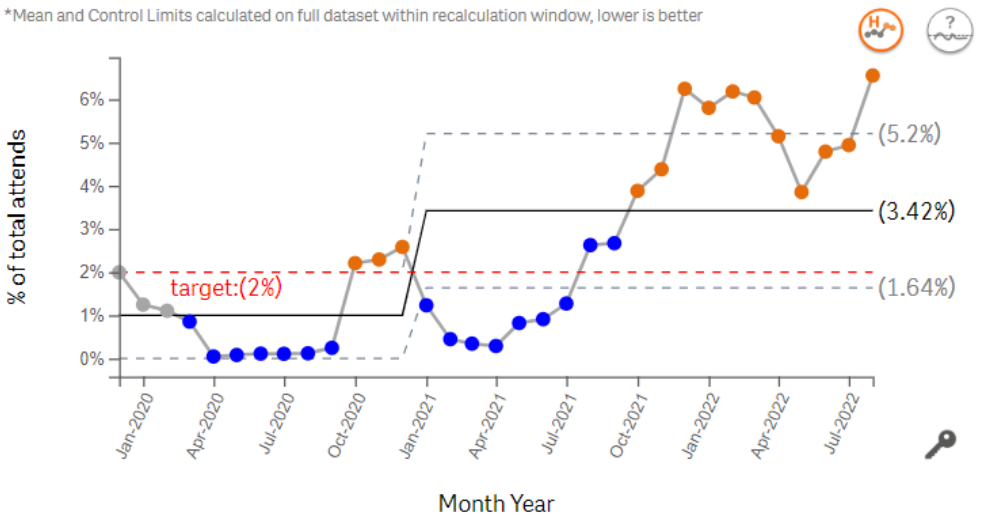
*Mean and Control Limits calculated on full dataset within recalculation window, higher is better



Latest
70.9%
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

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



Latest
6.6%
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, with mean performance of 81% before the Covid 19 pandemic, 86% to December 2020 and 76% 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 August 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 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 11 points of special cause variation- concern in the most recent months.

Actions

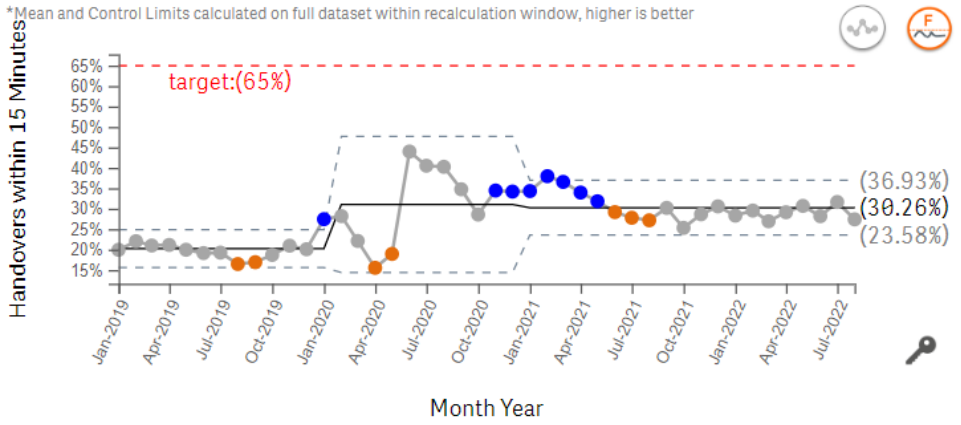
- **Same Day Emergency Care** - operational 12 hours, 5 days a week with 43% 0-day LOS. Substantive recruitment is a key focus to further expand to weekend provision.
- **Frailty & Virtual Wards** - 20 Frailty virtual ward beds have been introduced. Occupancy of the first 10 Frailty virtual beds in the first 4-weeks has been 44%. An area within the current Frailty Unit at the RLI has been designated for Frailty SDEC and is used by the FIT team to redirect circa 5-7 patients per day from the ED.
- **RLI UTC** – On track for first patients to be seen in first week in December.
- **Reducing NMC2R** – off-track against our intended trajectory for the reduction in patients with NMCR which have increased to over 150 patients (~25% of G&A beds). Discussions ongoing with ICB & LA partners, but current proposals are insufficient to assure the delivery of overall target of 12% by Dec-22.
- **Transfer of Care Hub -** Go-live of Phase 1 (discharge support) started week commencing 5th Sept-22.
- A benchmarking exercise has been identified as a requirement for ED Decongestion, and 3 further benchmarking audits are now in train for Paediatric Assessment & Mental Health.
- Clinically-led ward processes Healthcheck planned for September (EDD, C2R, LLoS, SAFER, etc)
- **Triage-** a senior clinician in ED in place from August to triage and redirect to the UTC and stream to SDEC. Implemented in August but further strengthened to ensure a consistently robust process.
- Strengthening of internal discharge processes to improve flow inc. criteria led discharge and allocation of Estimated Date of Discharge.

Assurance

- Benchmarking - ED 4 Hr (Type 1 performance)- 33rd out of 110 national Trusts in August. Although not achieving the 95% standard, UHMB is 2nd out of the 4 local Trusts within the ICB and actions within the UEC Improvement Programme are designed to improve on this position.

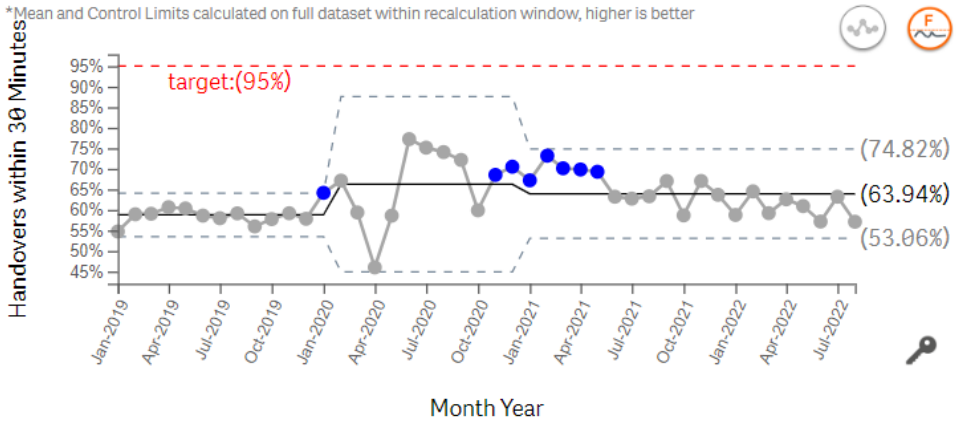
Urgent Care Performance

Percentage of Ambulance Handovers within 15 Minutes



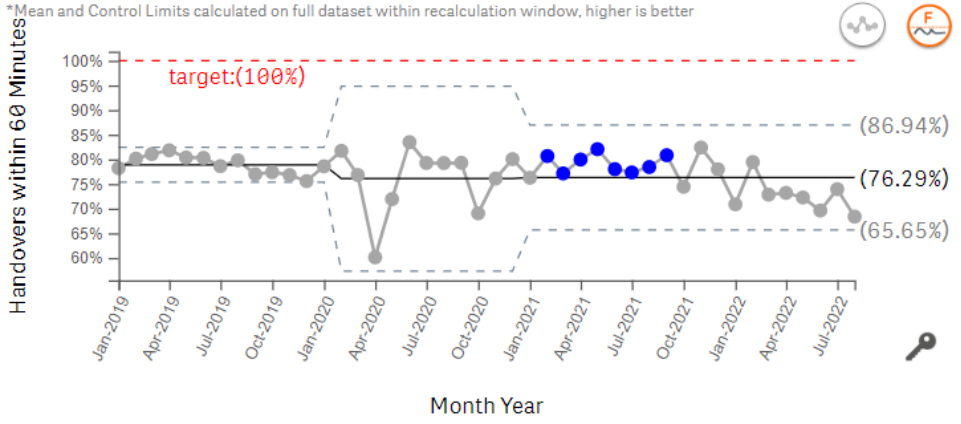
Latest
27.4%
Variance Type
Common cause variation
Target
65%
Target Achievement
The system is expected to consistently fail the target

Percentage of Ambulance Handovers within 30 Minutes



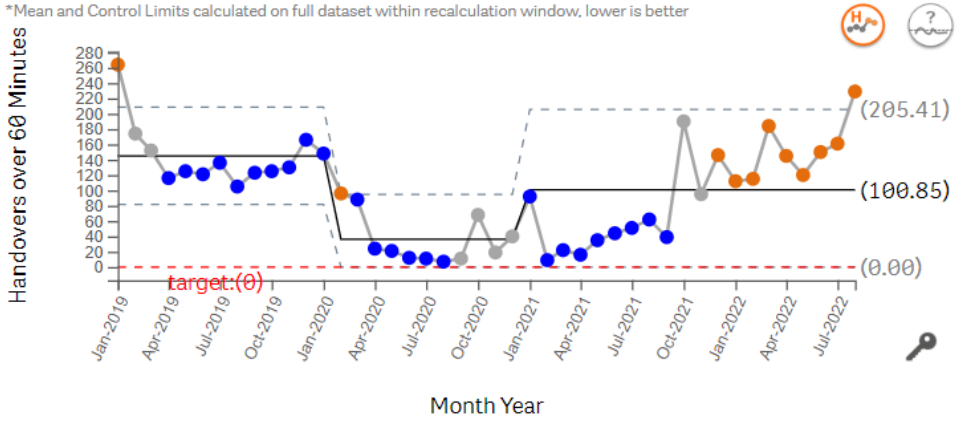
Latest
57.1%
Variance Type
Common cause variation
Target
95%
Target Achievement
The system is expected to consistently fail the target

Percentage of Ambulance Handovers within 60 Minutes



Latest
68.4%
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

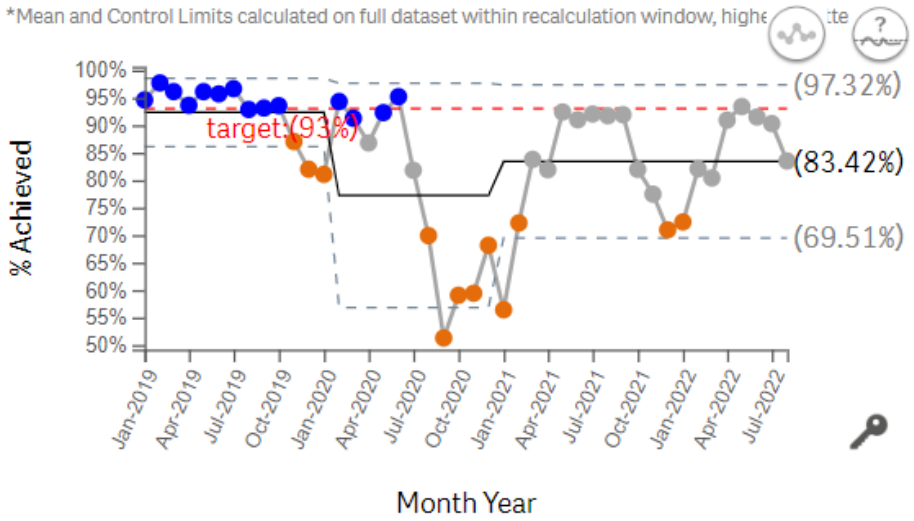


Latest
229
Variance Type
Special cause variation - cause for concern (indicator where high is a concern)
Target
0
Target Achievement
The system may achieve or fail the target subject to random variation

Summary	Actions	Assurance
% of Ambulance Handovers. Within 15 mins- the mean has improved from 20% before the pandemic to 30% since January 2020. 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**- is in special cause concern with a mean of 100 with a target of 0.	3 projects to optimize patient flow are under development within the Decongesting ED workstream; • Improve efficiencies in ambulance handovers • Ensure impactful site-coordination structures and processes which enable real time capacity and demand management • Ensure the number of patients being cared for in the corridor are minimised and patients are safe	

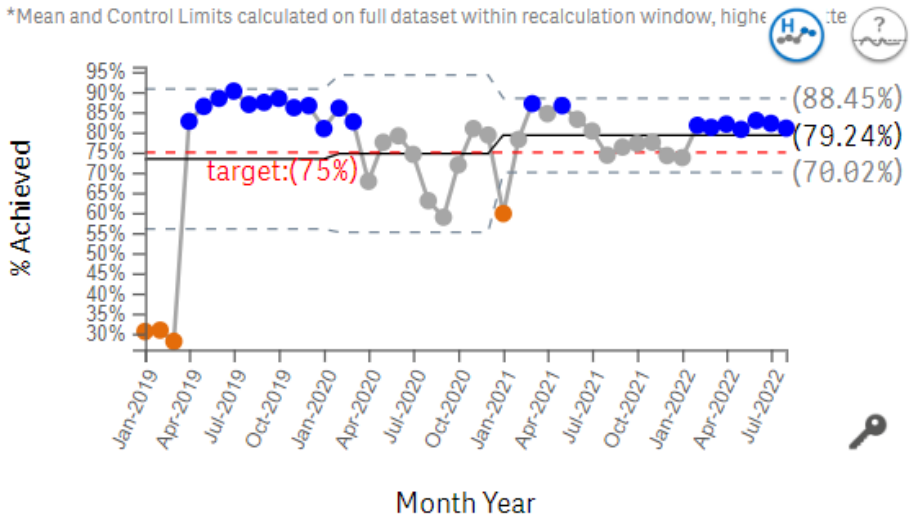
Cancer 2 Week Wait and 28 Day Faster Diagnosis Standard- August Performance

Cancer 2ww



Latest
83.5%
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



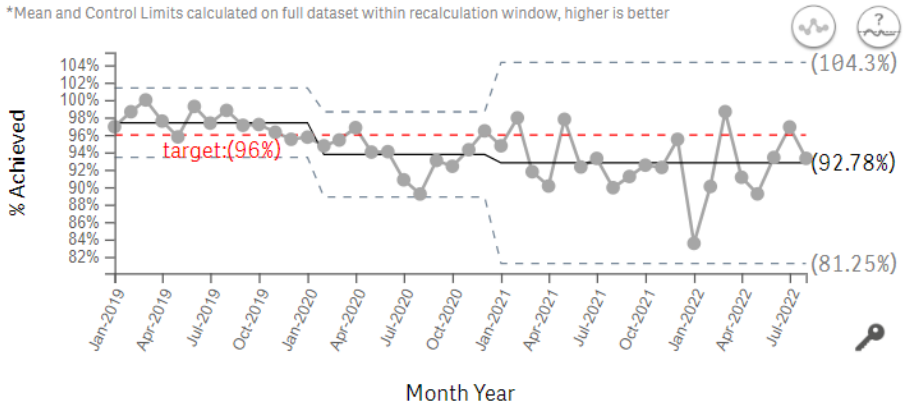
Latest
81.0%
Variance Type
Special cause variation - improvement (indicator where high is good)
Target
75%
Target Achievement
The system may achieve or fail the target subject to random variation

Summary - August Performance	Actions	Assurance
• **Cancer 2 Week Wait (C2WW)** Pre-pandemic the target was achieved before a rapid decline and is now in common cause variation, may or may not achieve the target. In August 2022, the highest number of breach patients and lowest %'s were in Gynaecology due to lack of hysteroscopy capacity (88 patients) and Colorectal (84 patients). The impact of the BMA rate has reduced the number of additional activity sessions available. • **Faster Diagnosis Standard (FDS)** – the target has been achieved for 7 consecutive months (please see the Assurance box).	Specialty level Remedial Action Plan actions: • Gynaecology – 6 additional hysteroscopy clinics per week to be provided from February 2023, with additional adhoc capacity required where possible. • Colorectal-start date to be agreed with I.S provider for super weekend clinics. Appointment of 3rd FGH Colorectal Surgeon- start date 24/10/22. • Quarterly review of outpatient capacity and demand shared, to facilitate capacity meeting demand for C2WW slots. Outcomes required-14 day target sustainably met (>93%)/ 7 day target maximised.	• The FDS standard was achieved between February and August and is predicted to achieve going forward. • FDS- In August UHMB was 1st in L&SC ICB at 81.6% and 25th of 140th overall (Target 75%/ L&SC average 68.0%).

Cancer 31 Day Performance –August Performance

Cancer 31 Day First Treatment

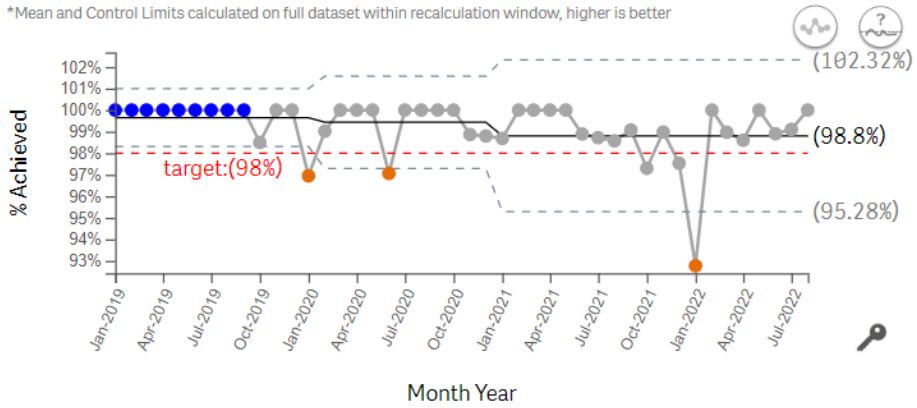
*Mean and Control Limits calculated on full dataset within recalculation window, higher is better



Latest
93.3%
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

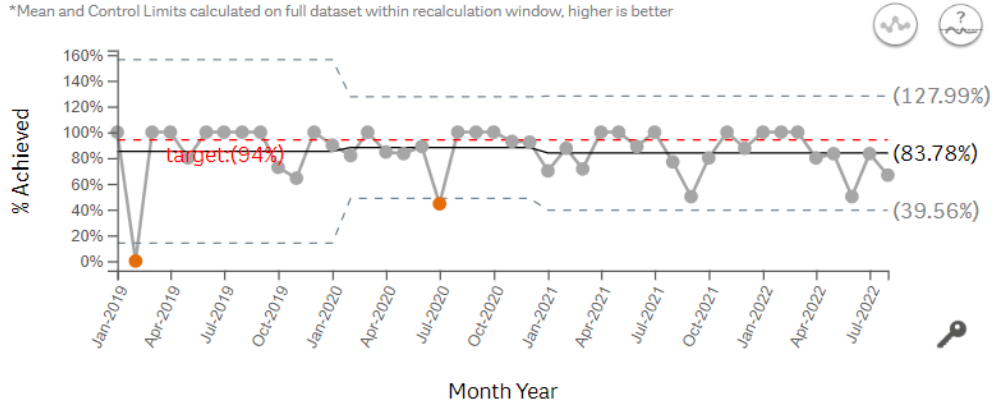
*Mean and Control Limits calculated on full dataset within recalculation window, higher is better



Latest
100.0%
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

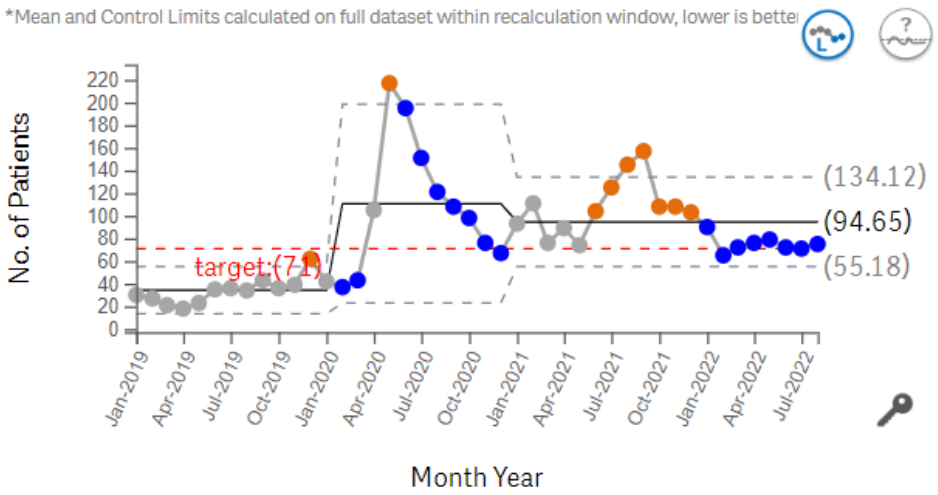


Latest
66.7%
Variance Type
Common cause variation
Target
94%
Target Achievement
The system may achieve or fail the target subject to random variation

Summary	Actions	Assurance
Cancer 31 Day 1st Treatment- was not achieved in August at 93.3% (96% standard) 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. Impact of BMA rate card upon the availability of additional activity sessions. **Cancer 31 Day Subsequent Drugs** standard was achieved in August. The standard may or may not be met due to the small numbers (103 total treatments in July). **Cancer 31 Day Subsequent Surgery-** was not achieved due to the very small numbers involved, the standard may or may not be achieved (12 total	**Breast**- plan to increase capacity at WGH- no date. Appointment of a Specialty Dr with independent working to backfill theatre lists. Target start date December 2022. T&F Group with NHSI started 19/09/22 to identify pathway blockages and plan the implementation of the national timed pathway.	• In August, UHMB C31 Day performance was ranked 1 out of 4 in L&SC ICB at 93.3% (England average 92.1%). The actions outlined are designed to achieve the 31- day standards.

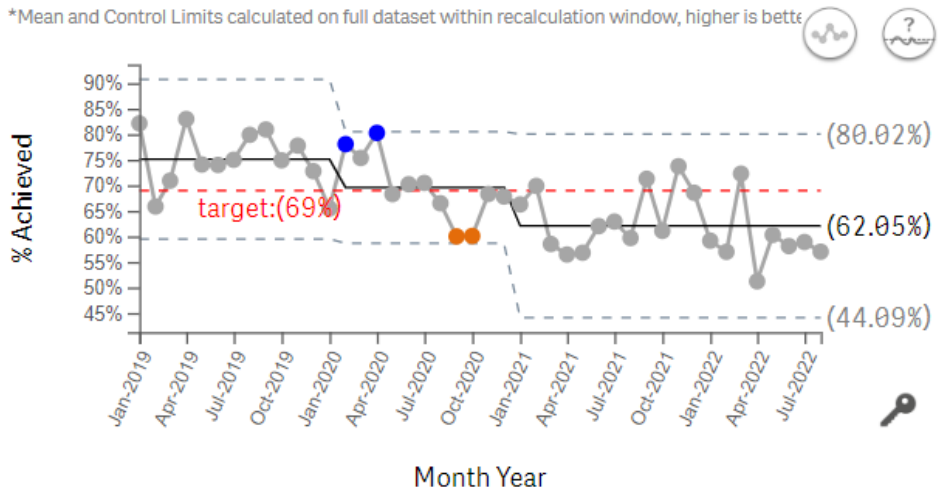
Cancer 62 Day Performance- August Performance

Number of Patients on Cancer PTL Over 62 Days



Latest
75
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



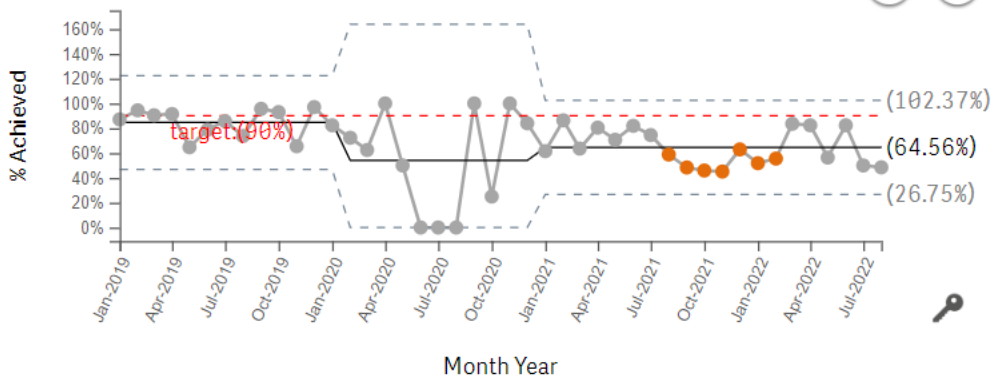
Latest
57.0%
Variance Type
Common cause variation
Target
69%
Target Achievement
The system may achieve or fail the target subject to random variation

Summary	Actions	Assurance
Patients >62 days on the PTL - The trajectory for September of 71 patients waiting was not achieved at 115.. The most recent position on 20/10/22 shows an improving position of 112 patients waiting >62 days, after a spike in numbers, earlier in October. This increase was forecast due to seasonal reduction in capacity and patient choice. The seasonal recovery in September and October has been impacted by the reduction in activity due to the BMA rate card. **C62 Day performance** The mean before the pandemic was 75% (85% target). From January 2021 the mean has reduced to 63%, with an ICS target of 69% for March 2023. The confirmed position for August is 57%, with Breast, Urology and Lung sharing 73% of the breaches. Colorectal, Gynaecology and Skin achieved the Cancer 62 day standard. Top 3 reasons for delay: 1) insufficient outpatient/diagnostic capacity in Urology for cystoscopies and precision point biopsies; 2) Outpatient capacity across tumour groups 3) Breast capacity for first appointments in previous months.	The delivery of the 62 Day Standard is dependent on 3 factors; clinical leadership, sufficient outpatient, diagnostic and theatre capacity plus the implementation of the national timed pathways. Task and Finish groups to directly deliver the pathways have been set up for the following tumour groups; • The perfect prostate pathway to match national timed pathway has been signed off with a start date of 07/11/22. • 2 mapping sessions for the perfect colorectal pathway have taken place with a further 2 to complete the pathway, including the inclusion of new national FIT guidance received 17/10/22. Sign off to be achieved by 20/11/22. • The first Task and Finish groups for Gynaecology and Breast took place w/c 19/09. Delivery dates to be agreed. • The Lead Cancer Clinician has been appointed with a start date of 26/09/22. • Mutual aid from local Trusts sought, to provide additional breast surgeon and urology cystoscopy capacity due to capacity constraints at existing tertiary providers.	• Benchmarking - in August, UHMB's C62 day performance was 99th out of 140 Trusts nationally and 2nd out of the local ICB Trusts. • The actions within the RAP and overarching across tumour group actions are designed to improve this position.

Cancer 62 Day Performance-August Performance

Cancer 62 Day Screening

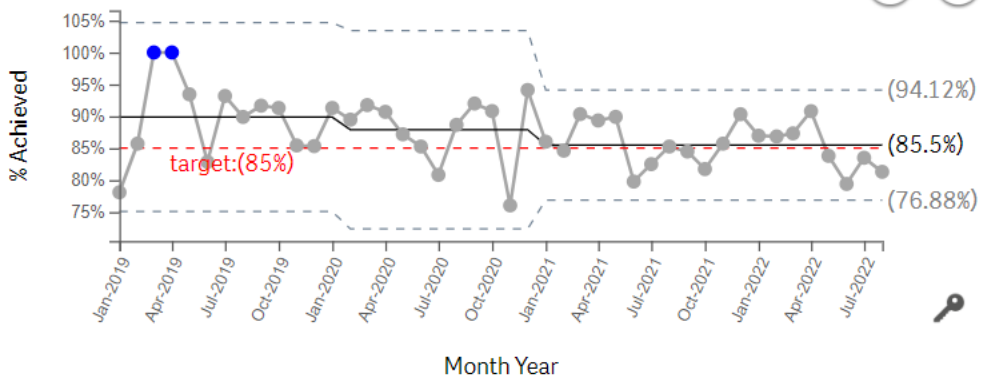
*Mean and Control Limits calculated on full dataset within recalculation window, higher is better



Latest
48.5%
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

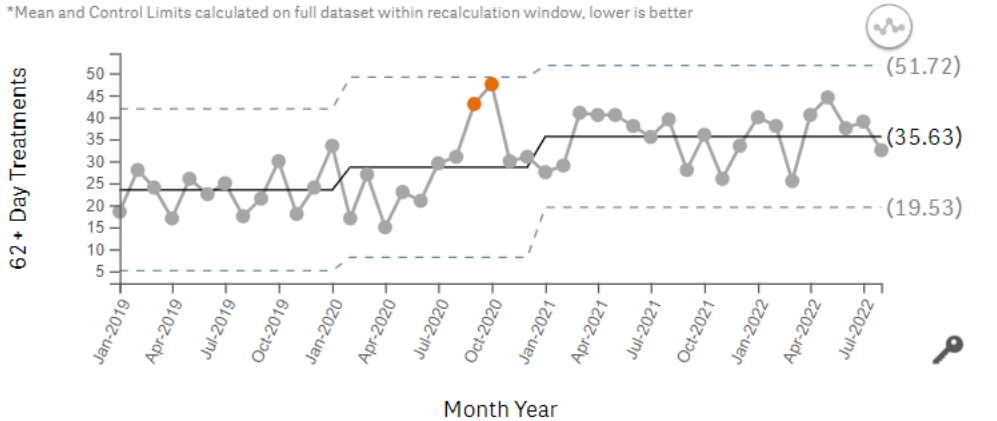
*Mean and Control Limits calculated on full dataset within recalculation window, higher is better



Latest
81.3%
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

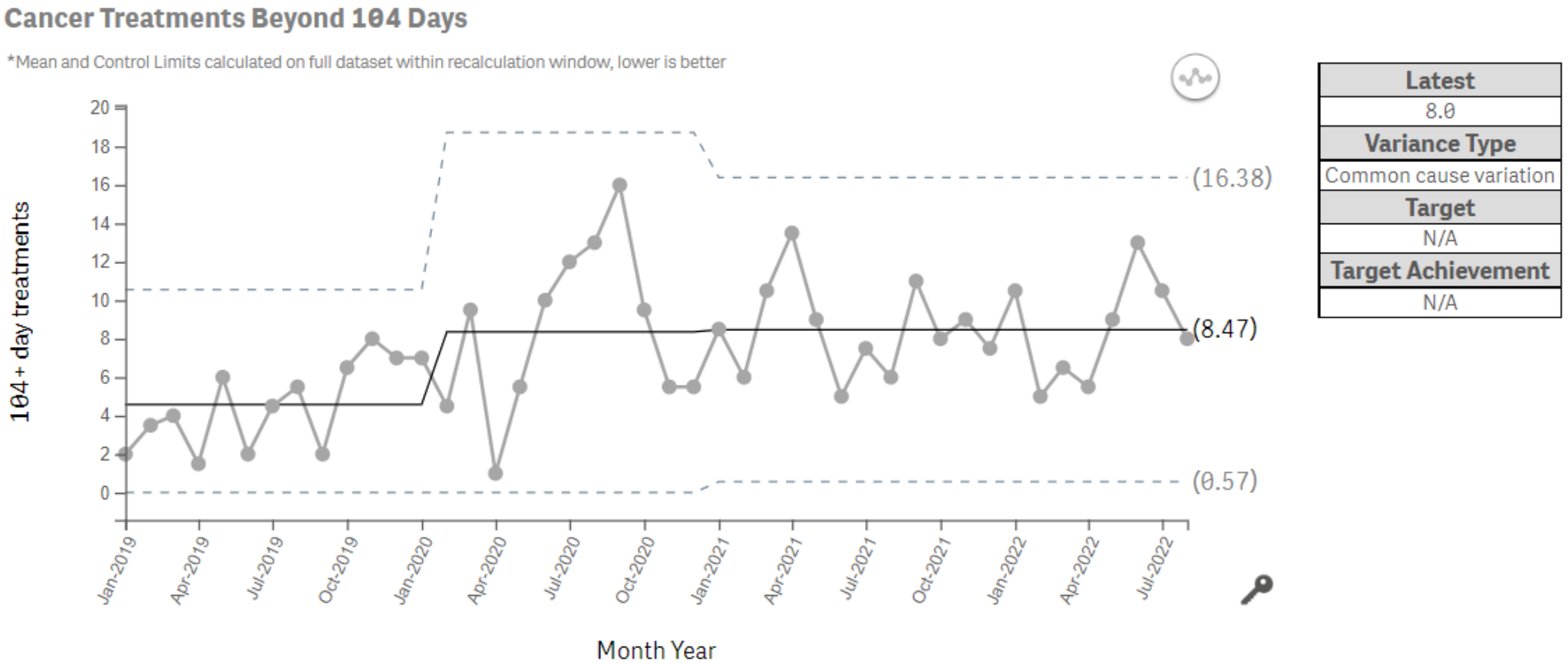
*Mean and Control Limits calculated on full dataset within recalculation window, lower is better



Latest
32.5
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 64.5%. The standard is unlikely to be consistently achieved due to the small numbers involved. **Cancer 62 Day Upgrade.** The mean has declined from 90% to 85.5% since before the pandemic. The standard may or may not be achieved due to the small numbers involved. **Cancer Treatments >62 days**- performance directly mirrors the cancer 62 day % achievement chart on the previous slide.	• Analysis of the impact of the BMA rate card- please see Assurance. • 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.	Analysis of the BMA rate card has forecast that 100% of breast patients referred on a C2WW pathway will breach the 62 day standard. Performance will decrease by 9% each month

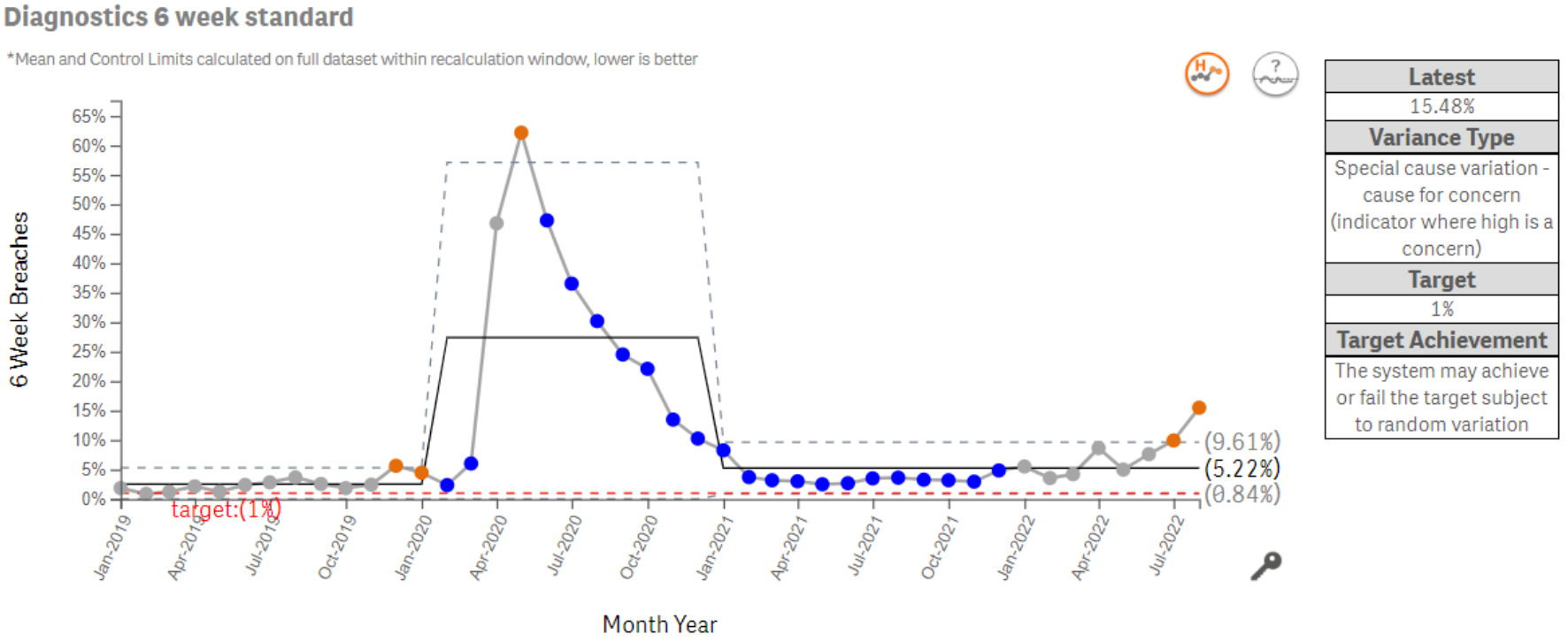
Cancer Treatments Beyond 104 Days- August Activity



Latest
8.0
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Summary	Actions	Assurance
In August, 8 cancer patients were treated >104 days after referral. The chart shows the patients with confirmed cancer with treatment in July, more than 104 days after referral. The tumour groups with the most patients waiting over 104 days for treatment in June were: Urology (4 patients), Lung (1 patient), Lower GI (1 patient), Haematology (1 patient), Skin (0.5 patients), Gynaecology (0.5 patients). There is no target for the **treatment** of patients waiting > 104 days, however there should be 0 patients **waiting** >104 days.	• The NW Long Waits Policy for Managing Long Waiting Patients will be fully implemented with the implementation of the harm process for any patient waiting >73 days on a 31-day pathway on 01/11/22. • Please see C62 Day and FDS actions for further detail.	• Targeted actions in place to ensure that no avoidable 104 day breaches take place going forward. • RCA's are completed for all 104 day breaches, in line with the Trust's standard operating procedure.

Diagnostic 6 Week Standard



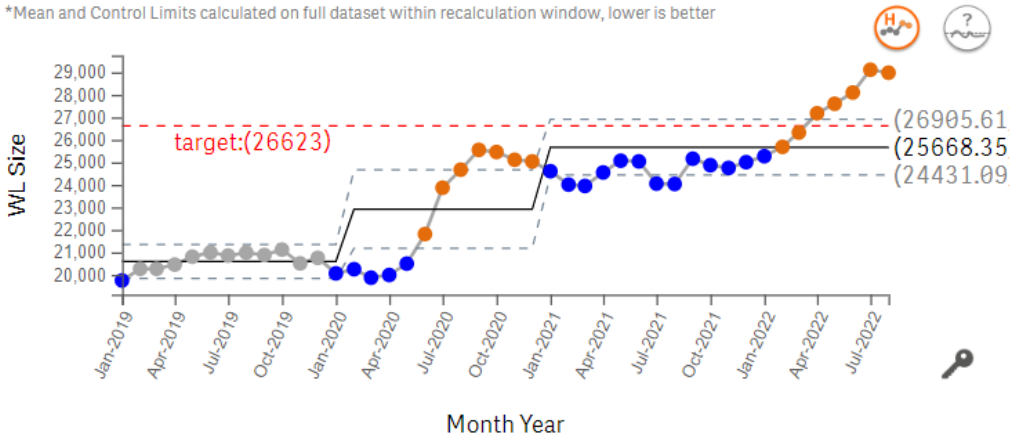
Latest
15.48%
Variance Type
Special cause variation - cause for concern (indicator where high is a concern)
Target
1%
Target Achievement
The system may achieve or fail the target subject to random variation

Summary	Actions	Assurance
Following 18 months of special cause variation-improvement, the standard is now in special cause concern and unless achieved in the next few months will predict a sustainably failing position. The most challenged modalities by number of patients are Imaging with 863 breaches (15.7%), of which 838 of the patients were waiting for Ultrasound and DEXA with 363 breaches (48.8%).	• **DEXA** – At the end of August, the total DEXA waiting list was 744 patients, against the plan of 681. 31 slots were lost in August/September due to equipment breakdown. Mitigating actions are evening and weekend additional lists, with a Locum starting in October for 13.5 hours a week. At the end of August, 14 patients were waiting over 13 weeks. Trajectories have been finalised to improve DEXA performance to 4% by end of November 2022. Latest performance at 16/10/22 is 35.93%. • **Ultrasound –** At the end of August, the total waiting list was 3652 patients, against the plan of 3709. 289 slots were delivered by AAS sessions in August, but this was 50% of the expected level due to leave and locum cover only provided 118 slots in August, against the expected 320. There continue to be unfulfilled vacancies at FGH (where there is the largest backlog of patients waiting). At the end of August, 82 patients were waiting over 13 weeks. Trajectories have been finalised to improve Ultrasound performance to 10% by November 2022. Latest performance at 16/10/22 is 17.7%.	Benchmarking - In July (latest available NHSE data) UHMB's diagnostic performance was 139th out of 342 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

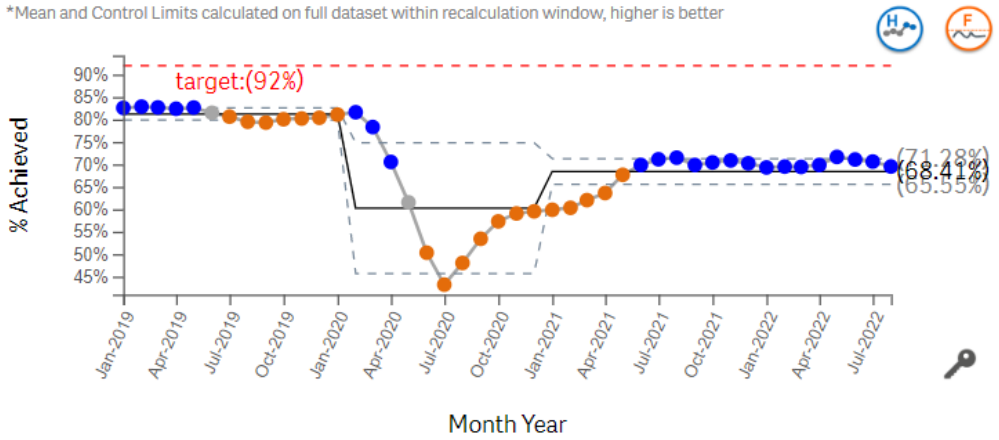
*Mean and Control Limits calculated on full dataset within recalculation window, lower is better



Latest
28,982
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

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



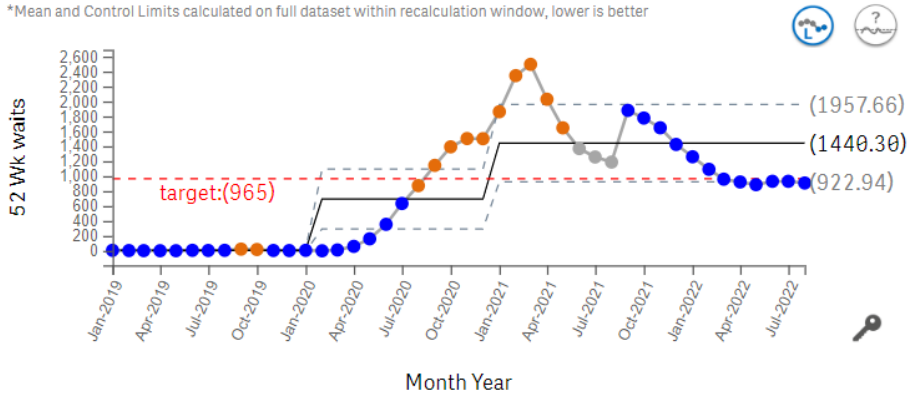
Latest
69.5%
Variance Type
Special cause variation - improvement (indicator where high is good)
Target
92%
Target Achievement
The system is expected to consistently fail the target

Summary	Actions	Assurance
Total waiting list size-Pre covid the mean was 20,500 with minimal variation, post covid the mean is 25,668 with a run of 7 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 15 months but is predicted to fail due to the distance away from the 92% standard. **Risk**- the impact of the BMA rate card on clinical willingness to undertake additional activity sessions. This will have a negative impact upon the ability to treat the longest waiting patients and achieve all RTT/long waiter trajectories. See next slide for forecast impact.	• Implementation of the NHSI/E recommendation to develop specialty level recovery plans based on capacity and demand, including quantifiable improvement actions. Remedial Action Plans (RAPs) are being refined to include quantified improvement actions across all specialties. These are being used to set Specialty level improvement trajectories by November 2022. • 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 need to be seen, 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. Since 25/07/22, 2324 patient records from targeted areas on the waiting list have been validated, with 1643 records updated with a clock stop in the past. • Colorectal/General Surgery insourcing: plans for Xyla provider to see 240 patients a week (at all main sites); transfer routine new patients to Fulwood IS provider; plus a Colorectal Locum to provide full job plan from 07/11/22 for 6 months. • Identification of additional resource to treat the longest waiting patients through mutual aid across the ICS. Mutual aid has been agreed for 31 T&O patients, to have their operations at Blackpool Victoria Hospital and 1 patient is being transferred to Wrightington.	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

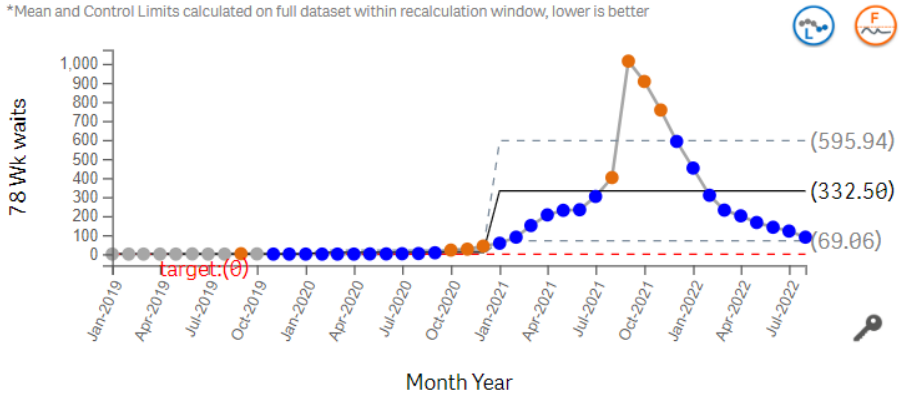
*Mean and Control Limits calculated on full dataset within recalculation window, lower is better



Latest
908
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

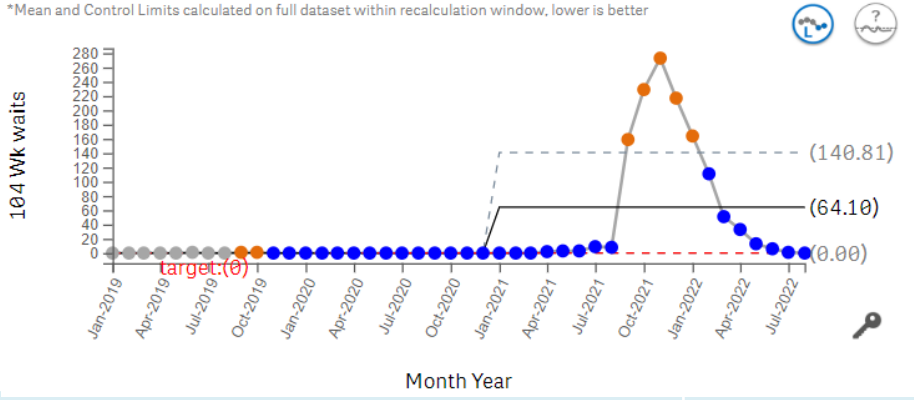
*Mean and Control Limits calculated on full dataset within recalculation window, lower is better



Latest
89
Variance Type
Special cause variation - improvement (indicator where low is good)
Target
0
Target Achievement
The system is expected to consistently fail the target

RTT 104 Week Waits

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



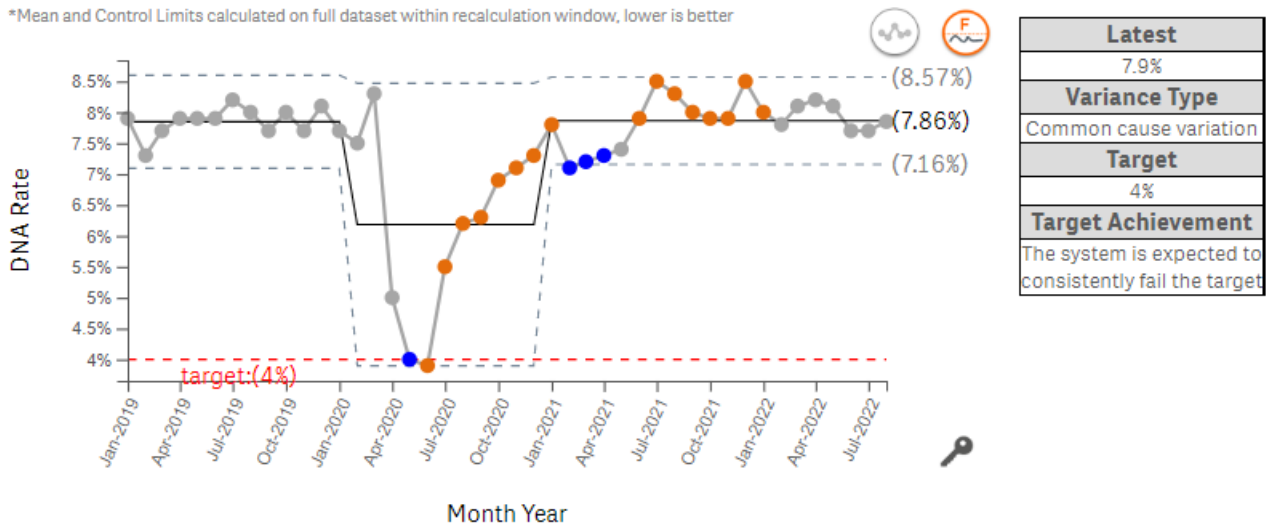
Latest
0
Variance Type
Special cause variation - improvement (indicator where low is good)
Target
0
Target Achievement
The system may achieve or fail the target subject to random variation

Summary	Actions	Assurance

52 Weeks- pre-pandemic the mean was 0 patients, which has increased to 1440 since Jan 2021. The last 12 months have been in special cause improvement and the target may or may not be achieved. **The 78 week target** mirrors the 52-week position but is predicted to fail as the lower process limit is above the target. **104 week waits-** the standard has been in special cause variation –improvement, but the impact of the BMA rate card will adversely impact capacity (see Actions section).
There were no patients waiting over 104 weeks at the end of August.
	• Impact of the BMA rate card: refreshed analysis has put the risk of reduced AAS sessions impacting on waiting times at March 2023 as:
	  • If no further AAS, 3349 patients over 52 weeks (trajectory was 965)
	  • If AAS resumed from Nov 22, 1967 patients over 52 weeks
	  • If no further AAS, 928 patients over 78 weeks (trajectory was 0)
	  • If AAS resumed from Nov 22, 38 patients over 78 weeks
	  • If no further AAS, 12 patients over 104 weeks (trajectory was 0)
	  • If AAS resumed from Nov 22, 0 patients over 104 weeks
	• This accounts for services not undertaking AAS plus the impact of reduced baseline activity in order to cover trauma/on call commitments.
		UHMB was 2nd out of the 4 local ICB Trusts for patients waiting over 52 weeks on 18/09/22, with 8.8% of the L&SC total.
		
		UHMB was also 2nd out of the 4 local ICB Trusts for patients waiting over 104 weeks on 18/09/22, with 2.8% of the L&SC total.
		
		The actions within the Remedial Action Plans are designed to achieve the trajectories.

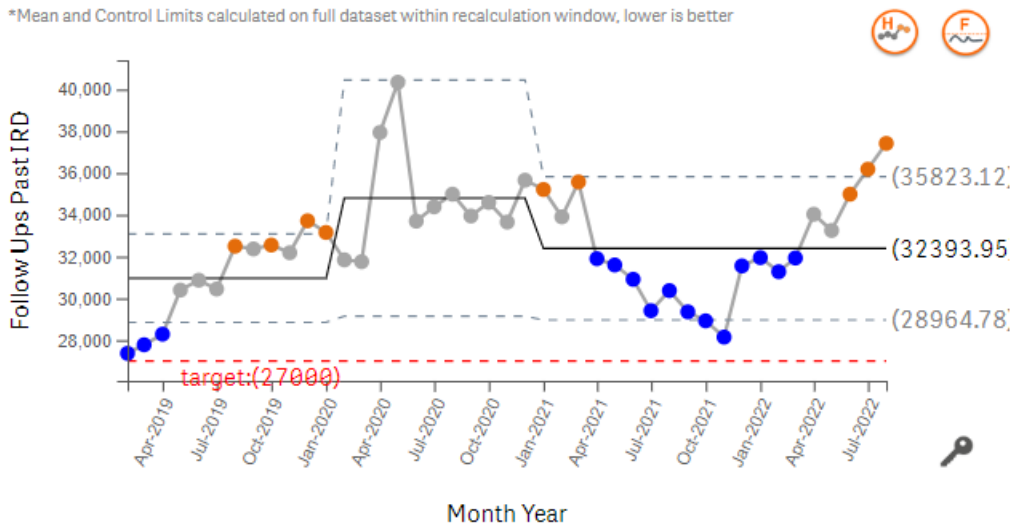
Did Not Attend and Follow-Up Patients Past the Indicative Review Date

OP DNA Rate



Latest
7.9%
Variance Type
Common cause variation
Target
4%
Target Achievement
The system is expected to consistently fail the target

Follow Ups Past IRD



Latest
37,417
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 August was 7.9% against a best practice target of 4%. **Follow ups past IRD** are in a period of special cause concern, with an increase to 37,417. The mean has increased from 31,000 pre pandemic to 32,393 from January 2021.	**DNA:** • Plan to roll out fully enabled ERS booking which allows patients to choose their appointment dates at a time that suits them. In 2022-23 to date, 44.3% 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 August was 20.8%, with trajectory of 25% for March 2023. **Follow-ups**: • Report being developed to highlight instances of a mismatch between the E-outcome clinical review date intention and the actual review date on Lorenzo. Impact to be included in November IPR. Correcting these review dates may reduce the backlog of follow-up patients waiting.	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

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 to level C from level D in the SSNAP score.

	FGH	Q2	Q3	Q4	Q1
1	Scanning	A	A	A	A
2	Stroke Unit	B	B	C	B
3	Thrombolysis	B	C	A	B
4	Specialist Assessments	A	A	A	A
5	Occupational Therapy	B	C	B	C
6	Physiotherapy	C	C	B	C
7	Speech and Language Therapy	C	C	B	C
8	MDT Working	C	C	B	B
9	Standards by Discharge	B	C	B	B
10	Discharge Processes	B	B	C	A

1) Out of hours scan times remain a focus
2) Breach meetings continue cross bay
3) Improvements shown averaging 20%
4) Remains good at FGH
5) Improvements shown
6) Improved but staffing issues
7) Additional staff recruitment in process
8) Focus for Q3
9) Small changes required
10) Documentation changes on Lorenzo will improve this

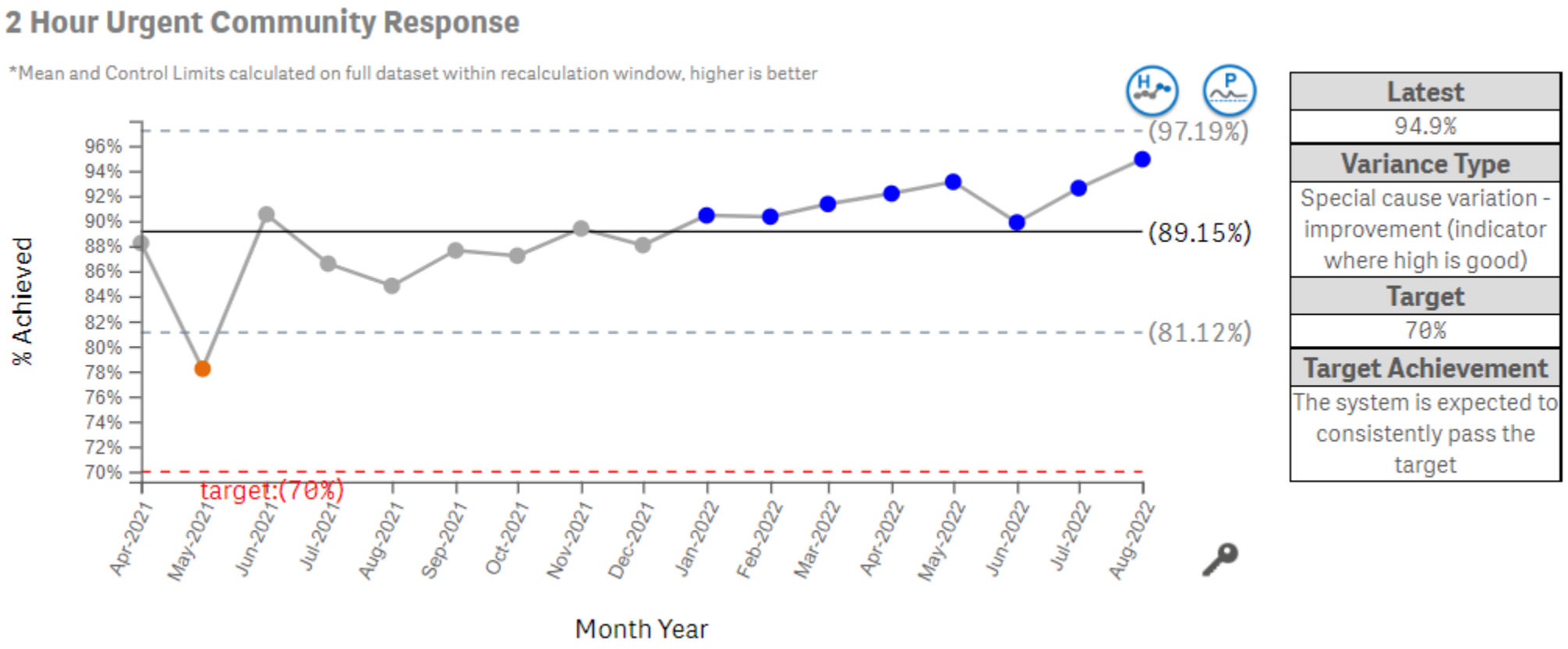
	RLI	Q2	Q3	Q4	Q1
1	Scanning	A	A	A	A
2	Stroke Unit	D	D	D	D
3	Thrombolysis	D	D	E	E
4	Specialist Assessments	B	B	B	C
5	Occupational Therapy	D	C	C	C
6	Physiotherapy	D	D	D	C
7	Speech and Language Therapy	E	D	D	E
8	MDT Working	D	D	D	D
9	Standards by Discharge	C	B	C	B
10	Discharge Processes	A	A	A	A

1) Good overall with continual monitoring
2) Ring fenced beds a key focus
3) Improving trajectory
4) First line assessments improving weekly
5) Staffing plans in place
6) Staffing plans in place - recruitment
7) Additional recruitment continues
8) Improvements made in documentation
9) improvements in process showing good outcomes
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
94.9%
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 8 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

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%**	

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	SHMI	Green	N/A	101.44	102.07	100.4
Overall	HSMR	Green	N/A	101.54	100.84	99.88
HED Alert	SHMI	Red	Peripheral and visceral atherosclerosis	193.61	202.95	233.25
HED Alert	SHMI	Red	Fracture of neck of femur (hip)	174.01	168.69	178.85
HED Alert	HSMR	Amber	Fracture of neck of femur (hip)	158.07	168.32	167.05

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		

REPORT TO BOARD OF DIRECTORS

DATE OF MEETING: 26 October 2022

University Hospitals of Morecambe Bay NHS Foundation Trust

CHAIR'S REPORT

Reporting Group/Committee:	People Committee			
Data and time:	3 October 2022 at 9am			
Chairperson	Adrian Leather Non-Executive Director			
Attendance:	**Quorate:**	Yes	**Not Quorate:**	
If not quorate, state reason:				
Key items discussed:	1. People and OD Risk Report			
	2. Financial Wellbeing Update			
	3. CQC/RCS/Niche Improvement Plan Update			
	4. Medical Workforce Update			
	5. Policy Development Update			
	6. Cultural Transformation Programme Update			
	7. Flourish Strategy for 2022-2027			
	8. Health and Wellbeing Action Plan 2022/23			
	9. External HR Review Update			
	10. Freedom to Speak Up Update			
	11. Safe Staffing Recovery Support Programme Exit Report			
	12. People & OD Integrated Performance Report			
	13. Employee Relations – Hotspots Progress Update			
	14. National Staff Survey 2022			
Alert:	1. There are 17 overdue risks, 5 of which are high value.			

(where a matter needs sharing with another committee/Board in relation to areas of non-compliance or matters that need addressing urgently with details of actions taken to address the matter.)	2. Concerns around the BMA Rate Card relating to Consultants and SAS doctors with negotiations being held this week.
	3. Concerns around Job Planning not being completed with an impact on Waiting List Initiative work.
	4. Consultant and Midwifery recruitment remains a concern with actions being taken to address.
	5. Demand for psychological support continues to grow with further training and development place for the team to increase capacity.
Advise: (where there is a matter that has on-going monitoring and any new developments need sharing to the committee/Board)	1. The number of colleagues who have attended the Leadership Development Programme is 772 with the process being on schedule; however, there may be winter pressures going forward.
	2. Although UHMB lost some of the extensions for completion of Core Skills Training, there has been a strong recovery with a positive overall impact.
	3. National Staff Survey has launched – UHMB current response rate 11.3%, which is above the national average of 7.6%
Assure: (where an update has been provided to the Committee and assurance has been received)	1. Plans are being put in place to support Care Groups around the potential industrial action.
	2. Plans and actions are continuing to support colleagues with the cost of living issues via the Financial Wellbeing Strategy Group; this includes overall health and wellbeing and the impact of the potential industrial action.
	3. Work continues to progress outstanding policies for review with an additional Policy Development meeting taking place on 17 Oct with the regular meeting on 18 Oct.
	4. The Health & Wellbeing Action Plan is progressing as part of the overall Flourish Strategy and actions have been identified to meet the needs of colleagues.
	5. The People Committee were assured by the safe staffing progress and compliance with the exit criteria for the RSP.
	6. Agency spend has reduced and continues to be monitored.
	7. EASE service has been successfully rolled out to support colleagues in their first few days of absence.
	8. Covid vaccine roll out starts w/c 03 Oct; flu vaccine starts w/c 10 Oct.
	9. Workforce Cell has been re-established to support all colleagues in light of approaching winter pressures.
	10. Progress continues to be made on Employee Relations cases .
Name of committee for escalation: (parent committee)	Board of Directors

Chair's Narrative on the meeting: (if applicable, covering points otherwise not discussed elsewhere in the template)
Date, Time & Location of next meeting: Monday 28 November 2022 at 1.30pm via Microsoft Teams.

Please note, it is the Chair of this Group's/Committee's responsibility to share feedback from any other Committee this report is shared with at the next meeting of this Group/Committee.

THIS PAGE IS INTENTIONALLY BLANK

REPORT TO BOARD OF DIRECTORS

DATE OF MEETING: 26 October 2022

University Hospitals of Morecambe Bay NHS Foundation Trust

CHAIR'S REPORT

Reporting Group/Committee:	Audit Committee			
Data and time:	20 October 2022 at 9am			
Chairperson	Sarah Rees Non-Executive Director			
Attendance:	**Quorate:**		**Not Quorate:**	Not quorate
If not quorate, state reason:	The Chair of the Audit Committee was unable to attend the meeting on the day of the meeting.			
Key items discussed:	1. Reports from the external and internal auditors			
	2. Report from the Head of Financial Services			
	3. Board Assurance Framework Update			
	4. Report on Fraud Risk Exercise			
	5. Report on the application of the Fit and Proper Person Policy			
Alert: (where a matter needs sharing with another committee/Board in relation to areas of non-compliance or matters that need addressing urgently with details of actions taken to address the matter.)	1. The meeting was not quorate. It was agreed to ensure the attendance of at least 4 Non-Executive Directors to guarantee future meetings were quorate.			
Advise: (where there is a matter that has on-going monitoring and any new developments need sharing to the committee/Board)	1. The challenge around vesting certificates at year-end would be raised nationally.			
	2. The Committee supported that the current generic fraud risk be closed, and seven thematic risks be assessed and captured on the risk register.			
Assure: (where an update has been provided to the Committee and assurance has been received)	1. MIAA (internal auditors) explained that the regular meetings with Sarah Nicholls, Finance Manager, had resulted in really good progress in reducing the number of outstanding recommendations.			
Name of committee for escalation: (parent committee)	Board of Directors			
Chair's Narrative on the meeting: (if applicable, covering points otherwise not discussed elsewhere in the template)				

Date, Time & Location of next meeting: Thursday 19 January 2023 at 9am in the Board Room, Westmorland General Hospital and also via Microsoft Teams.

Please note, it is the Chair of this Group's/Committee's responsibility to share feedback from any other Committee this report is shared with at the next meeting of this Group/Committee.

REPORT TO BOARD OF DIRECTORS

DATE OF MEETING: 26 October 2022

University Hospitals of Morecambe Bay NHS Foundation Trust

CHAIR'S REPORT

Reporting Group/Committee:	Finance and Performance Committee			
Data and time:	26 September 2022 at 10am			
Chairperson	Steve Ward Non-Executive Director			
Attendance:	**Quorate:**	Yes	**Not Quorate:**	
If not quorate, state reason:				
Key items discussed:	1. M5 financial and operational reports			
	2. Insurance renewals			
	3. National Cost Collection return			
	4. CQC update			
Alert: (where a matter needs sharing with another committee/Board in relation to areas of non-compliance or matters that need addressing urgently with details of actions taken to address the matter.)	1. Awaiting formalised positions to provide assurance in respect of the ICS stretch income component of the financial plan which threatens to increase the UHMB deficit. The system process and output/recommendation will be reported to the PCB and is absorbing significant amounts of CFO time.			
	2. Increasing Care Group expenditure run rates and slippage in CIP achievement have been offset by a combination of cost pressure mitigations, non-recurrent solutions and technical measures year to date, pressure will increase and opportunity to offset is reduced in remainder of the year.			
	3. New BMA rate card will reduce additional activity sessions and impact on Surgery services in-particular.			
	4. No progress on additional measures to provide the additional domiciliary or residential care required to alleviate unscheduled care pressures driven by the volume of patients not meeting criteria to reside.			
Advise: (where there is a matter that has on-going monitoring and any new developments need sharing to the committee/Board)	1. Approved renewal of insurances noting limited availability of cyber risk cover.			
	2. Supported new contract for electricity supply incorporating Government cap.			

Assure: (where an update has been provided to the Committee and assurance has been received)	1. Round 3 of Performance Accountability Framework meetings showed improvement in some Care Groups while overall clinical engagement was limited.
Name of committee for escalation: (parent committee)	Board of Directors
Chair's Narrative on the meeting: (if applicable, covering points otherwise not discussed elsewhere in the template)	
Date, Time & Location of next meeting: Monday 24 October 2022 at 10am via Microsoft Teams.	

Please note, it is the Chair of this Group's/Committee's responsibility to share feedback from any other Committee this report is shared with at the next meeting of this Group/Committee.

REPORT TO BOARD OF DIRECTORS

DATE OF MEETING: 26 OCTOBER 2022

University Hospitals of Morecambe Bay NHS Foundation Trust

CHAIR'S REPORT

Reporting Group/Committee:	Quality Assurance Committee			
Data and time:	17 October 2022 13.00 – 16:00			
Chairperson	Hugh Reeve Non-Executive Director			
Attendance:	**Quorate:**	Yes	**Not Quorate:**	
If not quorate, state reason:				
Key items discussed:	1. Integrated Performance Report			
	2. Progress Report on Care Quality Commission & Royal College of Surgeons Improvement Plan			
	3. Monthly Maternity Assurance Report			
	4. ATAIN Report			
	5. Quarterly Maternity Safety Champions Report			
	6. Quarterly Covid Infection Prevention Board Assurance Framework			
	7. Quarterly Fundamentals of Care			
	8. Commissioners' Local Quality and Reporting Requirements			
	9. Care Group Quarterly Report – Core Clinical			
	10. Care Group Quarterly Report – Integrated Community Care			
	11. Stroke Improvement Update			
	12. Bowel Cancer Screening Update			
	13. Annual Cervical Screening Update			
	14. Royal College of Surgeons Trauma and Orthopaedic Review			
	15. Patient Experience Quarterly Report			

	16. Patient Relations Annual Report
	17. Risk Register Report
	18. Quarter 2 – Operational Plan Priorities and Board Assurance Framework
	19. SI Panel 3 A Report
	20. QGPS 3 A Report
	21. Executive Review Group 3 A Report
	22. RSA 3 A Report
	23. Patient Safety Group 3 A Report
	24. Niche External Investigation Assurance
Alert: (where a matter needs sharing with another committee/Board in relation to areas of non-compliance or matters that need addressing urgently with details of actions taken to address the matter.)	1. A number of actions in the CQC action plan will not be completed as intended by the end of October 22. **Actions: The QAC has asked that these delays be reviewed in terms of any impact on patient safety, and assurance has been requested on the mitigating actions being taken to address any issues that arise.**
Advise: (where there is a matter that has on-going monitoring and any new developments need sharing to the committee/Board)	1. The Royal College of Surgeons Trauma and Orthopaedic closure report was received and accepted. **Actions: The QAC has asked the Director of Governance to develop a standard process by which the Trust revisits the actions/outcomes of reviews such as this. This approach will apply to both internal and external reviews.**
	2. The Stroke Improvement Update was received indicating significant improvements achieved over the past 18 months at both sites, although further key improvements need to occur at RLI, in part related to the estate that is being updated at present. **Actions: A broader approach to stroke improvements (encompassing more than the SSNAP targets) will be implemented from now on including national standards and regional priorities.**

	3. Virtual wards – the Integrated Community Care Group is making good progress with implementing virtual beds in the community. The current staff capacity can service 19 virtual beds which are not at present fully utilised, mainly due to unfamiliarity with this concept of care across the local health system. **Actions: Various actions are being taken by the Care Group to familiarise staff both in hospital and community based, with this approach, using a Patient Story along with others communication approaches.**
Assure: (where an update has been provided to the Committee and assurance has been received)	1. The Core Clinical Care Group has cleared the histology reporting backlog and is now achieving target turnaround for both urgent (suspected cancer) and routine reports. **Actions: Continued focus is being maintained on the suspected cancer reporting timelines.**
	2. The Cervical Screening Provider Annual Report was received which shows the Trust's Colposcopy and Histology services have not only achieved all of the national requirements but have exceeded many of them, providing an excellent, quality assured Cervical Screening Service to our local population. **Actions: No specific actions required.**
Name of committee for escalation: (parent committee)	Board of Directors
Chair's Narrative on the meeting: (if applicable, covering points otherwise not discussed elsewhere in the template)	
Date, Time & Location of next meeting:	
Monday 21 November 2022 at 13.00 via Microsoft Teams.	

Please note, it is the Chair of this Group's/Committee's responsibility to share feedback from any other Committee this report is shared with at the next meeting of this Group/Committee.

THIS PAGE IS INTENTIONALLY BLANK

BOARD OF DIRECTORS

Date of Meeting	26 October 2022
Title	Quarter 2 Review 2022/23
Report of	Aaron Cummins, Chief Executive
Prepared by and contact details	Suzanne Hargreaves, Associate Director of Strategy & Transformation suzanne.hargreaves@mbht.nhs.uk Paul Jones, Company Secretary paul.jones4@mbht.nhs.uk

Confidentiality	Non-Confidential

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

The purpose of this report is to:

- provide the Board with a review of progress made in Q2 against the Trust key area of focus;
- Identify the key priorities for Q3/4 period; and
- Invite the Board to consider the Board Assurance Framework.

Summary of Key Issues

Q2 Review of Operational Plan Priorities

As part of our governance process we provide a quarterly report to the Board on progress made against our Operational Plan priorities / Key areas of focus.

The Key Actions Resulting from Quarter 1 Review were:

To address our challenge around pace we will ensure greater collaboration across Care Groups and teams to support delivery.

- Prioritise the health & wellbeing of our colleagues;
- Development of our clinical strategy;
- Development of virtual ward capacity for implementation of first cohort beds by September 22;
- Implementation of our Performance Accountability Framework;
- Focus on expenditure control and delivery of financial efficiencies;
- Progress our improvement programme workstreams;
- Continue to drive improvements in elective and urgent care; and
- Progress work to align and develop 'live' planning function.

Review of progress made in Q2 against our key areas of focus; any emerging risks and identification of priorities and actions required in Q3/4 is scheduled on 21 October at the TMG (Trust Management Group) away day; therefore the detail of the review will follow.

	Review of Board Assurance Framework The Board Assurance Framework will be revised further following the TMG away day and will be circulated at the same time as the Q2 review. The Board is asked to review the Board Assurance Framework in the light of the Q2 review.

Prior Discussions	Committee	Date	Recommendations/ Concerns
	Trust Management Group	21 October 2022	To be confirmed following the session

Action to be recommended to the Committee/Board	The Board is asked to :- 1. Consider the progress made in Quarter 2 2. Discuss any specific risks 3. Agree the actions and focus for Quarter 3/4 4. Consider proposed revisons to the Board Assurance Framework

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	

BOARD OF DIRECTORS

Date of Meeting	26 October 2022
Title	Integrated Care Board (ICB) Update / Provider Collaborative Board (PCB) Update
Report of	Aaron Cummins Chief Executive
Prepared by and contact details	Paul Jones Company Secretary

Confidentiality	Non-Confidential

Purpose of Report	**To Advise/Alert**	**To Assure**	**To Approve**	**To Update**
		x		
	In the Chief Executive's Report, an overview of the work of the ICB and the PCB was provided. The purpose of this paper is to present further detail on the most recent meetings of the ICB and the PCB.			

Summary of Key Issues	A meeting of the ICB took place on 12 October 2022; the main agenda items were as follows: • Finance Performance Report; • Performance Report; • Urgent and Emergency Care – Deep Dive; • Approach and oversight for the urgent and emergency care assurance framework; • Emergency Preparedness, Resilience and Response / Business Continuity policies; and • Lancashire and South Cumbria Clinical Commissioning Groups: 2021/22 Annual Reports and Accounts. An overview from the PCB is attached to this report including an update on establishing a single L&SC Collaborative Bank.

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

Action to be recommended to the Committee/Board	The Board of Directors is asked to consider the contents of the report and note the progress with the programmes of work within the ICB and the PCB.

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 is a risk to the Trust's ambitions to achieve integrated care across the Bay area. Seeking assurance on the work pf the ICS and PCB will reduce the risk			
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

Overview from the Integrated Care System Board

Finance Performance Report

1. An update was given on the latest reported financial position at the end of August 2022, an assessment of the risks and details on the actions required to ensure the system can achieve its 2022-23 financial targets. As at the end of August 2022 (month 5) the ICB is £35.1m off the expected plan position. This position is largely driven by slippage against savings plans for all organisations. The operational pressures in the system are impacting on the financial positions but all organisations are working to deliver their plans with a focus on ensuring recurrent impact for 2023/24

Performance Report

2. An update was given on the performance of the Lancashire and South Cumbria health care system. Work had commenced to further develop the ICB performance framework and to develop an integrated performance report with appropriate balance scorecards to enable the ICB to maintain oversight of progress against their strategic priorities and enable them to respond to identified and emergent risks.

Urgent and Emergency Care – Deep Dive

3. An overview was given on the Lancashire and South Cumbria urgent and emergency care system. The deep dive covered

    • Context
    • Constitutional requirements
    • Performance against current key metrics
    • Current challenges
    • Key risks
    • Mitigation and immediate actions.

Approach and Oversight for the Urgent and Emergency Care Assurance Framework

4. An overview was given on the planned Lancashire and South Cumbria (LSC) approach to the Urgent and Emergency Care Assurance Framework which included winter planning.

Emergency Preparedness, Resilience and Response / Business Continuity Policies

5. A report which set out the submission of the ICB Emergency Preparedness, Resilience and Response (EPRR) Policy and ICB Business Continuity Policy. The report provided a summary of the EPRR work programme next steps.

Lancashire and South Cumbria Clinical Commissioning Groups: 2021/22 Annual Reports and Accounts

6. The report summarised the process and governance stages undertaken by Lancashire and South Cumbria Clinical Commissioning Group prior to disestablishment on 30 June 2022, and for the receipt and publication of the respective 2021/22 Annual Report and Accounts.

Next Meeting of the ICB

7. It was noted the next meeting of the ICB would take place on Wednesday 2 November 2022.

8. Please see link below to access the meeting of the Integrated Care Group.

   Lancashire and South Cumbria Integrated Care Board :: Meetings and papers (icb.nhs.uk)

Overview from the Provider Collaboration Board

9. An Overview from the Provider Collaboration Board meeting on 15 September 2022 is attached to this report.

10. At the meeting on 15 September 2022, the agenda items included:

    - Performance update - urgent/emergency care and mental health and learning disabilities;
    - Financial update;
    - Corporate collaboration update;
    - Clinical Strategy update; and
    - Pathology collaboration update.

11. Work continues developing an effective governance framework for the PCB to support its operations.

12. The next meeting of the PCB is scheduled for 20 October 2022.

13. The Board at its last meeting asked to be kept informed on PCB activity regarding Bank and Agency. Included on the Agenda for 20 October 2022 is an update on bank and agency. The paper gives an analysis of the current workforce picture across the ICS. The paper notes there is a need to develop solutions that can facilitate delivery of a challenging agency ceiling of £80.5m for the financial year 2022-23, which represents a 29% reduction on previous years costs. The £80.5m is the aggregate sum of each Trusts agency plan. The report recommends establishing a single L&SC Collaborative Bank. If approved the programme will be led by an Oversight Steering Group.

Recommendation

14. The Board of Directors is asked to consider the contents of the report; and note the progress on the work within the ICB and PCB.

Lancashire and South Cumbria Provider Collaborative

NHS

Overview from the Provider Collaboration Board

Summary from meeting held 15 September 2022

1. Introduction and AOB

- Terms of reference for the Provider Collaboration Board (PCB) and the operating process of accountability to the Integrated Care Board (ICB) would be discussed and reviewed at the October meeting.

- As the system architecture was now in place, the Board would move towards having an agenda focused on decision making and assurance and this would be considered further at the October meeting.

- David Flory, chair of the Integrated Care Board (ICB), and chief executive Kevin Lavery had an open invitation to join all or part of all PCB meetings.

- There had been a change of Chair of a number of Committees as follows:

  - The Clinical Services integrated Group would be chaired by Martin Hodgson, Chief Executive of East Lancashire Teaching Hospitals (ELTH)
  - The Corporate Collaboration Board would be chaired by Aaron Cummins, Chief Executive of University Hospitals of Morecambe Bay (UHMBT)
  - Trish Armstrong-Child, Chief Executive of Blackpool Teaching Hospital Foundation Trust (BTHFT), would be the acute provider representative at the Integrated Care System (ICS) People Board
  - David Fearnely, Medical Director of Lancashire and South Cumbria Foundation Trust (LSCFT), would lead on Physical and Mental Health Integration

- At future meetings colleagues at each Trust would be asked to take it in turn to come forward with updates on initiatives where we can look at further increasing our collaboration. LSCFT were asked to present to the next meeting.

2. Performance Update

Emergency & Urgent Care

- Footfall through Emergency Departments was 3% down on July; however, this was still a 4% increase from August last year and August 2019 which is the pre-pandemic benchmark that the NHS uses to compare activity figures.

- 12-hour waits and ambulance handover times remain a key area of regulatory interest. Significant work was underway at all Trusts to address this and North-West Ambulance Service (NWAS) has set up an Improvement Board. Trish Armstrong-Child is the provider CEO representative on this.

- Medically fit to reside numbers remain high across our providers, apart from East Lancashire Teaching Hospitals (ELTH), with more than four hundred patients in acute beds every day who should be elsewhere in the system.

- We had no capacity breaches for 104-week waits across Lancashire and South Cumbria. The focus was now on the removal of the 78-week waits, of which there was a significant backlog. However, with the trajectories we have set and the work that is ongoing we aim to achieve this by March 2023.

- Funding had been approved for additional theatre and endoscopy capacity at Lancashire Teaching Hospitals (LTH) following a bid to the Targeted Investment Fund (TIF). A bid for funding for ELTHT was due to go to a panel on 22 September, with a bid from Blackpool Teaching Hospitals Foundation Trust (BTHFT) still at the regional stage.

- Cancer referral rates were significantly higher than pre-pandemic at 118% resulting in a deterioration in performance towards meeting the cancer standards. The Cancer Alliance has identified some additional resources and are looking at both internal and external funding options through the private sector to increase capacity.

Mental Health & Learning Disabilities

- Data is showing that community services are becoming more robust following work to improve admissions avoidance.

- A Listening into Action Group had been established with colleagues from the acute sector to look at Mental Health Urgent Care Assessment Centres (MUACs) and how the pathways could be improved.

- The twelve bedded Kentmere Ward in Kendal has now been reopened, the third this year, with the eleven bedded Skylark due to open at Royal Preston shortly which would continue to have a positive impact on reducing out-of-area placements as well as significantly reducing costs.

- Colleagues were working closely with the acute sector to look at integrating the pathways for eating disorders.

3. Financial Update

- The forecasting plan was based on a break forward position, but the ICB had not yet made the progress needed to reduce the financial deficit. Early indications were that the position was stabilising at month five.

- There was an ongoing shortfall on Cost Improvement Programme targets, particularly in relation to recurrent schemes so future meetings would consider how each provider was performing and what could be done to help them.

- Future meetings would consider and agree an annual planning cycle.

4. Corporate Collaboration Update

- Work to align corporate services continues and a programme of engagement is underway to update executive teams on progress as well as what is and is not in scope.

- The OD around the programme would be particularly important and further discussion on this would take place at the next meeting.

- Monthly updates would now come to this meeting.

5. Clinical Strategy Update

- The developing clinical strategy describes the clinical vision for the provider collaboration, and how, through a networked approach to service delivery, we can be more effective, efficient, and resilient.

- Internal engagement is ongoing with presentations arranged for Trust Part ii Board meetings.

- An engagement plan was being developed to help people have the right conversations with staff, patients and the wider public where appropriate.

6. Pathology Collaboration update

- Following news of Mark Hindle's forthcoming retirement, Kevin McGee led tributes thanking him for his contribution both to the collaborative and the wider NHS during 45 years of service.

- Professor Anthony Rowbottom is now leading the project on a day-to-day basis.

- An engagement exercise had taken place over the summer with pathology staff which had been well received and confirmed that there was wide support for the collaboration. The approach was to work across all Trusts on a number of key projects to develop what would effectively become a single service that would be co-designed with staff.

7. Next Meeting

- The next meeting takes place on Thursday 20 October 2022.

THIS PAGE IS INTENTIONALLY BLANK

BOARD OF DIRECTORS

Date of Meeting	26 October 2022
Title	New Hospitals Programme Quarter 2 Report
Report of	Scott McLean, Chief Operating Officer
Prepared by and contact details	Jerry Hawker, New Hospitals Programme SRO 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 for the Quarter 2 period: July to September 2022.

This quarterly report is presented to the following Boards:

- University Hospitals of Morecambe Bay NHS Foundation Trust
- Lancashire Teaching Hospitals NHS Foundation Trust
- East Lancashire Hospitals NHS Trust
- Blackpool Teaching Hospitals NHS Foundation Trust
- Provider Collaborative

Summary of Key Issues	The report includes the progress against plan for July to September 2022, in particular the detailed analysis of the shortlisted options, recommendations for preferred options and alternative options for Royal Lancaster Infirmary and Royal Preston Hospital, and presentation to Boards. It provides an update on the submission of a bid for early / enabling works for Furness General Hospital. It outlines next steps, with the commencement of further analysis to determine the viability of potential new sites such as equality impact assessment and travel and transport analysis. It describes key dependencies with the National New Hospital Programme business case, Cohort 4 funding and the right sizing of new hospital facilities.

	The report also provides an update on engagement and communications activities during the options development period to date, including publication of Your Hospitals, Your Say and launch of the latest programme milestone update.

Prior Discussions	Committee	Date	Recommendations/ Concerns

Action to be recommended to the Committee/Board	It is recommended the Board: • Note the progress undertaken in Quarter 2. • Note the activities planned for the next period.

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	
BCRs	Benefit to Cost Ratios
CIAM	Comprehensive Investment Appraisal Model

HMT	Her Majesty's Treasury
L&SC	Lancashire and South Cumbria
LTHTr	Lancashire Teaching Hospitals NHS Foundation Trust
NHP	Lancashire and South Cumbria New Hospitals Programme
PCB	Provider Collaborative Board
PCBC	Pre-Consultation Business Case
SOG	Strategic Oversight Group
UHMBT	University Hospitals of Morecambe Bay NHS Foundation Trust

NEW HOSPITALS PROGRAMME Q2 BOARD REPORT

1. Introduction

1.1 This report is the 2022/23 Quarter 2 update from the Lancashire and South Cumbria (L&SC) New Hospitals Programme.

2 Background

2.1 Lancashire Teaching Hospitals NHS Foundation Trust (LTHTr) and University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBT) are working with local NHS partners to develop a case for investment in local hospital facilities. The programme is part of Cohort 4 of the Government's commitment to build 40 new hospitals by 2030. Together with eight existing schemes, this will mean 48 hospitals built in England over the next decade, the biggest building programme in a generation. Further information can be found on the 'Improving NHS infrastructure' website.

2.2 The L&SC New Hospitals Programme (NHP) offers a once-in-a-generation opportunity to transform the region's ageing hospitals and develop new, cutting-edge hospital facilities that offer the absolute best in modern healthcare.

The national New Hospital Programme team will be presenting an updated business case to HMT in late Quarter 3. The outcome of this will determine the capital allocation and phasing for New Hospital Programme Cohorts 3 and 4. In the interim, the national New Hospital Programme team continues to work with schemes to determine the best approach to demand and capacity modelling, sustainable buildings, standard design, digital capabilities, assessing the benefits of new hospital facilities, as well as understanding the most effective commercial frameworks that can be applied.

3 Progress against plan (for the period July to September 2022)

3.1 **Shortlist of options** – the focus at the outset of Quarter 2 was to conclude the analysis below for presentation to the Trust's Boards of Directors and the Strategic Oversight Group (July 2022):

- **Deliverability** – each of the potential new site options have been appraised against a technical assessment criteria to determine sites that are technically deliverable i.e., a new hospital facility could be accommodated on the site. These criteria will continue to be applied to any additional potential new sites that

emerge over the coming period. In addition, the viability of the partial rebuild options on the existing sites was concluded.

- **Clinical viability** – the programme continues to ensure that options and the emerging business case are aligned with the Lancashire and South Cumbria Integrated Care Board clinical strategy, emerging Provider Collaborative Board (PCB) clinical vision and Trust clinical strategies.
- **Baseline travel analysis** – work to identify the current and future issues in relation to travel, transport and access for patients, staff and our population at the current sites for Royal Lancaster Infirmary and Royal Preston Hospital concluded. This provides a baseline for comparison against potential new sites.
- **Affordability and value for money** – updated financial modelling including the return on investment concluded. This is crucial in articulating and quantifying the financial impact of our ageing estate and benefits of new hospital facilities.
- This work has brought the programme to a significant milestone resulting in **recommendations for preferred and alternative options for both Royal Preston Hospital and Royal Lancaster Infirmary** which the Trust Boards of Directors discussed and approved at their meeting in September (UHMB) and October (LTHTr) 2022. Please see section 4 below for further information.

3.2 **Equality impact –** The Programme continues to put equality, diversity and integration at the heart of each option. As part of this commitment, the programme has begun assessing the likely effects of the options on people in respect of protected characteristic groups, health inclusion groups and groups who may be more likely to experience health inequalities.

3.3 **Further travel and transport analysis for new sites –** Detailed analysis is underway and will continue in Quarter 3, considering the impacts of the potential new site options for different people – paying particular attention to protected characteristic groups and health inclusion groups. This important work will sit alongside other equality impact assessment work and will be used to inform decision making at a later date.

3.4 **Early / enabling works** – the programme welcomed the opportunity to bid for funding towards early/enabling works. It should be noted that bids are required to be option agnostic i.e. will need to be completed regardless of the scope, approvals and outcome of schemes. Following extensive work and much consideration with the Trusts a bid was submitted for early works at Furness General Hospital. This would

mark a significant and positive step forwards demonstrating tangible steps to new hospital facilities in Lancashire and South Cumbria.

3.5 **Developing our business case** – the culmination of Quarter 2 was a draft Pre-Consultation Business Case (PCBC). The purpose of PCBC at this stage is to bring together all work undertaken to date and use this to articulate and clearly demonstrate the urgent need for investment in Royal Preston Hospital, Royal Lancaster Infirmary and Furness General Hospital. The PCBC also details how the shortlisted options (section 3.1) could be delivered, the risks and the benefits. Finally, the PCBC really clearly lays out how the programme delivers against the published Case for Change via delivering new hospital facilities for our patients, staff and population of Lancashire and South Cumbria. The PCBC will continue to develop over the coming period.

4 Recommendations for preferred options and alternative options

4.1 As detailed in section 3.1, each shortlisted proposal has been comprehensively assessed for deliverability, affordability, value for money, and viability, considering feedback from patients, local people and staff. To recap, the published shortlist is:

- A new Royal Lancaster Infirmary on a new site, with partial rebuild / refurbishment of Royal Preston Hospital
- A new Royal Preston Hospital on a new site, with partial rebuild / refurbishment of Royal Lancaster Infirmary
- Investment at both Royal Lancaster Infirmary and Royal Preston Hospital, allowing partial rebuilding work on both existing sites
- Two new hospitals to replace Royal Lancaster Infirmary and Royal Preston Hospital (new sites).

4.2 Key elements have been considered to help evaluate each shortlisted option. This includes service configuration; what would be required in terms of rooms, beds and other provisions to be able to meet the operational, space and location requirements; and site location options. This has resulted in recommendations for preferred options and alternative options for both Royal Preston Hospital and Royal Lancaster Infirmary.

4.3 Both the preferred and alternative options and combinations of these are aligned to the published shortlist, and each will be considered in the context of capital affordability and benefits including addressing inequalities, clinical outcomes, productivity and wider socio-economic benefits. They will also be considered alongside “business as

usual" and "do minimum" options, both standard options in all business cases.

4.4 Lancashire and South Cumbria New Hospitals Programme's **preferred option for Royal Lancaster Infirmary** is a new state-of-the-art hospital on a new site, with an ultra-modern Urgent and Emergency Care village, with dedicated areas for same day emergency services, frail patients, patients with mental health needs and those requiring ambulatory care. This option provides an opportunity to significantly improve patient experience, the quality of services provided, and improve the environment for patients, visitors and staff.

4.5 The preferred option of a new build hospital on a new site would bring significant health and care system wide benefits. It would fully address the Case for Change, improve care for patients, improve the work environment for staff, meet environmental commitments, such as Net Zero Carbon, and maximise the wider socio-economic potential. A new build on a new site offers the best clinical, operational and efficiency benefits and meets the requirements set out by the national New Hospital Programme, such as delivering an environmentally friendly and sustainable building, with more single en-suite rooms.

4.6 The Programme's alternative option for RLI is an improved Royal Lancaster Infirmary in the current location to include a new urgent and emergency care village, together with reprovision of critical care, maternity and neonatal, and some inpatient accommodation and diagnostics. 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.

4.7 The alternative option would bring a range of improvements, particularly for patients needing urgent and emergency care and people accessing maternity services, along with improving clinical adjacencies. However, it only partially addresses the Case for Change and does not address all the required backlog maintenance or the ambitions of the national New Hospital Programme. For example, it would only partially deliver on environmental and sustainability targets because some of the old buildings and existing gas boilers would remain. As much of the new facilities would provide single en-suite rooms for patients as possible, but this would not be at the scale achievable

within a new build. It also limits opportunities to make service and quality improvements in the future.

4.8 Lancashire and South Cumbria New Hospitals Programme's **preferred option for Royal Preston Hospital** is a new state-of-the-art hospital on a new site, with an improved and enhanced urgent and emergency service, increased capacity for specialised services and the opportunity to maximise significant quality and productivity gains.

4.9 A new build Royal Preston Hospital on a new site would bring significant health and care system wide benefits. It would fully address the Case for Change, improve care for patients, improve the work environment for staff, meet environmental commitments, such as Net Zero Carbon, and maximise the wider socio-economic potential. A new build on a new site offers the best clinical, operational and efficiency benefits and meets the requirements set out by the national New Hospital Programme, such as delivering an environmentally friendly and sustainable hospital, with more single en-suite rooms.

4.10 The Programme's alternative option for RPH is an improved Royal Preston Hospital on the current site to include a new urgent and emergency care village, together with replacement of some inpatient facilities for non-elective medical and surgical patients, and the replacement of nine theatres and diagnostic facilities. 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.

4.11 The alternative option would bring a range of improvements, particularly for patients with urgent and emergency needs and would improve clinical adjacencies. However, it only partially addresses the Case for Change and the ambitions of the national New Hospital Programme. For example, it would only partially deliver on environmental and sustainability targets because some of the old buildings and existing gas boilers would remain. As much of the new facilities would provide single en-suite rooms for patients as possible, but this would not be at the scale achievable within a new build. It does not address all of the required backlog maintenance required or tackle issues with the long-term viability of current facilities, such as the much-needed replacement of the

ageing ward block, which would therefore still need to be addressed longer term. It also limits opportunities to make service and quality improvements in the future.

5 Public, patient and workforce communications and engagement

5.1 Hearing and reflecting the views of people living and working in Lancashire and South Cumbria is an essential part of shaping plans and proposals for new hospital facilities. Engagement with and involvement of patients, local people, staff and stakeholders is incorporated throughout the New Hospitals Programme's process. Throughout the programme there will be a clear process and regular opportunities for local people and staff to have their say and to influence the business case, helping to shape the future of hospital care in our region.

5.2 The programme team have continued to implement a programme of regular communications and engagement opportunities during the options development period, designed to make sure local people are aware and informed about proposals, know how they can get involved, understand why decisions are made, feel enthusiastic about what is possible, and have trust in the process.

5.3 As of 31 August 2022, 15,579 different individuals have been involved in one or more Lancashire and South Cumbria New Hospitals Programme engagement activities, interacting with us 30,802 times. Public and patients account for 32% of these interactions and NHS staff account for 19%. Health inclusion groups (including those with protected characteristics) and service users (especially those who have difficulty with mobility, stamina, dexterity and mental cognisance) together make up 45% of interactions. The remaining interactions have come from expert patient groups and political stakeholders.

5.4 The key themes of feedback have been as follows:

- There is widespread support in favour of funding for new hospital facilities. Local people, patients and staff all acknowledged the ageing population of the region and health inequalities as a driver for urgent improvements for hospital facilities.
- Travel and accessibility considerations are the biggest talking point.
- People are open to the use of digital tools to enable care closer to home.

- A single new hospital on a new central site is not acceptable to most audiences. The main concerns centred on services being located too far away and potential difficulties travelling to and around the hospital.
- New hospital facilities should be designed with sustainability in mind. Design, layout, and sustainability was the second most popular discussion point after travel and accessibility.
- Hospital sites must be 'future-proofed' to meet the region's long-term needs. Patient-centred care was the most important topic for inclusion groups. People wanted the future of healthcare to be based on holistic care, collaboration, prevention and tackling health inequalities. Inclusion groups hope that there will be more emphasis on training hospital staff to raise their understanding of the needs of under-represented people.

5.5 A public-facing report titled Your Hospitals, Your Say has been produced to provide an overview of activity that has taken place during the options development period and share what the programme has heard from people in Lancashire and South Cumbria to date (as of 31 August 2022). Published in September 2022, the Your Hospitals, Your Say report is available online at https://newhospitals.info/YourHospitalsYourSay. It has been shared with stakeholders and staff and promoted through New Hospitals Programme and NHS partner internal and external communications channels.

5.6 The latest programme milestone update announcing recommendations for preferred options and alternative options for Royal Lancaster Infirmary and Royal Preston Hospital was launched on 26 September 2022, with issue of stakeholder briefings, a media release, internal communications, NHP and partner social media, email newsletter updates, and more. This has resulted in a wide range of local media coverage and positive reaction from local political stakeholders. A new online survey has been launched to capture views on the proposals and on what is most important to people for new hospital facilities.

6 Stakeholder management

6.1 Stakeholder engagement has continued during Quarter 2 with the programme joining discussions at Chorley Council and South Ribble Council.

6.2 The programme team presented an update at the Lancashire Health and Adult Services Scrutiny Committee and Cumbria Health Scrutiny Committee this period.

6.3 Lancashire and South Cumbria and neighbouring area MPs and local authorities, and wider stakeholders have been briefed on the latest programme milestone update and publication of Your Hospitals, Your Say during September 2022, with a further invitation to meet to discuss the programme further.

7 Programme governance and risk

7.1 During Quarter 2, the Programme has made significant progress on recommendations regarding programme governance and assurance. The Programme continues to review and strengthen the approach to risk as well as continuing to manage dependencies within the integrated care system and national teams.

8 Next period – Q3 2022/23

8.1 Quarter 3 takes us into a period of further detailed analysis on the shortlisted options in preparation for the outcome of the national New Hospital Programme business case. The programme looks forward to working with the national Programme team to understand the outcome of the business case and what this means for new hospital facilities in Lancashire and South Cumbria.

9 Conclusion

9.1 This paper is a summary of progress on the Lancashire and South Cumbria New Hospitals Programme throughout Quarter 2 2022/23.

10 Recommendations

10.1 The Board is requested to:

- Note the progress undertaken in Quarter 2.
- Note the activities planned for the next period.

Rebecca Malin
Programme Director
October 2022

Jerry Hawker
Programme Senior Responsible Officer

THIS PAGE IS INTENTIONALLY BLANK

BOARD OF DIRECTORS

Date of Meeting	26 October 2022
Title	Research and Development Update
Report of	Jane McNicholas Chief Medical Officer
Prepared by and contact details	Andy Lancaster Head of Research and Development Andrew.lancaster@mbht.nhs.uk Tel: 01524 516484 Ext: 46484

Confidentiality	Non-Confidential

Purpose of Report	**To Advise/Alert**	**To Assure**	**To Approve**	**To Update**
				x
	This report is a brief overview of the current situation in the UHMBT Research and Development department, from the point of view of the relatively new Head of department after six weeks in post. It comprises a brief summary of the background and current situation in terms of strengths, weaknesses, opportunities and threats. It concludes with a summary of initial steps being taken to prevent any further deterioration in the service and reduce risk of failure to meet future metrics.			

Summary of Key Issues	As R&D remains financially independent, the main considerations are for support with establishing more permanent dedicated clinical areas where research participants can be seen safely and confidentially in all three main Trust hospital sites. Also prioritising the re-centralisation of most major clinics, especially oncology, to our main sites (RLI where possible) with easy access to support departments, especially pharmacy aseptics units.

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 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	None			
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

Research and Development (R&D) Update

Introduction:

1. The Research and Development Team at UHMBT is relatively small but has managed to create and maintain a good reputation for the delivery of Clinical Research studies over the years leading up to the Covid-19 pandemic. This in turn has helped enhance the reputation of UHMBT, adding to our appeal as a potential employer.

2. With the onset of the pandemic, the majority of non-Covid research was paused, allowing the team to concentrate on the urgent studies into the causes and potential treatments for Coronavirus. This effort, especially the search for a safe, effective vaccine, were acknowledged and applauded throughout the world, enhancing the reputation of Clinical Research in general with the Morecambe Bay research team as part of that. Possibly our greatest contribution was the highly successful trials of the Novavax vaccine. This brought recognition to our small team as a major contributor to commercial pharmaceutical research with promises of further opportunities in the future.

3. Sadly, this does not seem to have led to overall growth of our portfolio, income or longer-term acceptance as an integral part of the Trust's clinical service.

Research Delivery: Strengths and Opportunities

4. In line with NIHR Managed Recovery programme, the UHMB Research team have restarted 84% of our overall pre-Covid portfolio.

5. The team have learnt many lessons and improved practice from the experience of delivering such important studies during the pandemic with all the associated problems. Not least are the improved ability to rapidly set-up new studies and a commitment to flexible cross-team working – an "all-hands-on-deck" approach. Many individuals have shown strengths of resilience, adaptability, team working and organisational strength. All of which can be utilised, in present and future roles,

6. In addition to the permanent base on the Top Floor of pointer Court at RLI and the Walney Suite at FGH, the Trust has provided the Research department with areas of clinical space which have enabled large studies (including vaccine trials) to be run efficiently within our estate cross-bay. This will prove invaluable for future research delivery across a range of conditions.

7. In common with most commercial research, the Novavax vaccine trial provided financial recompense for our efforts. In this case, it was on a sufficient scale to provide a financial reserve, which has already funded several new Research Administration posts. This is particularly significant as the Research and Development Department operate financially independently of the Trust, responsible for our own income and expenditure. This being derived through research activity (as described above) and an activity-based annual contribution to delivery staff salaries made by the NIHR through the NW Coast Clinical Research Network.

Research Delivery: Weaknesses and Threats

8. Despite the apparent gain in reputation, we have not been successful in taking on new studies, particularly commercial, to replace the significant number of older studies that

have recently closed to recruitment (or will soon) and the number of new studies opened has failed to keep up with this attrition.

9. During this calendar year, there have been two changes of Departmental Manager and the Research Director has retired. These factors have inevitably influenced staff morale, leaving many concerned and unclear about the future for themselves and the department.

10. Previous managers have started to introduce plans to restructure the staff and roles within the department, but these have only been partly implemented and, in the view of the current Head of R&D, are rather limited failing to address the lack of portfolio growth, particularly in commercial studies which attract the highest financial income. Similarly, issues of staff morale and retention remain unaddressed.

11. The pandemic period of diverted resources has taken attention away from developing and maintaining our suite of SOPs and quality measurement systems. This has left us exposed in the event that that we were to be inspected by the MHRA or CQC. It also means that we would struggle to fulfil our responsibilities as Sponsor of any future locally-driven research studies.

Initial recovery plan (with new Head of R&D):

12. In order to maintain financial independence and generate funds to re-invest within the team, our strategic aim is to increase the value of research income with particular emphasis on commercial activity increasing the opportunity for our patient population to access more clinical research, potentially offering an increased number of novel and improved therapeutic treatment options. To achieve this, we intend to utilise some of the existing financial reserve to create a new post for a senior research nurse, with specific interest and experience in opening commercial research studies. This post is intended to generate enough income within12-18 months to become self-funding. If successful, this could lead to recruitment of a second research nurse in the future. Meanwhile a current Band 7 will be specifically tasked with increasing our non-commercial portfolio of studies.

13. We are going to utilise the EDGE study management software to greater effect, with a dedicated administrator, making this a more efficient tool for realising income from studies through efficient use of the activity invoicing system.

14. Other changes in the team will include a Band 7 with responsibility for our Quality Management system, building and maintaining a full suite of SOPs and instigating regular quality audits on all hosted studies.

15. To facilitate this growth in portfolio, it is imperative that we are able to maintain and increase the clinical space available for us to carry out clinics for Research participants and to achieve this in the commercial sector, which is largely based in oncology, this clinical working area must be serviced by Trust support departments, including pharmacy and pathology. Prioritising the re-centralisation of Oncology clinics will greatly assist this.

Recommendation

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

BOARD OF DIRECTORS

Date of Meeting	26 October 2022
Title	Guardian of Safe Working Hours Quarterly Update
Report of	Jane McNicholas Chief Medical Officer
Prepared by and contact details	Dr Alan Minchom 07811004731

Confidentiality	Non-Confidential

Purpose of Report	**To Advise/Alert**	**To Assure**	**To Approve**	**To Update**
		x		x
	The purpose of the report is to update the Board of Directors on the work of the Guardian of Safe Working Hours.			

Summary of Key Issues	The paper gives an overview of the Guardian's work informing the Board that the majority of the junior doctors have moved onto the new terms and conditions. The main reasons for the junior doctors submitting the exception reports are covered in this report. The current Guardian was appointed into the Guardian of Safe Working role on 1 January 2022. Data for this report has been collated from DRS.

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 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	Safety concerns re intensity of work, WTR breaches, inadequate staffing and raising fines			
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

Guardian of Safe Working Hours Report

1. The 2016 contract applies to trainee doctors in post at UHMB.

2. The current Guardian of Safe Working was appointed and joined from 1ST January 2022. Administrative support for GOSW was appointed in February 2020. Admin support also acts as a liaison with Human resources department as and when needed; such as validating a trainee's contractual hours.

3. We are presenting aggregated data for July 2022 to September 2022 in this paper.

4. The GOSW and his Assistant receive support from the cross bay Medical Workforce Advisor, who is based in Workforce.

5. The Guardian or his Assistant / representative regularly attend Medical Learners forum, via Teams, cross site, in line with the expectations of the 2016 contract.

6. To maintain distance between the educational and HR elements, the meetings are held in two distinct parts focusing on general issues of Education with site based educational leads first and Guardian business thereafter. Informal discussions with trainees have revealed low attendance. Attempts are made to encourage wider attendance from trainees at all stages of training. Attendance has improved by the use of teams and inviting a wider group of doctors in training.

7. The Guardian has conducted an audit of the fatigue and facilities provision for UHMBT. This report has been forwarded to the Medical Director and is included as an Appendix to this report. An action plan is being developed with the deputy medical directors.

8. The GOSW has attended Inductions for junior doctors and explained the DRS4 and Exception Reporting process to new trainees and encouraged them to log in whenever an exception happens.

9. The GOSW and his assistant plan to continue to attend induction meeting for new trainees as well as Junior Doctor Forum meetings at Both UHMB sites in future.

10. Between July 2022 and September 2022 there were 158 exception reports, this compares with 62 in the same period in 2021, an approximately 150% increase

11. These breakdown as follows

Quarter - 01.July.2022 to 30.September.2022										
Month	**Department**	**Site**	**Grade**	**Open Reports**	**Closed Reports**	**Duplicates**	**Rejected**	**Total Number of Exceptions**	**Monthly**	**Total**
July	General Medicine	RLI	F1	0	11	0	3	14		
July	General Medicine	RLI	IMT1	0	1	0	0	1		
July	General Medicine	RLI	ST4	0	6	0	2	8		
July	General Practice	FGH	GPST1	0	0	0	0	0		
July	General Surgery	FGH	F1	0	0	0	0	0		
July	General Surgery	RLI	F1	0	4	0	1	5	**28**	**July**
August	General Medicine	RLI	F1	2	18	0	2	22		
August	General Medicine	FGH	F1	0	0	0	0	0		
August	General Medicine	RLI	ST1	0	4	0	1	5		
August	General Medicine	RLI	F2	0	5	0	0	5		
August	A & E	RLI	F2	0	2	0	0	2		
August	General Pathology	RLI	F2	0	1	0	0	1		
August	Paediatrics	RLI	ST1	0	1	0	0	1		
August	General Surgery	RLI	F2	0	9	0	0	9		
August	General Surgery	FGH	F1	0	1	0	0	1		
August	General Surgery	RLI	F1	0	18	0	3	21	**67**	**August**
September	General Medicine	RLI	F1	3	11	0	1	15		
September	General Medicine	FGH	F1	0	1	0	0	1		
September	General Medicine	RLI	ST4	0	0	0	0	0		
September	General Medicine	RLI	F2	0	6	0	0	6		
September	General Medicine	RLI	ST1	0	2	0	1	3		
September	A & E	RLI	F2	0	3	0	2	5		
September	General Surgery	FGH	F1	1	0	0	0	1		

September	General Surgery	RLI	F2	0	6	0	0	6		
September	General Surgery	RLI	F1	6	20	0	0	26	**63**	**September**
Total				**12**	**130**	**0**	**16**	**158**		

12. It is quite apparent that there is a growing problem amongst F1 grade doctors (largely at RLI) in both medicine and surgery related to intensity of workload. There is a negligible (or no) such problem at FGH. This appears to be a growing problem as presented in the quarterly report.

2022 Jul-Sep	**RLI**	**FGH**	**Total**
A & E	7	0	7
General Medicine	79	1	80
General Surgery	67	2	69
Obs & Gynae	0	0	0
General Pathology	1	0	1
Paediatrics	1	0	1
TOTALS	**155**	**3**	**158**

13. The changes from the same period last year. A similar level of increase has been seen in other north west trusts.

Difference Jul-Sep	RLI	FGH	Total
A & E	7	0	7
General Medicine	55	0	55
General Surgery	35	-1	34
Obs & Gynae	0	-1	-1
General Pathology	0	0	0
Paediatrics	1	0	1
TOTALS	**98**	**-2**	**96**

14. The Guardian has fed this back to both medicine and surgery management teams.

15. The Guardian has issued 3 fines, totalling £242.22. All 3 were in August and all in the department of medicine.

16. The use of the money in the guardian's fund will be discussed at the November medical learners forum.

Action Plan

17. GOSW and his assistant to attend cross site Medical Learners forum when these forums are held, mainly via Teams app.

18. GOSW to improve awareness amongst trainees. The Guardian (with the permission of the lead clinicians) has written to the F1s in medicine and surgery reiterating the system for getting breaks whilst on shift, to hopefully ameliorate some of the exception reports.

19. GOSW to continue to improve awareness and engage Educational supervisors.

20. GOSW has undertaken an audit into facilities and fatigue provision, this has been forwarded to the CMO

21. The guardian and their assistant are chasing educational supervisors that are not addressing exception reports in a timely manner

22. The guardian has been liaising with the lead clinicians in both medicine and surgery at RLI to attempt to find resolutions to the growing Exception Reporting problem.

Recommendation

23. The Board of Directors is requested to take a note of this paper and the concerns it contains.

Appendix 1 – Fatigue and Facilities Charter

BMA Fatigue and facilities Charter Audit Chart			
Standard	**Met at RLI**	**Met at FGH**	**Notes**
Rostering and Rota Designs			
Do rotas comply with NHS employers and BMA standards	Yes	Yes	
Forward rota designs (day/late/night)	Yes	Yes	
Adequate recovery time after night shifts (46 hours after completing night shift)	Yes	Yes	
No more than 4 long shifts in a row	Yes	Yes	
Maximum 7 consecutive shifts	Yes	Yes	
Max 72 in 168 hours	Yes	Yes	
Emergency requests should not exceed above limits	No	No	Not necessarily implemented by department rota teams
Rostered breaks - Between 1 and 2 30min breaks ina shift (5hrs/9hrs)	No	Yes	
Team based hospital at night - call filtering/policies to allow breaks	No	Yes	
Ability to raise concerns re missed breaks	Yes	Yes	GoSW
Staffing numbers allow for full allocation of annual/study leave, with flexibility allowing for advanced notice	Yes	Yes	
Staffing numbers allow for safe cover in the event of unexpected absence (sickness/compassionate)	No	Yes	
Induction and Training			

At induction, provide advice aboutsleep/working nights/healthy working	No	No	
Regular screening of shift workers for sleep disorders	No	No	
Emphasise importance of taking breaks and run regular campaigns to encourage this	No	Yes	
Give information about the location of rest facilities and how to access them	Yes	Yes	
Recognise the importance of rest in reducing error and organisational response to raising concerns	No	No	Trust policy explicitly forbids napping during rest breaks
Common room or mess			
Provide an easily accessible mess with rest facilities open 24/7 with ability to nap	Yes	Yes	
Nap/rest areas separate from food prep/handover areas (should be a rest area not a clinical one)	Yes	Yes	
Lounge with power points and tv	Yes	Yes	
Office study area with power points, telephone and internet access	Yes	Yes	
Equipped kitchen (sink/hotplate/microwave/toaster/fridge/freezer/kettle/coffee machine + tea/coffee/milk and bread)	Yes	Yes	Does not fully meet charter requirements but adequate
Changing facilities and showers	Yes	Yes	
Storage area including lockers for doctors	No	Yes	
Secure cycle storage	Yes	Yes	
Catering			
Open 365 days per year	Yes	Yes	
Adequate, varied, efficiently served and freshly prepared meals	Yes	Yes	

Healthy eating and vegetarian options and for cultural and dietary requirements	Yes	Yes	
Hot food for extended meal times (breakfast, lunch and dinner)	No	No	
Open until 11pm	No	No	
Open again for a 2 hr period between 11pm and 7 am	No	No	
Hot food to be available when canteen closed (e.g. microwave meals) easily accessible/restocked/pay by card	No	No	Vending machines available, poorly stocked, no hot food
Travel			
Provide sufficient parking	No	No	
Short/safe route to and from the hospital	No	Yes	Need to check on lighting and camera provision. Escort available ?
Reserved spaces for doctors travelling after dark	No	No	
Above to include non resident on call	No	No	
Adequate sleep facilities for doctors too fatigued to drive after a long/late or night shift	No	No	
Where sleep facilities are not available ensure alternative travel arrangements are provided	No	No	
Rest facilities for doctors working on call			
Free of charge sleep facilities for staff rostered or voluntarily resident on call	Yes	Yes	Available but severely inadequate numbers and poor quality

Good quality bed	No	Yes	On call rooms in Med Unit 1 very poor
Linen changes every 3 days and for new occupant	Yes	Yes	
Towels changed daily	Yes	Yes	
Telephone with access to switchboard	Yes	Yes	
Power points	Yes	Yes	
Independantly controlled heating	No	No	3 rooms in Ed centre RLI, no ventilation and heating pipes
Adequate sound and light proofing to allow sleep day and night	No	No	Medical student access at RLI Ed centre - busy corridor
Fixing problems			
Appoint a nominated employer representative to deal with fatigue and facilities	No	No	
Where above standards are not met, employer rep to bring action plan to the LNC	No	No	
Action plan to be implemented within 6 months	No	No	
Where action plan is not implemented GoSW to include such in quarterly report to the board	No	No	GoSW cannot act due to above points

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												
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 (resigned 30/09/2022)												
Stephen Ward, Non-Executive Director (term of office ended 30/09/2022)												

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 Safety Champion Report	Maternity Services Update	Maternity Services Update	Maternity Services Update including ATAIN update Maternity Safety Champion Report	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

University Hospitals of Morecambe Bay NHS Foundation Trust
Board of Directors' Forward Plan 2022/23

	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
		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		

University Hospitals of Morecambe Bay NHS Foundation Trust
Board of Directors' Forward Plan 2022/23

							New Hospitals Programme Update Q2	New Hospitals Programme – internal governance (Jane Kenny)				
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		

University Hospitals of Morecambe Bay NHS Foundation Trust
Board of Directors' Forward Plan 2022/23

												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	• 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

		• Cultural and OD Improvement • Operational Plan • Operational Resilience Plan • Health and Safety Strategy • Freedom to Speak Up Policy	Committee) • Standards of Business Conduct (Audit Committee) • Governance and Assurance Strategy (Audit Committee)