University Hospitals of Morecambe Bay
NHS Foundation Trust

We are UHMBT

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

QUALITY ACCOUNT 2022/2023

Contents

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Part 1: Statement on Quality from the Chief Executive

Welcome to the Quality Account for University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBT) 2022/23.

In many ways, 2022/23 was a time of incredibly positive change as the grip of the COVID-19 pandemic gradually loosened and our focus shifted towards improving and sustaining excellent services for the benefit of our patients and wider communities.

As individuals, in our hospital and community teams, and with our partner organisations, we continued to put patients first and took forward intensive improvement programmes to make our services sustainable now and into the future..

This account provides us with an opportunity to look back on the year and highlight some of the main developments to our services and the improvements we have made to our care over the past year across Morecambe Bay, whilst also reporting on how we have performed against key national clinical standards.

UHMBT aims to be one of the safest organisations within the NHS. Our staff are committed to providing high-quality care to patients all of the time. The quality of the services is measured by looking at patient safety, the effectiveness of treatments patients receive and patient feedback about the care provided. We do not always get this right, but we work hard to learn lessons and continually improve. The Trust takes the time to understand complaints and issues when they are raised and responds to them fully, learning lessons and making changes where that is appropriate. In response to safety concerns in some of our services, we have provided support and developed recovery plans to ensure quality and safety are maintained.

2023/24 will be another challenging year for UHMBT as we focus on the recovery of our services and delivering the best care possible and achieving outcome and access targets alongside an ever increasing demand for our services coupled with tighter financial constraints. This Account sets out our priorities for quality improvement for 2023/24

UHMBT will continue working with patients, citizens, staff, regulators, commissioners, and healthcare providers to deliver further improvement to quality during 2022/23.

To the best of my knowledge the information in the document is accurate.

Aaron Cummins
Chief Executive

Date: 29 June 2023

WHAT IS A QUALITY ACCOUNT?

Quality Accounts are annual reports to the public from us about the quality of healthcare services that we provide. They are both retrospective and forward looking as they look back on the previous year's data, explaining our outcomes and, crucially, look forward to defining our priorities for the next year to indicate, how we plan to achieve these, and quantify their outcomes.

Part 2: Priorities for improvement and statements of assurance from the board

2.1 Priorities for Improvement

In 2022/23, our new Trust Strategy – Patients First – was approved by the Board and launched along with our 'Vision, Values and Areas of Focus'. This strategy has set our direction of travel up until 2027 and is clinically led, quality and safety driven and puts patients first.

The Strategy aims to ensure we deliver excellent care, every time to every patient. Central to this is reducing harm and creating a culture of learning and openness, transparency, and candour consistent with the highest standards in the NHS.

We worked productively with our health and care partners to achieve and sustain our improvements and to find new ways of collaborating with neighbouring NHS Trusts and other healthcare organisations.

Through our teams we heard a very strong commitment to a strategy that is Patients First, Quality & Safety driven and clinically led. The purpose, vision, values, and strategic priorities are outlined below.

'Putting Patients First' was also the main focus of our evolving UHMBT Clinical Strategy, which continues to be refreshed with valuable input from clinicians, leaders, the public and stakeholders across our health and care communities. Patients, colleagues, partners, the public and stakeholders contributed to the strategy and clinical delivery plans were created.

Our areas of focus for 2022/23 were defined as...

You're *safe* in our hands - quality and safety of services.

2022/23 priorities…

We said everyone who uses our facilities should expect to receive consistent and high standards of safe care.

We will:

- Standardise clinical pathways and reduce variation to improve standards of care and outcomes for all service users.
- Ensure our services are clinically led and co-designed with patients and service users.
- Improve patient access to and experience of our urgent and emergency care services.
- Reduce our waits for elective care assessment and treatment.

We did:

- Improve care across stroke pathways and in maternity care.
- Reduce in Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) indicators and specifically on the Fractured Neck of Femur (#NOF) measure.
- Commenced work on a ward level quality dashboard.
- Co-design and implement the Quality Governance Assurance Framework.
- Improve our urgent and emergency services by increasing access to same day emergency care services. This included the development and opening of an urgent treatment centre at the Royal Lancaster Infirmary (RLI).
- Improve our waits for elective care and had no patients waiting longer than 78 weeks by the end of March 23.
- Develop and approved a refreshed Clinical Strategy co-designed with staff and stakeholders.

How will we measure success?

- Trust and Care Group level key performance action plans developed considering the refreshed Performance and Accountability Framework (PAF).
- Sharing data with directorates whilst focusing on best practice and learning from Root Cause Analysis (RCA).
- Incidence and rate of pressure ulcers will be monitored at Ward, Directorate and Trust level.
- Benchmarking.
- Utilise recognised quality improvement methodology for measuring data.
- Continue to report Methicillin-sensitive Staphylococcus aureus (MSSA), Clostridium difficile (CDiff) and E. coli infections monthly, internally, and nationally; and
- Continue to report constitutional access targets.

Where will we report this to?

- Care Groups and Quality Governance Groups
- Quality Committee
- Trust Board
- Performance and Accountability Framework meetings.
- The public via the Integrated Board Report; and
- Public Health England.

2.2 Statements of Assurance from the Board of Directors

The information in this section is mandatory text that all NHS Foundation Trusts must include in their Quality Account. We have added an explanation of the key terms and explanations, where applicable.

Information on the Review of Services

During 2022/23, the University Hospitals of Morecambe Bay NHS Foundation Trust provided and/or subcontracted 40 relevant Health Services.

The University Hospitals of Morecambe Bay NHS Foundation Trust has reviewed all the data available to them on the quality of care in 40 of these relevant Health Services.

The approximate income generated by the relevant Health Services reviewed in 2022/23 represents 99% of the total income generated from the provision of relevant Health Services by the University Hospitals of Morecambe Bay NHS Foundation Trust for 2022/23.

Participation in Clinical Audit

Participation in Quality Account audits 2022-23

Annually, NHS England publishes a list of national clinical audits and clinical outcome review programmes that it advises trusts to prioritise for participation and inclusion in their Quality Account for that year. This will include projects that are ongoing and new items.

During 2022-23, 48 national clinical audits and 7 national confidential enquiries covered relevant health services that University Hospitals of Morecambe Bay NHS Foundation Trust provides.

During that period, University Hospitals of Morecambe Bay NHS Foundation Trust participated in 94% national clinical audits and 100% national confidential enquiries which it was eligible to participate in. There were 3 audits that the Trust did not participate in. The Trust plan to take part in these audits in 23/24 and can confirm they are on the 23/24 forward audit plan. These were:

- National Cardiac Rehabilitation Audit - lack of capacity and resources within the cardiac team.
- National Diabetes Foot Care Audit - data was not submitted because at the time of the audit the team had a significant operational pressure with the number of vacancies in the service. The clinical lead had to stand down all non-essential work to prioritise and mange patient workload and focus on patients who required urgent care due to limb or life-threatening conditions.
- National Ophthalmology Database Audit – Software, there wasn't a budget in year.

The table below shows:

1. The national clinical audits and national confidential enquiries that University Hospitals of Morecambe Bay NHS Foundation Trust was eligible to participate in during 2022-23.
2. The national clinical audits and national confidential enquiries that University Hospitals of Morecambe Bay NHS Foundation Trust participated in during 2022-23.
3. The national clinical audits and national confidential enquires that University Hospitals of Morecambe Bay NHS Foundation Trust participated in, and for which data collection was completed during 2022-23, are listed below alongside the number of cases submitted to each audit or enquiry.

No.	National clinical audits and clinical outcome review programmes	Eligible	Participated	Number of cases submitted
1.	Breast and Cosmetic Implant Registry	Yes	Yes	Trust (25)
2.	Case mix Programme	Yes	Yes	Cases Submitted
3.	Elective Surgery: National Patient Reported Outcome Measures (PROMs) Programme	Yes	Yes	Cases Submitted
4.	Royal College of Emergency Medicine (ROYAL COLLEGE OF EMERGENCY MEDICINE) QIPs: Mental Health Self Harm	Yes	Yes	Data entry ongoing until October 23
5.	Falls and Fragility Fracture Audit Programme: National Audit of Inpatient Falls	Yes	Yes	Trust (9)
6.	Falls and Fragility Fracture Audit Programme: National Hip Fracture Database	Yes	Yes	RLI (302) FGH (152)
7.	Gastro-intestinal Cancer Audit Programme: National Bowel Cancer Audit	Yes	Yes	Trust (248)
8.	Gastro-intestinal Cancer Audit Programme: National Oesophago-gastric Cancer	Yes	Yes	Trust (301)
9.	Inflammatory Bowel Disease Audit	Yes	Yes	Cases Submitted
10	LeDeR – learning from lives and deaths of people with a learning disability and autistic people (previously known as Learning Disability Mortality Review Programme)	Yes	Yes	Cases Submitted
11	National Adult Diabetes Audit: National Diabetes Core Audit	Yes	Yes	Trust (2092)
12	National Adult Diabetes Audit: National Diabetes Inpatient Safety Audit	Yes	Yes	Cases Submitted
13	National Adult Diabetes Audit: National Pregnancy in Diabetes Audit	Yes	Yes	Cases Submitted
14	National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme: Adult Asthma Secondary Care	Yes	Yes	FGH (42) RLI (91)
15	National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme: Chronic Obstructive Pulmonary Disease Secondary Care	Yes	Yes	FGH (268) RLI (190)
16	National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme: Paediatric Asthma Secondary Care	Yes	Yes	FGH (38) RLI (63)
17	National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme: Pulmonary Rehabilitation	Yes	Yes	Trust (219)
18	National Audit of Breast Cancer in Older Patients	Yes	Yes	Data Submitted
19	National Audit of Care at the End of Life	Yes	Yes	FGH (44) RLI (50)
20	National Audit of Dementia	Yes	Yes	Trust (73)
21	National Cardiac Arrest Audit	Yes	Yes	FGH (65) RLI (46)
22	National Cardiac Audit Programme: Myocardial Ischaemia National Audit Project	Yes	Yes	Data entry ongoing until June 23
23	National Cardiac Audit Programme: National Audit of Cardiac Rhythm Management	Yes	Yes	Data entry ongoing until June 23
24	National Cardiac Audit Programme: National Heart Failure Audit	Yes	Yes	Data entry ongoing until June 23
25	National Child Mortality Database	Yes	Yes	Cases Submitted
26	National Early Inflammatory Arthritis Audit	Yes	Yes	Trust (63)
27	National Emergency Laparotomy Audit	Yes	Yes	Data entry ongoing until May 23
28	National Joint Registry	Yes	Yes	FGH (311)

				RLI (231)
29	National Lung Cancer Audit	Yes	Yes	Trust (261)
30	National Maternity and Perinatal Audit	Yes	Yes	Not yet received 2022/23 data from NHS England
31	National Neonatal Audit Programme	Yes	Yes	Cases Submitted
32	National Paediatric Diabetes Audit	Yes	Yes	Data entry ongoing until May 23
33	National Perinatal Mortality Review Tool	Yes	Yes	Cases Submitted
34	National Prostate Cancer Audit	Yes	Yes	Trust (286)
35	Perioperative Quality Improvement Programme	Yes	Yes	Cases Submitted
36	Renal audits: National acute kidney injury audit	Yes	Yes	Cases Submitted
37	Renal audits: UK renal registry chronic kidney disease audit	Yes	Yes	Cases Submitted
38	Respiratory audits: Adult respiratory support audit	Yes	Yes	Data entry ongoing until 31st May
39	Sentinel Stroke National Audit Programme (SSNAP)	Yes	Yes	Data entry ongoing until May 23
40	Serious Hazards of Transfusion National Haemovigilance Scheme	Yes	Yes	Trust (10)
41	Society for Acute Medicine Benchmarking Audit	Yes	Yes	FGH (28) RLI (27)
42	Trauma Audit and Research Network (TARN)	Yes	Yes	Trust (585)
43	UK Cystic Fibrosis Registry	Yes	Yes	Trust (13)
44	UK Parkinson's Audit	Yes	Yes	Trust (80)
45	Epilepsy 12: National Clinical Audit of Seizures and Epilepsies for Children and Young People	Yes	Yes	Data still ongoing Nov 23
46	National Adult Diabetes Audit: National Diabetes Foot Care Audit	Yes	No	
47	National Ophthalmology Database Audit	Yes	No	
48	National Audit of Cardiac Rehabilitation	Yes	No	

No.	National Confidential Enquiries	Eligible	Participated	Number of cases submitted
1.	Transition from child to adult health services	Yes	Yes	Trust (154)
2.	Epilepsy	Yes	Yes	Trust (348)
3.	Crohn's Disease	Yes	Yes	Trust (13)
4.	Testicular Torsion	Yes	Yes	Trust (46)
5.	Community Acquired Pneumonia	Yes	Yes	Trust (377)
6.	Endometriosis	Yes	Yes	Trust (95)
7.	Maternal Infant and Newborn Clinical Outcome Review Programme: Mothers and babies: Reducing risk through audits and confidential enquiries across the UK	Yes	Yes	Cases submitted

The reports of 19 National Clinical Audits were reviewed by the provider in 2022/23. University Hospitals of Morecambe Bay NHS Foundation Trust intends to take, or has taken, the following actions to improve the quality of healthcare provided.

No.	Title of National Clinical Audit reports received in 2022/23	Details of actions taken or being taken to improve the quality of local services and the outcomes of care.
1.	National Paediatric Diabetes Audit - Paediatric Diabetes Report on care and outcomes (NPDA)	• To add acknowledgement of review of Blood Pressure (BP) result to Qlik sense paediatric diabetes app as part of ongoing work to develop the app. Action now completed. • To identify a suitable sleep questionnaire for obstructive sleep apnoea. No validated sleep questionnaire is available for us in these circumstances. To be discussed at team meeting but will be left to clinical discussion and individual decision whether further investigation is warranted. See attached email confirmation. • To add 'Type 2 diabetes Annual Review' set of bloods to paediatric picklist. Action completed 1 week after email request sent. See attached email confirmation.
2.	Society for Acute Medicine Benchmarking Audit (SAMBA)	• Further discussion needed regarding referral pathway to acute Medicine (Appropriateness for single point of access/FY1s taking referrals) to help to identify patients suitable for Same Day Emergency Care (SDEC) early to help to direct them away from the Emergency Department (ED).
3.	Suicide and mental health – Annual report: UK patient and general population data (NCISH)	• Mental health self-assessment form: • Email communication to be sent out to the safeguarding team to highlight the importance of completing the mental health self-assessment form upon ED attendance. • Results from National Audit to be added into Ulysses: • Ongoing Action - Request for results to be reviewed and added into Ulysses sent via email. To discuss at the next Safeguarding audit review meeting in February 2023.
4.	Eighth patient report – National Emergency Laparotomy Audit (NELA)	• To discuss between teams the importance of improving time to theatre for high-risk patients. Discussed at surgical/anaesthetic joint audit meeting • Arrival in theatre should be within appropriate timescale. To initiate discussions to determine the possibility of opening a second theatre for high-risk cases when availability is an issue. • Antibiotics administered within 1 hour to patients with suspected sepsis. To remind clinicians of the importance of antibiotics being administered in a timely manner to improve outcomes. Discussions were held during the meeting about the importance of antibiotics being administered in a timely manner to improve outcomes
5.	National Neonatal Audit Programme summary	• Focus on daily safety huddles and their importance - post- National Neonatal Unit (NNU) ward round - is it possible for the consultant to join on the weekends for huddle and senior support? • Night registrar or consultant on-call to liaise with NNU early on in night shift - this may be dependent on the clinical situation on the children's ward as to whether this can be in person or via phone
6.	National Early Inflammatory Arthritis (EIA) Audit: Year 4 annual report	• Due to delay in initiating Disease-modifying antirheumatic drugs (DMARD) promptly, the trust needs to look at increasing nurse capacity as this is the current rate limiting step. There are plans to recruit a replacement nurse, but this needs to be expended to increase the nurse team. • Look at nurse job planning and improving the access to the nurse helpline. The nurse helpline should provide support in < 24 hours and we are not currently achieving this standard (currently 72 hours). • GP engagement - a planned protected learning time session is to take place in March 2023 where the EIA audit will be discussed, and referral pathways reviewed.
7.	National Paediatric Diabetes Audit Report: Parent and patient reported	• Reduction in uptake of retinal screening. Highlight at annual review appointment when last screening took place and discuss importance of screening. This is now standard practice.

	experience measures	• Reduced uptake of retinal screening. Review screening data before clinics to highlight people in clinic and at team meetings to support emphasis on this over audit year 2022/23. Reviews have taken place regularly throughout the year. Multidisciplinary team (MDT) coordinator sending intermittent reminders of all outstanding patients who are overdue screening. • Low rates of dietitian appointments being taken up. Note this relates in part to only face to face reviews being allowed to count and the team having reduced dietetic time over this audit period. Dietitian to attend annual review clinics to see people as part of annual review attendance. Where possible with work commitments and room availability a dietitian is attending annual review clinic. If not present then opportunity to see at next routine appointment or separate review is offered. • The improvement in Hba1c has slowed down so that local values are now higher than national levels. Access to diabetes technology has widened under new guidance. Plan to offer continuous glucose monitoring to all existing patients with type 1 diabetes and within the first month of diagnosis for all newly diagnosed patients. • Reduction in uptake of retinal screening. Create a flyer about accessing retinal screening and put into clinic letters over the next 3 months. Plan revised. Reminder sent via digibete app to all patients. Links between retinopathy screening and diabetes team strengthened so that all failed attendances or failure to respond to invites are shared with diabetes team coordinator. Resources targeted at this group of patients who now all receive an email from the team and are highlighted to the clinical team for discussion at next appointment. • Reduction in take up of retinal screening. Education post on digibete app to remind families of importance.
8.	National Audit of Care at the End of Life (EOL): Third round of the audit	• Business case to be written by Team Lead/Clinical lead/Operational lead for specialist doctor in training (SPCT). • Workforce plan to be undertaken to assess increased staffing needs to enable a safe delivery of a 7-day service. • Ensure documentation reflects communication with patient and families at the end of life, especially explaining patient is in the dying. Link in with Care of the Dying Pathway guidance (CDP). • Prioritise Advance care planning and communication skills training. • Audit use of CDP care plan via EOL Clinical Reference group and Link nurses • To link in with End-of-Life reference group. Confirmation from Emma - ongoing process • Prioritise the care of the dying patient 5 module training for all qualified nurses. • To develop a training Matrix regarding end-of-life care • Assessment of medical and nursing education plan for the next 12 months.
9.	Child and Young Person Asthma Organisational Audit: Summary report	• The provision of a personalised asthma action plan on discharge was reported at FGH 100%, RLI 42%. On checking the patient records and National Asthma and Chronic obstructive pulmonary disease (COPD) Audit Programme (NACAP) patient records I suspect the staff member submitting the data at the time who has now left did not realise that the asthma action plan that UHMBT use was also known as a personalised asthma action plan (PAAP) therefore ticked no instead of yes. Unfortunately, it was too late to change the report. To monitor the next report, staff member was still in post for part of the next report. Should see compliance improve. Have now ensured that staff inputting data are aware of what a PAAP is. Developed of updated PAAP in progress but awaiting national transformation work Training ongoing for both nursing and medical staff regarding PAAPS. Target date extended to allow for completion. • Systemic steroids should be given within one hour of arrival in hospital. At FGH although 76% received steroids, only 29% of those patients received them within the hour. At RLI 96% received steroids,

		only 24% received them within the hour. Most of those patients presented initially in ED. This appeared to delay the prescribing of systemic steroids and quite often not given until attending the ward. Cross Bay training required for medical staff, both in ED and on the ward about the shortcut and the BTS/SIGN guidance and the evidence why they should be prescribed steroids within the hour. We have introduced the use of dexamethasone over prednisolone which should help with administration issues as more tolerable and updated the ED nurses that have attend Paediatric Update Day (PUD) but not medical staffing due to COVID restrictions. • Parent/carers tobacco dependency addressed. At FGH it was addressed 100% of the time. At RLI it appears that it was not addressed in below 50% of those that smoked. There is now an asthma discharge care bundle which is now being rolled out across both sites and records smoking dependency on discharge. Figure should improve over time (2021) although I also suspect that staff imputing audit data may have missed the need to also tick a second box in the discharge section of NACAP. Training required to those submitting data to ensure they tick a second box in the discharge section of NACAP. The team will ensure that the doctors are aware of the tick box and PAAP when she goes through the audit with them.
10.	National Diabetes Audit: Adolescent and Young Adult Type 1 Diabetes	• Reduction in uptake of retinal screening. Highlight at annual review appointment when last screening took place and discuss importance of screening. This is now standard practice. • Reduced uptake of retinal screening. Review screening data before clinics to highlight people in clinic and at team meetings to support emphasis on this over audit year 2022/23. Reviews have taken place regularly throughout the year. Multi-Disciplinary Team coordinator sending intermittent reminders of all outstanding patients who are overdue screening. • Low rates of dietitian appointments being taken up. Note this relates in part to only face to face reviews being allowed to count and the team having reduced dietetic time over this audit period. Dietitian to attend annual review clinics to see people as part of annual review attendance. Where possible with work commitments and room availability a dietitian is attending annual review clinic. If not present then opportunity to see at next routine appointment or separate review is offered. • The improvement in Hba1c has slowed down so that local values are now higher than national levels. Access to diabetes technology has widened under new guidance. Plan to offer continuous glucose monitoring to all existing patients with type 1 diabetes and within the first month of diagnosis for all newly diagnosed patients. • Reduction in uptake of retinal screening. Create a flyer about accessing retinal screening and put into clinic letters over the next 3 months. Plan revised. Reminder sent via digibete app to all patients. Links between retinopathy screening and diabetes team strengthened so that all failed attendances or failure to respond to invites are shared with diabetes team coordinator. Resources targeted at this group of patients who now all receive an email from the team and are highlighted to the clinical team for discussion at next appointment. • Reduction in take up of retinal screening. Education post on digibete app to remind families of importance.
11.	Management of Heart Attack: Summary report (MINAP)	• To remind staff, cases not going to critical coronary care unit (CCCU) are entered onto the database. • Staff to ensure more MI's go to CCCU at FGH and direct to Coronary Care Unit at RLI. • To ensure contra-indications to specific therapy are documented
12.	National Heart Failure Audit: 2022 Summary report	• To share heart failure plan on a page to all staff. • To develop a cardiac rehab programme for heart failure patients. • To remind staff that heart failure patients should be seen by a heart failure specialist, ideally heart failure specialist nurse.

13.	National Audit of Cardiac Rhythm Management Summary report	• To consider the introduction of digital device management system. • To remind staff to ensure database indications for devices are accurate. • To remind staff to ensure device complication/ reintervention rates are logged.
14.	National Audit of Breast Cancer in Older Patients: 2022 annual report	• No actions needed. High assurance given. • To continue management of patients as per National Institute for Health and Care Excellence (NICE) and local treatment guidelines.
15.	Royal College of Emergency Medicine Pain In Children RLI	• To circulate an email to all RLI ED staff to highlight the below: • Initial assessment of pain in children within 15 minutes of arrival in A&E, using age appropriate screening tool. • Provision of analgesia in children with moderate to severe pain, within 30 minutes. • Reassessment with documentation of pain score at 60 minutes. • Consider 2nd. dose of analgesia if required, after re-assessment and document. • To liaise with I.T to find out the possibility of creating a 1-10 scale or age-appropriate scale for pain score rating, during initial and re-assessment, to be included on nursing pathway documentation
16.	National Lung Cancer Audit	• To establish how many of our patients within the following parameters 'performance status 0-2 patients with Stage I/II disease' go on to have curative intent treatments • To continue to ensure data completeness
17.	National Asthma RLI	• Inform and discuss Asthma National Audit and COPD Audit requirements with ED staff • Plan teaching with ED staff
18.	Royal College of Emergency Medicine Infection Control RLI	• Discuss at doctor and nurses' hand-over - Improvement efforts should consider reducing the time taken to isolate patients that are confirmed or, suspected to be infectious. Ask senior nurse staff to monitor • Email all ED staff about Infection control Recommendations and recordkeeping (Doctors and nurses) • To print the list of Clinically extremely vulnerable people may include the following people and put it in triage room
19.	Royal College of Emergency Medicine Fractured Neck of Femur RLI	• To email audit findings to all ED staff • To discuss lack of anaesthetic documentation on Lorenzo with all ED staff during morning handover

Local clinical audit is important in measuring and benchmarking clinical practice against agreed markers of good professional practice stimulating changes to improve practice and re-audit to determine that service improvements have been made.

The reports of 119 local clinical audits were reviewed by the provider in 2022/23 and University Hospitals NHS Foundation Trust has taken and intends to take the following actions to improve the quality of healthcare provided:

No.	Local Clinical Audits	Details of actions taken to improve the quality of local services and the outcomes of care
1.	A review of Mitomycin C instillation in patients undergoing Trans Urethral Resection of Bladder Tumour (TURBT)	• To increase training (in person training) among rotating cohort of staff (FY1's) regarding Mitomycin C administration.
2.	NICE - Oxygen prescribing on Inpatient admission at FGH and RLI Trauma and Orthopaedic Department	• To discuss with the Clinical Director the quality improvement project to be implemented in Lorenzo and the re-audit.

3.	Assessment of revision arthroplasty surgery in hip and knee joints: A local audit	• Increasing aseptic loosening rates in arthroplasty would require annual monitoring of arthroplasty cases to review revision rates in line with Getting it Right First Time (GIRFT) guidance.
4.	Re-admission rates for RLI within 28 days of discharge	• Readmission rate is around 6.5% which is close to audit standards (6.3%). No further action required.
5.	Re-Audit Audiogram	• To feedback to the team at the next Cross Bay Meeting No further action required at this stage. • Continue to monitor on a yearly basis to ensure our work is still complying with British Standards Association standards.
6.	NICE Hyponatremia - Early Identification, Appropriate Treatment and Outcome at RLI	• Clear documentation. • Changes in the trust policy. • Teaching sessions for Junior doctors. Emphasis on lab alerts. Lab alerts are in full use and has been since the issue was raised as clinical risk. Verbally discussed and implemented. • Poster Regarding Hyponatremia.
7.	Re-audit of trust Venous thromboembolism (VTE)	• To increase Venous thromboembolism (VTE) compliance on the wards that have the poorest performance. • Bulletin to all staff with compliance percentages by ward monthly. Bulletin provided through VTE Steering Group using Trust data through BI analytics. • Need better use of patient education aids. Encourage staff to provide VTE leaflet booklets to new inpatients. VTE Steering Group & Ward VTE Champions to monitor. • Need sharing of VTE data more widely amongst doctors. Regular review of clinical indicators. Monthly bulletin. Monitored by Junior Doctors and Ward Managers and presented at each VTE audit meeting. • Junior doctor VTE champions to lead next VTE audit with leads.
8.	Audit of Orthodontic Record Keeping Standards (2021-2022)	• Re-Audit • Modify Orthodontic Treatment Template to provide prompt to record basic periodontal examination for each encounter. • Presentation at Departmental Audit Meeting.
9.	Re-audit of smoking cessation in pregnancy	• NHS Long Term Plan? UHMBT has been identified as the next trust to receive funding to initiate a maternity led approach recommended by the NHS Long Term Plan. Implementation of maternity led smoking cessation service. • Documentation and data collection issues Implementation of badger net. • No co-monitoring stopped during COVID 19 pandemic. CO monitoring to be reintroduced? A new standard operating procedure (SOP is currently going through the procedural document group for the reintroduction of CO screening in line with manufacturer recommendations. SOP published in 2021 • Share findings. Present at Obstetrics & Gynaecology Audit. • Training Learning Management System (LMS) wide training commenced.
10.	Royal Colleges - Re-audit of Laparoscopic Hysterectomies X-bay	• Liaison with the anaesthetic team to create enhanced recovery pathway that helps improve postoperative pain score, improve recovery, and reduce postoperative stay time. • Dissemination of Audit results to staff to ensure early trial without catheter (TWOC) and optimum pain management. Flag this up to Dr starting in August and email Ward 16 manager to update staff.
11.	Re-audit to Assess Compliance with the 2017 Public Health England “Screening Women with Breast Implant” Guidelines	• No actions required as 100% compliant.

12.	Audit of correct application and accuracy of 'Red Dot' Commenting / Preliminary Clinical Evaluation (PCE) by Radiographers when assessing trauma MSK radiographs	• Lack of comments and arrows. Determine why the use of the comments and picture archiving computerised system (PACS) arrows is low. A questionnaire to staff would be appropriate.
13.	Survey - COVID risk with elective orthopaedic surgery	• Baseline Audit, no action plan required.
14.	CQC - Deprivation of Liberty (DoLS) Quarter 3	• Assurance compliance continues. Continue to monitor compliance throughout in the form of quarterly audits on the forward audit plan. Q4 Audit registered. • CQC notifications not being completed. CQC Notifications to be completed for the outcome of every deprivation of liberty safeguards (DoLS) application on step down. Access to the CQC portal allows for timely submission of notifications. • Assurance of any missed DoLS application where a PSI has not been submitted. Weekly Lorenzo report to be ran to pick up any DoLS created on Lorenzo and cross checked against spreadsheet to ensure all have been picked up and processed.
15.	NICE Prescribing and monitoring of direct oral anticoagulants (DOACs) indicated for Non-Valvular Atrial Fibrillation (NVAF)	• To share findings with Junior doctors at educational teaching session. Findings from the audit have been built into the new anticoagulants teaching session for the FY1 as part of the pharmacy dept. education programme. • To arrange direct oral anticoagulants (DOAC) refreshed training for pharmacists about the need to use of creatinine clearance (C+G) to estimate renal function, risks of underdosing & main contraindications. Information was presented to pharmacists as part of case study presentation
16.	Assess the utility of Epworth Sleepiness Scale (ESS) and STOP-Bang questionnaires for diagnosis Obstructive Sleep Apnoea (OSA) in adults	• Re-audit registered
17.	Re-audit of use of Gentamicin in Urology Procedures at FGH	• Correct dose of perioperative gentamicin for urology surgical patients. To email urology surgeons to give a reminder about the correct dose of perioperative gentamicin for urology surgical patients and also ensure that the anaesthetist is reminded at team brief to administer dose based on height of patient. • To ensure a guide chart regarding correct gentamycin dosage is placed in theatre 7, FGH.
18.	NICE - Re-audit Primary postpartum haemorrhage >1500mls (PPH) NICE CG190/4	• Improve IV access and blood sampling when appropriate Further improvement in activation of major obstetric haemorrhage (MOH) protocol. Need to improve documentation of management details and people involved. Since introduction of Badgernet it will be helpful for improvement in documentation, identifying incidents and analysing data. Regular postpartum haemorrhage (PPH) drills are ongoing and also new staff members are being informed to be aware of PPH management guidelines, participate in drills and complete documentation appropriately.
19.	Re audit - Paediatric MRI with DWI sequence following inconclusive USS abdomen for appendicitis	• The accuracy of diagnosing appendicitis improved with the addition of the Diffusion weighted imaging (DWI) sequence and agreed with the published literature. The measurement of the apparent diffusion coefficient (ADC) value in attempting to differentiate simple from complicated appendicitis is promising and would benefit from a larger perspective study.

20.	Royal Colleges of the Physicians (RCP) & NICE Withdrawal of treatment for patients in ITU	• To hold a team meeting to inform staff of the documentation requirements involved in withdrawal of treatment discussions.
21.	Royal Colleges - Audit of Chest X-rays in the Paediatrics Department in Royal Lancaster Infirmary	• All actions were complete through the presentation of teaching of the audit in the teaching section. • Re-Audit following the presentation at teaching session are planned to go forward.
22.	NHS England - Saving Babies Lives V2 - Premature Birth Risk Assessments	• Audit demonstrated at Obstetric meeting regarding required standard of antenatal booking care assessments to comply with Saving Babies Lives Care Bundle V2 - No action required.
23.	Re-audit Trust VTE Audit	• VTE tick box on quick note. • Repeat VTE re-audit in 6 months. • To promote VTE assessment within 24 hours of admission and post-take consultant/SAS doctor led ward round. • VTE awareness month in January. To organise a series of teaching and presentation events in collaboration with the audit department to increase awareness of VTE, promote verbal and written leaflets to be given to patients which can be done by nurses and doctors.
24.	NICE - Placental Growth Factor Testing (PLGF)	• Alert acknowledgement on Lorenzo regarding Placental Growth Factor Testing (PLGF) repeated in 2weeks. • Tick box or mandatory box to check patient is 20-36+6wks on requesting PLGF • Check PLGF guideline appendix on Day Assessment Unit and Delivery Unit. See attached email confirming completion. • To remind staff about not repeating PLGF unless with consultant advice within 2 weeks via 3-minute brief and between doctors and to disseminate it during Day Assessment Unit (DAU) meeting.
25.	Maternity Safer Sleeping	• Discussion of safer sleep in the antenatal and postnatal period not 100% compliant. Continue to build upon work already done around safer sleep guidance through supervision and mandatory training. Action followed through continuous training and supervision of all staff in WACS. • Staff questionnaire to be created to look at existing knowledge and barriers to discussing safer sleep with service users.
26.	Deprivation of Liberty (DoLS) - Quarter 4	• Access to CQC portal now allows for timely submission of notifications. • Q4 Audit registered
27.	Antenatal care for uncomplicated pregnancies: NICE CG62	• Staff education needed regarding when to measure Symphysis fundal height (SFH). SFH measuring to be added to ed. Bus. Plus, part of routine training annually now for all midwives. • Small for gestational age (SGA) detection guideline needs amendment to clarify when to measure. Guideline for amendment. • Guidelines amended and launched.
28.	Partial Mammography Audit	• Further Ionising Radiation Medical Exposure regulations (IRMER) training - To ensure 50% or more of the breast is imaged to justify exposures under IRMER guidance. • Further training for breast screening staff - To ensure only recorded images as partials if NHS Breast screening programme (NHSBSP) positioning standards cannot be met due to Wheelchair uses, medical devices, chronic health conditions. • To improve documentation of partial reasoning on National Breast Screening Service (NBSS) or picture archiving computerised system (PACA) for future audits. • To review mammographers practice for the recording of breast screening patients with medical devices such as Hickman line.
29.	Re-audit Fluid Balance Chart Audit	• Request and response from Acute Kidney Injury (AKI) lead. Discuss response with Head of Midwifery (HOM) and Matrons. • Discuss the calculation of the fluid balance charts.

		• Share Audit findings at Matrons Catch up meeting. Shared at Maternity & Governance sip rep meeting
30.	Audit of UHMBT Yellow Card Reporting	• No actions required. • Registration Only. Conducted by external agency Medicines and Healthcare products Regulatory Agency (MHRA) and reviewed annually and reported internally to Medicine Safety Group.
31.	Upper Limb Trauma Service Evaluation Re-Audit (Comparison with Audit last year)	• No actions required. • Findings were satisfactory and comparable to last audit. Acceptable waiting times for Surgery. Reduced waiting times for referred patients to Upper limb consultants. Continue current practice of referral and management of upper limb trauma.
32.	VTE risk assessments in patients with lower limb immobilisation in the urgent treatment centre	• Educate clinicians on the requirement to complete the VTE risk assessment and that walking boot and plaster application, regardless of clinical diagnosis. Education delivered during presentation. • Encourage compliance through posters and ongoing education.
33.	Quality improvement on Coagulation profile requests sent from the Emergency department.	• To present audit findings at band 6 nursing meeting • Obtain feedback from staff on different indication for sending a coagulation profile via staff survey. • Obtain feedback from staff on the different strategies to improve coagulation profile requests via staff survey. • To present audit findings in junior teaching session. • Print off audit standards to display in Emergency Department (ED) triage. Posters displayed in various areas in ED
34.	Re-audit CTG (Cardiotocography) record keeping	• Devise proforma to include intermittent auscultation. • To ensure the trust have adequate supplies of brown envelopes to facilitate the correct storage of Cardiotocography (CTGs) • Target work regarding hourly fresh eyes.
35.	Audit of Family History referral patterns	• Family History Questionnaires are sent to patients by post, prior to COVID when the clinic was held Face to Face the patient returned them at the time of the appointment, and these were then scanned onto Lorenzo following the appointment to form part of the Electronic Patient Record (EPR). Since COVID in line with the Regional Genetics Service the appointments were held by Telephone and whilst questionnaires are still sent being sent to patients as a tool, they are generally retained by patients and used to aid their appointment discussion. These are not available to scan but are used as a tool from the patient perspective, so therefore we do not have evidence that patients completed these questionnaires. Put a plan in place with the Clinical Service Manager (CSM) that with administrative hours, the breast co-ordinator will be a central point of contact for patients to return the family history questionnaire by post or email and will then scan onto Lorenzo.
36.	Audit of Coronectomy Procedures in the Maxillofacial Department	• To share findings at departmental audit meeting to advise clinicians to fully document any discussions with patient if treatment is outside of Royal College Surgeon (RCS) guideline recommendations.
37.	Patient & medical staff awareness of Alendronic Acid side effects, the way of taking Alendronic Acid and contraindications FGH	• No actions required – baseline audit (survey)
38.	Early SARS-2 COVID antibody testing upon admission FGH	• To create a poster regarding early Sars COVID antibody testing which will be available for front line staff. • To provide a teaching session to relevant clinicians regarding early Sars COVID antibody testing.
39.	Pelvic fracture cases which received advice from the Wrightington pelvic team within 72 hours of presentation	• To highlight audit results to the orthopaedic clinic lead.

40.	Re-audit Imaging of nasogastric tubes (NG)	• Radiographer image interpretation has decreased by 20%. Continue to provide new radiographers with full nasogastric tubes (NG) tube training. See attached email regarding progress of training. • Adjustment of images in terms of exposure and centring to visualise the tip of the NG tube has seen a slight drop. Provide follow up refresher training on NG image interpretation for all existing radiographers, whilst waiting for a national Training Management System (TMS) training package. • The application of arrows indicating the tip of the NG tube and radiographer comments have decreased. Regular reminders and attaching visual prompts to NG requests to improve image interpretation.
41.	Audit of Orthodontic Record Keeping Standards (2nd Cycle)	• Presentation at departmental audit meeting.
42.	Re-audit Sepsis Audit - use of screening tool following the Sepsis Guidance Review	• Liaise with ED design authority to make Lorenzo alert for patients screened red flag sepsis. • Sepsis to be discussed at each ED handover at least once a week for the next 2 months. • Email to be sent to all RLI ED staff to remind them to complete sepsis screening tools for all patients who are showing signs of sepsis on admission.
43.	Re-audit of Smoking Cessation in Pregnancy	• CO monitoring at each antenatal contact. Maternity managers and matrons to increase communication and attendance at community midwives' meetings. Maternity Support Workers to be Issued CO monitors. 3 Minute Brief Link: • Roll out NHS Long Term Plan? Term Plan maternity led smoking cessation service. Implement the UHMBT business case. 27th June 22 referrals to the new maternity led smoking cessation service now being received. • Improve documentation within the EPR system for effective data collection and reporting. Increase communication about the use of the smoking in pregnancy field. • Reintroduction of CO monitoring. Maternity managers to check records for CO monitoring at booking in the first instance and email midwives who are not completing this directly.
44.	The management of acute Cholecystitis during the COVID-19 pandemic: The CHOLECOVID audit	• No actions required. • CHOLECOVID provides a unique overview of the treatment of patients with cholecystitis across the globe during the first months of the SARS-CoV-2 pandemic. It highlights the need for system resilience in retention of elective surgical activity. Cholecystectomy was associated with a low risk of mortality and deferral of treatment results in an increase in avoidable morbidity that represents the non COVID cost of this pandemic. Overall, there was a slight increase in mortality during pandemic period, however there was no excess mortality from respiratory complications post operatively. There was also no increase in bile leaks or bile duct injuries during the COVID observation period.
45.	Re-audit Post-Menopausal Clinic Audit (Department: Gynaecology OPD RLI)	• Review the performance by re-auditing. New Audit commenced. Audit registered on Ulysses. • 87% women had USS only instead of 100% target. Email Head of Sonography if any scan training support could be provided to clinicians. There was no consensus on need for further sonography support or scan list support with Post-Menopausal Bleeding (PMB) Clinic. • 44% of thin endometrium women had endometrial biopsy which may not be needed in many women. Circulate findings to relevant team members through audit presentation. Audit Presented.
46.	Re-audit Management of lichen sclerosis	• Ensure all staff aware of treatment flow chart. Disseminate flowchart to all O&G doctors. flow chart in guideline now therefore available to all -

		• Ensure appropriate British Association of Dermatologists (BAD) leaflet is available in Gynae OPD across bay. Ensure this is available or patient tis linked to this.
47.	Re-audit of Induction of Labour: NICE CG70.	• Prostaglandin being administered prior to prescribing. Midwives not to give prostaglandin prior to administration - monthly monitoring of this to ensure 100% compliance within 3 months.
48.	Modified Obstetric Early Warning System (MOEWS) assessment of women attending WGH for intrapartum and postnatal care	• Recommend closure after presenting as compliance standard. Met and these criteria will be reviewed in other audits.
49.	Trust VTE Audit in A&E	• To reaudit in 6 months. To register a re-audit in 6 months after VTE awareness month • To increase awareness of VTE risk among patients with lower-limb immobilisation. Through VTE awareness month, encouraging staff to complete VTE assessment for all patients with lower-limb immobilisation, giving them flyers and appropriate prescription.
50.	Re-Audit on Call Medical Handover AMU FGH	• FGH Acute Medical Unit (AMU) team continuously reminding the on-call team regularly on completing the handover sheet adequately. Discussed regularly at morning handovers.
51.	Quality of Death Summaries and Sudden Death Reports in Urology at UHMBT	• To remind responsible doctors' death summaries should be completed within 48 hours of death. • Submit a template for how death summaries should be done to bereavement office. • Bereavement clinical nurse specialist (CNS) nurse to add importance of quality of death summaries in presentations.
52.	Audit of prostate biopsy reporting X-Bay	• Feedback to Urology Clinical Reference Group (CRG) with a view to ending routine Network pathology review of prostate core biopsies (and bladder cancer biopsies/TURs). Discussed at urology CRG meeting and agreed routine Network pathology review no longer required. • Feedback to urology team regarding prevalence of Functional magnetic stimulation (FMS) in cores. Actioned at urology MDM, anecdotally there has been significant improvement. • Feedback to urology team regarding use of limited biopsies in clinically malignant prostates, do they need to develop a protocol? • Repeat this audit in 1 to 2 years
53.	Audit of Referrals for Neonates with an identified Murmur to Specialist Cardiology Services	• Innocent murmurs can go to registrar clinic instead of specialist. To draw up new algorithm for referrals of murmurs to reduce referrals to specialist clinic
54.	Re-audit Labour risk assessments / intrapartum care	• Stall in audit - various factors - COVID / National submissions therefore request from Head of Midwifery (HOM) for current sprint audit. Register Sprint Audit. • Record keeping exemplars to be in clinical areas to include the use of management plans. • Discussed this audit with HOM and matrons at the M&G Catch up meeting today given the age of the audit plan to complete a sprint audit of the Lorenzo risk assessments. Findings to be shared through audit on a page with all staff.
55.	Maternity Icon	• Discussion of ICON in the postnatal period not currently 100% compliant. Embed ICON discussion in new maternity electronic system (Badgernet) as routine via safeguarding updates, supervision and mandatory Level 3 safeguarding training. There will be specific areas in both antenatal and postnatal records on Badgernet. ICON is now well established as a discussion point within the discharge process postnatally. A video is available for all patients to watch prior to discharge from the maternity unit. ICON discussion also now forms

		part of the "transfer of care smart form" when a baby is discharged from hospital. This should be completed for all babies. • ICON training has been delivered in the Mandatory training Day 2 for all maternity colleagues. The 21/22 programme is now complete so the training will have reached the majority of the maternity workforce. • Discussion of ICON forms part of every response to a referral to maternity safeguarding provided by the safeguarding midwife and Named Midwife for Safeguarding. The safeguarding midwife and Named Midwife are satisfied this action is complete and any improvements due to this will be reflected in the re-audit • Discussion of ICON in the postnatal period not currently 100% compliant. Re-audit by same standard in 12 months' time to review progress.
56.	Usage of Sticky Labels during consenting of Total Hip (THR) and Total Knee Replacements the last 100 cases	• Use of the labels for Total Hip Replacement (THR) in trauma cases. During presentation encourage clinicians to use the labels for THR in trauma cases. Re-audit in September to determine improvements. • To improve the availability of hemiarthroplasty sticker availability in trauma office. In Trauma room labels will be to be stored in the special Coloured folder, so everybody will know where to find stickers for the specific operative intervention.
57.	Rapid Access Chest Pain Clinic Audit	• To arrange education sessions for medical staff regarding current national guidelines for chest pain. • To explore ways to try and streamline requests and increase capacity for Computed Tomography Cardiac Angiography (CTCA).
58.	Consent in ophthalmology	• Overall high compliance, slight improvement on last year's audit. No need to re-audit. • E-consent form being launched by the Trust which will be prepopulated for name and designation for consultant and will eliminate almost all other problems like eligible handwriting, secretary details, etc. Out of the hands of the auditors now, once e consent form is launched compliance should be higher again.
59.	Information sharing for women wishing to labour and birth in a birthing pool	• Launch of digital maternity note system and need to document advice given to women prior to entering pool. Work with IT Midwife to ensure sticker information is available on Badgernet. Awaiting addition of further boxes to Badgernet by software developer. • Work with unit leads to ensure stickers available and all staff aware of need to use? All staff on 3 sites updated and aware of stickers in each pool room. • Need to update action plan for incident 220644 following completion of audit. Update clinical incident report on Ulysses? incident update with audit findings by AA Governance lead. 220644 incident updates. • Poor compliance to guideline due to lack of staff knowledge. Relaunch Guideline cross bay via 3 min brief and audit on page - info sharing poster displayed in all 3 Birth areas for staff to be made aware of need to use stickers • Ensure senior team are aware of audit findings. Verbally feedback findings to Senior Management Team at M&G Meeting? Action plan agreed and guideline relaunch agreed. Item to be added to education bus for Dec 2021. • Information sharing of audit findings. Feedback to update Ulysses regarding clinical incident and Healthcare Safety Investigation Branch (HSIB) recommendations.
60.	Re-Audit Real Ear Measurements	• No further action recommended; the standard required is being met. These results will be brought up in the next staff gathering across bay. In 1 years', time it will be worth repeating the audit to ensure this standard is being maintained.
61.	Head and neck 2 week wait referrals	• Information is already monitored within the Care Group so no action required.
62.	Compliance with DoH and GMC guidance on following the correct procedure for obtaining	• Presentation to Clinical Leads for consideration of training needs within individual departments. • To explore the possibility of updating consent documentation by means of electronic consent form to reflect best practice for decision-

	consent for surgical procedures in patients who lack mental capacity	making for patients who lack capacity. Discussed with IT and now sits with them until it can be rolled out. • Poor compliance. Advise to undertake a further audit needed. • Share audit with Safeguarding teams for comment.
63.	Baseline Audit of Safeguarding – Supervision (performance survey)	• There was a low number of responses to the Safeguarding Supervision audit, only 39 people responded. It was noted that over half of those who responded were Midwives. - The reason for this is that the Safeguarding Midwife ensured she directed the midwives to this audit at every opportunity. This audit will be repeated in 12 months' time. Safeguarding supervision training is being rolled out. It is hoped that the outcome of the next audit will reflect in the next audit results. The results of this audit will be fed back and shared with Supervisor so they can discuss in their sessions and develop a plan of action to address some of the issues.
64.	Re-audit Termination of Pregnancy	• Communicate to GPs re referral method • Revise Lorenzo documentation to allow data extraction. Form made by IT and ready to go live as soon as seen by FGH. • Improve referral to appointment time by centralising appointments - to look at feasibility. • Re-audit annually but include complications/readmission audit. To re-audit once new guideline is up and running. • Improve contraception service offered. Investigations into providing coil insertions at local GP practice proved too expensive per patient so therefore continuing with current service. Link have been made with local sexual health consultant and difficult cases are to be referred directly to her.
65.	Postnatal Care - up to 8 weeks of birth CG37 2006	• Cascade findings by 5 ways of communication. Cascade findings to unit leads via 3 min brief, AAA and poster. • Guideline requires clarification. Meet to assess where the bladder care guideline is in relation to loss of sensation and highlight need for clarity. Amendment. • Plan needed regarding re-audit time scale. Discuss timing of next post-natal (PN) audit with Audit leads in relation to Forward Audit Planning.
66.	Departmental antibiotic use following emergency cholecystectomy	• To advise in the Audit presentation to use the Modified Tokyo classification to grade emergency Acute calculus cholecystitis. Discussed and mentioned in the Audit and agreed upon. • To advise clinicians in the Audit presentation to use to new operative note proforma containing the classification guide called "Laparoscopic cholecystectomy Tokyo Classification" in Lorenzo. • To advise clinicians in the Audit presentation to decide need for post-operative antibiotics based on the Modified Tokyo classification in the operative note.
67.	Surgical Site Infection (SSI) in Maternity	• Improve coding for Surgical Site Infection (SSI) by completing proforma on Badgernet. • Use of different types of dressings with no good evidence to suggest that it would reduce risk of infections. Leukomed was recommended by NICE. Improve training of use of dressings by organising a course. • Improve the education on post caesarean section (CS) dressings.
68.	Thyroid Fine needle aspiration cytolog (FNAC) reporting with histological correlation	• Ensure extra-departmental pathologist include THY category by providing an SOP for reporting. Reporting SOP updated to include Thyroid categories. • e-audit April 2023. Planning to Re-audit April 2023.
69.	Acute Kidney Injury (AKI) Patients in Acute Medical Unit FGH	• To deliver a teaching session to FY1 staff about Acute Kidney Injury (AKI) in medical practice. Teaching given to junior and senior staff. • To update the Junior staff during the post- take ward round about the importance Acute Kidney Injury (AKI) and fluid balance chart. • To send a reminder email to the medical consultant team about importance of fluid balance chart.
70.	KEOGH Ward Round Re-audit	• Allow time for documentation or completing checklist during ward round. Documentation is now facilitated by mobile Laptops available in the wards and documentation can be made in time.

		• Make KEOGH rota accessible. The KEOGH rota is made accessible to the KEOGH team's members. • Create a ward round checklist on Lorenzo. Ward round check list is now created on Lorenzo (ward round note). • At least 1 member of ward round team (WR) should attend MDT Board round. To ensure at least 1 member of WR team should attended MDT Board round. Already completed as the Re-audit found that more than one member of the team is involved in the board round.
71.	Care of Newborn (including identification of Newborn)	• Documentation processes have either changed or changing to use new EPR system. Review improvements within Badgernet EPR. One to one session with Badger net clever med representative, excellent comprehensive system available for the recording and documentation for new-borns. All women will be completely on the badger net system from the beginning of April. • Share learning via 3-minute brief. • Share audit findings. • Share as an audit on a page.
72.	Re-audit Obstetric Cholestasis	• Amend trust guideline to reflect current RCOG guidance. • Arrange teaching session on obstetric cholestasis for junior doctors. • Coagulation screen, Cardiotocography (CTG) in labour, and postnatal liver function tests (LFTs) not being performed as required by RCOG. Highlight the importance of clotting on admission, CTG in labour and postnatal LFTs in 3 Minute Brief.
73.	Anaesthetic chart documentation re-audit	• Information is already available within the care group. No action required.
74.	Postoperative ileus after elective colorectal surgery	• To advise to increase Epidural use over patient control anaesthetic (PCAs) to decrease risk of post-operative ileus (POI). Clinicians advised at presentation to increase Epidural use over PCA's to decrease risk of POI.
75.	Trans perineal Biopsies of Prostate	• To advise that each clinician undertaking biopsies should regularly present their own findings to improve practice. • Offer biopsies under GA if younger patients and small prostate to reduce FMS especially if there is concern that they may not be able to tolerate procedure well.
76.	Excisions of Basal Cell Carcinoma	• To ensure job plans allow 1 Oculoplastic surgeon to represent this. Subspeciality at Skin MDT meeting, for those particular patients which are to be discussed there at least. To liaise with service manager to ensure job plans allow 1 Oculoplastic surgeon to represent this Subspeciality at Skin MDT meeting, for those particular patients which are to be discussed there at least. • To advise clinicians at presentation to ensure 3.5mm margin, 4mm at medial canthus to make extra sure of full removal. To advise clinicians at presentation to ensure 3.5mm margin, 4mm at medial canthus to make extra sure of full removal. • To advise clinicians during presentation to document function and cosmesis.
77.	Re-audit Maternal Sepsis and pyrexia in labour. NG51	• New end to end system now in place for patient records. Re-audit to ensure use of sepsis tool in Badgernet is embedded. • Golden hours of sepsis not being met. Prompt staff regarding going hours of sepsis care. • staff need to be aware and use sepsis toll in Badgernet ensure all staff are aware of need to use Badgernet sepsis tool to ensure correct coding and capture of sepsis patients. • Unable to gain a list of women with sepsis in pregnancy via coding team. Escalated issue regarding coding issues to Sepsis lead nurse, audit team and coding teams. Digital midwife also aware of issues and has offered advice regarding resolution - sepsis coding process in place with follow up if coding uncertain.
78.	Audit of Effectiveness of the Daily Triage of Incidents Process and	• Processes had changed in Incident Management. Policy update required to ensure that it accurately reflects new processes.

	its Compliance with the Trust's Reporting and Management of Incidents including Serious Incidents Procedure.	
79.	Exotropia Audit	• Results comparable to or may be better than the published studies no further actions needed.
80.	Audit of Orthodontic Clinical Photographs - Intraoral	• No immediate actions. To re-audit in 12 months' time
81.	Assessing SSNAP Parameters of Thrombolysis Patients Admitted in Acute Stroke Unit RLI	• To increase stroke consultant cover. Stroke consultant cover increased from 2 to 4. • Highlight stroke pathway to all ED staff.
82.	Post-operative Infection in Orthopaedics Re-audit	• No actions needed. Improvement from last year's audit of 1.28% to 0.79%. Also meeting national standard of 2.1%
83.	Prevention of Infection in the Newborn	• Findings to be presented to perinatal meeting.
84.	Peri-operative Management of Anticoagulation in Urology Patients (Bridging Guidelines)	• Pre-operative assessment (POA) only identify comorbidities of a patient and do not clearly document whether the patient is high risk/low risk etc. Consider the possibility of POA documenting in Lorenzo whether high risk/ low risk etc. • Consider whether a separate Urology specific SOP is required. New anticoagulation management SOP created.
85.	Re-Audit of Quantity of Bone Cement in Total Knee Arthroplasty	• No actions required. • In Press Fit Condylar (PFC) knee replacements up to size 3could be managed with 40 gm cement. Size 6 and above need 80 gm, while size 4and 5 needs 60 gm cement. There is improvement in sticking on to this guideline compared to the previous audit. However, we would like to emphasize that we do not recommend compromising surgery. No further action plan is required now
86.	Re-audit Perineal Trauma 3/4th Degree Tears	• Improve documentation of perineal tear repair steps, post-operative instructions and debrief by standardising to method of documentation. Badgernet being introduced to ensure appropriate electronic documentation. • Ensure written consent. QIP done already by Dr Krishna regarding consent forms for 3rd & 4th perineal tear. New stickers being introduced. Message shared with the team in the Audit meeting. • Improve debrief, provide patient information leaflets, improve incident reporting, improve physio and GOPD referral, improve repair in theatre. To share findings with team in the Audit meeting.
87.	Spine patient admissions from A&E under Trauma &Orthopaedic care	• Improve the communication. To discuss and agree within the team that suspected Cauda Equina patients should be discussed with Preston specialty registrar (SpR) for immediate transfer plan. Agreed at orthopaedic audit meeting that urgent call with Preston SpR is needed to arrange transfer. • Arrange an urgent MRI for patients presenting with the 3 classical features of Cauda Equina. To discuss and agree that for suspected Cauda Equina cases a full clinical examination should be carried out and documented by the ortho team for patients presenting with back pain, urinary and bowel incontinence and arrange an urgent MRI
88.	Re- audit Medical and Midwifery Record Keeping including Prescription Charts	• Some staff have an ineffectual pin number for documenting CDs. Identify staff affected by Pin issue and cascade resolution plan. See attachments from 2 other actions for evidence of highlighting need to change on and this being disseminated to all staff. • Feedback to staff is vital to ensure practice is changed in line with Trust Guidelines. Feedback audit findings to staff highlighting documentation requirements.

		• Junior Doctors need to ensure pre-existing medications are clerked correctly. Discuss medicine clerking with Unit leads to cascade findings to Junior Doctors. Email to FGH and RLI leads regarding clerking pre-existing medications on admission sent for cascading to Junior Doctors. • CD's not being correctly signed for on Electronic Prescribing & Medication Administration (ePMA). This has been noted to be due to issues with ePMA pin numbers. Discuss issues with pin input on Lorenzo with Pharmacy ePMA lead & WACs Lead Pharmacist and formulate plan to resolve. AAA poster and 3 min brief. • Findings need to be presented at Care Group Audit meeting. Present findings at O&G Audit. Presented at O&G audit.
89.	Re-audit Obesity Audit	• Documentation for Nutritional advice and Vitamins was poor. Improve Documentation for Nutritional Advice and Vitamins in Badgernet net app by involving Karen Bridgeman. Previous information entered in error - wrong audit. • Anaesthetic referral was not clearly documented. Improve anaesthetic referral documentation on Badgernet. Information sent out via WACS Business Support Unit. • Early mobilisation was not documented clearly postnatally. Improve postnatal documentation on Badgernet. information cascaded via Woman and children's business support unit
90.	Anaesthetic management of patients with obesity	• To remind clinicians to ensure weight management strategies/smoking cessation should be included in pre-operative counselling and pre-optimisaton of obese patients.
91.	QIP Handover Process in Obs & Gynae Department FGH	• Current handover needs to be made electronic so it can be stored securely. To change the present paper handover to electronic hand-over. Badger net has a hand over sheet. All staff should be familiar with this and start using it. Electronic handover sheet available in Badgernet. • Anaesthetist does not present at all handovers. Request Anaesthetist team to attend handover. Document attendance on newly designed digital handover sheet. Anaesthetists are coming to the handover now a days • Not all staff aware of information in 3-minute brief. Three minutes brief should be informed in every handover and the staff are expected to stay even if they knew the content already. 3-minute brief circulated to all staff • RLI handover interrupting on FGH ongoing handover. RLI handover to be done either at the start of handover or at the end of handover. This is practiced now and no interruption.
92.	Is Emergency Laparotomy Best Practice Tariff (BPT) Being Achieved at FGH	• To advise clinicians that there is a system in place now with the Care of elderly team (COTE) team. Clinicians to complete a yellow referral for all relevant emergency laparotomy patients. To advise clinicians that there is a system in place now with the COTE team. Clinicians to complete a yellow referral for all relevant emergency laparotomy patients. Advised clinicians of the yellow referrals system in place to review patients who fit COTE NELA review criteria. • To encourage presence of consultant anaesthetists and admission to ITU. Discuss with anaesthetic staff and ensure awareness raised of the importance of consultant anaesthetist being in theatre and admission of high-risk patients to ITU to ensure BPT is met. Discussed with anaesthetic staff at joint anaesthetic/surgical audit meeting. • Recommend calculating the NELA score during the pre-op WHO checklist period to encourage presence of consultant anaesthetists and admission to ITU. Recommend to clinicians to calculate the NELA score during the pre-op WHO checklist period to encourage presence of consultant anaesthetists and admission to ITU.
93.	The management and registration of stents	• No actions needed, continue to add in stent register and re-audit

94.	Re-audit of Minimising radiation dose in computed tomography of kidneys, ureters and bladder (CT-KUB)	• To present findings to CT radiographers at FGH and RLI and reiterate that the upper extent of CT kidney, ureter and bladder (KUB) can be limited to the superior end plate of T10
95.	QIP to improve post-op pain relief in gynaecology abdominal surgery patients	• Length of stay higher than national average especially in open surgery. Discuss issue with gynae surgeons and interrogate data to ascertain causes for increased length of stay and present to the gynae surgeons at joint meeting. • Specific pain relief guidelines for major gynae surgery. Produce specific pain relief guidelines to add into existing guideline for major gynae surgery. Guidelines now updated and awaiting review by pain team. • Did not achieve target for laparoscopic patients. Present findings and encourage colleagues to use spinal anaesthesia for laparoscopic surgery.
96.	An audit of Day case mastectomy at UHMBT	• No actions needed. Improving day case mastectomy rate is an ongoing national agenda. • Patient education to encourage same day discharge. • Audit / study to assess conversion rate of day case mastectomy to overnight stay. • To create a dedicated day case surgery unit to improve performance with staff training to facilitate this.
97.	IR(ME)R audit to check pregnancy and breast-feeding status of Nuclear Medicine patients	• 100% compliance of standard - no action required
98.	Tranexamic Acid in Neck of Femur Fracture Surgery	• Tranexamic acid and antibiotics usage discussed at team brief for most cases where indicated. • The T&O team was made aware of the protocol of Tranexamic acid use through the audit itself. Aim to re-audit in 12 months' time.
99.	Re-audit Elective caesarean section (cs) RLI: NICE CG132	• Improve documentation of patient counselling for Vaginal Birth After Caesarean Deliver (VBAC). • Inform all stakeholders/clinicians to using VBAC proformas using 3-minute brief. • Improve Safe Active Birth (SAB) referral rates for women who had traumatic delivery and maternal request CS. • Use 3-minute brief to email and improve the awareness of referral services. • Improve Steroid discussion documentation as Guideline has now changed. Improve Steroid discussion documentation as Guideline has now changed. Not all over 37wks need Steroid, but an effective discussion with parents is of paramount. This issue has been raised with IT Midwife. Also, a 3-minute brief should be emailed with the information to raise awareness.
100	DNACPR in all patients; including a retrospective audit of patients with Learning Disability	• Poor completion of all elements of the current Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) form. To introduce the uDNACPR to the Trust and CCG Audit to be closed and actions are met through new U DNACPR electronic systems. • Poor sharing of DNACPR information with primary carers. Mandate the inclusion of DNACPR information in the discharge summary. Ensure DNACPR order is transferred between care settings on discharge. Identify the clinical rationale for DNACPR in the Lorenzo alert. 02/12/2022. • To pilot training for Junior doctors with regards to legal and ethical issues of completing DNACPR forms. • Pilot training for junior doctors that may be introduced to improve the completion and documentation of DNACPR. • The UHMBT DNACPR form can be validated by a Doctor with GMC Licence, or Registered Health Care Professional with validated competency. There is currently no training to support Registered

		Health Care Professional to evidence their competency. Introduce a Nurse/AHP competency assessment process to evidence competency to validate DNACPR forms. Introduce a Practical Course for Discussions and Decision-Making regard to DNACPR available to all staff who complete DNACPR forms. Develop a flow diagram that details the DNACPR decision making and recording process based on the Trust DNACPR policy. This action can be closed as no longer part of the action plan as currently it has been agreed at ECN that nurses as yet do not need to be competent on this skill. • Poor recording of CPR decision making discussion. Mandate that all questions on the revised DNACPR form must be answered and information recorded in the patient's ePR. Provide training for all staff who hold DNACPR discussion and complete the form. An audit of 25 patient DNACPR orders were conducted and compared to DNACPR of general population
101	Re-audit Emergency Caesarean Section (CS) FGH: NICE CG132	• Needs to improve in: vaginal preparation if history of rupture membrane before caesarean section. - cord blood sampling in all emergency C/S. - Documentation of contraception counselling and debriefing. Regularly discuss the issue during handover time, like 3 minutes briefings (staff can remind new staff). • email all staff to improve Pre-op vaginal preparation prior to Emergency CS with ROM, take cord blood samples for Cat 1-3 CS , documentation on debrief and contraception after Emergency CS • Need to improve in documentation of contraception counselling and debriefing. Junior doctors to be updated regularly about contraceptive counselling and documenting before discharging patients. Checklist included in the Junior doctor's folder on TEAMS. AAA sent to all WACS members.
102	Ptosis Outcomes	• To advise clinicians that better documentation is needed which includes full patient examination / measurement of surgical results and any patient comments. • Maintain booking of postop appointments within Oculoplastic clinic for continuity of care. We are awaiting installation of Medisoft Ophthalmic clinical care EPR, bought 6 months ago, which should improve data entry from clinical encounters. No action needed just maintain post-op appointments for continuity of care.
103	Re-audit Neonatal Resuscitation	• Audit standards not achieved. Presentation of audit findings to all staff involved. Findings presented at labour ward forum. Audit findings presented at paediatric teaching. • Inadequate documentation of interventions used at resuscitation. Education of staff involved of required documentation. Add education to induction program for new doctors commencing August/September. Documentation and training in its use was presented at new doctor's induction. • Suboptimal temperature for 17% of audited babies. Temperature management at birth is part of the antenatal optimisation toolkit and improvement strategies will be introduced as part of this initiative. Improvement strategies have now been introduced and feedback given to all staff involved. • Lack of midwives trained in neonatal life support (NLS). 12 in total have NLS compliance on TMS. Discuss with maternity team the need to increase numbers of midwives who are NLS trained. All band 7 midwives will be NLS trained. This will continue with band 6 midwives being trained next. • Optimal cord clamping time is not well documented. If immediate cord clamping is clinically necessary, the reason for this should be documented. Antenatal Optimisation toolkit work should address this issue and achieve improved compliance. Progress is ongoing as part of the Maternity and Neonatal Safety Improvement programme.
104	Routine Enquiry (RE) Domestic Violence	• On antenatal assessments "reason for not asking RE" is frequently documented as "inappropriate environment" or "partner/friend present". In community the reason RE isn't asked if often that service users are accompanied. To create a card to be used in day

		assessment units / hospital bays / when accompanied at home to ask RE safely (To include clear guidance for colleague who will use this card).
105	Re-audit Elective caesarean section FGH: NICE CG132	• There is overall improvement in compliance to standard across all areas been audited. However, there is need for improvement in the areas of documentation of MSRA swabs taken prior to elective caesarean section as well and counselling of risks and benefits of caesarean section Vs vaginal birth. Both areas recorded 94% compliance. The action plan/ recommendation from this audit to be included in the daily 3-minute brief of the week. The recommendation is as follows: All maternity and obstetric staff should please endeavour to make use of the elective C section checklist provided on badger during the antenatal period. This will help ensure compliance to audit standard. Also ensure to document every counselling/advice given during antenatal period regarding the decision for elective caesarean section.
106	Re-audit - To investigate variation in paediatric inpatient care at Furness General Hospital	• Sub optimal compliance with timely documentation on patient records when plan of management deviates from guidelines at time of change to management plan. Present findings in cross bay senior meeting.
107	NHSE/CCG Children's Safeguarding Review Audit	• CPM arrangements and documentation. To undertake an audit of Child Protection Medicals (CPM). To do dip sample of 24 CPM's for assurance and identification of inconsistency. • Think Family General Safeguarding Children and Adults - think the unthinkable Health representation at strategy meetings. Training programme for 2022/3 to incorporate identified actions. Care groups will need to sign up to this programme and commit to attendance. Training has been ongoing since April 2022 inclusive of learning from the Child safeguarding practice reviews (CSPR's), general safeguarding children, think family approach and parental vulnerabilities that may impact on children and young people. • Policy, procedures and practice guidance Implementation of Think Family Child safeguarding assessment- CPIS System/process challenges - Badgernet access- raise awareness on how to access PSI- quality and purpose. Failure to follow process Non mobile baby tool. Bruising in non-mobile/NAI Inclusion and engagement of health professionals involved Standardised information from Mental Health colleagues to be inputted onto acute records to ensure robust handover of care and understanding of MH treatment plan. Ultimately strapline required on record- to state child is fit/safe to be discharged. How are children/dependents considered when vulnerable adults attend ED? - Think Family Consider adopting the Safeguarding Adult assessment to ED Children's Policy recently revised. Named Nurse and Named Doctor to review for gaps following audit. Regular liaison between Named Nurse and Named Doctor occurring and will continue Core safeguarding business to ensure safety netting in place. Immediate and sustainable learning within care group, focus on new cohorts of staff Named Nurse for UHMBT to share with Named Nurse for Lancashire and South Cumbria NHS Foundation Trust (LSCFT) this area of findings from the audit. Regular bulletin produced by safeguarding team for dissemination with all care groups. Adult safeguarding assessment- work ongoing to roll out. Named Nurse for Safeguarding Adults to report back in 6 months' time. Implementation of Think Family Child safeguarding assessment • Record Keeping & Information Sharing, Accessibility to meeting minutes, Implications of not documenting conversations with parents. Expected practice around accountability re information sharing. Decision making. Safeguarding oversight, Demographics, Vitamin K administration, Share immediate findings of audit on KIDS Day and WACS divisional governance assurance group (DGAG) with a focus on the upcoming training strategy.

		• Achieved, ongoing work to improve as part of core business. Voice of the child what does that mean, how is recorded? How do we hear it? Lived experience. Being seen alone if appropriate- when is it appropriate? What is best practice in terms of seeing alone- does the rest of the child DG assessment inform this? Do we need to consider adults in this too? Involvement of all care givers. Achieved, ongoing work to improve as part of core business Not applicable. Recognised scope for improvement however UHMBT compliant when it comes to contractual arrangements of Section 11. Work as part of ongoing training/supervision/communications/updates via intranet will address on an ongoing basis.
108	Audit of acute care of patients living with frailty at the front door FGH	• Medical staff to ensure AMT/4AT is completed for each patient over 65 on admission. given during presentation • EDD being set on post take ward round (PTWR). • Education for ED staff re CFS. Highlighted during audit presentation that CFS training is ongoing in ED. • Frailty team to review mode of referral to ensure not missing patients.
109	Survey of Patient Experience at RLI (At least 6 months following diagnosis of primary breast cancer)	• Patient knowing who they are seeing at consultation - DTR ask admin staff to create laminated signs to by displayed on clinic doors. Written information leaflets not available at the time of clinic appointment: Breast specialist nurse to disseminate to secretarial team list of website links to be included in letters. Breast specialist e to disseminate to secretarial team list of website links to be included in letters. Breast specialist nurse to ask admin staff to create laminated signs to by displayed on clinic doors.
110	Re-audit Perineal Repair Audit	• WACs are moving onto a new EPR maternity record system therefore audit tool will need amending prior to next audit dependant on what data can be collated. Discuss mandatory field for completion for perineal repair on Badgernet. Discussion has led to all required fields being made mandatory. • Audit findings require presenting and Care Group Audit Meeting. Present findings at O&G Audit Meeting. • Staff awareness of audit findings needs to be ensured so changes in practice can occur. Cascade key messages to staff via 3 min brief and audit on a page formats. • Record keeping across bay needs improvement in relation to perineal repair and information sharing. Ensure staff are made aware of need for complete and accurate record keeping*. Record keeping exemplars already in place as part of Q&I project.
111	Audit of Intraoral Radiography	• Provide a presentation and hands on tutorial session for radiography staff to assist them in improving the quality of the radiographs they take. Presentation of findings at Departmental Audit Meeting.
112	Audit of Epidural Practice	• Audit data required not able to be taken from all databases available to Audit Midwife. Alteration of epidural proforma & Data relevance, collection methods & collection responsibilities. Audit proforma reviewed for agreement on splitting into Anaesthetic Department and Midwifery specific criteria. • Previous audit highlighted needs for epidural block testing to be added to Midwives mandatory training and this has not happened. Meeting regarding addition of epidural refresher in Midwife Mandatory Training. • Maternity moving onto new EPR based record system, therefore audit criteria will need to be amended prior to next audit. Speak with IT Midwife regarding how epidurals will be documented on Badgernet to identify what data will be collectable via EPR. • Findings to be fed back to O&G audit group. Feedback findings in O&G Audit meeting. • Practice improvements required cross bay in relation to anaesthetic documentation and practice. Feedback findings in relation to Anaesthetic practice

113	QIP - To evaluate the scan duration for MRI imaging of suspected cauda equina syndrome and positive yield	• MRI scan times significantly longer (38min vs 15-20min). Whilst the audit does support the possibility of a limited protocol for cauda equina syndrome, there is still a significant pick-up rate for pathology in cervicothoracic spine (6.4%). In the interests of patient safety, GIRFT, potential confusion for protocoling/reporting such scans without access to full sequences, a complete MRI whole spine protocol will be continued in cases of suspected cauda equina compression.
114	Re-audit Sepsis Audit - use of screening tool following the Sepsis Guidance Review Cross-Bay	• Liaise with ED design authority to make Lorenzo alert for patients screened red flag sepsis. • Sepsis to be discussed at each ED handover at least once a week for the next 2 months. • Email to be sent to all RLI ED staff to remind them to complete sepsis screening tools for all patients who are showing signs of sepsis on admission.
115	Assessment of FAST positive Stroke patients in the RLI ED (Re-Audit)	• Teaching/Learning lessons/reflection on cases at departmental teachings and at morning departmental handover • Nurse training for stroke assessment & management incorporating to Nursing teaching sessions/monthly topics (Liaising with Nursing practice educators • EPIC/Nurse In-charge/Clinician to emphasize and allocate prioritisation of CT/Imaging for FAST+/? CVA patients • Tele-stroke and NIHSS training already added to Mandatory training for ED clinicians to be refreshed on yearly basis and at Induction for new starters.
116	DVT care in SDEC RLI	• Increase awareness of our colleagues who are based in SDEC and A&E about NICE and Trust DVT management pathway via printing paper form and making it available in doctors and nursing desks • Encourage clinicians to perform and document WELLS score • Encourage clinicians to order the US within 4 hours of the suspicion or 24 hours of starting
117	Hypercalcaemia Management according to Trust guidelines RLI	• To create and display posters in all RLI medical wards to remind staff the symptoms of Hypercalcaemia and how to manage.
118	Appropriate antibiotic use in patients over 65 with suspected UTI RLI	• Raising awareness of NICE UTI guidelines through junior teaching session • To display posters in all RLI medical wards as a reminder of the best practice - NICE UTI guidelines
119	Audit of UHMBT EBUS service against NHS EBUS service specification RLI	• We now have 2 endobronchial ultrasound (EBUS) scopes in the department compared to one scope before • There are now more operators. Operators who were being trained previously are now competent to perform list. Also, additional operator time recently due to change in job plan of a senior consultant.

Participation in Clinical Research in 2022/23

Research is vital to improve the knowledge needed to develop the current and future quality of care for patients. Carrying out high quality research gives the NHS the opportunity to minimise inadequacies in healthcare and improve the treatments patients receive. The Trust is only involved with research studies that have received a favourable opinion from the Research Ethics Committee within the National Research Ethics Service (NRES), and the Health Research Authority, signifying the research projects are of high scientific quality and have been risk assessed.

The Research Department is committed to providing patients with the opportunity to participate in research if they wish. We aim to ask all eligible patients if they would like to participate in a clinical trial.

The number of patients receiving relevant health services provided or sub-contracted by the Trust in 2022/23 that were recruited during that period to participate in research approved by a research ethics committee was 875.

Currently, there are 6 open research studies. This has reduced from previous years following the closure of several studies following the peak of the COVID pandemic as well as some that have not yet re-opened. All of these are adopted on to the National Institute for Health Research (NIHR) Clinical Research Network portfolio. These studies are high quality trials that benefit from the infrastructure and support of the Clinical Research Network (CRN) in England.

The Trust has a strong team of 21 dedicated Research Nurses and 8 clinical trials support staff working generically on a variety of research studies. The Trust has strong research activity in Cancer, Anaesthetics, Respiratory, Gastrointestinal, Cardiovascular, Dermatology, Surgery, Musculoskeletal and Paediatrics, and we actively encourage more departments to get involved. There are currently 20 clinical staff acting as the Trust Lead Investigator on approved research studies, across multiple specialties. This will increase as the portfolio grows with new studies being opened.

The Trust Research Nurses work closely with the clinicians to identify suitable research studies that fit with the patient population and to identify eligible patients to participate. It is envisaged that the continued dedication and flexibility of the Research Nurses, together with the enthusiasm and support of the clinicians will further raise the profile of Research and Development in 2023/24.

2022/23 has been a period of great change for the Research and Development department, as the majority of the Coronavirus research, including Vaccine trials, came an end. In addition, we have had a period of staff turnover. However, with new senior appointments, we are optimistic for a period of stability and a great future for Trust Research and Development.

New research studies are being introduced, quality systems introduced, and processes improved. There is also renewed energy for the collaboration with Lancaster University and closer links with neighbouring Trust Research teams, nurtured by the evolution of the Integrated Care system and an impending re-configuration of the Clinical Research support network, provided by the National Institute for Health and Care Research (NIHR).

Information on the use of the Commissioning for Quality and Innovation Payment Framework (CQUIN)

The Commissioning for Quality and Innovation (CQUIN) payment framework aims to support the cultural shift towards making quality the organising principle of NHS services. It aims to ensure that local quality improvement priorities are discussed and agreed at board level within and between organisations. The CQUIN payment framework is intended to embed quality at the heart of commissioner-provider discussions by making a small proportion of provider payment conditional on locally agreed goals around quality improvement and innovation.

Commissioning for Quality and Innovation (CQUIN) Schemes in 2022/23

A proportion of University Hospitals of Morecambe Bay NHS Foundation Trust's income is normally conditional on achieving quality improvement and innovation goals agreed as part of the contract. For the Clinical Commissioning Group (CCG) / Integrated Care Board (ICB) contracts, the Trust entered into a block payments approach arrangements in 2022/23 inclusive of CQUIN and it was locally agreed that CQUIN would not constitute a variable payment.

For the NHS England contract, a small proportion (10% - approximately £17k) of CQUIN value is variable if the Trust does not report against the data requirements. There is still a requirement for the trusts who have implemented a local departure from the aligned payment and incentive rules to report the CQUIN metric data for 2022/23 (National tariff Payment System 2022/23 document).

There were a total of 13 schemes for the Trust to report on in 2022/23, 11 in the CCG/ICB contract and 2 in the NHS England Specialised Commissioning contract. The table below outlines the schemes and performance against the national targets. All CQUIN metric data for 2022/23 was reported as per the national requirements.

As part of the project management process, we have moved these into sustain and review and agreed next steps for everything.

The schemes that continue into 2023/24 all have a project team and plan in place for delivery.
Those that don't continue and were below performance target were community acquired pneumonia (CAP) and urinary tract infection (UTI):

- UTI - Pharmacy and Infection prevention team are continuing to work on this scheme, and we agreed actions and an audit in 6 months to check progress.
- CAP - contacted leads with final performance to ask how they want to progress and will agree a plan.

We are also still working with teams on Iron Treatment and Liver Tests to agree a plan to continue to roll out and sustain performance.

Scheme Title	Baseline	Q1	Q2	Q3	Q4	Cumulative	Target
CCG1 - Flu vaccinations for frontline healthcare workers – ACUTE	58%	n/a	n/a	52%	53%	52%	90%
CCG1 - Flu vaccinations for frontline healthcare workers - COMMUNITY	58%	n/a	n/a	19%	20%	19%	90%
CCG2 - Appropriate antibiotic prescribing for UTI in adults aged 16+	25%	36%	32%	41%	53%	41%	60%
CCG3 - Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions	74%	98%	94%	90%	95% (Feb)	94%	60%
CCG4 - Compliance with timed diagnostic pathways for cancer services	0%	19%	16%	32%	40% (Feb)	27%	65%
CCG5 - Treatment of community acquired pneumonia in line with BTS care bundle	3%	2%	1.6%	0%	2%	2%	70%
CCG6 - Anaemia screening and treatment for all patients undergoing elective surgery	0%	85%	80%	83%	91%	85%	60%
CCG7 - Timely communication of changes to meds to community pharmacists via discharge meds service	0%	0%	0%	0%	0%	0%	1.50%
CCG8 - Supporting patients to drink, eat and mobilise after surgery	0%	90%	88%	86%	86%	88%	70%
CCG9 - Cirrhosis and fibrosis tests for alcohol dependent parties	0%	77%	38%	61%	39%	54%	35%
CCG13 - Malnutrition screening in the community	0%	81%	81%	82%	80%	81%	70%
CCG14 - Assessment, diagnosis and treatment of lower leg wounds	0%	72%	74%	82%	50%	69%	50%
CCG15 - Assessment and documentation or pressure ulcer risk	0%	71%	50%	68%	61%	62%	60%
PSS2 - Achieving high quality Shared Decision Making (SDM) conversations in specific specialised pathways	0%	n/a	91%	n/a	93%	92%	75%
PSS5 - Waiting List (Cardiology - complex cardiac devices)	0%	n/a	100%	100%	100%	100%	98%

Commissioning for Quality and Innovation (CQUIN) Schemes in 2023/24

The National Commissioning for Quality and Innovation (CQUIN) 23/24 guidance was published in December 2022, and it outlines the delivery requirements for trusts. The CQUIN schemes focus on specific evidence-based improvements, and indicators in the schemes:

- highlight proven, standard operational delivery methods.
- support implementation of relatively simple interventions.
- form part of wider national delivery goals that already exist, thereby not adding new cost pressures.
- are explicitly supported by wider national implementation programmes.
- command stakeholder support.

A proportion of the Trust's income in 2023/24 will be conditional on achieving quality improvement and innovation goals agreed between ICB and NHS England as part of the contract agreements. The Trust is required to report on all schemes and the financial incentive will be applied to 10 out of 13 schemes.

The delivery of schemes will be via teams from across our Clinical Care Groups supported by colleagues in I3, Programme Management Office and Strategy and Business Development so that improvements are fully embedded in a sustainable way.

There are a total of 13 schemes for the Trust to report on in 2023/24, 12 in the ICB contract and 1 in the NHS England Specialised Commissioning contract, the table below outlines the schemes and national performance targets.

Scheme Title	Summary of scheme
CQUIN01 - Flu vaccinations for frontline healthcare workers (ACUTE)	Achieving 80% uptake of flu vaccinations by frontline staff with patient contact
CQUIN01 - Flu vaccinations for frontline healthcare workers (COMMUNITY)	Achieving 80% uptake of flu vaccinations by frontline staff with patient contact
CQUIN02- Supporting patients to drink, eat and mobilise (DrEaMing) after surgery	Ensuring 80% of surgical inpatients are supported to drink, eat and mobilise within 24 hours of surgery ending.
CQUIN03- Compliance with timed diagnostic pathways for cancer services	Achieving 55% of referrals for suspected prostate, colorectal, lung, oesophago-gastric, head & neck and gynaecological cancers meeting timed pathway milestones as set out in the rapid cancer diagnostic and assessment pathways
CQUIN04 - Prompt switching of intravenous to oral antimicrobial treatment	Achieving 40% (or fewer) patients still receiving IV antibiotics past the point at which they meet switching criteria
CQUIN05 - Identification and response to frailty in emergency departments	Achieving 30% of patients aged 65 and over attending A&E or Same-Day Emergency Care (SDEC) receiving a clinical frailty assessment and appropriate follow up.
CQUIN06 - Timely communication of changes to medicines to community pharmacists via the Discharge Medicines Service	Achieving 1.5% of acute trust inpatients having changes to medicines communicated with the patient's chosen community pharmacy within 48 hours following discharge, in line with NICE Guideline 5, via secure electronic message
CQUIN07 - Recording of and response to NEWS2 score for unplanned critical care admissions	Achieving 30% of unplanned critical care unit admissions from non-critical care wards having a timely response to deterioration, with the NEWS2 score, escalation and response times recorded in clinical notes.
CQUIN10 - Treatment of non-small cell lung cancer (stage I or II) in line with the national optimal lung cancer pathway	Achieving 85% of adult patients with non-small-cell lung cancer (NSCLC) stage I or II and good performance status (WHO 0-1) referred for treatment with curative intent, as per the NICE QS17 recommendation
CQUIN12 - Assessment and documentation of pressure ulcer risk (ACUTE)	Achieving 85% of acute and community hospital inpatients aged 18+ having a pressure ulcer risk assessment that meets NICE guidance with evidence of actions against all identified risks.
CQUIN12 - Assessment and documentation of pressure ulcer risk (COMMUNITY)	Achieving 85% of acute and community hospital inpatients aged 18+ having a pressure ulcer risk assessment that meets NICE guidance with evidence of actions against all identified risks.
CQUIN13 - Assessment, diagnosis, and treatment of lower leg wounds	Achieving 50% of patients with lower leg wounds receiving appropriate assessment diagnosis and treatment in line with NICE Guidelines
CQUIN14 - Malnutrition screening in the community	Achieving 90% of community hospital inpatients having a nutritional screening that meets NICE Quality Standard QS24 (Quality statements 1 and 2), with evidence of actions against identified risks

Information Relating to Registration with the Care Quality Commission

University Hospitals of Morecambe Bay NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is Registered with Conditions.

The Care Quality Commission has undertaken enforcement action against University Hospitals of Morecambe Bay NHS Foundation Trust during 2022/23.

During a CQC inspection in April 2021, Inspectors became aware of concerns about the stroke pathway for patients and did a further unannounced responsive inspection of this service at Royal Lancaster Infirmary and Furness General Hospital.

Following this inspection, under Section 31 of the Health and Social Care Act 2008, CQC imposed urgent conditions on the registration of the provider in respect to the regulated activities for stroke and maternity services. The Trust undertook immediate actions to improve the stroke pathway and maternity care. It is delivering an improvement plan for the services. The Trust has submitted its application to remove the CQC conditions in Q4 2022/23. At the time of writing, the Trust is awaiting the outcome of this application from the CQC.

The Trust has worked through an improvement plan to address the findings and recommendations of the CQC report and has received mandated support through NHS Improvement/NHS England as part of the Recovery Support Programme. An independent well led review was completed in February 2023 which offered assurance of progress made since the last CQC inspection.

The Trust has participated in a national programme for urgent and emergency care system inspections. A report was issued to the Integrated Care System. The Trust's individual actions have been addressed. Following the last Quality Account, a report was published in July 2022. Trust specific actions have been monitored through Quality Committee and the Trust Board.

The Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

Information on the Quality of Data

High quality data, captured at the point of care, underpins the Trust's ability to deliver safe and efficient care and it is vital that we ensure it is captured in an accurate and timely manner. Fit-for-purpose data also forms the foundation for robust management information and business intelligence which are essential for delivery of care and optimal utilisation of resources for the benefit of patients and staff.

At UHMBT, this data is critical for:

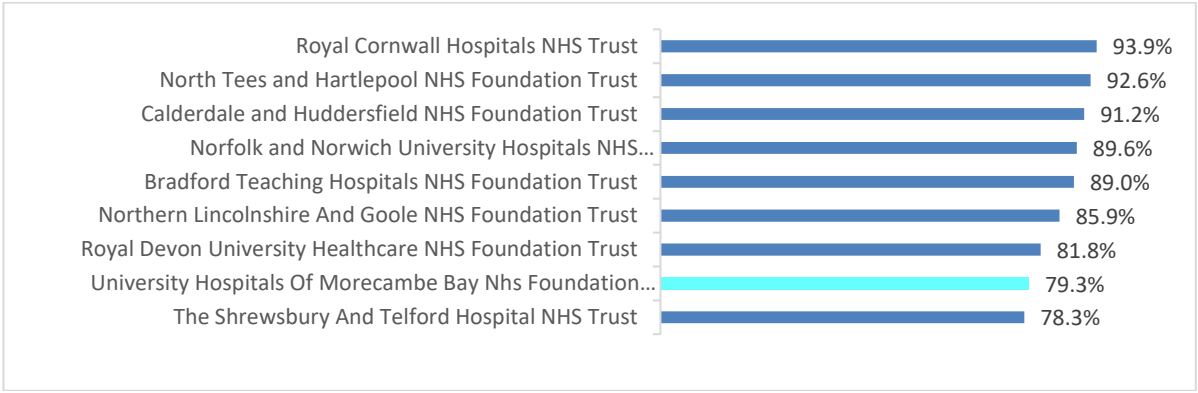
- The delivery of patient care within the e-Hospital environment.
- The delivery of the Trust's core business objectives.
- The delivery of the Trust's Business Intelligence framework, including on-demand real-time reporting and analytics.
- The development of a Clinical Information Culture including clinical outcomes analysis.
- Performance management against key standards as mandated nationally and locally.
- Clinical Governance and Clinical Audit.
- Accurate clinical coding.
- Service Level Agreement monitoring and contract management.
- Business planning; and
- Accountability and transparency.

The obligations upon all Trust staff to maintain accurate records are:

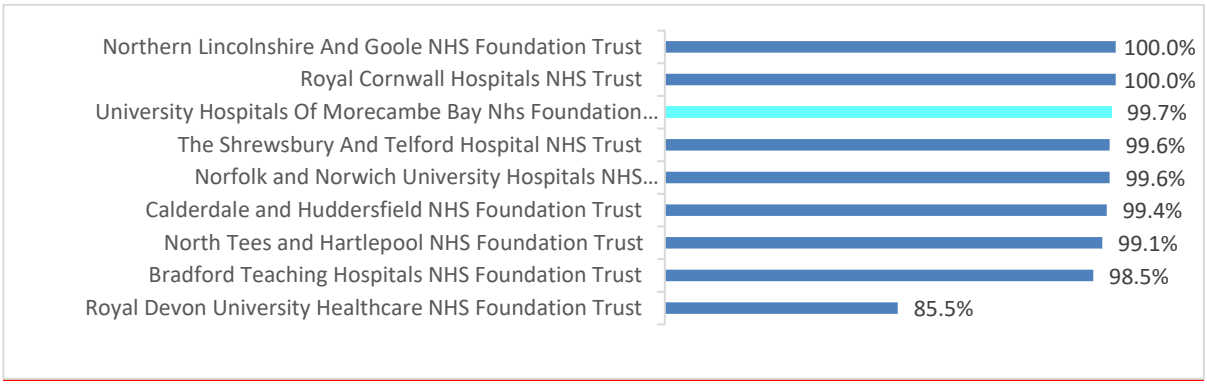
- Legal (Data Protection Act 2018).
- Contractual (Contracts of employment).
- Ethical (Professional codes of practice).
- Regulatory (CQC, Good Governance etc.).

Improving data quality requires effort, resources and commitment at all levels in the Trust and requires a focus on user behaviour and improving how staff interact with the Trust's Electronic Patient Record and core systems. The Trust is monitored internally, locally and nationally on the clinical data it generates and publishes. The following indicators are monitored by both local Health Service Commissioners, as well as by NHS England. The information below shows the Trust's performance for the latest available reporting month (November 2022) against its peer group:

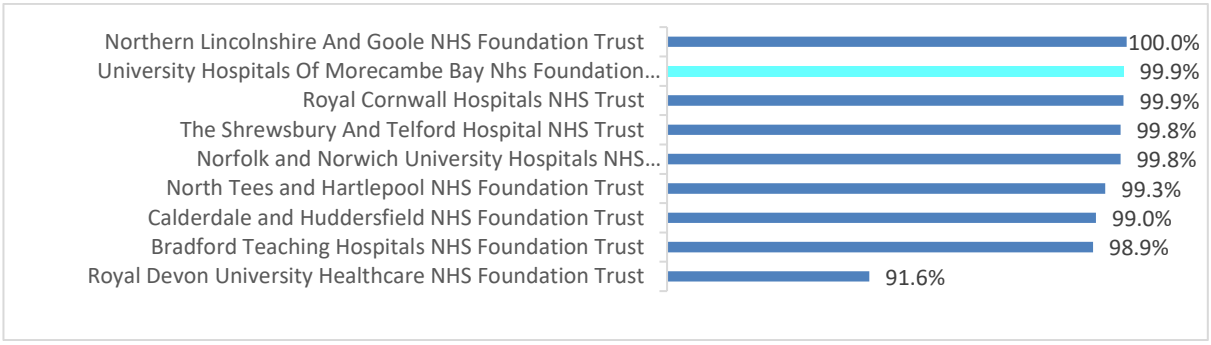
Accident & Emergency Data Quality:



Outpatient Data Quality:



Inpatient Data Quality:



NHS Number and General Medical Practice Code Validity

University Hospitals of Morecambe Bay NHS Foundation Trust submitted records during 2022/23 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:

which included the patient's valid NHS Number was:

- 99.9% for Admitted Patient Care.
- 99.8% for Outpatient Care; and
- 99.6% for Accident and Emergency Care.

which included the Patient's valid General Medical Practice Code was:

- 100.0% for Admitted Patient Care.
- 100.0% for Outpatient Care; and
- 100.0% for Accident and Emergency Care.

Latest available November 2022 and with a national data item average of 81.9%.

Information Governance Assessment Report 2021/22

University Hospitals of Morecambe Bay NHS Foundation Trust Information Governance Assessment (Data Security and Protection Toolkit) overall score for 2021/2022 was “Standards Met”.

Submission for the Data Security and Protection Toolkit is now submitted at the end of June each year on or before the 30th. We are hoping to again achieve ‘Standards Met’ for 2022/23.

Payment by Results (PbR) Clinical Coding Audit

University Hospitals of Morecambe Bay NHS Foundation Trust was not subject to the Payment by Results (PbR) clinical coding audit during 1st April 2022 – 31 March 2023 by the Audit Commission.

University Hospitals of Morecambe Bay NHS Foundation Trust will be taking the following actions to improve data quality:

- Focused data quality improvement directed through the Information Governance and Data Quality Group.
- Improving engagement with data quality and understanding of its importance.
- Implementation of a Trust-wide data quality monitoring framework.
- Developing a data quality indicator for reporting.
- Roll out of a data literacy training programme; and
- Focus on continued clinical system data quality to support patient care and real-time analytics.

Learning from Deaths

Reducing mortality is one of the Trust’s improvement objectives. Processes such as mortality reviews, monitoring mortality rates, receiving feedback from the bereaved via our Medical Examiner service ensure that we learn and share lessons from learning from deaths. This process also incorporates information and data mandated under the National Learning from Death Programme. A quarterly update on Mortality is given to the Quality Committee focusing on our Healthcare Evaluation mortality Data (HED) including monitoring of alerting diagnostic groups with relevant action plans as well as progress on the Better Tomorrow external peer review report and Medical Examiner progress. In addition, as part of our improvement plan in quality and safety, there is a monthly update on mortality via a Mortality Programme Board report to the Recovery Support Programme Board.

In May 2021, the Better Tomorrow peer review team worked with the Trust to review and support their systems and processes for mortality reviews and learning from deaths. The approach was agreed with the NHS England Improvement lead working with the Trust and with Trust clinical leads. To obtain a baseline, the Better Tomorrow team undertook a desktop review of the Trust’s systems and processes for learning from deaths, including a review of key documents such as its learning from deaths strategy and end-of-life care. In addition, in June 2022, the Better Tomorrow reported their findings on a defined cohort of 62 deaths that they reviewed as well as a comparative review of 39 cases, including 13 urology and 10 Trauma & Orthopaedics deaths at UHMBT which showed many areas of good practice with other areas where there is room for improvement. The report also highlighted the quality of our Structured Judgement Reviews (SJRs) in terms of their depth and comprehensiveness, learning identified and escalation.

The key findings included:

- Numerous examples of good care to describe “How we do it well.”
- The reviewers recognised and described instances of very good, holistic, compassionate care across specialities.
- First 24-hour care was graded at least good in 60% of cases.
- The Trust could deliver end of life care of high quality but needed to ensure consistency.
- Most deaths were expected and unpreventable.
- Good involvement of speciality teams.

The Trust were asked to consider the following:

- Use of positive lessons for reinforcement of practice.
- Use of negative lessons as a map for skills training.
- Reinforcing good practice in drug prescribing.
- Raising awareness of end-of-life care planning with GSF Framework and Deciding Right resources.

- Identifying and addressing missed opportunities in discharge planning or discharge.
- A review of specialist resources given comorbidities and age (dementia, palliative).
- Managing learning disability cases with LeDeR information.
- Standardising approaches to handover of information – verbal and electronic for clinical and coding clarity.

Opportunities to be explored by the Trust included redesigning its SJR form; to assure the skills and consistency of its clinical reviewers; to develop a reporting mechanism to track learning in cases that result in discussion at specialist governance meetings and to use this learning to demonstrate improvement and to ensure its SJR team is representative by involving more nurses and Allied Health Professionals (AHP) and to ensure objectivity. This work has progressed well with a modified SJR form becoming available, formal e-training provided to reviewers via Training Management System (TMS) including support from the Mortality lead for SJRs in the weekly mortality review meeting. Learning from incidents, Serious Incidents Requiring Investigation (SIRI) panels and inquests is being undertaken in the Care Group Quality and Governance meetings and then shared down to Speciality meetings. Learning is also shared in Mortality and Morbidity (M&M) within Speciality Audit and Governance Meetings. The SJR team now is multidisciplinary and consists of doctors, nurses and 1 AHP. The Matron for learning disability and autism has provided support to Care-Groups and specialities on managing learning disability patients reaching end of life and there is a video on the UHMBT intranet for all staff. Similarly, the palliative care team provided learning to Care Group specialities on improving end of life decision making and the SWAN model of care has been introduced.

In addition, from July 2022 the quarterly Mortality report included an update on progress against the Better Tomorrow actions and an update on Medical Examiner scrutiny and progress on the roll out to include primary care deaths from April 2023. The Mortality Steering Group meets monthly where an updated HED mortality data report is discussed with the focus being on understanding alerting groups and whether coding is accurate for these groups and ensure clinicians in alerting specialities can learn lessons following review of cases so as to reduce mortality. The group is led by the Deputy Medical Director, Care Group Clinical Directors, Associate Director of Operations or Nursing, Governance Business Partners, Coding leads and Medical Examiner representation. The HED data prompts Care Groups to understand their mortality data and how this is coded as well as scrutiny at speciality level and any associated learning. Each Care-group then provide action plans and areas for improvement in their respective alerting groups. Women's & Children's provide any learning from National MMBRACE reports or CDOP outcomes. Another great achievement is our Mortality dashboard which has SPC charts at Trust and speciality level so clinicians can scrutinise their mortality data.

The Medical Examiner Service are performing well with 100% of non-coronial death scrutiny as well as pilot roll out to primary care and hospices which is progressing well.

Currently, we also have a bi-monthly Mortality Data Triangulation Meeting led by the Deputy Medical Director and has representation from the Deputy Director of Governance, the Legal Team, Safeguarding and Medical Examiner team. In the first half of the meeting cases are reviewed where additional clarity is required by the Mortality and Quality Assurance Lead as to whether a SJR should be undertaken or not. There is triangulation in the second half of the meeting on incidents and complaints received in the previous 8 weeks including claims and litigations received during the year to draw out any lessons learnt. Our first Learning from Deaths Newsletter was published in March this year.

During the period 1 April 2022 to 31 March 2023, 1615, of University Hospitals of Morecambe Bay NHS Foundation Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

	Number of deaths
Quarter 1	372
Quarter 2	368
Quarter 3	453
Quarter 4	422
Total	1615

By 31 March 2023, 422 (26%) case record reviews (Primary SJR) and 392 (24%) investigations have been carried out in relation to 1615 of the deaths that occurred in the Trust (see a) above).

In 82 cases, a death was subjected to both a case record review and an investigation – 42 of these were reviews by a relevant specialty (e.g., stroke or orthopaedics) and 40 were requested for a secondary review of which 8 had a completed secondary review carried out by Mortality group members. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

	Number of deaths	Case Record Review	Incidents
Quarter 1	372	112	5
Quarter 2	368	113	9
Quarter 3	453	124	8
Quarter 4	422	73 (target completion date within 8 weeks of date of death)	7

In 2023/2024, 29 incidents were graded as 'Death'. 11 of these met the Serious Incident Framework's criteria for reporting on StEIS and have had a comprehensive Root Cause Analysis (RCA) to identify any learning for the organisation. For the 18 cases that were not reported on StEIS, 8 of these had 72 Hour Reviews undertaken, 7 were deemed a 'non-UHMBT' death and were shared with the relevant organisation for further investigation (if appropriate), 2 were indeed StEIS reported under another incident (not graded as death) and 1 relates to a staff member who collapsed at work.

Based on HOGAN scores of 3 or more, 2 cases' representing 0.12% of total patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of:

- 1 for Q1
- 0 for Q2
- 1 for Q3, and
- 0 for Q4

The single case in quarter 1 did go to the Serious Incidents Requiring Investigation (SIRI). The learning from this case was shared through the Surgery and Critical Care Governance meeting, and the patient safety manager shared the RCA and a completed Duty of Candour with the Next of Kin. The case was presented at the General and Colorectal Cross-Bay Audit meeting. The patient's surgery was found to be more difficult than expected, which then increased the risk of peri-operative complications.

Lessons learned in this case:

- Clinical decision making to stop bridging therapy post-operatively was contrary to SOP guidance.
- Discussions regarding risks / benefits of procedures should be documented

The single case in quarter 3 did not go to Serious Incidents Requiring Investigation (SIRI) and learning that was identified has been shared at the Mortality Steering Group meeting and through the Surgery & Critical Care Group Governance meeting as well as to the ward-based matron and her team. Although the patient had a good initial assessment and promptly organised surgery including postsurgical care, the following issues were found to be problems in care:

- Lack of continuity of treatment.
- Inability to recognise and treat Sepsis early.
- Inability to recognise and treat Acute Kidney Injury (AKI) 3 promptly.
- VTE on day one- next VTE assessment day ten- Due to patient's condition, comorbidities, and frailty, this should have been more regular. A Hogan 3 score was given as there was delayed recognition of a deteriorating patient.

Any avoidable deaths noted at the Mortality Steering Group are reported to the Quality Committee quarterly. The Trust also take account of the clinical incidents which are raised during mortality reviews and any clinical incidents raised during the patient's stay in hospital before the mortality review. Depending on the severity of harm, the incidents are discussed at the Executive Review Group where there is scrutiny via a 72-hour review initially and if appropriate the incident is reported to the Strategic Executive Information System (StEIS) and a full RCA and review is undertaken and scrutinised at the SIRI panel. If the incident is not for StEIS, then the Care Group will close the incident with appropriate reflection and action plans from the clinical team/person. The single case in quarter 3 did not go to SIRI and learning that has been identified has been widely shared through the Surgery & Critical Care Group Governance meeting.

101 case record reviews and 15 investigations completed after 31/03/22 which related to deaths which took place before the start of the reporting period.

11 representing 10.8% of the patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

4 representing 3.9% of the patient deaths during 2021/22 are judged to be more likely than not to have been due to problems in the care provided to the patient.

For all the cases, Duty of Candour has been completed where appropriate and families have been given the opportunity to look at the investigation for openness and transparency.

Through regular Mortality review meetings, the following examples of good practice include:

- good documentation.
- appropriate palliative care referral.
- good communication with patients and family.
- early involvement of senior clinicians.
- early involvement of ITU.
- good inter-disciplinary team involvement.
- appropriate instigation of uDNACPR.
- daily ward round reviews.
- early recognition of futility discussion with families.
- clear and caring discussion with the families regarding their wishes.
- prompt communication when patient has failed to respond to standard care.
- some good summaries in the death summaries.

Learning points and areas for improvement are shown in the table below:

Theme	Number of cases identified	Learning/Actions	Next Steps
Issue with assessment, documentation or implementation related to DNACPR	7	Shared with departmental teams, uDNACPR teams and patient safety team. Noted on the Lessons Learned Task and finish bulletin	Monitor through continued SJR, alert uDNACPR on EPR, Quality Improvement team dedicated to uDNACPR
Excellence in care delivery or in end-of-life care	4	Shared with departmental teams and the executive team. Noted in the Learning from Deaths Newsletter.	To identify departments who manage this well and share methods with other departments
Issue relating to documentation – medical and nursing	8	Shared with departmental teams and senior team members, in some cases incident reported	Monitor through continued SJR, alert clinical or nursing leads if no improvement. *Improving currently*
Issue with assessment, prescribing or administration related to VTE prophylaxis	2	Shared with departmental teams.	Monitor through continued SJR, alert VTE lead and steering group to improvements or lack of. Qlik-sense dashboard available for all teams
Patients who could have avoided hospital admission or would have benefitted from having an advance care plan	4	Patient stories and cases shared with departmental teams involved. Identified and spoke with Nursing/Residential homes to identify reasons the patient was admitted.	Identified by Lead for mortality when admitted to hospital unnecessarily, ensure that information is reaching the appropriate clinicians
Lack of inter-speciality working and communication leading to suboptimal care	3	Shared with clinicians involved, MDT discussions held and incident reported in some cases	Monitor through continued SJR, alert lead clinicians to improvement or lack of.
Delay in surgery for fractured neck of femur (#NoF)	1	Fractured Neck of Femur working group is established, Fractured Neck of Femur	Monitor through continued SJR, alert Fractured Neck of Femur steering group to

		steering group is established and working well. Delay in surgery is very closely monitored and reported as an incident when it occurs	improvement or lack of. *Improving currently*
Lack of appropriate ceiling of treatment or failure to recognise the futility of continued treatment	9	Shared with clinicians involved to inform reflection and improve care delivery. A palliative segment included in the Learning from Deaths newsletter to spread awareness.	Monitor through continued SJR, End of Life team to highlight issue and alert lead clinicians to improvement or lack of. *Improving currently*
Issue with absent or incomplete DOLS or MCA	1	Shared with department through a CIR	Monitor through continued SJR, alert lead nursing teams to improvement or lack of *improving currently*
Issue relating a poor or incomplete electronic death summary	8	Shared with individual clinicians involved to inform practice	Monitor through ME service and Care Groups including continued SJR, alert lead clinicians to improvement or lack of
Issue related to medication	6	Shared with departmental teams, incident reported	Monitor through continued SJR of case notes, alert lead clinicians to improvement or lack of
Issue related to identifying or treating sepsis	1	Shared with departmental teams and learning re-enforced	Monitor through continued SJR of case notes, alert lead clinicians to improvement or lack of

All opportunities for learning are shared immediately via safety huddles, safety pins and the monthly Quality & Governance Care Group meetings as well as at the Mortality Steering Group meeting. Three key learning points are highlighted in the quarterly Learning from Deaths Newsletter and further cases discussed in the monthly Lessons Learnt Trust-wide bulletins. All themes are also shared via the Governance Business partners and Triumvirates in the Care Group Quality & Governance monthly meeting. A Medical Examiner team member also attend the Mortality review meetings every week and the fortnightly Mortality Triangulation meetings so that themes or concerns can be fed-back to the Medical Examiners.

Reporting Against Core Quality Indicators

Set out in the table below are the Core Quality Indicators that Trusts are required to report performance in their Quality Accounts. In addition, where the required data is made available to the Trust by NHS Digital, a comparison of the numbers, percentages, values, scores, or rates of the Trust (as applicable) are included for each of those listed with:

- the national average for the same; and
- with those NHS Trusts and NHS Foundation Trusts with the highest and lowest for the same, for the reporting period.

Further information on these NHS Digital definitions can be accessed at www.digital.nhs.uk

Core Quality Indicators – Prescribed Information

The data made available to the Trust by the NHS Digital is with regard to:
The value and banding of the Summary Hospital-level Mortality Indicator ("SHMI") for the Trust for the reporting period.

	SHMI				Palliative Care Coding			
Period	Trust	England Average	England Highest	England Lowest	Trust	England Average	England Highest	England Lowest
Apr-20 to Mar 21	103.19 Band 1	100	120.91	70.18	32%	38%	63%	8%
May-20 to Apr-21	101.42 Band 1	100	118.18	71.65	33%	38%	65%	9%
Jun-20 to May-21	102.38 Band 1	100	117.21	71.93	34%	38%	65%	10%
Jul-20 to Jun-21	101.63 Band 1	100	116.87	71.2	33%	39%	64%	11%
Aug-20 to Jul-21	100.21 Band 2	100	116.68	72.3	33%	39%	64%	11%
Sep-20 to Aug-21	100.27 Band 2	100	117.08	72.48	33%	39%	64%	12%
Oct-20 to Sep-21	101.03 Band 1	100	118.2	72.45	33%	39%	63%	12%
Nov-20 to Oct-21	100.06 Band 2	100	118.37	73.65	33%	39%	64%	11%
Dec-20 to Nov-21	99.62 Band 2	100	119.66	72.93	34%	39%	64%	11%
Jan-21 to Dec-21	99.41 Band 2	100	119.82	72.48	34%	39%	64%	11%
Feb-21 to Jan-22	99 Band 2	100	120.02	71.88	34%	40%	66%	11%
Mar-21 to Feb-22	99.73 Band 2	100	119.14	71.86	N/A	N/A	N/A	N/A
Mar-21 to Feb-22	99.73 Band 2	100	119.14	71.86	N/A	N/A	N/A	N/A
Apr-21 to March-22	99.86 Band 2	100	119.42	69.64	34%	40%	66%	11%
May-21 to Apr-22	99.43 Band 2	100	119.52	70.72	35%	40%	66%	11%
Jun-21 to May-22	96.65 Band 2	100	119.82	71.18	35%	40%	66%	11%
Jul-21 to Jun-22	95.55 Band 2	100	121.12	70.47	36%	40%	65%	12%
Aug-21 to Jul-22	95.46 Band 2	100	121.32	71.17	36%	40%	65%	11%
Sep-21 to Aug-22	95.46 Band 2	100	122.46	69.79	37%	40%	65%	11%
Oct-21 to Sep-22	94.42 Band 2	100	123.40	64.54	37%	40%	65%	12%

Data includes the most recent publication on HED which utilises the NHS Digital HES Dataset. Latest publication: June 2022. Palliative care data acquired from NHS Digital Publications.

The University Hospitals of Morecambe Bay NHS Foundation Trust considers that this data is as described for the following reasons:

Over the last 12-month period the Trust SHMI score is 96.89 (SHMI November 2021-October 2022), indicating a decline in expected deaths. This means the Trust SHMI score has improved because 'Good' is recognised as a score under 100 and is better than average in peer groups and England average.

The University Hospitals of Morecambe Bay NHS Foundation Trust has taken the following actions to improve this rate/number, and so the quality of its services, by undertaking the following actions:

- See section on Learning from Deaths, page 32.

The data made available to the Trust by the NHS Digital with regard to the Trust's patient reported outcome measures scores for the following during the period reported:
(i) groin hernia surgery;
(ii) varicose vein surgery;
(iii) hip replacement surgery; and
(iv) knee replacement surgery.

Groin Hernia – Percentage of patients with improvement in EQ-5D health scores			
Year	Eligible Episodes	Trust	National Average
2016/17	100	53.0%	52.1%
April 2017-September 2017	78	47.4%	53.1%
2018/19	PROMs data was collected on varicose vein and groin hernia procedures in England, however following on from the NHS England Consultation on PROMs, collection of these procedures ceased on 1 October 2017.		
2019/20			
2020/21			
2021/22			
2022/23			

Varicose Veins – Percentage of patients with improvement in EQ-5D health scores			
Year	Eligible Episodes	Trust	National Average
2017/18	The Trust has not had any eligible patients within PROMS since 2014/15 following the transfer of Vascular services to Lancashire Teaching Hospitals NHS Foundation Trust.		
2018/19			
2019/20			
2020/21			
2021/22			
2022/23			

Hip Replacement – Percentage of patients with improvement in EQ-5D health scores			
Year	Eligible Episodes	Trust	National Average
2017/18	272	88.2%	89.4%
2018/19	299	89.3%	89.7%
2019/20	165	92.1%	89.4%
2020/21	42	92.9%	89.1%
2021/22	*No further data published since February 2022*		
2022/23			

Knee Replacement – Percentage of patients with improvement in EQ-5D health scores			
Year	Eligible Episodes	Trust	National Average
2017/18	347	83.3%	82.1%
2018/19	257	82.5%	82.1%
2019/20	173	85.0%	82.8%
2020/21	21	90.5%	81.2%
2021/22	*No further data published since February 2022*		
2022/23			

The University Hospitals of Morecambe Bay NHS Foundation Trust considers that this data is as described for the following reasons:
Pre-op
- There was a total of 1,011 procedures in 2019/20
- Of which there were 381 questionnaires completed in 2019/20
- In 18/19 the response rate was 54.6% with a deterioration to 37.7% in 2019/20

Post-op
- UHMBT performed 5.7% worse than the national average for groin hernias in 2017/18
- UHMBT performed 3.8% better than the national average for hip replacements in 2020/21
- UHMBT performed 9.3% better than the national average for knee replacements in 2020/21

The University Hospitals of Morecambe Bay NHS Foundation Trust intends to take the following actions to improve this percentage, and so the quality of its services, by the following actions:

- The Next Day Discharge programme at the Westmorland General Hospital site has focused on improving the pathway for patients attending for elective joint surgery including patient materials in printed form, embedding the use of a patient app and a virtual model for the delivery of hip and knee school. The focus of the project has remained on reducing length of stay (LoS). Month-on-month improvements have been experienced. To date this has seen a LoS reduction for delivered a quality improvement initiative for hip and knee replacement surgery. The work increased the number of in-patients discharged within two days to nearly 50% from a baseline of 6%, and a reduction in length-of-stay from 3.7 to 2.8 days on average. Due to the cross site working between the Royal Lancaster Infirmary (RLI) and Westmorland General Hospital (WGH) there have also been LoS improvements at the RLI. This project is currently being replicated on the Furness General Hospital site (FGH).
- The Surgery and Critical Care Group have devised and implemented a 'Set for Surgery' charter protocol in order to pre-habilitate engaged patients as far as is reasonably practicable; this process has been highly commended and is currently being worked on within the Integrated Care System with a view to replicating this across multiple, sub-regional trusts.
- A buddy system has been implemented to support the patient journey and 'Set-for-surgery' charter.

The data made available to the Trust by the NHS Digital with regard to the percentage of patients aged (i) 0 to 15; and (ii) 16 or over, readmitted to a hospital within 30 days of being discharged from a hospital which forms part of the Trust during the reporting period.

Year	Categories	<16 (%)	16+ (%)
2017/18	Trust	14.6	11.8
	England Average	11.9	14.1
	England Highest	54.9	491.4
	England Lowest	1.7	2.2
2018/19	Trust	13.8	12.6
	England Average	12.5	14.6
	England Highest	68.9	57.6
	England Lowest	1.9	2.1
2019/20	Trust	13.1	12.1
	England Average	12.5	14.7
	England Highest	56.8	37.5
	England Lowest	2.1	1.9
2020/21	Trust	11.6	13.6
	England Average	11.9	15.9
	England Highest	64.4	112.9
	England Lowest	2.8	1.1
2021/22	Trust	14.2	13.0
	England Average	12.5	14.7
	England Highest	46.9	41.5
	England Lowest	3.3	2.1
2022/23	*Data not yet published by NHS Digital*		

0-14			
Discharge period	Spells	Re-admitted	Readmission Rate
2019/2020	**9157**	**1097**	**11.98%**
2019-Apr	767	111	14.47%
2019-May	771	90	11.67%
2019-Jun	728	95	13.05%
2019-Jul	732	71	9.70%
2019-Aug	690	82	11.88%
2019-Sep	764	91	11.91%

15+			
Discharge period	Spells	Re-admitted	Readmission Rate
2019/2020	**87,951**	**6656**	**7.57%**
2019-Apr	7176	679	9.46%
2019-May	7603	576	7.58%
2019-Jun	7179	537	7.48%
2019-Jul	7825	587	7.50%
2019-Aug	7347	599	8.15%
2019-Sep	7224	556	7.70%

2019-Oct	877	106	12.09%	2019-Oct	7941	563	7.09%
2019-Nov	869	107	12.31%	2019-Nov	7517	533	7.09%
2019-Dec	894	106	11.86%	2019-Dec	7045	511	7.25%
2020-Jan	732	83	11.34%	2020-Jan	7902	587	7.43%
2020-Feb	709	104	14.67%	2020-Feb	7127	495	6.95%
2020-Mar	624	51	8.17%	2020-Mar	6065	433	7.14%
2020/2021	**6131**	**683**	**11.14%**	**2020/2021**	**83,625**	**5878**	**9.24%**
2020-Apr	332	29	8.73%	2020-Apr	3167	336	10.61%
2020-May	458	56	12.23%	2020-May	3844	444	11.55%
2020-Jun	445	41	9.21%	2020-Jun	4581	498	10.87%
2020-Jul	461	40	8.68%	2020-Jul	5484	568	10.36%
2020-Aug	513	65	12.67%	2020-Aug	5312	528	9.94%
2020-Sep	603	60	9.95%	2020-Sep	5605	529	9.44%
2020-Oct	549	57	10.38%	2020-Oct	6143	521	8.48%
2020-Nov	571	70	12.26%	2020-Nov	5968	525	8.80%
2020-Dec	564	63	11.17%	2020-Dec	6009	471	7.84%
2021-Jan	500	57	11.40%	2021-Jan	5480	429	7.83%
2021-Feb	513	60	11.70%	2021-Feb	5266	449	8.53%
2021-Mar	622	85	13.67%	2021-Mar	6766	580	8.57%
2021/2022	**7922**	**1032**	**13.03%**	**2021/2022**	**74,141**	**6322**	**8.53%**
2021-Apr	591	89	15.06%	2021-Apr	6519	565	8.67%
2021-May	759	105	13.83%	2021-May	6627	631	9.52%
2021-Jun	826	106	12.83%	2021-Jun	7110	629	8.85%
2021-Jul	773	82	10.61%	2021-Jul	7135	614	8.61%
2021-Aug	780	121	15.51%	2021-Aug	6633	540	8.14%
2021-Sep	789	96	12.17%	2021-Sep	6870	614	8.94%
2021-Oct	809	121	14.96%	2021-Oct	6962	567	8.14%
2021-Nov	706	74	10.48%	2021-Nov	7038	556	7.90%
2021-Dec	700	77	11.00%	2021-Dec	6527	534	8.18%
2022-Jan	617	83	13.45%	2022-Jan	6180	550	8.90%
2022-Feb	572	78	13.64%	2022-Feb	6540	522	7.98%
2022-Mar	686	75	10.93%	2022-Mar	7269	584	8.67%
2022/2023	**6540**	**802**	**12.27%**	**2022/2023**	**63,658**	**5259**	**8.26%**
2022-Apr	678	90	13.27%	2022-Apr	6384	516	8.08%
2022-May	707	87	12.31%	2022-May	7436	642	8.63%
2022-Jun	679	83	12.22%	2022-Jun	7075	584	8.25%
2022-Jul	805	93	11.55%	2022-Jul	7058	551	7.81%
2022-Aug	639	73	11.42%	2022-Aug	7342	639	8.70%
2022-Sep	649	83	12.79%	2022-Sep	7209	558	7.74%
2022-Oct	771	90	11.67%	2022-Oct	7219	623	8.63%
2022-Nov	764	96	12.57%	2022-Nov	7267	593	8.16%
2022-Dec	848	107	12.62%	2022-Dec	6668	553	8.29%

Data source: HED – Activity and Readmissions (Spells) module. Derived from NHS Digital HES dataset. Data period: Apr-2019 – Dec-2022 (Jan – Mar 2023) unavailable as of this data release).

The University Hospitals of Morecambe Bay NHS Foundation Trust considers that this data is as described for the following reasons:

- The data for both 0-14 and 15+ patients include readmissions that were for any reason regardless of the original admission reason.
- The figures provided report on all admissions under 15 years of age to UHMBT. It is difficult to give an accurate narrative as they consist of all three sites when young people may attend the emergency department (ED), assessment or inpatient wards.
- The readmission rate has dropped in the data pack from previous submission in both data groups.

The University Hospitals of Morecambe Bay NHS Foundation Trust has taken the following actions to improve this percentage and so the quality of its services, by the following actions:

- The theatre dashboard now includes unplanned returns to theatre alongside a recently completed 'Unplanned return to theatre Standard Operating Procedure (SOP). The expectation through the SOP is for this data to be reviewed at monthly audit meetings to analyse any outlying practice, outcomes or individual clinicians. This is reported through the Surgery Quality Governance Group (SQG).
- The General Surgical speciality has designed a dashboard that highlights readmissions into the Trust, prompting further investigation. This process and tool will be rolled out across all surgical specialities.
- A post infection review process for all surgical site infections that account for some readmissions has been established. This is a multidisciplinary review including input from microbiology and pharmacy in addition to this there is a well-established surgical site dashboard with quarterly thematic analysis presented through Infection Prevention Committee and Governance and Assurance Group meeting.

The data made available to the Trust by the Health and Social Care Information Centre (HSCIC) with regard to the Trust's responsiveness to the personal needs of its patients during the reporting period.

Year	Trust	England Average	England Highest	England Lowest
2015/16	71.7	69.6	86.2	58.9
2016/17	69.5	68.1	85.6	60.0
2017/18	69.6	68.6	85.0	60.5
2018/19	66.5	67.2	85.0	58.9
2019/20	68.0	67.1	84.2	59.5
2020/21	74.3	74.5	85.4	67.3
2021/22	*2021/22 data not available yet*			
2022/23	*Figures published annually in March - 2022/23 data not available yet*			

Source NHS Digital Outcomes Framework 4.2

The University Hospitals of Morecambe Bay NHS Foundation Trust considers that this data is as described for the following reasons:

Please note:
Following the merger of NHS Digital and NHS England on 1st February 2023, they are reviewing the future presentation of the NHS Outcomes Framework indicators. As part of this review, the annual publication which was due to be released in March 2023 has been delayed. Further announcements about this dataset will be made by NHS England in due course.

The University Hospitals of Morecambe Bay NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services:

Until the data is presented, we are unable to comment on the patient outcome figure or any developmental actions needed with the UHMBT.

NHS Digital. (n.d.). 4.2 Responsiveness to inpatients' personal needs. [online] Available at: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/march-2022/domain-4---ensuring-that-people-have-a-positive-experience-of-care-nof/4.2-responsiveness-to-inpatients-personal-needs [Accessed 10 May 2023].
Legacy unique identifier: P01779

The data made available to the Trust by the NHS England with regard to the percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends. This indicator was introduced in April 2014.

Year	Trust	England Average	England Highest	England Lowest
2017	70.1%	70.7%	89.5%	46.4%
2018	71.6%	71.1%	90.4%	39.7%
2019	65.5%	70.6%	90.5%	39.8%
2020	69.8%	74.3%	91.7%	49.7%
2021	59.1%	66.9%	89.5%	43.6%
2022	55.0%	62.9%	86.4%	39.2%
Please note: Figures taken from the Benchmark report from latest available data (2022 survey.)				

The University Hospitals of Morecambe Bay NHS Foundation Trust considers that this data is as described for the following reasons:

- In 2021, whilst the England average decreased by -7.4%, the Trust score declined by an additional 3.3%. This reduction coincides with Trust receiving a 'requires improvement' CQC rating in the summer preceding the national staff survey for 2021.
- In 2022, the Trust and National scores declined by 4.1% and 4% respectively. Possible causal factors include significant industrial action by doctors and nurses, which may be reflected nationally and locally in this indicator.

The University Hospitals of Morecambe Bay NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services:

- The Trust has a comprehensive recovery support programme in place to address the concerns raised during the 2021 CQC inspection. The programme includes a comprehensive Cultural Transformation Programme. The programme recognises the need for the development of psychological safety, improved leadership, and restorative approaches to incident management.
- The Cultural Transformation Programme has supported the Trust in its journey in SOF4 aiming towards SOF3 with over 1500 leaders have attended a leadership induction training programme that covers the implementation of the Trust's core values and organisational vision.

The data made available to the Trust by NHS England with regard to the percentage of patients who were admitted to hospital and who were risk assessed for Venous Thrombo-Embolism (VTE) during the reporting period.

Year	Trust	England Average	England Highest	England Lowest
2012/13	98.4%	94.2%	100%	84.6%
2013/14	99.4%	95.97%	100%	76%
2014/15	93.3%	96.00%	100%	86.4%
2015/16	94.3%	95.76%	100%	75.00%
2016/17	93.7%	95.62%	100%	77.84%
2017/18	93.1%	95.11%	100%	66.44%
2018/19	93.8%	96.0%	100%	74.03%
2019/20 (Q1-3)	94.1%	96.0%	100%	71.84%
2020/21	*Data collection suspended in March 2020 so figures for Q4 2020 and onwards are not available*			
2021/22				
2022/23				

The University Hospitals of Morecambe Bay NHS Foundation Trust considers that this data is as described for the following reasons:

VTE Risk assessment data is now available via Qliksense (a dashboard).

The University Hospitals of Morecambe Bay NHS Foundation Trust has taken the following actions to improve the 90-percentage compliance indicator, and so the quality of its services, by undertaking the following actions:

- VTE Clinical Lead and Patient Safety Matron appointed who monitor VTE risk assessments.
- VTE monitored through monthly Deteriorating patient Group chaired by DMD.
- VTE also monitored via monthly IPR and reported through Quality Assurance Committee.
- Exception report agreed for Venous thromboembolism in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism - NG 89 - Risk assessments will not be required for patients undergoing treatment under local anaesthesia where mobility is not affected.
- Electronic assessment form available for all admissions. https://sense.UHMBT.nhs.uk/sense/app/e2111e23-8f2f-4627-98d9-2732996e9d4a/sheet/63152ad1-dfe7-4e0f-ae01-33a9554bbf69/state/analysis gives live data on VTE RA.
- Ward Qlik sense dashboard being introduced where unassessed patients are highlighted.
- All foundation year Doctors have VTE in annual education programme.
- VTE Foundation year champions in post to improve performance and education.
- Annual Trust wide VTE RA audit undertaken.

The data made available to the Trust by the Public Health England with regard to the rate per 100,000 bed days of cases of Clostridium Difficile infection (CDI) reported within the Trust amongst patients aged 2 or over during the reporting period.

Rate per 100,000 bed days of cases of Clostridium Difficile Infection (all reported cases)				
Year	**Trust**	**England Average**	**England Highest**	**England Lowest**
2016/17	44.4	23.3	147.2	0.0
2017/18	45.0	23.9	156.4	0.0
2018/19	57.2	21.9	168.3	0.0
2019/20	43.1	23.5	142.8	0.0
2020/21	63.8	22.2	140.5	0.0
2021/22	*Data not published by Public Health England yet*			

The published data now includes the statistics for Hospital Acquired cases of CDI:

Rate per 100,000 bed days of cases of Clostridium Difficile Infection (HO Cases)				
Year	**Trust**	**England Average**	**England Highest**	**England Lowest**
2016/17	12.8	13.1	82.6	0.0
2017/18	9.4	13.6	90.4	0.0
2018/19	14.2	12.2	79.8	0.0
2019/20	14.2	13.6	51.0	0.0
2020/21	21.1	15.4	80.6	0.0
2021/22	78.91	43.3	138.4	0.0
2022/23	*Data not published by Public Health England yet*			

The University Hospitals of Morecambe Bay NHS Foundation Trust considers that this data is as described for the following reasons:

- There has been an understood increase across the UK for Clostridioides.difficile infection (CDI)
- There has been an acknowledgement of increase in UHMBT and a CDI working group continues with a DIPC lead thematic review group which adding to the themes, trends and the actions that come from the post infection review and feed into the CDI working group.
- The antimicrobial pharmacy team has a focus on inpatient areas that are high risk for Clostridioides difficile through the antibiotics that are routinely used and those areas that have been identified by Infection Prevention.
- The Infection Prevention and antimicrobial team work closely together to improve anti-microbial stewardship and have started a new way of working with C.diff cases and to engage directly with the prescriber as part of the post infection review.

- UHMBT data is the culmination of both Hospital onset – healthcare associated and Community onset healthcare associated.
- The Threshold for 2022/23 was 84.

The University Hospitals of Morecambe Bay NHS Foundation Trust has taken the following actions to improve this trajectory and so the quality of its services, by undertaking the following actions:

- Ensured that all staff are trained annually in hand hygiene.
- Cases are reviewed with the prescriber within 24 - 48 hours by Infection Prevention and the antimicrobial pharmacy team.
- Clostridioides difficile post infection review meetings are undertaken for all Clostridioides difficile cases identified as hospital onset healthcare associated within the Trust and Community onset healthcare associated.
- Cleaning products are being reviewed and this is being done in line with the ICS Trusts.
- The buildings are being scrutinised and there is co-ordinated work being completed with the Estates team.
- On reviewing the SHMI, UHMBT are taking part in the initiative with other Northwest Trusts and the NHSE Infection Prevention team around Hand hygiene questionnaires for patients. These have shared via QR code.

The data made available to the Trust by NHS Improvement with regard to the number of and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.

	Rate per 1000 bed days				Percentage of incidents			
	Incidents				Resulting in severe harm or death			
Period	Trust	England	Highest	Lowest	Trust	England	Highest	Lowest
Apr 2016 to Sep 2016	35.9	N/A	71.8	21.2	0.1	0.1	0.5	0.0
Oct 2016 to Mar 2017	38.9	N/A	69.0	0.1	0.1	0.2	0.5	0.0
Apr 2017 to Sep 2017	48.8	N/A	111.7	23.5	0.3	0.6	0.5	0.0
Oct 2017 to Mar 2018	49.4	N/A	124.0	24.2	0.1	0.3	1.5	0.0
Apr 2018 to Sep 2018	62.5	N/A	107.4	13.1	0.3	0.3	1.2	0.1
Oct 2018 to Mar 2019	73.9	N/A	95.9	16.9	0.2	0.3	1.8	0.1
Apr 2019 to Sep 2019	67.4	N/A	103.8	26.3	0.2	0.3	1.6	0.1
Oct 2019 to Mar 2020	60.5	N/A	110.2	15.7	0.1	0.3	1.5	0.0
Apr 2020 to Mar 2021	71.1	N/A	118.7	27.2	0.2	0.4	2.8	0.0
Apr 2021 to Mar 2022	84.4	N/A	205.5	23.7	0.2	0.4	1.7	0.0
Apr 2022 to Mar 2023	Data is now published annually by NHS E/I so this data will not be available until later in 2023							
The NRLS discontinued the use of the large Acute Trust cohort at its publication in April 2015.								

The University Hospitals of Morecambe Bay NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust continues to have a strong reporting culture which is evidenced in the table above. Despite the high volume of incidents reported, the majority of these are no or low harm incidents as evidenced by the percentage of incidents resulting in severe harm or death.

The University Hospitals of Morecambe Bay NHS Foundation Trust has taken the following actions to improve the percentage of patient safety incidents resulting in harm, and so the quality of its services, by undertaking the following actions:

- The Trust continues to encourage a strong reporting culture.
- The Reporting and Management of Safety Events Including Serious Incidents policy has been refreshed to ensure local processes align with national standards.
- Compliance with Duty of Candour continues to be strong with the principles of candour at the forefront of the organisation's approach to incident management.
- An Executive Review Group (ERG) meets three time per week to ensure Executive oversight and

challenge of all incidents resulting in moderate or above harm and ensure timely reporting of Serious Incidents on StEIS (Strategic Executive Information System).

- There has been an introduction of a Daily Triage of all Incidents and complaints, which enables an improved oversight of incident management enabling timely identification of serious incidents.
- Implementation of new RCA training across Care Groups.
- Successfully ran our second annual Patient Safety Day event with high calibre of speakers covering a range of patient safety topics.

Following a review undertaken by NHS England, the Lead Official for Statistics has concluded that the characteristics of the Friends and Family Test (FFT) data mean it should not be classed as Official Statistics.

Part 3: Our Quality Improvements and Progress Against our Priorities

Performance against Key National Priority Indicators and Thresholds

The NHS Outcomes Framework for 2022/23 sets out high level national outcomes which the NHS should be aiming to improve. The Board of Directors monitors performance compliance against the relevant key national priority indicators and performance thresholds as set out in the NHS Outcomes Framework 2022/23. This includes performance against the relevant access targets and outcome objective and performance thresholds set out in Appendix A of the NHS Improvement's Risk Assessment Framework 2022/23 which can be accessed via the following link: https://www.gov.uk/government/publications/risk-assessment-framework-raf.

NHS Improvement uses a limited set of national measures of access and outcome objectives as part of their assessment of governance at NHS Foundation Trusts. NHS Improvement uses performance against these indicators as a trigger to detect potential governance issues.

NHS Foundation Trusts failing to meet at least four of these requirements at any given time or failing the same requirement for at least three quarters will trigger a governance concern, potentially leading to investigation and enforcement action. Except where otherwise stated, any trust commissioned to provide services will be subject to the relevant governance indicators associated with those services.

Reporting Against Core Quality Indicators sets out the relevant indicators and performance thresholds outlined in Appendix A of NHS Improvement's *Risk Assessment Framework*. Unless stated in the supporting notes, these are monitored on a quarterly basis.

Please note where any of these indicators have already been reported on in Part 2 of the quality report, in accordance with the Quality Accounts Regulations, they will not be repeated here; only the additional indicators which have not already been reported in Part 2 will be reported here to avoid duplication of reporting.

Performance against the key national priorities is detailed on the Integrated Performance Report to the Board of Directors at each of its meetings and is based on national definitions and reflects data submitted to the Department of Health via Unify and other national databases.

Our Performance - National Operational Performance Standards and Targets

26 national operational standards and targets are reported to the Finance and Performance Committee and Board of Directors on a monthly basis. The standards and targets are spilt into 5 main categories, Urgent Care, Elective care, Cancer standards, Diagnostic standards and productivity metrics. Examples include the Urgent Care 4 Hour Standard, 92% Referral to Treatment Standard, number of patients on a cancer pathway waiting > 62 days, and % of patients who fail to attend an out-patient appointment. The metrics are reported to the Board of Directors monthly so that the Board can assure themselves of how the Trust is performing against the key quality indicators and ensure that mitigating actions are taken when areas of concern arise.

Following the COVID-19 global pandemic, the focus in 2022/23 was in diagnosing and treating the patients that were clinically prioritised as most urgent and reducing the backlog of the longest waiting clinically routine patients.

In 2022/23, there were over 10,000 more Emergency Department (ED) attendances than 2019/20. Suspected cancer referrals have far exceeded those received in 2019/21, by an additional 33%.

Key summary actions to taken to prioritise and treat the most urgent patients, whilst moving on to treat routine groups in 2022/23 included:

Patients on a Referral to Treatment (RTT) Urgent or Routine Pathway

- Goal to recover to the pre COVID 19 pandemic levels of activity and number of longer waiting patients.
- Longest waiting RTT active waiting patients reduced to 104 weeks by February 2023 and 0 patients who were fit and willing to undertake treatment waited >78 weeks by 31st March.

- Trajectories set to reduce the number of patients waiting >65 weeks by 31st March 2024 in line with national targets.
- 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.
- Cross system working across Lancashire and South Cumbria including mutual aid between providers.
- Use of the independent sector to treat patients through insourcing and outsourcing of capacity.
- Focus on increasing productivity of theatre and OP clinics against pre-COVID pandemic levels. (Number of theatre sessions in 2019/20 = 5017, 2023/24 = 5016).
- Incident Management Approach taken to ensure that no fit and wiling patient waited >78 weeks by 31/03/23.

In terms of benchmarking for RTT, in January UHMBT had the 59th highest performance out of all 170 Trusts and was 6th out of 26 trusts in our peer group. The NHSE Making Data Count Team have published a report, where UHMBT RTT performance "ranks significantly better than the median Trust."

Cancer Pathways
Implementation of the national best practice pathways for:

- Prostate (Urology)
- Gynae (4 pathways)
- Upper GI
- Lung
- Colorectal

The following further best practice pathways will be launched in 23/24 including Breast, Bladder, Head and Neck, Haematology and Skin.

The key focus of work has been to remove avoidable delays to treatment and ensure that the numbers of patients waiting >62 days recover to the pre pandemic levels. In March 2020, at the beginning of the pandemic 43 patients waited >62 days for treatment, with numbers substantially increasing through the pandemic. This has reduced to 39 on 31/03/23, despite referrals being 30% higher month on month than pre-pandemic levels.

The 28 Day faster diagnosis Standard has been achieved every month since February 2022.

In terms of benchmarking, a recent NHS England 'Making data Count' Benchmarking Report placed UHMBT 7th in the country for Cancer 2 Week Wait performance and 10th nationally for 28 Day FDS performance, out of 130 Trusts.

Elective Performance
Tables A and B below show the key backlogs by metric and recovery percentage against March 2022. Table A shows the position in March 2023 against the March 2022 position whilst table 2 shows that all key activity types have overachieved and completed more activity in March 2023 than in March 2020.

Tables A and B below show the key backlogs by metric and recovery percentage against March 2022. Table A shows the position in March 2023 against the March 2022 position whilst table 2 shows that all key activity types have overachieved and completed more activity in March 2023 than in March 2020.

Table A: Referral to Treatment Backlog and numbers waiting >52 weeks for elective first treatment.

Metric	Number in March 2023	% Increase from March 2022
>52 week waiters	1089	13.6%
>78 Week waiters	3	-98.7%
>104 week waiters	0	N/A
RTT Waiting List Size	32384	23.0%

Table B: Recovery in March 2022 as compared to March 2020

Metric	Number in March 2023	% Recovery of Activity in March 2023
ED activity	11630	157%
Non elective activity	3860	124%
GP/GDP Referrals Received	9414	136%
Total Outpatient Activity	47863	118%
Total Diagnostic Activity- Endoscopy	1230	164%
Total Diagnostic Activity- Radiology	10733	142%
Elective Activity	4239	150%

Due to the factors outlined above, the vast majority of constitutional standards were not achieved in 2022/23.

Tables C and D show the results from the Trust's assessment of performance against the healthcare targets and indicators over the past 3 years.

Tables C to G give the detailed assessment of performance against the healthcare standards including national and locally agreed targets.

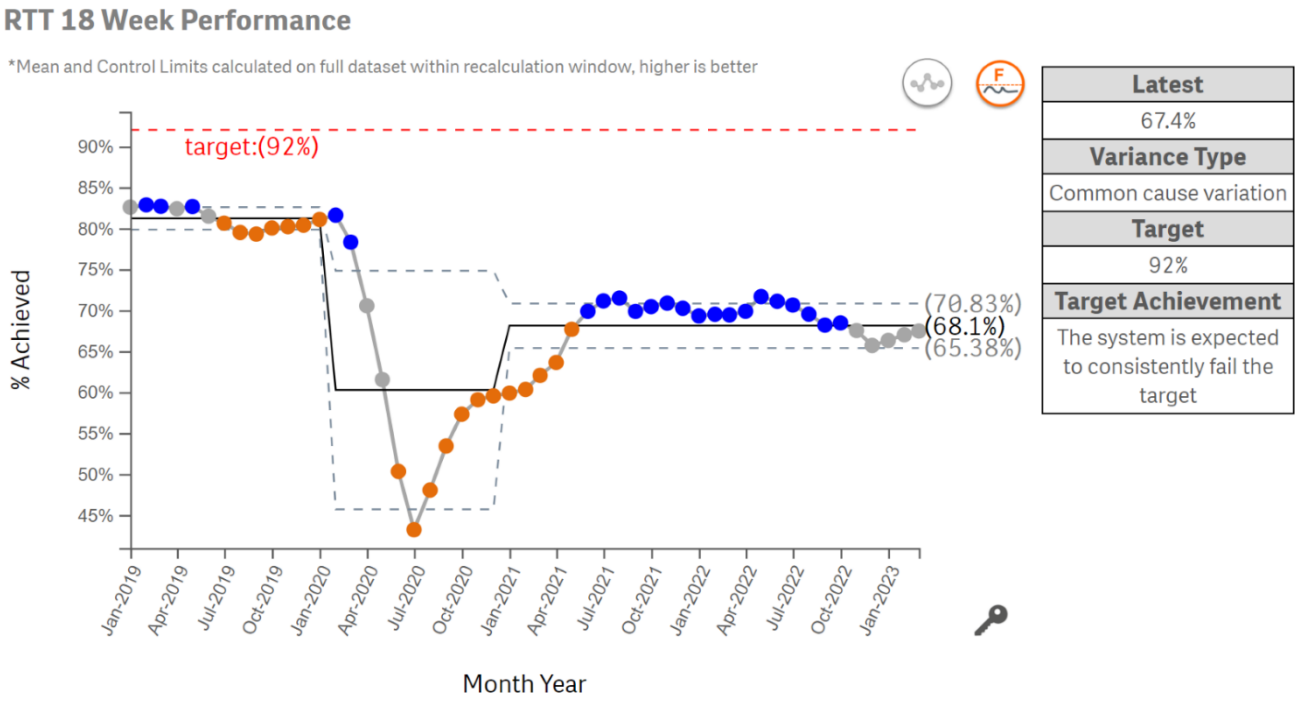
Table C: Performance against Quality Standards and Indicators - Quarterly Key Performance Indicators

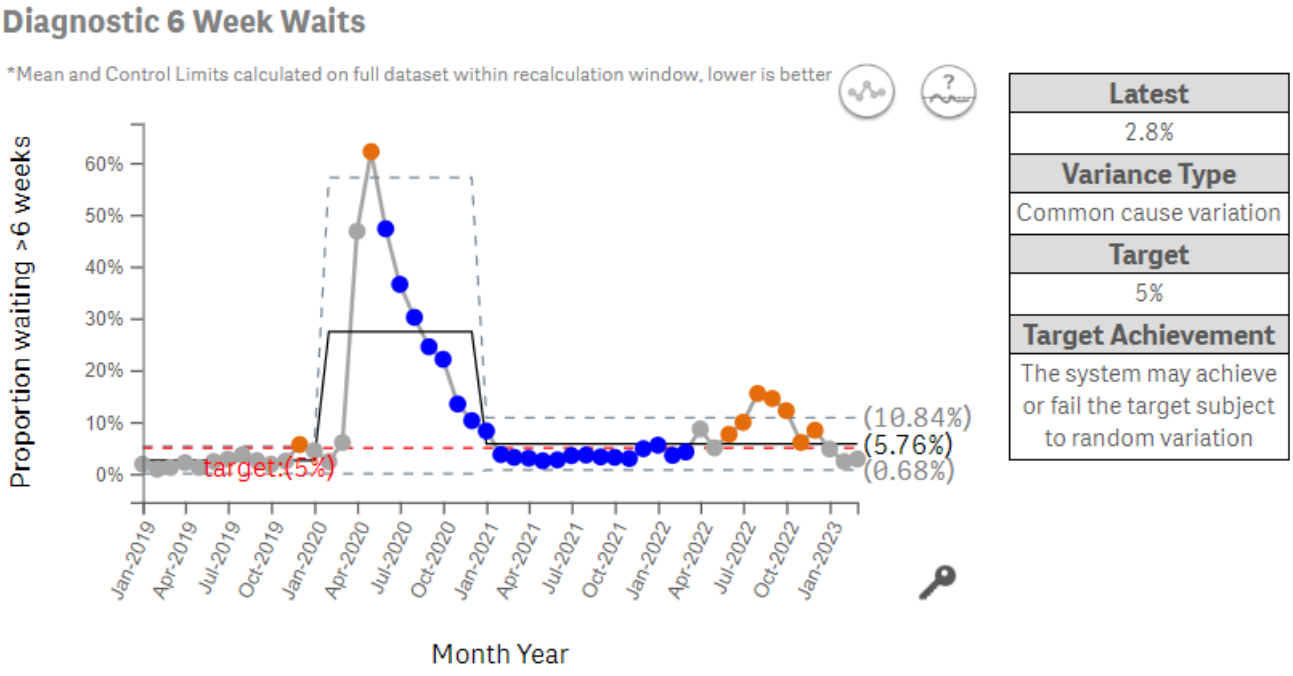
	2020/21				2021/22				2022/23			
Standard	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
A&E: maximum waiting time of four hours from arrival to admission/ transfer/ discharge	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet
All cancers: 31-day wait for second or subsequent treatment - surgery	Failed to Meet	Failed to Meet	Met	Failed to Meet	Met	Failed to Meet	Failed to Meet	Met	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet
All cancers: 31-day wait for second or subsequent treatment- drug treatment	Met	Met	Met	Met	Met	Met	Failed to Meet	Failed to Meet	Met	Met	Met	Met
All cancers: 62-day wait for first treatment from urgent GP referral for suspected cancer	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet
All cancers: 62-day wait for first treatment from NHS Cancer Screening Service referral	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet
All cancers: 31-day wait from diagnosis to first treatment	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet

Cancer: two week wait from referral to date first seen- all urgent referrals	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Met	Met
Data Source: Unify Data												

Table D: 2022/23 Performance against Quality Standards and Indicators - Monthly Key Performance Indicators for 2022/23.

Standard	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Maximum time of 18 weeks from referral to treatment– incomplete	69.86 %	71.66 %	71.08 %	70.62 %	69.51 %	68.17 %	68.45 %	67.51 %	65.69 %	66.30%	67.00%	67.45%
Diagnostic waits over 6 weeks	8.63%	4.98%	7.60%	9.92%	15.48 %	14.51 %	12.16 %	6.04%	8.39%	4.78 %	2.35 %	2.84%
Urgent Operations cancelled for the second or subsequent time	0	0	0	0	0	0	0	0	0	0	0	0
Ambulance Handover Time (mins)	28	25	29	27	33	40	37	27	51	28	17	20
Data Source: Unify Data												





Referral to Treatment (RTT) Data

The RTT standard has not been met in 2022/23.

Table E details month on month RTT performance for 2022/23 against the national standard of 92%.

Table E: Month on Month RTT Performance for 2022/23

RTT Performance	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Average for 21/22
RTT Incomplete Standard 92%	92 %	92 %	92 %	92 %	92 %	92 %	92 %	92 %	92 %	92 %	92 %	92 %	92%
<18 weeks against National Standard	**69.8 6%**	**71.6 6%**	**71.0 8%**	**70.6 2%**	**69.5 1%**	**68.1 7%**	**68.4 5%**	**67.5 1%**	**65.6 9%**	**66.3 0%**	**67.0 0%**	**67.4 5%**	**68.69%**
Data Source: Unify Data													

Accident and Emergency Department 4-hour standard for 2022/23

As shown in Tables F & G, the Trust did not achieve the 4-hour Accident and Emergency standard at Trust or site level in 2022/23.

Table F: Trust wide Accident and Emergency Department 4 hour standard for 2022/23

A&E Performance	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
A&E standard 95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Trust 95% performance	72.89%	72.74%	74.83%	72.53%	70.91%	67.35%	70.12%	75.45%	64.95%	74.54%	79.79%	74.47%
Data Source: Unify data: the indicator is in relation to the percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge												

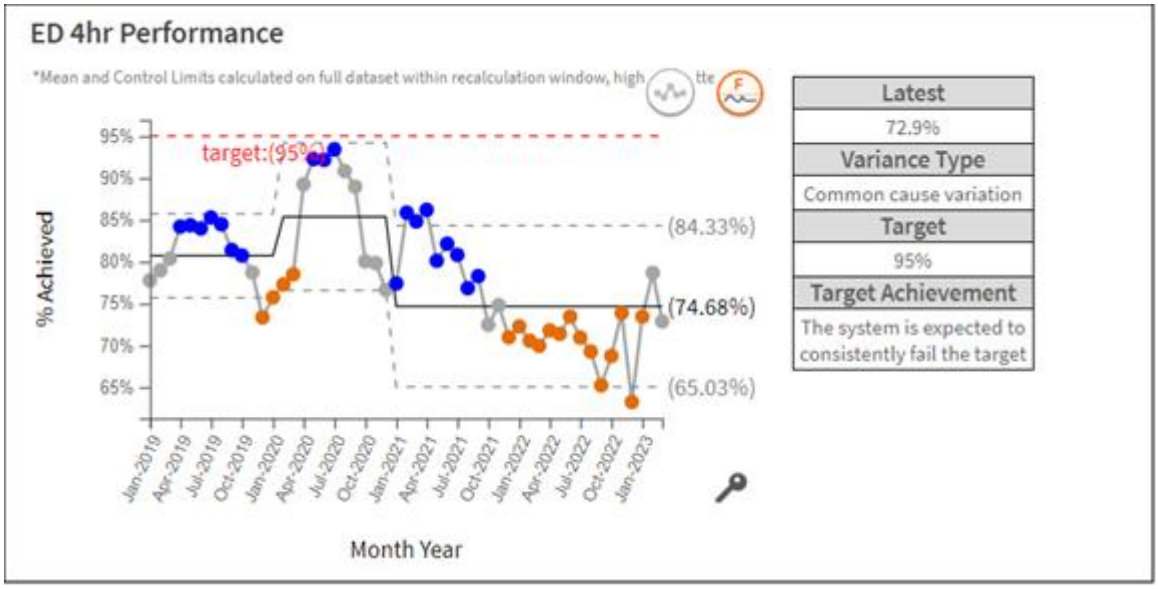
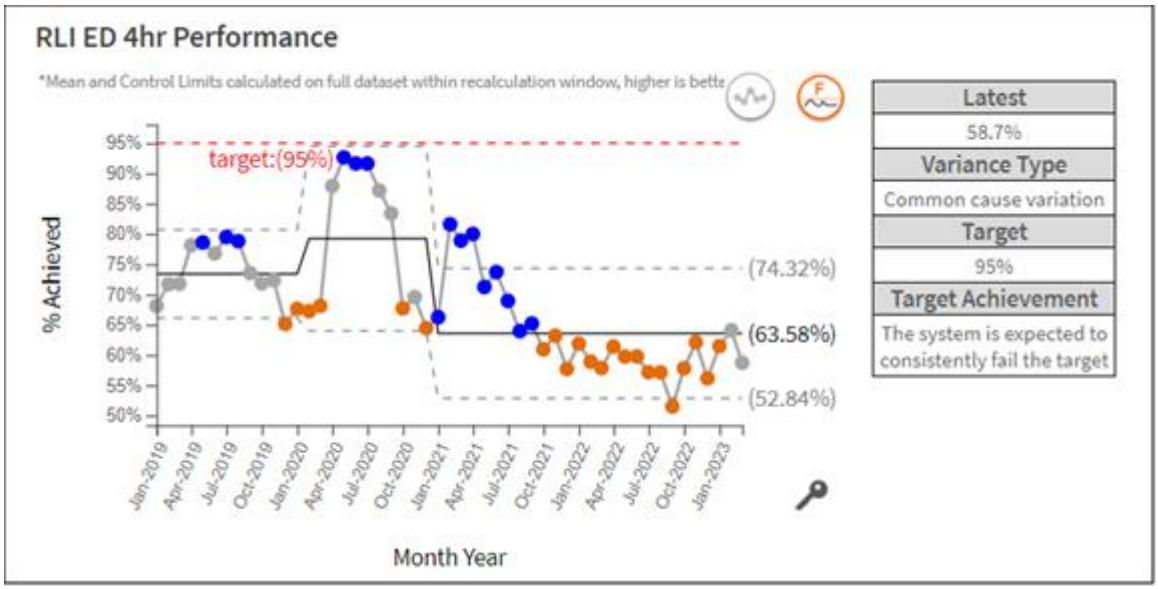
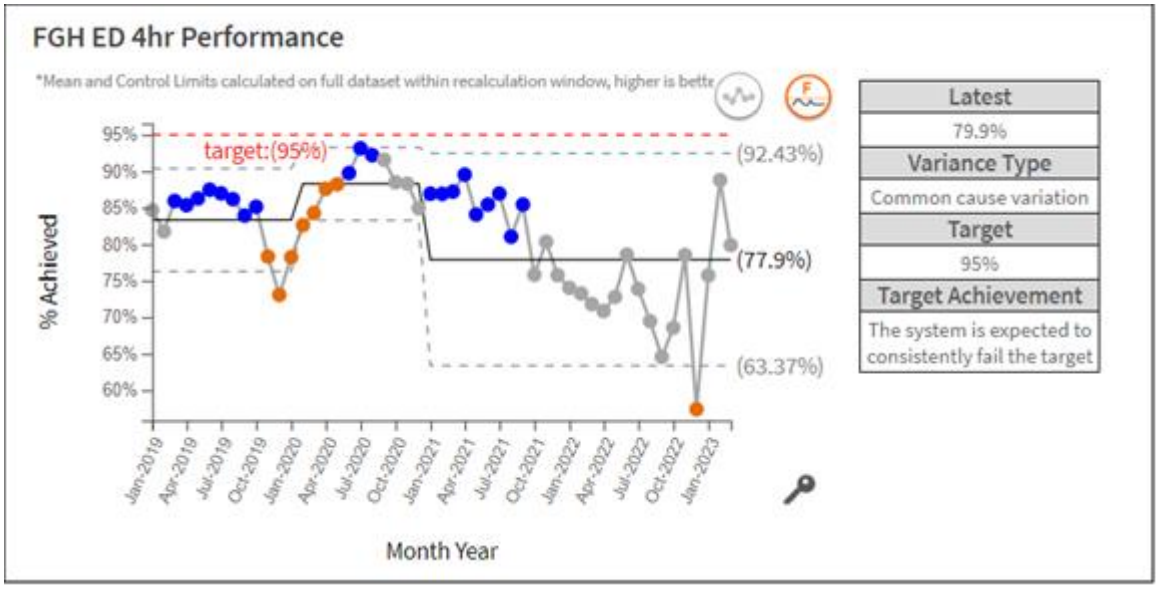


Table G: Site & Trust Wide Accident and Emergency Department 4-hour standard for 2022/23

A&E Performance	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Average for 22/23
A&E Standard 95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
RLI (All types)	61.40 %	59.71 %	59.73 %	57.13 %	57.12 %	51.47 %	57.79 %	62.08 %	56.12 %	61.45 %	64.08 %	58.31 %	58.82%
FGH (All types)	70.85 %	72.78 %	78.57 %	73.89 %	69.48 %	64.57 %	68.55 %	78.50 %	57.39 %	75.73 %	88.79 %	79.67 %	72.96%
Average RLI and FGH (Type 1)	65.26 %	65.03 %	67.35 %	64.01 %	62.32 %	56.93 %	62.06 %	68.40 %	56.62 %	67.22 %	73.61 %	67.08 %	65.26%
Data Source: Unify data: the indicator is in relation to the percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge													





In benchmarking UHMBT Emergency Department 4 Hr (Type 1 performance), the Trust was 10th out of 110 national Trusts in January 2023. UHMBT was also 5th out of the 22 Trusts within our Model Hospital peer group.

The Urgent & Emergency Care (UEC) Improvement Programme has been refreshed for 2022/23 with Bay and Health Care Partners (BHACP) to align with the Trust's planning priorities for the year. The overall aim has been to provide a safe, efficient and sustainable Urgent & Emergency Care patient journey that leads to better patient outcomes and experience, and improved working life for staff.

Schemes include:

- **SDEC** - delivery of a SDEC day-rate of 50%. Ongoing workforce plans to ensure provision of SDEC 12hrs per day, 7 days per week to create 15-20 beds of efficiency by July 23.
- **Frailty** – Develop a 7-day in-hospital Frailty service 70 hours per week by Jan 24
- **Reducing Not Meeting Criteria to Reside (NMC2R)** - reduce the number of NMC2R from a baseline of 120 patients (20%) to 95 patients (16%) by Jun-22, 72 patients (12%) by Dec-22 and 30 patients (5%), by end of Q4
- **Virtual Wards –** Provision of 150 virtual ward beds by the end of Q4 23/24 to release between 50-80 acute hospital beds of efficiency across the Trust.
- **Urgent Treatment Streaming** - 20-25% of RLI ED attendances to be redirected to a new RLI Urgent Treatment Centre (UTC) by end Nov-22, to decongest the Emergency Department and re-provide the capacity for additional majors equating to 3-4 additional cubicles.
- **Improving Ambulance Waiting Times (planning) –** maximisation of optimal structures, processes and behaviours, making ambulance hospital handovers as efficient as possible and ensuring patients are

cared for safely, compassionately and effectively. To achieve 95% of ambulance patients handover in 30 mins by March 31st (2023) and to achieve 65% of patients handed over in 15 minutes by 31st July 2023.

- **Paediatric Assessment (scoping)** - Development / delivery of an improvement plan, informed by RCPCH 'Facing the Future Standard' gap analysis and Paediatric data.
- **Mental Health (planning)** - In collaboration with Lancashire and South Cumbria NHS Foundation Trust (LSCFT) develop an acute trust mental health strategy, ensuring quality and safety standards are being met whilst also improving the timeliness of our mental health response.

Progress:

- **SDEC** - % medical admissions seen in SDEC has improved to trajectory levels for March at RLI, with a cross bay total of 38%. The highest number of patients streamed from ED was also observed in March. 7-day service is on track to commence at RLI, in April.
- **Frailty** – Continued provision of Frailty Intervention Team (FIT) service 50-60 hours per week versus 70 hour per week requirement, with the highest ever number (39%) of 75+ zero-day LOS admissions occurring in March, with no increase in reattendance rates within 24hrs/7 days. Data dashboard is giving benefit to the teams and recruitment strategy continues.
- **Reducing NMC2R** – Patients NMC2R equates to a small increase to 17.2% of G&A bed stock in Mar. Clinical leadership established for board round improvements and criteria led discharge.
- **Virtual Wards** - 47 beds live at the end of March against revised ICS trajectory of 72 by end of Mar '23. 483 patients have been cared for on the virtual wards with an average LOS of 6 days. Occupancy of the virtual beds averages at 39% in March, with a peak of 45%.
- **Urgent Treatment Streaming** - RLI UTC streaming 30% of ED attendances between the hours of 8am-8pm in March. Staffing/operating model continues to be discussed for a fully operational unit.
- **Improving Ambulance Waiting Times** – Handover and turnaround times at FGH maintaining improvements during March but slight deterioration at RLI due to ongoing hospital flow issues.
- **Paediatric Assessment** continues with inter-care group discussions around options for delivery under the SDEC remit, and **Mental Health** requires consideration by senior leadership regarding mitigation of delivery risks in line with 23/24 planning objectives.

Cancer 62 day Waiting Time Standard for first treatment

The Trust did not achieve Cancer 62 Day Standard in Quarters 1 to 4 2022/23. The Cancer 31 Day standard – drug treatment was met for each quarter and Cancer 14 Day Standard was met in Quarters 3 & 4.

Cancer 2 Week wait referral rates have increased by >30% year on year since 2019/20, placing pressures throughout the system from first outpatient appointment through to capacity at tertiary providers to treat patients. Key clinical vacancies have also contributed to delays in some tumour groups. Actions to ensure that >85% of patients receive their first treatment within 62 days in 2023/24 include the continued roll of out the national best practice pathways across the remaining tumour groups, continued focus on minimising avoidable delay, recruitment to key clinical posts where vacancies have contributed to wait times. e.g. the 4th Breast Surgeon commencing work in May 2023, discussion with patients to encourage them to attend offered appointments and investment in diagnostic services to reduce request to test and result reporting times.

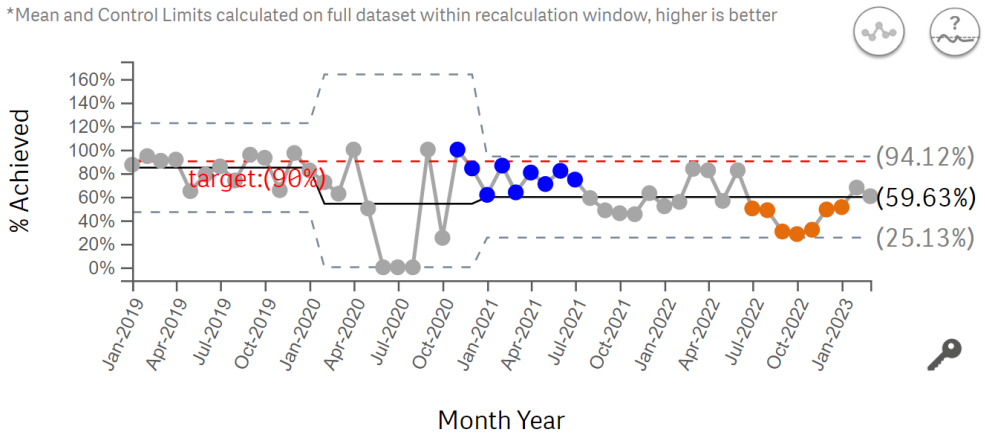
Performance against Cancer 62 day waiting time standard for first treatment- Quarterly Key Performance Indicators												
	2020/21				2021/22				2022/23			
Standard	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
All cancers: 62-day wait for first treatment from urgent GP referral for suspected cancer	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet
All cancers: 62-day wait for first	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet

treatment from NHS Cancer Screening Service referral												

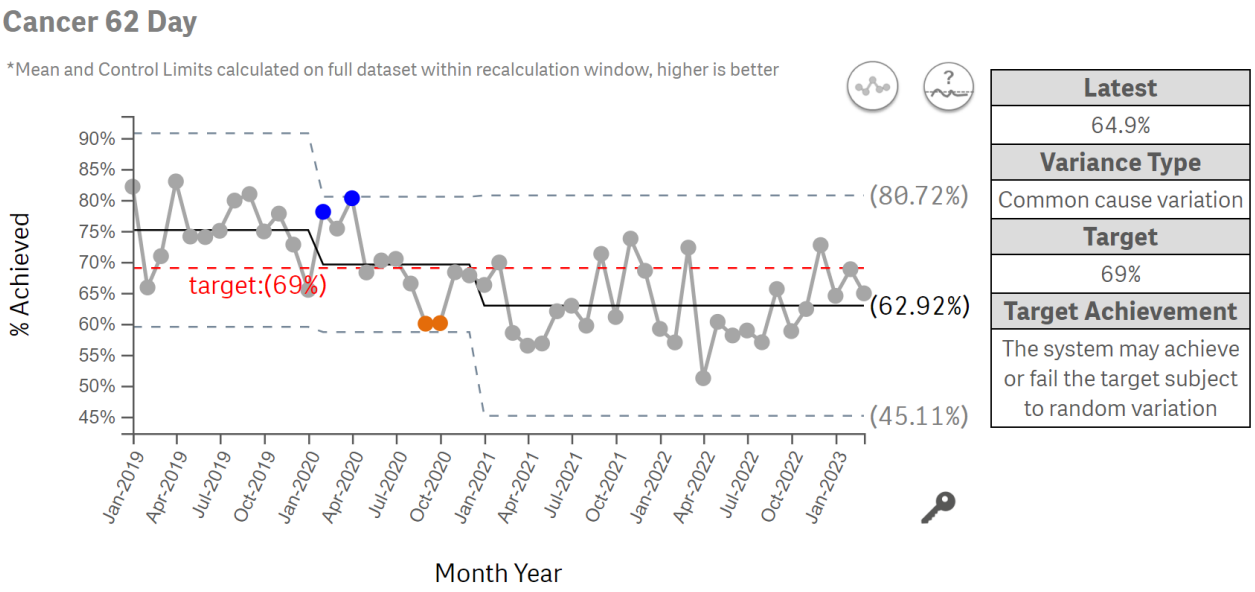
Performance against Cancer 62 day waiting time standard for first treatment- Quarterly Key Performance Indicators													
	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	
62 day standard 85%	**85%**	**85%**	**85%**	**85%**	**85%**	**85%**	**85%**	**85%**	**85%**	**85%**	**85%**	**85%**	**2022/23**
All cancers: 62-day wait for first treatment from urgent GP referral for suspected cancer	51.2 %	60.3 %	58.1 %	58.9 %	57.0 %	65.6 %	58.80%	62.3 %	72.7 %	64.5 %	68.3%	64.9%	62.1%
All cancers: 62-day wait for first treatment from NHS Cancer Screening Service referral	82.4 %	56.4 %	82.4 %	50.0 %	48.5 %	30.4 %	28.20%	31.8 %	49.1 %	51.1 %	67.7%	60.4%	49.4%
Data Source: Unify Data													

Cancer 62 Day Screening

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



Latest
60.4%
Variance Type
Common cause variation
Target
90%
Target Achievement
The system may achieve or fail the target subject to random variation



Emergency Readmissions within 28 days

Emergency readmissions occur when a patient is readmitted to the Trust following a previous elective or emergency stay. As part of the required definition, the admissions might not be connected. For example, the first admission could be for a hip replacement and the second (emergency) admission for a cardiac episode. With NHS Improvement, we measure readmissions within 28 days of discharge from the first admission.

Avoidable emergency readmissions can be linked to incorrect recording of treatment, incomplete support from community services or inappropriate discharge, resulting in patients being sent home without appropriate support in place. This results in a poor experience for patients as well as increased cost for the Trust through financial penalty via the contract for emergency readmissions. This also costs the Trust more money due to patients needing additional treatment.

Inpatient readmissions within 28 days

Care Group	Number of Readmissions < 28 Days			Percentage (%) of Readmission Rate < 28 Days			Number of Spells		
	2020/21	2021/22	2022/23 Q1-3	2020/21	2021/22	2022/23 Q1-3	2020/21	2021/22	2022/23 Q1-3
Acute Medicine	3566	4198	3232	9.91%	10.0%	9.57%	35972	41937	33780
Elective Medicine									
Women's and Children's	893	1323	904	8.49%	9.95%	9.01%	10516	13511	10032
Core Clinical Services	42	46	27	10.19 %	8.88%	6.82%	412	518	396
Surgery	2061	2440	1690	8.95%	7.33%	6.74%	23034	33501	25082
TRUST TOTAL	**6562**	**7354**	**5875**	**9.38%**	**8.95%**	**8.37%**	**69934**	**90119**	**70198**

Data Source: HED – Activity and Readmissions (Spells) module. 28-day emergency readmissions. Derived from NHS Digital HES dataset. Data period: Apr-2019 – Dec-2022 (Jan-March data unavailable as of this data release).

Seven Day Hospital Services

The Trust is committed to achieving the standards and continues to implement the priority clinical standards for seven-day hospital services. The Care Groups have all undertaken an assessment of their current compliance; actions to move them to compliance are being assessed and feature within each of their business plans.

Reducing Rota Gaps for our Doctors and Dentists in Training

The Trust works hard to fill rota gaps for our Doctors and Dentists in Training. We do this in several ways:

- If there is a known gap on a rotation that will be present for the duration of the training year, we will fill the gap in one of a few ways:
  - local recruitment,
  - reallocation of duties to a locally employed doctor who has the appropriate knowledge and skills,
  - employment of agency locum doctor - usually temporary until gap can be filled by the process above.
- If there is a short-term rota gap, e.g., due to illness, then we will prioritise the on-call system - asking colleagues to change shifts in short term, if necessary, and will redeploy locum juniors or locally employed juniors to ensure safe staffing.
- Through utilising the British Association of Physicians of Indian Origin (BAPIO) program, for middle grade doctors; this helps international doctors gain experience at core and higher levels in UK hospitals.

Freedom to Speak Up

Introduction

As a result of the public inquiry into Mid Staffordshire NHS Foundation Trust, which exposed unacceptable levels of patient care and a staff culture that deterred staff from raising concerns, the Freedom to Speak Up (FTSU) review was commissioned by the Secretary of State and chaired by Sir Robert Francis QC. One of the principles that came out of that review focussed upon the fact that raising concerns should be part of a routine business process for any well-led NHS organisation.

Robert Francis published his freedom to speak up review on the 11th of February 2015 and found that historically where staff had tried to speak up in the NHS, their concerns were often not welcomed. In the worst cases, the staff were treated very badly.

This endangers patients as we need to empower colleagues to be able to raise concerns, particularly where vulnerable patients are concerned. In response to this, NHS organisations were mandated to develop and embed the role of the FTSU guardian.

UHMBT launched its FTSU campaign shortly after the publication of the freedom to speak up review. UHMBT were one of the first trusts in the country to appoint a Freedom to Speak Up Guardian. Our first guardian started in post in July 2015 and the role has evolved since with a second guardian joining in August 2020. Both Guardians are members of the Northwest FTSU network, and they are involved in supporting other trusts through sharing learning and experience from UHMBT.

If any staff, volunteers, trainees, students, or governors have any concerns regarding patient or staff health and safety, professional or ethical misconduct, bullying, or any other matter that does not reflect what we expect as part of our vision and values, the Freedom to Speak Up guardians are there to offer advice and support.

Their role is to provide guidance and advice on how those working in our services may raise and escalate concerns, including outside of usual line management structures. At UHMBT we want our colleagues to feel safe to raise concerns about patient safety and colleague well-being which is why we prioritise speaking up as business as usual.

The Trust Board approved funding for an additional FTSU Guardian to help support Business as Usual (BAU) and to help drive implementation activities. Interviews were held in February and the successful candidate starts on 10th April for a 6-month period.

Freedom to Speak Up Strategy

The Freedom to Speak Up Strategy was created as part of the Freedom to Speak Project that has been initiated as part of the Recovery Support Programme. The Strategy Document and associated plan was created as a by-product of the team's investigation into specific areas, in conjunction with colleagues from NHSE and direct liaison with the National Guardians Office (NGO).

The National Guardian's Office leads, trains and supports a network of Freedom to Speak Up Guardians in England and provides support and challenge to the healthcare system in England on speaking up.

This was further to reviews and reports into the service being undertaken by NHS England and Mersey Internal Audit (MIAA),

The Strategy contains and has delivered the following 14 Strategic Priorities:

1. Ensure FTSU processes are Fit for Purpose and in line with Best Practice and Exemplar Sites.
2. Clarify & refine the FTSU Guardian Role at UHMBT.
3. Create a wider Network of FTSU Champions.
4. Work with our Board & Exec. Team to ensure they have all received Training on FTSU.
5. Increase the Visibility and Influence of the FTSU Service.
6. FTSU Embedded in all Learning Development Programmes.
7. Training and Visibility for FTSU across UHMBT.
8. FTSU Communication Strategy.
9. Update our 'Speaking Up Policy' in line with Best Practice.
10. Implement improved information exchange and intelligence between departments.
11. Conduct and Independent Peer Review.
12. Implement a New FTSU App.
13. Design and Implement a New Case Management System for the FTSU Guardians.
14. Refine and improve the format and Method of Board Reporting.

A summary of each of the elements of the strategy is listed below:

1. **Ensure FTSU processes are Fit for Purpose and in line with Best Practice and Exemplar Sites.**

This piece of work was done to ensure that the plans created as part of the project were aligned to "Best Practice" for running a FTSU Service.

The National Guardians Office provided the Trust with 12 statements that describe what they considered to be the key components of an exemplar FTSU Service. The FTSU Team assessed and documented the current UHMBT Position against each one of these statements to ensure that the FTSU High Level Plan contained the activities that would either deliver the required improvements or verify the current position.

In addition, the FTSU Team completed the Reflection and Planning tool provided by the National Guardians Office. The Tool is designed to help you identify strengths in yourself, your leadership team, and your organisation – and any gaps that need work.

All the items in the tool where the trust scored a 3 or less (Amber or Red) were reviewed. Apart from one item, all the other issues identified in the report were picked up as part of the Project plan that was already underway. The plan was updated to examine the format of the FTSU reports currently provided to Board and People Committee.

The FTSU team are planning to use the reflection and planning tool again in the summer of 2023 to monitor progress.

2. **Clarify & refine the FTSU Guardian Role at UHMBT.**

A review of job descriptions was undertaken to assess their suitability and alignment to Best Practice / NGO Priorities.

The Recovery Support Programme approved funding for an additional FTSU Guardian to help support BAU and to help drive implementation activities. Interviews were held in February and the successful candidate started on 10th April for a 6-month period.

We were particularly keen to hear from protected groups during the interview process – including BAME, LGBT+ and people with a disability. The successful candidate was originally from the Philippines.

A revised FTSU Guardian job description now exists aligned to Best Practice / NGO Priorities. This was reviewed by the Guardians on Wednesday 5th April.

The business schedule used by the FTSU Guardians has been updated to reflect the updated Job Description that has a more information and influenced work plan. Although, this has been in use for several months, it was reviewed and updated on Wednesday 5th April in the light of the appointment of the new FTSU Guardian.

3. **Create a wider Network of FTSU Champions.**

The ambition of the Project was to restructure and re-align resources to enable a more comprehensive support of the FTSU Function and part of the Broader Cultural Transformation work.

This was be achieved by:

- bolstering the numbers of people who are now more reactive with regards to FTSU following an approach from a member of staff.
- enabling staff to be able to advise and channel concerns to the right area. (To supplement the network training and to assist with the communication with staff, content was created to help ensure that staff are clearer in terms of who to approach with a particular type of issue).
- Ensure the guardians undertake the proactive parts of their role.

From Mid-March, each of the Networks listed below had the following e-Learning courses added to their (Training Management System) TMS Profile:

- **Speak Up** - This module covers what speaking up is and why it matters. It is designed to help you understand how you can speak up and what to expect.
- **Listen Up** - This module focuses on listening to concerns and understanding the barriers to speaking up. During the training, Managers will complete both Speak Up and Listen Up to ensure they understand what speaking up is and how they should respond.

Post the training, each of the participants were sent a link to a video relating to Freedom to Speak Up. The Video is approximately 20 minutes long and describes the steps that someone needs to go through to raise concerns within Morecambe Bay.

The following Networks within UHMBT were identified as being able to assist in this area to help create this movement of approximately 220 advocates for FTSU:

- Respect and Civility Team.
- Recovery Champions.
- Culture Change Champions.
- Occupational Health Team.
- Learning and Organisational Development Facilitators.
- Workforce Advisors.
- Mental Health First aiders.
- Inclusion Networks.
- PNA Nurses.

4. **Work with our Board and Executive Team to ensure they have all received Training on Freedom to Speak Up.**

To help ensure that the board not only listen, but listen in the right way, all the board members completed formal training in FTSU (Freedom to Speak Up) as part of the revised Freedom to Speak Up Strategy.

In January 2023, the Trust Board received a precis of the work done to date within the FTSU service. In March 2023, the Board received the Final Module of e-Learning training provided by the National Guardians Office – “Follow Up”, after they had completed their Level 1 and Level 2 training.

5. **Increase the Visibility and Influence of the FTSU Service.**

To increase the visibility and help to ‘re-launch’ FTSU, a schedule of business was compiled detailing monthly, all the different duties that they are expected to undertake.

The schedule includes corporate inductions, On-site walkabouts, engagement with care group managements teams, and current networks.

Our current networks are:

- Black, Asian and Minority Ethnic Network
- Carers Network
- Disability Network
- Forces Network

- LGBT+ (Lesbian, Gay, Bisexual, Transgender) Network
- Network for Inclusive Healthcare
- Respect and Civility
- Women Leaders Network

6. **FTSU Embedded in all Learning Development Programmes.**

The UHMBT Leadership Development Programme was launched on Monday 4 July with the first focus being on 'What Good Leadership Looks Like at UHMBT'. The Course ran from July 2022 to December 2022. The remaining focus areas are due to run over the next 3 years and have FTSU content integral to them.

Focus 2 was called 'Me as Leader'. Having created the expectation of leadership in UMBHT, Focus Two addressed the feedback from the deep dive that several leaders do not have the skills required to lead. 'Me as leader' was launched in Mid-February 2023. All the FTSU e-Learning Courses are flagged to delegates during this course and the course designers embedded a FTSU question into the diagnostic section of the course.

This forms part of an ongoing programme with modules planned for up to three years each with a specific focus to help leaders focus on one aspect of leadership at a time.

7. **Training and Visibility for FTSU across UHMBT.**

Speaking up is everybody's business. If we do not speak up it can have profoundly dire consequences. It can affect staff wellbeing, your morale and, that affects patient outcomes. These are the very people at the centre of everything we are trying to do here at the University Hospitals of Morecambe Bay.

The National Guardians Office have developed 3 e-Learning Modules called 'Speak Up, Listen Up and Follow Up'. This training was rolled out across UHMBT from Mar 2023. This training helps learners understand the vital role they can play in a healthy speaking up culture which protects patient safety and enhances worker experience.

An overview of each of the training modules is shown below:

- **Speak Up** - Core Training for all workers. Target 85% completion by Feb 2024. This module covers what speaking up is and why it matters. It will help you understand how you can speak up and what to expect.
- **Listen Up** - For all staff who conduct appraisals. Target 85% completion by Feb 2024. This module focuses on listening to concerns and understanding the barriers to speaking up.
- **Follow Up** - Board members, Non-executive Directors, Executive Directors, and their deputies. Target Approx 250 staff – 95% completed by End of June 2023. This module aims to promote a consistent and effective Freedom to Speak Up culture across the system which enables workers to speak up and be confident they will be listened to, and action taken.

Senior leaders are expected to complete all three modules, Speak Up, Listen Up and Follow Up to ensure they have a full understanding of the speaking up process.

Each of these courses have been integrated with the Trust's TMS so we are able to report over time with regards to progress against each one of these targets.

8. **FTSU Communication Strategy.**

Freedom to Speak Up was and will continue to ensure the FTSU Service continues to be promoted in various ways including:

- Articles in our 'Improving Together' Recovery Support Programme (RSP) newsletter. Online and printed.
- Regular updates in Weekly News
- Video with Deputy Chief Nurse Dan West.
- Ongoing promotion on the intranet, large electronic screens, and screen savers.
- Further all-colleague briefings.
- FTSU information incorporated into our UHMBT Leadership Programme.
- Printed materials including stickers, flyers, and posters.
- Walkabouts by FTSU team.

- The comms materials produced are also being shared with our Trust Governors, Staff Inclusion Networks, our Staff-Side colleagues, and the Trust Management Group.

9. **Update our 'Speaking Up Policy' in line with Best Practice.**

Rachel Hunt, People and OD Business Partner in conjunction with the Freedom to Speak Up Guardians undertook a review of this policy to ensure it was aligned with Best Practice.

This 'standard integrated policy' was one of several recommendations of the review by Sir Robert Francis into whistleblowing in the NHS, aimed at improving the experience of whistleblowing in the NHS.

Our local process has been integrated into this policy and provides more detail about how we investigate a concern. The Trust policy review / approval committee for this Policy sat in November 2022 with final sign off granted in Mid December 2022.

10. **Implement improved information exchange and intelligence between departments.**

FTSU is less isolated within the organisation because of the establishment of Data Triangulation meetings. The Triangulation meeting is designed to sit alongside the other concern raising elements of the organisation and facilitates information exchange and Trust wide decisive action on concerns, incidents, reporting through respect and civility and safeguarding departments.

The meeting commenced in November 2022 and is attended by:

- Deputy Chief Nurse.
- Head of Culture and Organisation Development.
- FTSU Guardians.
- Head of Safeguarding.
- Respect Team Lead.
- Head of Inclusion and Engagement.
- Director of Governance.
- Occupational Health Lead.

The Head of Culture and Organisation development was made the chair of the group. The Governance pathway for this meeting is that it reports into the people committee. The Speak up triangulation meeting takes place each month at a time that meets the commitments of attendees and reflects the availability of the relevant data.

This delivers a sustainable approach to intelligence within the trust to help ensure the trust is continually on the lookout for potential issues to emerge.

The first meeting of this Multi-Disciplinary Group led to the initiation of an action plan targeted at a specific location based on the data presented and discussed at the session.

11. **Conduct and Independent Peer Review.**

The purpose behind the Independent Peer Review was to try and gain an understanding of what best practice is and compare that against the where the service at UHMBT features.

The exam question being posed was, "How do you know what you're doing is the right thing and in line with best practice?"

This review was conducted by John Walsh who is a Freedom to Speak Up Guardian from Leeds Community Healthcare NHS Trust.

The review was undertaken using the following methods:

- Desktop analysis of the current strategy, self-assessments, and work plan.
- Gap analysis of current state versus best practice opportunities
- Individual and/or team meetings with relevant colleagues
- Individual and/or team meetings with key stakeholders
- Any other relevant documents reasonably requested by the reviewer.

Interviews took place in Feb with the draft report made available for the Trust to review in March 2023.

The first, and one of the main reflections in the report, is as follows:

"The first is I heard positive and good work to recast the FTSU service. This is working and developing across the trust and creating new relationships with key elements such as the leadership programmes. Senior leaders are driving and supporting this work. MBHT colleagues described feeling a change for the better".

The Recommendations within the report form the basis for the next PDSA cycle and is reflective of the continuous improvement lens not only within the FTSU service but across the Trust.

12. **Implement a New FTSU App.**

The Freedom to Speak Guardians worked in conjunction to the i3 Department at the trust to build a local version of the FTSU app that replicated the functionality of the previous app. This was to ensure that there are several different ways for people to access the service and to help make it as easy as possible for them.

The previous FTSU App was no longer available to download on the App Store and ceased to work in the event it was already downloaded onto an iPhone at the end of 2022.

As part of the work to rebuild this local version of the app, the functionality it delivered was enhanced in 3 areas:

- Wording – the wording used within the app was updated to reduce the formality and make it more appealing.
- Video's – The new app delivers the capability of being able to insert videos, so videos narrated by the FTSU Guardians were added that explained the importance of key elements of the process and app functionality.
- Feedback – A feedback form where users can record feedback about the service was added.

The App was launched in October 2022 as part of the overall FTSU communications plan.

13. **Design and Implement a New Case Management System for the Freedom to Speak Up Guardians.**

This element of the project delivered a far more secure and purpose-built tool for the Guardians to use and meant that moving forwards that all the FTSU data including those cases that have come in via the FTSU App were all stored in one place.

February 2023 marked the go-live of the Case Management Tool for the Freedom to Speak Up Guardians.

This in turn helped to ensure that the reporting delivered via the FTSU Dashboard is both comprehensive and robust.

14. **Refine and improve the format and Method of Board Reporting.**

A list of Metrics was created in conjunction with the FTSU Team as part of the project. Each Metric has their own specific Statistical Process Control Chart (SPC) within the FTSU Dashboard.

These charts have helped the FTSU Guardians to understand their data over time rather than at a point in time. In addition, these charts have allowed the guardians to differentiate between common cause and special cause variation.

The Qlik Sense reporting platform facilitated the creation of additional boxes where a summary, actions and assurance are now entered by the guardians and displayed in the dashboard.

Once the Guardians enter this data, it is now utilised as part of a standard report delivered to NED's or a particular board, so they now receive a summary of the latest SPC charts for the service plus the commentary at the press of a button.

Concerns raised at the Trust through FTSU from 1/4/22 - 31/3/23.

Data submitted to the National Guardian's Office and categorised by the themes requested from the National Guardian's Office.

Quarter	Total	Anonymous	Patient Safety / quality of Care	Unacceptable Behaviours (with element of B&H)	Suffered Detriment	Other Issues
4	24	10	0	5 (0)	3	5
3	68	13	11	45(8)	15	39
2	37	19	6	16(1)	5	18
1	43	8	4	32(5)	13	26
Annual Total 22/23	172	50	21	98 (14)	36	88
Annual Total 21/22	124	41	41	88(13)	5	73

These are the concerns brought through FTSU and so are formally recorded. The Raising Concerns policy describes the opportunity for individuals to raise matters informally in the first instance, which would not be recorded by FTSU.

Work continues to develop the open and transparent culture that is necessary to encourage staff to raise matters, and for speaking up for patient safety and staff well-being to be routine. The resulting number of formal cases suggests that staff feel comfortable to raise matters and that informal resolution is achieved in most cases.

It is important to remain focused on feedback from individuals who have raised concerns and relevant stakeholders within the process to ensure the current policy captures the spirit of the Trust's values and that staff feel that they can raise concerns or issues without fear of victimisation, blame or reprisal. The FTSU Guardians have had concerns raised from all colleague groups.

Listening to our Patients and Meeting their Needs

Patient Experience

We are committed to improving the experience for our patients, families, and carers. Our new Patient Experience, Carer Involvement and Volunteer Strategy, ensuring we continue to:

- Promote the role and benefits of patients and the public in shaping our services.
- Develop new, innovative ways of working with patients, citizens, and carer.

The strategy facilitates the delivery of four Strategic Priorities but has a significant contribution to the Clinical Strategy. Through stakeholder engagement, we have heard a solid commitment to having an approach that recognises the patient, their families and carers as a partner in the health and care journey. You can read the full Patient Experience, Carer Involvement and Volunteer Strategy here https://www.UHMBT.nhs.uk/get-involved/patient-experience

The Embedding Kindness project has had a positive impact. Partnership working has continued, supporting Carers, who help patients (Community, Inpatients and Outpatients).
Work is underway on the 23/24 patient Experience Strategy; this will further develop embedding kindness work and a focus on creating a culture where carers are welcome to support their loved ones, and actively seeking out feedback from those who are most likely to experience inequality experience or outcomes.

The Friends and Family (FFT) refresh, which occurred in December 2022, has changed in its format. We now encourage patients to provide feedback at multiple points in their care journey. In 2022/23 79,342 patients and their families or carers gave the trust feedback.

Several new Patient Experience projects have been developed during the past year.

The Relatives Loved One's messaging service was introduced during the pandemic and continues today, with many compliments. Families have been very impressed with the Trust for implementing such a service and found this resource invaluable.

Learning from complaints is a priority, and evidence of this how is captured and reported. We now link complaint themes with patient stories and ensure the stories are shared from Board to ward, you can read some of our patient stories here https://www.UHMBT.nhs.uk/get-involved/patient-experience/patient-stories

Public engagements - we have undertaken several public engagements throughout the year. We call these, “What Matters to You" events, reaching out to the community to get representative voices from our diverse population. We have also developed a strong survey presence to seek live feedback on our services, we have and continue to make it easy for people to contact us when they have experience to report.

Quality Improvement Programme for our Ward Managers. The first cohort focused on Fall and Pressure Ulcer improvement developing expertise in quality improvement methodology. The improvement work was triangulated with the themes emerging from the harm free care meetings and rapid reviews.

The Harm Free Care team meets weekly and reviews the last 7 days incidents of pressure ulcers and falls. All Care Groups are represented at the meeting, this is creating an opportunity to discuss cases and identify key learning enabling us to share good practice and further drive improvement across the trust.

Falls Improvement work has resulted in 56 members of staff becoming Falls Champions, with bespoke training. A Falls Practitioner provides staff with the knowledge and understanding at ward level. A full review of all recurrent fallers by Practitioner ensures Best Practice is being followed in line with Policy and to provide additional support to clinical staff.

A Call Don't Fall initiative has been applied to Clinical Areas with a continued focus on "Get up & Keep moving" to prevent patient deconditioning. Patients that are prone to falling will receive a pair of yellow socks and a yellow blanket when they are treated in the Emergency Department, as part of an innovative to reduce the risk of falls.

A Falls Improvement Forum has been established; all falls from Care Groups are presented to the Harm Free Care Meeting with an alert added to electronic patient records to flag patients at risk of recurrent falls if appropriate.

Pressure Ulcer Improvement, a deep dive into Hospital Acquired Pressure Damage has been completed in year. Support is provided to care group teams by the Fundamentals Of Care practitioners and senior nursing teams. The Acute Tissue Viability team has worked to innovate with trust Information and technology (i3) department to create dashboards for e-referrals and a pressure ulcer dashboard. Bed side imaging developed with I3 is now embedded in practice.

Nutrition and Hydration A “Mouth Care Matters” Lead is now in place, they are driving the importance of maintaining good oral hygiene for all patients. Learning from best practice at other Trusts, has results in the recruitment of Patient Activity Volunteer who also help the patient at mealtimes. These posts are improving the care of the elderly with their dietary intake.

End-of-Life Care in 2022 saw the official launch of the nationally recognised "Swan Model" of care across the Trust. The model promotes dignity, respect and compassion at the end of life. "Swan Huddles" have been established regularly throughout the weekly to identify End of Life patients and ensure preferred care is in place.

Dementia/Delirium Dementia Champions workshops were held during 2022 with a wide range of invited speakers. The aim being for the champions to learn more about dementia and share the learning across clinical areas. This was attended by all members of the multi-disciplinary team and included care homes.

In 2023, the workshop days will also cover Learning Disability and Autism. Admiral Nurses have been recruited at both Lancaster and Barrow in Furness. Their role is to support patients and their families across the whole pathway ensuring they receive care in line with dementia UK standards.

Dementia specific menus have been made available to all patients with all inpatient wards provided with a Dementia Trolley which enables patients to undertake activities. We have also adapted cubicles/rooms to better reflect the needs for people with dementia.

The Patient Experience and Involvement Group is now well established and is made up of public members supported by NHS colleague. The group offers independent views and advice from a patient, carer, or visitor perspective on many aspects of the patient experience while using our services. This group monitors our developmental themes and trends from a number of sources including complaints, Patient Advice Liaison, Healthwatch reports local and national surveys.

National Survey Results

We use national surveys to find out about the experience of the people who have received care and treatment from our Trust. The National Surveys presents us with contemporaneous data on the experiences of many patients. It is a rich source of information, but viewed alongside the data we gather from complaints, FFT and local surveys.

The National survey results help us to ensure we direct our improvement efforts towards actions that will have the greatest impact on patients' experience of care and treatment. While clearly there will be standalone 'quick win' actions to take, equally important are the opportunities influence our transformation and improvement initiatives by encouraging them to take on board insight that the national inpatient survey offers us.

You can view our National Survey results here https://www.cqc.org.uk/provider/RTX/surveys

- Cancer Experience survey results were published in July 2023.
- Adult inpatient survey results were published on the 29th of September 2022.
- Maternity survey results were published on the 11th of January 2023.

Macmillan Information and Support Services (MCISS) offer high quality information, emotional support, and practical advice to people affected by cancer. As a non-nursing service the team continue to work alongside the Cancer Teams providing support for the people of North Lancashire and South Cumbria.

We have recently relaunched our Cancer Information and Support Service (MCISS) at Furness General Hospital (FGH) last week. The service has been renamed as the 'Furness General Hospital Macmillan Information and Support Centre'. The purpose-built space boasts an office and quiet room with a feature wall which will allow the team to carry out face-to-face appointments. The redevelopment was funded by Bay Hospitals Charity and two grants from Macmillan Cancer Support.

Patient feedback has included: · "I recently reached out to the service at Lancaster, I am delighted to see the relaunch of the centre in Barrow. I have looked around the new centre. The new centre feels friendly, set in a private environment at the main entrance of Furness General Hospital. I am sure patients, and their families, friends or carers will welcome this local face-to-face service".

Sallie Robinson, Macmillan Cancer Information and Support Service Manager, said: "This is a really generous joint venture between Bay Hospitals Charity and Macmillan. It's created a beautiful, welcoming environment, with the idea that our service will be able to offer face-to-face appointments and drop-in support which will benefit the local area of Barrow. "It is fantastic that Macmillan has also separately funded a new MCISS assistant who will be supporting the service at Barrow along with our volunteers."

"Cancer services are a key area of focus for the Trust, and this is an area where we are constantly driving improvements. You can read our 2022/23 Macmillan Information and Support Services annual report here https://www.UHMBT.nhs.uk/our-services/services/cancer-services/macmillan-information-and-support-service

Patient quotes

Mrs Moore for Morecambe said, 'Having recently been a patient at the Royal Lancaster Infirmary. I was delighted to have been asked for my comments on the service received. I completed the EDS2 and Friends and Family questionnaires together and hope my feedback contributes to the ongoing work of my local NHS. Thank you for asking for my ideas'.

Mr Ridge, Ulverston, Cumbria said, the Sunflower is a globally recognised symbol for non-visible disabilities, also known as hidden disabilities or invisible disabilities. 'Since wearing my Sunflower lanyard, I have felt more comfortable visiting the hospital, as my disability prevents me from wearing a surgical mask'.

Patient Safety Partner – An exciting new role has been introduced, our Patient Safety Partners (PSP) is a new and evolving role developed by NHS England to help improve patient safety across health care in the UK. We have recruited three PSPs to work alongside our colleagues, patients, and families to influence and improve safety within our hospitals and community services.

Care and communication hospital and community passports provides information about a patient's preferences and communication needs. We now have over 1000 completed passports and more continue to be uploaded to the patients' electronic record.

Evidence suggests that having a passport significantly enhances patient and staff experience and provides a positive and inclusive patient experience. You can view our Trust's digital passports by clicking here https://www.UHMBT.nhs.uk/get-involved/patient-experience/care-and-communication-passports

Children's waiting area, children who attend the Emergency Department at Lancaster now have an attractive new waiting area designed to improve their care, safety, and experience while in hospital.

The new RLI Children's waiting area in the A&E is a bright, welcoming, and relaxing room for children and families with space for social distancing and toys that can be easily cleaned for the prevention of infections such as COVID-19. The area in the RLI A&E department also includes a Children's Triage Room and three new Ambulatory Assessment Bays, one of which is specifically designed to be more welcoming for children.

Veteran Aware. We have been recognised for our commitment to improving NHS care and support for veterans, reservists, members of the Armed Forces and their families.

Awarded by the Veterans Covenant Healthcare Alliance (VCHA), the Veteran Aware mark highlights NHS trusts which have made a series of pledges, such as ensuring members of the armed forces community are never disadvantaged when receiving care, training staff on veteran specific needs, and supporting the armed forces as an employer.

Youth Forum 'Youth Bay Vision' The 2021 census shows that around 29.5% of the North West's population are under 25 years of age. We are in the process of re-developing the trusts youth forum and plan to call this work our 'Youth Bay Vision'. We have been actively promoting the forum on social media pages and via a wide range of contacts. To switch up tactics and rather than wait for young people to approach us, we have become more proactive in going out and approaching them and collaborating with already established youth groups.

Kendal Youth Zone have invited us to work collaboratively with them and their youth group. This will provide opportunity to reach out to young people (age 10-18 years) and give them a voice in what matters to them within healthcare. They have provided further contacts for Youth Zones in Lancaster and Barrow areas. An area that has been highlighted after discussion with a range of contacts is that young people are unsure of services available to them, working with colleagues we now have a young person transitioning to adulthood pathway poster and online material. The group are currently reviewing the inpatient paediatric food choices and daily menus.

DFN Project SEARCH is a transition to work programme committed to transforming the lives of young adults with a learning disability and autism or both. The DFN Project SEARCH leads at Westmorland General have welcomed 'Youth Bay Vision' to attend a morning meeting once a month to discuss healthcare topics/improvements to services and feedback from their young interns (age 17–25) that are currently working within the trust. This provides feedback from fresh eyes that are centred in the middle of our healthcare services.

Hospital Acquired Infections

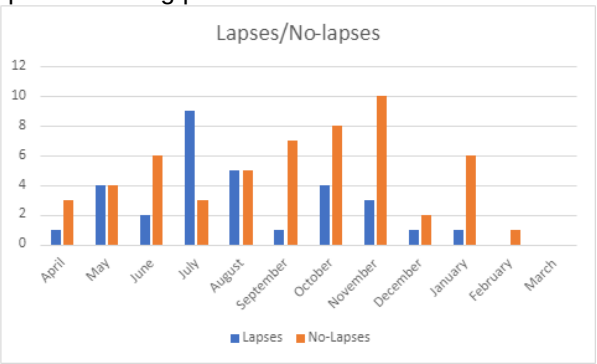
UHMBT continue to commit to the reduction in Health Care Acquired Infection (HCAI) by reducing the avoidable cases of *Clostridioides difficile* infection (CDI) in line with the annual threshold outlined in the NHS England Standard contract.

The annual threshold in 2022/23 for both Hospital onset healthcare associated and community onset healthcare associated Clostridioides difficile infection (CDI) and was set at 84 cases. The total number for this financial year to date is 95 cases a 17% increase on this time last year (March data is not available until after 10.04.23). Our aim is that no patient is harmed by a preventable infection, and this is the maximum number of cases expected for our population, not a target. The threshold for 2023/2024 has not been set yet, however reported nationally CDI cases have increased 42% in the Acute Trusts and 16% in the Community.

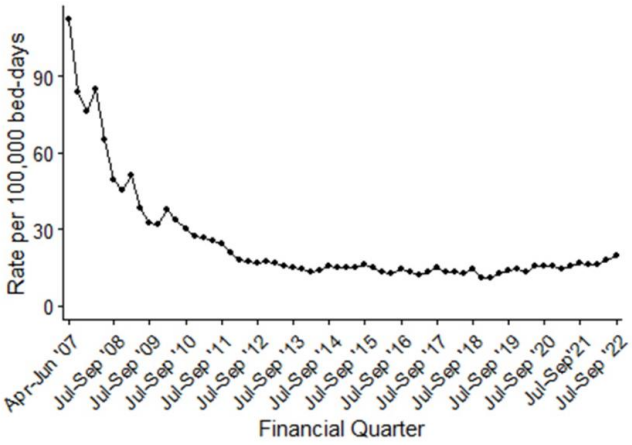
- Between April 2022 and February 2023, there have been 53 cases of hospital onset healthcare associated cases and 42 community onset healthcare associated cases of CDI. A risk remains on the

risk register for breaching the threshold and a cross care group CDI working group is ongoing. This has seen improvement in lapses in care, throughout the financial year. The Infection Prevention team are working closely with the antimicrobial pharmacy team to support improvement in antimicrobial stewardship, timely learning from post infection reviews and constantly trying new ways of engaging teams.

- Please see lapses vs no lapses following post infection reviews:



- The increase in CDI has been a challenge not only for UHMBT but England as a whole has seen an increase in cases, of which a significant focus is on antimicrobial stewardship and how this has been challenged during the Pandemic.
- Please see data below that shows the national picture steadily increasing since July 2018:



- Please see Comparison across the ICS for January ’22 to January ’23, CDIs have for the majority of Trusts been higher than the previous year.

	Jan '22	Feb '22	March '22	April '22	May '22	June '22	July '22	August '22	Sept '22	Oct '22	Nov '22	Dec '22	Jan '22
East Lancs	2	8	5	5	6	3	5	6	5	9	2	6	7
Blackpool	3	7	2	7	5	10	9	12	11	12	5	7	4
Lancs teaching	15	13	14	15	11	21	20	20	16	15	15	11	22
UHMBT	6	5	7	4	8	8	13	11	8	12	12	3	9

The Trust reviews all hospital onset healthcare associated and Community onset healthcare associated CDI cases, completing Post Infection Reviews (PIR). The Hospital onset Healthcare associated cases were reviewed by the Ward responsible for the patient’s care and were supported by clinical staff involved in the patient’s journey. The Trust IP team lead on the post infection review meeting which is currently done within 2 weeks of the CDI being identified. Although how to best engage with prescribers is under constant scrutiny, so alongside the anti-microbial team a new way of working will be started in the new financial year to best support this.

The Integrated Care System (ICS) Infection Prevention (IP) team have oversight of all the outcomes.

A lapse in care would be indicated, by evidence, that policies and procedures consistent with national guidance and standards were not followed by the relevant provider, actions are created and monitored through the CDI working group.

To date in 2022-2023, there has been no Period of Increased Incidence (more than 1 case in the same area within 28 days) where the cases have been linked by typing.

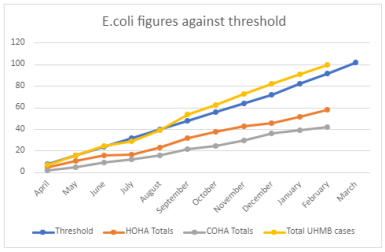
Themes well understood are:

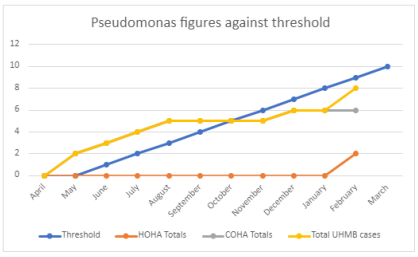
- Compliance not met in cleaning standards, including commodes.
- Compliance not met with infection prevention precautions such as hand hygiene.
- Delayed isolation.
- Anti-microbial stewardship.
- Following the Diarrhoea care pathway.

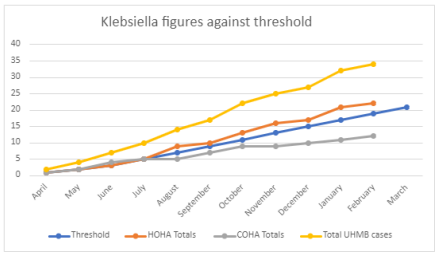
Gram negative Blood stream infections

The threshold for Gram negative organisms for 2022/2023 (E.coli, Pseudomonas and Klebsiella) encompasses Hospital onset healthcare associated and Community onset healthcare associated. The following threshold has been given to UHMBT:

- E.coli – 102
- Pseudomonas aeruginosa – 10
- Klebsiella – 21





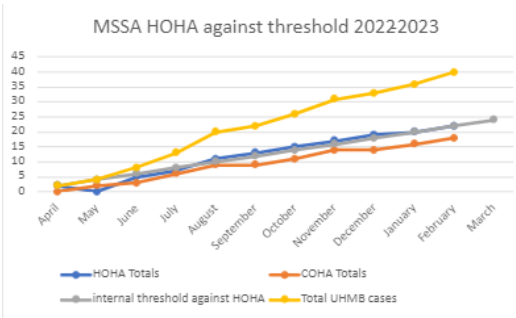


The themes for gram negative blood stream infections have historically well understood. Currently the Infection Prevention team complete quarterly thematic reviews to monitor these themes are trends. Gram negative focus has begun with care groups to support ongoing work streams that have been undertaken by Infection Prevention.

MSSA/MRSA Blood stream infections

MSSA

There is no national threshold for MSSA; for internal monitoring a 10% reduction against Healthcare associated was used and currently there have been 22 HOHA cases and the threshold up to February 2022 is 22.



MRSA

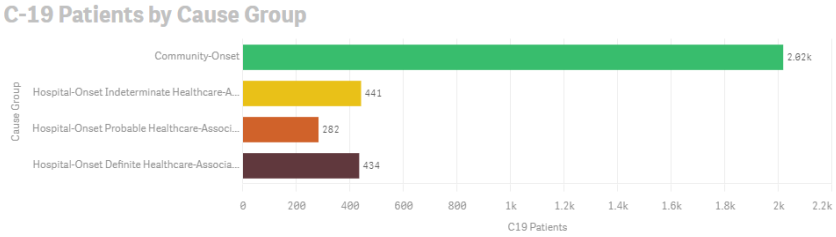
There is a zero tolerance of MRSA bloodstream infections. There are currently, as of 31.03.23, zero cases of MRSA bloodstream infections in 2022-2023. This will not be confirmed until after 10.04.23 due to awaiting cultures.

Catheter associated Urinary Tract Infection (CAUTIs)

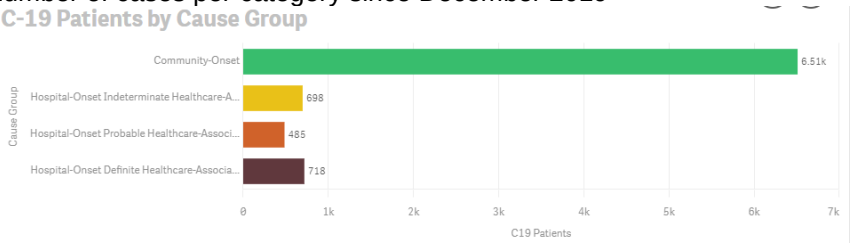
CAUTIs have not historically monitored by the Trust. A standardised definition of a CAUTI has not been available, there is now a Trust agreed definition based on the NICE guidance to support with monitoring. Having this standard will allow consistent monitoring, with the next step where best to see this recorded in Lorenzo.

COVID
Now 'living with COVID', there is no longer individual post infection reviews for each healthcare associated case as agreed through governance. Post infection reviews continue to be completed for any outbreaks. COVID-19 continues to impact on the work of the Infection Prevention team due to fluctuations in local numbers.

Please see below number of cases per category April 2022 – March 2023



Please see below number of cases per category since December 2019



Community onset classifications:
Community onset – Anytime up to day 2 of admission.

Hospital onset indeterminate association – Day 3 to Day 7 of admission.

Hospital onset classifications:
Hospital onset Probable healthcare association – Day 8 to Day 14 of admission.

Hospital onset Definite healthcare association – Over 14 days of admission.

Below please see COVID waves over time since January 2020 – March 2023

Other Additional Information in Relation to the Quality of NHS Services

We reported last year we had experienced a number of serious concerns, requiring the Trust and following assessment by the new NHS System Oversight Framework (SOF), UHMBT has been given access to mandatory national intensive support and placed in the Recovery Support Programme. UHMB was given a SOF 4 rating

During 2022/23 the NHS regionally and nationally have worked collaboratively with us and local partners across Morecambe Bay to better understand the root causes of the challenges we face, agree, and deliver a package of intensive support, and set and monitor progress against an improvement plan which would allow us to exit out of the programme in a sustainable way. The Recovery Support Programme has given us access to additional expertise and resources to ensure sustainable improvements are made as quickly as possible.

We are very thankful of this support and looking ahead to 2023/24, the Trust is confident that sustainable improvements are being made as quickly as possible and have begun seeking a review of its NHS System Oversight Framework (SOF) rating.

Patient Safety Incidents Framework

The national Patient Safety Strategy was launched in July 2019. This strategy sits alongside the NHS Long Term Plan (LTP) and the LTP Implementation Framework. During quarter 1 of 2022/23, a new national patient safety incident framework (PSIRF) was published setting out a new approach to responding to patient safety incidents. A Patient Safety Incident Response Plan is being developed in Q1 2023/24 to identify areas of focus for system level investigations. PSIRF will introduce a different emphasis with regards to patient safety investigations.

Infection Prevention and Acute Tissue Viability 2022/23 Highlights

The Infection Prevention work streams continue to be impacted from the COVID pandemic, however protocols have consistently been updated as national guidance changes and normal business returns.
This has included the move away from completing post infection reviews on all hospital onset COVID and the focus being on lessons and themes being taken from any outbreaks.

There has been an increase in clostridioides difficile infections which has also been evidenced Nationally. Gram negative blood stream infections had a threshold for the first time in 2022-2023; E. coli, Klebsiella and Pseudomonas as noted previously. For Actions were within the Infection Prevention strategy for 2022/2023 with work streams including: CDI working group, catheter associated UTI recognition and definition now agreed, catheter passports, maintain monitoring of contamination of blood cultures and Staph aureus bacteraemia and line care work.

These are being monitored closely and reported through the Infection Prevention Control Committee and the Quality committee via the IPR.

There have been zero MRSA bloodstream infections in year 2022-2023.

After a number of years of work, the Catheter Passport has been agreed, this Passport will follow the patient through their care episodes. This ensures that the provenance and rationale for the catheter is understood wherever the patient is. The Catheter Passport does not promote the use of catheters but supports the HOUDINI protocol, which is a nurse lead protocol for catheter removal. It was launched on the 31st March 2023 in conjunction with a Multi-Disciplinary Team leading to a successful Bowel and Bladder fundamentals day.

The Infection Prevention team have continued to collaborate with the clinical skills team on bloodstream contamination rates and there is a process agreed in place for monitoring and managing if there is an increase.

Aseptic non-touch technique (ANTT) has been reviewed and this has resulted in a change in how ANTT is managed. This is to support best practice and to ensure that the theory behind ANTT is not lost as historically the theory only had to be completed once with annual visual assessment. The new process asks that the e-learning theory is completed yearly, with visual assessment every other year.

IP outbreak management meetings have continued to be dynamic through the week and increased and decreased as required, with the focus remaining on COVID outbreaks. This virtual meeting is reviewed regularly to ensure that it is running to best serve patient care. IP maintains it's on call presence at the weekends and attends the site calls.

Outbreak post infection review meetings have been routine, with the winter months bringing Influenza, Norovirus and COVID outbreaks, due to the close working relationship with the clinical site teams and wards/departments minimising closed beds and the risk that adds to the emergency department. There are no longer individual Ulysses reports submitted for individuals and all outbreaks are managed the same.

The use of technology is embraced and where possible move to automation of processes where possible. The smartboards have continued to be used for visual effect with: COVID, Influenza, patients Immunocompromised, those with symptoms of a respiratory infective illness and those with a diarrhoea having a starburst colour which is then clearly identified. The Infection Prevention dashboard is being rebuilt with a review on the data presented and how this can be interrogated with the care groups. A new way of the IP team receiving results is being built to improve timely information and support to wards.

The Northwest IP NHSI/E Lead visit showed that there was understanding of improvement from the visit in the previous year having completed the action plan agreed. The May visit gave a new action plan and this is being monitored via IPCC.

The IP team also works closely with the ICS Trusts IP leads to ensure parity and agreement with impacting decisions on patient care.

The Infection Prevention team have been instrumental in getting the Site Utilisation group up and running which supports appropriate environmental reviews and single room provision.

Tissue Viability

The Tissue Viability Nurses which are a team of two clinical nurse specialists and there has been a continued focus on how to support in education, visibility and cross bay support.

This has resulted in a number of work streams:

- To support these virtual staff clinics have been put in place to which allows increased patient assessments and can be done remotely.
- The Quality Improvement Project for Pressure Ulcers and boot camps with the Fundamentals of Care practitioners have been supported by the Tissue Viability team.
- They are present on the Harm free care meetings
- A quarterly thematic review of serious incident Pressure ulcers is undertaken by the Head of Tissue Viability which identifies actions for improvement and areas of good practice.
- There have been Tissue Viability education days put on, on all sites and on external sites which have been well attended.
- Due to having to triage the e-referrals, any Category 1 or 2 pressure ulcers as lower down on the triage are sent an email with supportive information including how to care for a patient with a pressure ulcer and prevention for pressure ulcers. This goes to the staff member making the referral, their ward/unit manager and the Matron to ensure visibility.

There has been a long-standing concern with the timeliness of specialist dressing deliveries. To improve this experience and ensure timely access there is now an agreement across care groups for a store controlled by Tissue Viability. This will have a cross section of specialist dressings that when advised by the team can be accessed immediately. This is in the last stages of organisation now with procurement completing the last of the actions.

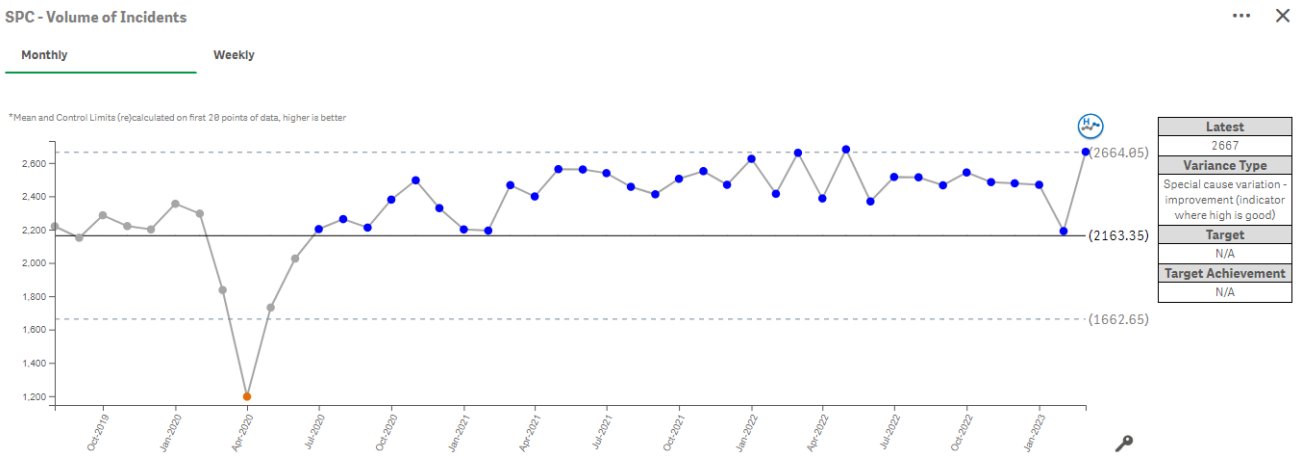
The Tissue Viability dashboard is being used routinely by care groups and as part of Harm free care review.

The wound imaging project is now well established and embedded as business as usual.

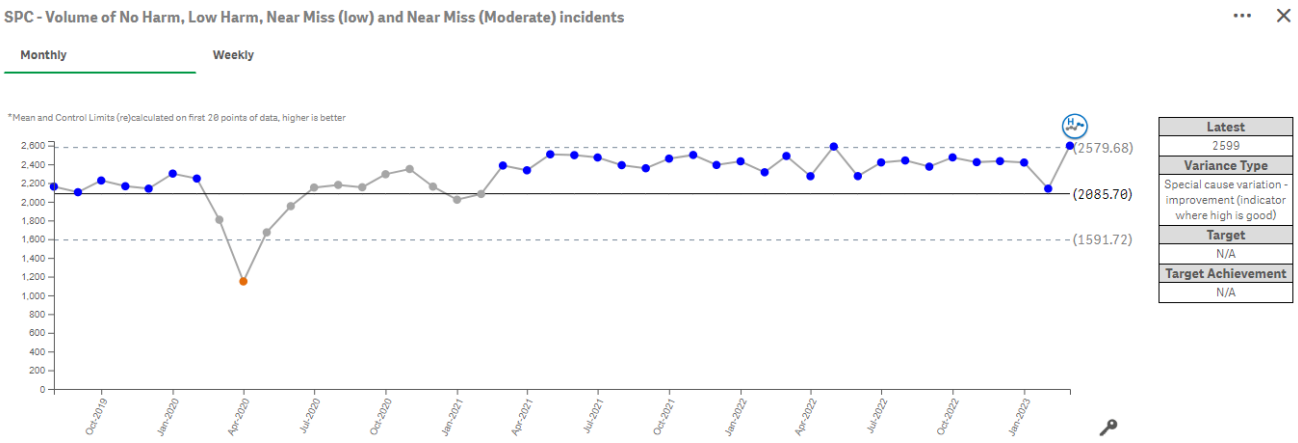
Reporting Incidents

In June 2022, the Trust became the first organisation using Ulysses Safeguard to migrate from the National Reporting and Learning and System (NRLS) to the Learn from Patient Safety Events (LFPSE) system. LFPSE is a new system, which is being introduced nationally as a key component of the National Patient Safety Strategy. It introduces improved capabilities for the analysis of patient safety events occurring across healthcare, and enables better use of the latest technology, such as machine learning, to create outputs that offer a greater depth of insight and learning that are more relevant to the current NHS environment. The Trust was regarded as an early adopter and has since supported multiple organisations with their transition.

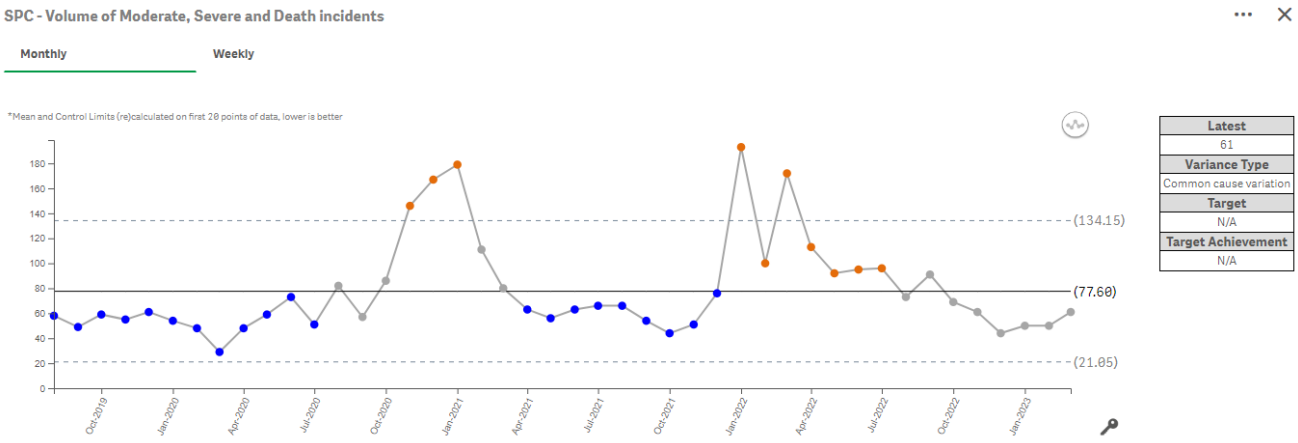
LFPSE regards the reporting of a high volume of incidents as an indication of a healthy reporting culture. The SPC chart below provides an overview of the Trust's overall reporting rates since 01/08/2020. This demonstrates that the Trust has a strong reporting culture. Reporting rates were consistent within 2022/2023 with a monthly average of 2481:



When we view these from a harm (caused by the organisation) perspective, the 96.99% of incidents reported in 2022/2023 caused no or low harm to the patient which is in line with expected incident harm grading:



In contrast, incidents causing moderate or above harm have been in steady decline throughout 2022/2023:



CAS Alerts

The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care.

The Trust utilises the alert module within Ulysses Safeguard to distribute and manage alerts. At present, all alerts are coordinated by the Trust's Patient Safety Team and distributed to relevant staff across the Trust. Completed alerts are then forwarded to the Deputy Director of Clinical Governance (or appropriate Deputy) who reviews the alert and approves closure unless a National Patient Safety Alert which will be reviewed by the appropriate Executive Lead.

In 2022/2023, the Trust received 191 alerts which is a slight increase from 2021/2022.

Financial Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Grand Total
2018-19	20	17	22	20	10	17	12	11	10	14	16	15	184
2019-20	21	17	14	21	16	19	31	21	21	16	29	20	246
2020-21	22	20	15	20	13	20	12	20	20	8	20	17	207
2021-22	15	14	17	9	14	19	13	25	19	9	20	14	188
2022-23	22	20	11	15	22	17	17	15	13	14	9	16	191
Grand Total	**100**	**88**	**79**	**85**	**75**	**92**	**85**	**92**	**83**	**61**	**94**	**82**	**1016**

National Patient Safety Alerts typically require action to be centrally coordinated on behalf of the whole organisation, rather than by multiple individual teams, care groups or directorates, as had often been the case for previous alerts.

All National Patient Safety Alerts need executive level oversight of governance systems that provide evidence that the required actions have been fully completed before any National Patient Safety Alert is recorded as 'action completed' on the Central Alerting System (CAS). In 2022/23, 12 NatPSA alerts were issued and 11 of these were actioned and closed within the identified timeframe.

National Patient Safety Alerts (2022 – 2023)													
Financial Year	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Grand Total**
2022-23	1	2	1	1	2	0	1	1	0	2	1	0	12

Clinical Audit

Clinical audit forms an integral part of the clinical governance framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. Clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic measurement against explicit criteria and the implementation of any necessary change(s): New Principles of Best Practice in Clinical Audit, Healthcare Quality Improvement Partnership, 2nd Edition, 2011.

All NHS organisations are required to have in place a comprehensive programme of quality improvement activities that includes healthcare professionals participating in regular clinical audit. Clinical audit is the governance vehicle in relation to determining assurance with clinical practice and is integral to the core business of the Trust.

The Clinical Audit Department is committed to raising the profile of clinical audit within the Trust and is dedicated to its mission that the annual forward audit plan should be a valuable resource in the Trust's aim to continually improve patient outcomes and experience and to provide assurance in areas in which this is already demonstrated. The Trust-wide Forward Audit Plan 2022/23 was implemented at the start of the business year following approval by the Clinical Audit & Effectiveness Steering Group (CA&ESG) and also by the Quality Assurance Committee.

To support robust and effective clinical audit activity, the Clinical Audit Department works in accordance with the Clinical Audit Procedural document. The purpose of the procedure is to sustain a culture of best practice in clinical audit and it clarifies the roles and responsibilities of staff engaged in the clinical audit process within UHMBTFT. Its aim is to encourage and facilitate good quality clinical audit from all staff tasked with undertaking an audit project.

The Clinical Audit Department maintains a Trust-wide clinical audit database of all clinical audit activity and the progress thereof. The system utilised is a specifically formatted module within the Ulysses System. This system also maintains the Risk Register, Safety Alerts, Complaints and Compliments. Thus, the progress of audit activity and storage of all audit materials is held within the electronic governance system. There is a designated manager for the Ulysses System as a whole and a business analyst who creates and formats structure and automated reports as required.

A Clinical Audit Facilitator is assigned to each Care Group in order to support Clinical Audit Specialty Leads with the delivery of clinical audit progress reports, for which definitions are provided below. Audits are graded into 4 distinct elements and this is in line with national guidance from the Healthcare Quality Improvement Partnership (HQIP). Clinical audits are prioritised into one of four levels, as per the table below, with Level 1 being given the highest priority.

Priority Levels for Clinical Audits: HQIP Definition with Local Modification

Priority	Level	**Audit Type
Priority 1	**Level 1 audits (External must do)**	• National audits • NCEPOD / Confidential Inquires • NICE • CQUIN • Commissioner requirements • External Regulators/Bodies

Priority 2	**Level 2 audits (Internal must do)**	• Clinical risk/Safeguarding/Patient Safety • Serious untoward incidents • Complaints • Quality Improvement Project (QIP) • Re-audit • Professional / Royal College Guidelines • Regional topic • NatSSIPs & LocSSIPs
Priority 3	**Level 3 audits (Care Group priorities)**	• Local topics important to the Care Group
Priority 4	**Level 4 audits**	• Clinician / personal interest • Educational audits • SSMs / SAMP

How do trusts confirm which projects they must participate in?

The Department of Health legislation does not 'mandate' any requirement on a healthcare service provider to participate in specific national clinical audits or enquiries, simply to report on whether or not they have participated in them, in the annual Quality Account written report.

Every project within the National Clinical Audit and Patient Outcome Programme (NCAPOP) has been established to address a clinical area (or areas) where healthcare improvement is required, and the common aim of each project is to have a positive impact on patient care.

The requirement to participate in the HQIP commissioned NCAPOP projects stems from the NHS Standard Contract. This requirement does not extend to non-NCAPOP projects unless commissioners have chosen to add a requirement to participate, by adding variations to the local contracts.

Participation in National Clinical Audits and National Confidential Enquiries 2022/23

The NHS standard contracts for acute hospital; mental health; community and ambulance services set a requirement that provider organisations participate in appropriate national clinical audits that are part of the National Clinical Audit and Patient Outcome Programme (NCAPOP). This is in line with the government's intention to see increased accountability and transparency in the public sector. The requirement to participate in national clinical audits and enquiries does not extend to non-NCAPOP projects unless commissioners have chosen to add a requirement to participate, by adding variations to the local contracts. The Healthcare Quality Improvement Partnership (HQIP) hosts the contract on behalf of the NHS to manage and develop the NCAPOP, which comprises clinical audits that cover care provided to people with a wide range of conditions.

NICE Guidance

The National Institute for Health and Care Excellence (NICE) was established as a Special Health Authority in April 1999 to promote clinical excellence and effective use of resources within the NHS. NICE is an independent organisation which provides guidance, sets quality standards and manages a national database to improve people's health and prevent and treat ill health. Its recommendations are based on evidence of both clinical and cost effectiveness.

NICE currently produces the following types of guidance/standards:

- Clinical Guidelines;
- Technology Appraisals;
- Social Care Guidance;
- Medical Technologies;
- Interventional Procedures;
- Public Health;
- Quality Standards and
- Health Technology Evaluation

Putting NICE guidance into practice benefits everyone. People who use health and social services and their carers, the public, NHS organisations, local authorities, health and social care professionals, and policy makers. It can help organisations to meet the legal requirements of the NHS Constitution and Health and Social Care Act. NICE guidance and quality standards can also help us meet regulatory requirements from organisations such as the Care Quality Commission.

The Trust has a NICE Implementation lead that oversees the guidance process, escalates where there are concerns and provides support to the Care Groups, Care Groups NICE Leads and NICE Guideline Leads. The Trust NICE Lead has been appointed as Chair for the Northwest NHS NICE Forum Network and the meetings take place every quarter to review the management of NICE across the region and shared learning.

Since 2015, all NICE Guidance has been managed within the Ulysses Risk Management System. From February 2022, the process of transition of all applicable guidelines from Ulysses to the new system AMaT.

Following consultation with all relevant committees and leads a review to improve the assessment and reassessment took place with the introduction of new feasible KPI'S to support a clearer, implementation and review process (as depicted bellow Table 1 is now In line with best practice guidance from the Northwest Regional NICE Forum).

Steps from Published Date	Previous KPIs	New KPIs
DISSEMINATION (Including confirmation of acknowledgement)	7 days	• 30 days
IMPLEMENTATION	30 days	• 90 days for gap analysis • 60 days for action plans/business case etc.
MONITORING	Nil	• 6 month/1 year/3 years (depending on the gap analysis result)

In March 2022, during the transfer process there were guidelines identified where there was lack of robust evidence to support assurance of compliance. These included:

- a lack of description of the current practice in the baseline assessment tool.
- no action plans to support the gap analysis.
- no identified lead responsible to implement and monitor the implementation.
- lack of supporting evidence.

In April 2022, regular working groups with the Governance Business Partners and NICE Leads from each care group were set up to address the challenges outlined above.

Papers have previously been submitted providing oversight of the Trust's position to the following meetings:

- Clinical Audit Standards Group.
- Patient Safety Group.
- Quality Assurance Committee.

To enable consistency of compliance monitoring, the Trust has introduced 6 categories for NICE guidance for all guidelines that are applicable to the organisation. These are:

- **In progress** - Compliance is under review (in date) – guidance has been sent to the lead and a response is awaited but is still within timeframe, KPI 120 calendar days.
- **In progress** - Compliance is under review (overdue) – guidance has been sent to the lead, but a response has not been received within timeframe mentioned above.
- **Not Achieved** - The Trust is not compliant with the guidance.
- **Fully Achieved** - The Trust is compliant with the guidance and full evidence received.
- **Partially Achieved - Improvement needed** - The Trust have partial compliance with the guidance as not all recommendations have been met.
- **Partially Achieved - Acceptable** – The Trust has received full evidence and has full compliance within its services, however, cannot be assessed as fully achieved due to not offering all services within the guideline.

TRUST NICE guidelines compliance position
This covers all UHMBT applicable NICE guidelines until 31.03.2023

- There are a total of 585 guidelines registered in the new system AMAT (depicted in Table 2), of which 534 were identified as applicable to the organisation and 51 not applicable.
- Of the 534 publications that were identified as relevant to the organisation 383 have now been benchmarked as detailed below;
    - 314 are “Fully achieved and Partialy Achieved – acceptable”;
    - 69 Partially achieved – Improvement needed- action plans have been identified

Type of Guidance	Total	Fully Achieved	Partially Achieved (Acceptable)	Partially Achieved- Improvement needed	Not Achieved	Not Applicable	% Total guidelines revisited	In progress	% Total guidelines outstanding
Clinical Guideline	269	115	18	40	0	7	67%	89	33%
Quality Standard	160	96	2	25	0	3	79%	34	21%
Technology Appraisals	67	42	0	0	0	9	76%	16	24%
Interventional Procedure Guidance	39	10	0	2	0	22	87%	5	13%
Medical Technology Guidance	30	16	0	2	0	10	93%	2	7%
Diagnostic Guidance	15	14	0	0	0	0	93%	1	7%
Health Technology Evaluation	2						0%	2	100%
Highly Specialized Technology	3	1	0	0	0	0	33%	2	67%
Total	585	294	20	69	0	51	74%	151	26%

The project has been divided by care groups and all applicable statements have been diseminated to the relevant specialities (depicted in Table 3). This project has generated improvement actions such as changes in service, changes in pathways or protocols etc. We have completed a high amount of outsanding actions and have introduced the option for care groups to include the Quality Standards guidelines in the Audit Forward plan for 2023-2024 as this will generate more assurance for areas where we need to demonstrate our compliance and subsequently to generate approriate improvement actions.

NICE Compliance 31.03.2023	Corporate	Women's Health (WACS CC)	CYP (WACS)	Community	Medicine	Surgery and Critical Care	Core Clinical Services
Total Guidelines	138	49	56	40	174	79	177
Fully Achieved	77	26	16	39	106	42	128
Partially Achieved (Acceptable)	1	2	4	1	9	1	4
% Total guidelines fully achieved	56.52%	57.14%	35.71%	100.00%	66.09%	54.43%	74.58%
Partially Achieved- Improvement needed	9	12	24	0	21	20	12
% Total guidelines partially achieved - improvement needed	6.52%	24.49%	42.86%	0.00%	12.07%	25.32%	6.78%
In progress guidelines to be reviewed	51	9	16	0	38	16	33
Number of improvement actions		105	91	0	39	45	34
Number of outstanding actions		51	63	0	9	19	8

Next Steps for 2023-2024:

- Increase involvement in reporting for NICE Care Group leads
- Align and centralised correspondent NICE Procedural documents
- Align, centralise, standardise and support easier accessibility of patient leaflets

- Increase overall Trust compliance with NICE
- Audit annually NICE Trust compliance
- Audit annually Service Quality Standard compliance
- Introduce new sources of guidelines to be implemented and monitored
- Introduce new technologies with an aim for digital technologies
- Create weekly/monthly NICE News
- Create an intranet page with access to new guidelines
- Raise profile for all categories of staff on how to use AMaT guidance module with easy access to information
- Centralise all improvements on services and patient care generated after NICE guidelines gap analysis
- Introduce NICE Annual Forward savings planner
- Annual NICE Report

Duty of Candour

If an incident is entered as moderate or above the harm level should be validated within 10 working days. This is in line with the regulatory requirement. If after this period the harm level is confirmed, or still unclear, Duty of Candour must be completed.

In 2022/2023, Duty of Candour was applied to 665 incidents. This is slight reduction on last year's figures but aligns with the reduction in moderate and above harm incidents within the Trust.

Duty of Candour Completed					
Financial Year	**FQ1**	**FQ2**	**FQ3**	**FQ4**	**Grand Total**
2020 - 2021	86	77	282	239	684
2021 - 2022	92	126	120	360	698
2022 – 2023	220	213	119	113	665
Grand Total	**398**	**416**	**521**	**712**	**2047**

Complaints

The Trust actively encourages feedback from our patients, relatives and visitors, both positive and negative as it provides an opportunity for the Trust to review services and make any appropriate changes and meet patients' needs.

The Patient Advice and Liaison Service (PALS) handled 2830 concerns/enquiries in 2022/23 across the three sites. PALS staff are available to provide resolution to concerns as they arise, and support patients and their relatives to navigate NHS services or signpost them to appropriate voluntary or public sector services. Early identification of concerns enables the Trust to respond to those enquiries in a timely and efficient manner which in turn reduces patients and relatives' anxieties and formal complaints. The Patient Relations Senior Case Officers handled 399 formal complaints in 2022/23.

Information on how to complain is clearly advertised in key areas. Information is also available on the Trust's website.

The service has:

- A staffed complaints helpline Monday to Friday, 9am to 5pm.
  - A dedicated Senior Case Officer informs each complainant at first contact of the complaint's procedure, including how long it is likely to take and provide details of advocacy services available, if required.
  - All complainants receive a dedicated Senior Case Officer who assist the complainant in confirming what they think went wrong with their care and the questions they would like to answer.
  - Complainants are regularly updated with progress of their complaint; and
  - Response letters are written in a way that complainants can understand and avoid, where possible, clinical terminology; however, if used, a clear explanation in layman's terms is also given.

Key Performance Indicators have been set to ensure Care Group staff (who provide information for the investigation) respond within the agreed timescales. Escalation processes are also in place with support from Directors to ensure the complaints function is supported at Board level.

Once local resolution has been exhausted, the complainant is informed of their right to contact the PHSO for a review of their complaint.

The number of complaints received in 2022/23 was 399 and the number of PALS cases was 2830.

Analysis of Number of Complaints

Year	Concerns/Comments PALS Received	Complaints Received
2016/17	2662	516
2017/18	2511	425
2018/19	2669	430
2019/20	2541	440
2020/21	2281	277
2021/22	3009	337
2022/23	2830	399

In 2022/23, there were a total of 17 cases with the PHSO. Of these, 7 cases were new case received during 2022/23 with the remaining 10 cases being received before 2022/23.

During 2022/23:

- The Trust was advised that 8 cases would not be proceeding to formal investigation.
- 2 cases were still being assessed.
- 1 case was still being investigated.
- Following investigation, the Trust was advised that 2 cases were not upheld; and
- A further 4 cases were partly upheld, one of which the Trust has received the final report and is currently in the process of forming an action plan.

Part 4: Our Priorities for 2023/24

Our safety and quality priority for 2023/24 is to deliver outstanding care an experience.

Deliver Outstanding Care and Experience

NHS University Hospitals of Morecambe Bay NHS Foundation Trust

WE WILL:	How we will deliver?	How will we know how we are doing? What will we measure?
Improve access, standards of care & outcomes across all our services	• Embed clinical service reviews • Harm free care forum • Continuing to develop and embed the organisations approach to learning • Develop & implement our Whole System Flow & Outpatient Transformation programme	• Reduction in patient falls with moderate harm • Reduction in grade 2 pressure ulcers • Improved mortality measures • Delivery of the 76% urgent care target by March 24 • Improved performance against cancer & elective care standards: no 65ww by March 24; compliance with 28 day FDS
Have plans in place to ensure the right people with the right skills are in the right place at all times to provide safe, high-quality care.	• Undertake Bi-annual workforce reviews • Develop workforce safeguards • Implement effective job planning processes • Develop workforce transformation plans aligned to clinical strategy	• Fill rates • Improved staff experience • Reduction in sickness and turnover rates • 100% of job plans signed off
Focus on embedding a culture of continuous improvement	• Establish a transformation and improvement board • Develop and implement year 1 delivery plans across the 6 Transformation & Improvement workstreams: *Whole System Flow; Outpatient Transformation; Clinical Strategy; People; Digital; Finance;* • Rationalisation of improvement activity and alignment with resources	• Monthly reports from the TIB to Board • Delivery of identified improvements across the 6 Transformation & Improvement workstreams
Embed evidence-based practice across all services & ensure we have the processes in place to truly learn when we get things wrong.	• Through the clinical effectiveness forum ensure compliance with GIRFT & NICE standards • Delivery of the forward audit plan aligned to risk and issues • Via the roll out of PSIRF we will increase the learning from patient experience • Embed mortality review process and approach to learning	

Statements from Local Clinical Commissioning Groups (CCG's), Local Healthwatch Organisations (HO) and Overview and Scrutiny Committees (OSCs)

The statements supplied by the above stakeholders in relation to their comments on the information contained within the Quality Account can be found in Annex 1. Additional stakeholder feedback from Governors has also been incorporated into the Quality Account. The lead Clinical Commissioning Group has a legal obligation to review and comment on the Quality Account, while Local Healthwatch organisations have been offered the opportunity to comment on a voluntary basis. Following feedback, wherever possible, the Trust has attempted to address comments to improve the Quality Account whilst at the same time adhering to NHS Improvement's Foundation Trusts Annual Reporting Manual for the production of the Quality Account and additional reporting requirements set by NHS Improvement.

Quality Account Production

We are very grateful to all contributors who have had a major involvement in the production of this Quality Account.

The Quality Account was discussed with the Council of Governors which acts as a link between the Trust, its staff and the local community who have contributed to the development of the Quality Account.

How to Provide Feedback on the Quality Account

The Trust welcomes any comments you may have and asks you to help shape next year's Quality Account by sharing your views and contacting the Chief Executive's Department via:

Telephone: 01539 716684
Email: Paul.Jones4@mbht.nhs.uk
Company Secretary
University Hospitals of Morecambe Bay NHS Foundation Trust
Trust Headquarters
Burton Road
Kendal
LA9 7RG

Quality Account Availability

If you require this Quality Account in Braille, large print, audiotape, CD or translation into a foreign language, please request one of these versions by telephoning 01539 716698

Additional copies of the Quality Account can also be downloaded from the Trust website:
http://www.UHMBT.nhs.uk/about-us/key-publications/

Our website

The Trust's website gives more information about the Trust and the quality of our services. You can also sign up as a Trust member, read our magazine or view our latest news and performance information via: http://www.UHMBT.nhs.uk/trust/

Annex 1: Statements from Commissioners, Local Healthwatch Organisations and Local Overview and Scrutiny and Scrutiny

Statement from Lancashire and South Cumbria Integrated Care Board on the Quality Accounts – 30th May 2023

Lancashire and South Cumbria Integrated Care Board (LSCICB) welcomes the opportunity to review and comment on the University Hospital of Morecambe Bay Trust (UHMBT) Quality Account 2022/23. The commentary provided in this letter relates to services commissioned by LSCICB as well as some general observations.

Firstly, we would like to commend the hard work, commitment and resilience Trust staff continue to demonstrate through the recovery of the COVID-19 pandemic and the dedication to quality improvement of services for our patients. This pays testament to the continued resilience shown by staff in light of what has and continues to be a very challenging operating environment.

Within the account, the Trust has demonstrated positive quality achievements against the priorities identified for 2022/23. LSCICB has seen improvements in stroke and maternity pathways and we are pleased to see the lifting of CQC conditions for stroke services, which have demonstrated sustained improvement against the Sentinel Stoke National Audit Programme (SSNAP).

LSCICB has been a partner on the Trust's CQC Support and Review Panels which have overseen evidence against the improvement plan to address recommendations from the CQC inspection in 2021. LSCICB has noted improvements against all CQC domains and we are pleased that the independent review of well led also recognised the level of improvement since the last inspection. At the time of writing, the CQC are carrying out a well led inspection at the Trust and we await their findings.

The Trust's approach to the use of data to inform patient care, safety and improvement is evident through quality dashboards which allow early identification and proactive management of any issues. LSCICB has worked with the Trust on their overarching Clinical Strategy, which aligns to the wider system strategy and identifies key aims for the populations of Lancashire and South Cumbria.

LSCICB note that there were three national audits the Trust did not participate in we were disappointed that the Trust did not take part in the National Audit of Cardiac Rehabilitation for a second year in a row. However, we do recognise and support the Trust in prioritising patient workload over audit activity for diabetes foot care. LSCICB is encouraged that learning from the other national and local audits continues to inform quality improvements and outcomes of care.

The Trust has performed well against the requirements of the Commissioning for Quality and Innovation (CQUIN) schemes. For the indicators that did not meet targets;

- Flu uptake rates have been lower nationally in 2022/23. The Trust has shared plans with LSCICB for improving uptake in 2023/24.
- Antibiotic prescribing for urinary tract infections is not continuing as a CQUIN in 2023/24, however the Trust has agreed an action plan to continue improvement work.
- Timed diagnostic pathways for cancer will continue as a CQUIN into 2023/24 and includes an additional two pathways. The Trust are working with other partner organisations to identify and resolve pathway delays.
- Timely communication of medicine changes will continue as a CQUIN into 2023/24. The Trust has been working with LSCICB and Refer to Pharmacy supplier, however technical delays have impacted on referrals in 2022/23. The system is due to go live in May 2023 and LSCICB expects to see the benefits of reduced readmissions and length of stay for patients who receive this service.

LSCICB has agreed CQUIN indicators with the Trust for 2023/24 and we look forward to working together on these schemes to improve the quality of services for our patients.

During 2022/23, the Trust has strengthened their processes for learning from deaths, and it is positive to see improvements that have been made to the Structured Judgement Review process following the Better Tomorrow peer review, along with the introduction of a Mortality Data Triangulation meeting and the learning from deaths newsletter. The Trust continues to recognise and share good practice as well as actions being taken to make improvements as a result of learning.

The Trust has a strong incident reporting culture and a desire to learn from best practice and through analysis of patient safety events. LSCICB recognises that the Trust were an early adopter of the Learn from Patient Safety Events (LPSE) system and have offered support to other organisations with their transitions to this system. LSCICB look forward to working with the Trust on their Patient Safety Incident Response Plan, where there will be opportunities to improve patient safety at a system level.

LSCICB is happy to see the development of the Freedom to Speak Up Strategy to support staff in raising and escalating their concerns and prioritising speaking up as business as usual. The Trust has a clear communication strategy with staff which includes feedback and learning and triangulates with the wider patient safety agenda to develop an open and transparent culture, promoting the achievement of open and transparent outcomes.

LSCICB is pleased with the progress being made with the patient experience programmes and how patient and carer feedback is being utilised to transform services to meet patient needs. It is positive that the Patient Experience and Involvement Group are providing an external view of intelligence and have a strong voice in terms of ongoing developments. National patient survey results are promising and reflect the continued improvements being made to patient safety and experience.

LSCICB supports the Quality Improvement priorities identified for 2023/24, with a focus on staffing skill mix, improving outcomes, culture of improvement and evidence-based learning.

The Quality Account provides an open account of the achievements made in the past year, areas for improvement and describes the priorities for 2023/24. This is an important contribution to public accountability in relation to quality and LSCICB appreciates the amount of work involved in producing this report.

Yours sincerely

pp **Professor Sarah O'Brien**
Chief Nursing Officer
Signed by Claire Lewis, Associate Director – Quality Assurance,
on behalf of Sarah O'Brien

Quality Accounts commentary from Healthwatch Cumbria - comments have been invited.

Quality Accounts commentary from Healthwatch Lancashire – comments have been invited.

Quality Accounts commentary from Cumbria Health Scrutiny Committee – comments have been invited.

Quality Accounts commentary from Lancashire County Council Health Scrutiny Committee – 25th May 2023

The Lancashire County Council Health Scrutiny function welcomed the detail included in the Quality Accounts report on the examples of the challenges faced in 2022-23 and how improvements had been made.

The range of information that the Trust is required to reference in this report was acknowledged, and members noted the challenges in producing a report for both professionals and the public. The Quality Account is well presented and reflects the requirements to benchmark against peers.

The Committee noted that due to the complexity of the information reported, consideration could be given to producing a summary document of the report with the focus on patients and the public as the key audience. In addition, members would like to have seen a summary at the start of the report outlining the high level key issues, actions taken and future plans.

On the Trust's assessment of elective performance, it was noted that many of the health targets and indicators shown in Tables C and D (pages 50-51) were not met over the last 3 years. However, it was acknowledged that a focus had been given to those clinically prioritised as most urgent and reducing the backlog of the longest waiting clinically routine patients, as well as the rise of suspected cancer referrals by 33% since 2019/20. Members however felt that additional information showing a comparison nationally would have helped to provide some more context to this information.

It was felt that some of the data included in the report was challenging to read for patients and the public (the table on Core Quality Indicators, page 39 as an example) with the use of banding and codes.

Members noted that there appeared to be little information on access to services and staffing and would like to have seen more detail on these particular areas, the challenges and plans in place.

However, the Trust should be commended in providing a very comprehensive report which was felt to be an honest reflection of the challenges faced.

The Lancashire Health Scrutiny function welcomed the opportunity to comment on the University Hospitals of Morecambe Bay NHS Foundation Trust Quality Accounts for 2022/23 and would welcome early involvement with the planning process to produce the Trust's 2023/24 Quality Account.

Sam

Samantha Parker (she/her)
Senior Democratic Services Officer
Overview and Scrutiny
Legal and Democratic Services
Lancashire County Council

Annex 2: Statement of Directors' Responsibilities for the quality report

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

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

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

- The content of the Quality Report meets the requirements set out in the Quality Account regulations and guidance;
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period 1 April 2022 to 31 March 2023;
    - Papers relating to quality reported to the Board over the period 1 April 2022 to 31 March 2023;
    - Feedback from commissioners – Lancashire and South Cumbria Integrated Care Board dated 30th May 2023
    - Feedback from Lancashire Health Scrutiny Committee dated 25th May 2023
    - The latest Trust's complaints report required under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 22 August 2022;
    - The latest published National Patient survey;
    - The 2022 National Staff Survey published March 2023;
    - The Head of Internal Audit's annual opinion over the Trust's control environment dated April 2023 and
    - Care Quality Commission Inspection report dated 20 August 2021.
- The Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered.
- The performance information reported in the Quality Report is reliable and accurate.
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice.
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review, and
- The Quality Report has been prepared in accordance with the Quality Account regulations and guidance.

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

By order of the Board

Mike Thomas
Chair

Date: 29 June 2023

Aaron Cummins
Chief Executive

Date: 29 June 2023