PUBLIC TRUST BOARD OF DIRECTORS' MEETING

Thursday 22 December 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					
175	Welcome and Introductions • Apologies for absence received from Chris Adcock (Helen Cobb, Director of Finance to deputise), Bev Edgar (Ray Olive, Assistant Director of People and Organisational Development to deputise) and Phil Woodford • Declaration of conflicts of interest	Chair	To note	Verbal	9.30am-9.31am (1 Minute)
176	Minutes of the Board of Directors' Meeting held on 30 November 2022 *To approve the Minutes of the Meeting held on 30 November 2022.*	Chair	To approve	Attached	9.31am-9.33am (2 Minutes)
177	Action Sheet and Matters arising from the Minutes of the Public Meeting of the Board of Directors held on 30 November 2022 *To consider the action sheet and note the actions taken.*	Chair	To note	Attached	9.33am-9.35am (2 Minutes)
Matters for Consideration					
178	Chair's Report *An update presented by the Chair.*	Chair	To note	Attached	9.35am-9.40am (5 Minutes)
179	Chief Executive's Report *An update presented by the Chief Executive.*	Chief Executive	To note	Attached	9.40am-9.50am (10 Minutes)

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180	Head Governor Update *An update presented by the Head Governor.*	Head Governor	To note	Attached	9.50am-9.55am (5 Minutes)
Quality and safety: ***Delivering outstanding care and experience***					
181 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	9.55am-10.05am (10 Minutes)
181 ii	Niche External Investigation Assurance *A report to present the current position, progress of and cross-cutting themes of the NICHE recommendations.*	Director of Governance	For assurance	Attached	10.05am-10.10am (5 Minutes)
182 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	10.10am-10.40am (30 Minutes)
182 ii	Six Monthly Continuity of Carer Report *A report to provide an update on the current status of midwifery continuity of carer at UHMBT and the revised expectations of maternity services from NHS England.*	Chief Nursing Officer / Director of Midwifery	For assurance	Attached	
182 iii	Maternity Incentive Scheme Year 4 Report *A report to provide an update on the progress with the Maternity Incentive Scheme Year 4.*	Chief Nursing Officer / Director of Midwifery	For assurance	Attached	
182 iv	Ockenden Review Update *A report to provide an overview of the position of the Trust in relation to the compliance with the 7 Immediate actions from the Ockenden Report 2020 and a progress update of the action plan from the regional Insight visit*	Chief Nursing Officer / Director of Midwifery	For assurance	Attached	

	which took place on the 20th and 21st July 2022.				
182 v	NHS Resolution Thematic Review 2017-2022 *A report to provide an overview of the progress made against the NHS Resolution action plan.*	Chief Nursing Officer / Director of Midwifery	For assurance	Attached	
183	Recovery Support Programme – UHMB Improvement Plan *A report to present the Trust's improvement plan in response to being placed in the NHSI/E Recovery Support Programme.*	Deputy Chief Executive / Intensive Support Director	To consider	Attached	10.40am-10.50am (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				
184 i	Performance Update *The Deputy Chief Executive will present this report covering quality and safety, operational, people and financial performance.*	Deputy Chief Executive	For assurance	Attached	10.50am-11.10am (20 Minutes)
184 ii	Minutes and 3A Reports from Assurance Committees a) People Committee Minutes from Meeting on 3 October 2022 and Update from the Meeting on 16 December 2022 b) Finance and Performance Committee Minutes and 3A Report from Meeting on 28 November 2022 and an Update from the Meeting on 19 December 2022 c) Quality Committee Minutes and 3A Report from Meeting on 21 November 2022 and Update from Meeting on 19 December 2022	Chairs of the Assurance Committees	To note	Please refer to Board of Directors' Reference Pack for copies of the Committee Minutes	11.10am-11.15am (5 Minutes)
Closing Administration					
185	Attendance Monitoring Register	Chair	To note	Attached	11.15am-11.20am (5 Minutes)
186	Schedule of Business	Chair	To note	Attached	
187	Urgent Business	Chair	To note	Verbal	

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188	Date, Time and Venue of Next Meeting: Wednesday 25 January 2023 at 10am in the Board Room, Westmorland General Hospital, Kendal LA9 7RG and via Microsoft Teams.
189	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 20 December 2022.

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Board of Directors' Declarations of Interest

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

Date of Declaration	Name	Role	Nature of Interest	Do you envisage a conflict of interest between outside employment and your NHS employment?	Nil Declaration
13/04/2022	Chris Adcock	Chief Financial Officer / 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	Chief Nursing Officer			✓
11/11/2022	Paul Jones	Company Secretary	Chair of the Westmorland and Furness Shadow Authority Independent Remuneration Panel	A material conflict of interest does not exist as the role of the Independent Remuneration Panel is not connected to the NHS.	
19/07/2022	Scott McLean	Chief Operating Officer			✓
05/04/2022	Jane McNicholas	Chief Medical Officer			✓
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			✓
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.	
21/11/2022	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 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	Potentially a material conflict of interest may arise from the role with activities being undertaken by his consultancy and NHS Highland. However, Hugh would have to consider the circumstances; make a declaration and consider withdrawing from any meetings where the matter	

			NHS Highland region. Also ad hoc locums in GP Practices in the Morecambe Bay area.	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			✓
09/12/2022	Mike Thomas	Chair	Chair of the Board of national health and social care charity, Making Space	A material conflict does not exist. However Mike may wish to make a declaration and consider withdrawing from any meeting where Making Space is being discussed.	

Minutes of the Trust Board of Directors' Meeting held on Wednesday 30 November 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
	Bev Edgar (BE)	Interim Chief People Officer
	Adrian Leather (AL-NED)	Non-Executive Director
	Bridget Lees (BL)	Chief Nursing Officer
	Scott McLean (SM)	Chief Operating Officer
	Jane McNicholas (JM)	Chief Medical Officer
	Hugh Reeve (HR-NED)	Non-Executive Director
	Sarah Rees (SR-NED)	Non-Executive Director
	Liz Sedgley (LS-NED)	Non-Executive Director
	Jill Stannard (JS-NED)	Non-Executive Director
In attendance:	Nicola Barnes	Trust Board Administrator
	Olivia Caton	Deputy Company Secretary
	Helen Cobb	Director of Finance
	Leanne Cooper (LC)	Deputy Chief Operating Officer
	Lorraine Crossley-Close (LCC)	Head Governor
	Jennifer Dewar	Clinical Team Leader – Musculoskeletal Service (for item 156 – Patient Story)
	Rebecca Hogan	Assistant Director – Recovery Support Programme
	Paul Jones (PJ)	Company Secretary
	Sakthi Karunanithi (SK)	Advisor to the Board
	Ben Maden (BM)	Staff Side Chair
	Barry Rigg (BR)	Head of Patient Experience (for item 156 – Patient Story)
	Richard Sachs (RS)	Director of Governance
	Dan West	Deputy Chief Nurse
	Phil Woodford (PW)	Director of Corporate Affairs

22/153 Welcome and Introductions

MT welcomed SK, HC, RH and DW to the Board of Directors' meeting.

Apologies for Absence

Apologies for absence were received from Scott McLean.

Declarations of Conflicts of Interest

None.

22/154 Minutes of the Board of Directors' Meeting held on 26 October 2022

Decision: That the Minutes of the meeting held on 26 October 2022 be agreed as an accurate record.

22/155 Action Sheet and Matters Arising from the Minutes of the Public Meeting of the Board of Directors held on 26 October 2022

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

22/156 Patient Story

BL introduced BR who explained the patient story focused on the musculoskeletal service at Carnforth which had moved temporarily to the Westmorland General Hospital (WGH). BR shared an audio description of the patient describing the impact of moving the service from Carnforth to WGH.

JD shared reflections and actions from the patient story.

BR advised that all patient experience informed progress in clinical areas.

MT thanked BR and JD for attending.

AL-NED thanked BR commending the fact that patient experience informed progress to benefit patients. AL-NED sought assurance on the impact on finances to provide and how replicable this approach would be to commit to provide local services within rural communities at scale. AC advised the imperative for change in clinical models was driven by the response to the pandemic. CA would reference this when presenting the financial strategy to Board members in terms of returning to pre-COVID services. AC explained that the impact on patients was considered when making clinical decisions along with equality impact and financial costs. AC acknowledged it was important to balance patient care closer to home, workforce and financial challenges whilst ensuring the needs of patients were met when discussing service change.

BL advised that the clinical strategy would inform the future. There was a wider piece of work being undertaken by the Care Group and BR agreed to ensure financial colleagues were informed.

PW thanked BR and team. PW felt this was a situation which could have been avoided. PW suggested patients were involved in the equality assessment. PW requested the patient was reimbursed for the financial loss of the additional travel offering to cover the costs himself.

LS-NED echoed PW comments in terms of service access for patients and avoidable travel given the cost of living which would impact patients. Delivery of services was paramount.

KD-NED thanked BR and team and the patient. Related to the wider piece of work BL spoken to, KD-NED requested personal risk factors as well as financial factors were taken into account.

AC advised the clinical strategy was due to be presented to the Board of Directors in January 2023 and would include addressing the balance, access to services, outcomes and ensuring the Trust did not promote further health inequalities.

It was agreed BR would contact the patient on behalf of the Board of Directors to explain there would be changes based on his experience.

Decision:
1. The Head of Patient Experience to contact the patient on behalf of the Board of Directors to explain there would be changes based on his experience and ensure the patient was financially reimbursed for the cost of travel to WGH.

22/157 Chair's Report

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

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

Decision: That the report be noted.

22/158 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. Nationally, the autumn budget statement was presented in November 2022. There had been mixed responses to the financial decisions made. CA would be leading a discussion regarding the finance strategy later today. In terms of health and social care, the focus remained on balancing quality and safety, improvement and financial challenges. There would be a review of the future workforce plan for health and social care over the next 15 years. UHMB would contribute to this.
2. Regionally, the focus continued on the recovery support programme and progressing towards satisfying the criteria to exit System Oversight Framework level 4. The objective was to continue the improvement work to progress towards System Oversight Framework level 3. The Integrated Care Board focused on preparations for the winter period with a new structure in place from 1 December 2022. UHMB would contribute to this. The focus for the Provider Collaborative Board was resetting and discussing the programme of decision making and key programmes to be mobilised.
3. AC thanked all UHMB colleagues for their innovation, tenacity and managing patient flow and services everyday whilst balancing this with operational pressures. Feedback from colleagues suggested that the work of the clinical operational teams such as the Same Day Emergency Care unit was starting to impact.
4. AC explained that the Royal College of Nursing ballot had reached the threshold for industrial action with confirmed dates in December 2022. The Trust was working on mitigating plans.
5. A new Chief People Officer had been appointed and would join the Trust on 1 January 2023 from Wigan, Wrightington and Leigh NHS Foundation Trust. BL would be leaving the Trust in April 2023 and joining Blackpool Teaching Hospitals NHS Foundation Trust.

LC would also be leaving the Trust early 2023 to take up her first Board position as the Chief Operating Officer at Airedale NHS Foundation Trust.

During deliberation of this item the following points were considered:

6. JS-NED expressed her concern regarding the Trust not meeting criteria to reside and would like to see an explicit plan to understand how the extra funding would be used to impact this.
7. AL-NED sought assurance on the new hospitals programme. AC advised the new Prime Minister had previously committed to the 2019 mandate of which the new hospitals programme was part of that. An announcement from the Treasury on the budget available was awaited. AC agreed to keep the Board of Directors updated on developments of this programme.
8. MT sought assurance on securing executive support as the Trust continued to drive improvements. AC advised the Chief Operating Officer would review the structure of the operational team following the departure of LC. AC was working with an external company in terms of executive director search and talent management of succession to continue the work of the Chief Nursing Officer.

Decision: That the report be noted.

22/159 Head Governor Update

Consideration was given to a report presented by LC.

The following points were made in discussion:

1. Staff Governor elections took place and the vacant seat in estates and facilities had been filled.
2. Non-Executive Director recruitment continued.
3. Council of Governors meeting took place on 15 November where the following reports were provided:
    - Niche External Investigation Assurance
    - Winter Plan
    - External Auditors report on the Annual Report and Accounts
    - Governor Development Plan (approved)
4. The Annual Members' Meeting took place on 22 November 2022.
5. A new governor introductory meeting with the Chair and Chief Executive took place.
6. A briefing with the Trust's Council of Governors on trauma and orthopaedics, together with the Investigation by Design authors and Board of Directors was scheduled for 1 December 2022.
7. A joint meeting of the Council of Governors and Non-Executive Directors would take place in mid-December 2022.
8. Appointment of a Deputy Head Governor would be undertaken in December 2022.

Decision: That the report be noted.

22/160 Summary of Confidential Investigation Report on behalf of the University Hospitals of Morecambe Bay NHS Foundation Trust / Investigation by Design Report

Consideration was given to a report presented by JM.

The following points were made in discussion:

1. JM clarified the report focused on whether medical leaders had acted appropriately upon receipt of the clinicians' concerns.

2. The investigators found evidence that the Trust, including the medical leaders, did not recognise and treat the clinicians as whistleblowers. They did not recognise that concerns were raised in line with their rights under the Freedom to Speak up or claimed to recognise this but did not follow the relevant policy. They should have been treated as whistleblowers.
3. The concerns were raised by two consultants into a colleague's practice. The report confirmed there was no evidence of cover up and collusion in the way the medical leaders responded to those concerns.
4. The report listed the detriment to the consultants following the concerns they raised.
5. Following receipt of the report, an action plan had been developed; some actions had been completed and those that remained outstanding would be overseen by the appropriate Assurance Committee.
6. JM was grateful to the consultants who raised concerns and explained the Trust had learnt from this. On behalf of the Trust and Board, JM, apologised for the detriment caused to consultants for the failure in how the Trust responded to their concerns.

During deliberation of this item the following points were considered:

7. MT sought clarification which Committee would oversee the recommendations of the report. JM advised it would be the People Committee.
8. AC reiterated thanks to the clinicians who raised the issues and apologised to them both for the experience they had been through. AC commended the actions that had been undertaken and was pleased with the commitments from colleagues to make the necessary changes with continued focus on learning lessons and driving forward improvements.
9. JS-NED thanked those clinicians who raised the issues, particularly reflecting on the work done to improve processes and procedures of the Freedom to Speak Up service. JS-NED sought assurance on the evidence that medics were operating at the right level of competence by ensuring concerns were addressed through the monitoring of medical competence. JM advised that the process of sharing data at governance and audit meetings to identify any outliers had been developed.
10. AC reflected that the work to develop the quality framework and mortality framework would provide much earlier insight.
11. KD-NED sought assurance on how the action plan from this investigation connected with the cultural improvement work programme and other Assurance Committees. JM advised the action plan connected with the culture and OD work programme.
12. LCC sought assurance on the development of behaviour policies at medical school. JM had discussed this with the local medical school to explore this further. MT suggested the Board of Directors were kept informed of this and would like an update at the Board of Directors' meeting in February 2023.
13. LS-NED sought assurance on the work undertaken to support clinicians to have difficult conversations to drive forward the improvements. JM advised the support would be provided via the culture and OD work programme which was not limited to the trauma and orthopaedic service. The Trust was in the process of developing a leadership development programme for all clinical leads.
14. PW echoed LCC comments and advised the just and restorative work would support the work to show how many incidents were raised and those clinicians raising them. MT suggested the Board of Directors were kept updated on the just and restorative work programme. AC advised the just and restorative work would feature as part of the culture programme update.
15. AL-NED was pleased to note there had been no evidence of a cover up or collusion. As Chair of the People Committee, he welcomed the support of the Committee to monitor the action plan. Process and pace were referenced throughout the report. AL-NED was assured by the process outlined but not the pace. JM responded that the role of the

responsible officer and deputy medical director would focus on medical standards to drive forward the actions of the report.

16. AC acknowledged that the theme of pace was not unrelated to process. It was important to achieve the right balance.
17. SR-NED sought assurance on the risk of harm. The Quality Committee had considered the Royal College of Surgeons closure report and the Committee sought assurance on the embedded actions. It was important to balance this. SR-NED would welcome an update on progress against the action plan in February 2023.

Recommendation:

1. That the report be noted;
2. The Board of Directors acknowledged and supported the sincere gratitude towards the two colleagues who raised the clinical concerns;
3. The Board of Directors acknowledged and endorsed the apology stated for the colleague who was judged to have suffered a detriment as a result of them raising concerns;
4. That the Board of Directors agreed that immediate and ongoing actions would be overseen by the People Committee;
5. The Chief Medical Officer would discuss the development of behaviour policies at medical school with the local medical school and provide an update at the Board of Directors' meeting in February 2023.
6. An update on progress against the action plan would be provided to the Board of Directors in February 2023 as part of the monthly update report to the Board of Directors.

22/161i Care Quality Commission (CQC) and Royal College of Surgeons (RCS) Improvement Plans

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 on the recommendations undertaken.
2. Information on the actions to be taken during quarter 4 had been included in the report.
3. From October 2022, the impact on patient care as actions were completed was included in this report and this would continue to feature in future reports to demonstrate improved patient care due to completed / embedded actions.

During deliberation of this item the following points were considered:

4. MT sought assurance on the support provided to the Medicine Care Group. RS advised on the actions and support provided.
5. HR-NED explained the report was presented to the Quality Committee, and the Committee were assured on the actions taken.
6. SR-NED confirmed the check and challenge meetings with the Medicine Care Group were positive and was assured by the actions the Care Group were taking.
7. KD-NED sought assurance on whether the anticipated impact of winter pressures and industrial action had been included and how this had been mitigated. RS advised the industrial action and winters pressures had been factored into the programme to provide appropriate support the Care Group. KD-NED would welcome a further update in the report presented to the Board of Directors in December 2022.

Decision:

1. That the report be noted; and

2. A further update on the mitigations in place to manage winter pressures and industrial action would be included in the report presented to the Board of Directors on 22 December 2022.

22/161ii 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 clarified level 2 and 3 compliances.
2. The case note review conducted by Niche Consulting had been a positive experience for UHMB. The outcome of the review was awaited.
3. RS advised that future reports, as with the Care Quality Commission / Royal College of Surgeons update, would include the impact of completed actions.
4. RS advised there were no concerns to alert the Board to.

During deliberation of this item the following points were considered:
5. HR-NED confirmed this report was considered in detail at the Quality Committee. HR-NED suggested the attendance of clinicians at a future Quality Committee would provide greater insight into how the recommendations of the Niche report had been embedded. RS advised that RS/PJ were discussing a future date for the Board of Directors to meet the clinicians.
6. KD-NED sought assurance on how the recommendations outside UHMB were being taken forward and monitored. RS advised that he had regular meetings with colleagues from NHS England who were responsible for those recommendations. They provided assurance to Niche as the actions were completed.
7. AC clarified this was discussed at the System Improvement Board and an action was taken by the Chair of that Board to ensure the recommendations outside of UHMB were implemented. AC agreed to raise this again at the next System Improvement Board and would provide an update to the Board of Directors.
8. KD-NED sought assurance on the anticipated timeframe towards levels 4 and 5. RS advised the Trust was committed to achieving level 3 and was dedicated to ensuring all recommendations to level 4 and 5 had been woven into the new quality and governance framework.
9. MT clarified there would be an operational plan to support the UHMB ambition to achieve System Oversight Framework level 2.
10. LS-NED welcomed the addition of an impact report in future reports to demonstrate the difference completed actions had made to improve patient care.

Decision: That the report be noted.

22/162i Maternity Safety Update

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

The following points were made in discussion:
1. HG presented the key highlights from the monthly update. The learning themes were detailed in the report. The report detailed that moderate harm had increased due to the changes in reporting harms. Rolling stillbirth rate was outlined. EMBRACE published a peri-mortality report in October 2022 which showed the Trust was not an outlier and a

full report would be submitted to the Quality Committee in December 2022.

2. Regarding CNST safety standards, it was expected the Trust would achieve 7/10 which was good in comparison to 2021 (1/3).
3. Midwifery Support Worker, Nicola Potts had been awarded the Chief Midwifery Officer's MSW Award for continually demonstrating NHS values. This was a new award scheme by the NHSE Chief Nursing Officer, Ruth May.
4. The Kirkup Report "*Reading the signals – Maternity and neonatal services in East Kent – the Report of the Independent Investigation"* had been referenced in the report which summarised the outcome of the independent investigation published in October 2022. There were four broad national recommendations: *monitoring safe performance – finding signals among noise; standards of clinical behaviour – technical care was not enough; flawed teamwork and organisational behaviour – looking good whilst doing badly*.

During deliberation of this item the following points were considered:

5. PW thanked HG for the concise report and referenced the importance of communication and reputation.
6. AC reflected on the importance of focusing on the thematic learning points.
7. KD-NED thanked HG for the report and referring to the recommendation on *finding signals among noise* and the UHMB maternity dashboard sought assurance on the data. HG advised the data accuracy was good and the next step was to split the data by site to provide greater assurance it was accurate. KD-NED sought assurance on the timeframe for this. HG suggested this was discussed in further detail at the next maternity safety champions meeting.
8. HR-NED confirmed the Quality Committee considered all the maternity reports.

Decision: That the report be noted.

22/162ii Perinatal Mortality Review Tool Report

Consideration was given to a report presented by HG.

The following points were made in discussion:

1. A PMRT review was undertaken following a request from NHSE following an external review. It was advised UHMB undertook a review of the grading of care and the involvement of families in the PRMT process. This review was undertaken in July 2022 and August 2022. This report had been presented to a previous private meeting of the Board of Directors and for the purposes of a public report, all patient identifiable data had been removed.
2. 29 cases were reviewed as 1 set was not available. The report outlined the issues identified. Out of the 29 cases, 4 of the PMRT cases were reclassified from a C to an A rating. The 4 cases had been raised as a serious incident and the team were supporting the families.
3. There were 26 families the external review group recommended the Trust contacted regarding their PMRT findings and reports. There was evidence in two cases the families had received their PMRT review findings.
4. For all the families involved in the review, they had been offered specialist bereavement counselling. Staff involved in the cases where the care had been upgraded had also been offered support. The team were working with all families to ensure the PMRT was inclusive of their questions and involvement. HG advised 12/26 reviews had been completed with the families and it was anticipated that by the end of December 2022 all cases would have been completed, noting this date was fluid as it was guided by the families.

During deliberation of this item the following points were considered:

5. AC confirmed this was considered at a recent private Board of Directors' meeting and to be transparent, it was agreed this report would be presented at a public Board of Directors' meeting.

Decision: That Board of Directors received the findings and recommendations of the external review and endorsed and supported the actions which had been undertaken and requested the Quality Committee seek further assurance on the sustainable delivery of the PMRT action plan.

22/162iii Maternity Workforce Staffing Reports

Consideration was given to the following reports presented by HG.

CNST Obstetrics Anaesthetic Workforce Report

1. This was a report to approve the evidence of compliance with Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1. This evidence is required for NHS Resolution Maternity Incentive Scheme Year 4. HG advised the Trust had achieved full compliance with this standard.

Decision: That the Board of Directors noted the Trust had achieved full compliance with this standard.

CNST Midwifery Workforce Report

2. This was a report to demonstrate an effective system for midwifery workforce planning and monitoring of safe staffing levels from May 2022 to October 2022. This is a requirement of the NHSR Maternity Incentive Scheme for Safety Action 5.

Decision: That the Board of Directors noted the Trust had met the recommendations of CNSTs 10 maternity safety actions.

CNST Neonatal Workforce Report

3. This was a report to demonstrate an effective system for clinical workforce planning. This is a requirement of the NHS Resolution Maternity Incentive Scheme for Safety Action 4. HG advised the Trust had achieved full compliance with this standard.

Decision: That the Board of Directors noted the Trust had achieved full compliance with this standard.

22/162iv Maternity Voice Partnership Report

Consideration was given to a report presented by HG.

The following points were made in discussion:

1. HG advised this report provided an update on the work of the Maternity Voices Partnership (MVP). The MVP was a service user representation group, commissioned by the Integrated Care Board who work closely with maternity services and the Local Maternity and Neonatal System (LMNS).

During deliberation of this item the following points were considered:

2. HR-NED confirmed this report was considered by the Quality Committee.

Decision: That the report be noted.

22/163 Learning from Better Tomorrow External Review Progress, Mortality Update and Medical Examiner Update

Consideration was given to a report presented by JM.

The following points were made in discussion:

1. JM confirmed the action plan following the Better Tomorrow external review of deaths and peer review of structured judgement reviews (SJR) in June 2022 was progressing and improving the mortality review processes. Improving mortality processes formed part of the recovery support programme workstream to improve learning from deaths, reviewing and refreshing the UHMB policy and establishing culture and practice to improve care for the living.
2. JM paid tribute to Ameeta Joshi (AJ), Deputy Medical Director, for preparing the improvement plan. The Better Tomorrow team had presented to the Care Groups. The learning from deaths policy had been updated to reflect the findings of the review. AJ was working with the Better Tomorrow team and I3 team to develop an improvement mortality dashboard.
3. Referring to SJRs, JM confirmed additional colleagues had been recruited to conduct the SJRs; there were 12 colleagues in total who were able to carry out these reviews. JM advised that the number of reviews had decreased due to the availability of the reviewers. Once all 12 reviewers were in place, following training, it was anticipated the number of reviews would increase.
4. The first meeting of the Mortality Triangulation Group took place in November 2022. The Terms of Reference had been aligned to best practice. The group reported to the quality governance group structure.
5. AJ had arranged for the end of life lead and learning disability matron / dementia matron to present to all Care Group audits from December 2022 to February 2023 to further improve end of life decision making for patients.
6. The mortality data was outlined.
7. Referring to fractured neck of femur, JM advised this was a longstanding issue overseen by the Quality Committee. JM provided an update on the actions taken and explained it formed a focused piece of work overseen by the trauma and orthopaedic fractured neck of femur steering and working groups with active action plans. There were signs of improvement, and it was anticipated from January 2023 onwards, the Trust would be able to demonstrate an improved trajectory in SHMI data for fractured neck of femur.
8. JM advised that in relation to the peripheral and visceral atherosclerosis cases, they continued to be reviewed by the clinical lead for surgery/mortality with no concerns identified in terms of care provided.
9. The medicine team were currently reviewing all cases related to congestive heart failure, non-hypertensive.
10. JM provided an updated on the medical examiner service which was hosted by UHMB but independent to the Trust. JM advised that from April 2023 medical examiners were mandated to undertake scrutiny for all non-coronial deaths and roll out into primary care. The Trust was working with 2 pilot practices – Lancaster Medical Group and Park View Medical practice to start roll-out of medical examiner scrutiny from January 2023.

During deliberation of this item the following points were considered:

11. SR-NED sought assurance on the outcome of the review of congestive heart failure by the medicine team. JM advised this would be reported to the Mortality Steering Group

and then to the Quality Committee. SR-NED sought assurance on the response to supporting colleagues delivering improved end of life care. JS advised on the actions being undertaken.

12. BR advised of the workstreams undertaken in respect of end of life care.
13. Referring to end of life care, KD-NED commended Dan West's promotion of the SWAN model used to support and guide the care of patients and their families during end of life care. KD-NED sought assurance on whether the work on learning disabilities related to people with autism and those with mental health challenges. JM advised she would review this to confirm.

Decision: That the report be noted.

22/164 Recovery Support Programme – UHMB Improvement Plan and Overview of Gateway Review Process

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 reflected that several reports on the agenda were connected to the recovery support programme. CA advised there were two sections to the report: the latest version on the delivery of the programme and a supplementary report on the wider gateway review process. Part 1 of the report provided a progress update of the recovery support programme directly related to the exit criteria. The update included information on stroke services, the work ongoing in respect of the Care Quality Commission *must do* recommendations and the freedom to speak up arrangements. The second section of the report provided an update on the gateway review process. CA advised of core processes last month. This was set out in the assurance section of the report. The assurance approach, scope and sequencing of the assessment process that would be used to determine the Trust's exit from the recovery support programme and level 4 of the System Oversight Framework (SOF) had been included in the report. A status update on each of the core systems and processes had been included in the report. CA advised that the financial position of the Trust did not contribute to the Trust being placed in SOF level 4. The licencing conditions, however, were specific about financial improvements; the financial improvement section of this report would be updated to take this into account.

Decision: That the report be noted.

22/165i Integrated Performance Dashboard and Report Month 6

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. CA advised work to refine and improve the integrated performance report in partnership with the NHSI/E improvement team continued. The development of a Care Group integrated performance report was on track.
2. BL advised the quality section of the report had been discussed at the Quality Committee. There had been an increase in StEIS reporting which reflected the change in processes. Referring to pressure ulcers, BL advised the top 3 areas had been targeted using quality improvement methodology. The position for UHMB in November 2022 showed there had been a reduction in pressure ulcers but it would continue to be

monitored. BL provided an update on the *clostridium difficile* position. Nationally there was an increase in *clostridium difficile* cases. BL provided an update on the friends and family test data.

3. JM provided an update on venous thromboembolism assessments.
4. Referring to appraisals. BE advised this formed a focused review by business partners to improve compliance. Bank and agency fill rates were outlined. BE advised the current flu uptake was 42%; communication would continue to promote uptake as this was a particularly difficult strain of flu.
5. CA advised in relation to the Pay Control Board, the first meeting in its new form would meet on 6 December 2022. CA advised of the Trust's financial position at the end of September 2022. The team were working on a revised forecast and associated improvement plans which were reported to the Finance Committee. The outcome of the month 9 review was awaited.
6. BE advised the vacancy rate masked the consultant rate at 15% and midwifery level at 20%. In terms of the consultant vacancy rate, BE advised there was an improving picture in the Medicine Care Group compared to the end of September 2022. The team were working to ensure the vacancies were filled as soon as possible. The People Committee would continue to monitor this.
7. JM advised on the support given to the teams with the level of vacancies. In terms of personal support, the support of the Clinical Directors, Deputy Medical Directors and occupational health were available.
8. LC provided an update on urgent care; the Trust remained under pressure with sustained deterioration. The drivers for this had been articulated at previous Board of Directors' meetings. The not meeting criteria to reside standard had reduced from 150/170 to 120. Regarding meeting the four hour Emergency Department standard, UHMB was currently operating at 78% which was the third best regionally and top 10 for type 1 in the country. The key focus remained on implementing the urgent care and winter plans. Cancer performance was outlined. The implementation of the diagnostic performance improvement plan would ensure the Trust was working towards the national standard of 1% and in line for 5% by March 2025. Referral to treatment performance was 68%; with the biggest focus on patients waiting 52 weeks.

During deliberation of this item the following points were considered:

9. JS-NED sought assurance on stroke data and whether the Quality Committee would be monitoring this. LC advised there had been a static position at Furness General Hospital (rated B) and at the Royal Lancaster Infirmary (rated C) which was fragile. Key areas of focus remained on therapies and thrombolysis which would be measured and reported to the Quality Committee. The new therapies unit would be up and running in January 2023. The sub-domains were demonstrating signs of improvement on the SPC charts which sat under the SSNAP score. JS-NED noted the actions taken to address this and would feel assured that the Quality Committee continued to monitor this.
10. SR-NED sought assurance on how response to the Care Quality Commission *must do* recommendations was reflected in the integrated performance report. BL advised that that *must do* recommendations were included at dashboard level.
11. LS-NED explained the performance accountability reviews were helpful to understand the Care Groups issues. LS-NED sought assurance on the response to the medical consultant vacancy rate in the Medicine Care Group.
12. KD-NED confirmed the Finance and Performance Committee considered the financial improvement plan.
13. SR-NED sought assurance on what was driving the cancer 62-day performance. LC advised the team were working with NHSE colleagues and cancer alliance to review best practice.
14. AL-NED commented that in terms of the did not attend rate, he welcomed further

information on the success of the patient appointment system and how effective this would make an impact on that. AL-NED sought assurance on the reason the not meeting criteria to reside standard had improved. LC advised the winter plan had been deployed and had enabled the improvements to be made as well as reviewing the effectiveness of the ward board rounds.

Decision: That the report be noted.

22/165ii Assurance Committee Minutes and Chairperson's Report

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

Finance Committee

KD-NED provided an update on the work of the Committee. The outreach acute care team business case was presented. In terms of the British Medical Association (BMA) rate card, the Committee noted the significant reduction in the elective recovery fund; this had been reported as a potential risk.

Quality Committee

HR-NED provided an update on the work of the Committee. Referring to the BMA rate card, circa 2000 patients had had their treatment delayed due to the additional sessions not taking place. JM met with the Joint Local Negotiating Committee and there was agreement in principle; the team were currently working through the detail. AC advised that in agreeing a different rate, agreement was reached in relation to a review of job plans and a commitment to the minimum levels of activity. HR-NED advised the Committee considered the Royal College of Surgeons' closure report.

Quality and Safety of Mental Health, Learning Disability and Autism in Inpatient Services

An assurance report from the Quality Committee following a letter received from Claire Murdoch, National Director for Mental Health, in September 2022 regarding quality and safety of mental health, learning disability and autism in in-patient services. This had been mandated for submission to the Board of Directors' meeting.

Decision:
1. That the report be noted; and
2. That the Board of Directors were assured that systems were in place to prevent and detect cultures that cause harm to patients and families.

Culture Programme Board

AC provided an update on the work of the programme.

22/166 Development of the Clinical Strategy for UHMB

Consideration was given to a presentation by JM which included:
1. Details on the development of the strategy.
2. Engagement to date from July 2022.
3. Testing of the clinical strategy to improve quality and meet patient expectation whilst being financially sustainably.
4. Models of care: urgent and emergency care; outpatients; cancer; planned, integrated

care and maternity.
5. Emerging themes outlined.
6. Next steps outlined.

During deliberation of this item the following points were considered:
7. MT sought assurance on patient involvement. JM clarified the Head of Patient Experience was part of the group and was responsible for ensuring patient representation.
8. KD-NED sought assurance on how patient safety data would inform the strategy. JM clarified mapping to best practice of clinical practice was included. SH advised the data packs were robust which included get it right first time data.

Decision: That the report be noted.

22/167 Cultural Transformation Programme Update

Consideration was given to a report presented by BE.

Decision: That the report be noted.

22/168i Integrated Care Board Update / Provider Collaborative Board Update

Consideration was given to a report presented by AC.

The following points were made in discussion:
1. AC advised a standard report produced by the Provider Collaborative Board (PCB) would be shared with all Trusts across the provider collaboration to inform the Trusts on the work / priorities of the PCB.

During deliberation of this item the following points were considered:
2. JS-NED sought assurance on the outcomes from the PCB. AC would ensure a retrospective view was included in future reports to track impact and the actions agreed by the PCB.

Decision: That the report be noted.

22/168ii Provider Collaboration Joint Committee and Delegation of Powers Proposal

Consideration was given to a report presented by PJ.

The following points were made in discussion:
1. PJ advised the report included the formal proposal by the Provider Collaborative Board (PCB).

During deliberation of this item the following points were considered:
2. SR-NED stated that the chair's term may be renewed and sought clarity on the number of times. In terms of delegated decision making, SR-NED sought assurance on whether the Council of Governors would be kept informed. MT confirmed Browne Jacobson, who were the legal team supporting the PCB, would discuss this with the Council of Governors, but their approval was not required.
3. HR-NED sought assurance on whether this proposal was temporary or permanent. MT clarified this was a permanent proposal under the new legislation.

Decision:
1. That the Board of Directors noted the report and the Terms of Reference and approved the document setting out the formation of a Joint Committee and the delegation of powers as per section 5 pf the Terms of Reference; and
2. Agreed the process for seeking approval from the ICB and NHS England to progress before 1 April 2023 as set out in the Executive Summary.

22/169 Introduction of the CQC Single Assessment Framework

Consideration was given to a report presented by RS.

The following points were made in discussion:
1. RS advised this report articulated the summary of key issues and the Board were requested to note the change in framework from 1 January 2023. The team would review this but there were no concerns to alert the Board to. MT requested a further update once the framework was in place.

Decision:
1. That the report be noted; and
2. A further update would be given once the single assessment framework was in place.

22/170 Attendance Monitoring Register

Noted.

22/171 Schedule of Business

Noted.

22/172 Urgent Business

None.

22/173 Date, Time and Venue of Next Meeting

It was noted that the next meeting of the Board of Directors would be held on Thursday 22 December 2022 at 9.30am in the Board Room, Westmorland General Hospital, Kendal LA9 7RG and also via Microsoft Teams.

22/174 Exclusion of the Press and Members of the Public

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

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Meeting Title	**Board of Directors' Meeting (Public) Action Tracker**
Meeting Chair	**Mike Thomas**
Previous Meeting Date	30/11/2022
Next Meeting Date	22/12/2022

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	25/01/2023			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	22/02/2023			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	25/01/2023			This has been scheduled for January 2023.	**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
28/09/2022	115	CEO Report	It was agreed a colleague engagement report would be presented to a future Board meeting.	Interim Chief People Officer	25/01/2023				SBM
26/10/2022	144	Quarter 2 / Board Assurance Framework Review 2022/23	It was agreed that the BAFR2: Colleague psychological and physical well-being score be lowered to 9.	Company Secretary	25/01/2023			The Board Assurance Framework would be updated to reflect this.	SBM
26/10/2022	146	Chief Medical Officer's Update	It was agreed an update following the review of the BMA fatigue and facilities charter by the Deputy Medical Directors would be included in the next Guardian of Safe Working Update report.	Chief Medical Officer	25/01/2023			An update will be included in the next report.	SBM
30/11/2022	156	Patient Story	The Head of Patient Experience to contact the patient on behalf of the Board of Directors to explain there would be changes based on his experience, and ensure the patient was finanically reimbursed for the cost of travel to WGH..	Head of Patient Experience	30/11/2022			Feedback has been given to the patient. Financial reimbursement will be offered and an update will be given at the meeting.	SFM
30/11/2022	160	Summary of Confidential Investigation Report on behalf of the University Hospitals of Morecambe Bay NHS Foundation Trust / Investigation by Design Report	The Chief Medical Officer would discuss the development of behaviour policies at medical school with the local medical school and provide an update at the Board of Directors' meeting in February 2023.	Chief Medical Officer	22/02/2023				SBM
30/11/2022	161i	Care Quality Commission (CQC) and Royal College of Surgeons (RCS) Improvement Plans	A further update on the mitigations in place to manage winter pressures and industrial action would be included in the report presented to the Board of Directors on 22 December 2022.	Director of Governance	22/12/2022			An update has been included in the report.	SFM
30/11/2022	169	Introduction of the CQC Single Assessment Framework	A further update would be given once the single assessment framework was in place	Director of Governance	22/02/2023				SBM

BOARD OF DIRECTORS

Date of Meeting	22 December 2022
Title	Chair's Report
Report of	Professor Mike Thomas, Chair
Prepared by and contact details	Maria Caparelli maria.caparelli@mbht.nhs.uk

Confidentiality	Non-Confidential

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

The content of this report outlines:

- Introduction
- An outline of the Chair's activities throughout December 2022;
- An outline of the Non-Executive Directors' activities throughout December 2022
- Final Remarks

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

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

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

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

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

Acronyms	

UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST

Chair's Report

Introduction

1. I would like to begin by welcoming colleagues to today's Trust Board of Directors meeting. You will note that today's agenda is significantly lighter than usual, due to the November meeting only being three weeks previous, and an early December Board prior to Christmas.

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. As we come to the end of the year, the Trust remains focused on enhancing and improving our services and sustaining change in-line with our organisational priorities, into the New Year.

4. I would like to offer a huge thank you to everyone in the Trust for all they have done in the past year. Also, my thanks to my Board colleagues, the Council of Governors, and to the System Improvement Board.

5. Finally, my best wishes to all for a peaceful festive period and New Year.

Chair's Activities

6. Meetings and events I attended in the month of December included, but not limited to, Provider Collaborative Board (PCB) meeting, Place Development session, Armed Forces Veterans' session, Chair, Head Governor and Deputy Head Governor meeting, Joint Governor and Board Session, New Hospitals Programme (NHP) Trust Engagement meeting, Chair and Non-Executive's meeting, and Chair and Chaplaincy meeting.

7. On 15 December 2022, I attended, together with the Chief Executive and Executive colleagues, the Annual PCB Event. Colleagues came together to discuss a number of key issues on the current agenda via a series of breakout sessions. This was a valuable opportunity to come together ahead of the New Year.

8. 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.

Non-Executive Directors' Activities

9. Meetings Non-Executive Directors attended for December 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.

10. 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.

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

Final Remarks

12. I am 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.

13. I look forward to the next meeting of the Trust Board in January 2023.

Professor Mike Thomas
Chair

December 2022

TRUST BOARD OF DIRECTORS

Date of Meeting	22 December 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 our meeting agendas, 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: • Urgent Care • Industrial Action • Winter Vaccinations

Prior Discussions	Committee	Date	Recommendations/ Concerns

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

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

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

Acronyms	

UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST

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 Care Quality Commission (CQC) and Royal College of Surgeons (RCS) Improvement Plans, Niche External Investigation Assurance, Maternity Safety Update, Recovery Support Programme (RSP) – UHMBT Improvement Plan – plus the usual standing items for the Board to consider and receive. It is important to note however that given the proximity to the November Board meeting, today's agenda is lighter agenda than usual.

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

4. Urgent care is pressured across our hospitals, our departments are full, and we have a number of patients not meeting criteria to reside. We have also seen a number of younger patients with Streptococcus A (Strep A) and general respiratory issues.

5. Colleagues and teams continue to work incredibly hard to ensure the safety of our patients across our hospitals and in the community. We are working hard to support colleagues particularly during this difficult time.

6. As we head into 2023, our focus remains on our Recovery Support Programme (RSP) and working towards exiting System Oversight Framework (SOF) 4, preparation for winter, our quality and safety improvement and financial improvement work.

7. We are also focussed on the development of our system, in particular the Provider Collaborative and Place-Based Partnerships. A series of Place-Based sessions have been taking place during November and December and I look forward to seeing these partnerships develop.

NATIONAL AND REGIONAL UPDATES

Industrial Action

8. Trade unions representing staff in the ambulance service have announced strike action dates for December 2022.

9. UNISON, Unite and the GMB have confirmed that members will take part in strike action on Wednesday 21 December 2022. GMB members will take part in an additional strike day on Wednesday 28 December 2022.

10. Strikes on these dates will mainly impact NHS ambulance services. We are working through the implications of this action on our services and the mitigations we can put in place to minimise impact.

Lancashire and South Cumbria Integrated Care Board (ICB)

11. 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.

12. I plan to include the following section as a standing item in my reports each month as it serves as a useful reminder of the new structures.

13. 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.

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

15. 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.

16. 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.

17. 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.

18. 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.

19. Additionally, a copy of the ICB CEO Board Report from their meeting on 7 December 2022 containing key updates is appended to this report for information.

20. The next standing bi-monthly integrated Care Board Update / Provider Collaborative Update will feature at the January Board meeting.

Lancashire & South Cumbria Provider Collaborative Board (PCB)

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

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

Programme Board update, Pathology Collaboration update, Clinical Integration update and joint committee working.

23. On 15 December 2022, an Annual PCB Event was held where partners came together in workshop mode to talk through some of the key workstreams underway - and some of the challenges and opportunities these present.

24. A series of breakout sessions focussed on:

- Mental and Physical Health Integration
- Clinical Strategy
- Corporate Collaboration/Common Services
- Reset for the Growing Financial Sustainability Challenge
- Workforce Challenges
- Engaging and Involving our Workforce/Communities
- Barriers to Collaboration and How to Overcome Them
- Provider Collaboration – The Next Steps

25. This event was a useful opportunity to come together and spend some quality time on a number of key issues.

Morecambe Bay Place-Based Partnerships

26. 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.

27. The Bay Health & Care Partners (BHCP) Place-Based Leadership Team meet regularly and the next formal meeting is scheduled to take place on 19 January 2023. In-between the formal meetings, a series of Place-Based sessions have taken place in support of developing the new partnerships.

Primary Care Networks

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

TRUST UPDATES

Winter Vaccinations

29. Our Occupational Health and Wellbeing team (OH) is continuing to run a roving vaccination campaign this year and are visiting all departments and areas on both hospital and community sites over the coming weeks.

30. There are separate drop-in clinics and walkabouts being held for the Influenza vaccination and for the COVID-19 booster vaccination. Colleagues will not be able to get both at the same time. Dates and times are being circulated via corporate communications

31. As well as our OH roving vaccination campaign there are many other options available to colleagues. If you are able to, we strongly encourage you to get your COVID-19 booster or Influenza vaccination as soon as possible through your local sites such as:

    - GPs
    - Primary Care Network centres
    - Pharmacies

32. NHS colleagues may need to show some ID as proof you are a healthcare worker for eligibility reasons.

33. If you do go to a community site for your vaccinations, please contact our Occupational Health Team on occhealth.referrals@mbht.nhs.uk to let them know so your records can be updated accordingly.

34. Vaccinations only take a few minutes and getting vaccinated against flu and COVID-19 is the best form of protection for you and those around you for these serious illnesses.

RELATIONSHIPS AND PARTNERSHIPS

Engaging with colleagues across the Trust

35. I mentioned in last month's report that I would be re-launching my Tea and Talk session from the beginning of December.

36. There will be a number of sessions at different times each month which are a mixture of face to face in the restaurant at each of our three main hospitals, and virtual via Microsoft Teams.

37. The aim of this approach is to try and reach as many colleagues as possible - including those working shifts and those working remotely. I know there is no easy time to capture all colleagues but hopefully, this mix will work for most.

38. My dedicated Tea and Talk sessions with our community teams will continue but community colleagues are, of course, welcome to attend any of the above if and when they can.

39. The sessions are completely informal with no agenda, and you can just drop in when it suits you so don't worry if you can only join for part of it. If you have something on your mind, want to ask me a question or simply just have a chat about something, please come along.

FINAL REMARKS

40. 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

41. 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”.

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

43. The next meeting of the Trust Board will be held on 25 January 2023. Some of the items featuring on the agenda will be: Care Quality Commission (CQC) and Royal College of Surgeons (RCS) Improvement Plans, Niche External Investigation Assurance, Maternity Safety Update, Recovery Support Programme – UHMB Improvement Plan, NHS Resolution Year 4, Avoiding Term Admissions into Neonatal Units (ATAIN) Report, Quarter 3 – Operational Plan Priorities and Board Assurance Framework Review, Draft UHMB Clinical Strategy, Effectiveness Review of Trust Strategy, Cultural Transformation Programme Update, Nursing, Midwifery and Allied Health Professional Bi-annual Staffing Report, New Hospital Programme Quarter 3 Report, Integrated Care Board Update / Provider Collaborative Update, UHMB Green Plan, Freedom to Speak Up Review, Patient Safety Incident Response Framework Update – plus the usual standing items for the Board to consider.

44. 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. I wish you all the very best for the festive period and the New Year.

Aaron Cummins
Chief Executive

December 2022

Lancashire and South Cumbria Integrated Care Board

Integrated Care Board

Date of meeting	**07 December 2022**
Title of paper	Chief Executive's Board Report
Presented by	Kevin Lavery, Chief Executive Officer, Integrated Care Board
Author	Lisa Roberts, Business Manager and Executive Team lead contributors
Agenda item	5
Confidential	No

Purpose of the paper

This paper provides the CEO with the forum to update Board members on actions since the last board and highlight emerging issues and key areas of focus, to ensure Board members are sighted on the business of the Integrated Care Board (ICB) and its wider operating environment.

Executive summary

The ICBs ambition is for Lancashire and South Cumbria (LSC) to become a world class, community-centric health and care system with great health outcomes and narrowing inequalities.

My CEO report last month focused on where we need to address performance issues, to improve quality and close the financial gap. Although the ICBs NHS System Oversight Framework (SOF) rating is SOF 3, there is a lot to be proud of and this report highlights three examples of high performance and innovation - Virtual Wards, Chatbot and Falls Lifting service.

This report also provides an update regarding the launch of the The Mutually Agreed Resignation Scheme (MARS) and consolidation of accommodation across our region. Both schemes will help us to achieve financial sustainability through recurrent savings.

Recommendations

The Lancashire and South Cumbria Integrated Care Board is requested to note the updates provided.

Governance and reporting (list other forums that have discussed this paper)

Meeting	Date	Outcomes
n/a	n/a	n/a

Conflicts of interest identified

Not applicable

Implications

If yes, please provide a brief risk description and reference number	**Yes**	**No**	**N/A**	**Comments**
Quality impact assessment completed			x	
Equality impact assessment completed			x	
Privacy impact assessment completed			x	
Financial impact assessment completed			x	
Associated risks			x	
Are associated risks detailed on the ICS Risk Register?			x	

Report authorised by:	Kevin Lavery Chief Executive

Integrated Care Board - 7 December 2022

Chief Executive's Board Report

1. INTRODUCTION

1.1 The ICB's ambition is for LSC to become a world class, community-centric health and care system with great health outcomes and narrowing inequalities. We are not going to have extra resources as we have had in recent years, so there will need to be a step-change in productivity in our system, a positive, joined-up culture, high performing trusts and a joined-up partnership with local government and the voluntary sector on integration of care and health, plus investment in domiciliary care. We will also need to see a much stronger primary care system with more focus and investment in prevention and early intervention.

1.2 My CEO report last month focused on where we need to address performance issues to improve quality, close the financial gap and improve our NHS System Oversight Framework (SOF) rating. Despite being a SOF 3 ICB, with generally SOF 3 trusts, there is a lot to be proud of and this month I want to shine a light on some examples of high performance and innovation.

2. VIRTUAL WARDS

2.1 I was on a regional call last week where East Lancashire Hospitals Trust (ELHT) was held up as the 'holy grail' in terms of their utilisation of virtual wards. We need to help our other trusts to level-up, as the use of virtual wards will make a significant contribution to system pressures this winter. ELHT had an 80% occupancy rate for the period from 15-21 November, compared to the overall LSC figure of 56% for the same period.

2.2 We recognise that the starting point for this work varies across each trust. The success at ELHT is built on years of sustained investment in and transformation of intermediate tier home-based services, well-established relationships, a culture of working together across primary, community and secondary care, avoidance of unnecessary admissions from A&E and enabling earlier discharges.

2.3 A virtual ward model has been developed and implemented for LSC to incorporates best practice from across our system, including the development of sustainable workforce plans and improving admissions and referral rates which were showcased at a National Virtual Ward Clinical Summit last week, presented by colleagues from both ELHT and Blackpool Hospitals Trust (BTH).

2.4 We have spent a lot of time on 'hearts and minds' work with clinicians across LSC enabling us to scope options for expansion into different pathways and services from an original base of frailty and respiratory and into end-of-life care, paediatrics and eating disorders services.

2.5 It is very much alive and innovative and further opportunities have been identified to connect this with similar schemes implemented through our local authority partners. Alongside that, we are exploring system efficiencies and the development of a shared platform for all of our trusts to adopt as the current systems and reporting requirements are bureaucratic and onerous.

2.6 There are expansion opportunities (supported by national funding streams), but virtual wards should be viewed as part of the ICB and Integrated Care Partnership (ICP) longer-term solution, alongside investment into domiciliary care, intermediate care, and the whole frailty pathway, with significant Virtual Ward funding mainstreamed through the ICB 3-year budget and the Better Care Fund (BCF) which is jointly funded by health and local government.

3. CHATBOT

3.1 I have been really impressed with how we are working as a system to reduce the waiting times for treatment thanks to innovations such as Chatbot, which is helping to provide a greater level of control over treatment and condition management and is on track to contact 30,000 patients before the end of March 2023.

3.2 Chatbot was designed by Lancashire Teaching Hospitals (LTH) colleagues to reach patients on waiting lists to determine if they still require treatment; guiding patients through a series of questions designed by NHS consultants and healthcare experts. Following a pilot in Morecambe Bay and Preston, this has now been rolled out to other hospitals and medical specialties in Lancashire and South Cumbria and is being adopted by other ICBs.

3.3 So far, out of 13,583 validated patient contacts in LSC, almost 1,200 patients, 9% have indicated they could leave the waitlist and 22% indicated they require an appointment sooner.

4. FALLS LIFTING SERVICE

4.1 The NHS England's (NHSE) 'Going Further for Winter' letter required all ICBs to implement a Falls Lifting Service as part of winter resilience measures, but we are somewhat ahead of the game here with a 24/7 365 days-a-year, falls response and pick up service across Lancashire, Blackburn with Darwen, and Blackpool which is seen as a leader regionally. We are in the process of scoping and implementing the service for South Cumbria and looking to finalise a solution in the next month.

4.2 The service works closely with North West Ambulance Service (NWAS) call handlers to re-route patients from NWAS to the falls lifting service, who have an average response time of under 30 minutes. The alternative would be a category 3 or 4 Ambulance which may take several hours leading to 'long lies' for people on the floor which inevitably result in hospital conveyance/admissions and poor health outcomes.

4.3 Across Lancashire, Blackburn with Darwen, and Blackpool the service responded to 1500 call outs in October 2022. In effect this saved around a

thousand ambulance call outs in one month alone, freeing them up to deal with more urgent ill and injured patients.

4.4 The service continues to expand and now also cover falls within care homes across Lancashire, Blackburn with Darwen, and Blackpool and Local Authority domiciliary care agencies. Further improvements are underway to identify people earlier in the referral process and to enhance the electronic links between services.

5. SPECIALISED COMMISSIONING

5.1 NHSE is currently the accountable commissioner for 154 prescribed specialised services. In line with the Health and Care Act 2022, there is the provision for the commissioning of these services to be delegated to the ICB from April 2023. LSC ICB submitted a Pre-Delegation Assessment Framework (PDAF) to NHSE on 4 November in readiness for the national moderation panel on 16 December 2022.

5.2 There are risks associated with the April 2023 timeframe arising from the lack of clarity regarding the new financial allocation methodology; the operational model including workforce arrangements; and governance arrangements particularly where services are delegated across multi ICBs. As a consequence, the PDAF submitted by LSC declared a preference for joint working arrangements with NHSE from April 2023 with delegation commencing in April 2024. At a national level, only two ICBs stated a preference for delegation from April 2023 and this has resulted in a national decision that no system will have specialised services delegated at that time.

5.3 Work is now commencing on ensuring that systems are ready for joint working arrangements from 1 April 2023 and focusing on three key areas: technical requirements, including governance, finance and contracting arrangements; support for areas of development identified in individual ICB PDAFs; and the development of an Organisational Development (OD) programme between NHSE and ICBs.

6. MUTUALLY AGREED RESIGNATION SCHEME (MARS)

6.1 The Mutually Agreed Resignation Scheme (MARS) was launched on 15 November, following endorsement by the ICB Remuneration Committee and NHSE, and agreement by the staff-side representative. This is a voluntary, one-off scheme open to all staff employed by LSC ICB. The scheme and will help us to achieve financial sustainability by mutual agreement. The scheme will run until 2 December 2022, and we intend to notify staff of the outcome before Christmas. A further update to Board members will be provided at the meeting.

7. ACCOMMODATION

7.1 We currently have six properties that are largely empty and expensive to run. We are not an organisation of home workers, but through the introduction of agile working, we have more office space than we need, which is not necessarily in the right place or in the right style for our modern working practices. In July, the decision was taken to look at options to rationalise our estate to provide better accommodation that promotes collaboration and saves money.

7.2 This work has led to the consolidation of our buildings into two headquarters, based at the Lancashire County Council building in the centre of Preston, and the Lancaster University Health Innovation Campus, both of which have good accessibility by public transport and space that gives us the opportunity to integrate closer with our external partners, particularly local authorities, and universities. In addition, we have an indicative list of seven touchdown spaces across the four 'places' in LSC. The intention is to have a good spread of these facilities, referred to as touchdown spaces, across our patch to offer colleagues a space to work that is closer to their home. The accommodation we are moving to is vastly superior to our current accommodation and will save us around £650k per annum recurrently from 2023 onwards.

8. STAFF SURVEY

8.1 The 2022 NHS Staff Survey closed on Friday 25 November, with a final completion rate of 78.8% (372 respondents from an eligible sample of 472 staff) as an organisation. Once the results are published in January, the executive team will review the main themes and the directorate-specific feedback with a task and finish group to develop targeted actions that respond to the main concerns raised.

8.2 It is important for that we understand how our people are feeling across our organisation, so that we can take forward timely actions to improve their experience and make things better going forwards. We will be using a 'listening into action' approach to address what matters most for our people. We will focus on things that will make the greatest difference in improving the experience of our staff at work each and every day and we will be accountable for our success in delivering these improvements.

9. HSJ ARTICLE

9.1 You may have seen the recent HSJ coverage, which included reference to a staff briefing, a video of which was passed on and subsequently shared on Twitter, which is unfortunate. We removed the link as soon as this came to light and are employing Vimeo technology for future staff briefings, but we are unable to completely remove the risk of this happening again. I stand by what I said, there will be tough decisions ahead, but staff need to know that we are doing everything we can to ensure these briefings are a safe space where they are able to contribute and ask questions without this risk of this being shared with a wider audience.

10. REGISTERS OF INTEREST AND MANAGEMENT OF CONFLICTS OF INTEREST

10.1 Julian Kelly, Chief Finance Officer NHSE, wrote to ICB Chief Executives, Chief Finance Officers and Audit Chairs on 21 November requesting that all ICBs undertake an urgent self-assessment of their local register of interests and management of conflicts of interests and respond to NHSE by Monday 5 December. The letter outlined ten self-assessment questions, some of which go over-and-above the current guidelines that we are already adhering to, and we are reviewing and updating the ICB's declaration of interest register in light of this additional level of scrutiny. The Board development session in January will include a fraud awareness session, delivered by the ICB's Anti-Fraud Specialist, and will

include fraud, bribery and corruption, cyber fraud, conflicts of interest and gifts and hospitality.

11. RECOMMENDATIONS

11.1 The Lancashire and South Cumbria Integrated Care Board are requested to note the updates provided.

Kevin Lavery
7 December 2022

BOARD OF DIRECTORS

Date of Meeting	22 December 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: • Joint Board and Governor T&O Briefing • Appointment of the Deputy Head Governor • Meeting of the Chair & Head Governor • Lancaster University Governor Appointment Looking ahead to January 2023: • Non-Executive Director and Associate Non-Executive Director recruitment ongoing with plans to hold interviews in January 2023

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	22 December 2022
Title	Progress Report on Care Quality Commission (CQC) Improvement Plan
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

- This report summarises the current position and progress of the Improvement plans to address:
  - CQC Must Do recommendations
  - CQC Should Do recommendations
- This report combines the findings of three CQC inspections (August 2021, October 2021 and July 2022) into one report, which has been designed to meet the reporting requirements of Trust Assurance Committees, Trust Board and System Improvement Board (SIB).

Summary of Key Issues	• In the last reporting period (November 2022), 12 'Must Do' recommendations and 7 'Should Do' recommendations were completed. This meant that at the end of November, overall, 52/112 (46.4%) of the recommendations were complete. • At the end of November 28/61 (45.9%) 'Must Do' recommendations and 24/51 (47.0%) 'Should Do' recommendations were completed. • This represents an improvement of 16.9% from October 2022. • Underpinning each recommendation, there are groups of actions that must be completed for the recommendation to be recorded as closed. At the end of November 2022, 115/197 (58.4%) actions were completed, an improvement of 19.8% from October 2022. • At the end of November 2022, 73/120 (60.8%) 'Must Do' actions and 42/77 (54.5%) 'Should Do' actions were complete. • As demonstrated above, since the last Trust Board, good progress has been made towards action completion. However, in November there have been some challenges with our electronic recording system. This means that 27/55 actions due to be completed in November 2022 are showing as ongoing. A reconciliation exercise is being completed at the time of reporting. A further update will be provided at Trust Board. It is important to note that for the purpose of this report, these actions have been excluded from the completed actions denoted above.

	• Nine actions that were scheduled to complete from December 2022 – March 2023 have been closed ahead of schedule. • Action completion has been achieved by targeted focus by Care Groups. In Medicine the progress has been enabled by additional resource from a Compliance Specialist (1 day per week) and a Quality Improvement Facilitator (2 days per week) working in partnership with the Care Group and their leadership triumvirate. • To support timely and comprehensive completion of actions, Support and Review Panels remain weekly for Medicine, twice monthly for WACS and monthly for Pharmacy and Surgery. • The Trust will not be impacted by strike action. Therefore, this will not impact on completion of the recommendations. Winter pressures have been considered in the scheduling of the target completion dates for actions.

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

Action to be recommended to the Committee/Board	The Trust Board are asked to: Note: • The good progress made in November 2022 in relation to completion of recommendations (52/112 complete – 46.4%) and actions (115/197 complete – 58.4%). • A reconciliation piece of work is being undertaken in relation to 27/55 actions currently recorded as ongoing. These actions were due to complete in November 2022. A further update will be provided at this meeting. • Nine actions from December 2022 – March 2023 completed ahead of timeframe. • Action completion has been achieved by targeted focus by Care Groups. In Medicine the progress has been enabled by additional resource from a Compliance Specialist (1 day per week) and a Quality Improvement Facilitator (2 days per week) working in partnership with the Care Group and their leadership triumvirate. • To support timely and comprehensive completion of actions, Support and Review Panels remain weekly for Medicine, twice monthly for WACS and monthly for Pharmacy and Surgery. • The Trust will not be impacted by strike action. Therefore this will not impact on completion of the recommendations. Winter pressures have been considered in the scheduling of the target completion dates for actions.

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 CQC action plan has an appropriate risk detailed 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
BAF	Board Assurance Framework
CQC	Care Quality Commission
HSCA	Health and Social Care Act 2008
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) Improvement Plan

Key Points

1. In the last reporting period (November 2022), 12 'Must Do' recommendations and 7 'Should Do' recommendations were completed. This meant that at the end of November, overall, 52/112 (46.4%) of the recommendations were complete.

2. At the end of November 28/61 (45.9%) 'Must Do' recommendations and 24/51 (47.0%) 'Should Do' recommendations were completed.

3. This represents an improvement of 16.9% from October 2022.

4. Underpinning each recommendation, there are groups of actions that must be completed for the recommendation to be recorded as closed. At the end of November 2022, 115/197 (58.4%) actions were completed, an improvement of 19.8% from October 2022.

5. At the end of November 2022, 73/120 (60.8%) 'Must Do' actions and 42/77 (54.5%) 'Should Do' actions were complete.

6. As demonstrated above, since the last Trust Board, good progress has been made towards action completion. However, in November there have been some challenges with our electronic recording system. This means that 27/55 actions due to be completed in November 2022 are showing as ongoing. A reconciliation exercise is being completed at the time of reporting. A further update will be provided at this meeting. It is important to note that for the purpose of this report, these actions have been excluded from the completed actions denoted above.

7. Nine actions that were scheduled to complete from December 2022 – March 2023 have been closed ahead of schedule.

8. Action completion has been achieved by targeted focus by Care Groups. In Medicine the progress has been enabled by additional resource from a Compliance Specialist (1 day per week) and a Quality Improvement Facilitator (2 days per week) working in partnership with the Care Group and their leadership triumvirate.

9. To support timely and comprehensive completion of actions, Support and Review Panels remain weekly for Medicine, twice monthly for WACS and monthly for Pharmacy and Surgery.

10. The Trust will not be impacted by strike action. Therefore, this will not affect completion of the recommendations. Winter pressures have been considered in the scheduling of the target completion dates for actions.

Background/Context

11. The CQC Improvement Plans contains a combined total of 112 recommendations (61 Must Do and 51 Should Do).

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

13. Underpinning each recommendation, there are groups of actions. All actions must be completed for the recommendation to be recorded as completed. There are 197 actions underpinning the 112 recommendations the Trust received.

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

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

Improvement Plan Implementation Update

16. A summary of progress for the recommendations in the CQC inspection is showed 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 (November Position)					
Recommendation Status	**Must Do's**	**Priority Should Do's**	**Should Do's**	**Total**	**Status[4]**
Not Applicable	**0**	**0**	**0**	**0**	**UC**
Unable to Complete	**0**	**0**	**0**	**0**	**UC**
Not Started (new recommendations)	**0**	**0**	**0**	**0**	**UC**
Behind Schedule (Completion by Nov 2022)	**19**	**1**	**2**	**22**	**N/A**
Behind Schedule (Completion by Dec 2022)	**11**	**5**	**2**	**18**	**N/A**
Behind Schedule (Completion by Jan 2023)	**0**	**0**	**3**	**3**	**N/A**
Behind Schedule (Completion by March 2023)	**0**	**0**	**0**	**0**	**UC**
Behind Schedule (Completion after March 2023)	**2**	**0**	**1**	**3**	**UC**

On Schedule (Completion by March 2023)	**12**	**10**	**8**	**30**	**B**
On Schedule (Completion after March 2023)	**1**	**0**	**0**	**1**	**UC**
Fully Completed (awaiting approval)[1]	**0**	**0**	**2**	**2**	**MB**
Fully Completed & Approved[2]	**16**	**0**	**17**	**33**	**MB**
Total	**61**	**16**	**35**	**112**	

Notes:
1. Lead has confirmed actions completed, evidence to be scrutinised at Support & Review Panel
2. Completed and evidence scrutinised and approved at Support & Review Panel
3. Status Key:
   - **N/A - Not Applicable**
   - **UC – Unchanged**: No Change on figures in previous report
   - **B – Better** (Up to 10% Improvement)
   - **MB – Much Better** (Greater than 10% Improvement)
   - **W – Worse** (Up to 10% Deterioration)
   - **MW – Much Worse** (Greater than 10% Deterioration)
4. The use of % measurements means that any changes in a Recommendation Status that contain less then 10 Recommendations can only be reported as 'Much Better' or 'Much Worse', please see section 2

Improvement Plans - Combined Dashboard (December Position)					
Recommendation Status	**Must Do's**	**Priority Should Do's**	**Should Do's**	**Total**	**Status**[4]
Not Applicable	**0**	**0**	**0**	**0**	**UC**
Unable to Complete	**0**	**0**	**0**	**0**	**UC**
Not Started (new recommendations)	**0**	**0**	**0**	**0**	**UC**
Behind Schedule (Completion by Nov 2022)	**10**	**3**	**1**	**14**	**MB**
Behind Schedule (Completion by Dec 2022)	**0**	**0**	**0**	**0**	**MB**
Behind Schedule (Completion by Jan 2023)	**0**	**0**	**0**	**0**	**MB**
Behind Schedule (Completion by March 2023)	**0**	**0**	**0**	**0**	**MB**
Behind Schedule (Completion after March 2023)	**0**	**0**	**0**	**0**	**MB**
On Schedule (Completion by March 2023)	**23**	**9**	**13**	**45**	**MB**
On Schedule (Completion after March 2023)	**0**	**0**	**0**	**0**	**MB**
Fully Completed (awaiting approval)[1]	**0**	**0**	**0**	**0**	**MB**

Fully Completed & Approved[2]	**28**	**4**	**24**	**33**	**MB**
Total	**61**	**16**	**35**	**112**	

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

Actions per area

17. As proposed in the November 2022 report to Trust Board, in order to ensure more effective monitoring of progress, this report will now focus mainly on actions rather than recommendations.

18. The table below shows progress of actions to date, along with a summary of targeted actions by date:

Actions position as at 30 November 2022								
Area	Target Dates				Total number of actions per area	Completed actions		
	Nov-22	Dec-22	Jan-23	Mar-23		Oct-22	Nov-22	% actions completed
Medicine	37	19	0	20	121	45	68	56.2
WACS	11	2	5	5	38	15	27	71.1
SCC	1	0	4	0	8	3	5	62.5
CCS	2	0	1	6	14	5	7	50
Corporate	7	0	0	1	16	8	8	50
Trust wide	61	21	10	29	197	76	115	58.4

19. In November there have been some challenges with our electronic recording system. This means that 27/55 actions due to be completed in November 2022 are showing as ongoing. A reconciliation exercise is being completed at the time of reporting. A further update will be provided at this meeting. It is important to note that for the purpose of this report, these actions have been excluded from the completed actions denoted above.

Positive Impact of Recommendations completed in the last month

20. **Must Do 66**: "The service must ensure there are sufficient maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm to provide the right care and treatment"

    - To address this recommendation Maternity have implemented a training needs analysis guideline, which is in alignment with the national core competency framework for maternity services and safety action 8, NHS Resolution 10 Safety Actions. The maternity services compliance for all staff groups is above the 90% national standard for training compliance.

21. **Must Do 14**: "The service must ensure that audit information (including national audits) is submitted, up to date, accurate and properly analysed and reviewed by people with the appropriate skills and competence to understand its significance. When required, results should be escalated and appropriate actions taken to improve."
    - To address this recommendation the Medicine Care Group strengthened the local Audit processes and leadership to ensure audits are completed and submitted as required in line with RCEM requirements and any remedial actions are implemented. They also put a process in place to ensure that clinicians with suitable experience review audit findings, thus ensuring that audits are appropriately interpreted.

22. **Should Do 76**: "The service should act to improve the quality of safety information shared in SBAR handovers"
    - The maternity services have refreshed the format of handovers at the multidisciplinary handover. The handovers are now compliant with NHSE

guidance for handovers and huddles and are monitored by the clinical lead and head of midwifery. Team of the shift has also been implemented as part of the handover, which was recommended, by the Royal College of Obstetricians and Gynaecologists in May 2022. Team of the shift fosters a psychological safe environment and supports escalation.

Alert

23. 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

24. 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

25. The Trust Board is requested to:

Note:

- The good progress made in November 2022 in relation to completion of recommendations (52/112 complete – 46.4%) and actions (115/197 complete – 58.4%).
- A reconciliation piece of work is being undertaken in relation to 27/55 actions currently recorded as ongoing. These actions were due to complete in November 2022. A further update will be provided at this meeting.
- Nine actions from December 2022 – March 2023 completed ahead of timeframe.
- Action completion has been achieved by targeted focus by Care Groups. In Medicine the progress has been enabled by additional resource from a Compliance Specialist (1 day per week) and a Quality Improvement Facilitator (2 days per week) working in partnership with the Care Group and their leadership triumvirate.
- To support timely and comprehensive completion of actions, Support and Review Panels remain weekly for Medicine, twice monthly for WACS and monthly for Pharmacy and Surgery.
- The Trust will not be impacted by strike action. Therefore, this will not affect completion of the recommendations. Winter pressures have been considered in the scheduling of the target completion dates for actions.

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BOARD OF DIRECTORS

Date of Meeting	22 December 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. The paper also describes progress made.			

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 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 is underway and commenced October 17th, 2022. This paper describes the detail of Phase 5 and the UHMB (University Hospitals of Morecambe Bay) processes in place to prepare for, and

	progress against the Phase 5 review. The paper describes our progress in preparation for the evidence review.

Prior Discussions	Committee	Date	Recommendations/ Concerns
	Quality Assurance Committee – updates monthly	17 October 2022 21 November 2022	Paper received
	UHMB Trust Board – updates monthly	26 October 2022 30 November 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
UIU	Urology Investigation Unit

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 complete, with the Trust supported by Niche during Phase Four to share the findings and recommendations across the Trust given the remit for wider applicability.

3. Phase Five comprises of a repeat of the Current Case Review and an evidence-based assurance review/ interview process commencing 6-12 months post the publication of the report which was published on 24 November 2021.

4. A repeat of the Current Case Review commenced on the 17 October 2022 in advance of the wider assurance review. The review of current cases provide evidence for the assurance process with individual patient assessment covering many recommendations with an interim report due mid-November 22. An interim and final report has now been received with the trust contributing to factual accuracy.

5. Evidence upload (as part of Phase five) is underway with Executive Director sign off for all evidence submitted.

6. This paper describes the preparation and planning for Phase five, the status of the recommendations in preparation for the review and debrief from the current case review.

The Report

7. The 72 recommendations in the report are addressed to several stakeholders:
   - University Hospitals of Morecambe Bay NHS Foundation Trust (48) (plus three shared recommendations) = 51.
   - NHS England and NHS Improvement (12)
   - Care Quality Commission (1)
   - Royal College of Surgeons (1)
   - General Medical Council (1)
   - Clinical Commissioning Groups (now becoming Integrated Care Systems (ICS)) (6)
   - Shared national recommendations (2)

The trust is working collaboratively with partners in shared recommendations and/or can be mutually contributory. An ICB colleague is a regular attender at the weekly support and review meeting and is also supporting the walkabouts to all sites to observe and support. Where possible, we are sharing evidence that strengthens recommendation submission.

A monthly call with NHSE colleagues is also permitting the discussion and mutual understanding of complimentary work.

8. 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)

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.

UHMB Phase five

Governance processes

9. An external compliance and assurance expert reviews all evidence against the Niche Investigation Assurance Framework (See appendix 1) on the quality of the evidence and to rate evidence on a scale of (0-5).

10. Opportunities are taken to share updates and to welcome questions with the wider Urology team through Business meetings, Audit meetings and a fortnightly working party. Monthly Urology drop-in sessions have now been established with executive leadership.

11. A twice weekly Support and Review (S&R) meeting continues with the Surgery and Critical Care Group triumvirate and Urology specialty leads. This will continue through to March 23 to focus on any actions from the Current Case Review and to support further progress to level 4 and 5.

12. Walkabouts continue 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). This is being supported by the ICB.

13. 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.

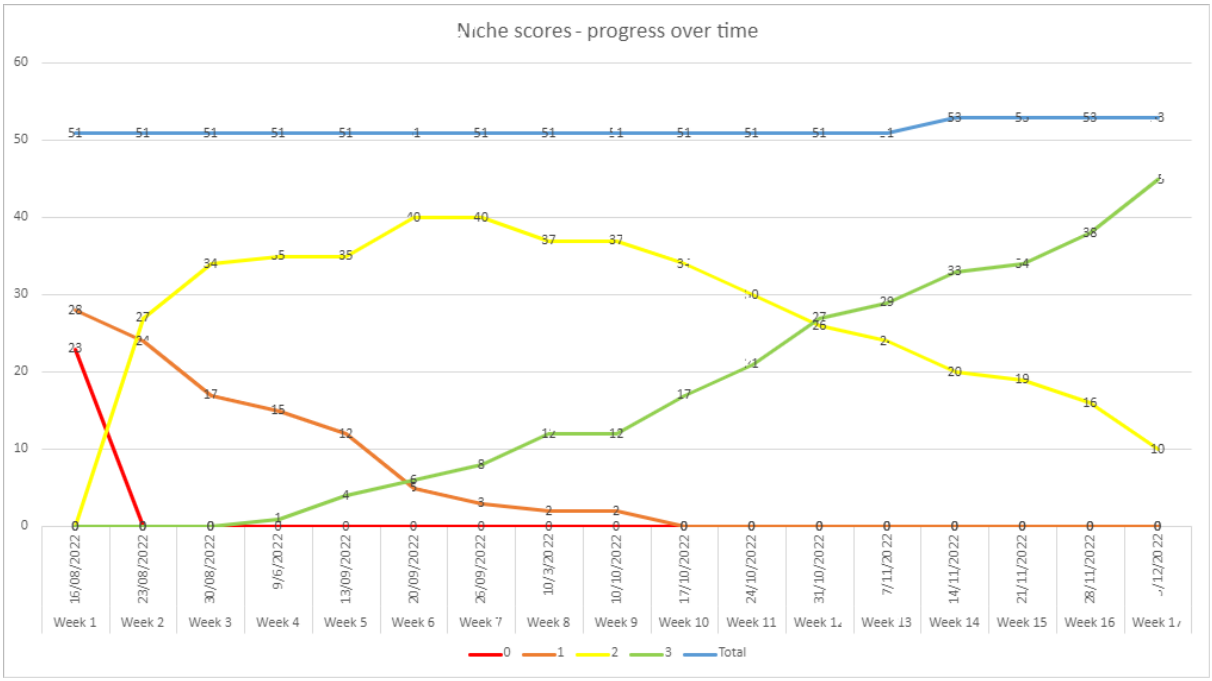
14. Executive briefing packs have been shared with Executive colleagues and supported by 1:1 meetings and a board briefing session to provide assurance and to close gaps in assurance and actions required. A further pack will be shared with all board members to provide further narrative and examples of impact from the improvements made.

15. 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.

16. Monthly Executive team drop-in sessions for the Urology team have now been established and will commence December 22 (See Appendix 2).

Progress – Update 12/12/2022

17. The graph below shows weekly progress with a reduction in zero, 1 and 2 scores, and the increase in 3 scores (45 recommendations graded as 3). The Director of Governance informs the weekly Executive Directors Group of progress and escalations.



Our initial expectation was to achieve a level 3 in all recommendations (action complete but not yet tested) however it is acknowledged that our improvement journey is only partial. It is our aspiration to take our improvements to level 4 and 5 with the demonstration of sustainable improvement both for Urology and for wider applicability.

This will be achieved through the application of the learning acquired though the Recovery Support Programme, our internal service improvement 'Hive' and through lessons learnt from the Niche investigation process:

- The RSP has provided the learning on establishing trust wide improvements on a large scale and to focus on a set of clear objectives, with the support of all corporate functions e.g., PMO, P&OD, Finance, Communications.
- The trust has embraced learning on the synergy between programmes of work and the elimination of silos in delivering improvements.
- The support provided by regulatory colleagues as part of SOF4 has helped us to identify assurance, robust evidence, and impact for our patients and staff

- The RSP programmes have enabled the improvement infrastructure and resource to support clinical leadership and accountability
- Our progress to exit from SOF4 has enabled us to celebrate success supported through assurance, robust evidence, and plans for sustainability.
- The 5 phases of the Niche enquiry has supported our understanding of in-depth review, management of external forces (media etc) and intense regulatory scrutiny.
- Lessons learnt from stent management - this is currently scored as a '4' by Niche and reflects regular clinical engagement, MDT inclusion, I3 support, audit, and ongoing changes as a cycle of improvement.
- Patient involvement - feedback from our patients will influence decision making and improvements. The team are currently showcasing a 6 monthly return as part of the Checkpoint 5 process in collaboration with the patient experience team. This is captured in the Safe Today paper. ICB contribution to walkabouts and mystery shopper provide rich feedback and any complaints receive scrutiny to identify gaps in care. Urology also had a patient representative, and this will be re-instated.

Evidence submission

46 folders have been uploaded with a full reconciliation of all requirements for supplementary evidence.

16 folders have supplementary evidence to follow to strengthen, and are a mix of the following:

- Minutes of meetings taking place November 22, December 22, and January 23 (recordings are also saved as evidence)
- Paper submissions to follow in December 22 and January 23 as part of standard business
- Audit data to follow - December 22
- 1 x policy sign off

Current case review feedback

The current case review featured the following activities:

a) Case note request – a UHMB Business Intelligence generated patient list with c100 patients selected randomly for review by the Niche team.

b) Site visit – the Niche team attended site for a five days to review the clinical care for the records selected (paper records and Lorenzo EpR (Electronic Patient Record)).

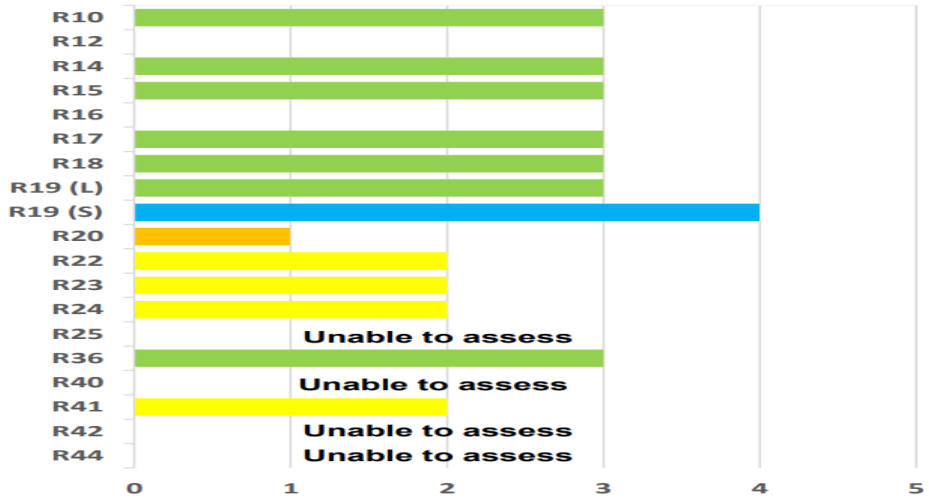
c) issues were escalated to the UHMB team in real time. 25 escalations were received, most completed, and closed on the day with 7 requiring onward action. No serious issues were escalated. The escalation log was finalised and submitted to Niche.

On completion of the case review, the Clinical Lead for Urology, the Director of Governance, and the Associate Director received a verbal debrief from the Niche investigation team.

Interim progress

An interim report was received mid-November 22 with the trust meeting the deadline for a factual accuracy check. The final report has now been shared with the trust and with NHSE.

The table below describes the Niche assessment (and scores) against a set of recommendations reviewed as part of the current case review.



The case review conclusions can be summarised as follows:

This case review has demonstrated sufficient initial evidence to support good progress being made against seven recommendations. This includes in relation to:

• R10, R15 – mortality reviews.
• R14 – fluid balance recording.
• R17 – capacity assessment.
• R18 – consenting practice.
• R19(L) – acknowledgement of results on Lorenzo; and
• R36 – pathway priority management.

Significant progress has also been made against the following recommendations including in relation to:

• R19(S) – stent register.
• R22 – pathway for bladder cancer management.
• R24 – (uro)sepsis and management of stents; and
• R41 – Cancer MDT management.

The review indicates that two recommendations requiring further work – now underway:
• R20 – ethnicity recording; and
• R23 – particularly in relation to venous thromboembolism (VTE) assessments.

The report will be shared with the following for discussion and any actions from the report will be captured and managed through the weekly Urology specialty and care group review meeting.

a) Urology team - Urology Audit meeting 14th December 22
b) Care group - Triumvirate Senior Management Team 14th December 22

c) Quality and Assurance Committee 19th December 22
d) Care group - Surgical Governance and Assurance Group 20th December 22
e) Trust board – 22nd December 22

Timelines

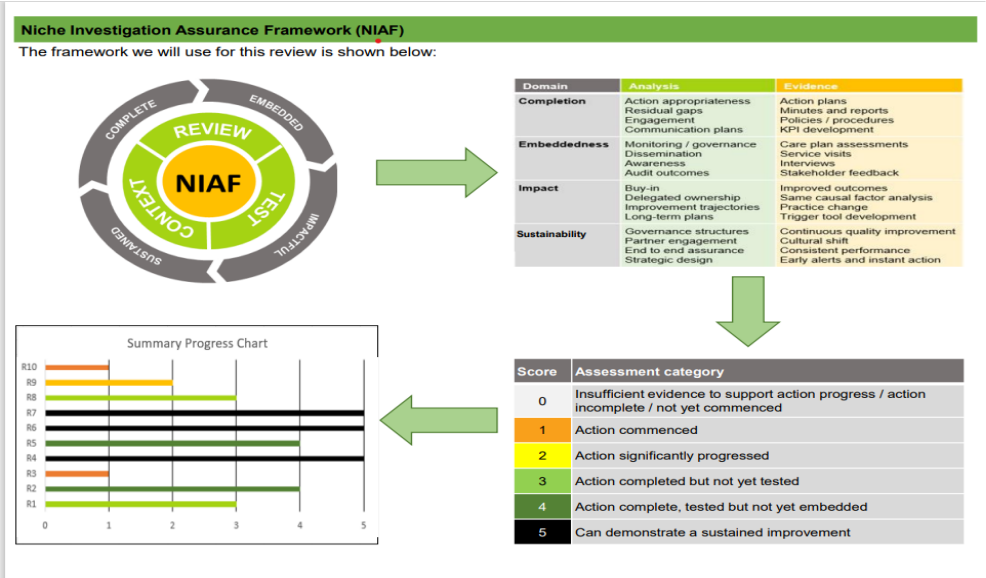
The following describes the timescales where known:

Date	Action	Responsible	
6th October 22	Distribution of Exec Director briefing packs	CA	Complete
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	Complete
W/B 10th October 22	1:1 with execs to discuss briefing pack content	CA/HK	Complete
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	Complete
20th October 22	Board development session (Niche Update)	RS/CA/HK	Complete
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.	In progress
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	In progress
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	In progress
To be confirmed - Early Feb 22	Timescale for preparing the first draft report	Niche	TBC
To be confirmed – late Feb 22	Opportunities for factual accuracy checks, feedback, and submission of any additional evidence	UHMBT	TBC

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

End of report

Appendix 1



Appendix 2

MONTHLY UROLOGY TEAM DROP-IN MEETINGS DEC 2022 – DEC 2023

DATE	TIME	TIME	LOCATION	NOTES
2022				
Mon 12 Dec		16:30 – 17:30	F2F FGH Education Centre Rooms 2 and 3 with MS Teams Option	Richard Sachs and Paul Jones to jointly attend
2023				
Thurs 12 Jan	12:30 – 13:30		MS Teams	
Wed 08 Feb		16:30 – 17:30	F2F RLI Education Centre Room 5 with MS Teams Option	*Collect room key Tbc if Chris Adcock can jointly attend with Richard Sachs
Tues 07 Mar	12:00 – 13:00		MS Teams	Bridget Lees and Richard Sachs to jointly attend

Wed 12 Apr		16:30 – 17:30	MS Teams	
Mon 15 May	12:00 – 13:00		F2F FGH Education Centre room 2 with MS Teams Option	
Thurs 15 Jun		16:30 – 17:30	MS Teams	
Wed 12 Jul	12:30 – 13:30		MS Teams	
Tues 15 Aug		16:30 – 17:30	F2F RLI Education Centre Room 5 with MS Teams Option	*Collect room key
Fri 15 Sep	12:30 – 13:30		MS Teams	
Thurs 12 Oct		16:30 – 17:30	MS Teams	
Mon 06 Nov	12:30 – 13:30		F2F FGH Education Centre Conference Room with MS Teams Option	
Tues 05 Dec		16:30 – 17:30	MS Teams	

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BOARD OF DIRECTORS

Date of Meeting	22 December 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
	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 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	• Learning being identified and actioned through identification of moderate harms and above. • Training compliance for all maternity professionals to attend PROMPT reached 90% by the CNST submission deadline. • Issues of inclusion raised by staff engagement events; action plan being developed. • Maternity vision and strategy developed. • Achieved UNICEF BFI Stage one.

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.

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
	Direct link to patient safety and experience			

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	
PMRT	Perinatal Mortality Review Tool
HSIB	Healthcare Safety Investigation Branch
STEIS	Transfer of Strategic Executive Information System
PPH	Postpartum Haemorrhage
ITU	Intensive Therapy Unit
NICU	Neonatal Intensive Care Unit
GAP/GROW	Grow Assessment Protocol
SBLCBV2	Saving Babies Lives Care Bundle Version 2
PROMPT	Practical Obstetric Multi-Professional Training
CQC	Care Quality Commission
CNST	Clinical Negligence Scheme for Trusts
IEAs	Immediate and Essential Actions
TC	Transitional Care
MSW	Midwifery Support Worker
HCSW	Health Care Support Worker
NHSR	NHS Resolution
RCOG	Royal College of Obstetricians and Gynaecologists
ATAIN	Avoidance of Term Admissions into Neonatal Unit
MSSP	Maternity Safety Support Programme
SPC	Statistical Process Control
MVP	Maternity Voices Partnership
PET	Pre-eclampsia (PET)

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).

2. 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 November 2022, except for where exceptions are highlighted.

Perinatal Deaths and Learning (CQC: S.28 i)

3. 0 new PMRT cases in month.

PMRT Review

4. 12 historical cases closed - no care and service delivery issues identified.

Moderate and above Harm incidents in November (CQC: S.28 i)

5. Moderate Harm x 9
   - 5 x PPH
   - 1 ITU and PPH
   - 1 ITU bronchospasm
   - 1 ITU for further observations
   - 1 missed diabetes and baby transferred out to level 3 tertiary centre for additional care

6. Severe x 2

   - 1 missed fetal anomaly
   - 1 severe HIE grade 3, case accepted by HSIB

7. Themes of learning in November's incidents (CQC: S.28 i)

   - Severe growth restriction should be referred to a tertiary centre
   - PPH proformas must be used in all cases of PPH
   - If a woman collapses, she must be moved quickly and using the appropriate manual handling equipment
   - Fresh eyes reviews must be performed as per guideline

- Documentation during/after an emergency must be robust and contemporaneously as possible
- Observations for 12 hours for the neonate is vital if a mother as received antibiotics in labour
- All learning has been translated into SMART actions

Training compliance exceptions (CQC S.28 iii)

8. CNST safety standard for 90% of all maternity professionals to receive PROMPT training by 5th December 2022 was achieved. Thank you for everyone's teamwork in achieving that standard. Focus will now be on GAP/GROW and SBLCv2 training compliance, particularly for Obstetric Medical Staff.

Staffing Exceptions (CQC S.28 ii)

9. Fill rates are back over 85%. A paper for enhanced bank payments for midwifery staff is currently being drafted to incentives bank work.

Establishment Review (CQC S.28 ii)

10. A full staffing establishment review has been commenced following concerns during the tabletop biannual staffing review, identified issues with calculations, changes in activity and in Director of Midwifery's professional judgement.

11. The establishment review is being supported by the MSSP and the regional midwifery team and is expected to be completed by the end of January. The newly developed draft workforce plan will not be ratified until the establishment review has been completed to ensure accuracy. A new monthly midwifery staffing dashboard is being piloted this month at MPLG (Midwifery Professional Leads Group) to monitor staffing issues more transparently and robustly.

Maternity Dashboard (CQC S.28 iv)

12. Please refer to Appendix 2 for Maternity Dashboard, exceptions are monitored through the Women's Health Board, QAC and Care Group performance meeting.

CNST Maternity Incentive Scheme Year 1 and Year 4 (CQC S.28 i)

13. CNST Year 1 evidence was submitted to NHS Resolution we are still awaiting the feedback.

CNST Year 4: please refer to the Maternity Incentive Scheme Year 4 report (agenda item 182iii).

Maternity Safety Support Programme (CQC S.28 ii)

14. The MSSP exit criteria progress report has been received from NHSE for October and again, shows progression see Appendix 3. The projected exit is on trajectory for exit July/August 2023.

Maternity Staff Engagement (CQC S.28 i & ii).

15. Weekly ‘Here to Hear and Safe to Say’ sessions with the Director of Midwifery are continuing for all staff across all sites. No themes evident for November's sessions, positive feedback received on ‘how it feels to work here’ staff reporting feeling ‘safer’.

16. Feedback received from engagement events held outside of WAC’s raising issues of inclusion. Meetings held with senior team and Hannah Chandisingh, Head of Inclusion and Engagement to discuss actions. Senior meeting arranged with maternity’s Executive Lead and Board Level Safety Champion Bridget Lees to develop action plan 13th December. External support sourced to explore cultural competency.

Maternity Vision and Strategy (CQC S.28 i & ii).

17. The draft maternity services vision and strategy has been developed and is being consulted on by staff and service users. This is a ‘holding’ vision and strategy for the next 12 months whilst the trust clinical strategy is being developed, to allow for consideration of the new pending HSE Maternity and Neonatal Plan (with revised deliverables) in 2023 and then allow time for service user engagement across all 3 sites and co-production of the full 5-year strategy. The development of a Maternity Vision and Strategy is a CQC must do action and a MSSP exit criteria action.

Successes and Celebrations

18. Achieved UNICEF Breastfeeding Stage 1 accreditation.

19. Midwifery Support Worker Nicola Potts was being awarded the Chief Midwifery Officers MSW Award for continually to demonstrate NHS values. This award was presented to Jess Read, Deputy Chief Midwife of NHSE and Claire Mathews, Regional Chief Midwife on 22nd November Nicola was one of two MSW in the UK to receive the new award.

20. HCSW and MSW Celebration Days held on 23th and 24th November. All WAC’s HCSW and MSW’s received a handwritten card and small gift. Team members celebrated their contribution at work with a sway detailing why they were valued.

Recommendation

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

Appendix 1 Perinatal Surveillance Model November 2022

This is included in the Board of Directors' Reference Pack.

Appendix 2 Maternity Dashboard Exception Report October 2022

This is included in the Board of Directors' Reference Pack.

Appendix 3 MSSP Progress October

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	Little	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	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	Good						

BOARD OF DIRECTORS

Date of Meeting	22 December 2022
Title	Six Monthly Continuity of Carer 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
	To update the Board of Directors on the current status of midwifery continuity of carer at UHMBT and the revised expectations of maternity services from NHS England.			

Summary of Key Issues	Maternity providers in England received a letter from NHS England, in September 2022, removing targets for the implementation of Midwifery Continuity of Carer (MCoC). This will remain in place until all maternity services in England are at full staffing establishment. Services without full staffing were advised to cease implementation with immediate effect. UHMBT has paused implementation of MCoC. Building blocks to support a firm foundation for MCoC have been developed. We retain 0.4 WTE Lead Midwife for MCoC funded by the LMNS to establish these building blocks at UHMBT.

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.

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	

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	
MCoC	Midwifery Continuity of Care
UHMBT	University Hospitals of Morecambe Bay Trust
WTE	Whole Time Equivalent
NHSE	National Health Service England
LMNS	Local Maternity and Neonatal System

UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST

Midwifery Continuity of Care

Introduction

1. Midwifery Continuity of Carer (MCoC) has been shown to deliver safer and more personalised maternity care. Building on the recommendations of Better Births and the commitments of the NHS Long Term Plan, the ambition for the NHS in England is for Continuity of Carer to be the default model of care for maternity services, and available to all pregnant women in England. Where safe staffing allows, and the building blocks are in place, with rollout prioritised to those most likely to experience poorer outcomes first**.**

Current position

2. The Board of Directors received the plan for implementation of MCoC at UHMBT in July 2022.

3. The implementation plan required 173.38 WTE midwives to implement. The November 2022 midwifery establishment in post is 149.7 WTE.

4. 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.

5. The UHMBT maternity service has paused implementation and is focussing on retention and recruitment of midwives.

6. UHMBT retains a specialist MCoC midwife funded by the LMNS on reduced hours.

Next Steps

7. MCoC will be targeted initially at women and pregnant people living in postcodes with the highest levels of deprivation.

8. The service is focussing on care outcomes for families living in areas of deprivation and prioritising seldom heard voices. This will inform MCoC provision when implementation recommences.

9. A full workforce review is underway with support from regional and MSSP colleagues.

Recommendation

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

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NHS University Hospitals of Morecambe Bay NHS Foundation Trust

BOARD OF DIRECTORS

Date of Meeting	22 December 2022
Title	Maternity Incentive Scheme Year 4 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
	This report advises, assures, and provides an update on the progress with the Maternity Incentive Scheme Year 4. Trusts will need to report compliance with the Maternity Incentive Scheme by 2 February 2023.			

Summary of Key Issues	In January 2018 NHS Resolution (NHSR) introduced an incentive scheme to the Clinical Negligence Scheme for Trusts (CNST). The Maternity Safety Strategy set out the Department of Health's ambition to reward Trusts who have taken action to improve maternity safety. The scheme incentivises ten maternity safety actions. NHS Resolution is operating Year 4 of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care. Following the CQC inadequate overall rating for Maternity, NHSR requested a review of the evidence for Year 2 and Year 3. Following external validation and a local review identified information was lost due to the IT transfer over to 365, the money received for Year 2 was paid back to NHSR and the Trust did not receive funds for Year 3. A package of funding has been offered of £260,000 however a review of the Year 1 CNST submission had to be undertaken. The Trust is currently awaiting a decision regarding compliance with the evidence submitted for Year 1. The Trust has been requested to pay back £525,619.16 from 2019/2020. In order to be eligible for payment under the scheme, the Trusts must submit their completed Board declaration form to NHS resolution by 12 noon on 2 February 2023 and must comply with conditions detailed within the report.

	The safety actions are the same as those in previous years of the scheme however the minimum requirements have been revised and, in some safety, actions have additional requirements to reflect the national safety agenda. The requirements to meet the 10 safety actions for Year 4 require a higher level of compliance. There must be no reports in 2021/22 or 2022/23 that provide conflicting information to the declaration such as a CQC inspection report and HSIB. The precise detail for what is required under each action and how this should be evidenced is in Appendix 1 - Maternity Incentive Scheme Action Plan. The position for each safety action is shown in Table 1. There is full compliance with 7 out 10 safety actions. Further diligence is being undertaken for safety action 10 to provide assurance all cases have been reported to HSIB between 1st April 2021 and the 5th December 2022. The position for safety action 10 will be presented at the January 2023 Trust Board meeting. The Board of Directors is asked to receive this report for discussion and assurance that the maternity services have achieved a minimum of 7 out 10 and a further presentation of evidence will take place in January 2023.

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

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
	Direct link to patient safety			

Impact on Board Assurance Framework or Corporate Risk Register				
Risk Impact Assessment	Is this required?	**Y**	If Yes, Date Completed	02/12/2022

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	
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
CGGAG	Care Group Governance Assurance Group
ToR	Terms of Reference
PMRT	Perinatal Mortality Review Tool
CNST	Clinical Negligence Scheme for Trusts
CGGAG	Care Group Governance Assurance Group
CQC	Care Quality Commission
MSDS	Maternity Services Data Set
TC	Transitional Care
ICS	Integrated Care System
MCoC	Maternity Continuity of Carer
HSIB	Health Service Investigation Beau
MVP	Maternity Voice Partnership
SBLCB	Saving Babies Lives Care Bundle
BAPM	British Association of Perinatal Medicine

UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST

Maternity Incentive Scheme Year 4 Report

Purpose

1. The purpose of this paper is to provide an update on the status of University Hospitals Morecambe Hospitals Trust compliance with the NHS Resolution (NHSR) Maternity Incentive Scheme (MIS) Year Four and to highlight areas of risk with compliance.

Background

2. In January 2018 NHS Resolution (NHSR) introduced an incentive scheme to the Clinical Negligence Scheme for Trusts (CNST). The Maternity Safety Strategy set out the Department of Health's ambition to reward Trusts who have taken action to improve maternity safety. The scheme incentivises ten maternity safety actions.

3. NHS Resolution is operating Year 4 of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care.

4. UHMBT CNST premium for 2021/22 is £13,227,310. The standard maternity element of this is £5,572,241. The maternity incentive contribution is 10% of this i.e. £557,224. The total maternity contribution is £6,129,46.

5. The Trust submitted the data set required for the ten maternity safety action points at 12 noon on 15 July 2021 as per the submission requirements. The Board declaration form was signed off for all ten maternity safety actions.

6. Following the CQC inadequate overall rating for Maternity NHSR requested a review of the evidence for Year 2 and 3. Following external validation and a local review identified information was lost due to the IT transfer over to Microsoft 365, the money received for Year 2 was paid back to NHSR and the Trust did not receive funds for Year 3. A package of funding has been offered of £260,000 however a review of the Year 1 CNST submission had to be undertaken. The Trust has been requested to pay back £525,619.16 from 2019/2020 and is currently awaiting a decision regarding compliance with the evidence submitted for Year 1.

7. Following the re-launch of the fourth year on 9th August 2021, NHS Resolution, and the Collaborative Advisory Group (CAG) continued to monitor all Trusts' position in relation to Covid-19, staffing and acuity and the challenges faced by Trusts in achieving the Scheme's safety actions. A revision was made to some of the safety actions' sub-requirements. The revised scheme was published on 12th October 2021 extending the Scheme's interim deadlines to support Trusts submission.

8. On the 23rd December 2021 NHS Resolution paused the majority of reporting requirements relating to the Maternity Incentive Scheme for a minimum of 3 month in recognition of the current pressure on the NHS and maternity services. On the 6th May 2022 the Maternity Incentive Scheme published the revised technical guidance and there was a further update in October 2022.

9. In order to be eligible for payment under the scheme, the Trusts must submit their completed Board declaration form to NHS resolution (nhsr.mis@nhs.net) by 12 noon on 2 February 2023 and must comply with the following conditions:

    - Trusts must achieve all ten maternity safety actions
    - The declaration form is submitted to Trust Board with an accompanying joint presentation detailing maternity safety actions by the Director of Midwifery/Head of Midwifery and Clinical Director for Maternity Services.
    - The Board declaration form must be signed and dated by the Trust's Chief Executive Officer (CEO) to confirm that:
        - The Trust Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required safety actions sub requirements as set out in the safety actions and technical guidance.
        - There are no reports covering either year 2021/22 or 2022/23 that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration (e.g., Care Quality Commission inspecting report, Healthcare Safety Investigation Branch investigation reports etc). All such reports should be brought to the MIS team's attention before 2nd February 2023.
    - The Trust declaration form must be signed by the Trust's CEO, on behalf of the Trust Board and by the accountable Officer (AO) of Clinical Commissioning Group/ Integrated Care System.
    - As in previous years, Trusts that can demonstrate they have achieved all of the ten safety actions will recover the element of their CNST contribution that relates to the maternity incentive fund (10% of the maternity premium) will also receive a share of any unallocated funds.
    - Year 4 data set required compliance against the revied 10 safety action points for 8 August 2021 to 2 February 2023.
    - If the Trust does not achieve all of the ten actions, it will not recover their contribution to the maternity incentive fund but may be legible for a small discretionary payment from the scheme to help progress against actions that have not been achieved. This payment would be at a much lower level that the 10% contribution to the incentive fund.

Analysis / Discussion

10. This year the 10 safety actions are:

    - Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
    - Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?
    - Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal Units Programme?
    - Can you demonstrate an effective system of clinical workforce planning to the required standard?
    - Can you demonstrate an effective system of midwifery workforce planning to the required standard?
    - Can you demonstrate compliance with all five elements of the Saving Babies' Lives Care Bundle Version Two?

- Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?
- Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS Year 4? In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and new-born life support, starting from the launch of MIS Year 4?
- Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?
- Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) scheme for 2021/22?

11. The safety actions are the same as those in previous years of the scheme however the minimum requirements have been revised and, in some safety, actions have additional requirements to reflect the national safety agenda. The requirements to meet the 10 safety actions for Year 4 require a higher level of compliance. There must be no reports in 2021/22 or 2022/23 that provide conflicting information to the declaration such as a CQC inspection report and HSIB. The precise detail for what is required under each action and how this should be evidenced is in Appendix 1 - Maternity Incentive Scheme Action Plan.

12. The trust is expected to provide a report to the Board demonstrating achievement (with evidence) of each of the ten actions. The Board is expected to consider the evidence and complete a Board declaration form for submission.

13. Trust submissions will be subject to range of external validation points, these include cross checking with: MBRRACE-UK data (safety action 1 standard a, b and c), NHS England and Improvement regarding submission to the Maternity Services Data Set 9 safety action 2, criteria 2 to 7 inclusive) and against the National Neonatal Research Database (NNRD) and HSIB for the number of qualifying incidents reportable (safety action 10, standard a). Trust submissions will also be sense checked with the CQC and for any CQC visits undertaken within the time period, the CQC will cross reference to the maternity incentive scheme via the key lines of enquiry.

14. Reporting of all qualifying Early Notification cases to NHS Resolution's Early Notification (EN) Scheme has been reinstated from the 1st April 2022. The Maternity Governance team have put processes in place together with the Trust legal team to ensure all cases are reported.

15. Updates on the progress against the action plans have been continually reviewed at the Women's Health Quality Board, Maternity Safety Champions meeting, Assurance Committee and Trust Board. The position for each safety action is shown in Table 1. There is compliance with 7 out 10 safety actions. Further diligence is being undertaken 1st April 2021 and the 5th December 2022. The position for safety action 10 will be presented at the January 2023 Trust Board meeting.

CNST Year 4			
Safety Standard 1	PMRT	**Safety Standard 6**	SBLCBV2
Safety Standard 2	MSDS	**Safety Standard 7**	MVP
Safety Standard 3	Transitional Care	**Safety Standard 8**	MDT Training
Safety Standard 4	Clinical Workforce Planning	**Safety Standard 9**	Board Assurance on SIs/Maternity Safety
Safety Standard 5	Midwifery Workforce Planning	**Safety Standard 10**	HSIB Cases

16. Maternity services are declaring non-compliance with safety action 3 and safety action 5. For safety action 3, the neonatal nursing model is not compliant with the BAPM transitional care guidance at RLI. In addition, transitional care activity is captured across two EPR systems which does not support all the audit data required for this safety action. There is an allocated lead nurse who is leading on the transitional care project and a business case is being developed to support 24/7 nursing cover to the required standard. Safety action 5 there has been no historical monitoring of the midwife to birth ratio, red flag events and monitoring of supernumerary status of the band 7 co-ordinator for the totality of the reporting period. The regional team are supporting a midwifery establishment and workforce review, and a midwifery staffing dashboard will be implemented in December 2022 capturing all the required minimum information going forward.

Recommendation

17. The Board of Directors is asked to note the content of this report and agree the recommendations:
    a. The maternity services are currently on target to meet 7 out of the 10 safety actions, with a potential for 8 out 10 following a review of safety action 10.
    b. The group is asked to receive this report for discussion and assurance the maternity services have achieved a minimum of 7 out 10 and a further presentation of evidence will take place in January 2023.

Appendix 1

Maternity Incentive Scheme – Year 4 – revised safety actions

Key for RAGBW rating of Actions:

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

Safety Action		Required standard	Minimal evidential requirement	Lead responsible for action	Target Date	Evidence of Progress and completion	Date Action Completed and RAG
Safety Action 1:	**Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?**						
	a)	i. All perinatal deaths eligible to be notified to MBRRACE-UK from 6 May 2022 onwards must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within one month of the death. Deaths where the surveillance form needs to be assigned to another Trust for additional information are excluded from the latter. ii. A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 6 May 2022 will have been started within two months of each death. This includes deaths after home births where care was provided by your Trust.	Notifications must be made, and surveillance forms completed using the MBRRACE-UK reporting website. The perinatal mortality review tool must be used to review the care and reports should be generated via the PMRT. A report has been received by the Trust Board each quarter from 6 May 2022 onwards that includes details of the deaths reviewed and the consequent action plans. The report should evidence that the PMRT has been used to review eligible perinatal deaths and that the required standards a), b) and c) have been met. For standard c) for any parents who have not been informed about the review taking place, reasons for this should be documented within the PMRT review.	Donna Southam Quality, Safety and Assurance Lead Midwife, Joe Ogah Consultant Obstetrician	5/12/22	All cases notified within 7 days and surveillance information completed within one month. PMRT meetings established from September 2022 and all reviews will are multidisciplinary including an external expert. The Bereavement Lead Midwives are the primary contact, and all women are given the DOC leads contact details. The Quality and Safety Midwife has contacted all women were the	
	b)	At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from 6 May 2022 will have been reviewed using the PMRT, by a multidisciplinary review team. Each of these reviews will have been completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death and the report published within six months of each death.		Donna Southam Quality, Safety and Assurance Lead Midwife, Joe Ogah Consultant Obstetrician	5/12/22		

	c)	For at least 95% of all deaths of babies who died in your Trust from 6 May 2022, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any questions and/or concerns they have about their care and that of their baby have been sought. This includes any home births where care was provided by your Trust staff and the baby died either at home or in your Trust. If delays in completing reviews are anticipated parents should be advised that this is the case and be given a timetable for likely completion. Trusts should ensure that contact with the families continues during any delay and make an early assessment of whether any questions they have can be addressed before a full review has been completed; this is especially important if there are any factors which may have a bearing on a future pregnancy. In the absence of a bereavement lead ensure that someone takes responsibility for maintaining contact and for taking actions as required.	Audit of all cases in progress to ensure compliance	Donna Southam Quality, Safety and Assurance Lead Midwife, Joe Ogah Consultant Obstetrician	5/12/22	report remains on going. There is a PMRT SOP and ToR. Quarterly Board reports commenced in September 2022.	
	d)	Quarterly reports will have been submitted to the Trust Board from 6 May 2022 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions.	A report has been received by the Trust Board each quarter from 6 May 2022 onwards that includes details of the deaths reviewed and the consequent action plans. The report should evidence that the PMRT has been used to review eligible perinatal deaths and that the required standards a), b) and c) have been met. For standard c) for any parents who have not been informed about the review taking place, reasons for this should be documented within the PMRT review.	Donna Southam Quality, Safety and Assurance Lead Midwife	5/12/22		

Safety Action		Required standard	Minimal evidential requirement	Lead responsible for action	Target Date	Evidence of Progress and completion	Date Action Completed and RAG
Safety Action 2:	**Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?**						
		1) By October 2022, Trusts have an up to date digital strategy for their maternity services which aligns with the wider Trust Digital Strategy and reflects the 7 success measures within the What Good Looks Like Framework. The strategy must be shared with Local Maternity Systems and be signed off by the Integrated Care Board. As part of this, dedicated Digital Leadership should be in place in the Trust and have engaged with the NHSEI Digital Child Health and Maternity Programme. 2) Trust Boards to assure themselves that at least 9 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria in the "CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria" data file in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2022. The data for July 2022 will be published during October 2022. 1. July 2022 data contained height and weight data, or a calculated Body Mass Index (BMI), recorded by 15+0 weeks gestation for 90% of women reaching 15+0 weeks gestation in the month. 2. July 2022 data contained Complex Social Factor Indicator (at antenatal booking) data for 95% of women booked in the month. 3. July 2022 data contained antenatal personalised care plan fields completed for	1) Criteria 1 will be reported to NHS Resolution as part of trusts' self-declaration using the Board declaration form. For criteria 2 to 7, the "CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria" data file in the Maternity Services Monthly Statistics publication series displays whether trusts have passed the requisite data quality thresholds.	Karen Bridgeman/ Digital Midwife	5/01/23	Maternity has a dedicated Digital Midwife. Maternity Digital strategy was submitted to the LMNS on the 18th October 2022. The Digital Midwife is a part of the Regional Digital Midwives Expert Reference group CQIMs are fully compliant with October 2022.	

		95% of women booked in the month. (MSD101/2) 4. July 2022 data contained valid ethnic category (Mother) for at least 90% of women booked in the month. Not stated, missing, and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001) 5. Trust Boards to confirm to NHS Resolution that they have passed the associated data quality criteria in the "CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria" data file in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2022 for the following metrics: **Midwifery Continuity of carer (MCoC)** i. Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks and also have the CoC pathway indicator completed. ii. Over 5% of women recorded as being placed on a CoC pathway where both Care Professional ID and Team ID have also been provided. iii. At least 70% of MSD202 Care Activity (Pregnancy) and MSD302 Care Activity (Labour and Delivery) records submitted in the reporting period have a valid Care Professional Local Identifier recorded. Providers submitting zero Care Activity records will fail this criterion. Criteria i and ii are the data quality metrics used to determine whether women have been placed on a midwifery continuity of carer pathway by the 28 weeks antenatal appointment, as measured at 29 weeks gestation. Criteria iii are fundamental building blocks and a necessary					

		step towards measuring whether or not women have received midwifery continuity of carer (though it is not the complete measurement). The data for July 2022 will be published in October 2022. If the data quality for criteria 7 are not met, trusts can still pass safety action 2 by evidencing sustained engagement with NHS Digital which at a minimum, includes monthly use of the Data Quality Submission Summary Tool supplied by NHS Digital (see technical guidance for further information).					

Safety Action		Required standard	Minimal evidential requirement	Lead responsible for action	Target Date	Evidence of Progress and completion	Date Action Completed and RAG
Safety Action 3:	**Can you demonstrate that you have transitional care services to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?**						

	a)	Pathways of care into transitional care have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care.	Local policy/pathway available which is based on principles of British Association of Perinatal Medicine (BAPM) transitional care where: Evidence for standard a) to include: • There is evidence of neonatal involvement in care planning • Admission criteria meets a minimum of at least one element of HRG XA04 but could extend beyond to BAPM transitional care framework for practice • There is an explicit staffing model • The policy is signed by maternity/neonatal clinical leads and should have auditable standards. • The policy has been fully implemented and quarterly audits of compliance with the policy are conducted.	Nicola Askew Associate Director of Nursing &Therapies for Children and Young	1/9/24	Transitional Care Operational Guideline. A review of the nursing staffing model for Transitional Care has identified non compliance with the BAPM transitional care standards. Business case to be developed.	
	b)	The pathway of care into transitional care has been fully implemented and is audited quarterly. Audit findings are shared with the neonatal safety champion, LMNS, commissioner and Integrated Care System (ICS) quality surveillance meeting each quarter.	An audit trail is available which provides evidence that ongoing audits from year 3 of the maternity incentive scheme of the pathway of care into transitional care are being completed as a minimum of quarterly. If for any reason, reviews have been paused, they should be recommenced using data from quarter 1 of 2022/23 financial year. Audit findings are shared with the neonatal safety champion on a quarterly basis. Where barriers to achieving full implementation of the policy are encountered, an action plan should be agreed, and progress overseen by both the board and neonatal safety champions	Nicola Askew Associate Director of Nursing &Therapies for Children and Young	18/7/22	Discussed at the maternity safety champion meeting. Report submitted to Quality Committee quarterly. Transitional care audits to be incorporated into ATAIN report.	
	c)	A data recording process (electronic and/or paper based for capturing all term babies transferred to the neonatal unit, regardless of the length of stay, is in place.	Data is available (electronic and/or paper based) on all term babies transferred or admitted to the neonatal unit. This will include admission data captured via	Nicola Askew Associate Director of Nursing	18/7/22		

			Badgernet as well as transfer data which may be captured on a separate paper or electronic system. If a data recording process is not already in place to capture all babies transferred or admitted to the NNU this should be in place no later than Monday 18 July 2022.	&Therapies for Children and Young		All data captured electronic on Badgernet and Lorenzo.	
	d)	A data recording process for capturing existing transitional care activity, (regardless of place - which could be a Transitional Care (TC), postnatal ward, virtual outreach pathway etc.) has been embedded. If not already in place, a secondary data recording process is set up to inform future capacity management for late preterm babies who could be cared for in a TC setting. The data should capture babies between 34+0-36+6 weeks gestation at birth, who neither had surgery nor were transferred during any admission, to monitor the number of special care or normal care days where supplemental oxygen was not delivered.	Data is available (electronic or paper based) on transitional care activity (regardless of place - which could be a TC, postnatal ward, virtual outreach pathway etc.). Secondary data is available (electronic or paper based) on babies born between 34+0-36+6 weeks gestation at birth, who did not have surgery nor were transferred during any admission, to monitor the number of special care or normal care days where supplemental oxygen was not delivered to inform future capacity management for late preterm babies who could be cared for in a TC setting.	Nicola Askew Associate Director of Nursing &Therapies for Children and Young	18/7/22	To be captured in the ATAIN audit	
	e)	Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data set (NCCMDS) version 2 are available to be shared on request with the operational delivery network (ODN), LMNS and commissioners to inform capacity planning as part of the family integrated care component of the Neonatal Critical Care Transformation Review and to inform future development of transitional care to minimise separation of mothers and babies.	Evidence for standard e) to include Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2 are available to share on request, for example to support service development and capacity planning, with the LMNS, ODN and/or commissioner	Nicola Askew Associate Director of Nursing &Therapies for Children and Young	5/1/23	Minimum data available on request	
	f)	Reviews of babies admitted to the neonatal unit continue on a quarterly basis and findings are shared quarterly with the Board Level Safety Champion. Reviews should now include all neonatal unit transfers or admissions regardless of their length of stay and/or admission to	An audit trail is available which provides evidence that ongoing reviews from year 3 of the maternity incentive scheme of term admissions are being completed as a minimum of quarterly. If for any reason, reviews have been paused, they should be	Donna Southam. Quality, Safety and Assurance Lead	18/07/2022	To be incorporated	

		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 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. Findings of the review have been shared with the maternity, neonatal and Board level safety champions, LMNS and ICS quality surveillance meeting on a quarterly basis.	recommenced using data from quarter 1 of 2022/23 financial year. If not already in place, an audit trail is available which provides evidence that reviews from Monday 18 July 2022, now include all term babies transferred or admitted to the NNU, irrespective of their length of stay, are being completed as a minimum of quarterly. If your reviews already included all babies transferred or admitted to the NNU then this should continue using data from quarter 1 of 2022/23 financial year. Evidence that the review includes: the number of transfers or admissions to the neonatal unit that would have met current TC admission criteria but were transferred or admitted to the neonatal unit due to capacity or staffing issues and the number of babies that were transferred or admitted to or remained on NNU because of their need for nasogastric tube feeding but could have been cared for on a TC if nasogastric feeding was supported there. Evidence that findings of all reviews of term babies transferred or admitted to a neonatal unit are reviewed quarterly and the findings have been shared quarterly with the maternity and neonatal safety champions and Board level champion, the LMNS and ICS quality surveillance meeting.	Midwife, Nicola Askew Associate Director of Nursing &Therapies for Children and Young		into ATAIN audit report	
	g)	An action plan to address local findings from the audit of the pathway (point b) and Avoiding Term Admissions Into Neonatal units (ATAIN) reviews (point f) has been agreed with the maternity and neonatal safety champions and Board level champion.		Nicola Askew Associate Director of Nursing &Therapies for Children and Young, Donna Southam	18/07/22	Quarterly audit is shared at the Maternity Safety Champion meeting and with the board. ATAIN Report	

				Quality, Safety and Assurance Lead Midwife		shared with board in July/ October 2022 and Safety Champions August/ November 2022. Pathway for sharing to be developed with LMNS and ICS.	
	h)	Progress with the revised ATAIN action plan has been shared with the maternity, neonatal and Board level safety champions, LMNS and ICS quality surveillance meeting.		Donna Southam Quality, Safety and Assurance Lead Midwife	18/7/2022	Action plan was shared with the Safety Champions in August 2022 and added to the forward planner quarterly. Shared with Trust Board in July/ October 2022 and added to the forward planner quarterly. Action plan shared with the board, ICS and LMNS in November 2022.	

Safety Action		Required standard	Minimal evidential requirement	Lead responsible for action	Target Date	Evidence of Progress and completion	Date Action Completed and RAG
Safety Action 4:	**Can you demonstrate an effective system of clinical workforce planning to the required standard?**						
	a)	**Obstetric Medical Workforce** 1) The obstetric consultant team and maternity senior management team should acknowledge and commit to incorporating the principles outlined in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/ 2) Units should monitor their compliance of consultant attendance for the clinical situations listed in this document when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance. Trusts' positions with the requirement should be shared with the Trust board, the board-level safety champions as well as LMNS.	Obstetric medical workforce Sign off at Trust Board level acknowledging engagement with the RCOG document along with an action plan to review any non-attendance to the clinical situations listed in the document. Trusts should evidence their position with the Trust Board, Trust Board level safety champions and LMNS meetings at least once from the relaunch of MIS year 4 in May 2022.	Mr Mark Davies Clinical Director of Obstetrics and Gynaecology	16/6/22 29/7/22	SOP available on intranet. Audit commenced and monthly report presented at CGGAG from August 2022. The compliance to be added to the Perinatal Quality Surveillance model going forward.	
	b)	**Anaesthetic medical workforce** A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other	The rota should be used to evidence compliance with ACSA standard 1.7.2.1.	Dr Kate Boothroyd Consultant Anaesthetist	5/1/2023		

		responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients (ACSA standard 1.7.2.1)		Cross Bay Clinical Lead for Anaesthesia		Compliant with the ACSA standards. Rota submitted as evidence for Anaesthetic medical workforce report submitted to QAC and Board in November 2022 demonstrating compliance. Neonatal medical workforce report submitted to the board in November 2022 with action plan	
	c)	**Neonatal medical workforce** The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing. If the requirements had not been met in both year 3 and year 4 of MIS, Trust Board should evidence progress against the action plan developed in year 3 of MIS as well include new relevant actions to address deficiencies. If the requirements had been met in year 3 without the need of developing an action plan to address deficiencies, however they are not met in year 4, Trust Board should develop an action plan in year 4 of MIS to address deficiencies.	The Trust is required to formally record in Trust Board minutes whether it meets the recommendations of the neonatal medical workforce. If the requirements are not met, Trust Board should evidence progress against the action plan developed in year 3 of MIS to address deficiencies. A review has been undertaken any 6 month period between August 2021 and 2nd February 2023.	Linda Womack, Associate Director of Operations	5/1/2023		
	d)	**Neonatal nursing workforce** The neonatal unit meets the service specification for neonatal nursing standards. If the requirements had not been met in both year 3 and year 4 of MIS, Trust Board should evidence progress against the action plan developed in year 3 of MIS as well include new relevant actions to address deficiencies. If the requirements had been met in year 3 without the need of developing an action plan to address deficiencies, however they are not met in year 4, Trust Board should develop an	The Trust is required to formally record to the Trust Board minutes the compliance to the service specification standards annually using the neonatal clinical reference group nursing workforce calculator. For units that do not meet the standard, the Trust Board should evidence progress against the action plan developed in year 3 of MIS to address deficiencies. A copy of the action plan, outlining progress against each of the actions, should be submitted to the Royal	Nicola Askew Associate Director of Nursing &Therapies for Children and Young, Donna Southam Quality, Safety and Assurance Lead Midwife	5/1/2023	Report submitted to board in November 2022 Action plan submitted to Royal College of Nursing, LMNS and Neonatal ODN	

		action plan in year 4 of MIS to address deficiencies and share this with the Royal College of Nursing, LMNS and Neonatal Operational Delivery Network (ODN) Lead.	College of Nursing (doreen@crawfordmckenzie.co.uk), LMNS and Neonatal Operational Delivery Network (ODN) Lead Neonatal nursing workforce Nursing workforce review has been undertaken at least once during year 4 reporting period (August 2021 and 2nd February 2023).				

Safety Action		Required standard	Minimal evidential requirement	Lead responsible for action	Target Date	Evidence of Progress and completion	Date Action Completed and RAG
Safety Action 5:	**Can you demonstrate an effective system of midwifery workforce planning to the required standard?**						
	a)	A systematic, evidence-based process to calculate midwifery staffing establishment is completed.	The report submitted will comprise evidence to support a, b and c progress or achievement. It should include: • A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated • In line with midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. • Where Trusts are not compliant with a funded establishment based on BirthRate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment.	Heather Gallagher Director of Midwifery	5/01/23	BirthRate +undertaken 2021 Midwifery staffing paper submitted in December 2021 Midwifery staffing report submitted in November 2022 No historical reporting of midwife to birth ratio, red flags,	
	b)	Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above.		Heather Gallagher Director of Midwifery	5/01/23		
	c)	The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service		Heather Gallagher Director of Midwifery	5/1/23		

			The plan must include mitigation to cover any shortfalls. • The plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified must be shared with the local commissioners. • Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staffing. -The midwife to birth ratio -The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives. • Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator status and the provision of one-to-one care in active labour. Must include plan for mitigation/escalation to cover any shortfalls.			labour ward supernumerary status.	
	d)	All women in active labour receive one-to-one midwifery care		Heather Gallagher Director of Midwifery	5/1/23		
	e)	Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year four reporting period.		Heather Gallagher Director of Midwifery	5/1/23	Midwifery staffing paper submitted in Dec 21 and November 22.	

Safety Action		Required standard	Minimal evidential requirement	Lead responsible for action	Target Date	Evidence of Progress and completion	Date Action Completed and RAG
Safety Action 6:	**Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?**						
	1.	Trust Board level consideration of how its organisation is complying with the Saving Babies' Lives care bundle version two (SBLCBv2), published in April 2019. Note: Full implementation of the SBLCBv2 is included in the 2020/21 standard contract	**Element One Process indicators:** A. Percentage of women where Carbon Monoxide (CO) measurement at booking is recorded. B. Percentage of women where CO measurement at 36 weeks is recorded. Note: The relevant data items for these process indicators should be recorded on the provider's Maternity Information System (MIS) and included in the MSDS submissions to NHS Digital in an MSDSv2 Information Standard Notice compatible format, including SNOMED-CT coding. The Trust board should receive data from the organisation's MIS evidencing an average of 80% compliance over a four month period (i.e., four consecutive months in during the MIS year 4 reporting timeframe). If there is a delay in the provider Trust's ability to submit these data to MSDS then compliance can be determined using their interim data recording method. The denominator should still be the total number of women at booking or 36 weeks gestation, as appropriate for each process indicator.	Holly Parkinson Quality Improvement Lead Midwife, Kath Granger Consultant Obstetrician	5/01/23	Quarterly care bundle survey reinstated in May 2022. Audits being undertaken quarterly for all 5 elements.	
	2.	Each element of the SBLCBv2 should have been implemented. Trusts can implement an alternative intervention to deliver an element of the care bundle if it has been agreed with their commissioner (CCG). It is important that specific variations from the pathways described within SBLCBv2 are also agreed as acceptable clinical practice by their Clinical Network.		Holly Parkinson Quality Improvement Lead Midwife, Kath Granger Consultant Obstetrician	5/01/23		
	3.	The quarterly care bundle survey should be completed until the provider Trust has fully implemented the SBLCBv2 including the data submission requirements. The survey will be distributed by the Clinical Networks and should be completed and returned to the Clinical Network or directly to England.maternitytransformation@nhs.net from May 2022 onwards. Evidence of the completed quarterly care bundle surveys should be submitted to the Trust board.		Holly Parkinson Quality Improvement Lead Midwife, Kath Granger Consultant Obstetrician	5/1/23		

			A Trust will fail Safety Action 6 if the process indicator metric compliance is less than 80%. If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%. In addition, the Trust board should specifically confirm that within their organisation they: 1) Pass the data quality rating on the National Maternity Dashboard for the 'women who currently smoke at booking appointment' Clinical Quality Improvement Metric. 2) Have a referral pathway to smoking cessation services (in house or external). 3) Audit of 20 consecutive cases of women with a CO measurement ≥4ppm at booking, to determine the proportion of women who were referred to a smoking cessation service. 4) Have generated and reviewed the following outcome indicators within the Trust for four consecutive months within the MIS year 4 reporting period: • Percentage of women with a CO measurement ≥4ppm at booking. • Percentage of women with a CO measurement ≥4ppm at 36 weeks. • Percentage of women who have a CO level ≥4ppm at booking who subsequently have a CO level. **Percentage of women where Carbon Monoxide (CO) measurement at booking is recorded** Women declining CO testing at booking / 36 weeks appointment Standard A and B of element 1 require Trusts to demonstrate that 80% of women had CO testing at				

			booking and at 36 weeks respectively and that this is recorded in the Trusts' information system. In the event of a high number of women declining CO testing a Trust would be at risk of failing standard A and B by not reaching the 80% testing rate. We suggest Trusts proactively monitor their testing rate and consider interventions to maintain adequate compliance. **Element Two Process indicator:** 1) Percentage of pregnancies where a risk status for fetal growth restriction (FGR) is identified and recorded using a risk assessment pathway at booking and at the 20 week scan (e.g., Appendix D). Note: The relevant data items for these indicators should be recorded on the provider's Maternity Information System and included in the MSDS submissions to NHS Digital in an MSDSv2 Information Standard Notice compatible format, including SNOMED-CT coding. The Trust board should receive data from the organisation's MIS evidencing 80% compliance. If there is a delay in the provider Trust Maternity Information System's ability to record these data at the time of submission an in house audit of 40 consecutive cases of women at 20 weeks scan using locally available data or case records should have been undertaken to assess compliance with this indicator. A Trust will fail Safety Action 6 if the process indicator metric compliance is less than 80%. If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%. In				

			addition, the Trust board should specifically confirm that within their organisation: 2) Women with a BMI>35 kg/m2 are offered ultrasound assessment of growth from 32 weeks' gestation onwards 3) In pregnancies identified as high risk at booking uterine artery Doppler flow velocimetry is performed by 24 completed weeks gestation 4) There is a quarterly audit of the percentage of babies born 37+6 weeks' gestation. 5) They have generated and reviewed the percentage of perinatal mortality cases for 2021 where the identification and management of FGR was a relevant issue (using the PMRT). 6) Their risk assessment and management of growth disorders in multiple pregnancy complies with NICE guidance or a variant has been agreed with local commissioners (CCGs) following advice from the Clinical Network. 7) They undertake a quarterly review of a minimum of 10 cases of babies that were born 37+6 weeks' gestation. The review should seek to identify themes that can contribute to FGR not being detected (e.g., components of element 2 pathway and/or scanning related issues). The Trust board should be provided with evidence of quality improvement initiatives to address any identified problems. Trusts can omit the above mentioned quarterly review of a minimum of 10 cases of babies that were born 37+6 weeks' gestation for quarter 3 of this financial year (2021/22) if				

			staffing is critical and this directly frees up staff for the provision of clinical care. **Element Three Process indicators:** A. Percentage of women booked for antenatal care who had received reduced fetal movements leaflet/information by 28+0 weeks of pregnancy. B. Percentage of women who attend with RFM who have a computerised CTG (a computerised system that as a minimum provides assessment of short term variation). Note: The SNOMED CT code is still under development for RFM and therefore an in-house audit of two weeks' worth of cases or 20 cases of women attending with RFM whichever is the smaller to assess compliance with the element three process indicators. A Trust will fail Safety Action 6 if the process indicator metric compliance is less than 80%. If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%. **Element Four** There should be Trust board sign off that staff training on using their local CTG machines, as well as fetal monitoring in labour are conducted annually. The fetal monitoring sessions should be consistent with the Ockenden Report recommendations, and include intermittent auscultation, electronic fetal monitoring with system level issues e.g., human factors, escalation, and situational awareness. The Trust board should specifically confirm that within their organization 90% of eligible staff (see				

			Safety Action 8) have attended local multi-professional fetal monitoring training annually as above. Please refer to safety action 8 for more information re training. **Element five Process indicators:** A. Percentage of singleton live births (less than 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth. B. Percentage of singleton live births occurring more than seven days after completion of their first course of antenatal corticosteroids. C. Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior birth. D. Percentage of women who give birth in an appropriate care setting for gestation (in accordance with local ODN guidance). Note: The relevant data items for these process indicators should be recorded on the provider's Maternity Information System and included in the MSDS submissions to NHS Digital in an MSDSv2 Information Standard Notice compatible format, including SNOMED-CT coding. If there is a delay in the provider Trust MIS's ability to record these data, then an audit of 40 cases consisting of 20 consecutive cases of women presenting with threatened preterm labour before 34 weeks and 20 consecutive cases of women who have given birth before 34 weeks using locally available data or case records should have been undertaken to assess compliance with each of the process indicators. The Trust board should receive data from the organisation's				

			Maternity Information System evidencing 80% compliance. A Trust will not fail Safety Action 6 if the process indicator scores are less than 80%. However, Trusts must have an action plan for achieving >80%. In addition, the Trust board should specifically confirm that within their organisation: • They have a dedicated Lead Consultant Obstetrician with demonstrated experience to focus on and champion best practice in preterm birth prevention. (Best practice would be to also appoint a dedicated Lead Midwife. Further guidance/information on preterm birth clinics can be found on https://www.tommys.org/sites/default/files/2021-03/reducing%20preterm%20birth%20guidance%2019.pdf • Women at high risk of preterm birth have access to a specialist preterm birth clinic where transvaginal ultrasound to assess cervical length is provided. If this is not the case the board should describe the alternative intervention that has been agreed with their commissioner (CCG) and that their Clinical Network has agreed is acceptable clinical practice. • An audit of 40 consecutive cases of women booking for antenatal care has been completed to measure the percentage of women that are assessed at booking for the risk of preterm birth and stratified to low, intermediate, and high risk pathways, and the percentage of those assessed to be at increased risk that are referred to the appropriate preterm birth clinic and pathway. The assessment should use the criteria in Appendix F of				

			SBLCBv2 or an alternative which has been agreed with local CCGs following advice from the Clinical Network. • Their risk assessment and management in multiple pregnancy complies with NICE guidance or a variant that has been agreed with local commissioners (CCGs) following advice from the provider's clinical network.				
	The survey will be distributed by the Clinical Networks and should be completed and returned to the Clinical Network or directly to England.maternitytransformation@nhs.net						

Safety Action		Required standard	Minimal evidential requirement	Lead responsible for action	Target Date	Evidence of Progress and completion	Date Action Completed and RAG
Safety Action 7:	**Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your MVP to coproduce local maternity services?**						
		Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?	**Evidence should include:** • Terms of Reference for your MVP. They reflect the core principles for Terms of Reference for an MVP as outlined in annex B of Implementing Better Births: A resource pack for Local Maternity Systems • Minutes of MVP meetings demonstrating how service users are listened to and how regular feedback is obtained, that actions are in place to demonstrate that listening has taken place and evidence of service developments resulting from coproduction between service users and staff. • Written confirmation from the service user chair that they are being	Alison Major Head of Midwifery and Gynaecology/ MVP chair		There is a ToR Bi monthly MVP meetings and they are minuted. Witten confirmation has been received from the MVP chair	

			remunerated as agreed and that this remuneration reflects the time commitment and requirements of the role given the agreed work programme. Remuneration should take place in line with agreed Trust processes. • The MVP's work programme, minutes of the MVP meeting which agreed it and minutes of the LMNS board that ratified it • Written confirmation from the service user chair that they and other service user members of the MVP committee are able to claim out of pocket expenses, including travel, parking, and childcare costs in a timely way. • Evidence that the MVP is prioritising hearing the voices of women from Black, Asian, and Minority Ethnic backgrounds and women living in areas with high levels of deprivation, given the findings in the MBRRACE-UK reports about maternal death and morbidity and perinatal mortality. • Evidence that the MVP Chair is invited to attend maternity governance meetings and that actions from maternity governance meetings, including complaints' response processes, trends, and themes, are shared with the MVP.			has been remunerated & committee members have been able to claim out of packet expenses. The MVP works programme agreed at the LMNS. MVP's have organised a coffee morning with women living in high areas of deprivation Invite the MVP chair to maternity governance meetings. MVP chair has	

						informal meetings with DOM to discuss issues and feedback/co-production etc//	

Safety Action		Required standard	Minimal evidential requirement	Lead responsible for action	Target Date	Evidence of Progress and completion	Date Action Completed and RAG
Safety Action 8:	**Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4? In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance, and newborn life support, starting from the launch of MIS year 4?**						
	a)	A local training plan is in place to ensure that all six core modules of the Core Competency Framework, will be included in your unit training programme over the next 3 years	It is recognised that temporary modifications may be necessary in light of the Covid-19 pandemic. In such cases the Board must ensure that these are mitigated and agreed to ensure the safe provision of services. Details of any modifications, and the agreed mitigations will be expected to be shared with the Trust Board by 16 June 2022	Helena Brown Practice Development Midwife	5/1/23	Face to face training for PROMPT was reinstated in April 2022. All other training is virtual All staff groups >90% compliance. Monthly compliance monitored at CGGAG, LMNS and perinatal	
	b)	90% of each relevant maternity unit staff group have attended an annual 'in-house' one day multi-professional training day, to include maternity emergencies starting from the launch of MIS year four		Helena Brown Practice Development Midwife	5/1/23		
	c)	90% of each relevant maternity unit staff group have attended an annual 'in-house' one day multi-professional training day, to include antenatal and intrapartum fetal		Helena Brown Practice	5/1/23		

		monitoring and surveillance, starting from the launch of MIS year four		Development Midwife		quality surveillance model shared with Trust Board monthly.	
	d)	Can you evidence that 90% of the team required to be involved in immediate resuscitation of the newborn and management of the deteriorating newborn infant have attended your annual in-house neonatal life support training or Newborn Life Support (NLS) course starting from the launch of MIS year four		Helena Brown Practice Development Midwife	5/1/23	Compliance for all staff groups >90%	

Safety Action		**Required standard**	**Minimal evidential requirement**	**Lead responsible for action**	**Target Date**	**Evidence of Progress and completion**	**Date Action Completed and RAG**
Safety Action 9:	**Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?**						

	a)	The pathway developed in year 3, that describes how safety intelligence is shared from floor to Board, through local maternity and neonatal systems (LMNS), and the Regional Chief Midwife has been reviewed in line with the implementing-a-revised-perinatal-qualitysurveillance-model.pdf (england.nhs.uk) The revised pathway should formalise how Trust-level intelligence will be shared with new LMNS/ICS and regional quality groups to ensure early action and support is provided for areas of concern or need.	Evidence for points a) and b) • Evidence of a revised pathway which describes how frontline midwifery, neonatal, obstetric and Board safety champions share safety intelligence between a) each other, b) the Board, c) new LMNS/ICS quality group and d) regional quality groups involving the Regional Chief Midwife and Lead Obstetrician to ensure early action and support is provided for areas of concern or need in line with the perinatal quality surveillance model. • Evidence that a clear description of the pathway and names of safety champions are visible to maternity and neonatal staff. • Evidence that discussions regarding safety intelligence, including the number of incidents reported as serious harm, themes identified, and actions being taken to address any issues; staff feedback from frontline champions and engagement sessions; minimum staffing in maternity services and training compliance are taking place at Board level no later than 16 June 2022. NB- The training update should include any modifications made as a result of the pandemic / current challenges and a rough timeline of how training will be rescheduled later this year if required. This additional level of training detail will be expected by 16 June 2022. • Evidence of bi-monthly engagement sessions (e.g., staff feedback meeting, staff walkaround sessions etc.) being undertaken by a member of the Board. • Evidence of progress with actioning named concerns from staff workarounds are visible to both maternity and neonatal	Heather Gallagher Director of Midwifery/ Bridget Lees Chief Nursing Officer	16/6/2022	Pathway of safety intelligence updated to reflect changes in the LMNS/ ICB. Update provided to board regarding mandatory training in monthly DoM report and perinatal quality surveillance model Monthly safety champion walk arounds have been arranged and are evidenced. Claims Scorecard discussed at Divisional Governance in August 2022 with Executive	
	b)	Board level safety champions present a locally agreed dashboard to the Board quarterly, including the number of incidents		Heather Gallagher Director of	16/6/2022		

		reported as serious harm, themes identified, and actions being taken to address any issues; staff feedback from frontline champions and walk-abouts; minimum staffing in maternity services and training compliance are taking place at Board level no later than 16 June 2022. NB, The training update should include any modifications made as a result of the pandemic / current challenges and a rough timeline of how training will be rescheduled later this year if required. This additional level of training detail will be expected by 16 June 2022.	staff and reflects action and progress made on identified concerns raised by staff and service users. • Evidence that the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions to help target interventions aimed at improving patient safety at least twice in the MIS reporting period at a Trust level quality meeting. This can be a board or directorate level meeting. Evidence of a revised written pathway, in line with the perinatal quality surveillance model, that is visible to staff and meets the requirements detailed in part a) and b) of the action is in place no later than 16 June 2022. The expectation is that work has already commenced on this in line with the Ockenden response (Ockenden, 2021).	Midwifery/ Bridget Lees Chief Nursing Officer		Safety Champion in attendance	
	c)	Board level safety champions have reviewed their continuity of carer action plan in the light of Covid-19. A revised action plan describes how the maternity service will work towards Continuity of Carer being the default model of care offered to all women by March 2024, prioritising those most likely to experience poor outcomes.	Evidence of an action plan that describes how the maternity service will work towards Midwifery Continuity of Carer (MCoC) being the default model of care offered to all women by March 2024. The plan covers: • The number of women that can be expected to receive MCoC, when offered as the default model of care • A midwifery redeployment plan into MCoC teams, phased alongside the fulfilment of safe staffing levels • How MCoC teams are established in compliance with national principles and standards. • How rollout will be prioritised to those most likely to experience poor outcomes,	Heather Gallagher Director of Midwifery/ Bridget Lees Chief Nursing Officer	16/6/2022	Action plan for MCoC was discussed at Maternity Safety Champion meeting in April 2022 and update in October and November 2022	

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			including ensuring rollout to 75% of women from Black, Asian, and mixed ethnicity backgrounds and also from the most deprived 10% of neighbourhoods by March 2024. • Developing an enhanced model of MCoC that provides extra support for women from the most deprived 10% of areas. • How care will be monitored locally, and providers ensure accurate and complete reporting on provision of MCoC using the Maternity Services Dataset • Evidence of Board level oversight and discussion of this revised continuity of carer action plan. An action plan to evidence how MCoC will be the default model of care offered to all women by March 2024, prioritising those most likely to experience poor outcomes, agreed by the Board safety champion by 16 June 2022.				

	d)	d) Board level and maternity safety champions are actively supporting capacity and capability building for staff to be involved in the Maternity and Neonatal Safety Improvement Programme (MatNeoSIP)	Evidence for point d): Evidence of how the Board and Safety Champions have supported staff involved in part d) of the required standard and specifically in relation to: • active participation by staff in contributing to the delivery of the collective aims of the MatNeo Patient Safety Networks, and undertaking of specific improvement work aligned to the MatNeoSIP national driver diagram and key enabling activities • engagement in relevant improvement/capability building initiatives nationally, regionally or via the MatNeo Patient Safety Networks, of which the Trust is a member • support for clinicians identified as MatNeoSIP Improvement Leaders to facilitate and lead work through the MatNeo Patient Safety Networks and the National MatNeoSIP network • utilise insights from culture surveys undertaken to inform local quality improvement plans • maintain oversight of improvement outcomes and learning, and ensure intelligence is actively shared with key system stakeholders for the purpose of improvement. Attendance or representation at a minimum of two engagement events such as Patient Safety Network meetings, MatNeoSIP webinars and/or the annual national learning event by the end of MIS year 4 on 2nd February 2023. Evidence that insights from culture surveys undertaken have been used to inform local	Heather Gallagher Director of Midwifery/ Bridget Lees Chief Nursing Officer	5/1/23	MatNeo launch meeting on the 20 September 2022. NED and Maternity Champions attended. Quarterly Maternity Safety Champion report submitted to board	

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			quality improvement plans by 2nd February 2023.				

Safety Action		Required standard	Minimal evidential requirement	Lead responsible for action	Target Date	Evidence of Progress and completion	Date Action Completed and RAG
Safety Action 10:	**Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) Scheme from 1 April 2021 to 5 December 2022?**						
	a)	Reporting of all qualifying cases to HSIB from 1 April 2021 to 5 December 2022	**Trust Board** sight of Trust legal services and maternity clinical governance records of qualifying HSIB/EN incidents and numbers reported to HSIB and NHS Resolution.	Donna Southam Quality, Safety and Assurance Lead Midwife	5/1/23	Review to be undertaken to ensure all cases reported to HSIB since 2021 SI and HSIB cases included in monthly reports to board Process and SOP agreed for HSIB/EN scheme	
	b)	Reporting of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 1 April 2022 until 5 December 2022	**Trust Board** sight of evidence that families have received information on the role of HSIB and EN scheme	Donna Southam Quality, Safety and Assurance Lead Midwife	5/1/23		
	c)	For all qualifying cases which have occurred during the period 1 April 2021 to 5 December 2022, the Trust Board are assured that: 1. the family have received information on the role of HSIB and NHS Resolution's EN scheme; and 2. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour	**Trust Board** sight of evidence of compliance with the statutory duty of candour.	Donna Southam Quality, Safety and Assurance Lead Midwife	5/1/23		

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BOARD OF DIRECTORS

Date of Meeting	22 December 2022
Title	Ockenden Review Update
Report of	Bridget Lees, Executive 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
	To advise, alert and approve. This report provides an overview of the position of the Trust in relation to the compliance with the 7 Immediate actions from the Ockenden Report 2020 and a progress update of the action plan from the regional Insight visit which took place on the 20th and 21st July 2022.			

Summary of Key Issues	The purpose of this report is to provide an update on the current compliance with seven Immediate and Essential Actions (IEAs) identified against the recommendations of the Ockenden first report, Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust (December 2020) and a progress update of the action plan from the regional Insight visit which took place on the 20th and 21st July 2022. 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 an Ockendon assurance visit on the 20th/ 21st July 2022, as part of the ongoing assurance of compliance and sustainability of improvement, supported by the Regional Chief Midwife. The trust received a report with recommendations which are included in an action plan following the visit (Appendix 1). The insights team provided a summary of the Ockenden immediate and essential actions status (Appendix 2). Appendix 3 shows a summary of the

	status against the Ockenden immediate and essential actions position in December 2022. This report provides the Committee with a progress update of the Trust's position in relation to the compliance with the 7 Immediate actions from the Ockenden Report 2020 and the progress of the recommendations from the insights visit conducted on the 20th and 21st July 2022. The action plan is overseen by the senior multidisciplinary group meets monthly to commit to implementing all immediate and essential actions. The action plan will be monitored at the Women's Quality Board and shared with the LMNS. The Maternity services are fully compliant with 2 immediate actions and partially compliant with 5 immediate actions. In addition, 6 essential actions have also been self-assessed as fully compliant. The service has progressive plans to ensure all areas RAG rated as Amber and Red have further action taken to achieve full compliance. The Insights team have accepted the offer to return to the Trust to support their improvement journey. The next visit will take place in February 2023. The Board of Directors is asked to receive this report for discussion and assurance of a plan in place to achieve full compliance with the immediate and essential actions as well as the Insights team feedback and recommendations.

Prior Discussions	**Committee**	**Date**	**Recommendations/ Concerns**
	Women's Health Quality Board	13th December 2022	None

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
	Direct link to patient safety			

Impact on Board Assurance Framework or Corporate Risk Register	

Risk Impact Assessment	Is this required?	**Y**	If Yes, Date Completed	05/12/2022
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	
CNST	Clinical Negligence Scheme for Trusts
MIS	Maternity Incentive Scheme
RCOG	Royal College of Obstetrics and Gynaecology
LMNS	Local Maternity and Neonatal System
CGGAG	Care Group Governance and Assurance Group
PMRT	Perinatal Mortality Review Tool
PROMPT	Practical Obstetric Multi-disciplinary Professional Training
MVP	Maternity Voice Partnerships
MSDS	Maternity Services Dataset
MDT	Multidisciplinary Team
NICE	National Institute of Clinical Excellence
BSOTS	Birmingham Symptom Specific Obstetric System
SOP	Standard Operating Procedure
IEA	Immediate Essential Action

UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST

Ockenden Review Update

PURPOSE

1. The purpose of this report is to provide an update on the current compliance with seven Immediate and Essential Actions (IEAs) identified against the recommendations of the Ockenden first report, Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust (December 2020) and a progress update of the action plan from the regional Insight visit which took place on the 20th and 21st July 2022.

BACKGROUND

2. The Ockenden report was written in the wake of a review at The Shrewsbury and Telford Hospital NHS Trust following a letter from bereaved families, raising concerns where babies and mothers died or potentially suffered significant harm whilst receiving maternity care at the hospital. The former Secretary of State for Health and Social Care, Jeremy Hunt instructed NHS Improvement to commission a review assessing the quality of investigations relating to new-born, infant and maternal harm at that Trust.

3. There were seven Immediate and Essential actions (IEAs) within the first Ockenden report comprising 12 specific urgent clinical priorities. The Trust was tasked to set out plans for their response in relation to the Immediate and Essential actions (IEAs), some of which require direct investment to enable delivery.

4. 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.

5. The Final Ockenden Report published on the 30th March 2022 reports on the care of all families included in this review of maternity services at Shrewsbury and Telford Hospital NHS Trust. It explores internal and external factors that may have contributed to the failings in care. The report is particularly focussed on the Trust's failings in governance processes which directly led to the harm that families experienced.

6. Since the publication of the first report, trusts and maternity services across England have shared their plans to ensure full implementation of the seven IEAs takes place. The NHS has been working with regions, systems and Royal Colleges to implement the IEAs. Significant funding has been provided by the NHS, although we all recognise that much more is needed. The NHS has also reviewed the Maternity Transformation Programme to ensure future are in line with the seven IEAs.

7. All trusts have now assessed their position against the IEAs and submitted evidence to demonstrate compliance which has been independently quality assured. The commitment to system-wide improvement in maternity services has also seen all NHS standard contracts include conditions whereby any provider delivering maternity services must provide and implement an action plan, approved by its governing body, describing, with timescales, how it will implement the immediate and essential actions set out in the Ockenden Review.

8. The Government's announced additional investment into maternity services in March 2021 for £95.6million across England and in July 2021 a further £2.45m that were allocated to the Royal College of Obstetricians and Gynaecologists (RCOG) to find the best ways of spotting early warning signs of infants in distress. For 2021/22, more than £80m of additional funding has been allocated to be distributed as targeted System Development Funding. This funding will be focused on areas where it will have the biggest impact on delivering the immediate and essential actions and ensuring the safety of women, babies, and their families.

9. With a national shortage of midwives, and concerns around continuing attrition of midwives and obstetricians, actions have been taken to increase the workforce by recruiting midwives internationally and £4.5m funding for 2021/22 has been allocated. Additional investment has also been made in Professional Midwifery Advocates, who provide educational and psychological support for Midwives, increasing the number to 800 in England. To support retention of Midwives, NHSE&I has also funded a pastoral care Midwife role in every maternity unit during 2021/22.

10. In March 2022 a further investment of £127 million over two years was announced to fund further workforce expansion, leadership development, capital to increase neonatal cot capacity, additional support to the LMNS and retention support.

11. The trust received an Ockendon assurance visit on the 20th/ 21st July 2022, as part of the ongoing assurance of compliance and sustainability of improvement, supported by the Regional Chief Midwife. The trust received a report with recommendations which are included in an action plan following the visit (Appendix 1). The insights team provided a summary of the Ockenden immediate and essential actions status (Appendix 2). Appendix 3 shows a summary of the status against the Ockenden immediate and essential actions position in December 2022.

12. This report provides the Committee with a progress update of the Trust's position in relation to the compliance with the 7 Immediate actions from the Ockenden Report 2020 and the progress of the recommendations from the insights visit conducted on the 20th and 21st July 2022. The action plan is overseen by the senior multidisciplinary group meets monthly to commit to implementing all immediate and essential actions. The action plan will be monitored at the Women's Quality Board and shared with the LMNS.

ANALYSIS/DISCUSSION

13. An Insights visit to the University Hospitals of Morecombe Bay services took place on the 20th and 21st July 2022. The purpose of the visit was to provide assurance against the 7 immediate and essential actions from the interim Ockenden report. The Insight Visit Team used an appreciative enquiry and learning approach to foster partnership working to ensure that the actions taken to meet the interim Ockenden recommendations were embedded in practice. Conversations were held with various members of the senior leadership team and various frontline staff ranging in job roles. Emerging themes from conversations were organised under the immediate and essential actions heading:
    - Enhanced Safety
    - Listening to Women & Families
    - Staff Training and Working Together
    - Managing Complex Pregnancy
    - Risk Assessment Throughout Pregnancy
    - Monitoring Fetal Well-Being
    - Informed Consent
    - Workforce Planning and Guidelines.

14. The Insights team acknowledged the large geographical area the Trust served and the unique challenges this brought regarding cross site working. In addition, there was acknowledgment the Trust offered an open and transparent overview of the services, identifying areas of good practice and areas that had ongoing challenges. Furthermore, the regional team acknowledged the Trust Board was sighted on the challenges within maternity services, and these are recorded on the corporate risk register.

15. The Insights team understood the Trust had a new maternity leadership team in place and this would take time to embed and acknowledged the improvement journey had commenced. In addition, the Trust had invested in the midwifery leadership team, including the appointment of a Consultant midwife and several specialist midwifery roles. In November 2022, a new Clinical Obstetric team has been appointed. In addition, there is active recruitment for an Associate Director of Midwifery/ Nursing.

16. There was acknowledgment the Trust was aware the governance processes required to strengthen and had undertaken a review with plans in place to improve. In addition, there was an improvement plan for investigating a back log of serious incidents. The Insights team felt that the delay in reporting on StEIS was in part due to the decision to StEIS report being made at the Executive Review Group, the Insights team felt this could be improved by delegating this to the MDT. It was noted the Trust had invested in a Quality, Safety, and Assurance Lead Midwife to support the governance team. As of November 2022, there are no incidents outside 30 days and all StEIS reporting has been undertaken within the national timeframe since August 2020.

17. The Insights team identified the midwifery led offer varied by site and felt the Trust should review without delay the midwifery led offer at the Barrow site. In addition, BadgerNet had been implemented and the Insights team felt this was positive and would assist the Trust with their audit function and capability. The Insights team heard the Trust had plans in place to review guidance to ensure it is reflective of NICE guidance.

18. The Trust was assessed as partially compliant with all the immediate actions from the first Ockenden report 2020 at the Insights visit (Appendix 2).

19. Immediate Action 1 Enhanced Safety was awarded partial compliance following the Insights visit. The current position remains partially compliant however two essential actions have been completed. The Senior Leadership team meet frequently. There is a quarterly report submitted to Trust Board on serious incidents and associated action plans. There is no longer a backlog of incidents outside of 30 days in Maternity. MSDS dataset is fully compliant to meet CNST safety action 2 in October 2022. There is an action plan in place to address the PMRT backlog and the Trust board have received reports relating to PMRT in September 2022 and November 2022. The backlog of PMRT cases should be completed by the end of January 2023.

20. Immediate Action 2 Listening to Women & Families was awarded partial compliance following the Insights visit. The current position remains partially compliant. The MVP chair has been invited to the Women's health quality board, Maternity Safety Champions and Labour Ward Forum and is unable to attend due to capacity of her own work. A meeting has been arranged with the LMNS to explore options for MVP support. There is a newly appointed Non-Executive Director safety champion and there is a quarterly safety champion report presented at Trust Board. The NED has also attended a Mat Neo safety collaborative and plans to attend the MVP meetings going forward.

21. Immediate Action 3 Staff Training and Working Together was awarded partial compliance following the Insights visit and following a review of the evidence in December 2022. Maternity services are now fully compliant. Training compliance for all staff groups >90% and the Maternity Services have achieved compliance with safety action 8 for CNST. The training needs analysis (TNA) has been approved.

22. Immediate Action 4 Managing Complex Pregnancy was awarded partial compliance following the Insights visit. The current position remains partially compliant. The SoP for maternal medicine is in draft and awaiting to be circulated and to go through governance sign off.

23. Immediate Action 5 Risk Assessment Throughout Pregnancy was awarded partial compliance following the Insights visit. The current position remains partial compliant. BadgetNet has a mandatory field to ensure all service users are risk assessed at every contact and this is recorded within the personalised care plan. The risk assessment and referral audit submitted as part of the evidence demonstrated referrals were made in most cases, the insights team were concerned that 3 (from 66) safeguarding referrals had not been sent, the Trust was advised to investigate as a matter of urgency. A review was undertaken, and all cases had been reviewed by the safeguarding team. A repeat audit is being undertaken for assurance purposes.

24. Immediate Action 6 Monitoring Fetal Well-Being was awarded partial compliance following the Insights visit. Following a review of the evidence in December 2022 Maternity services are now fully compliant. PA time for leads has been reviewed and is in accordance with the maternity self-assessment tool. The Trust has appointed a fetal monitoring lead at the RLI and at FGH. There are fetal monitoring leads on both sites with a job description detailing roles and responsibilities.

25. Immediate Action 7 Informed Consent was awarded partial compliance following the Insights visit. The current position remains partially compliant. An audit is being undertaken to review the compliance against this essential action.

26. Workforce Planning & Guidelines was awarded partial compliance following the Insights visit. The current position remains partial compliant. The Trust had invested in the maternity leadership team, appointing to several leadership roles including a Director of Midwifery, Consultant midwife and Quality, Safety and Assurance Lead Midwife. There has been a reduction in over 50 out of date guidelines at the time of the insights visit to 18 out of date guidelines. The maternity services are on target to achieve full compliance with all guidelines being in date by the end of January 2023. The Insights team felt the Trust should work closely with the LMNS as a vehicle to support the updating of guidance. The Paediatric Consultant's had a 1:3 on call rota, which is currently being reviewed.

27. The Maternity services are fully compliant with 2 immediate actions and partially compliant with 5 immediate actions. In addition, 6 essential actions have also been self-assessed as fully compliant. The service has progressive plans to ensure all areas RAG rated as Amber and Red have further action taken to achieve full compliance.

28. The Insights team have accepted the offer to return to the Trust to support their improvement journey. The next visit will take place in February 2023.

RISKS

29. The partial compliance with seven immediate essential Ockenden actions has been added to the WACS Risk Register. This is a risk of 15.

30. The rating received from the national team will be shared with the CQC as part of the regulatory process. A detailed breakdown was published of each Trust's compliance with the 7 Immediate Actions in May 2022.

RECOMMENDATION

31. Following the final audit results being received the maternity service have developed a robust action plan to address the actions identified against each of the Immediate Essential actions and has established a senior multidisciplinary working group. The service has progressive plans to ensure all areas RAG rated as amber and red have further action taken to achieve full compliance.

32. The Committee is asked to receive this report for discussion and assurance of a plan in place to achieve full compliance with the immediate and essential actions as well as the Insights team feedback and recommendations.

Appendix 1

Ockenden Insights Visit Action Plan

Recommendation	Action	Designation of Responsible Officer	Target Date	Evidence of Progress and Completion	Monitoring and Evaluation group	Date Action Completed
Recommendations made following Insights Visit						
The Trust had a significant number of action plans for maternity services, the appointment of a project support officer to co-ordinate should be progressed without delay.	Develop a job description and advertise	Heather Gallagher Director of Midwifery	30/12/2022	Project support manager from the recover support program in place 2-3 days a week to support WACS. Exploring budget to review funds to support role	Women's Health Quality Board and Quality Assurance Committee	
A robust assessment process when non-evidence based guidelines are used to ensure the decision is clinically justified.	Develop a SOP detailing the process	Donna Southam Quality Safety, and Assurance Lead Midwife	31/12/2022	Draft SOP developed and awaiting approval at the December procedural document group	Women's Health Quality Board and Quality Assurance Committee	

The Trust must also progress the review of guidance without delay to ensure compliance whilst ensuring ratified guidance is not published as draft	Trajectory in place to ensure all guidelines which has passed their review date are updated by 30/1/2023.	Donna Southam Quality, Safety and Assurance Lead Midwife	30/1/2023	Trajectory in place to ensure all guidelines which have passed their review date are updated by 30/1/2023. A review has been undertaken to ensure high risk guidelines are prioritised.	Women's Health Quality Board and Quality Assurance Committee	
The Trust and LMNS need to establish regular proactive engagement.	Pathways and meetings to be confirmed. Dates to be forwarded to the senior team at UHMBT	Heather Gallagher Director of Midwifery	30/9/2022	DoM has contacted Governance Lead Midwife and programme manager at LMNS and requested dates for all meetings. LMNS undertaking a review of the meeting structures	Women's Health Quality Board and Quality Assurance Committee	Completed 30/10/2022
The Trust should without delay review the on-call rota for Consultants to ensure compensatory	Review to be undertaken by Clinical Director for Obstetrics and the WACS Associate Director of Operations	Linda Womack WACS Care Group Associate Director of Operations	30/12/2022	A review of the rotas and job planning is in progress	Women's Health Quality Board and Quality Assurance Committee	

rest.						
The Trust should consider the introduction of BSOTS without delay.	Implementation of BSOTS	Holly Parkinson Quality Improvement Lead Midwife Tamsin Cripps Head of Midwifery Alison Major Head of Midwifery and Gynaecology	30/1/2023	Project plan developed. Business case being developed for RLI triage. Current triage system under review	Women's Health Quality Board and Quality Assurance Committee	
The Trust must address without delay the estates at the Lancaster site for telephone triage	Review of relocation of telephone triage at Royal Lancaster site.	Alison Major Head of Midwifery and Gynaecology	30/9/2022	Following a review staff have been informed not to repeat information when taking calls to ensure there is no breach in confidentiality	Women's Health Quality Board and Quality Assurance Committee	Completed 30/9/2022
The Trust should review its midwifery led offer across sites to ensure this is available to all service users	Review to be undertaken at Furness General Site	Chantelle Winstanley, Consultant Midwife	30/1/2023	All three sites offer Midwifery Led Care. Audit of care to be undertaken.	Women's Health Quality Board and Quality Assurance Committee	

The Trust should without delay put a process in place to ensure a robust system for safeguarding referrals.	Review to be undertaken of the audit	Alison Major Head of Midwifery and Gynaecology	30/9/2022	New reporting workflow reviewed in the EPR system to cross check safeguarding referrals	Women's Health Quality Board and Quality Assurance Committee	Completed 30/9/2022
The Trust should continue to form part of the MVP and work with the MVP and MVP Chair at the earliest opportunity to ensure co-production	MVP invited to all governance meetings. MVP to be invited to labour ward forums. Discussion at MVP September meeting regarding co-production	Alison Major Head of Midwifery and Gynaecology	Ongoing	There have been challenges with the MVP's not receiving remittance for some of 2022. This has impacted on some co-production. The MVP does not have capacity to attend all meetings but has been invited.	Women's Health Quality Board and Quality Assurance Committee	
Additional issues						
Frequent Leadership meetings with the Clinical Lead in attendance	Appointment of Clinical Lead at Royal Lancaster Hospital. Monitoring attendance going forward	Mark Davies Clinical Director of Obstetrics and Gynaecology	30/9/2022	Appointment of Clinical Lead at RLI in November 2022. Attendance to be monitored by the Clinical Director	Women's Health Quality Board and Quality Assurance Committee	

Address the backlog of incidents	All incidents to be closed within 30 days unless further investigation is warranted	Donna Southam Quality, Safety and Assurance Lead Midwife	30/9/2022	No incidents outside 30 days open in maternity. Monitored daily at daily triage	Women's Health Quality Board and Quality Assurance Committee	Completed 30/10/2022
Improved process of declaring STESIS reportable incidents	Director of Governance to review and implement a process which ensures STESIS reportable incidents are declared within 2 working days	Richards Sachs Director of Governance	30/8/2022	3 times a week ERG implemented. STESIS reportable cases can be escalated to the Executive Chief Nurse	Women's Health Quality Board and Quality Assurance Committee	Completed 30/8/2022
MSDS dataset to include Continuity of Carer	MSDS dataset to capture Continuity of Carer compliance	Karen Bridgemen Digital Midwife	30/8/2022	MSDS dataset now includes Continuity of Carer	Women's Health Quality Board and Quality Assurance Committee	Completed 30/8/2022
Full implementation of PMRT	PMRT undertaken in accordance with NHS Resolution timeframes and PMRT national guidance	Donna Southam Quality, Safety and Assurance Lead Midwife	30/8/2022	PMRT scheduled for 2022. PMRT ToR and PMRT SOP in place. Plan in place to address remaining PMRT cases. Two PMRT reports submitted to Trust board.	Women's Health Quality Board and Quality Assurance Committee	Completed 30/10/2022

Invite the MVP to the Maternity Safety Champion meetings	Invitations to be sent to MVP chair for Maternity Safety Champion meeting	Donna Southam Quality, Safety and Assurance Lead Midwife	30/9/2022	Maternity Safety Champion minutes and attendance log	Women's Health Quality Board and Quality Assurance Committee	Completed 30/11/2022
Obstetric attendance and support to deliver PROMPT	Lead Obstetrician allocated to lead on education with the lead practice development midwife and forward planner	Mark Davies Clinical Director of Obstetrics and Gynaecology, Linda Womack Associate Director of Operations	30/10/2022	Obstetric attendance >90%. Awaiting appointment of Obstetric educational lead	Women's Health Quality Board and Quality Assurance Committee	
Training Needs Analysis to be updated	Training Needs Analysis to be updated	Helena Brown Practice Development Midwife	30/10/2022	Training needs analysis to be approved and on intranet	Women's Health Quality Board and Quality Assurance Committee	Completed 31/10/2022
Maternal Medicine SOP	Maternal Medicine SOP to be developed and approved	Mark Davies Clinical Director of Obstetrics and Gynaecology, Linda Womack Associate Director of Operations	30/1/2023	Draft SOP developed. To be circulated and approved at the procedural document group	Women's Health Quality Board and Quality Assurance Committee	

Antenatal Care Guideline was submitted with a draft watermark	Ensure guideline is in final draft	Donna Southam Quality, Safety and Assurance Lead Midwife	30/8/2022	The guideline is available on the intranet	Women's Health Quality Board and Quality Assurance Committee	Completed 30/8/2022
Fetal Monitoring Obstetric Job description to be finalised	Approved job description of the Fetal Monitoring Obstetric Lead	Mark Davies Clinical Director of Obstetrics and Gynaecology, Linda Womack Associate Director of Operations	30/9/2022	Final job description	Care Group Governance and Assurance Group meeting and Quality Assurance Committee	Completed 30/10/2022
Saving Babies Lives Midwife to network with other Saving Babies Lives Midwives in the region	Networking with other Saving Babies Lives Care Bundle Midwife	Holly Parkinson Quality Improvement Midwife	30/9/2022	Ongoing networking and attendance at meetings	Women's Health Quality Board and Quality Assurance Committee	Completed 30/10/2022
PA time for leads was being reviewed to ensure adequate time was allotted to lead posts and the obstetricians had clear roles and responsibilities	Review of the Obstetric job plans	Mark Davies Clinical Director of Obstetrics and Gynaecology, Linda Womack Associate Director of Operations	30/9/2022	Allocated PA time in alignment with the maternity self-assessment tool kit	Care Group Governance and Assurance Group meeting and Quality Assurance Committee	

Appendix 2

Summary of Insight Visit Review of Ockenden Immediate Essential Actions Status

Summary of Insight Visit Review of Ockenden IEAs Status

IEA								
1) Enhanced safety	Q1 Dashboards	Q2 – External review of SIs	Q3 – SIs to Board/LMNS	Q4 - PMRT	Q5 - MSDS	Q6 - HSIB	Q7 - PCQSM	Q8 – SIs to Board/LMNS
2) Listening to women and families	N/A	N/A	Q11 – NED	Q12 - PMRT	Q13 – Service user feedback	Q14 – Bimonthly safety champ meetings	Q15 – Service user feedback	Q16 – NED
3) Staff training and working together	Q17 – MDT Training	Q18 – Cons. Ward Rounds	Q19 – Ring-Fenced Funding	Q20 – workforce planning	Q21 – 90% MDT Training	Q22 – Cons Ward Rounds	Q23 – MDT Training Schedule	
4) Managing complex pregnancy	Q24 – MMC Criteria	Q25 – Named Consultant	Q26 – Complex Pregnancies	Q27 – SBLCBv2	Q28 – Named Cons/Audit	Q29 – MMC		
5) Risk assessment throughout pregnancy	Q30 – Risk assessment	Q31 – Place of Birth RA	Q32 – SBLCBv2	Q33 – RA recorded with PCSP				
6) Monitoring fetal well-being	Q34 – Leads in post	Q35 – Leads expertise	Q36 – SBLCBv2	Q37 – 90% MDT Training	Q38 – Leads in post			
7) Informed consent	Q39 – Accessible Information, Place of Birth	Q40 – Accessible Information, All Care	Q41 – Decision making and Informed Consent	Q42 – Women's Choices Respected	Q43 – Service User Feedback	Q44 - Website		
Workforce Planning	Q45 – Clinical Workforce Planning	Q46 – Midwifery Workforce Planning	Q47 – D/HoM Accountable to Exec Dir	Q48 – Strengthening Midwifery Leadership				
Guidelines	Q49 - Guidelines							

Appendix 3

Compliance with Ockenden Essential as of December 2022

IEA Compliance as of December 2022 Self Assessment								
1. Enhanced Safety	Q1 Dashboards	Q2 External review of SIs	Q3 SIs to Board	Q4 PMRT	Q5 MSDS	Q6 HSIB	Q7 Perinatal surveillance Model	Q8 SIs to Board/LMNS
2. Listening to women and families	N/A	N/A	Q11 NED	Q12 Service user Feedback	Q13 Maternity Safety Champions	Q15 Service user Feedback	Q16 NED	
3. Staff Training and working together	Q17 MDT training	Q18 Consultant ward rounds	Q19 ring fenced funding	Q20 workforce planning	Q21 90% Training compliance MDT	Q22 Consultant Ward rounds	Q23 MDT training Schedule	
4. Managing complex Pregnancy	Q24 Maternal Medicine Criteria	Q25 Named consultant	Q26 Complex Pregnancies	Q127 SBLCBV2	Q28 Named Consultant/Audit	Q29 Maternal Medicine Clinic		
5. Risk Assessment throughout pregnancy	Q30 Risk assessment	Q31 Place of Birth Risk assessment	Q32 SBLCBV2	Q33 Risk assessment with PCSP				
6. Monitoring Fetal Wellbeing	Q34 leads in post	Q35 Leads expertise	Q36 SBLCBV2	Q37 MDT training	Q38 Leads in post			
7. Informed Consent	Q39 Accessible information/place of birth	Q340Accessible information all care	Q41 Decision making and informed consent	Q42 Womens choices respected	Q43 Service User Feedback	Q44 Website		
Workforce Planning	Q45 Clinical workforce planning	Q46 Midwifery workforce planning	Q47 DOM accountable to Executive Director	Q48 Strengthening Midwifery Leadership				
Guidelines	Q49 Guidelines							

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BOARD OF DIRECTORS

Date of Meeting	22 December 2022
Title	NHS Resolution Thematic Review 2017-2022
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
	To advise, assure, approve, and update. This report provides an overview of the progress made against the NHSR action plan.			

Summary of Key Issues	The purpose of this report is to provide an update on the progress made against the NHSR thematical review action plan following the report received in March and the action plan was submitted to NHSR in August 2022. The number of reported cases from the UHMBT between 2017 to 2019 is in line with the national average reported to the Early Notification Scheme. There is no comparable data between 2019-2021 however the case numbers are in keeping with previous reported years. All maternity services that are rated as inadequate by the CQC are offered a thematic review of their qualifying cases by NHS Resolutions. This is a supportive measure to assist with learning and safety improvements. NHS Resolutions presented the findings of their review to University Hospital Morecambe Bay Trust in March 2022. The review covers all cases referred to NHS Resolutions through the Early Notification scheme and the Healthcare Safety Investigation Branch (HSIB). The summary of the main themes from the analysis are neonatal factors, fetal monitoring, delayed escalation, delayed transfer, lack of senior support.

	The action plan has been developed by the senior multidisciplinary team and was shared at the Quality Assurance Committee, Trust Board and with the Trust Board Safety Champions in September 2022. The action plan was be shared with NHS Resolutions and has been monitored through the Care Group Governance Assurance Group (newly formed Women's Health Quality Board). The Committee is asked to receive this report for discussion and assurance of the progress made against the action plan.

Prior Discussions	Committee	Date	Recommendations/ Concerns
	Women's Health Quality Board	13th September 2022	

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

Impact on Board Assurance Framework or Corporate Risk Register				
Risk Impact Assessment	Is this required?	**Y**	If Yes, Date Completed	6/12/2022
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	
NHSR	National Health Service Resolution
NLS	Neonatal Life Support (a more advanced training than the minimal standard Newborn Life Support)
CNST	Clinical Negligence Scheme for Trusts
EN Scheme	Early Notification Scheme
CGGAG	Care Group Governance Assurance Group
CQC	Care Quality Commission

UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST

NHSR Thematic Review 2017-2022

PURPOSE

1. The purpose of this report is to provide an update on the progress made against the NHSR thematical review action plan following the report received in March and the action plan was submitted to NHSR in August 2022.

BACKGROUND

2. The Early Notification Scheme was introduced on the 1st April 2017, and reportable cases include babies born, following labour with a potentially severe brain injury diagnosed in the first seven days of life.

3. The aim of the Early Notification Scheme is to identify learning and share at a national, regional, and local level. Secondly, improve the experience for both the families and staff affected. In addition, reduce formal litigation in the courts and the associated legal costs.

4. The number of reported cases from the UHMBT between 2017 to 2019 is in line with the national average reported to the Early Notification Scheme. There is no comparable data between 2019-2021 however the case numbers are in keeping with previous reported years.

5. All maternity services that are rated as inadequate by the CQC are offered a thematic review of their qualifying cases by NHS Resolutions. This is a supportive measure to assist with learning and safety improvements. NHS Resolutions presented the findings of their review to University Hospital Morecambe Bay Trust in March 2022. The review covers all cases referred to NHS Resolutions through the Early Notification scheme and the Healthcare Safety Investigation Branch (HSIB).

6. The identified themes were in line with improvement work already completed and underway.

ANALYSIS

7. The summary of the main themes from the analysis are:
   - **Neonatal factors:** Lack of presence at delivery, CT scan use, delayed intubation, Neonatal Life Support guidance not followed.
   - **Fetal monitoring:** Misinterpretation, inappropriate modality, fresh eyes reviews.
   - **Delayed care delivery:** Delayed delivery of baby, delayed obstetric review, delayed examination.
   - **Delayed escalation:** Midwifery to medical staff, registrar to consultant.
   - **Delayed transfer:** Both neonatal and maternal.
   - **Lack of senior support:** Midwifery and neonatal.

8. The identified themes were in line with improvement work already completed and underway.

9. NHS Resolutions requested feedback on the below actions by the 29th July 2022.

The Trust should share the findings of the thematic review with wider maternity, neonatal and governance teams.

10. The findings were shared with the Trust Board in March 2022 and the Maternity and Neonatal governance meeting on the 2nd March 2022. The action plan will be shared at CGGAG on the 23rd August 2022 and with the Board level safety champions at the Maternity Safety Champions meeting.

The Trust will feedback how their ongoing improvement work relates to the themes identified in the review

11. Please see action plan below.

Clarifications related to previous correspondence, which concerned feedback from an individual case. Is a stethoscope included in the routine homebirth kit?

12. The Trust has implemented the standardised Baby Lifeline homebirth bags. These contain a stethoscope.

Are you satisfied that the safety of both women and staff is assured in your home birth protocol, and that this approach supports informed maternal choices?

13. The homebirth guideline was updated to ensure practise is aligned to national recommendations and provides a safe framework to ensure safety for women and babies. A Consultant Midwife who commenced in post on the 4th July 2022 will be working with the Maternity Voice Partnership to ensure maternal choice is reflected.

Has the second midwife involved in the neonatal resuscitation had any additional training?

14. Both Midwives attended NLS training courses immediately following the case in 2018. Neither Midwife works in the community setting at the present time. We have since implemented in house NLS training and Community Midwives are prioritised to attend.

Monitoring of the Action Plan

15. The action plan has been developed by the senior multidisciplinary team and was shared at the Quality Assurance Committee, Trust Board and with the Trust Board Safety Champions in September 2022. The action plan was be shared with NHS Resolutions and has been monitored through the Care Group Governance Assurance Group (newly formed Women's Health Quality Board).

RECOMMENDATIONS

16. The Committee is asked to receive this report for discussion and assurance of the progress made against the action plan.

Action Plan from NHSR Thematical Review

Concern	Action	Responsible Officer	Planned Completion Date	Actual Completion Date	Progress/ Evidence
Fetal Monitoring					
1	Appoint Fetal Monitoring Leads in line with IEA* of the Ockenden review Dec 2020	Head of Midwifery, Clinical Director for Obstetrics and Gynaecology	March 2021	March 2021	Allocation on rotas and job descriptions
2	Departmental fetal heart rate monitoring meetings to share learning from case reviews.	Fetal Monitoring Leads	Ongoing	Ongoing	Case review presentation and minutes with attendance
3	Fetal monitoring leads to review all cases of adverse outcome involving poor interpretation of the fetal heart rate	Fetal Monitoring Leads	Ongoing	Ongoing	Fetal monitoring leads included on the authors for 72-hour reviews and investigation reports.
4	Improve compliance with K2 fetal monitoring package >90%	Fetal Monitoring Leads, Practice Development Midwife	November 2022	July 2022	Compliance >90% and is monitored monthly at the Women's Health Quality Board/ Perinatal quality surveillance model/ Trust Board report.
5	Baby Lifeline CTG masterclass offered to	Fetal Monitoring Leads	85% of maternity	May 2022	Training Management System (TMS)

	all staff, throughout February to May 2022		staff have attended. No further training sessions planned.		
6	Continuous fetal monitoring and intermittent fetal monitoring audit	Fetal Monitoring Leads	Quarterly audit programme in place for January, April, July, October.	Ongoing	Audit report. Audit meeting agenda/ minutes
7	Antenatal CTG Audit	Fetal Monitoring Leads	Six monthly on audit programme for September and March.	Ongoing	Audit report. Audit meeting agenda/ minutes
Delayed Escalation					
1	Guideline for escalation and attendance	Clinical Director for Obstetrics and Gynaecology	Complete	21/12/2021	The Guideline Help- When to Call (OBS/GYNAE/GUID/027) is available on the intranet. Audit monthly and included on the perinatal quality surveillance model.
2	UHMB Pilot site for Each Baby Counts Learn & Support programme. This was a	Local development Lead	Commenced March 2021	Pilot completed Sept 2021	Women's Health Quality Board

	national RCOG and RCM quality improvement programme to improve clinical escalation.				
3	The LMNS wide Human Factors training	Practice Development Midwife	Complete	21/22 Mandatory Training cycle completed. On-going in 22/23 cycle	TMS and Course programme/ evaluations
4	Baby Lifeline Human Factors Workshop	Associate Director of Operations (ADOP)	Complete	September 2021	Attendance list
5	Safety Huddles to be introduced	Quality Improvement Lead, Clinical Leads for Obstetrics	Complete	June 2022	Recordings. Senior Leadership team undertaking observational audits. Monthly report presented at Labour Ward forum
6	Development of a maternity clinical escalation guideline which will include teach or treat and Advice, Inform, Do	Quality, Safety and Assurance Lead	December 2022		Guideline in draft awaiting approval
7	Include maternity clinical escalation toolkit (Teach or treat	Practice Development Midwife	Commence Jan 2023		Lesson plans

	and Advice, Inform, Do) on the maternity mandatory training				
8	Introduction of team of the shift from the RCOG toolkit	HoM's/Quality Improvement Midwife	Commence Sept 2022	Oct 2022	Introduced in safety huddle in September 2022. All safety huddles are recorded
9	Audit to be undertaken in relation to maternity escalation	Quality and Safety Team	March 31st 2023		Audit report. Audit meeting agenda/ minutes
Delayed Care Delivery					
1	Waterbirth guideline to include information for women on leaving the pool	Community Midwifery Matron	Complete	1st December 2020	Water birth (OBS/GYNAE/GUID/021) available on intranet
2	Emergency training for community births including ambulance communication	Community Midwifery Matron, Practice Development Midwife	Joint training with paramedics in place 2018-2020. Community PROMPT Wales to commence October 2022	Ongoing	TMS, Course programmes/ evaluations. Training dates set from Jan 2023
3	Transfer of women / babies from a	North West Coast Clinical Network	January 2023		Draft Standard Operating Policy has been circulated for comment.

	community setting to an acute setting SOP in draft and developed by the region				
4	Rolling quarterly caesarean section audit includes decision to delivery times	Audit Leads	Incorporated on the audit programme for 2022/23.	Ongoing	Audit agenda and minutes. Presented in November 2022.
5	Audit of ambulance transfers from home and Helme Chase MLU over last 12 months	Community Matron	30th December 2022		Audit presentation, agenda/ minutes
6	Consultant Midwife who commenced in post on the 4th July 2022 will be working with the Maternity Voice Partnership to ensure maternal choice is reflected in the homebirth guidance.	Consultant Midwife	31st October 2022	31/10/2022	Guideline
Lack of Senior Support					
1	Twice Daily Consultant led ward rounds	Clinical Director	Complete	Complete	Job plans, Audit to be undertaken monthly and presented at Labour Ward Forum
2	Audit of compliance against the Guideline for Help- When to Call	Audit Leads	Reported Monthly from August	Ongoing	Women's Health Quality Board minutes

	(OBS/GYNAE/GUID/027) in accordance with the RCOG Roles and responsibilities of the Consultant 2022.		2022 – will be reviewed monthly at CGAG and quarterly by the maternity safety champions		Maternity Safety Champions meeting minutes. Audit results included in the Perinatal Quality Surveillance model.
Unstructured Approach to Neonatal Resuscitation at a Home Birth					
1	Facilitate attendance on the NLS course for community midwives	Practice Development Midwife	In house NLS commence, community midwives prioritised for places	Ongoing	Training records
2	Implement validated community specific emergency training	Practice Development Midwife	Train the trainer August 11th 2022 Training to be commenced October 2022	Completed	Course Programme and Training records
3	Provide standardised home birth equipment bags	Community Midwifery Matron	Complete May 2022	May 2022	Baby Lifeline Homebirth Bags in situ
NLS Guidance Not Adhered To (Hospital)					

1	In house NLS course was commenced April 2021 Exclusively for UHMBT staff at present time.	UHMB NLS faculty	Annual forward programme for 4 courses per year	On-going	Programme ongoing
2	Increase the number of UHMBT staff who are NLS trainers	UHMB NLS faculty	5 midwives identified as trainers, 2 completed General Instructor Training (GIC) training to date (Dec 2022)	On going	Resus Council certificates
3	Bi-monthly skills drills in clinical areas, including the multidisciplinary team in Consultant units.	Practice development midwife Neonatal practice educator.	Commence September 2022	Ongoing	Practice development midwife report to Women's Health Quality Board.
4	Standardised resuscitation proforma to be developed	ANNP - neonates	Proforma developed April 2021	April 2021	Appendix of Newborn Resuscitation guideline (OBS/GYNAE/GUID/056)
5	Audit of the documentation of babies receiving resuscitation	Audit Leads Advanced Neonatal Nurse Practitioner (ANNP)	January 2023		Audit presentation, agenda and minutes
Delayed Intubation					

1	Skills training around delayed intubation Video laryngoscope, teaching sessions 6 monthly, simulation training. Middle grade and above to take part	Neonatal Educator	Feb 2023 In-house training provided for video laryngoscope – complete. Difficult intubation trolley available Simulation training will be commenced from September 2022 (face to face simulation training was paused during Covid)	6 monthly thereafter	Peer evaluation.
2	Ensuring timely escalation for help with difficult intubations.	Neonatal/Educational Leads	September 2022 On call consultants included in	Completed	Training/Teaching records

			emergency call process.		
3	Ensure difficult intubation trollies available in maternity theatres	HOMs	August 2022	December 2022	Difficult intubation kit is available in a labelled bag as part of each neonatal emergency trolley.
Lack of Senior Neonatal Support					
1	Quarterly audit to ensure practice is aligned to local standards for calling a paediatrician	Audit midwife	January 2023		Audit agenda/minutes
2	To refresh and update the guideline – Neonatal attendance at birth OBS/GYN Guid 048	Neonatal Consultant Clinical Lead	September 2022	30th September 2022	Guideline
3	Share learning in relation to updated Neonatal Attendance at Birth guideline on education bus, safety boards, safety newsletter on staff meeting agendas and Band 7 meeting agenda	Quality and Safety Team	October 2022	30th September 2022	Education bus newsletter, Meeting agendas
4	Ensure that Induction information for new staff is aligned with	Clinical lead neonatal consultant	August 2022	Completed	Induction programme

	neonatal attendance at birth guideline				
5	Skills and drills to include when to call a paediatrician bi-monthly	Practice development midwife	September 2022	Ongoing	Monthly report to Care group governance meeting monthly
Delays in Transfer and Contact with Transport Team					
1	North West Neonatal Operational Delivery Network (NWNODN) Clinical Advice Guideline incorporates advice from tertiary units and MDT conference calls	Neonatal Medical Clinical Leads	April 2021	April 2021	Guideline
2	Audit to ensure compliance with NWNODN clinical advice guideline	Paediatric guideline Lead	30th Jan 2022		Audit agenda/minutes
3	Introduction of Maternity & Neonatal Safety Huddles twice daily 11am and 11pm to support perinatal collaboration (Neonatal handovers undertaken 3 times a day to identify any issues)	Quality Improvement Midwife	May 2022	May 2022	Safety huddle recordings. Senior Leadership team undertaking observational audits. Monthly report presented at Labour Ward forum

Identification of Cranial bleed on ultrasound					
1	To review training needs for paediatricians in relation to training updates	Clinical Neonatal Consultant Lead	28th February 2023		Agreed training needs for clinicians who undertake cranial ultrasound.
GBS identified postnatally					
1	Update of GBS (prevention of Early onset neonatal infection) guideline	Quality, Safety and Assurance Lead Midwife	30th August 2022	30th September 2022	Guideline
2	A review of the current process of identification of GBS and recording within the EPR and notification to the mother	Community Matron/Digital Midwife	30th September 2022	30/9/2022	Guideline
3	Audit of the new GBS guidance to include appropriate antenatal counselling	Audit Midwife	30th December 2022		Audit presentation, agenda and minutes
4	Audit of the observations of the baby in the early neonatal period of a GBS positive mother	Audit Midwife	30th December 2022		Audit presentation, agenda and minutes
5	Audit of recognition and management of the signs of early onset infection in the neonate	Audit Midwife	30th December 2022		Audit presentation, agenda and minutes

Missed SGA					
1	Small for Gestational Age Fetus, Antenatal care guideline (OBS/GYNAE/GUID/081) has been updated to reflect changes in-line with SBLCBv2	SBLCBv2 Lead Obstetrician	30th December 2022		Guideline in draft. On the agenda for the 13th December for approval
2	Quarterly SBLCv2 audit undertaken by the Quality Improvement Midwife	Quality Improvement Midwife	30th June 2022	On-going	Presented at Women's Health Quality Board monthly
3	Annual training for GAP and GROW for midwives and Obstetricians	Practice Development Midwife	On-going	On-going	Presented at Women's Health Quality Board monthly
Poor Antenatal attendance					
1	Antenatal care/Missed appointments guideline (GUIDE/432) available on the intranet	Community Matron	Due for review March 2024		Guideline
2	Audit to be added to forward audit programme for 22/23	Audit Midwife	31st December 2022		Audit presentation, agenda and minutes
Anaesthetic Issues					
1	Audit to be undertaken for indications for General Anaesthetic caesarean sections, and multiple attempts at siting spinal	Anaesthetic Leads	28th February 2023		Presentation at Labour Ward Forum. Audit presentation, agenda and minutes.

Placenta not sent for histology					
1	New placental histology SOP developed	Guideline Lead	31st August 2022	31st August 2022	Guideline
2	Education with the roll out of the new guidance	Practice Development Midwife	30th September 2022	31st August 2022	Education Bus newsletter
3	Audit to be undertaken as part of the forward audit programme 22/23	Audit Midwife	28th February 2023		Audit presentation, agenda and minutes

Other Identified Factors (Occurred 1/12)

Identified Factor	UHMB Actions undertaken
Mismanagement of fetal bradycardia	• Fetal monitoring guideline in-line with national guidance • Fetal monitoring leads perform quarterly audits • Weekly fetal monitoring training sessions
Impacted fetal head	• Incorporated within forward plan of PROMPT training • Fetal pillows in use
Incorrect diagnosis of full dilatation	• Additional support and training offered on an individual basis if concerns identified.
Loss of situational awareness	• Included in mandatory training
Lack of 1:1 care in labour	• 1:1 care recorded and reported monthly at Trust Board and regional level. • 100% 1:1 care maintained on all sites and monitored monthly.
No obstetric review before second round of induction	• Induction of labour guideline updated • Induction of Labour audit

Prolonged instrumental with multiple instruments	• Operative birth guideline currently under review
Management of retained placenta	• Guideline reviewed and updated June 2021
Chosen place of birth not available	• Regional escalation policy developed and being implemented. • Helme Chase Midwifery Led Unit has implemented a night shift to reduce unavailability of the service.
Delay in evacuating pool	• Risk assessment stickers created with patient information for when they would be asked to leave the pool. Proforma now available on Badgernet. • Skills drills
Signs of sepsis not recognised	• Modified Early Obstetric Warning scoring tool implemented on all sites and including homebirth. • Sepsis included in rotational skills drill forward plan. • Sepsis included in PROMPT training cycle. • Sepsis Audit to be undertaken November 2023.
Sliding scale not commenced when indicated	• Increased establishment of diabetic specialist midwives to increase teaching sessions in clinical areas and cross site presence for advice and guidance. • Individual education provided for staff members. • Guideline currently under review
Oxytocin mismanagement	• Guideline reviewed and updated Nov 2021
Prolonged induction of labour	• Change of guideline to ensure all women are offered caesarean section following 24 hrs of Propess. • Included as a standard in the induction of labour audit.
Prolonged use of Propess	• Guidance for use of Propess incorporated within guideline and audited for assurance.
Fetal heart and pool temperature not checked prior to delivery	• Waterbirth guideline updated • In January 2022 the education theme of the month was waterbirth to share the learning. • Audit to be completed in November 2022.

Poor quality local RCA	• Trust training developed • Baby Lifeline training accessed • HSIB training accessed

BOARD OF DIRECTORS

Date of Meeting	22 December 2022
Title	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 summarises the progress made against the Trust's improvement plan since the November 2022 Trust Board report, focusing on any material changes to our position against the delivery of the criteria for our exit from the RSP since that date on an exception basis.			

Summary of Key Issues	Please identify the key messages, risks, improvements, impacts and benefits which you would like the reader of the report to consider. This paper outlines the Trust's progress towards the achievement of the objectives of the RSP via the delivery of a sustainable improvement programme. Key issues outlined in this paper include: - The validated Sentinel Stroke National Programme (SSNAP) scores for quarter 2 2022/2023. - The impact of a national supply chain issue on the planned opening of the co-located Urgent Treatment Centre (UTC) at Royal Lancaster Infirmary (RLI)

	- The current position, and planned recovery approach, for mortality reviews.

Prior Discussions	Committee	Date	Recommendations/ Concerns

Action to be recommended to the Committee/Board	The Board of Directors is asked to note the contents of the report and endorse the mitigations that are planned to recover the position associated with the mortality workstream.

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
SSNAP	Sentinel Stroke National Programme
UTC	Urgent Treatment Centre

RLI	Royal Lancaster Infirmary
FGH	Furness General Hospital
COO	Chief Operating Officer
SALT	Speech and Language Therapy
U&EC	Urgent & Emergency Care
SDEC	Same Day Emergency Care
ED	Emergency Department
SJR	Structured Judgement Review
DMD	Deputy Medical Director

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

Introduction

1. This report is intended to highlight to the Board the key areas of relevance associated with the delivery of the Trust's Improvement Plan since the report provided in November 2022.

2. Given the truncated reporting period in December this paper focuses on any material changes to our position against the delivery of the criteria for our exit from the RSP on an exception basis.

Key progress updates

Stroke

3. The Board is aware following our previous reports that the Section 31 notice related to stroke services at the Royal Lancaster Infirmary (RLI) remains in place. At the time of the November 2022 Board report the validated SSNAP position for quarter two was awaited. This data has now been received for both RLI and Furness General Hospital (FGH) and has confirmed that:
   a) An improvement in the overall SSNAP position for FGH from a B in Q1 2022/2023 to an A in Q2 2022/2023.
   b) A consolidation of the overall position for RLI with a further C in Q2, following the C achieved in Q1.

4. Targeted improvement work continues for RLI overseen by the fortnightly task and finish group chaired by the Chief Operating Officer (COO) and is focused on the three areas outlined below. Whilst we recognise the consolidation of the position for RLI demonstrated by the Q2 SSNAP position a further period of sustained performance is required before any request to lift the notice will be made. An update on the anticipated timescale for that request will be provided to Trust Board in January.
   a) Time to thrombolysis: Pre-alerts, early identification of suitable patients, ensuring early bolus
   b) Therapy minutes: The opening of the gym planned for January is expected to support an increase in the number of minutes the service can deliver.
   c) Increasing Speech and Language Therapies (SALT) availability: The availability of SALT workforce is a well known issue nationally. Whilst the team continues to explore agency and other options temporary workforce options continue to be used (bank etc).

Urgent and Emergency Care Improvement

5. One of the planned outcomes of the Urgent and Emergency Care (U&EC) Improvement workstream is the establishment of the co-located Urgent Treatment Centre (UTC) at RLI, which was expected to go live by the end of December 2022. The modular unit was delivered to site on 05.12.2022 and the fit-out programme has commenced. However, we have now been notified of a national supply chain issue

related to the availability of ventilation material which will delay the completion of that process. As a result, the unit is not expected to be ready to receive its first patient until February 2023, meaning a delay in the associated reduction in ED attendances it was expected to achieve as a result of redirecting patients.

6. In the meantime the same day emergency care (SDEC), frailty and virtual ward workstreams will all continue to support the management of flow in the Emergency Department (ED), with SDEC activity exceeding 45% in line with the planned trajectory during November, and further activity underway to support pathway integration between virtual wards and SDEC.

Mortality reviews

7. The RSP metrics for November 2022 showed a further deterioration in the number of hospital deaths receiving a review, with 11% being reviewed against our 30% Trust target. The need for additional trained reviewers has previously been identified as part of the mortality workstream and activity is underway to train additional reviewers. However, analysis of the average rate of monthly reviews required has shown that there are in the region of 120 outstanding (Structured Judgement Reviews) SJRs that would need to be undertaken to bring us back in line with the Trusts target. The completion of SJRs is critical to our ability to demonstrate our ability as an organisation to learn from deaths.

8. Discussions with the Deputy Medical Director (DMD) who is overseeing the workstream have identified that whilst additional reviewers have been identified and are in the process of being trained some concerns have been raised by the individuals in relation to their capacity to undertake the reviews alongside their usual activities.

9. A recovery plan has been developed by the DMD to enable the outstanding reviews to be undertaken by a separate group of individuals so as not to impact capacity for ongoing reviews, the current trajectory for that plan would see our position recovered in 3 months, provided the additional reviewers currently being trained meet the 30% Trust target from January 2023 onwards. It is however recognised that this poses a risk and will require a clear indication of the individual commitment required by each reviewer to achieve this.

10. In recognition of this a risk has been raised on the corporate risk register (3217) highlighting that we are not currently meeting local targets for SJR completion and that a backlog is being created. The delivery of the recovery plan will be monitored via the RSP governance processes and an update on progress will be reported to the January 2023 Trust Board.

Risk Management

11. Since the last report to Trust Board a change control request has been considered and approved related to the risk management workstream. This highlighted that capacity to deliver one aspect of the work plan had been impacted, namely the inclusion of additional information regarding risk management and scoring in all relevant organisation policies, resulting in an inability to achieve the target completion date. The revision to the delivery date is not expected to have a material impact as the current documents remain live via the procedural documents library and support regarding risk management and scoring remains available via the Risk Management function.

Conclusion

12. The organisation continues to take action to meet the requirements of the exit criteria for the RSP and the majority of the workstreams remain on track to deliver their intended objectives.

13. The impact of national supply chain issues on the planned trajectory for the opening of the UTC at RLI will continue to be reviewed via the RSP governance mechanisms. In the interim the workstream will continue to ensure that streaming to Morecambe UTC is optimised, alongside the ongoing activity related to SDEC, frailty and virtual ward capacity.

14. A recovery plan has been established to manage the impact of the reduction in reviews undertaken on hospital deaths and an update will be provided to January Trust Board on performance against that trajectory.

Recommendation

15. The Board of Directors is asked to consider the contents of the report and note the alerts related to the mortality and U&EC workstreams.

BOARD OF DIRECTORS

Date of Meeting	22 December 2022
Title	Performance Update – October 2022
Report of	Chris Adcock Chief Financial Officer / Deputy Chief Executive
Prepared by and contact details	Rhiannon Tinson, Head of Performance Ray Olive, Assistant Director of People and OD Ian Lacey, Head of Financial Management Lynne Wyre, Deputy Chief Nursing Officer

Confidentiality	Non-Confidential

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

Please note this is not the full integrated performance report. The purpose of this report is to present a performance update to the Board of Directors to provide an opportunity to seek assurance on performance and governance during the winter period and delivery of the winter plan.

The composite integrated performance report for October 2022 will be distributed to Board members early January 2023.

Appended to this report are the individual performance sections covering:

- Operational performance;
- People and Organisational Development; and
- Quality and Safety.

Summary of Key Issues	**Operational Performance** Please see attached appendix (agenda item 184i.i) **People and Organisation Development** Please see attached appendix (agenda item 184i.ii)

Vacancy and Recruitment: Consultant recruitment remains concern for the Trust; Consultant vacancy position decreased from 14.8% to 14.4% in month. This picture is in line with the risk profile highlighted by the Care Groups but will improve as several successful consultants have been appointed. Midwives vacancy rate is of significant concern although this has decreased to19.1%, this a 2% decrease in month and Additional Professional Scientific and Technical Staff group has seen an increase to 14.1% (Increase by2.6%). Values Based Recruitment (VBR) Briefing issued to all recruiting managers with 259 people through the new VBR module and the New Recruitment Policy has been put to Policy group for ratification.

Leadership programme: Attendance forecast based on current bookings is on track for completion of 95% of 1850 leaders to have completed the course by mid-December 2022. Names of non-booked colleagues have been shared with all ADoPs. The Triumvirate Leadership Programme was scoped at the of end July, with planned commencement originally planned for September. However, further work was required with the provider meaning that the programme started in October 2022.

Attendance: Decreased in October 2022, absence decreased to 6.4% from 6.5% in September 2022, but this is within statistical variation tolerances and not directly influenced by actions taken and the EASE service has been successfully rolled out with the performance dashboard showing the impact. The use of the EASE service has seen 76% of colleagues referred for MSK return to work and 60% of colleagues returned to work who had been referred for Mental Health.

Quality and Safety

Please see attached appendix (agenda item 184i.iii)

Financial Performance (October 2022)

An extensive discussion took place in the peer review check and challenge with the ICB on 7 November 2022. The Trust has been notified that a recovery plan needs to be submitted to the ICB describing the recovery trajectory to a breakeven position. The recovery plan was signed off by the Trust Board for submission on 25 November 2022.

At the end of month 7, the year-to-date actual deficit was £6.3m, an adverse variance to plan of £2.4m, a favourable variance in the month of £0.3m.

This position accounts for receiving 42% of the stretch income allocation the remaining 58% still being under negotiation by the ICB and therefore resulting in a deficit in the Trusts financial position. The unmitigated forecast outturn is £17.5m adverse. The current recovery planning process will propose mitigations to deliver the financial obligations of the Trust. These was presented to the Board for

	approval and onwards submission to the ICB on 25 November 2022.

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				
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	

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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

Operational Performance Report

Board of Directors
December 2022, October 2022 performance

Executive Summary

The Operational 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 December Finance and Performance Committee (October performance) is now in the fifth month, with continued work to refine and improve the document, in partnership with the NHSI/E Improvement Team and the Recovery Support Programme (RSP).

A new addition to the report is the inclusion of benchmarking against Model Hospital peers where appropriate, in addition to a cross Lancashire and South Cumbria comparator.

In October

- **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.
  - Cancer Faster Diagnosis Standard- although the assurance icon is still showing 'hit and miss,' the standard has been met for nine consecutive months and is predicted to be achieved going forward.

- **Metrics which are in special cause concern and predicted to fail going forward.**
  - Urgent Care 4 Hour Standard
  - Ambulance handover- within 30 and 60 minutes and greater than 60 minutes.
  - RTT 18 Week standard
  - Number of patients awaiting follow-up past their Indicative Review date

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.

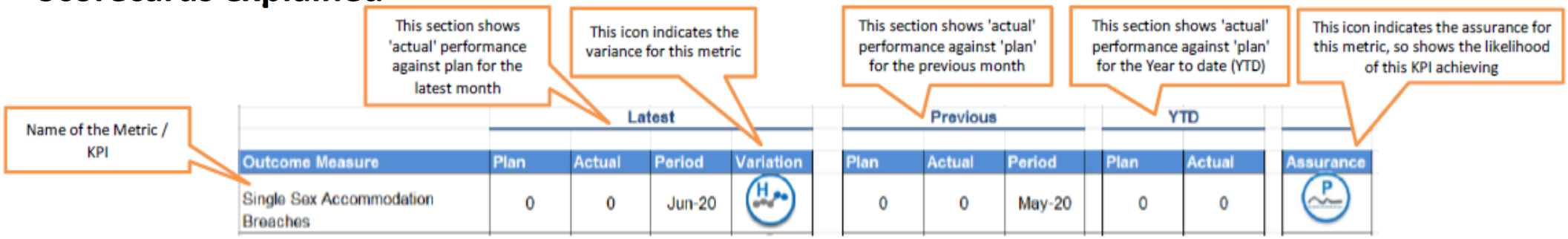
Special Cause Concern - this indicates that special cause variation is occurring in a metric, with the variation being in a favourable direction. Low (L) special cause concern indicates that variation is upward in a KPI where performance is ideally above a target or threshold e.g. ED or RTT Performance.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

Areas 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 a 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/

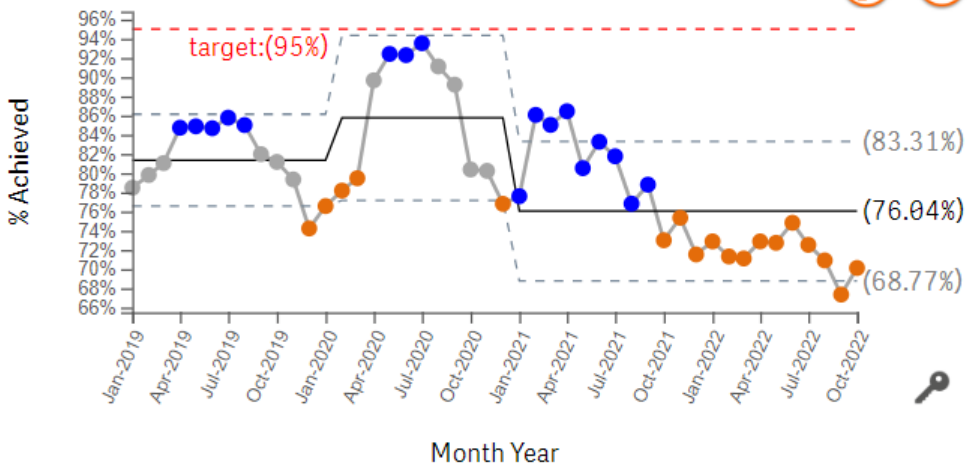
Metrics Scorecard

	Latest				
Outcome Measure	Target	Actual	Period	Variation	Assurance
ED 4 Hours (%)	95%	70.1%	Oct-22		
% of ED Attends >12 hrs	2%	7.6%	Oct-22		
Ambulance Handovers within 15 mins (%)	65%	25.3%	Oct-22		
Ambulance Handovers within 30 mins (%)	95%	51.7%	Oct-22		
Ambulance Handovers within 60 mins (%)	100%	64.5%	Oct-22		
Ambulance Handovers over 60 mins (no.)	0	270	Oct-22		
Cancer 2WW (%)	93%	91.2%	Oct-22		
Cancer 28 Day FDS (%)	75%	79.6%	Oct-22		
Cancer 31 Day (%)	96%	86.2%	Oct-22		
Cancer 31 Day Subsequent Drug (%)	98%	100.0%	Oct-22		
Cancer 31 day Subsequent Surgery (%)	94%	60.0%	Oct-22		
Number of Patients on Cancer PTL over 62 Days (no.)	71	98	Oct-22		
Cancer 62 Day (%)	69%	58.8%	Oct-22		
Cancer 62 Day Screening (%)	90%	28.2%	Oct-22		
Cancer 62 Day Upgrade (%)	85%	78.1%	Oct-22		
Cancer Treatments Beyond 62 Days (no.)	N/A	40.0	Oct-22		N/A
Cancer Treatments Beyond 104 Days (no.)	N/A	10.5	Oct-22		N/A
Diagnostic Waits > 6 weeks	1%	12.2%	Oct-22		
RTT Total Waiting List Size	26623	30251	Oct-22		
RTT <18 Weeks (%)	92%	68.4%	Oct-22		
RTT 52 Weeks (no.)	965	1135	Oct-22		
RTT 78 Weeks (no.)	0	59	Oct-22		
RTT 104 Weeks (no.)	0	4	Oct-22		
OP DNA Rate (%)	4%	7.8%	Oct-22		
Follow-Ups Past IRD	N/A	38857	Oct-22		
2 Hour Urgent Community Response	70%	93.9%	Oct-22		

Urgent Care Performance

ED 4hr Performance

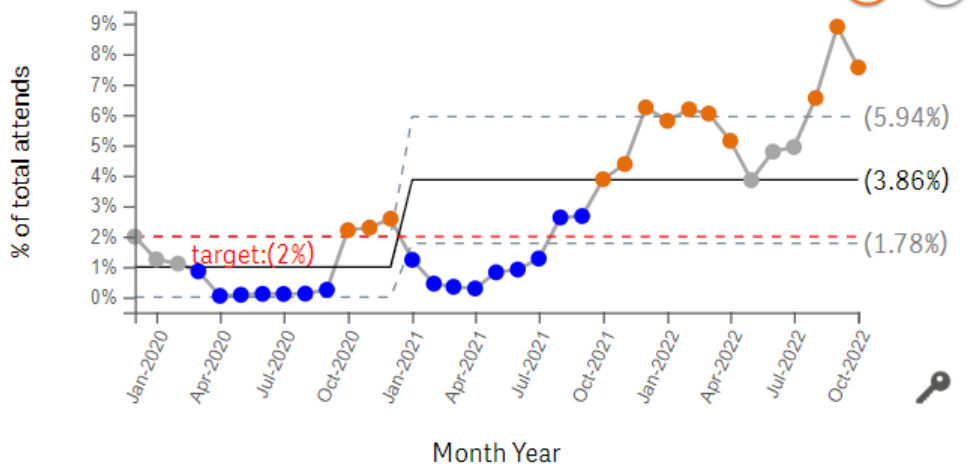
*Mean and Control Limits calculated on full dataset within recalculation window, higher is better



Latest
70.1%
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
7.6%
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

The Urgent Care 4-hour standard is in special cause concern. Since January 2021, variation between the upper and lower process limits has increased. In October, performance remained below the post-2020 mean of 76.0% for the 13th consecutive month.

%of attendances waiting >12 hours is in special cause concern. Performance has significantly declined from before the pandemic, with a shift of mean from 1% to 3.9% since January 2021. The lower control limit is very close to the target and if it moves to above the target, the icon will display a consistent fail going forwards.

Actions

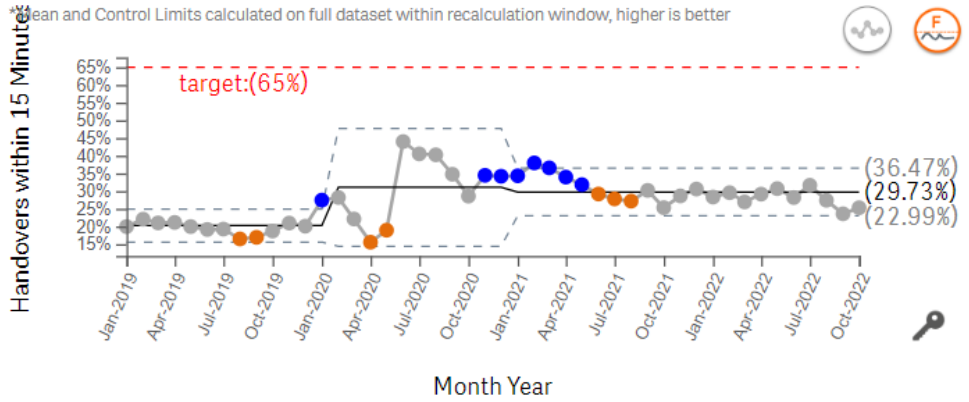
- **SDEC** - Same Day NEL activity has now exceeded 45% and in line with planned trajectory.
- **Frailty** - Frailty dashboard developed will be in place from Dec-22. Currently providing 50-60 hours per week versus 70 hour per week requirement.
- **Reducing NMC2R** – A new strategic approach with senior leadership is now underway, to regain traction on meeting the 5% national target. The number of NMC2R patients in Oct 22 is circa 140 patients. Update on 07/12/22 an increase to 139, following a reduction in November.
- **Virtual Wards** - 27 beds have been introduced to date, a further 26 due by end Dec-22. 115 patients have been cared for on the virtual wards with an average LOS decreasing to 6.7 days. Occupancy of the open virtual beds has increased to 29%.
- **RLI UTC** Modular shell unit was delivered to site 5th Nov 2022 with fit-out programme commenced. On track.
- **Improving Ambulance Waiting Times** – Planning activities continue in partnership with NWAS and community colleagues, with workstream leads now established and project plans to be agreed during December. Initial conversations have identified areas requiring urgent focus. Current ambulance turnaround time remains high at 49.8 mins.
- Stakeholder playbacks have continued in November for **Paediatric Assessment and Mental Health**, with further project planning activities to continue in December.

Assurance

- Benchmarking - ED 4 Hr (Type 1 performance)- 55th out of 110 national Trusts in September. UHMB is 8rd out of the 26 peer trusts and actions within the UEC Improvement Programme are designed to improve on this position.

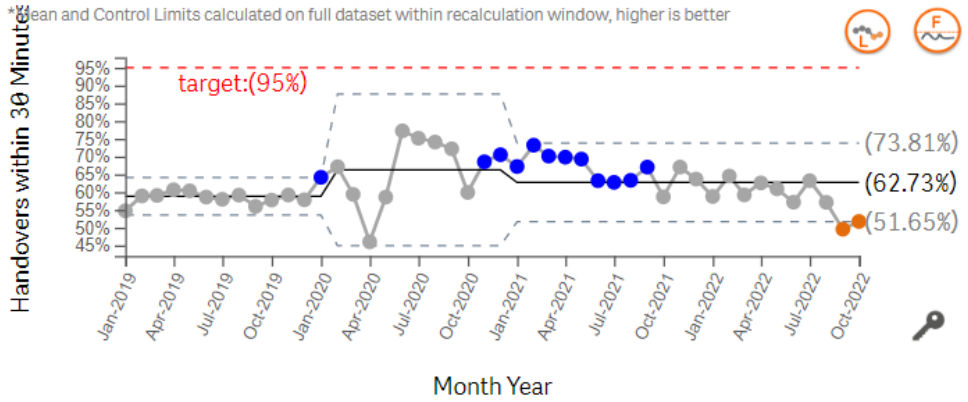
Urgent Care Performance

Percentage of Ambulance Handovers within 15 Minutes



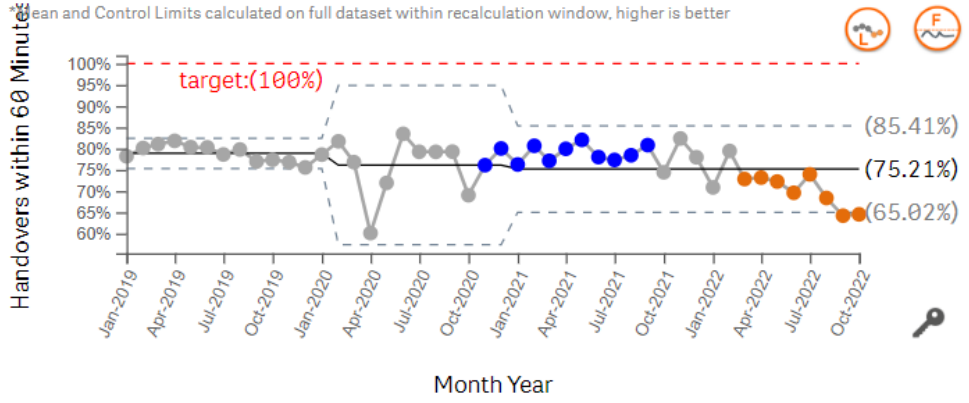
Latest
25.3%
Variance Type
Common cause variation
Target
65%
Target Achievement
The system is expected to consistently fail the target

Percentage of Ambulance Handovers within 30 Minutes



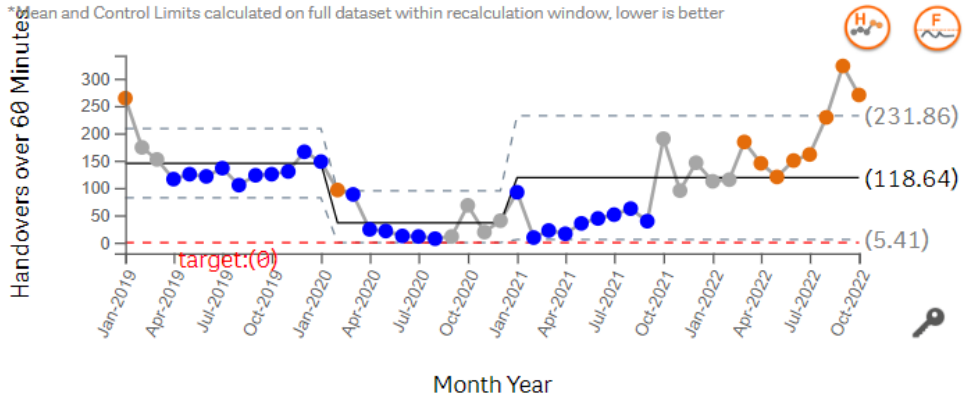
Latest
51.7%
Variance Type
Special cause variation - cause for concern (indicator where low is a concern)
Target
95%
Target Achievement
The system is expected to consistently fail the target

Percentage of Ambulance Handovers within 60 Minutes



Latest
64.5%
Variance Type
Special cause variation - cause for concern (indicator where low is a concern)
Target
100%
Target Achievement
The system is expected to consistently fail the target

Number of Ambulance Handovers over 60 Minutes

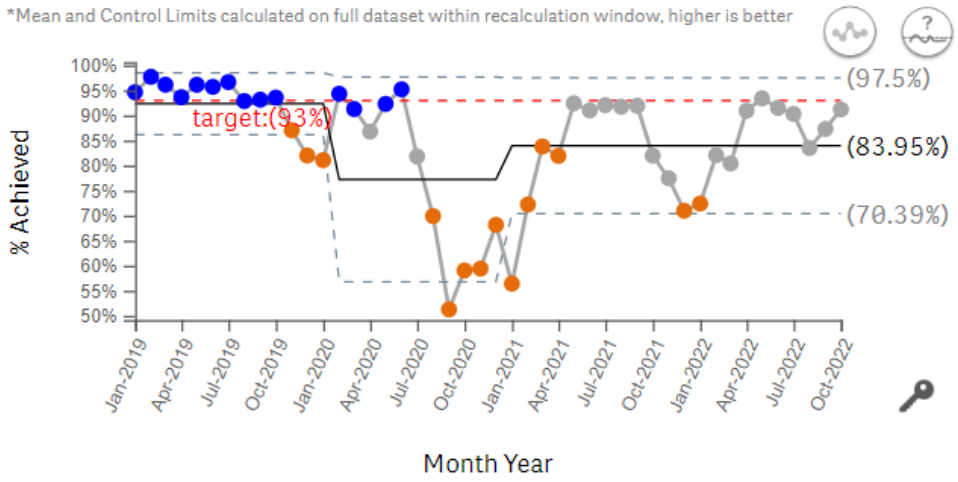


Latest
270
Variance Type
Special cause variation - cause for concern (indicator where high is a concern)
Target
0
Target Achievement
The system is expected to consistently fail the target

Summary	Actions	Assurance
% of Ambulance Handovers. Within 15 mins-is in common cause variation and is significantly below the 65% target. 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 and is in special cause concern. **Within 60 mins**-performance for the longest waiting patients has deteriorated with 8 months of special cause concern. **Number of Ambulances >60 mins**- is in special cause concern with a mean of 119 with a target of 0.	1. Reducing Demand -Out of Hospital Alternative Dispositions-Monitored impact of NWAS engagement with further review with NWAS planned. (via 2hUCR working group). Delivery date- January 2023 2. Reducing Demand, In Hospital Alternative Dispositions –audit started to understand the opportunities for direct access e.g. direct pathway to SDEC. Implementation plan and trajectories due by 31/12/22. 3. Redesign to ensure safety & efficiency-dedicated nursing staff now covering arrivals to handover 24/7 at the RLI, 'Front Door' SOP to be completed to ensure consistency. Implementation plan and trajectories due by 31/12/22.	Of the four ICB trusts UHMB had the highest proportion of handovers within 15 minutes at 25.3%. The regional average performance was 17.1%

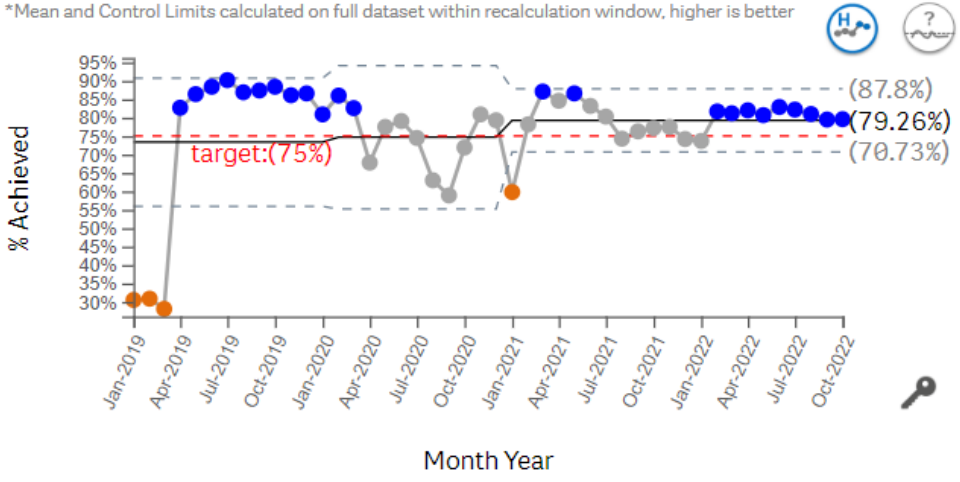
Cancer 2 Week Wait and 28 Day Faster Diagnosis Standard - October Performance

Cancer 2ww



Latest
91.2%
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



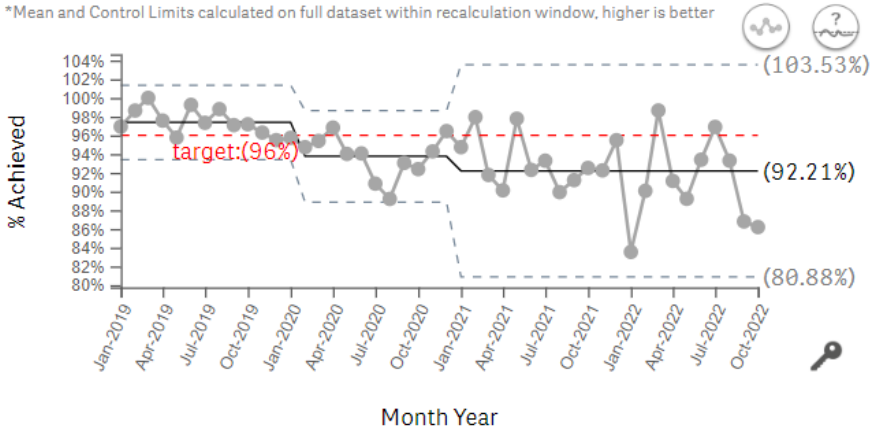
Latest
79.6%
Variance Type
Special cause variation - improvement (indicator where high is good)
Target
75%
Target Achievement
The system may achieve or fail the target subject to random variation

Summary - October 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 October 2022, the highest number of breach patients were in Colorectal (71 patients) and Breast (17 patients each). The impact of the BMA rate has significantly reduced the number of additional activity sessions available. The standard is anticipated to be met in November. • **Faster Diagnosis Standard (FDS)** – the target has been achieved for 9 consecutive months (please see the Assurance box).	Specialty level Remedial Action Plan actions: • **Colorectal**- new timetable went live on 07/11/22 • Appointment of 3rd FGH Colorectal Surgeon- started date 24/10/22 resulting in 63 additional C2WW slots over a 6 week rota. • **Breast** -Business case for 4th Consultant has been approved at the Investment & Priorities Group and is now in the recruitment stage. • Plan to increase workforce and increase C2WW capacity with prospective cover for the year.(Agency Locum for 3 months from February 2023, pending Locum Consultant). • I.S supporting 2ww capacity by providing 48 slots per weekend from 8/10/2022. •	• C2WW- In October 2022, 8/11 Tumour Groups exceeded the 93% target • The FDS standard was achieved between February and October 2022. • FDS- In September UHMB was 6th of 25 peer trusts and 28th of 142 overall (Target 75%/ L&SC average 65.1%).

Cancer 31 Day Performance – October Performance

Cancer 31 Day First Treatment

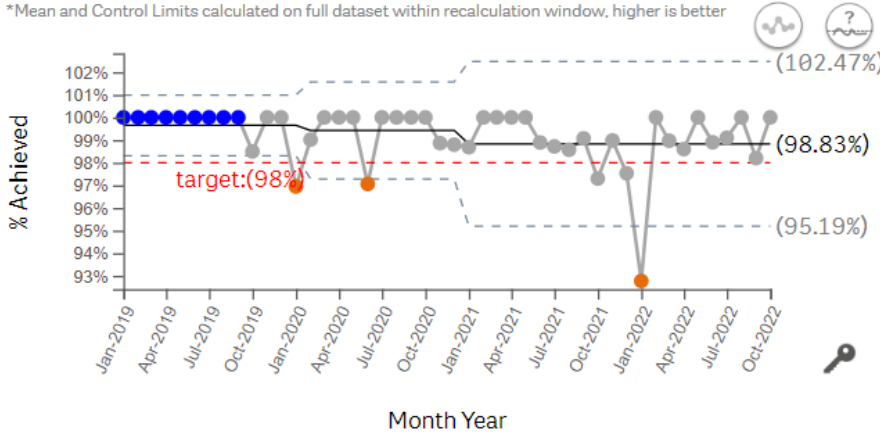
*Mean and Control Limits calculated on full dataset within recalculation window, higher is better



Latest
86.2%
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

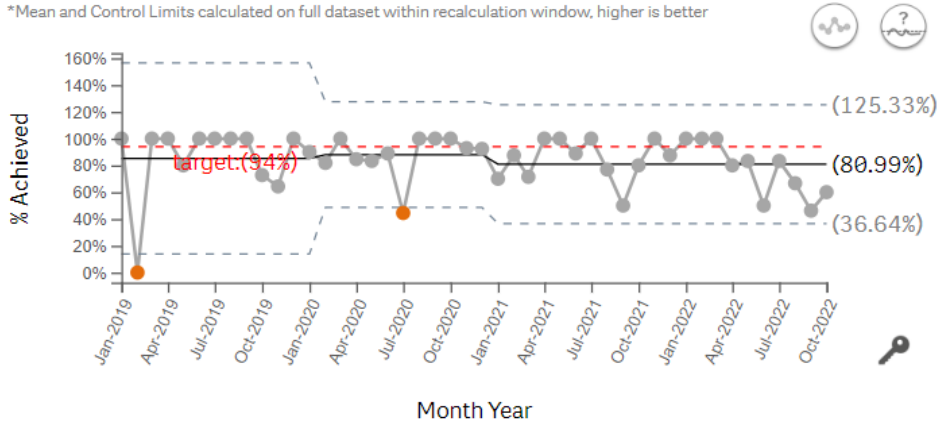
*Mean and Control Limits calculated on full dataset within recalculation window, higher is better



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



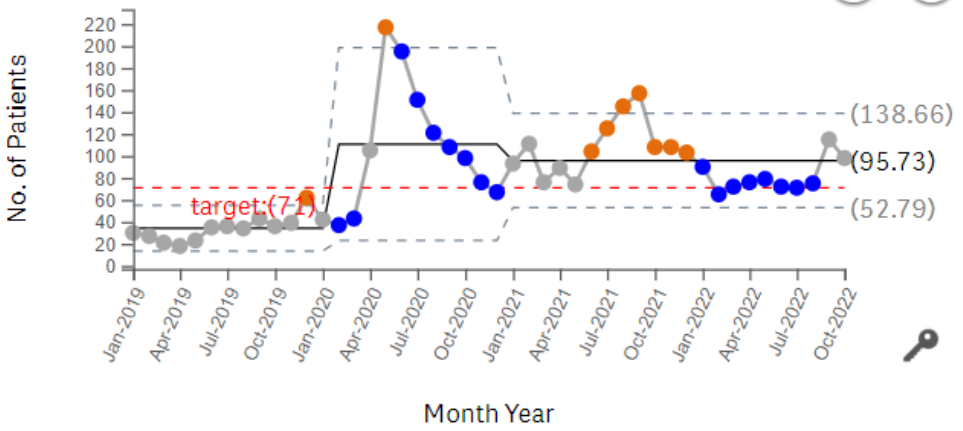
Latest
60.0%
Variance Type
Common cause variation
Target
94%
Target Achievement
The system may achieve or fail the target subject to random variation

Summary	Actions	Assurance
Cancer 31 Day 1st Treatment- was not achieved in October at 86.2% (96% standard) Variation in performance has increased since before the pandemic with a reduction in mean from 97.5% to 92.2%. The BMA rate card has adversely impacted upon additional OP & theatre capacity, particularly in breast and colorectal. **Cancer 31 Day Subsequent Drugs** standard was achieved in October. The standard may or may not be met due to the small numbers (98 total treatments in October). **Cancer 31 Day Subsequent Surgery-** not achieved for the 7th consecutive month, with the majority of breaches within breast and colorectal, as set out above.	Breast- Locum breast surgeon appointed for a 3 month fixed term focusing on backfilling theatre lists. Start date December 2022. 6 months trust Locum approved, waiting to go out to advert. T&F Group with NHSI started 19/09/22 to identify pathway blockages and plan the implementation of the national timed pathway.	• In September, UHMB C31 Day performance was ranked 18th out of 25 in our peer group at 86.8% (England average 91.1%). The actions outlined are designed to achieve the 31- day standards.

Cancer 62 Day Performance - October Performance

Number of Patients on Cancer PTL Over 62 Days

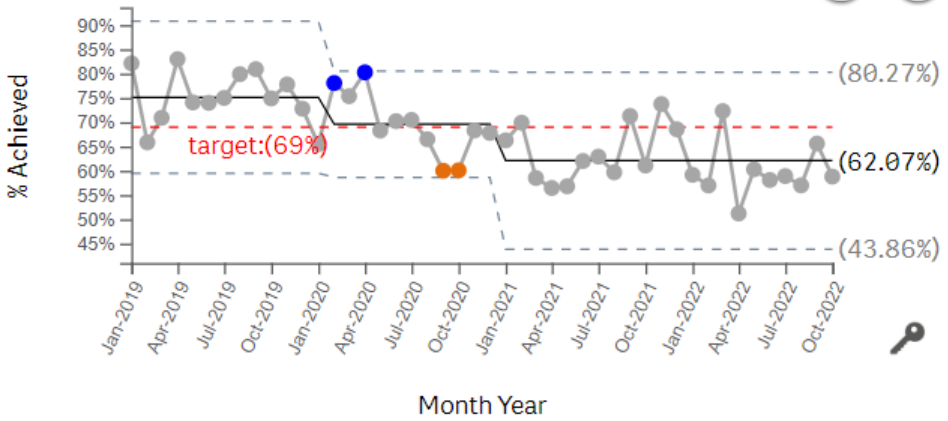
*Mean and Control Limits calculated on full dataset within recalculation window, lower is better



Latest
98
Variance Type
Common cause variation
Target
71
Target Achievement
The system may achieve or fail the target subject to random variation

Cancer 62 Day

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



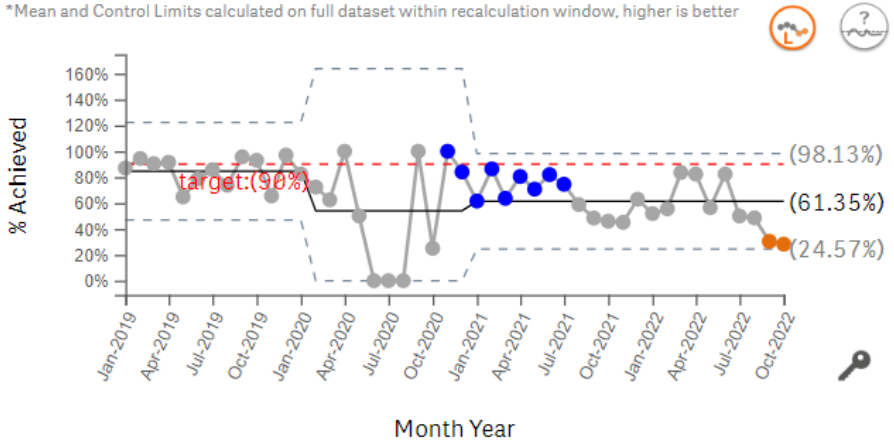
Latest
58.8%
Variance Type
Common cause variation
Target
69%
Target Achievement
The system may achieve or fail the target subject to random variation

Summary	Actions	Assurance
Patients >62 days on the PTL - The trajectory for October of 71 patients waiting was not achieved at 98. The most recent position on 07/12/22 shows an improved position of 55 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 62%, with an ICS target of 69% for March 2023. The confirmed position for October is 58.8%, with Breast and Urology sharing 46% of the breaches. Only Haematology achieved the Cancer 62 day standard. Top 2 reasons for delay: 1) insufficient outpatient/diagnostic capacity in Urology for cystoscopies and precision point biopsies; 2) Breast capacity for first appointments in previous months and current reduction in theatre capacity due to the impact of the BMA rate.	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; • **Prostate**- The perfect prostate pathway to match national timed pathway, including the inclusion of new national FIT guidance commenced on 07/11/22. • **Gynae-** national timed 'perfect' pathway agreed. Focus upon providing sufficient capacity to ensure that the pathway milestones are completed within the correct times. E.g. diagnosis and communication by day 28. • Mutual aid from local Trusts sought, to provide additional breast surgeon and urology cystoscopy capacity due to capacity constraints at existing tertiary providers. • Daily focus on expediting the treatment of patients, with particular focus on those patients waiting >62 days.	• Benchmarking - in September, UHMB's C62 day performance was 61st out of 141 Trusts nationally and 14th out of 24 in our peer group • The actions within the RAP and overarching across tumour group actions are designed to improve this position.

Cancer 62 Day Performance - October Performance

Cancer 62 Day Screening

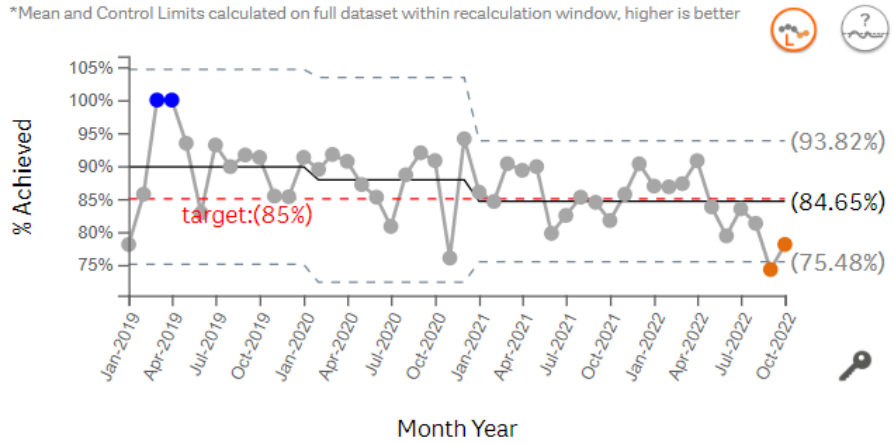
*Mean and Control Limits calculated on full dataset within recalculation window, higher is better



Latest
28.2%
Variance Type
Special cause variation - cause for concern (indicator where low is a concern)
Target
90%
Target Achievement
The system may achieve or fail the target subject to random variation

Cancer 62 Day Upgrade

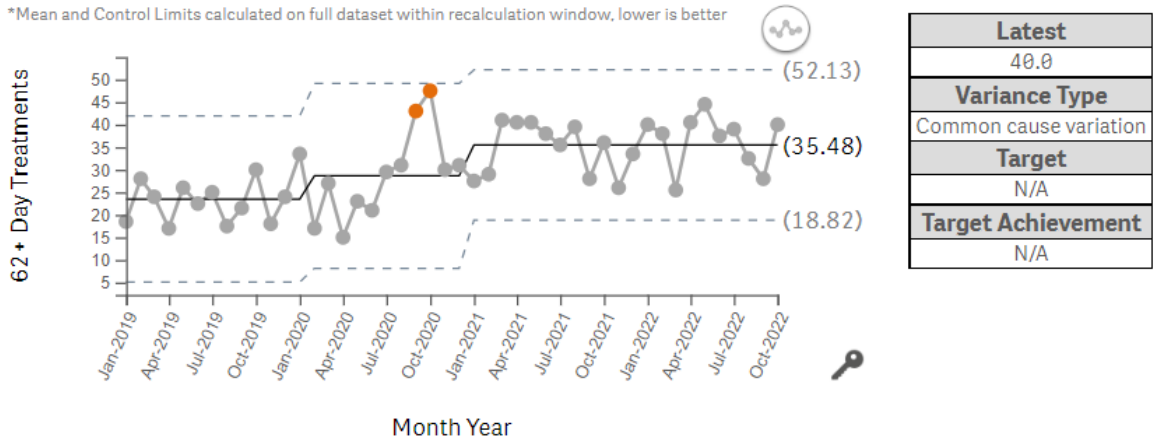
*Mean and Control Limits calculated on full dataset within recalculation window, higher is better



Latest
78.1%
Variance Type
Special cause variation - cause for concern (indicator where low is a concern)
Target
85%
Target Achievement
The system may achieve or fail the target subject to random variation

Cancer Treatments Beyond 62 Days

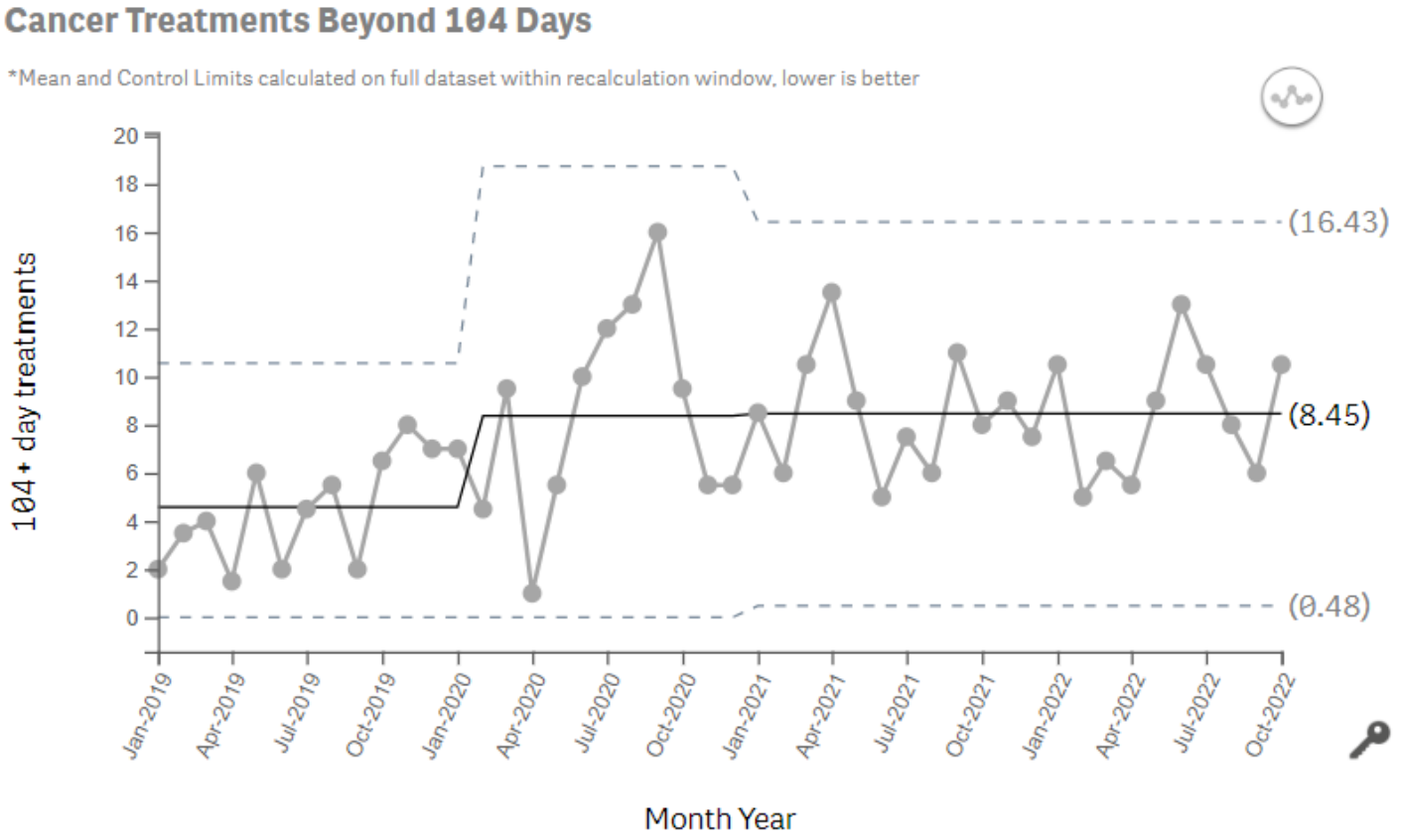
*Mean and Control Limits calculated on full dataset within recalculation window, lower is better



Latest
40.0
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 61.4%. 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 84.7% since before the pandemic. The standard may or may not be achieved due to the small numbers involved and is in special cause concern. **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

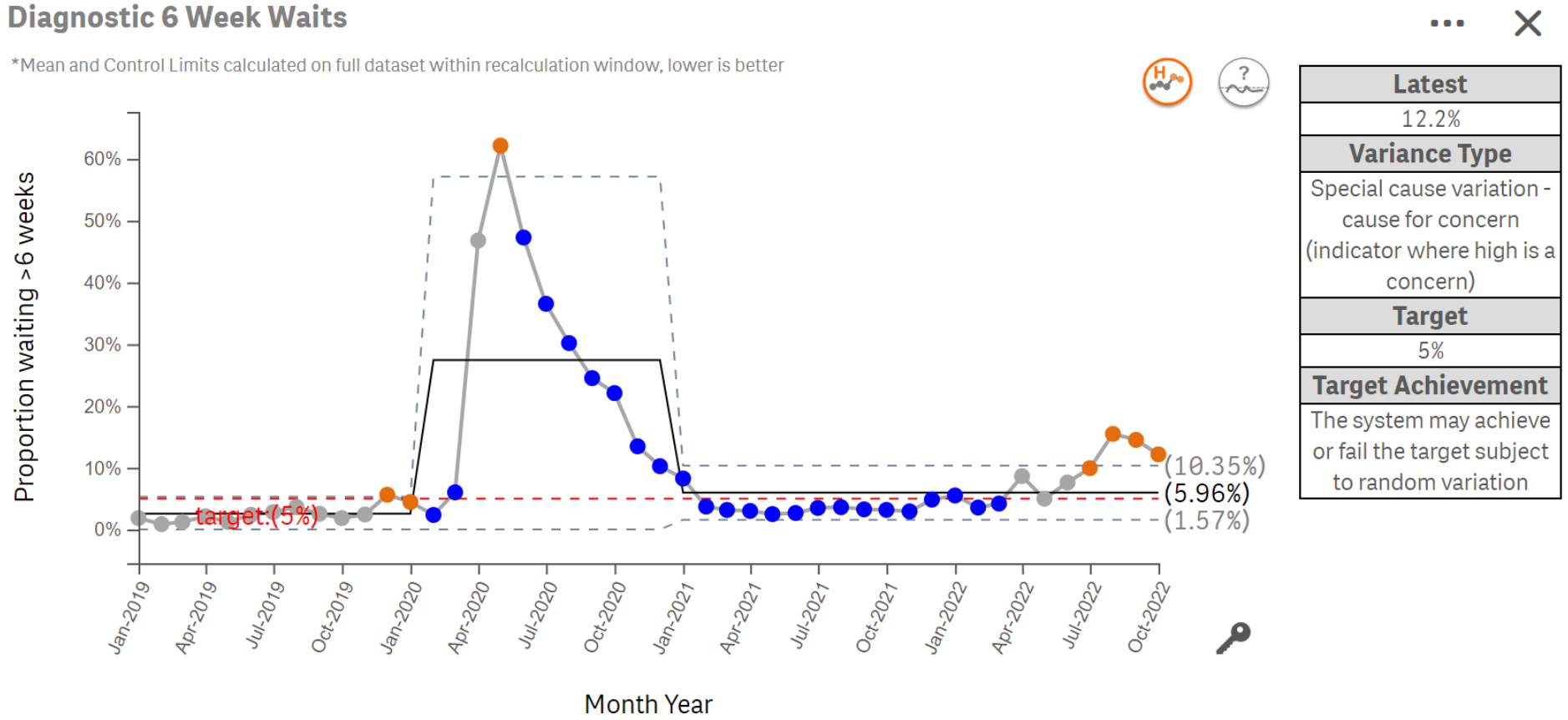
Cancer Treatments Beyond 104 Days - October Activity



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

Summary	Actions	Assurance
The chart shows the patients with confirmed cancer with treatment in October, more than 104 days after referral. 10.5 cancer patients were treated >104 days after referral. In October 6 of the 10.5 breaches took place in Urology, with 1 each in Skin, Lung, Colorectal and Breast and 0.5 in UGI.	• The NW Long Waits Policy for Managing Long Waiting Patients including the implementation of the harm process for any patient waiting >73 days on a 31-day pathway was fully implemented 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

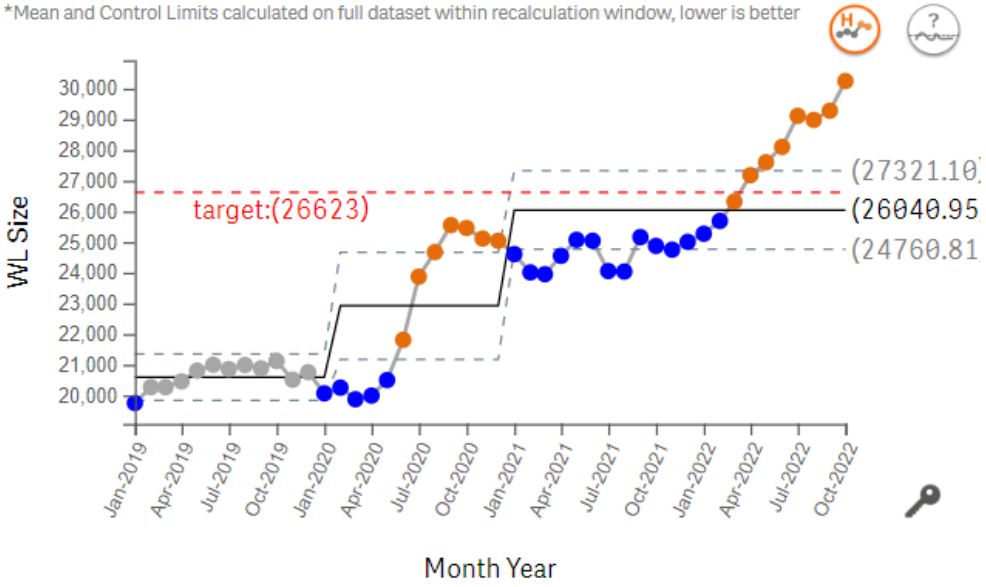


Summary	Actions	Assurance
Following 18 months of special cause- variation-improvement, the standard is now in special cause concern and may or may not achieve the standard going forward. The Trust achieved 12.2% in October, against the ICS trajectory of 10.8%. The most challenged modalities by number of patients are; Imaging, with 653 breaches (12.8%), of which 625 of the patients were waiting for Ultrasound and DEXA with 235 breaches (37.5%).	• **DEXA** – At the end of October, the total DEXA waiting list was 627 patients, against the plan of 583. Performance was 37.5%, so DEXA did not meet their ICS improvement trajectory of 22.8% for October, due to the ongoing impact of losing slots due to equipment breakdown and staff sickness in September. Latest performance is 20.0% (as at 27/11/22). Mitigating actions are evening and weekend additional lists. There are an additional 130 slots available per month from November onwards due to Locum cover for evenings and weekends and recruitment of 0.6 WTE to provide cross cover. • **Ultrasound –** At the end of October, the total waiting list was 3449 patients, against the plan of 3483. Performance was 18.1%, which achieved the ICS improvement trajectory of 18.2% for October. Latest performance is 9.8% (as at 27/11/22), which is within the 9.8% improvement trajectory for November.	Benchmarking – In September UHMB's diagnostic performance was 240th out of 411 trusts nationally and 8th of 26 in our peer group. Actions within the Remedial Action Plans will further improve the position.

Referral to Treatment Time

RTT Total Waiting List Size

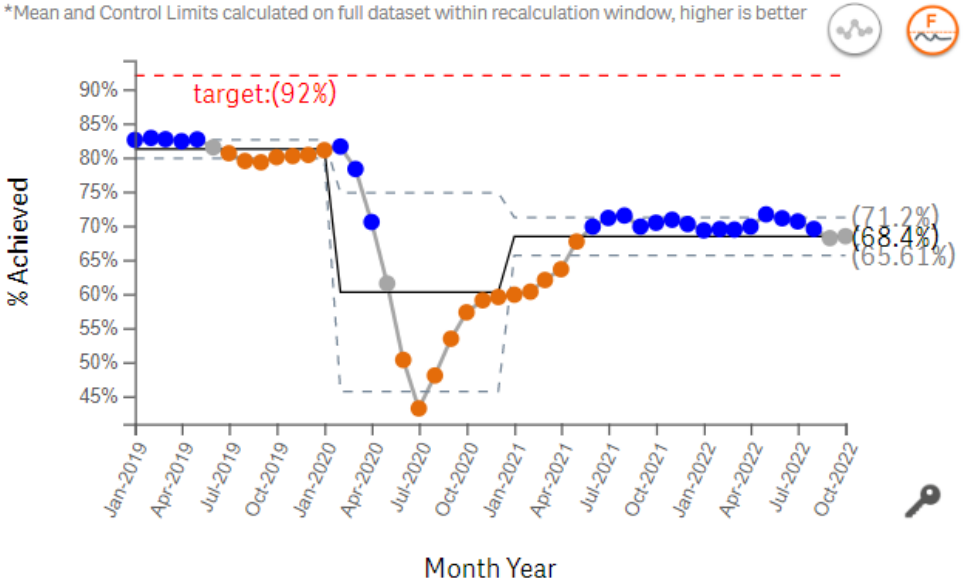
*Mean and Control Limits calculated on full dataset within recalculation window, lower is better



Latest
30,251
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
68.4%
Variance Type
Common cause variation
Target
92%
Target Achievement
The system is expected to consistently fail the target

Summary

Total Waiting List Size - Pre covid the mean was 20,500 with minimal variation, post covid the mean is 26,040 with a run of 8 points of special cause concern from March to October 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 2021. Performance had been in special cause improvement for 15 months prior to September 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 has had 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. If activity deferred due to industrial action, it will impact on waiting list size and treatment of the longest waiting patients.

Actions

- Remedial Action Plans (RAPs) have been refined to include quantified improvement actions across all specialties. These have been used to set Specialty level improvement trajectories.
- 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. The aim was to reduce the waiting list size by 300 patients per month and achieve the ICB trajectory by December 2022, but this looks unlikely given the level of lost activity due to the BMA rate card. Since 25/07/22, 3583 patient records from targeted areas on the waiting list have been validated, with 2334 records updated with a clock stop in the past.
- T&O: 4 month Locum being sought to see upper limb/hand and wrist patients, as 38% of the T&O patients waiting over 52 weeks have upper limb/hand and wrist conditions. Possible start date mid-Dec. A Lancashire NHS provider have agreed to a transfer of 6 UHMB T&O patients through mutual aid.
- 75 General Surgery patients have been triaged for transfer to the independent sector, however, 20 were found to either not meet the criteria or the patients chose to remain at UHMB. An insourcing company is to see 80 new patients in December to help treat all patients waiting 78 weeks by March 23

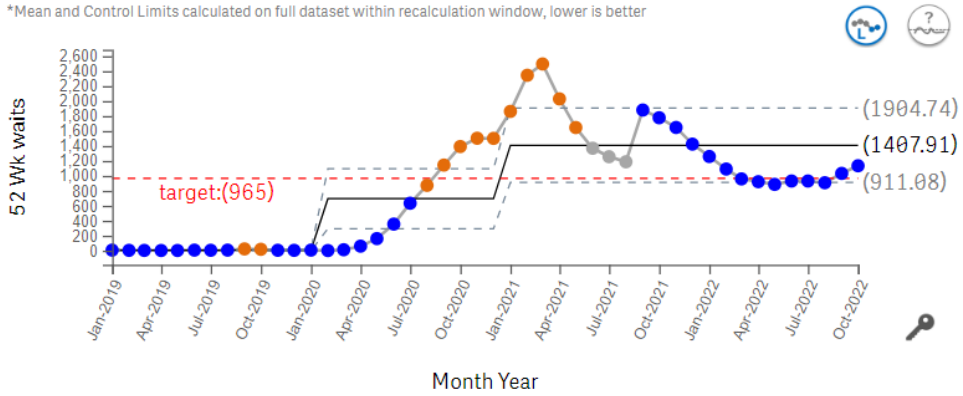
Assurance

RTT- in September UHMB had the 60th highest performance out of all 168 Trusts and was 8th out of 26 peer group trusts

Referral to Treatment Time

RTT 52 Week Waits

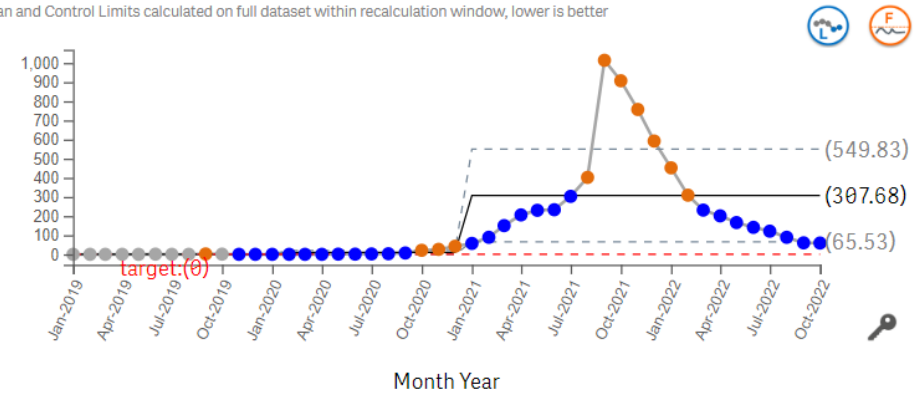
*Mean and Control Limits calculated on full dataset within recalculation window, lower is better



Latest
1,135
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

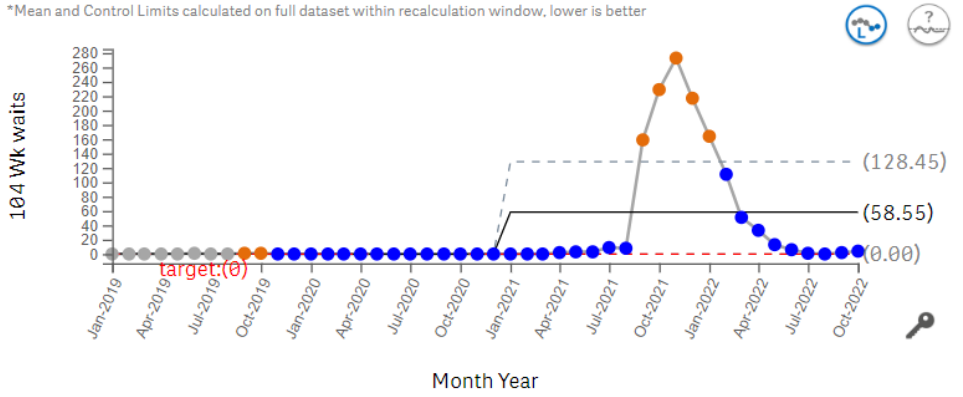
*Mean and Control Limits calculated on full dataset within recalculation window, lower is better



Latest
59
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



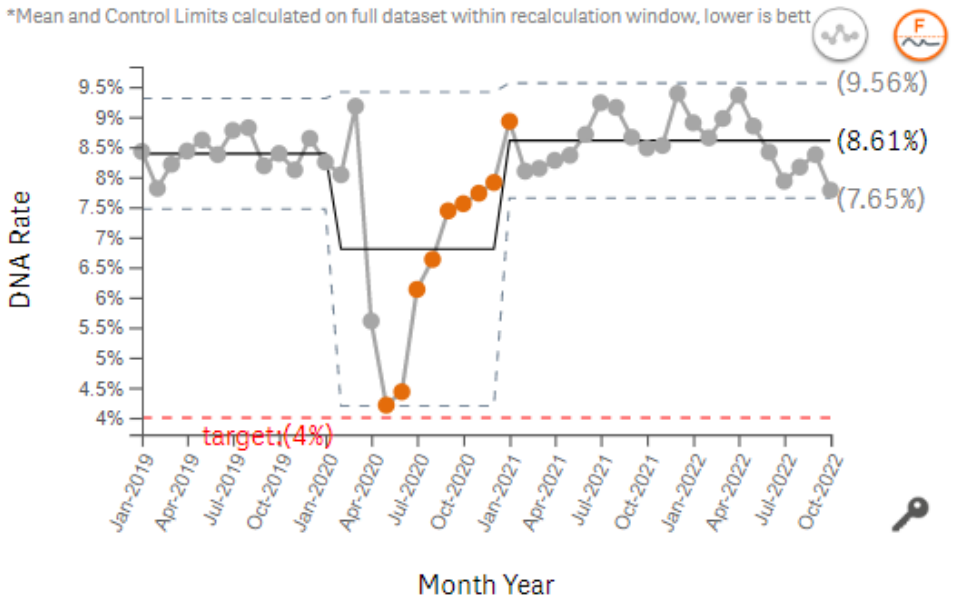
Latest
4
Variance Type
Special cause variation - improvement (indicator where low is good)
Target
0
Target Achievement
The system may achieve or fail the target subject to random variation

Summary	Actions	Assurance

52 Weeks - pre-pandemic the mean was 0 patients, which has increased to 1407 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 is likely to adversely impact capacity.
There were 4 patients waiting over 104 weeks at the end of October.
	• 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 Jan 23, 2274 patients over 52 weeks
	  • If no further AAS, 928 patients over 78 weeks (trajectory was 0)
	  • If AAS resumed from Jan 23, 425 patients over 78 weeks
	  • If no further AAS, 12 patients over 104 weeks (trajectory was 0)
	  • If AAS resumed from Jan 23, 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 11th out of the 26 trusts in our peer group for patients waiting over 52 weeks in September 2022, with 1.20% of the total.
		
		UHMB was 14th out of the 26 trusts in our peer group for patients waiting over 78 weeks in September 2022, with 0.54% of the total.

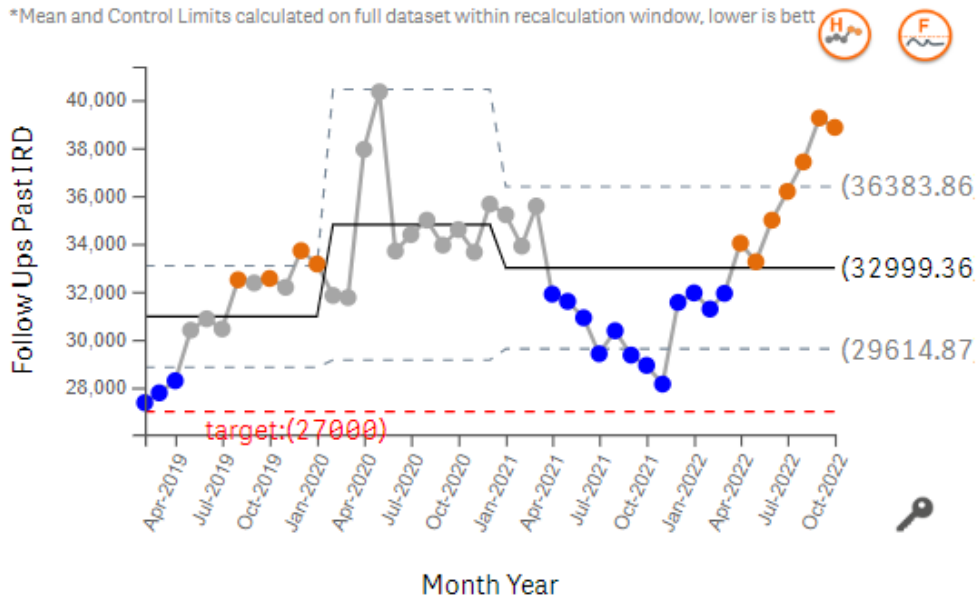
Did Not Attend and Follow-Up Patients Past the Indicative Review Date

OP DNA Rate



Latest
7.8%
Variance Type
Common cause variation
Target
4%
Target Achievement
The system is expected to consistently fail the target

Follow Ups Past IRD



Latest
38,857
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 9%, following an artificial improvement during the pandemic due to the reduced number of face-to-face appointments. Performance in October was 7.8% against a best practice target of 4%. **Follow ups past IRD** are in a period of special cause concern, with an increase to 38,857. The mean has increased from 31,000 pre pandemic to 32,999 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, 45.1% 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 October was 19.2%, with trajectory of 25% for March 2023. **Follow-ups**: • Paper to Quality Committee in December on the potential harm due to backlogs of patients waiting for follow-up.	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 3

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

Performance- **Quarter 2 SSNAP data-** FGH has improved from 77 to 81 and attained a level A. The RLI has improved from 60 to 61 and remained at level C.

Patient-centred SSNAP scores by site:

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

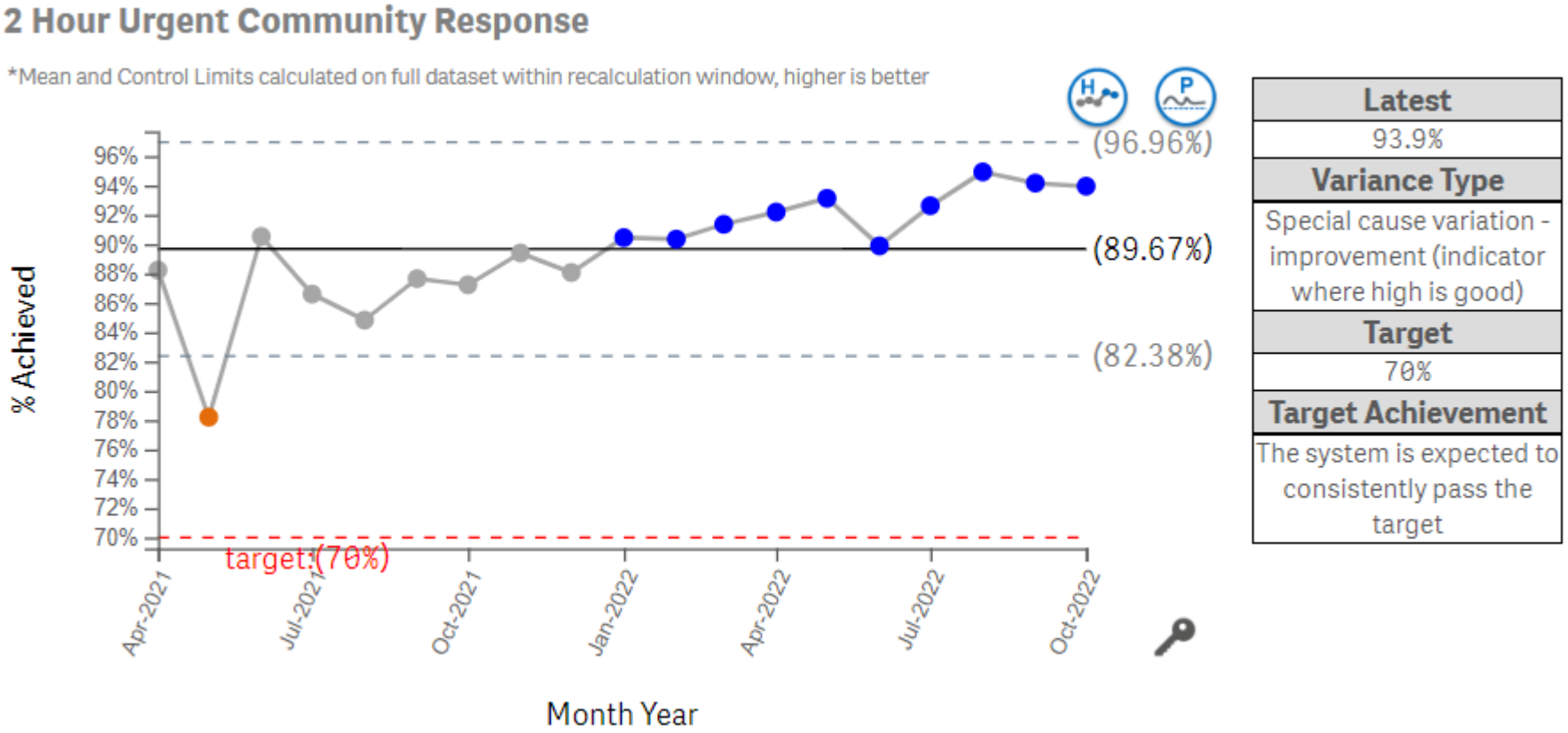
	RLI	Q3	Q4	Q1	Q2
1	Scanning	A	A	A	A
2	Stroke Unit	D	D	D	D
3	Thrombolysis	D	E	E	D
4	Specialist Assessments	B	B	C	B
5	Occupational Therapy	C	C	C	C
6	Physiotherapy	D	D	C	C
7	Speech and Language Therapy	D	D	E	E
8	MDT Working	D	D	D	D
9	Standards by Discharge	B	C	B	B
10	Discharge Processes	A	A	A	A

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
93.9%
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 10 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 that given time. • The impact of work to increase referrals through 111/ Care Homes has not yet had an impact despite engagement and comms. • We have seen significant uptake from the NWAS 999 pathway in terms of referral numbers and have commenced direct referral pathways from Falls Response services. • Workforce/workflows will be monitored as/when referral rates do increase to maintain responsiveness.

Appendix

Number of Patients who Waited More Than 104 Days for Treatment

Tumour Pathway		Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
Brain	Number of Breaches												
Breast	Number of Breaches	1.5		1								1	1
Gynaecology	Number of Breaches			0.5	0.5			1		1.5	0.5		
Haematology	Number of Breaches						0.5	1.5	4	0.5	1		
Head and Neck	Number of Breaches	0.5	0.5		0.5		0.5		1	0.5			
Colorectal	Number of Breaches			1	2.5	2.5	1	1	3	2	1	2	1
Lung	Number of Breaches	2		1		1				2	1	0.5	1
Sarcoma	Number of Breaches												
Skin	Number of Breaches		1		0.5	0.5	1.5	1	0.5		0.5		1
Upper GI	Number of Breaches		0	0.5				1.5	2	0.5		1	0.5
Urology	Number of Breaches	5	5	6.5	1	2	2	3	2.5	3.5	4	1.5	6
Other	Number of Breaches		1			0.5							
Trust	Number of Breaches	9	7.5	10.5	5	6.5	5.5	9	13	10.5	8	6	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	**36.4%**	
Gynaecology	2.5	**37.5%**	
Haematology	1	**85.7%**	
Head and Neck	1.5	**0.0%**	
Colorectal	5	**58.3%**	
Lung	3	**70.0%**	
Skin	5	**65.5%**	
Upper GI	3	**44.4%**	
Urology	11.5	**62.9%**	
Other	1	**33.3%**	
Trust	40	**58.8%**	

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		

Workforce Scorecard

Well Led

Outcome Measure	Target	Actual	Variation	Assurance
As of Month - Vacancy %	8.0%	4.8%	H	P
Turnover %	8.5%	0.5%		P
Average time to Hire (advert close to booked start date)	55	48.2		?
Bank & Agency Fill Rate	75%	71.3%		?
As of Month - Absence %	5.0%	6.6%		?
Registered Nurse Fill Rate	85.0%	90.7%		P
Appraisals	95%	73.9%		F

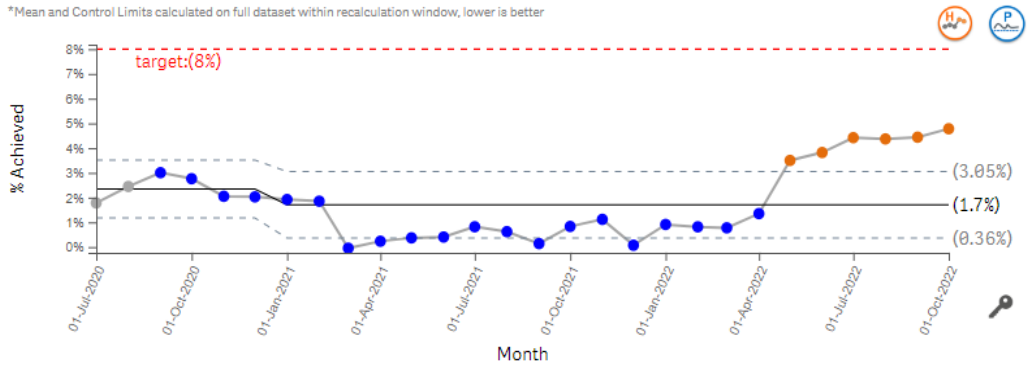
Safe

Outcome Measure	Target	Actual	Variation	Assurance
Core Skills Framework	95%	92.5%	L	?

Workforce

Vacancy Rate %

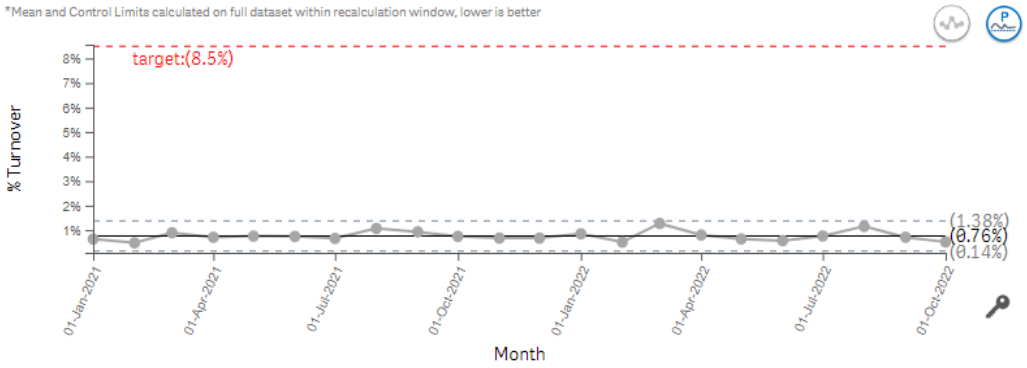
*Mean and Control Limits calculated on full dataset within recalculation window, lower is better



Latest
4.8%
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 %

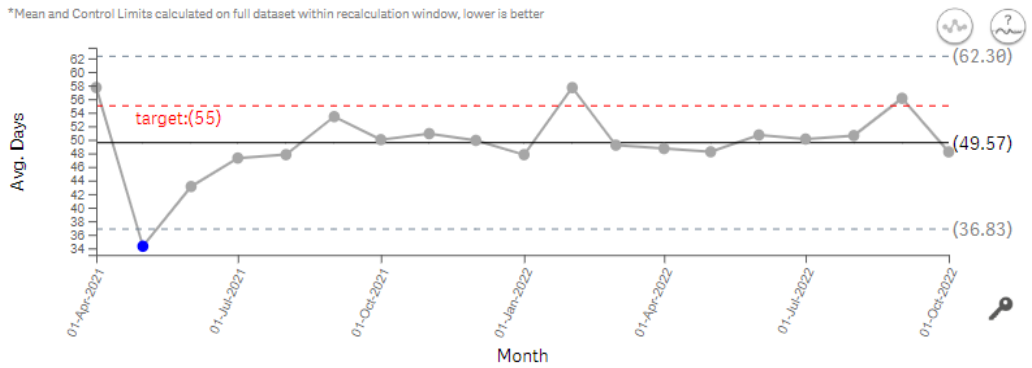
*Mean and Control Limits calculated on full dataset within recalculation window, lower is better



Latest
0.5%
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
48.2
Variance Type
Common cause variation
Target
55
Target Achievement
The system may achieve or fail the target subject to random variation

Summary

Time to Hire: Time to hire had a common cause variation due to a number of external agencies now responding within usual time frames, this has seen the target time return to normal and meet target.

Turnover: Current target for the trust will consistently be achieved, based upon the target for a rolling 12 month period. Current performance against this is 9.6% SCV. Turnover has remain constant and within statistical limits that were forecast.

Vacancy Rate: although under the overall trust target, Consultant vacancy position remains a concern (decreased from 14.8% to 14.2%), with several hotspot areas. Midwifery remains high at 19.9% and Additional Professional Scientific and Technical Staff group has seen an increase to 14.1%

Actions

Time to Hire: Work has been done to address the current situation and to return the Time to Hire back below trust target. External pressure has eased and internal processes are being reviewed to drive improvements.

Turnover: In line with the review of metrics, the target for turnover will be reassessed and the way the data is presented to People Committee will be reviewed.

Vacancy Rate: To address the situation with Consultant vacancies, a concerted effort has been made. The Acute and General medicine conference was attended and this has led to a number of expressions of interest that are being followed up to attract talent to hotspot areas.

Assurance

Time to Hire: The review of the process and the removal of the special cause variation has seen the target met. An assurance report on Recruitment will be presented to PC in the New year.

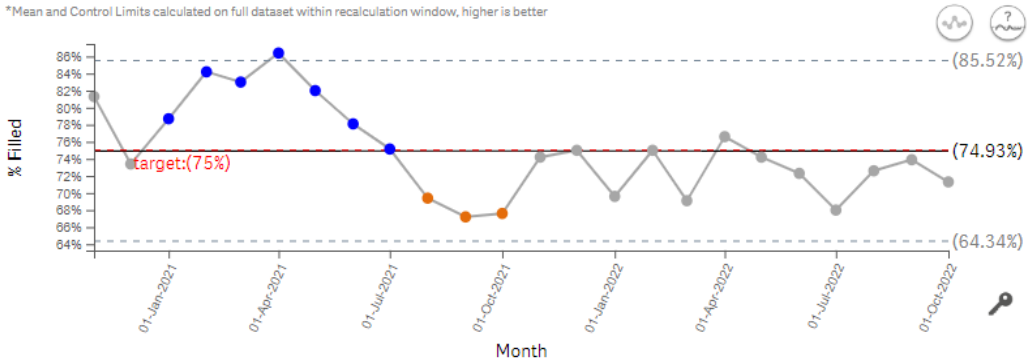
Turnover: Is reducing when we look at the overall 12 month rolling picture, and this trend is being monitored to highlight areas of concern. it can be seen from the SPC chart that current performance is within statistical variation.

Vacancy Rate: Overall trust vacancy continues to be within statistical variance and below trust target. Positive changes in several areas including in the Higher and Junior Doctors where significant successful recruitment has taken place.

Workforce

Bank & Agency Fill Rate

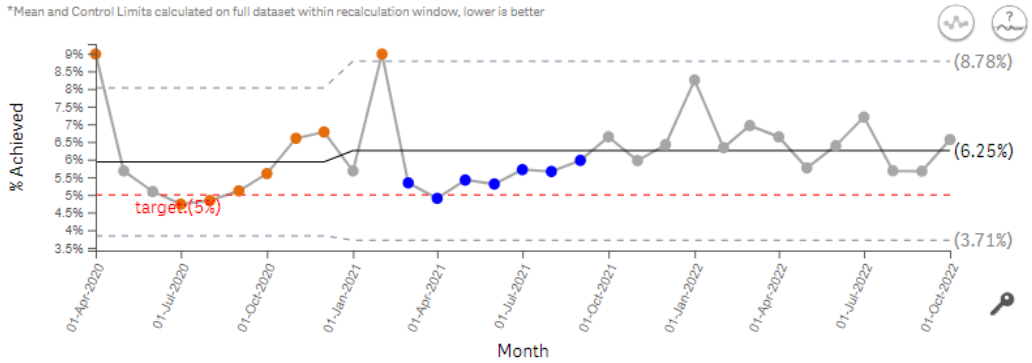
*Mean and Control Limits calculated on full dataset within recalculation window, higher is better



Latest
71.3%
Variance Type
Common cause variation
Target
75%
Target Achievement
The system may achieve or fail the target subject to random variation

Absence FTE %

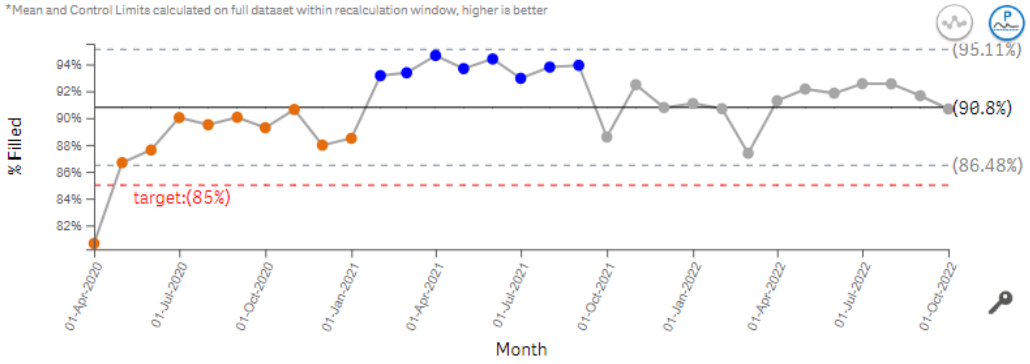
*Mean and Control Limits calculated on full dataset within recalculation window, lower is better



Latest
6.6%
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

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



Latest
90.7%
Variance Type
Common cause variation
Target
85%
Target Achievement
The system is expected to consistently pass the target

Summary

RN fill rate data: Continues to achieve above 85% consistently however 10 wards/departments had an RN fill rate below 85% during October

Bank and Agency: continues to show common cause variation with intermittent achievement of 75% fill rates.

Absence: In October 2022 there were a total of 516 colleagues (exc bank) absent through either sickness / isolation. The main reasons for absence are anxiety/stress/depression and MSK. Additional support is now available through the EASE service.

Actions

RN fill rate and bank fill rate: A bank rate incentive scheme will be launched in November with the aim of improving both RN and CSW fill rates on wards and departments. The scheme incentivises bank rates of pay for CSW and RN staff working clinically in the hospital and community services.

Absence: The use of the EASE service has seen 76% of colleagues referred for MSK return to work and 60% of colleagues returned to work who had been referred for mental Health. The use of this service is expanding and impacting upon reducing demand to OH services.

Assurance

RN fill rate and Bank & Agency: Fill rates continue to be monitored closely by senior clinical teams, monthly review and sign off meetings are now in place to ensure data cleansing and narratives are clear and accurate. Twice daily staffing assurance meetings are held to support care groups to maintain safe staffing levels and service provision.

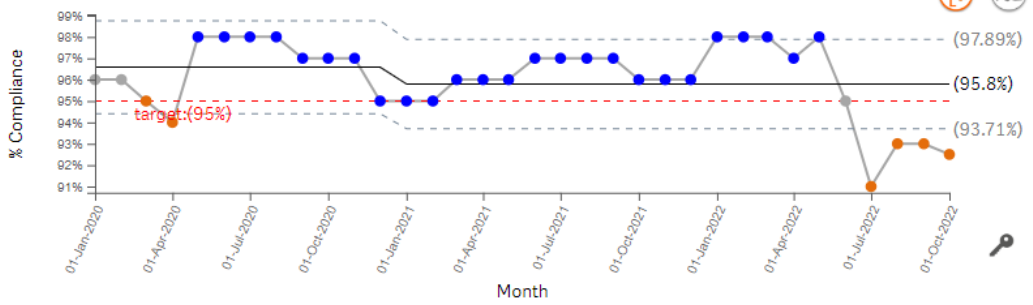
Absence: Overall trend data analysis suggests that absence has been demonstrating an improvement when compared over time. However, Trend analysis tells us that as we move into Winter absence is likely to deteriorate, peaking in January

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

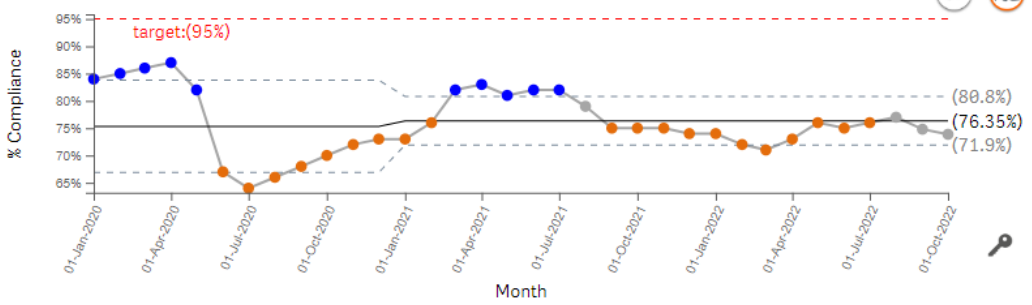


Latest
92.5%
Variance Type
Special cause variation - cause for concern (indicator where low is a concern)
Target
95%
Target Achievement
The system may achieve or fail the target subject to random variation

Appraisal Compliance

% of staff compliant as start of month

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



Latest
73.9%
Variance Type
Common cause variation
Target
95%
Target Achievement
The system is expected to consistently fail the target

Summary

Core skills Framework (CSF): Removal of 12 month extensions (Granted for COVID) for various Training modules has occurred in month, which has caused a special cause variation in the data. Although there has not been the significant drop that was expected.

Appraisal; Appraisal compliance is within statistical variation and the target is not expected to be met. Workshops have been set to look at improving compliance across all Care Groups and Teams.

Actions

CSF: The CSF core modules require a full review of the current requirements. This will be done as part of a project team in the ICS looking at creating a system wide programme of excellence for CSF. This partnership has commenced and will continue in early 2023 to produce recommendations on changes.

Appraisal: The appraisal working group has been put together. First meeting on 22/11/22. The proposal is to refresh the appraisal process and align with TMS 2. The Appraisal will form part of Focus 3 of the leadership programme 'me and my team'. Building on the foundation of Focus 2, 1:1s.

Assurance

CSF: Although compliance with CSF is below trust target, it is above national and regional averages. There are hotspots within the trust that compliance is low, which is being investigated to understand how improvements can be made. BLS/ALS is one area of focus

Appraisal: No assurance can be given that the trust will meet its current target for appraisals overall, however compliance for 8a and above remains high.

Executive Summary

Quality and Safety

FFT – Out of 31,223 potential responses 17,640 were received, a 14% response rate against a KPI of 15%.
Work continues to raise awareness within the Care Groups.
30 poor/ v poor responses for IP's (23 at RLI and 7 at FGH)

VTE – Improvements in IP compliance still required. A new clinical lead is in post. Work is ongoing to ensure only relevant cohorts included. This would improve the compliance figure closer to 95%.

Clostridium Difficile – continues above year-to-date threshold, this is a similar picture across the NW (NHSI/E feedback). Chief Nursing Officer meeting with care group leads and IPC.

Never Events - There has been a sustained period where there have been no reported Never Events.

Scorecard

Caring

Outcome Measure	Target	Actual	Variation	Assurance
A&E - % Rating the Service as Good or Very Good	84%	79.0%		
Inpatients - % Rating the Service as Good or Very Good	94%	89.3%		
Outpatients - % Rating the Service as Good or Very Good	94%	93.0%		
Trust Overall (inc ED,OP & IP) - % Rating the Service as Good or Very Good	94%	90.8%	L	F
Complaints per 1000 Bed Days	0.40	1.75		F
Mixed Sex Accommodation Breaches	0	23		

Effective

Outcome Measure	Target	Actual	Variation	Assurance
Overall % of Inpatients Receiving a VTE Assessment	95%	84%		F

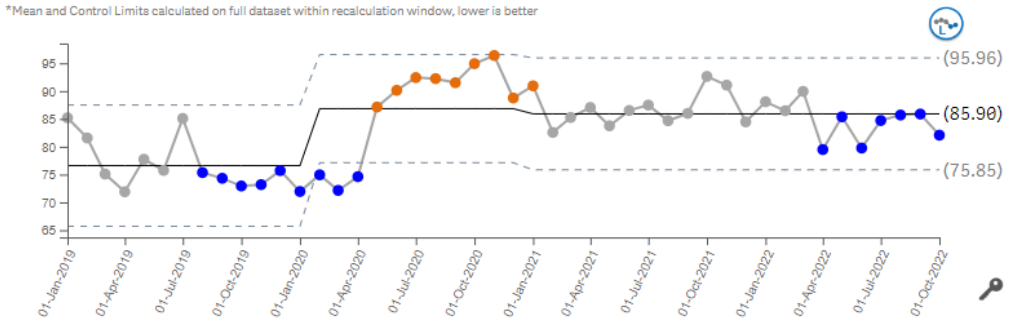
Safe

Outcome Measure	Target	Actual	Variation	Assurance
Patient Safety Incidents per 1000 Bed Days	---	82.08	L	
StEIS Incidents Reported to CCG	0	15		
Never Events	---	0	L	
Moderate and Above Harm Patient Safety Incidents	---	52		
Hospital Falls per 1000 Bed Days Resulting in Moderate Harm or Above	0.13	0.10		
Inpatient Category 2, 3 & 4 Pressure Ulcers Per 1000 Bed Days	---	2.10		
Patient Safety Alerts by Date Received	---	1		
Total Number of MRSA Hospital Cases	0	0.00	L	
Total Number of MSSA Hospital Cases	---	5		
Total Number of GNBIs	11	15		
Total Number of c.Diff Infections	7	12		

Patient Safety

Patient Safety Incidents per 1000 Bed Days

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

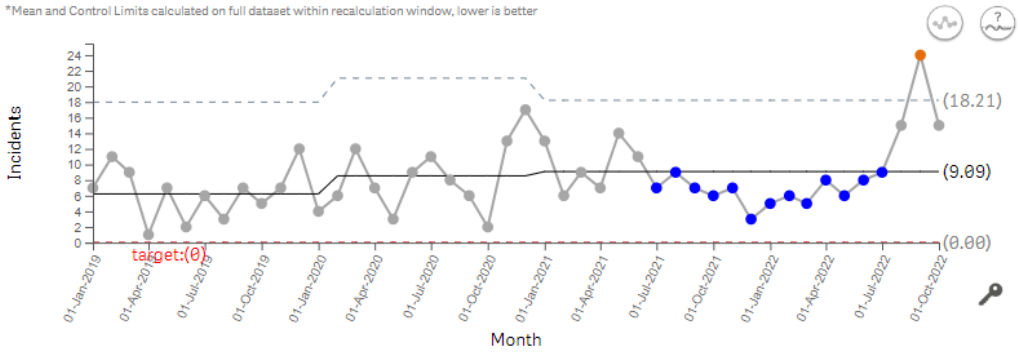


Latest
82.08
Variance Type
Special cause variation - improvement (indicator where low is good)
Target
N/A
Target Achievement
N/A

Awaiting revised national benchmarking before setting local target

StEIS Incidents by Month Reported to CCG

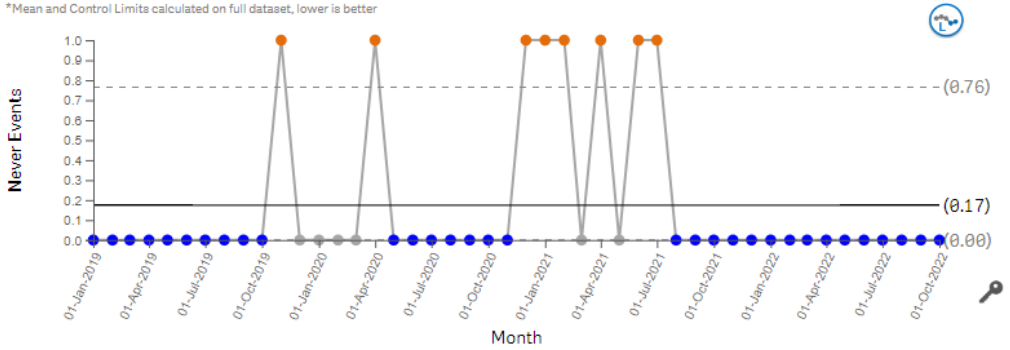
*Mean and Control Limits calculated on full dataset within recalculation window, lower is better



Latest
15
Variance Type
Common cause variation
Target
0
Target Achievement
The system may achieve or fail the target subject to random variation

Never Events

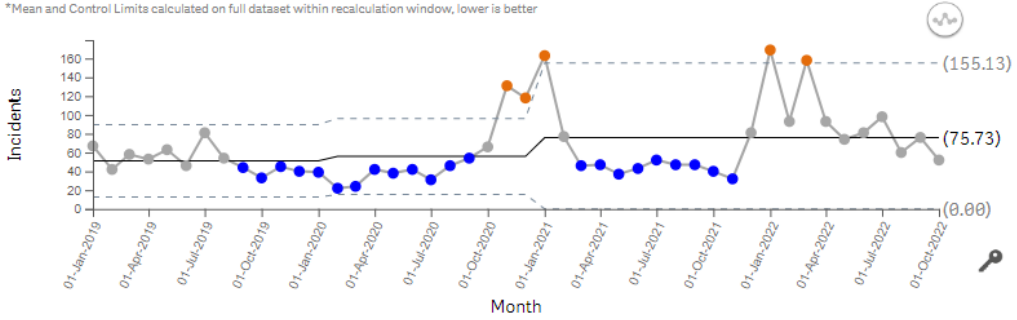
*Mean and Control Limits calculated on full dataset, lower is better



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 better



Latest
52
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Awaiting revised national benchmarking before setting local target

Summary

StEIS Incidents by Month Reported to CCG: In October there were 16 incidents reported on StEIS. 8 of these occurred within the Surgery and Critical Care, 6 within Medicine and 2 within Women and Children's.

4 of the incidents related to Tissue Viability and 3 related to a delay in treatment. There were no other themes identified.

Moderate and Above Harm Patient Safety Incidents: The graph shows a reduction in incidents causing moderate or above harm. When reviewing the data via category you can see a notable reduction in the volume of COVID incidents being reported.

Actions

StEIS Incidents by Month Reported to CCG: The Trust continues to identify and proactively StEIS report serious incidents.

Assurance

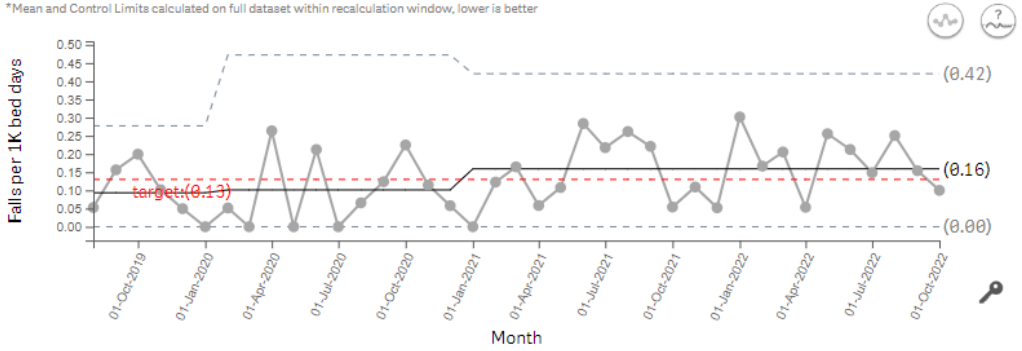
Never Events: The Trust has had a sustained period without a Never Event.

Moderate and Above Harm Patient Safety Incidents: There has been a notable reduction in the volume of incidents relating to infection control – related to C19.

Patient Safety

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

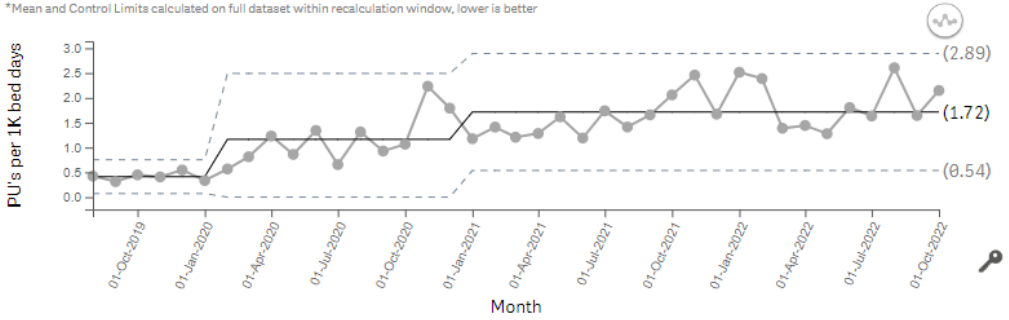
*Mean and Control Limits calculated on full dataset within recalculation window, lower is better



Latest
0.10
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

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



Latest
2.1
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

Falls: There was a total of 137 slips, trips, and falls - 2 resulting in moderate harm 1 which has been reported on STEIS.

19 patients suffered recurrent falls (more than one fall within their stay), One falling four times during their admission.

The data shows a reduction in falls with harm for a second consecutive month.

Pressure Ulcers: Considerable focus on reducing avoidable harm from pressure ulcers continues.

Actions

Falls: Continue to monitor falls daily and provide additional support to areas with increased incidence. Falls training has commenced for clinical staff and 56 members of staff have committed to becoming falls link nurses.

Pressure Ulcers: This month has seen specialised mattress toppers introduced in the ED dept for those patients who are waiting on trolleys for long lengths of time.

The Tissue Viability team are supporting the FOC "boot camps".

Key learning from incidents includes, lack of risk assessment (recognising frailty) and documentation, although improvements can be seen in the recent incidents reviewed at the SI panel.

Assurance

Falls: All falls resulting in Harm are discussed at the weekly Harm Free Care meeting to identify lessons learned and share across Care Groups.

A Geriatrician has now joined the Falls Improvement Forum to ensure the medical teams are captured within training.

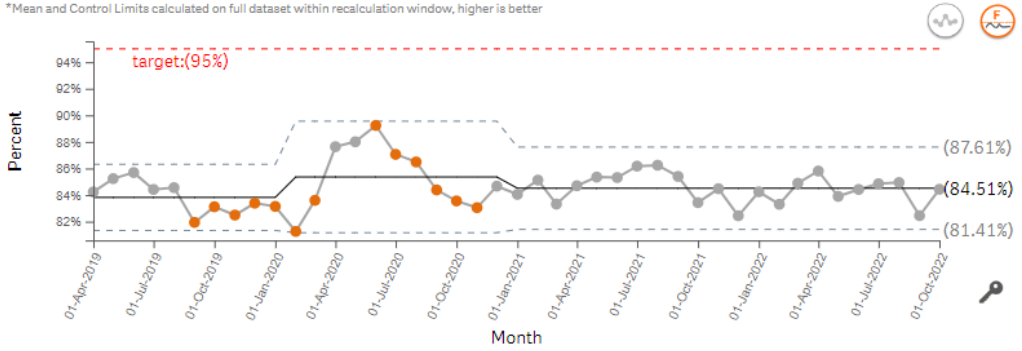
Pressure Ulcers: The MDT Pressure ulcer improvement forum continues.

The Tissue Viability Nurses continue to provide individualised care to wards where increased support is required.

Patient Safety

Overall Percent of Inpatients Receiving a VTE Assessment

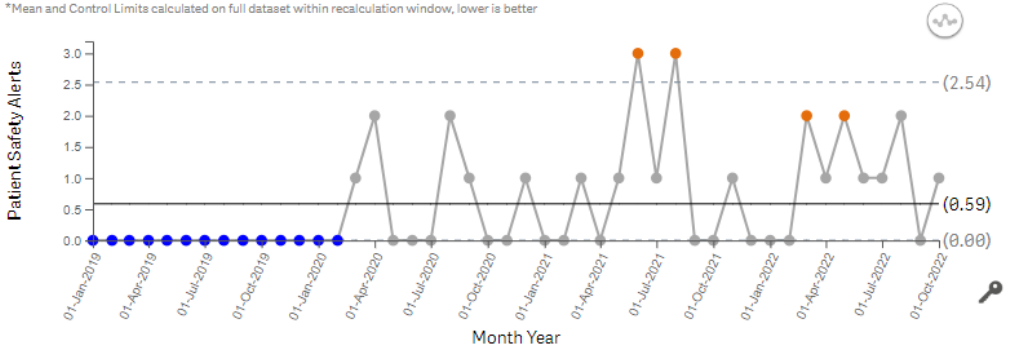
*Mean and Control Limits calculated on full dataset within recalculation window, higher is better



Latest
84%
Variance Type
Common cause variation
Target
95%
Target Achievement
The system is expected to consistently fail the target

Patient Safety Alerts by Date Received

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



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

Summary

Patient Safety Alerts by Date Received: The Trust received 1 National Patient Safety Alert in October 2022 and was successfully managed within the identified timeframe.

VTE - A new Clinical Lead for VE commenced on October 17th 2022.

Current compliance is 85.9 % - work is ongoing to ensure only the relevant cohorts included. This would significantly increase the compliance figure.

Actions

Patient Safety Alerts - Continue to respond within timescales

VTE: The VTE Steering group met or the 1st time on December 08th focussing on. Accurate Coding of Hospital Acquired Thrombosis (HAT). VTE Assessment in maternity led by Donna Southam. Communications to care group leads sent to Respective Care Groups to undertake VTE risk assessments, work with their governance partners and report their compliance and action plans to monthly VTE steering group meeting. Finalise the cohort of patients who must be included in the VTE risk assessment. Triangulate data from positive DVT and PE scans, IP stay, PM's - and cross reference them with the cohort of patients who were admitted to pick up hospital acquired thrombosis

Assurance

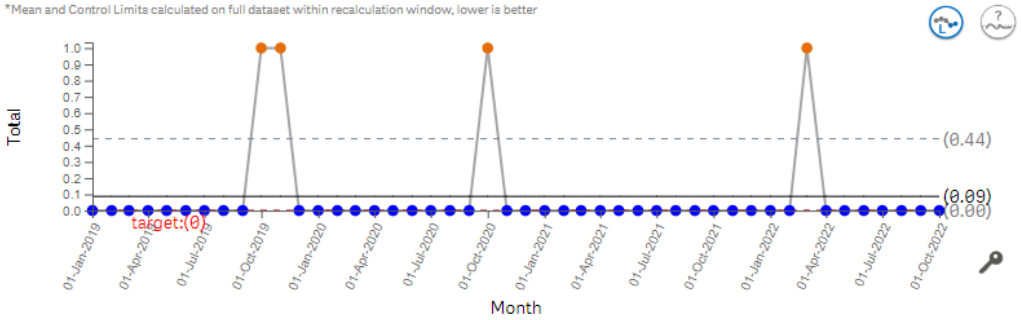
Patient Safety Alerts: Continue to respond within timescales

VTE: On review of the data, once the patient cohort and relevant areas wards where mandatory VTE assessment is required is finalised, the VTE lead is confident compliance be closer to the national target of 95%

Infection Prevention

Infection Prevention - MRSA (HOHA & COHA)

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

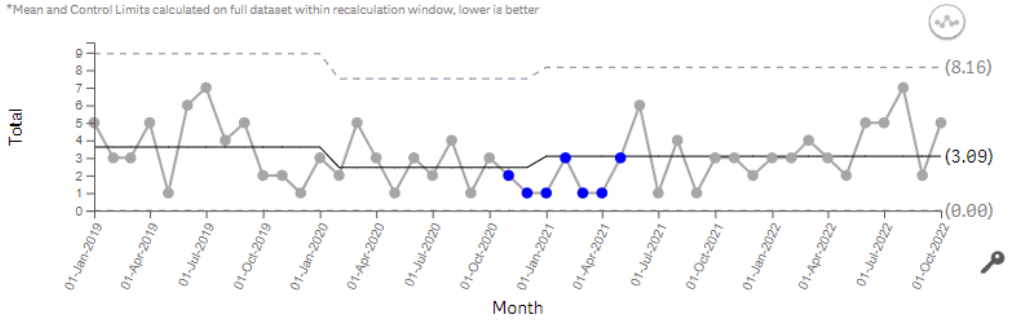


Latest
0
Variance Type
Special cause variation - improvement (indicator where low is good)
Target
0
Target Achievement
The system may achieve or fail the target subject to random variation

Target is nationally provided annual threshold (0) | Infections are Hospital Onset Healthcare Aquired & Community Onset Healthcare Aquired

Infection Prevention - MSSA (HOHA & COHA)

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

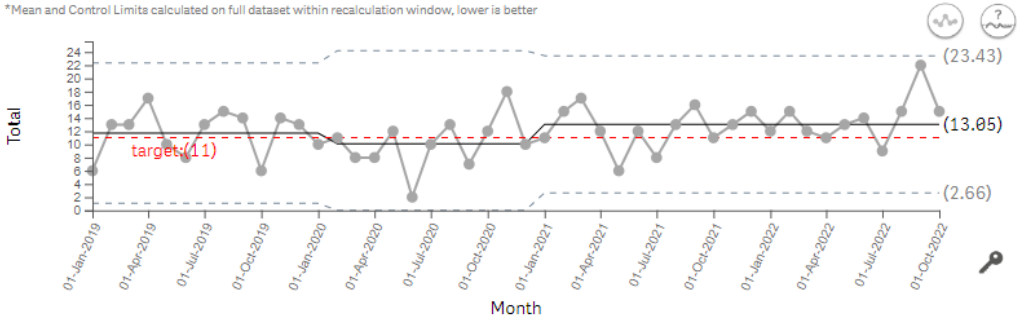


Latest
5
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Infections are Hospital Onset Healthcare Aquired & Community Onset Healthcare Aquired

Infection Prevention - GNBSI (HOHA & COHA)

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

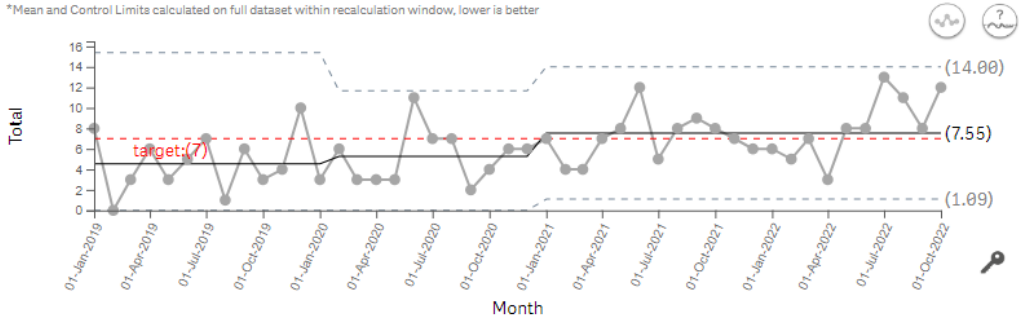


Latest
15
Variance Type
Common cause variation
Target
11
Target Achievement
The system may achieve or fail the target subject to random variation

Target is nationally provided annual threshold (133) split across 12 months | Infections are Hospital Onset Healthcare Aquired & Community Onset Healthcare Aquired

Infection Prevention - CDiff (HOHA & COHA)

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



Latest
12
Variance Type
Common cause variation
Target
7
Target Achievement
The system may achieve or fail the target subject to random variation

Target is nationally provided annual threshold (84) split across 12 months | Infections are Hospital Onset Healthcare Aquired & Community Onset Healthcare Aquired

Summary

Clostridium Difficile Infections continue to be over year to date threshold; this is a similar picture across the North West according to NHSIE NW team. The actions to reduce CDI cases are being scrutinised and the concerns discussed at IPCC.

Klebsiella is above year to date threshold. Analysis of Klebsiella blood stream infections will be the focus of the quarter 2 deep dive report and the Surgical care group have approached the IP team for collaboration on reducing GNBSIs.

Actions

Clostridium Difficile – A environmental review is underway Risks involving care groups, estates and facilities and Infection prevention and control teams.

Where necessary risks are added to the risk register to support with capital planning prioritisation.

Analysis of Klebsiella blood stream infections will be the focus of the quarter 2 deep dive report and the Surgical care group have approached the IP team for collaboration on reducing GNBSIs.

Following a review of ANTT training a decision has been made to utilise the ANTT.org official training rather than an in-house version. This will improve the quality of training provided.

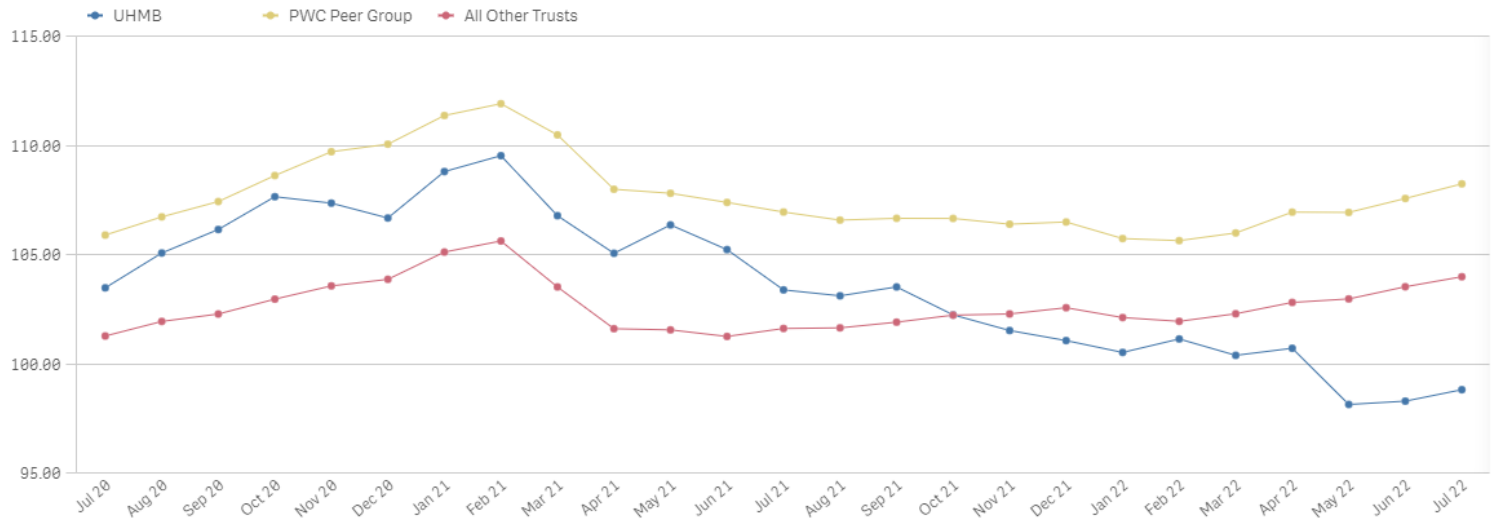
Assurance

All actions from CDI meetings will be added to Ulysses for individuals to manage, thereby giving full oversite to the care groups.

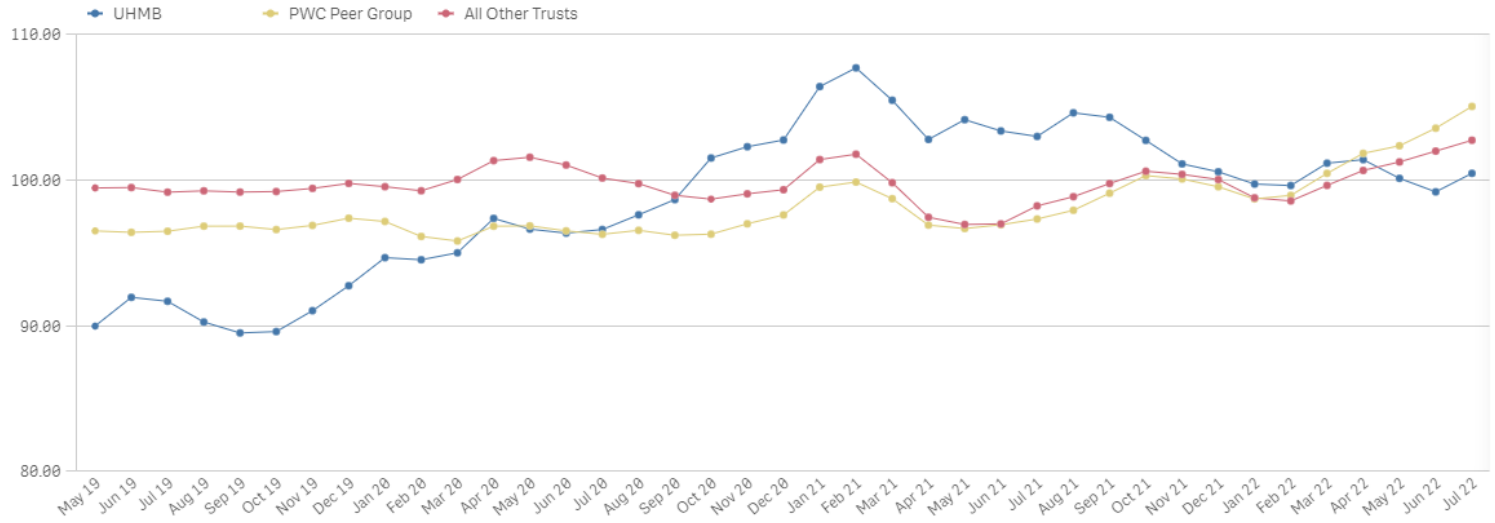
The cleaning audits and their visibility has improved after work through the IPOG & Cleanliness meeting. With the next step overlaying these with any estate works that is required on that ward which impacts the ability to clean.

Mortality

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



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



Summary

SHMI-rolling 12-Month SHMI (August 2021-July2022) score is 98.84 with 1620 observed deaths against 1639.06 expected. ALERT level Green.

HSMR -rolling 12-month position for HSMR (September 2021 – August 2022) is 98.90, with observed deaths at 1093 against 1105.16 expected. ALERT level Green.

Fractured neck of femur (red)There is a focused piece of work being undertaken by the Trauma & Orthopaedic fractured neck of femur steering and working groups with active action plans which show early signs of improvement.

Peripheral and visceral atherosclerosis (red): review of cases underway. Possible coding issue.

Congestive heart failure; non-hypertensive (amber). Possible coding issue.

Actions

The Fractured Neck of Femur Steering group are continuing to progress with improvements in performance. The CMO is sighted on the current discussions.

Dialogue with vice-chair of British Orthopaedic Association Trauma committee to examine the reasons and options appraisal with regards to the deteriorating mortality figures at the RLI which is worse than FGH. The T & O team believe the solution is increased Orthogeriatric support. CD for S&CC is discussing further with Medicine Care group to improve deliver improvements urgently.

Assurance

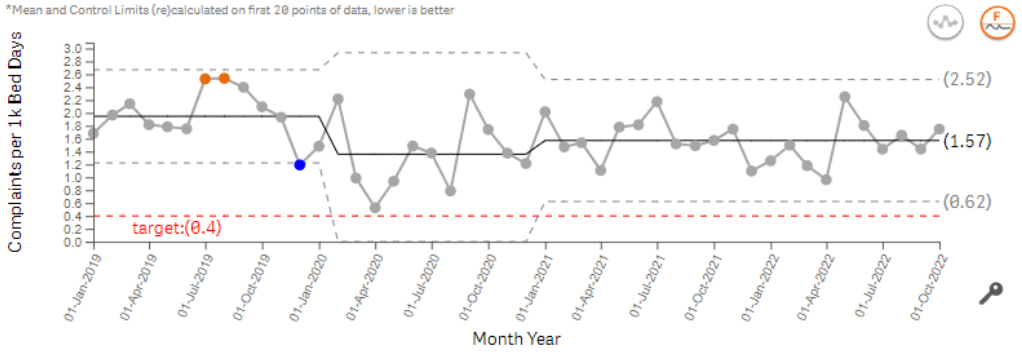
External support from Mr Bill Eardley will focus the T&O Consultants to take ownership of the mortality data and they need to actively participate in the Mortality Steering Group with action plans to discuss their improvement journey. An improvement in fractured neck of femur metrics is anticipated early 2023.

All FNoF are reviewed by the Mortality Reviewers to inform re problems in care and lessons to be learnt.

Patient Relations

Complaints per 1000 Bed Days

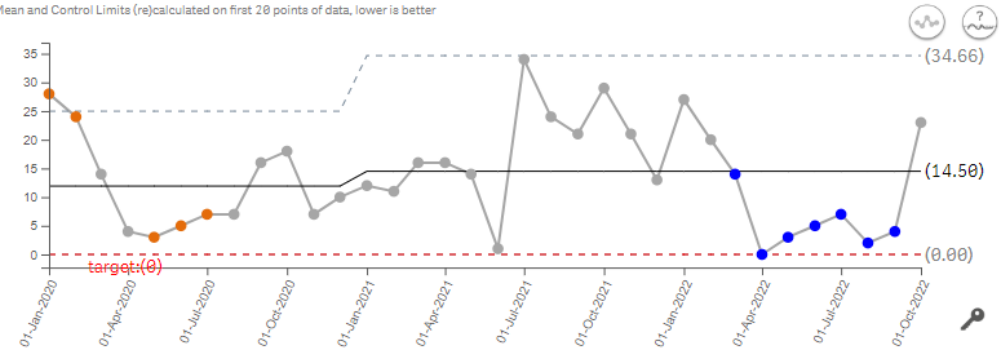
*Mean and Control Limits (re)calculated on first 20 points of data, lower is better



Latest
1.75
Variance Type
Common cause variation
Target
0.4
Target Achievement
The system is expected to consistently fail the target

Mixed Sex Accommodation Breaches

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



Latest
23
Variance Type
Common cause variation
Target
0
Target Achievement
The system may achieve or fail the target subject to random variation

Summary

Complaints: There are 3 cases over the 6 months regulatory time frame. One is awaiting approval from another care provider. One of which was going to meeting but the family now want the answers in writing - currently being investigated. One of which is a re-visit – currently awaiting consent to share

MSA Breaches: The number of breaches is showing as 2. After a check on accuracy in reporting - there is evidence of underreporting. Once Lorenzo has been updated the number of breaches is 23 . 21 are delays in transfer out of ICU due to capacity pressures.

Actions

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

MSA Breaches: The issue of underreporting has been addressed.

Assurance

Complaints: The number of outstanding complaints reducing and is currently standing at 111 with 10 in the very final stages for the approval and QA process.

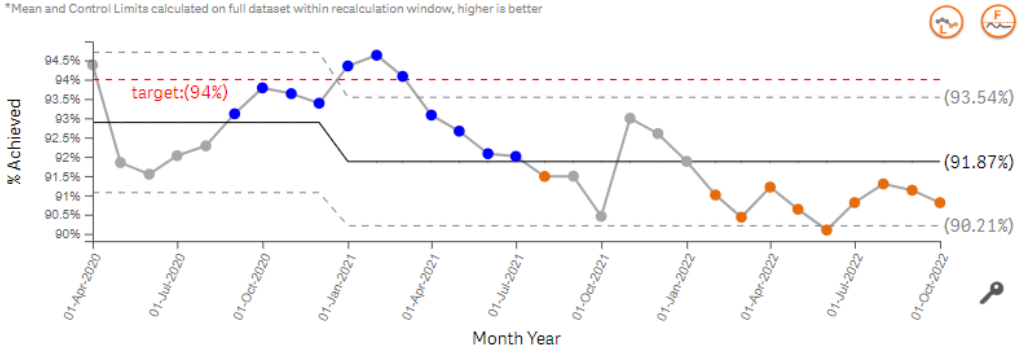
The new and amended complaints procedure is currently out for consultation. This will strengthen the process and improve timeliness of responses.

MSA Breaches: The number of MSA breaches will be monitored by DCN.

Friends and Family

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

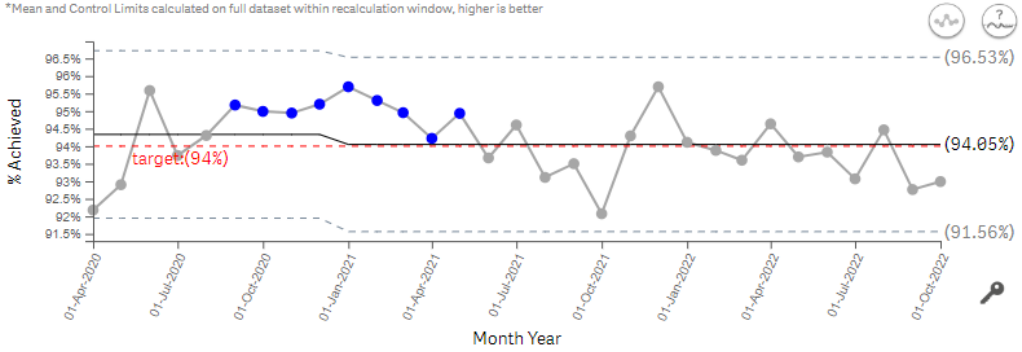
*Mean and Control Limits calculated on full dataset within recalculation window, higher is better



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

Outpatients - % Rating the Service as Good or Very Good

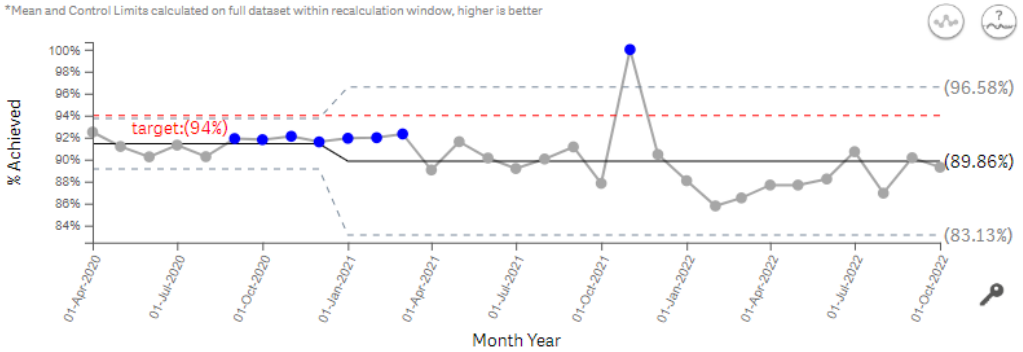
*Mean and Control Limits calculated on full dataset within recalculation window, higher is better



Latest
93.0%
Variance Type
Common cause variation
Target
94%
Target Achievement
The system may achieve or fail the target subject to random variation

Inpatients - % Rating the Service as Good or Very Good

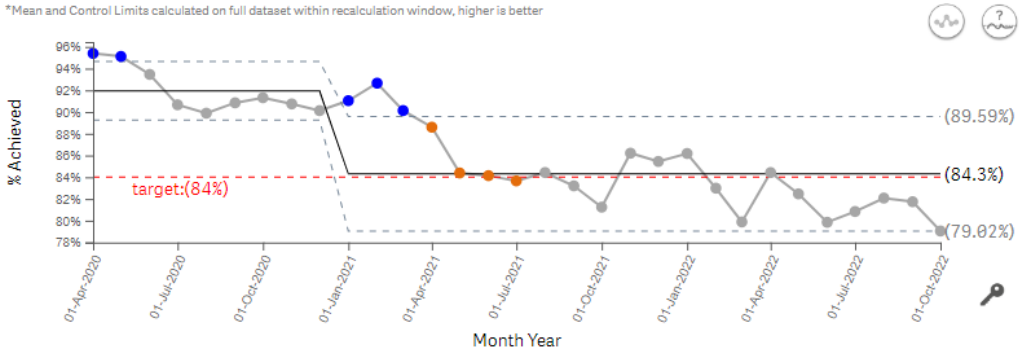
*Mean and Control Limits calculated on full dataset within recalculation window, higher is better



Latest
89.3%
Variance Type
Common cause variation
Target
94%
Target Achievement
The system may achieve or fail the target subject to random variation

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

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



Latest
79.0%
Variance Type
Common cause variation
Target
84%
Target Achievement
The system may achieve or fail the target subject to random variation

Summary

The trust prepared 31,223 patient surveys to be sent in October 2022; however, there 17,640 patients chose to opt-out. This resulted in a 14% sample response rate against a KPI of 15%.

There were 30 very poor or poor comments relating to inpatient services (23 at RLI and 7 at FGH). Comments were received from a wide range of age groups from 1- 93 years old.

The ICB has reset the FFT KPIs. Emergency & urgent care – from 84% - 80% satisfaction. Inpatients from 94% - 95% satisfaction.

There are no concerns in the outpatient, maternity, or community care group patient satisfaction results.

Actions

The experience team continue to support the UEC, Medical SDEC, Priority Assessment and Discharge Unit services and have issued QR codes for patients to provide real-time feedback/review with the satisfaction rating and comments again in 30 days.

Assurance

16 of the 30 negative responses relate to inpatient areas (6 - RLI Acute Surgical Unit). This has been highlighted to the Care Group Triumvirate.

Medical SDEC, Priority Assessment and Discharge Unit services at RLI received 11 of the 30 negative responses.

The experience team are working with several of these services and have completed local patient checkpoint five surveys to dig deeper into the patients' experience.

A FFT patient satisfaction bench marking paper (benchmarked with seven comparator trust) will be presented to the Quality and Governance group on the 30th of December 2022.

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REPORT TO BOARD OF DIRECTORS

DATE OF MEETING: 22 December 2022

University Hospitals of Morecambe Bay NHS Foundation Trust

CHAIR'S REPORT

Reporting Group/Committee:	Finance and Performance Committee			
Data and time:	28 November 2022 at 09.45			
Chairperson	Karen Deeny, Non-Executive Director			
Attendance:	**Quorate:**	X	**Not Quorate:**	
If not quorate, state reason:				
Key items discussed:	1. EPR Deep Dive and Strategic Outline Case			
	2. Investment and Priorities Group 3As report			
	3. Outreach Acute Care Team Business Case			
	4. Financial Recovery Plan			
	5. 2023/2024 Planning Approach and Assumptions			
	6. Month 7 Financial Performance Report			
	7. Operational Performance Report			
	8. Performance and Accountability Reviews Output Report			
	9. New Hospitals Programme Flash Report			
Alert:	**1. Business case for a Critical Care Outreach team** The Committee received a business case for a Critical Care Outreach team. Significant benefits were articulated, especially in the context of the infrastructure shortcomings at RLI in respect of enhanced care areas (for example respiratory and surgical care) and a relatively small ICU which these proposals help to mitigate. The benefits identified, although not immediately cash releasing, are consistent with the work being led by the Chief Operating Officer to establish the optimal models and capacity for the organisation and			

	therefore the Committee supported approval of this proposal based on: 1. The demonstration of affordability through the 23/24 planning round. 2. The inclusion of costs within the Trust's submitted financial recovery plan. 3. Confirmed annual revenue costs less than £1m. **2. Impact of the BMA rate card** The Committee were alerted to the significant impact of the BMA rate card and its impact on activity and the provision of patient care. A significant reduction in the elective recovery fund (ERF) position was also reported as a potential risk. The Committee was advised that ERF income claw back had not been incorporated into the latest year end forecast. The patient safety element of the impact will be overseen by the Quality Assurance Committee, with a full report scheduled for January 2023. The Committee agreed to reflect the alert position in its update to the Board of Directors with cross reference to the Quality Assurance Committee. **3. Consultant vacancy rate** A concern was highlighted in relation to a 30% Consultant vacancy rate in the Medicine care Group.
Advise:	**4. Electronic Patient Record (EPR) Deep Dive** The Committee considered a report and detailed presentation of the Hospital Electronic Patient Record (EPR) and a request to the support of the Committee for an Integrated Care Board (ICB) Strategic Outline Case (SOC) for a shared Core EPR. The shared core EPR SOC is a key enabler for system and process convergence, and further collaboration and merging of digital teams in line with the Provider Collaborative Board. The Committee agreed to recommend support for the SOC to the Board of Directors, noting caveats around ensuring effective capture of risks on risk registers; further detailed work ongoing; and to continue to be mindful of the developing ICB financial context. **5. Financial Recovery Plan** The Committee received a presentation detailing the Trust's Financial Recovery Plan. Agreed actions required to comply with the latest enhanced control

	environment were outlined noting that these were all mandatory but would be implemented in ways that supported the Performance Accountability Framework. The Committee requested assurance updates on QIA processes be provided alongside ongoing iterations of the Financial Recovery Plan. **6. 23/24 Planning Approach & Assumptions** The Committee received the planning approach and assumptions set out in the report noting collaborative work with Care Group, Workforce and Finance teams to ensure triangulation from the start. Workshops with each of the Care Groups will take place in December and ongoing work will be shared with the Committee. **7. Operational Performance** The Committee were advised that Urgent care remains under pressure with September seeing the lowest performance to date. Some improvement, however, was noted in the 4-hour standard throughout October and November. Key actions remain as part of the Urgent and Emergency Care Plan. It was also noted that not meeting criteria to reside had started to reduce following previous alerts to the Committee. In terms of diagnostics, an ICS performance improvement plan had been compiled to align with national requirements to achieve 5% by March 2025. Performance in November had improved significantly to around 7.5% in line with trajectory.
Assure:	**8. Performance and Accountability Reviews Output Report** The Committee received the first report showing outputs of performance reviews. This report will evolve with the further development of our metrics library and implementation of Care group level IPRs. An independent peer review had reported that developing and implementing the Trust PAF has been a very positive and key step forward in ensuring the Executive and Care Group Teams have a clear interface to support operational delivery. **9. Investment & Priorities Group Report** It was highlighted that prior approval and business cases coming through would be subject to enhanced rigour in line with the financial recovery plan.

Name of committee for escalation: (parent committee)	Board of Directors
Chair's Narrative on the meeting:	
A pilot review of the effectiveness of the Committee, led by the Trust Company Secretary, is planned for Q4. This was outlined verbally to the November meeting of the Committee and will be followed by a formal proposal paper to the next Committee meeting in December 2022.	
Date, Time & Location of next meeting:	
19 December 2022 at 10.00	

REPORT TO BOARD OF DIRECTORS

DATE OF MEETING: 22 December 2022

University Hospitals of Morecambe Bay NHS Foundation Trust

CHAIR'S REPORT

Reporting Group/Committee:	Quality Assurance Committee			
Data and time:	21st November 2022 at 13.00			
Chairperson	Hugh Reeve, Non-Executive Director			
Attendance:	**Quorate:**	X	**Not Quorate:**	
If not quorate, state reason:				
Key items discussed:	1. Integrated Performance Report			
	2. Progress on Care Quality Commission Improvement Plan			
	3. Introduction of the CQC Single Assessment Framework			
	4. Actual and potential consequences of reduced activity (due to a withdrawal of additional activity sessions) as they relate to patient safety, quality, elective activity, cancer and finance			
	5. Niche External Investigation Assurance			
	6. Royal College of Surgeons T&O Closure Report (final addendum)			
	7. Fractured Neck of Femur Update			
	8. VTE Update			
	9. Quarterly Care Group Report – Medicine			
	10. Monthly Maternity Assurance Report			
	11. PMRT Report			
	12. CNST Midwifery Workforce Report			
	13. CNST Neonatal Workforce Report			
	14. CNST Obstetric Anaesthetics Report			
	15. Maternity Voices Partnership			

	16. Safeguarding Annual Report
	17. Children Looked After Annual Report
	18. Chaperone Update Report
	19. Quality and Safety of Inpatient Services Report
	20. Chairs' reports from: Serious Incident Group, Executive Review Group, Quality Governance Group, Patient Safety Group, Recovery Support Group, Health & Safety Committee
	21. Updated terms of reference for the Executive Review Group
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. Inpatient Pressure Ulcers** These are showing a sustained increase on the IPR and are the subject of a deep dive and intense work. More detailed analysis is showing that the first 72 hours of an individual's hospital stay is critical – especially for those individuals who are frail and admitted via the ED and then the Acute Medical Unit. **Action**: The HIVE ward manager improvement programme is targeting Pressure Ulcers along with Falls. The introduction of Ward Quality Dashboards over the next month will also clearly identify those areas where more intense work is needed. The Quality Committee will keep this area under close review. **2. Potential reduction in clinical activity due to the withdrawal of additional activity sessions due to the impact of the BMA 'Rate Card' advice.** Discussions are ongoing locally and across the ICB through the Local Negotiating Committees to seek an agreement regarding the rate to be paid to consultants for additional activity sessions. At the time of the committee an agreement was close. An agreement on the rate to be paid will remove the risk of losing significant additional activity sessions which are critical in our work to reduce the waiting lists for outpatient appointments and treatments. To date around 2000 patients had been lost to the rate card and recovery would take many months. **Action:** Work is underway to identify those individuals on waiting lists who have conditions that warrant an urgent outpatient appointment, as some of these may have been delayed. No surgical procedures or other treatment have been delayed for cancer or other emergency problems or where it has been assessed that treatment is required within 3 months of listing for that treatment. It is expected that a final agreement will be reached quickly on the Rate Card and that the loss of any further sessions will be minimised. Going forward work is underway to identify whether additional specialist posts can be created to reduce the need for these additional sessions and for more clinical activity to take place as part of the normal working week.

	3. CNST Maternity Incentive Scheme Currently for the CNST Year 4 scheme maternity services anticipate achieving 7/10 safety standards, with three standards unlikely to be achieved. Although disappointing it is important to recognise the significant improvement from last year where only 3/10 safety standards were achieved. **Action**: A full paper will be brought to Board in December outlining this progress and the challenges still to be addressed.
Advise: (Where there is a matter that has on-going monitoring and any new developments need sharing to the committee/Board)	**1. Clostridium Difficile infections breaching the year-to-date threshold** The infection control team has investigated these infections and is confident following typing of the bacteria present that each incidence is an isolated event and does not represent outbreaks of infection. **Action:** C Diff infection rates are to be included on the Ward Quality Dashboards to focus attention on this issue. **2. Increase in the number of StEIS reportable incidents** It was noted the last quarter has seen a marked increase in the number of StEIS reportable incidents; that is those incidents reported into the national reporting system. A review of the number of incidents across the Trust over the same quarter that are thought to have caused moderate or severe harm has not shown any increase in the number of these incidents, if anything the number has dropped compared to the previous quarter. This indicates the increase in the number of StEIS reportable incidents reflects the change in the way these are now identified and classified, rather than an overall increase in serious incidents. **3. Ward Quality Dashboards** Dashboards showing key quality metrics are being introduced at ward level over the next couple of months. Initially these will identify ward level performance for areas such as infection control, pressure ulcers, falls and safer staffing. Further areas will be added. This will enable targeted support and action to those areas experiencing challenges with these metrics. **4. Fractured Neck of Femur – outlier in national mortality rates** The Committee received a progress report from the Steering Group addressing this issue. Significant progress is being made regarding initial pain control, mobilisation after surgery, access to physiotherapy the day after surgery, and nutritional and delirium assessments. Less progress has been made with reducing the time waiting for admission to an appropriate ward and time to surgery. A real focus is now needed on these two areas. The national mortality data is reported as a 12-month rolling average, it is expected we will start to see an improvement in our Trust's performance early in the New Year.

	5. CQC Improvement Plan – risk assessment of any impact for those actions missing their end of October deadline. The Committee considered the detailed risk assessment that had taken place for those actions that had missed the end of October deadline. The 'must do' actions remain a focus of attention. Those 'should do' actions that potentially could have an impact on patient safety and lead to a regulatory breach have been reprioritised as a 'priority should do', leaving a smaller number of 'should do actions. The new target dates reflect this realignment of priorities. **6. Introduction of the CQC Single Assessment Framework.** The Committee considered the new single Assessment Framework to be introduced by the CQC on 1/1/2023. Of particular note is that assessments and subsequent ratings will become more data driven and will be dynamic and not dependant on an inspection taking place and a report being issued – although at times inspections will still occur. The importance of valid, accurate and reliable data for submission either for national data sets or for submission to the CQC's provider portal, cannot be over emphasised. The Compliance and Assurance Team has started discussions with key groups within the Trust. Care Groups, Clinical and Business Intelligence (I3) and corporate functions will need to consider the implications of this new methodology.
Assure: (Where an update has been provided to the Committee and assurance has been received)	**1. Safeguarding and Children Looked After Annual Reports.** These annual reports were received and showed evidence of good practice and assurance that the procedures and general approaches being taken are of a good standard, and that our staff members are being appropriately trained. **2. Chaperone Procedures update report.** The CQC Inspection in August 2021 highlighted safeguarding concerns for patients on Medical Unit 2, and one issue highlighted was that the chaperone procedures were not being utilised sufficiently in order to protect both patients and staff. An initial audit was undertaken in December 2021 following the introduction of a number of changes and improvements. This audit was repeated in June 2022 across all 14 Medicine Care Group wards at RLI and FGH. There have been clear improvements over this timescale, however we can do better with regard to documentation to support the care that is in place. Some wards continue to have challenges regarding staffing and balancing chaperoning with timely care. The Care Group is repeating the audit in December 2022. **3. Royal College of Surgeons Closure Report** The Committee considered the letter received by the Trust from the RCS dated 11 November 2022, where having followed up the actions taken by the Trust following their report issued in September 2021 the RCS review team reiterated that Multi-Disciplinary-Team discussions of complex cases, review of morbidity and complications should be formalised. The review team confirmed they were now happy to conclude their active follow-up of their review in light of the continuing programme of work that was in place within the Trust.

	The Committee confirmed with the Surgical Care Group that appropriate arrangements were in place to continue monitoring progress with this improvement programme and in particular that the formalised MDT approach recommended would be established and monitored. The Committee will receive an update on progress in the Care Group's next quarterly report. **4. Report on the Quality and Safety of patients with Mental health issues, learning Disabilities and Autism in Inpatient Services** In September 2022 Claire Murdoch (National Director for Mental Health) wrote to national and regional leaders in the NHS regarding the quality and safety of mental health, learning disability and autism In-patient services. This was in response to a BBC Panorama programme which showed patients suffering abuse and cruelty whilst in the care of NHS services. In response, the Executive Chief Nurse at UHMBT requested assurance in relation to the safeguarding of the vulnerable and in particular those people with a learning disability, enduring and acute mental health illness and autism. The Committee received this detailed report and made some suggestions as to how it could be strengthened to fully represent the work that has taken place across the Trust over several years to support these patients while in our care. The Committee is assured that the systems are in place across the Trust so we can prevent and detect the cultures that would allow harm to occur to this group of patients and their families.
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)	
The Committee requests that its Terms of Reference be amended to allow up to two Non-Executive Directors as full members, in addition to the Chair of the Committee. One of these two Non-Executive Directors will be the nominated Vice Chair. This will allow up to three Non-Executive Directors in total as full members. At the current time this will allow the Board's Non-Executive Maternity Safety Champion to join the committee as a full member.	
Date, Time & Location of next meeting:	
Monday 19th December at 13.00.	

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.

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1 April 2022 – 31 March 2023
Trust Board Members' Attendance Monitoring

Public Board of Directors' Meetings

MEMBERS	27/04/2022	25/05/2022	29/06/2022	27/07/2022	31/08/2022	28/09/2022	26/10/2022	30/11/2022	22/12/2022	25/01/2023	22/02/2023	29/03/2023
Mike Thomas, Chair (Chair)												
Aaron Cummins, Chief Executive												
Chris Adcock, Chief Financial Officer / 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, Chief Nursing Officer												
Scott McLean, Chief Operating Officer (wef 01/07/2022)												
Jane McNicholas, Chief Medical Officer												
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				
										UHMB Strategy (6 monthly 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		

University Hospitals of Morecambe Bay NHS Foundation Trust
Board of Directors' Forward Plan 2022/23

			Freedom to Speak Up Annual Report	New Hospitals Programme Update Q1						New Hospitals Programme Update Q3		
							New Hospitals Programme Update Q2			Freedom to Speak Up Update (6 monthly update)		
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	Assurance Committee Annual Reports	Board / Committee Effectiveness Review	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)
		NHSI Submission of Annual Self-Declarations						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				UHMB Clinical Strategy – draft version	UHMB Clinical Strategy – final version	
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)