NHS Lancashire and South Cumbria Integrated Care Board

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

NHS University Hospitals of Morecambe Bay NHS Foundation Trust

PUBLIC TRUST BOARD OF DIRECTORS' MEETING

Wednesday 6 December 2023 in the Board Room, Westmorland General Hospital, Burton Road, Kendal LA9 7RG

Please note the meeting will also take place via Microsoft Teams

Commencing at 9am

Agenda					
Item		**Lead**	**Action**	**Paper**	**Time**
Opening Administration					
139	Welcome and Introductions • Apologies for absence • Declaration of conflicts of interest	Chair	To note	Verbal	9am-9.01am (1 Minute)
140	Minutes of the Board of Directors' Meeting held on 1 November 2023 *To approve the Minutes of the Meeting held on 1 November 2023.*	Chair	To approve	Attached	9.01am-9.03am (2 Minutes)
141	Action Sheet and Matters arising from the Minutes of the Public Meeting of the Board of Directors held on 1 November 2023 *To consider the action sheet and note the actions taken.*	Chair	To note	Attached	9.03am-9.05am (2 Minutes)
Matters for Consideration					
142	Patient Story *The patient experience team have taken feedback from patients on the measures expected to be undertaken to deal with clinics which routinely over-run significantly (over 30 minutes).* *The purpose of sharing this with the Board today is to demonstrate how we have responded to the issues raised by patients.* *Adam Lucas, UHMB Digital Analyst will outline his and his partner's experience following a recent outpatient clinic appointment. Adam will showcase some of the work of the Trust's i3 team to help address patient and carer information in the event of an overrunning clinic.*	Chief Nursing Officer	Please refer to Board of Directors' Reference Pack for further information	Attached	9.05am-9.25am (20 Minutes)

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

143	Chair's Report *An update presented by the Chair.*	Chair	To note	Attached	9.25am-9.30am (5 Minutes)
144	Chief Executive's Report *An update presented by the Chief Executive.*	Chief Executive	To note	Attached	9.30am-9.40am (10 Minutes)
145	Head Governor Report *An update presented by the Head Governor.*	Head Governor	To note	Attached	9.40am-9.45am (5 Minutes)
Quality and safety: ***Delivering outstanding care and experience***					
146	Continuous Quality Improvement Draft Strategy *A report to present the Trust's Continuous Quality Improvement Draft Strategy.* *Any exceptions or escalations will be reported to the Board of Directors by the Chair of the Quality Committee.*	Chief Nursing Officer	To approve	Attached	9.45am-9.55am (10 Minutes)
147 i	Review of Patient Relations Process *A report to share the review of the Trust's patient relations process.* *Any exceptions or escalations will be reported to the Board of Directors by the Chair of the Quality Committee.*	Chief Nursing Officer	For assurance	Attached	9.55am-10.05am (10 Minutes)
147 ii	Patient Relations Annual Report 2022/23 *An annual report to provide an overview of the compliments, complaints, comments and concerns cases handled during 2022/23.* *Any exceptions or escalations will be reported to the Board of Directors by the Chair of the Quality Committee.*	Chief Nursing Officer	For assurance	Attached	10.05am-10.10am (5 Minutes)
148	Maternity Safety Update *A report to provide an update of continuing monitoring and action taken on Quality, Performance and Service Delivery against national and local drivers within the Maternity and Neonatal Services.* *The following reports have been considered by the Quality Committee, and have been included in the Board of Directors' Reference Pack:*	Chief Nursing Officer / Director of Midwifery	For assurance	Attached	10.10am-10.30am (20 Minutes)

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

	I. *Obstetric Anaesthetic Medical Workforce Report – NHS Resolutions Year 5* II. *CNST Maternity Incentive Scheme Year 5 Report* *Any exceptions or escalations will be reported to the Board of Directors by the Chair of the Quality Committee.*				
149	Trust Improvement Plan *A report on progress of the Trust's Improvement Plan.*	Deputy Chief Executive	For assurance	Attached	10.30am-10.40am (10 Minutes)
	Morning Break				10.40am-10.50am (10 Minutes)
Performance and resources: Make the best use of our physical and financial resources					
	The items in this section will be discussed with reference to the Integrated Performance Report and other specific reports				
150 i	Integrated Performance Dashboard and Report Month 6 incorporating matters raised by the Executive Team and through the Assurance Committees. *The Deputy Chief Executive will present this report covering quality and safety, operational, people and financial performance.*	Deputy Chief Executive	For assurance	Attached	10.50am-11.25am (35 Minutes)
150 ii	Minutes and 3A Reports from Assurance Committees a) People Committee Minutes from Meeting on 18 September 2023 and 3A Report from Meeting on 30 November 2023 b) Finance and Performance Committee Minutes from Meeting on 16 October 2023 and 3A Report from Meeting on 20 November 2023 c) Quality Committee Minutes from Meeting on 23 October 2023 and 3A Report from Meeting on 27 November 2023 The 3A Reports are included as appendices to the Integrated Performance Report.	Chairs of the Assurance Committees	To note	Please refer to Board of Directors' Reference Pack for copies of the Committee Minutes	11.25am-11.35am (10 Minutes
Working in partnership *Working together as one with a culture of continuous improvement*					

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

151 i	Provider Collaboration Update *A report to present an update from the Provider Collaboration Board.*	Chief Executive	To note	Attached	11.35am-11.45am (10 Minutes)
151 ii	Provider Collaborative Board Joint Committee - Revised Terms of Reference *A report to share the draft revised Terms of Reference for the Provider Collaborative Board Joint Committee.*	Company Secretary	To consider & approve	Attached	
Governance and Assurance					
152	Chief Medical Officer Update *A report to provide an update on the following areas of the Chief Medical Officer's portfolio:* i. *Guardian of Safe Working Hours Annual Report, 1 April 2022 – 31 March 2023*	Chief Medical Officer	For assurance	Attached	11.45am-11.50am (5 Minutes)
153	Thirlwall Inquiry *A report to share:* *1. The Terms of Reference of the Inquiry; and* *2. The internal governance arrangements for overseeing the Trust response to the Inquiry.*	Company Secretary	For assurance	Attached	11.50am-11.55am (5 Minutes)
154	Policy and Publications Report *A report to provide the Board of Directors with information on recent policy developments from the Department of Health, NHS England, NHS Providers, NHS Confederation, Care Quality Commission (CQC) and Healthwatch.*	Chief Executive	To note	Attached	11.55am-11.56am (1 Minute)
Closing Administration					
155	Attendance Monitoring Register	Chair	To note	Attached	11.56am-12pm (4 Minutes)
156	Schedule of Business	Chair	To note	Attached	
157	Urgent Business	Chair	To note	Verbal	
158	Date, Time and Venue of Next Meeting: Wednesday 7 February 2024 at 9am in the Board Room, Westmorland General Hospital, Kendal LA9 7RG and also via Microsoft Teams.				
159	Exclusion of the Press and Members of the Public: To resolve that representatives of the press and other members of the public will be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted.				

Apologies to be given to Nicola Barnes by 4 December 2023.

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

Board of Directors' Declarations of Interest

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

Date of Declaration	Name	Role	Nature of Interest	Do you envisage a conflict of interest between outside employment and your NHS employment?	Nil Declaration
11/04/2023	Chris Adcock	Chief Financial Officer / Deputy Chief Executive			✓
17/04/2023	Alison Balson	Chief People Officer			✓
21/11/2023	Aaron Cummins	Chief Executive	1. Chief Executive of the Lancashire and South Cumbria Provider Collaborative (PCB) 2. Aaron has been appointed as a partner member of the Integrated Care Board (ICB).	1. Whilst this is not a statutory position, a material conflict of interest may arise from his role as Chief Executive Officer of the Trust. The PCB will be discussing matters relating to UHMB and circumstances could arise when Aaron might need to make a declaration and withdraw from any PCB meetings. 2. It is a requirement that the ICB have at least one partner member who is a Chief	

				Executive of one of the partner Trusts.	
01/06/2023	Tabetha Darmon	Chief Nursing Officer	Sue Ryder Trustee	A material conflict of interest does not exist as the role of is not connected to the Trust	
26/04/2023	Paul Jones	Company Secretary	Chair of the Westmorland and Furness Shadow Authority Independent Remuneration Panel	A material conflict of interest does not exist as the role of the Independent Remuneration Panel is not connected to the NHS.	
19/07/2022	Scott McLean	Chief Operating Officer			✓
24/04/2023	Jane McNicholas	Chief Medical Officer			✓
21/07/2023	Phil Woodford	Director of Corporate Affairs	1. Unpaid Volunteer Ranger at Brockholes nature reserve, Preston. 2. Family member is former employee of both Key Med UK and Olympus Corporation and may have retained a financial interest in both organisations.		
05/04/2023	Karen Deeny	Non-Executive Director	1. Director of Deeny Consulting Ltd 2. Co-Vice Chair and Senior Independent Trustee for Transforming Futures Multi-Academy Trust	Potentially a material conflict of interest may arise from the role with activities being undertaken by her consultancy. However, Karen would consider the circumstances; make a declaration and consider withdrawing from any meetings where the matter being discussed relates to her consultancy.	

14/11/2023	Amin Kamaluddin	Non-Executive Director	1. Amin is a Trustee of The Kokni Muslim Association 2. Director of Expertus Beauty Ltd	A material conflict of interest does not exist as the role of is not connected to the Trust	
21/11/2022	Adrian Leather	Non-Executive Director	Chief Executive Officer of Active Lancashire	Potentially a material conflict of interest may arise from his role as Chief Executive Officer of Active Lancashire. Active Lancashire holds contracts with the Integrated Care Board (ICB) and going forward, Active Lancashire could be contacted through the ICB to provide home-care services in Morecambe Bay. No direct contracts are held with UHMB. However Adrian would have to consider the circumstances; make a declaration and consider withdrawing from any meetings where Active Lancashire is being discussed.	
15/05/2023	Tony Oakman	Non-Executive Director	1. Director of Dam Head Consulting 2. Chair of Barnsley Children Services Development Board 3. Chair of Residential Regulated Social Housing Provider	Potentially a material conflict of interest may arise from any of these the roles. However, Tony would consider the circumstances; make a declaration and consider withdrawing from any meetings where the matter being discussed relates to any of these organisations	
16/05/2023	Sarah Rees	Non-Executive Director	Outside Employment - Head of Stakeholder	Sarah is the University's appointed NED on the Board of UHMBT. Should any conflict of interest	

			Relations at Lancaster University	arise, such as a development involving both the Trust and the University, Sarah would declare accordingly and take advice on how best to proceed.	
17/04/2023	Hugh Reeve	Non-Executive Director	1. Director of HA Reeve Ltd - a company set up to provide consultancy and GP services to health care organisations. 2. GP Locum Employment - In NHS Highland which is a region of NHS Scotland - provision of GP services to various communities in the NHS Highland region. Also ad hoc locums in GP Practices in the Morecambe Bay area.	Potentially a material conflict of interest may arise from the role with activities being undertaken by his consultancy and NHS Highland. However, Hugh would have to consider the circumstances; make a declaration and consider withdrawing from any meetings where the matter being discussed relates to his consultancy or NHS Highland or activities, they are accountable for.	
12/04/2023	Mike Thomas	Chair	1. Chair of the Board of national health and social care charity, Making Space 2. Chair of the PCB 3. Chair of the Mental Health and Physical Care Network 4. Chair of the ICS Clinical Academy 5. Chair of the HEE Co-Operative, (an inter-	A material conflict does not exist. However, Mike may wish to make a declaration and consider withdrawing from any meeting where Making Space is being discussed.	

			universities organisation). 6. Co-founder and member of Steering Group since 2010 7. Family member employed as a nurse at the Trust		
06/09/2023	Carrie Cobb	Associate Non-Executive Director	1. Deputy Chief Nurse at FCMS 2. Integrated Care Board Clinical Lead (virtual wards)	Potentially a material conflict of interest may arise from the activities being undertaken by FCMS and the Clinical Lead for virtual ward programme. However, Carrie would have to consider the circumstances; make a declaration and consider withdrawing from any meetings where the matter being discussed relates to FCMS or the virtual ward programme.	
01/03/2023	Alison Cole	Associate Non-Executive Director			✓
26/06/2023	Jalibani Ndebele	Associate Non-Executive Director			✓

THIS PAGE IS INTENTIONALLY BLANK

Minutes of the Trust Board of Directors' Meeting held on Wednesday 1 November 2023 in the Ash Meeting Room, Junction 36 Rural Auction Centre, Crooklands, Milnthorpe, Cumbria LA7 7NU

The meeting also took place via Microsoft Teams.

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

Present:	Mike Thomas (MT)	Chair
	Aaron Cummins (AC)	Chief Executive
	Chris Adcock (CA)	Chief Financial Officer / Deputy Chief Executive
	Alison Balson (AB)	Chief People Officer
	Tabetha Darmon (TD)	Chief Nursing Officer
	Karen Deeny (KD-NED)	Non-Executive Director
	Amin Kamaluddin (AK-NED)	Non-Executive Director
	Adrian Leather (AL-NED)	Non-Executive Director
	Scott McLean (SM)	Chief Operating Officer
	Jane McNicholas (JM)	Chief Medical Officer
	Tony Oakman (TO-NED)	Non-Executive Director
	Hugh Reeve (HR-NED)	Non-Executive Director
	Sarah Rees (SR-NED)	Non-Executive Director
In attendance:	Jill Alston (JA)	Colorectal Clinical Nurse Specialist (for item 23/122 only)
	Nicola Barnes	Business Support Manager – Company Secretary's Office
	Alison Cole (AC-NED)	Associate Non-Executive Director
	Tamsin Cripps (TC)	Head of Midwifery (for item 23/127 only)
	Louise Jones (LJ)	Assistant Director of Corporate Affairs
	Paul Jones (PJ)	Company Secretary
	Sakthi Karunanithi (SK)	Advisor to the Board
	Sue Mellor (SM)	Staff Side
	Helen Miller (HM)	Macmillan Right by You Manager (for item 23/122 only)
	Jalibani Ndebele (JN-NED)	Associate Non-Executive Director
	Annette Shepherd (AS)	Patient Experience Lead (for item 23/122 only)
	Andrew Thompson (AT)	Acting Deputy Associate Director of Nursing (for item 23/122 only)
	Shirley-Anne Wilson (SW)	Deputy Head Governor

23/119 Welcome and Introductions

Apologies for Absence

Apologies were received from Lorraine Crossley-Close, Carrie Cobb and Phil Woodford.

Declarations of Conflicts of Interest

AK-NED declared two roles: *Trustee of the Kokni Muslim Association and Director of Expertus Beauty Ltd.*

AC advised he would update his declaration to reference his role as Chief Executive of the Lancashire and South Cumbria Provider Collaborative (PCB) with effect from 1 October 2023.

23/120 Minutes of the Board of Directors' Meeting held on 4 October 2023

23/112: CQC Report and Update
It was agreed the following amendment be made: *KD-NED noted that all recommendations made by CQC in relation to maternity had already been identified by the Trust and had action plans in place. KD-NED sought clarity as to whether this applied to all recommendations. TD advised there were no surprises in the recommendations issued by the CQC*.

Decision: That, subject to the above amendment, the Minutes of the meeting held on 4 October 2023 be agreed as an accurate record.

23/121 Action Sheet and Matters Arising from the Minutes of the Public Meeting of the Board of Directors held on 4 October 2023

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

23/122 Patient Story

TD advised the Board a review of the patient story schedule was underway to provide greater clarity on the purpose for sharing stories with the Board of Directors.

TD introduced JA and advised the purpose of the story was to share how JA and team had arranged personalised care to meet the needs of a patient awaiting surgery.

JA shared the experience of a patient and explained the reasonable adjustments that were made to support them to receive surgery.

AC thanked JA for sharing the experience, noting that the story exemplified the Trust's work to drive improvements in quality and safety for patients. AC sought assurance on applying this level of care to other services when patient needs were identified. TD explained the collaborative care plan had been developed to ensure reasonable adjustments were made when they had been identified. Individual passports for those patients with additional needs enabled a process for the staff to follow. There was continual education in place for staff to ensure patients' needs were met.

HR-NED commended the review of the patient story schedule to clarify the purpose of sharing them with the Board of Directors. HR-NED considered the awareness of GPs and how the different pathways for those patients with specific requirements were communicated to GPs.

SR-NED thanked JA and sought assurance about the continuity of patient care should members of staff move on to different roles. TD advised Lorenzo recorded patient

requirements. There was a process in place for patients who did require adjustments which was stored via Lorenzo to avoid patients repeating their requirements to individual clinicians. JM cautioned the need to standardise information as GPs and consultants required different information. SM advised the patient initiated follow up and set for surgery initiatives and the emerging patient experience porta were synergistic with ensuring patient requirements were met.

KD-NED thanked JA and noted the connection between good leadership and making a difference for patients. JA explained that all colleagues were accommodating and pleased to contribute to ensuring the adjustments were in place. KD-NED suggested meeting with JA to explore the connection between good leadership and making a difference.

JM thanked JA and noted the story demonstrated the difference personalised and individualised made to patient care.

MT, on behalf of the Board, thanked JA.

23/123 Chair's Report

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

MT provided information on the number of meetings and walk rounds he had attended at the Trust throughout October 2023. The report also included information on the meetings the Non-Executive Directors had chaired and attended in October 2023, recent Trust news and MT future engagements.

MT explained the Constitution outlined that a Deputy Chair of the Board be appointed by the Council of Governors.

The role of the Deputy Chair was previously held by Elizabeth Sedgley whose term of office ended in September 2023. This provided an opportunity to review how that role might be fulfilled. In line with legislation of 2022 Act, the Chair was legally obliged to participate in partnerships and collaboration. MT explained the workload of the Chair had increased to include partnership work and engagement with the ICB. Upon discussions with the Company Secretary and Non-Executive Directors and consideration of succession planning arrangements, MT would like to explore the principal of appointing two Deputy Chairs – one would be outward facing and would hold a portfolio focussing on the system and the second role would focus on UHMB. One of these roles would also be designated as Deputy Chair to deputise in the absence of the Chair.

MT explained he would explore these arrangements before presenting to the Board of Directors and Council of Governors. MT reiterated that the constitution dictated that the Council of Governors confirmed the decision before discussion at the Board of Directors. A further update would be given in December 2023.

Decision:

1. That the report be noted; and
2. That the Chair's report presented to the Board of Directors in December 2023 would include an update on the appointment of the Deputy Chair.

23/124 Chief Executive's Report

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

The following points were made in discussion:

1. Nationally, NHS England was focused on winter preparations and response to the fragility in urgent care and financial position in NHS. Regarding the financial position at UHMB, CA would present an update on the Trust's financial position. Communication had been received from the British Medical Association which indicated they intended to undertake a ballot on further periods of industrial action. AC noted that although colleagues had become adept at managing these periods of industrial action, they did impact patients and colleagues' health and well-being.
2. AC explained that in October 2023, Lancashire Teaching Hospitals (LTH) confirmed the appointment of Silas Nicholls as their new substantive Chief Executive. Silas would join LTH in early 2024 with a start date to be confirmed.
3. Reflecting on discussions relating to equality, diversity and inclusion and the approach and investment required by the NHS to service those agendas, AC reiterated the Board's commitment to this agenda to ensure all colleagues' and patient needs were met.
4. AC explained that on 23 October 2023 the Trust was formally moved from System Oversight Framework (SOF) segment 4 to segment 3. This was ratified in a communication received from NHS England. AC commended all colleagues, particularly those who support the Women's and Children's and Medicine Care Groups, for their hard work and the impact this had had on improving patient care. Although pleased to have moved to SOF segment 3, AC reflected this was a platform to achieving SOF segment 2 status and beyond. Placing patients first and implementing clinically-led improvements would lead the Trust to meet the ambition of achieving SOF segment 2 status.
5. AC explained the Trust was visited by the national maternity safety support programme team on 10 October 2023. Although the outcome of the review was awaited, initial feedback had been positive.

Decision: That the report be noted.

23/125 Head Governor Report

Consideration was given to a report presented by SW.

The following points were made in discussion:

1. SW advised the governors undertook a development session supported by PJ and TO-NED to discuss areas of priority for governors to review. Areas suggested included how governors worked with stakeholders and engaged with the Board of Directors.

Decision: That the report be noted.

23/126 Annual Safeguarding Reports: Adults and Children and Young People

Consideration was given to a report presented by TD to provide assurance on the statutory functions of Named Nurse for Adults and Named Nurse Children and Young People.

The following points were made in discussion:

1. HR-NED advised this report had been considered by the Quality Committee with further safeguarding reports for midwifery and children in care to be considered in February 2024. HR-NED alerted the Board that the number of children in care over the last six months had increased. The Quality Committee would receive a further report in this regard.
2. TD advised that safeguarding reports were a statutory requirement for the Board of Directors to receive on an annual basis.

Decision: That the report be noted.

23/127 Maternity Safety Update

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

The following reports were considered by the Quality Committee and noted by the Board of Directors:

i. Avoiding Term Admissions into Neonatal Units and Transitional Care Report
ii. Maternity Safety Champion Report
iii. Workforce Reports
iv. Maternity Incentive Scheme

The following points were made in discussion:

1. HR-NED advised these reports had been considered by the Quality Committee. Regarding the maternity incentive scheme report, the Quality Committee noted that although the ambition was to achieve full training compliance, further periods of industrial action could impact this.
2. TC provided an update on the above reports.
3. TC presented the workforce reports as there was a requirement to present these as information to the Board of Directors. Where there was non-compliance against staffing standards and guidance, an action plan was included in the report to provide assurance that actions were in place to meet compliance.

During deliberation of this item the following points were considered:

4. MT advised the Board were required to be alerted to the risks and sought assurance that all risks identified had been shared with the Board. TC confirmed she had.
5. TD advised the maternity safety support programme exit report would be shared with the Board of Directors when available.

Decision:

1. That the report be noted; and
2. That the maternity safety support programme exit report would be shared with the Board of Directors when available.

23/128i Integrated Performance Dashboard and Report Month 5

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

The following points were made in discussion:

1. CA advised the executive summary set out the key performance indicators to

show which KPIs achieved the standards in August 2023 and whether the KPIs would sustainably achieve the standard going forward using statistical process control methodology. The report included the number of patients who did not meet the criteria to reside standard.

2. CA explained a meeting was held with the Non-Executive Directors on 2 October 2023 to review progress with the IPR and to consider how reporting may be improved, because of this session several improvements were being progressed which included inclusion of metrics for equality, diversity and inclusion and neonates, simplified narrative on the key areas of focus, identification of impact, cause and effect, and annotated SPC charts to identify when actions had been taken to support understanding of impact. Work had commenced on these actions and the Board would see inclusion within the reports over the next 3 months.
3. TD advised that work continued to improve the approach to complaints management. Capacity and capability issues in the complaints team had been identified which were being responded to. Recruitment was underway to strengthen the team. In terms of responses to complaints exceeding 6 months, there were 7 complaints that had been waiting for a response for over 6 months. The Trust's internal auditors, Mersey Internal Audit Agency had reviewed the complaints process; the outcome of which was shared with the Audit Committee on 26 October 2023. A further report on the management of complaints would be presented at the Board of Directors' meeting on 6 December 2023. TD advised there were 116 slips, trips and falls reported. 45/116 incidents were patients who frequently fell. There were three incidents which resulted in moderate harm. The team continued to make improvements to respond to this including capacity assessments through the quality improvement methodology. Referring to pressure ulcers, TD advised there had been one category 3 pressure ulcer reported for the first time since November 2022. Work was underway to improve training. Regarding the friends and family test, focus continued on obtaining patients' views whilst they were inpatients.
4. JM advised overall venous thrombo-embolism compliance remained below 95%. Overall mortality figures remained good. The two groups alerted to Board previously – acute cerebrovascular disease remained red. The alert for superficial injury was amber which had reduced from the previous month. Coding continued to be closely scrutinised. There had been no further increase in deaths in May 2023. It was anticipated this alert would reduce by January 2024.
5. AB alerted the Trust that the vacancy rate was a growing area of concern as the vacancy rate was 5.49% against a Trust target of 6%. AB advised a piece of work had been commissioned to review the hotspot areas from a thematic perspective. AB outlined the different approaches being explored to support a reduction in the vacancy rate. The People Committee would continue to monitor this. The absence rate had increased which was primarily aligned with seasonal trends due to an increase in cold and flu. Campaigns were underway to encourage the take up of the COVID and flu vaccinations; take up of the COVID vaccination was significantly lower than the flu vaccination. The People Committee would continue to monitor this. The work around the reduction in agency use for nursing workforce had had a positive impact with the Trust reporting a 3 year low for use of nursing agency. The challenge was to continue with that over the winter period. AB explained the Trust had been forecast to achieve the 3.7% agency ceiling by the end of the financial year due to the anticipated impact of recruitment activity. AB advised that in connection with the winter plan and the requirement for some additional use of agency staff, it was highly likely the Trust would exceed the 3.7% agency ceiling to support the requirements in managing the winter period. A piece of work had been commissioned to review how the Trust compared to other organisations and a review of medical locum rates locally.
6. CA advised the Board the Trust remained on plan at month 5. The actions to mitigate

risk were set out in the formal structured approach to the mandated forecast change protocol – the methodology for which had been agreed across the provider collaborative. The latest forecast risk would be shared with the Board later today. Regarding the Trust's cash position, cash support was not drawn down in October 2023 and not applied for in November 2023. It was anticipated cash support would be required in December 2023.

7. SM advised that the stroke performance demonstrated a sustained score at both the Furness General Hospital and Royal Lancaster Infirmary FGH and RLI. SM presented the diagnostics and elective recovery performance. The cancer standards were stable with many metrics beyond the current target. Regarding urgent care, the Trust achieved 73.5% for the four-hour standard and 95% for the 12-hour standard. The ambulance handover within 30-minute metric showed it was below the 80% target for quarters 3 and 4 at 74-79%. Not meeting medical criteria to reside remained at 16-18% and was rising revealing this was 22% as at 1 November 2023. SM explained *not therapy fit* referred to those patients who no longer required medical interventions but were not yet fit for therapy. SM advised he was sharing this information due to a codification change. SM alerted the Board that 200/600 beds were not accessible due to patients not meeting criteria to reside or were not therapy fit.

During deliberation of this item the following points were considered:

8. HR-NED welcomed SM explanation of those patients who were not therapy fit as it provided a true position of bed capacity. HR-NED noted the requirement for sufficient services in the community to better support those patients medically fit for discharge but required therapy support. The figure previously reported had not included this. SM confirmed the codification change provided a true picture of bed capacity. HR-NED sought clarity on those patients *not therapy fit*. SM advised it was a small group of patients who remained clinically unfit for therapy.
9. Reflecting on the Trust's ambition to achieve System Oversight Framework segment 2 status, AC suggested that within the quality reports inclusion of trajectories to achieve a position of delivery via the Assurance Committee. AC reflected that AB had advised the Board of potentially exceeding the 3.7% agency cap to deliver the winter plan. The risk to not achieving targets had been considered when reviewing the winter plan; associated mitigations had been included in the plan to offset the risks. Regarding not meeting medical criteria to reside, it was agreed at the last meeting AC discuss with the ICB. AC advised he had received formal communication from the ICB which referenced the clinical strategy and whole system programme of work to respond to the number of patients not meeting medical criteria to reside.
10. CA advised that the Trust's financial plan was built on the national standard of 5% for not meeting medical criteria to reside.
11. MT commented on the mitigations in place which impacted the drive to meet standard metrics and encouraged this not to be normalised.
12. TO-NED sought assurance whether the ICB response included reference to local authorities. AC advised it did; there were a number of meetings with system leaders on winter plans and mitigations. AC advised discussions with the ICB on next steps were underway. TO-NED sought assurance on investments in local government in line with spend. AC advised this was being reviewed by the Recovery and Transformation Board, which would review the ring-fenced allocations for social care support and the integrated care better care fund.
13. MT advised that the provider collaborative had requested, through the ICB, that local authorities lead the transformation. MT explained the patients' partnership group had approached the ICB to develop a project on how carers could support not meeting medical criteria to reside. Referring to the accelerator reform fund to local authorities across England from the Government, MT advised there were 12 priorities in the

accelerator reform fund. MT was supporting ICB in identifying 2 of those, one being not meeting medical criteria to reside.

14. SR-NED sought clarity on the acronym BCF. AC advised it was the better care fund and agreed to provide further information about this. AC agreed to circulate guidance on this. SR-NED sought assurance on the reconciliation of contract offer for 2023/24 in the context of discussions at the Audit Committee six months ago when the year-end external auditor report was reviewed, as they had referenced this. SR-NED sought assurance on the status of that process. CA explained the main point of the reconciliation work was that the fact the ICB would need to rebase the contracts as organisations emerged from the contractual forms used during the pandemic to the new contracts. ICB had permission to maintain a level of block contract through this period. CA advised he had chased this up as UHMB had been asked to accept a variation to the contract which was challenging to accept a variation of the contract without a contract to vary. CA had requested a timeline of the contract.
15. KD-NED commended the work to introduce equality, diversity and inclusion and neonatal metrics into the IPR and sought clarity on the timeframe for including those metrics in the IPR. TD and AB agreed to provide datelines. KD-NED sought clarity on when the communication strategy would be presented to Board. MT agreed to discuss with PJ. KD-NED noted the vacancies in midwives trajectory had demonstrated a much-improved position by December 2023. KD-NED sought assurance whether this rise in midwife vacancies compromised that trajectory and whether additional action was in place. TD advised this was being reviewed. She had met with the midwifery team to respond to the vacancies. TD commented that it was unlikely to impact the trajectory. AB echoed TD comments explaining the improvement trajectory was predicated on the number of students who qualified. AB agreed to provide additional information outside the Board meeting.
16. SK observed SHMI and HMSR and although they were good, the SHMI data had shown a rising trend. JM advised the SHMI was less than 100 and less than peer group, and within that there were several alerting groups. There had been no increase in the number of alerting groups and suggested expert advice was required to understand whether this required a further review.
17. MT noted the 3A Assurance Committee reports alerted the Board and this report provided a “helicopter” view in relation to staffing vacancies, referral to treatment metrics and the financial position. MT sought clarity on how the Board could be assured on the actions taken in response to these challenging areas.
18. TD advised that in terms of staffing, the Trust had the lowest nursing staffing vacancies. A rise in midwifery vacancies had been identified, which was a cause for concern and the teams were exploring ways to respond to this which triangulated with the issues around safer staffing.
19. JM suggested a further discussion with SK on the presentation of mortality data.
20. CA noted Board members’ comments and when producing the narrative reports, timelines and trajectories were included. Considering SK comments, the context was important.
21. SR-NED noted the Quality Committee and Board received the mortality report and agreed to consider the data to share.
22. HR-NED advised that the Quality Committee’s 3A report had highlighted that the Committee had received the safe staffing (nursing) report which did not identify any correlation with staffing and deterioration in quality of care. HR-NED sought assurance on the response to the cancer data regarding urology in terms of speed at which patients reviewed and treatment, noting a task and finish group had been established. HR-NED suggested the performance required detailed scrutiny and sought assurance this was taking place. Regarding dermatology, HR-NED noted the the team were reviewing patients and offering a diagnosis in a speedy timeframe. As

a GP, HR-NED had noted there was an issue with patients being reviewed and undergoing a biopsy and wondered if this referred to treatment. Regarding gynaecology, the issue seemed to be time to treatment and in response to this, HR-NED noted improvement trajectories would be established for cancer 2 week wait and 28 day faster diagnosis standards. HR-NED suggested this be monitored by the appropriate committee. HR-NED commented that the glossary to accompany the report required updating to include the new cancer standards. SM explained that in relation to the urology data, UHMB was the second-best performing Trust in its peer group. Regarding dermatology, SM advised there had been a 25% increase in referrals. Community dermatology was provided by a different provider with enhanced triage from November. Detailed work had begun to establish a start date for anticipated impact on demand. Regarding gynaecology, improvement trajectories were established for completion by the end of October 2023. SM welcomed a further discussion outside the Board meeting. JM explained the urology service was the most pressured pathway nationally and in response to this, the radiology team were working hard to meet demand and make the service as *one-stop* as possible.

23. MT sought assurance on the response to the patient who had sustained a level 3 pressure ulcer. TD advised the patient was recovering. Future reports would include a timetable to show the trajectory for improvement. MT encouraged continued focus on the Trust's financial position during the second half of 2023/24 noting the impact for 2024/25.

Decision:

1. That the report be noted; and
2. That the Board of Directors agreed future reports would include the trajectory for improvement if standards were not being met.

23/128ii Assurance Committee Minutes and Chairperson's Report

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

Audit Committee

TO-NED provided an update on the work of the Committee. The Trust's internal auditors, Mersey Internal Audit Agency, presented the outcome of their reviews in relation to the capital programme, complaints process and risk management self-assessment. Regarding the fit and proper person process, NHS England (NHSE) had issued guidance to strengthen the process. The Committee approved changes to the policy to reflect the new NHSE framework. Regarding overpayments of salaries, the Committee had requested further details which included benchmarking and trend analysis. The Committee approve the emergency planning, resilience and response self-assessment and the Trust major incident plan. Regarding the board assurance framework, it was agreed to reconvene an additional meeting to consider this. The Committee suggested reference to the ageing estate infrastructure, health inequalities and community services be included in the BAF. The Committee had recommended that the sequencing and management of the BAF would be discussed by the Committee at its next meeting in January 2024.

Finance and Performance Committee

KD-NED provided an update on the work of the Committee. KD-NED highlighted that the Committee remained focused on assurance regarding care group delivery against their cost improvement programme. A decision to defer approval of a business case was

made to enable focused and prompt work to be completed and submitted to the Committee for further consideration. The Committee received an overview of new finance metrics, a new scoring mechanism for the performance and accountability framework. The Committee welcomed this as it supported triangulation of information.

Quality Committee

HR-NED provided an update on the work of the Committee. The Committee considered a report from the Core Clinical Services Care Group which highlighted issues regarding capital equipment replacement for ageing equipment. Although not unique to this Care Group, potential impact on breast screening and nuclear medicine services was noted – the latter has received a Licence renewal of only two years rather than the usual five, due to ageing equipment at the Royal Lancaster Infirmary. The Committee considered the quarter 2 review report.

23/129 Quarter 2 Review – Strategic Priorities / Key Areas of Focus and Board Assurance Framework (BAF) Review

Consideration was given to a report presented by AC to provide assurance on progress during quarter 2 against the Trust's portfolio priorities aligned to the 2023/24 Trust Priorities:

- Deliver outstanding care and experience;
- Create the culture and conditions for our colleagues to be the very best they can be;
- Make the best use of our physical and financial resources; and
- Working in partnership.

The following points were made in discussion:

1. AC explained the Associate Director of Strategy had led the quarter 2 review; the outcome was detailed in the report. Reflecting on what had gone well during quarter 2 included the CQC inspection results, exit from System Oversight Framework segment 4, maternity safety support programme progress, achievement of JAG accreditation, achieved the financial plan, continued investment of urgent care at the Royal Lancaster Infirmary, sustained stroke and maternity improvements, commenced implement of the patient safety incident response framework, good internal audit reports and 5 star food rating across all catering sites.
2. Highlighted concerns/risks including complaints process, availability of capital funding not meeting medical criteria to reside, impact of industrial action, lack of resources to manage the winter period and system financial pressures.
3. PJ presented the BAF and advised that at the end of quarter 1 there was a request to review the score in relation to culture. An assessment had been carried out and the score had increased to 16. The BAF highlighted gaps and mitigations which would be addressed through the work of the Assurance Committee during quarter 3. In aligning the BAF with the Trust Wide Risk Register, it was noted that there had been an escalation of operational risk including capacity and activity challenges, financial delivery and not meeting medical criteria to reside. This was consistent with the areas of focus and exception and assurance reports to the Board in the last quarter. The Board and its Committees would need to seek assurance that escalating operational risks were being managed effectively when the Trust Wide Register was considered during the next quarter. A review of the timetable for preparing the BAF for 2024/25 was underway. PJ explained he had alerted the Audit Committee that the Trust's risk appetite statement would be reviewed as the Trust moved from SOF segment 4 to 3. PJ advised delivery of the new hospital programme was a significant undertaking.

During quarter 3 the Board would be asked to establish a Board Committee. This Committee would have oversight of the risk to achieving delivery of the NHP. This would be included in the BAF.

4. AC outlined the priority actions for quarter 3 which included prioritisation of the health and well-being of colleagues, Prioritise the health & wellbeing of our colleagues, working collaboratively with place-based partners and the wider system to ensure robust plans are in place for winter which included plans to reduce not meeting medical criteria to reside, continued focus on elective recovery activity and trajectories, focus on expenditure control and delivery of financial efficiencies, embed and sustain improvements made through the recovery support programme, agree and mobilise System Oversight Framework (SOF) segment 3 to 2 actions, improvement approach and programme, preparation for the implementation of the quality accreditation process and improve the experience of our internationally recruited colleagues.

During deliberation of this item the following points were considered:

5. HR-NED confirmed the Quality Committee reviewed this report. When considering those priorities falling under the Committee's remit it was felt there should be additional narrative where progress had not been as expected. The Committee suggested using the '*Even Better If*' approach.
6. AL-NED sought assurance on the actions for quarter 3 and the rationale attached to those areas of focus. AC advised they were prioritised on the risks associated within the BAF.
7. SR-NED sought assurance on the new hospital programme noting work was underway and sought assurance on including this programme within the BAF. AC agreed to discuss this further with SM. PJ advised there would be a separate standalone risk for this programme as per best-practice.

Decision:

1. That the report be noted; and
2. The Board of Directors approved the actions and focus for Quarter 3.

23/130 Winter Plan

Consideration was given to a report presented by SM to share the approach UHMBT (and system partners) were taking to prepare for the forthcoming seasonal winter period.

The following points were made in discussion:

1. SM explained the report set out the plans to response to the winter period and had been developed in the context of the significant pressures within the health and care system. SM advised that the Trust had not received external funding for 2023/24 seasonal winter additionality and in this context Board approval of the plan was sought noting the approval also approved resourcing of the winter plan from Trust resource up to a maximum of £1 million.
2. SM advised factors such as COVID, flu, not meeting medical criteria to reside and further industrial action would impact the forthcoming winter period.
3. SM clarified that in the event of system schemes not receiving funding to deliver the required impact, UHMB contingency plans had been created to expand surge capacity on both the Royal Lancaster Infirmary and Furness General Hospital. These schemes were not funded and would be delivered by deploying Trust resources.
4. TD supported the winter plan from an infection prevention perspective. TD advised of the process for managing COVID during the winter period. A communication had been issued to all staff for instances where there was a COVID or flu outbreak on the

ward with instructions on the surgical masks to use. Colleagues who were symptomatic of COVID/flu symptoms were encouraged to work from home if they were able to. The teams were working alongside occupational health and workforce to encourage take up of the COVID and flu vaccinations.

5. JM advised flu was predicted to be significant this year and explained this plan supported the Trust in providing the best care possible for patients.
6. MT echoed JM comments and noted the concerns. MT noted the mitigations and encouragement of vaccinations and sought assurance on patient safety. TD advised with the mitigations in place this would support patient safety but advised this with caution due to the impact SM outlined.

During deliberation of this item the following points were considered:

7. Reflecting on patient safety, AC advised there was an infrastructure internally to provide that assurance, which was escalated through the winter period. Mitigations had been put in place and this plan was the best plan to satisfy patient safety during the winter period. Discussions at a system level were ongoing to share respective risks and the response to mitigate these.
8. TO-NED sought clarity on what was being invested as additionality. MT and AC agreed to discuss this with the provider collaborative.
9. AL-NED supported the plan and noted the impact on health inequalities.
10. AK-NED supported the plan and noted the absence of local authority input.
11. SR-NED supported the plan and sought clarity that the financial forecast included the £1m as SM described. SM commented the plan had been developed to mitigate patient safety. CA confirmed the £1m as referred to by SM had been included in the current risk forecast. CA advised that the financial position was a planned deficit and approval of the recommendations by the Board was in the knowledge that this was in the context of the Trust being in deficit. Delivery of quality improvements had been demonstrated as per exit from SOF 4. CA advised it was important the Board recognised the forecast risk was not driven by this decision and the forecast risks were associated with the significant stretch target, inflationary fund pressures, not meeting criteria to reside, impact of pay pressures and industrial action. This was a decision to make in that context.
12. MT explained that it was important the Board recognised that by approving the resourcing of the winter plan, from Trust resources, up to a maximum expenditure of £1m, this was done in the knowledge this was a risk, despite it being budgeted. MT sought assurance on what would happen upon Board not approving resourcing of the plan through the max expenditure of £1m. CA advised of the importance of maintaining patient safety through the winter period.
13. TO-NED sought clarity on the opening of additional bed capacity to manage demand. SM advised of process.
14. MT sought clarity that the additional cost of agencies was included in the £1m. CA advised this had been included in the anticipated staffing model.
15. AC advised that this plan was deployed each winter and reflected that as the Trust moved into 2024/25 planning, management of the winter period be included in the annual plan. AC agreed to discuss this further with the executive team.

Decision: The Board of Directors approved the seasonal Winter Plan and approved resourcing the Winter Plan, from Trust resources, up to a maximum expenditure of £1m.

23/131 Emergency Preparedness, Resilience and Response (EPRR): Core Standards Self-Assessment Assurance Return

Consideration was given to a report presented by SM to present the EPRR self-

assessment assurance return.

The following points were made in discussion:

1. The report detailed the EPRR self-assessment assurance return. SM as the accountable emergency officer had signed the statement of compliance based on the self-assessment assurance return. Board approval was sought.

Decision:

1. That the report be noted; and
2. The Board of Directors approved the EPRR Core Standards Action Plan (EPRR Work Plan) and for the Accountable Emergency Officer to sign the Statement of Compliance.

23/132 Provider Collaboration Update

Consideration was given to a report presented by AC to present an update from the Provider Collaboration Board.

The following points were made in discussion:

1. The report detailed the work of the provider collaborative. AC advised that the pathology collaborative business case would be shared with the Board in early 2024. AC had discussed with the PCB company secretary on the information shared with Boards, moving away from general information to specific information.

Decision: That the report be noted.

23/133 New Hospital Programme Quarter 2 Report

Consideration was given to a report presented by SM to provide an update on the New Hospitals Programme for the quarter 2 period.

The following points were made in discussion:

1. SM advised the report included the progress against plan for July to September 2023, an update on the enabling work business cases, further work on potential new site locations and the emerging new governance model. Supported by PJ and SR-NED, SM would prepare the Terms of Reference for the New Hospitals Programme Sub-Committee and would present to the Board for consideration.

During deliberation of this item the following points were considered:

2. SW sought assurance on the funding allocation for the Furness General Hospital (FGH). SM advised the Trust remained committed to deploying that at FGH. The enabling works and consultation would provide more granularity to that.

Decision: That the report be noted.

23/134 Attendance Monitoring Register

Noted.

23/135 Schedule of Business

Noted.

23/136 Urgent Business

None.

23/137 Date, Time and Venue of Next Meeting

It was noted that the next meeting of the Board of Directors would be held on Wednesday 6 December 2023 at 10am in the Board Room, Westmorland General Hospital, Kendal LA9 7RG and also via Microsoft Teams.

23/138 Exclusion of the Press and Members of the Public

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

Meeting Title	**01/11/2023**
Meeting Chair	**Mike Thomas**
Previous Meeting Date	01/11/2023
Next Meeting Date	06/12/2023

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

Meeting Date	Action No	Agenda Item	Action Point	Owner	Due Date	Original Due Date	Completed Date	Progress	RAG Rating
29/03/2023	245ii	Assurance Committee Minutes and Chairperson's Report	A new engagement strategy was in development which would be presented to the Board.	Director of Corporate Affairs	01/05/2024			Development of an engagement strategy has been paused and will be progressed in 2024.	**SBM**
06/09/2023	87	CEO Report	The Board of Directors noted a review of the Trust's patient relations process led by the Chief Nursing Officer would be shared with the Quality Committee and Board of Directors in October and November 2023;	Chief Nursing Officer	06/12/2023			A report is included on the agenda.	**SFM**
04/10/2023	106	Chief Executive's Report	The Board of Directors noted a continuous quality improvement draft strategy would be presented to the Board of Directors at their meeting on 1 November 2023	Chief Nursing Officer	06/12/2023			A report is included on the agenda.	**SFM**
04/10/2023	106	Chief Executive's Report	The Board of Directors noted the Chief People Officer would keep the Board briefed on the development of the ONE LSC service.	Chief People Officer	07/02/2024				**SBM**
01/11/2023	123	Chair's Report	The Chair's report presented to the Board of Directors in December 2023 would include an update on the appointment of the Deputy Chair.	Chair	06/12/2023			An update is included in the report.	**SFM**
01/11/2023	127	Maternity Safety Update	That the maternity safety support programme exit report would be shared with the Board of Directors when available.	Chief Nursing Officer	07/02/2024				**SBM**
01/11/2023	128i	Integrated Performance Report	It was agreed future reports would include the trajectory for improvement if standards were not being met.	Chief Financial Officer	07/02/2024				**SBM**

THIS PAGE IS INTENTIONALLY BLANK

NHS Lancashire and South Cumbria Integrated Care Board

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

NHS University Hospitals of Morecambe Bay NHS Foundation Trust

BOARD OF DIRECTORS' MEETING

Date of Meeting	6 December 2023
Title	Chair's Report
Report of	Professor Mike Thomas, Chair
Prepared by and contact details	Cara Berriman cara.berriman@mbht.nhs.uk

Confidentiality	Non-Confidential

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

The content of this report outlines:

- Introduction
- An outline of the Chair's activities throughout November 2023;
- An outline of the Non-Executive Directors' activities throughout November 2023
- Final Remarks

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

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

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

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

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

Acronyms	

UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST

Chair's Report

Introduction

1. I would like to begin by welcoming colleagues to today's Trust Board of Directors meeting.

2. This report provides a number of general updates in relation to both Chair and Non-Executive Director activities, plus any other key updates related to the Trust, our Provider Collaborative, or the wider Integrated Care Board (ICB).

3. I would like to take this opportunity to thank all colleagues and teams across the Trust and our Community Services for their continued efforts in providing care for our patients. I would also like to offer my thanks to Board colleagues, the Council of Governors, and NHSE.

Chair's Activities

4. Meetings and events I attended in the month of November included, but not limited to, meetings with Board of Directors' meetings, an Anti-Racist Summit event, System Transformation & Recovery Board meetings, Provider Chair's meetings, and meetings with the Chaplaincy team. I also held my monthly meeting with Staff Governors, Chair to Chair meetings, Chair, Head Governor and Deputy Head Governor meetings, and met with the Non-Executive Directors for our monthly Chair and Non-Executive Directors' meeting.

Non-Executive Directors' Activities

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

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

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

Deputy Chair

8. Following the last meeting of the Board. I consulted with the Council of Governors on my proposal to appoint two Deputy Chairs. The Board will recall, one would be outward facing and had a priority on focussing on the system, and the second role would focus on UHMB. One of the roles would be designated as Deputy Chair to deputise on the absence of the Chair.

9. I am pleased to say that Karen Deeny and Sarah Rees have agreed to take on these roles.

Shadow Board Programme

10. The Board of Directors have previously indicated their support to commission a Shadow Board programme, funded by the NW Leadership Academy and facilitated by the Inspiring Leaders Network.

11. The programme is now up and running with the first module taking place on 27 November 2023 and Shadow Board meeting yesterday, 5 December 2023, chaired by myself.

Winter Challenges

12. Winter is always a pressure point for the Trust and this year is no different. Alongside that are the financial challenges facing the ICB and the Provider Trusts. We have all the preparatory processes in place to deal with Winter including a priority to support staff wellbeing which in turn ensures safe and high-quality care for our patients.

13. The financial challenges are not new, and planning is in progress and will be covered elsewhere in the agenda.

14. As always, the Board hugely appreciates the work of our colleagues throughout the trust and wish to convey our thanks for all that they do.

Final Remarks

15. This is the final Board meeting of 2023, and the Board would like to wish all our colleagues, patients, carers and partners the very best for the festive season.

16. I am grateful and thankful to all colleagues for their commitment to our patients and our communities, and for their continuous efforts to enhance the Trusts provision for the benefit of patients, carers, and families.

17. The next meeting of the Trust Board will be held on Wednesday 7 February 2024.

Professor Mike Thomas
Chair

6 December 2023

NHS Lancashire and South Cumbria Integrated Care Board

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

NHS University Hospitals of Morecambe Bay NHS Foundation Trust

BOARD OF DIRECTORS

Date of Meeting	6 December 2023
Title	Chief Executive's Report
Report of	Aaron Cummins, Chief Executive
Prepared by and contact details	Maria Caparelli, Business Manager to Chief Executive maria.caparelli@mbht.nhs.uk

Confidentiality	Non-Confidential

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

Summary of Key Issues / Concerns	This report provides a range of key updates on a monthly basis to the Trust Board, under a number of current headings and themes which link to our organisational priorities. These items include but are not limited to: a general Introduction highlighting items of relevance to our current operating environment, the National and Regional Context, Lancashire and South Cumbria Integrated Care Board (ICB), Lancashire & South Cumbria Provider Collaborative Board (PCB), Morecambe Bay Place-Based Partnerships, General Trust Updates, Financial Sustainability, Service Transformation and Improvement, and Relationships and Partnerships. Additional items referenced in this month's report under the headings above include: • Ministerial Changes • National Finance Briefing

	• National Maternity Safety Support Programme (MSSP) Exit • NHS Providers Annual Conference: Panel Session • Aspirant CEO Talent Event

Prior Discussions	Committee	Date	Recommendations/ Concerns

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

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

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

Acronyms	

UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST

Chief Executive's Report

INTRODUCTION

1. This report provides an update on current matters and priority areas for the Trust, as set out in the executive summary above.

2. Today's Board meeting agenda features a number of key areas and reports for discussion, including: Continuous Quality Improvement Draft Strategy, Review of Complaints Process, Maternity Safety Update, Trust Improvement Plan, Thirlwall Inquiry - plus the usual standing items for the Board to consider and receive.

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

4. As I always I would like to take this opportunity to offer my sincere thanks and gratitude to all colleagues and teams across the Bay. I spend a lot of time on our wards and departments, and I see first-hand the continued efforts to ensure the safety of our patients across our hospitals and in the community.

NATIONAL AND REGIONAL UPDATES

Ministerial Changes

5. On 13 November, Prime Minister Rishi Sunak announced a series of ministerial changes. It was confirmed that Victoria Atkins MP will replace Steve Barclay as the new Secretary of State for Health and Social Care.

6. Further information on the wider changes can be found on the NHS Confederation website, who have provided a briefing summarising the changes.

National Finance Briefing

7. On 7 November 2023, a national briefing took place for Chief Executive Officers and Chief Financial Officers. It was chaired by Chris Hopson - NHS Chief Strategy Officer, and led by Amanda Pritchard – NHS England Chief Executive, and Julian Kelly – NHS England Chief Financial Officer.

8. The briefing focussed on the financial and wider arrangements, including operational performance, for the remainder of 2023/24. An overview of actions and next steps was provided, with a separate session for finance directors to go through the detail.

9. The key messages from the briefing were as follows:

    - £800m into system allocations for balance of 2023/24 based on the number of clinical staff in each system to reflect where Industrial Action by system and provider has fallen

- Reducing the elective activity target for 2023/24 to a national average of 103%, which will now be maintained for the remainder of the financial year
- On average year to date c107% has been delivered so this would be additional £300m to systems
- Overall >£1bn to cover Industrial Action and elective recovery

10. Following the briefing, a letter was issued confirming the discussion and outlining agreed actions and next steps. For the remainder of the financial year, the agreed priorities are to achieve financial balance, protect patient safety and prioritise emergency performance and capacity, while protecting urgent care, high priority elective and cancer care.

11. In response, we were asked, both as a provider Trust, and as an Integrated Care System, to complete a rapid two-week exercise to agree actions required to deliver the priorities for the remainder of the financial year. This submission was made, in conjunction with the ICB, on 22 November 2023.

Lancashire and South Cumbria Integrated Care Board (ICB)

12. 1 July 2022 saw the formal establishment of the new Lancashire and South Cumbria Integrated Care Board. The eight Clinical Commissioning Groups across Lancashire and South Cumbria have been replaced by a single Integrated Care Board (ICB), which will be known publicly as NHS Lancashire and South Cumbria.

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

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

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

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

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

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

19. In support of the ICB establishment and the wider Lancashire & South Cumbria Health & Care partnership that sits underneath the ICB structure outlined above, we

have enabled a number of local partnership structures. An overview of these structures is provided below.

20. The most recent meeting of the ICB took place on 8 November 2023 and a copy of the Chief Executive's report is appended for reference.

Lancashire & South Cumbria Provider Collaborative Board (PCB)

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

22. The PCB meets monthly, and the most recent meeting took place on 16 November 2023, where the agenda covered: Performance Update – Urgent and Emergency Care, Elective Care, Mental Health and Learning Disabilities, Financial Update, One LSC Leadership Team – approval for initial roles, Clinical Programme Board Update, Pathology Network Board, and ICB feedback.

23. A PCB Workshop also took place on the same date, the aims of which were:

    - To review the role of the Joint Committee PCB (JCPCB) and reflect on what is working well and what could be improved
    - To review the operational and governance relationship between the PCB, ICB and Recovery Transformation Board
    - To identify and agree changes to the structure and/or Terms of Reference to the PCB
    - To review and agree the forward workplan for the rest of 2023/24 and 2024/25

24. I look forward to collation of the outputs and agreeing next steps.

25. The standing Provider Collaborative Update features at item 151i on today's agenda, plus the revised Draft Terms of Reference, at item 151ii.

Morecambe Bay Place-Based Partnerships

26. Planners and providers working together across health, local authority and the wider community, taking responsibility for improvement health and wellbeing of residents within a place.

27. The five place-based partnerships that make up the Lancashire & South Cumbria Partnership are: Morecambe Bay, Pennine Lancashire, West Lancashire, Fylde Coast and Central Lancashire, and they meet on a monthly basis.

Primary Care Networks

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

TRUST UPDATES

National Maternity Safety Support Programme (MSSP) Exit

29. I reported last month that the national MSSP team carried out a visit of the Trust as part of our support programme, on 10 October 2023.

30. Following this, the Trust met with the MSSP team again on 29 November 2023. The purpose of this visit was to inform next steps on exit from the programme. The care group were required to deliver a presentation; demonstrating the work carried out to-date, remaining actions and next steps, and assurance on how the improvements would be sustained into the future.

31. There was an opportunity for further reflections from the team and I, and time for questions.

32. We are committed to continuing to improve, and sustain, all aspects of quality and safety for the benefit our patients and families.

33. I would like to thank all colleagues in the care group for their hard work and efforts is reaching this point; and the MSSP team for their continued support.

34. The wider Maternity Safety Update features at item 148 on today's agenda.

RELATIONSHIPS AND PARTNERSHIPS

Engaging with colleagues across the Trust

35. I am continuing with my Tea and Talk sessions and there are a number of sessions at different times each month, which are a mixture of face to face in the restaurant at each of our three main hospitals, and virtual via Microsoft Teams.

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

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

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

NHS Providers Annual Conference: Panel Session

39. On 14 November 2023, I was delighted to be asked to join a panel session at the NHS Providers Annual Conference.

40. The session was hosted by Browne Jacobson, as part of the launch of their joint publication with NHS Providers, about collaboration.

41. The session took the form of a 30 mins Q&A, led by Sir Neil McKay, with a case study focus on the LSC Provider Collaborative.

42. The full report can be accessed here: Provider Collaboration: A practical guide to lawful, well-governed collaboratives (nhsproviders.org)

Aspirant CEO Talent Event

43. On 28 November 2023, I was pleased to be invited to participate in the North West Aspirant CEO Talent Event in Manchester.

44. The aspirant CEOs spent the morning reflecting on their career and how this will help them in considering their next steps. I joined them in the afternoon which started with a Networking Session, followed by me leading a 'speed connection' table, where the participants got to spend time in smaller groups with each CEO/regional lead, on a specific topic, before inviting them to rotate and move to the next table.

45. The topic I led was 'encouraging a culture in Freedom to Speak Up' and I was able to share specific examples, reflections and processes within UHMBT to aid discussions.

46. The aims of the session were to:

    - Help the talent pool member gain valuable insights on the topic areas from current CEOs/Regional Leads, identify any gaps in their knowledge and suggest how they may fill those
    - To offer practical steps/action to the talent pool members on the topic area
    - For the talent pool members to gain greater understanding and be 'ready' to apply for the next role

FINAL REMARKS

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

48. Our areas of focus are a vital part of how we will achieve what we set out in our Trust strategy and reflect our strategic priorities. A reminder of the areas of focus for 2023/24 are:

    - Deliver outstanding care and experience
    - Create the culture and conditions for our colleagues to be the very best they can be
    - Make the best use of our financial and physical resource
    - Working in partnership

49. The next meeting of the Trust Board will be held on 7 February 2024, and the meeting agenda will feature: Maternity Safety Update, Transformation and Improvement, Quarter 3 Review – Strategic Priorities / Key Areas of Focus and Board Assurance Framework Review, UHMB Strategy – 6 Monthly Review, Nursing, Midwifery and Allied Health Professional Bi-annual Staffing Report, New Hospital Programme Quarter 3 Report, UHMB Strategy – 6 Monthly Review, UHMB New

Hospitals Programme Governance Structure, Freedom to Speak Up, Lessons Learnt – plus the usual standing items for the Board to consider.

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

51. I wish you all the very best for the festive period and I look forward to continuing to work with you in the new year.

Aaron Cummins
Chief Executive

December 2023

Lancashire and South Cumbria Integrated Care Board

Integrated Care Board

Date of meeting	8 November 2023
Title of paper	Report of the Chief Executive
Presented by	Kevin Lavery, Chief Executive
Author	Hannah Brooks, Communications and Engagement Manager and Executive Team contributions
Agenda item	5
Confidential	No

Executive summary

This report sets out the current challenges that the ICB is facing in relation to delivering an ambitious recovery and transformation plan, and focuses on what needs to be in place in order for the plan to be achieved.

Major change will require strong commitment and leadership, and the right culture. This will be even more key as more complex programmes of transformation are developed.

There has not been enough progress in relation to the agreed recovery plan and the month six position means that it is now necessary to prepare for intervention from NHS England. Intervention should add value and help to improve the year-end position and future transformation.

Recommendations

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

Which Strategic Objective/s does the report relate to:		Tick
SO1	Improve quality, including safety, clinical outcomes, and patient experience	**x**
SO2	To equalise opportunities and clinical outcomes across the area	**x**
SO3	Make working in Lancashire and South Cumbria an attractive and desirable option for existing and potential employees	**x**
SO4	Meet financial targets and deliver improved productivity	**x**
SO5	Meet national and locally determined performance standards and targets	**x**
SO6	To develop and implement ambitious, deliverable strategies	**x**

Implications

	Yes	No	N/A	Comments
Associated risks			x	
Are associated risks detailed on the ICB Risk Register?			x	

Financial Implications			x	

Where paper has been discussed (list other committees/forums that have discussed this paper)		
Meeting	**Date**	**Outcomes**
Executive Management Team	31 October	Draft reviewed for agreement.

Conflicts of interest associated with this report
Not applicable.

Impact assessments				
	Yes	**No**	**N/A**	**Comments**
Quality impact assessment completed			x	
Equality impact assessment completed			x	
Data privacy impact assessment completed			x	

Report authorised by:	Kevin Lavery, Chief Executive

Integrated Care Board – 8 November 2023

Report of the Chief Executive

1. Introduction

1.1 We are acutely aware that we face some major challenges around the Integrated Care Board (ICB). There are even bigger challenges within our system. We are working hard to respond to those challenges, and we have a good plan in place for recovery and transformation, which we covered in detail at the last board meeting in September.

1.2 Since the last formal board meeting, we have held the first two meetings of the System Recovery and Transformation Board, which brings together the leadership of all of our NHS trusts, the ICB and local government.

1.3 We do, however, have some real risks around the speed of implementation of our recovery plan. In the NHS, we are not used to transformational change, and we are encountering some resistance to change. Lancashire and South Cumbria has low turnover and a conservative culture, so major change is a challenge in our system. We need to work closely with our senior and middle managers in the system to build on the positive work that is already taking place and ensure they have what they need to go further, faster and truly embed change.

2. The challenge of execution against our recovery plan

2.1 We have got a good plan, but it is high risk and requires trusts to work closely together, major hospital reconfiguration and a switch to community services. This is nothing short of a revolution. It is not surprising that execution of such an ambitious plan is challenging. It means a major change to how we do things around here and not all the relevant staff have the necessary experience and skills.

2.2 As American novelist Larry McMurtry describes, “what needed to be done was simple, if not easy”. We need to make progress and move forward. To do this, we need to gain momentum. There is a lot that needs to happen and as a system we need to be on the same page.

2.3 The challenge is not going to go away, and as leaders we will need to be decisive in the difficult decisions that we will face over the coming years. It is likely to be a difficult experience if we are going to achieve a real step change across the system.

2.4 It is important that we do not come up short in this respect. One of the things that we can really focus on is getting the culture and leadership right at every

level of our healthcare system, so that we can make big and difficult decisions for the overall benefit of the people of Lancashire and South Cumbria (LSC).

2.5 Our central services programme is one of the more mature and well-developed programmes. The Provider Collaborative joint committee has determined what is in store, set a joint timetable and agreed that East Lancashire Hospitals Trust (ELHT) will be the host organisation.

2.6 However, we are now encountering some slippage which is concerning. This is a perfect example of a programme that has achieved a lot in a short space of time, but now we must ensure that the environment around the programme is right, so that we can continue to meet the challenging and ambitious objectives of the programme. This will require strong commitment and leadership and the right culture. This will be even more key as we move onto more complex programmes of transformation, like clinical service reconfiguration.

2.7 I am keen, therefore, that we get some strong earthed leadership development for the system – for senior leadership and high-potential managers, focused on hard skills around our agenda, such as how to roll out virtual care and zero-based budgeting, soft skills such as collaboration and engagement with clinicians as well as building a community of leaders within our system. In doing so, we will reap the rewards for years to come for people living and working in Lancashire and South Cumbria.

3. Preparing for intervention

3.1 So far, we have been using a range of NHS England (NHSE) financial controls around discretionary spend, consultancy, contract renewals and staff vacancies across the LSC NHS system. We voluntarily adopted these measures in an attempt to improve our financial position.

3.2 Although the three-year recovery plan that we agreed with NHSE is a good one, the execution of the plan has fallen short of what we expected. There is a lot of risk within the plan, due to the underlying deficit.

3.3 Unfortunately, we are not making enough progress and our month six position means that we are now preparing for intervention from NHS England.

3.4 Intervention is not how it should be done. It is much better to get it right first time, rather than intervene after the event.

3.5 We need to make sure that any intervention adds value and helps improve our year-end position and our future transformation.

3.6 We need targeted support from specialists and experts from the national team, who are able to take an objective view of specific areas that would benefit from intervention. We will therefore ask for support in relation to certain areas of commissioning, transformation programmes that are encountering barriers, and the trusts in our system that are most financially off-plan.

4. Organisational development: a way to go

4.1 We are currently in the annual NHS Staff Survey period and in July we ran one of the quarterly NHS Pulse Surveys. This, alongside our monthly wellbeing check-ins with staff has shown that staff satisfaction and morale remains low.

4.2 As chief executive of the organisation, I take responsibility for the results of our surveys and have already begun working with our leadership team to look at how we can improve the experiences of our staff.

4.3 We have a way to go to get some of this right, but we are committed to listening to our staff and are making our organisation a great place to work for everyone.

5. Chief operating officer

5.1 We have updated the job title for Craig Harris to better reflect his portfolio. Although there is no change to Craig's portfolio or responsibilities, his job title is now chief operating officer, or COO. The updated job title is more akin to what is used in other NHS organisations and is intended to help people better understand Craig's role and portfolio.

6. Continuing Healthcare transfer of staff and new model

6.1 On 1 October the All Age Continuing Care (AACC) and Individual Patient Activity (IPA) service provided by Midlands and Lancashire Commissioning Support Unit (MLCSU) transferred into our ICB. This means that the AACC and IPA service has now become a team of circa 250 staff. This also includes existing ICB staff and 75 new starters.

6.2 Four place-based Continuing Healthcare (CHC) teams will operate across the ICB. Discharge to assess, children and young people's continuing care and IPA teams will operate at system level with place-based links.

6.3 A senior leadership team has been established within the ICB led by the director of adult health and care and the associate director of AACH and IPA.

6.4 This has been a significant milestone for the service and many compliments have already been received from external stakeholders and staff who have transferred over about the improved quality and responsiveness.

6.5 It should also be noted that the AACC team has met their NHSE quality premium trajectory and aim to achieve this consistently across all place teams from Q4 as approved by NHSE, which is another milestone achievement.

6.6 The board will be aware that we have got significant financial challenges in the CHC area, with high inflation on packages and increased volumes and some of that is associated with the transfer from MLCSU to us. At the same time, we are confident that that the new model is working really well. Already, we have eliminated the backlog and we are close to hitting our target for the time requirements for assessments. The new model has already received numerous compliments from stakeholders from across the system.

7. National Allied Health Professional Day

7.1 In the week leading up to Allied Health Professionals (AHPs) Day on Saturday 14 October, our AHPs showcased the breadth and depth of their system working innovation through events and social media, with a focus on ‘AHPs in the right place, at the right time, with the right skills’.

7.2 AHPs represent our third largest workforce across the ICB. They are integral to helping us move forward with new multi-professional clinical and care models that will holistically support the needs of our communities both now and in the future.

7.3 It is important to acknowledge the impact that AHPs have in patient care, inspire the future workforce and ensure AHPs play a central role in health and care transformation. Our allied health professions are art therapists, dramatherapists, music therapists, chiropodists/podiatrists, dietitians, occupational therapists, operating department practitioners, orthoptists, osteopaths, prosthetists and orthotists, paramedics, physiotherapists, diagnostic radiographers, therapeutic radiographers, speech and language therapists.

7.4 Katherine Simcock, principal speech and language therapist at Lancashire and South Cumbria NHS Foundation Trust won the ‘AHP leadership for equality, diversity and inclusion award’ the prestigious Chief AHP Officer Awards, announced as part of the national celebrations.

7.5 Katherine's work included a focus on the evidence base for language used to talk about autism. Through co-production with people in Lancashire and South Cumbria, Katherine produced a language guide to help professionals talk to autistic people about their preferences for language whilst continuing to recognise that every person is an individual and language is not ‘one size fits all’. This is a great example of the way in which we are keen to see our teams work across Lancashire and South Cumbria, and rightfully so, has earned national recognition.

8. Our ambition to become a truly anti-racist organisation

8.1 Every October marks Black History Month, which is a time to promote and celebrate Black contributions to British society, including our NHS colleagues across Lancashire and South Cumbria. While this is a time of celebration, it also shines a spotlight on some of differences and issues experienced by Black

people and people from other ethnic backgrounds.

8.2 Nationally, we know that NHS staff from ethnically diverse backgrounds experience disproportionately higher rates of bullying, harassment and discrimination when compared to their white counterparts and are less likely to be represented at senior levels within our workforce. We cannot allow this to be the experience of our people, and therefore we are committed as a senior team to challenge this behaviour and pave the way for equal opportunities for all of our people across the system.

8.3 Through our annual work on the NHS Workforce Race Equality Standard (WRES), we know that our ICB and provider trusts still have a long way to go to ensure that we have a representative workforce and that our people from ethnically diverse backgrounds are able to thrive in a workplace free from discrimination. We have recently completed our WRES System Report for 2023 and will be using this to formulate clear actions to improve the workplace experience of our ethnically diverse staff.

8.4 We are also in the process of engaging with the North West BAME Assembly's Anti-Racist Framework which will help us further in improving workplace experiences and amplifying the voices of our people from ethnically diverse backgrounds.

8.5 As part of our commitment to the Anti-Racist Framework, we will soon be publishing our anti-racism statement which will outline our organisation's stance. Our ambition as an ICB is to become a truly anti-racist organisation and we are fully committed to taking appropriate steps to ensure this happens.

9. Provider Selection Regime

9.1 The Provider Selection Regime (PSR) regulations have been introduced into Parliament by the Department of Health and Social Care (DHSC), and subject to scrutiny by Parliament, the DHSC intends for the new regulations to come into force on 1 January 2024.

9.2 The PSR will be a set of new rules for procuring health care services in England by organisations termed relevant authorities and will replace the existing procurement rules for NHS and local authority funded health care services. Relevant authorities are:

1. NHS England
2. Integrated Care Boards
3. NHS trusts and NHS foundation trusts
4. Local authorities and combined authorities

9.3 The PSR introduces greater flexibility when making decisions about how best to arrange healthcare services, with competitive tendering one of several potential

processes that may be followed.

9.4 To support implementation, NHS England have published draft statutory guidance (subject to parliamentary approval of the regulations) which will be supported by a set of resources including more detailed implementation tools such as process maps and template documents.

9.5 This will require a significant amount of planning for the ICB over the next eight weeks to ensure that we have our internal processes, contract reviews, and decision-making arrangements in place to implement the new regime. We will keep the board informed of any relevant updates in the lead up to anticipated implementation date.

10. Awards and recognition for our staff

10.1 I would like to finish by acknowledging some awards that our ICB staff have recently received.

10.2 Our ICB won an award at the HSJ Patient Safety Awards in the 'Improving Medicines Safety' category for our joint work with Midlands and Lancashire Commissioning Support Unit on enhancing inhaler prescribing practice.

10.3 Louise Hamer was also recently presented with the first ever 'Lads like Us' Ask Why award at the Institute of Health Visiting Evidence-based Practice Conference for showing tremendous trauma informed practice, and exercising professional curiosity.

10.4 Alison Marshall and Jane Shanahan won the Excellence in Pharmacy – Education and Development award at the National Conference for the Association for Pharmacy Technicians, after they collaborated across organisations and professions to share their learning and upskill the workforce in reducing harms and improving quality of life and outcomes for our most vulnerable patients.

10.5 Finally, Dr Andy Knox, associate medical director for population health, received an MBE last week in recognition of his services to primary care and tackling health inequalities across the region, awarded as part of The King's first birthday honours list. Dr Knox has been a leading figure in developing our population health model and the population health equity leadership academy, which launched last year.

10.6 As an ICB, we are keen to recognise and celebrate the hard work and dedication of our staff, and one of the ways that we plan to achieve that is through our new internal awards process.

10.7 In mid-September, we launched our first ever ICB Staff Excellence Awards, which centre around our new 'PROUD' values. During the nomination period we received over 175 nominations for the nine categories, and we will hold an

afternoon celebration event to announce the award winners on 6 December, which board members have been invited to.

Kevin Lavery

1 November 2023

THIS PAGE IS INTENTIONALLY BLANK

NHS Lancashire and South Cumbria Integrated Care Board

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

NHS University Hospitals of Morecambe Bay NHS Foundation Trust

BOARD OF DIRECTORS

Date of Meeting	6 December 2023
Title	Head Governor Report
Report of	Lorraine Crossley-Close Head Governor
Prepared by and contact details	Lorraine Crossley-Close Head Governor

Confidentiality	Non-Confidential

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

Summary of Key Issues / Concerns	On behalf of the Council, I want to again give thanks to all staff for the tireless efforts to provide safe care to all our patients. There have been a number of governor meetings and activities: • Meetings of the Chair, Head & Deputy Head Governor • COG Subgroup meetings – W/C 6 November 2023 • COG Pre-Meet – 21 November 2023 • Joint Council of Governors' and Board of Directors' Meeting – 1 November 2023 • COG meeting 5 December 2023 • Governor Development session 5 December 2023 The first COG Pre-Meet was well attended and productive with the COG highlighting some key themes which they would like to carry forward. Looking ahead: • Joint Council of Governors' and Board of Directors' Meeting – 7 February 2024 • COG Subgroup meetings – W/C 5 February 2024

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

	N/A		

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

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

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

Acronyms	
COG	Council of Governors.

NHS Lancashire and South Cumbria Integrated Care Board

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

NHS University Hospitals of Morecambe Bay NHS Foundation Trust

BOARD OF DIRECTORS

Date of Meeting	6 December 2023
Title	Continuous Quality Improvement Draft Strategy
Report of	Tabetha Darmon
Prepared by and contact details	Elizabeth.mcdougall@mbht.nhs.uk 07768701252

Confidentiality	Non-Confidential

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

As part of the ongoing review of improvement infrastructure within the organisation, a peer review of the continuous quality improvement (CQI) function was undertaken. One of the actions following the review was to refresh the CQI strategy. Additionally new national guidance from the NHS through the NHS Improving patient care together (NHS Impact) has been published that identifies key areas of focus for Trusts to follow.

This report seeks approval from the Board of Directors for the refreshed CQI strategy following presentation and comments from the Quality Committee on 27 November 2023. Following comments from the Quality Committee the draft delivery plan is also attached but with a caveat that currently there are ongoing discussions being made about structure to support delivery of transformation and improvement that may require an update to the attached strategy and delivery plan going forward.

Copies of the draft strategy and delivery plan are included in the Board of Directors' Reference Pack.

Summary of Key Issues / Concerns	Key messages. *This builds upon existing CQI strategy and aligns to the new Trust strategy and clinical strategy to support and enable the next phase of the trust's improvement journey.* • *Aligned to national NHS Impact* • *Identifies the CQI approach and methodology for Morecambe Bay* • *Aligned to Trusts strategic goals.*

	• *Identifies key improvement goals.* - *Capacity and Capability building* - *CQI expertise* - *Embedding a culture of CQI* - *Promoting shared Learning* - *Support and increase the use of measurement for improvement.*

Prior Discussions	Committee	Date	Recommendations/ Concerns
	Quality Committee	27 November 2023	

Action to be recommended to the Committee/Board	That the Board of Directors approve the refreshed CQI strategy.

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

Impact on Board Assurance Framework or Trust Wide Risk Register	To be completed with final delivery plan and structure			
Risk Impact Assessment	Is this required?	**N**	If Yes, Date Completed	
Equality Impact Assessment	Is this required?	**Y**	If Yes, Date Completed	
Quality Impact Assessment	Is this required?	**Y**	If Yes, Date Completed	
Environmental / Sustainability Impact Assessment	Is this required?	**N**	If Yes, Date Completed	

Acronyms	

NHS Lancashire and South Cumbria Integrated Care Board

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

NHS University Hospitals of Morecambe Bay NHS Foundation Trust

BOARD OF DIRECTORS

Date of Meeting	6 December 2023
Title	Review of Patient Relations Process
Report of	Tabetha Darmon Chief Nursing Officer
Prepared by and contact details	Richard Sachs, Director of Governance, Jane Kenny, Lead Nurse Jane.kenny@mbht.nhs.uk Sarah Rigby, Head of Patient Safety & Complaints Sarah.rigby@mbht.nhs.uk

Confidentiality	Non-Confidential

Purpose of Report	**To Advise/Alert**	**To Assure**	**To Approve**	**To Update**
		x		
	1. This report: ○ summarises the position (16 November 2023) regarding complaints and PALS cases within the Trust; ○ the action plans to date ○ oversight arrangements ○ opportunity for patient / client engagement			

Summary of Key Issues / Concerns	2. Within the Patient Relations Team there had been challenges with data quality that have resulted in variation of reporting in differing forums. This has been addressed with both the Patient Relations Team and Care Groups utilising the reporting function within Qlik Sense to support standardisation. 3. At the time of writing, the validated position in the Trust's system showed that there were 150 complaints, 115 Concerns , 14 Comments = 129 PALs cases outstanding. For the purposes of reporting elsewhere within the Trust, PALS and Complaints are usually reported together as an outstanding figure (total = 279). 4. Of the 150 complaints outstanding, 16 cases are awaiting consent. When a complaint does not have consent, it is unable to progress and is excluded from national reporting (until the consent is received). Within the Trust the timescale is paused, and these cases are excluded from overall numbers whilst consent is obtained. This means, at the time of reporting, there were 134 active open complaint cases. 5. There are a number of regulations that stipulate how complaints should be managed. One requirement of the regulations is for cases

	to be resolved within six months of them being raised. At the time of reporting 7 cases exceed 6 months, and of these 4 are revisits and have received an initial Trust response. The status of the 7 cases are 1 meeting held, 3 have meetings diarised (3) and 3 are awaiting care group reports. This is an improved position from July 2023 whereby there were 15 complaints exceeding 6 months and the department is on trajectory to have no complaints exceeding 6 months by 05 December 2023. 6. In addition, the team are focusing on those cases at 5 months with an aim to clear these by the end of December 2023, currently there are 13 cases. Of the 13, 2 are revisits, 1 of which has had a meeting, 1 is awaiting reports from the care group, 2 at drafting and the remaining 9 are at a stage of approval. 7. Plans to address the challenges within the Patient Relations Team are denoted within this report. These are divided into short, medium and long term plans with a focus on: ○ Resolution of challenges with the system ○ Addressing the data quality in the system ○ Ensuring accuracy of meaningful reports from the system ○ Developing stronger relationships with Care Groups ○ Improving performance 8. MIAA audit completed and action plan developed to support and monitor alignment of the revised complaints process against best practice standards. A number of actions have been completed however 6 actions are delayed due to ongoing staffing challenges. 9. Diarised daily team calls established with Interim Patient Relations Manager alongside weekly performance meetings with the Director of Governance to monitor progress of actions/workstreams.

Prior Discussions	Committee	Date	Recommendations/ Concerns
	Quality Committee	27 November 2023	

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

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

Impact on Board Assurance Framework or Trust Wide Risk Register	None			
Risk Impact Assessment	Is this required?	**N**	If Yes, Date Completed	
Equality Impact Assessment	Is this required?	**N**	If Yes, Date Completed	
Quality Impact Assessment	Is this required?	**N**	If Yes, Date Completed	
Environmental / Sustainability Impact Assessment	Is this required?	**N**	If Yes, Date Completed	

Acronyms	
PALS	Patient Advice and Liaison Service

UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST

REVIEW OF PATIENT RELATIONS PROCESS

Key Points

1. Within the Patient Relations Team there had been challenges with data quality that have resulted in variation of reporting in differing forums. This has been addressed with both the Patient Relations Team and Care Groups utilising the reporting function within Qlik Sense to support standardisation.

2. At the time of writing, the validated position in the Trust's system showed that there were 150 complaints, 115 Concerns, 14 Comments = 129 PALs cases outstanding (28 awaiting set off) This is an improved position in comparison to the last update report (July 2023) where there were 223 open PALS cases with 112 awaiting set off).

3. For the purposes of reporting elsewhere within the Trust, PALS and Complaints are usually reported together as an outstanding figure (total = 279).

4. Of the 150 complaints outstanding, 16 cases are awaiting consent. When a complaint does not have consent, it is unable to progress and is excluded from national reporting (until the consent is received). Within the Trust the timescale is paused, and these cases are excluded from overall numbers received whilst consent is obtained. This means, at the time of reporting, there were 134 active open cases.

5. There are regulations that stipulate how complaints should be managed. One requirement of the regulations is for cases to be resolved within six months of them being raised. At the time of reporting 7 cases exceed 6 months, and of these 4 are revisits and have received an initial Trust response. Of 7 complaints exceeding 6 month, 1 meeting held, 3 have meetings diarised (3) and 3 are awaiting care group reports. This is an improved position from July 2023 where there were 15 complaints exceeding 6 months and the department are on trajectory to have no complaints exceeding 6 months by 05 December 2023.

6. In addition, the team are focusing on those cases at 5 months with an aim to clear by the end of December 2023, currently there are 13 cases. Of the 13, 2 are revisits, 1 of which has had a meeting, 1 is awaiting reports from the care group, 2 at drafting and the remaining 9 are at a stage of approval.

7. Plans to address the challenges within the Patient Relations Team are denoted within this report. These are divided into short-, medium- and long-term plans with a focus on:
    - Resolution of challenges with the system
    - Addressing the data quality in the system
    - Ensuring accuracy of meaningful reports from the system
    - Developing stronger relationships with Care Groups
    - Improving performance

8. MIAA have also undertaken a review of the new complaints policy to ensure it represents best practise and in response to the report, and proportionate actions which are in alignment with the above streams of work have been developed. An overview of progress of these actions are outlined in appendix 2.

9. It is important to note that the challenges with Complaints and PALS management is not wholly attributable to the Patient Relations Team. Each case has involvement of a Care Group(s) and/or Corporate Service.

10. There are weekly performance meetings in place with the Director of Governance to monitor progress of actions/work streams identified.

Complaints and PALS position

11. As at 16 November 2023 the Patient Relations Team had the following active case profile:

Comments open	Concerns (PALS) open	Complaints open	Total
14	**115**	**134***	**263**

*****An additional 16 complaints cases require consent and do not count as active cases

Patient Relations Improvement workstreams

Resolution of challenges with the system and addressing the data quality in the system

12. A review of the system has identified:
    - Data quality challenges
    - That some reports pull data from fields not used to measure closure
    - The use of case status to manage cases, rather than use of it as a consistently defined and used progress measure
    - Inconsistencies in system usage resulting in varied outputs

13. A process mapping exercise has been undertaken with the Patient Relations Team and the Trust's Quality Improvement Team. The Trust has commenced the review of the complaints module within Ulysses which has identified the need to implement the use of 'complaint stages' instead of a 'complaint status'. This will enable the Trust to report on key performance indicators to gain assurance that timescales are being met and for targeted action to be taken. The stages have now been built into the Ulysses system however the transfer over of 263 cases has been delayed due to ongoing staffing challenges within the department and the need to focus resource on cases exceeding 5 months and the PALS backlog.

Ensuring accuracy of meaningful reports from the system

14. As part of the process review, work has been undertaken with support from I3 to ensure that meaningful reports are developed / fields used in current reports are pulling from the

correct source. Qlik sense report have been updated ready for when the complaints and PALS cases are moved over to stages, which will further improve quality of reports.

Developing stronger relationships with Care Groups

15. The suite of accurate reports, kept to the minimum needed, will help Care Groups have clearer oversight of the complaints and PALS that are regarding their services. Weekly meetings, based on volume and necessity, have been strengthened with all Care Groups. These are planned weekly with Medicine, Surgery and WACS and as required with the other Care Groups.

Improving performance

16. The above work, alongside the MIAA audit will ensure we embed best practice, and strengthen performance within Patient Relations. Assurance can be offered that there is a robust plan in place to target resolution / a meeting date for the 7 cases currently over 6 months and those that may reach 6 months old (13 cases) by the end of November 2023. Appendix one summarises the actions to address improvements in this area.

Opportunity for Patient Engagement

17. Whilst this is not appropriate or wanted for all, following several patient relations meeting opportunities have been provided for clients to provide patient stories, review and input to the administration letters used by the team and to join the dementia hub.

Workforce

18. The Patient relations department has carried a number of vacancies for several months and continues to have the following vacancies:

    - Band 7 Patient Relations Manager (1wte) – Post vacant since June. Explored redeployment which was unsuccessful, and interviews now booked 21 November 2023. Anticipated in post March 2024. Sarah Rigby and Jane Kenny picking up in interim.

    - Band 4 Assistant Patient Relations Case Officer (0.48wte) - currently shortlisting with interviews planned mid-November. Anticipated in post January 2024. Currently covering with bank.

19. Current Short and Long-term absences:
    - Senior Case office (0.60wte)
    - Case Officer (0.5wte)
    - Admin Assistant (0.75wte)

20. Further plans to support recovery
    - x1 full time band 4 assistant case officer 6-month secondment at shortlisting with interviews planned mid-November. Anticipated in post January 2024

    - Band 6 secondment from within the current team to backfill senior case officer. This will enable further capacity for drafting.

Recommendation

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

Appendix 1

SHORT TERM ACTIONS – completed July 2023

- Assign a role to complete daily triage prioritisation and urgency
- Gateway / signpost cases from the start to correctly allocate appropriate cases concerns/complaints to PALS i.e. quick wins
- Request from HR is there anyone suitable of the redeployment register to assist
- Employ Bank / Agency staff if deemed necessary to draft responses
- Reshuffle staff i.e. from PALS to best assist with backlog
- Assess current processes
- Redesign future state processes
- Identify short/medium term KPIs

MEDIUM TERM ACTIONS – completed September 2023

- Ensure effective team leadership and management capability
- Employ QI to work with the whole team
- Through 1:1s complete 'stress risk assessments'
- Assess team skills, training needs and support needed to complete roles
- Complete Occupational Health Management referrals if appropriate for stress / anxiety
- Develop cohesive relationships with Care Groups accountable for the shared responsibilities in relation to Complaints through performance
- Agree performance metrics and clear backlog
- Free up staff to draft responses – redistribution of case loads

LONG TERM ACTIONS – By December 2023

- Ongoing recruitment
- Review structure of Patient Relations
- Robust and capable Team Leadership in place
- Embed new processes and improvements
- Sustain and review performance measures

Appendix 2

MIAA Action Plan

MIAA Findings	Recommendation	Action Progress	Status
1 - Key Performance Indicator Reporting	The Trust should explore the functionality of the complaints module within Ulysses to ensure that key performance indicators are reportable.	The Trust has completed a review of the complaints module within Ulysses which has identified the need to implement the use of 'complaint stages' instead of a 'complaint status'. This will enable the Trust to report on key performance indicators to gain assurance that timescales are being met and for targeted action to be taken. The stages have now been built into the Ulysses system however the transfer over of 263 cases has been delayed due to ongoing staffing challenges within the department and the need to focus resource on complaint cases exceeding 5 months and the PALS backlog.	Action 80% complete Delayed
2 - Centralised Recording System	The Trust should explore the functionality of the complaints module within Ulysses and consider implementing this as the centralised record with editor access for staff outside of the Patient Relations Team in the overall management of complaints.	The Trust will explore the functionality of the complaints module within Ulysses and consider implementing this as the centralised record with editor access for staff outside of the Patient Relations Team. This requires development within the Ulysses system and dedicated staff resource to lead and implement the Ulysses develop. This stream of work has been delayed due to ongoing staffing Challenges & PSIRF launch.	Deadline 30 November 2023 Not on track and postponed until Q4
3 - Operating effectiveness	The Trust should undertake a service review of the administrative processes for the management of complaints, within the Patient Relations Team. This could include process mapping to identify the non-value adding steps in the process and alignment of value adding	The Trust has completed a review of the administrative processes for the management of complaints through a number of process mapping workshops supported by the Trust's Quality Improvement Team with the aim of reviewing current processes, removing non-value-added steps, agree the future state of the complaints management system and define clear roles and responsibilities across the relevant internal stakeholder.	Deadline 30 November 2023 On track

	steps to the relevant stakeholders.		
4 - Allocation of Case Handlers to Care Groups	The Trust should allocate complaints to Case Handlers based upon capacity, this should be overseen by the Patient Relations Manager who must provide clear leadership and performance management to the Patient Relations Team.	The Patient Relations Manager Post is currently vacant (Interviews scheduled 21 November 2023). In the interim, this role is being covered by the Head of Patient Safety and Complaints and Lead Nurse RSP programme. Caseload reviews are being completed to ensure a fair distribution of workload to case handlers. A daily call with case handlers is now in place to provide leadership and direction, fair distribution of workload and reduce the risk to business continuity. A review of the long-term caseload allocation has been delayed due to ongoing staffing challenges (vacancies and absences)	Action 80% complete Delayed to ongoing vacancies
5 - Operating effectiveness	○ Leadership from the Patient Relations Manager who has direct line management responsibility of the Patient Relations Team must address this and implement systems and processes to ensure that individual workloads are manageable and that the outputs are quality driven. ○ The Patient Relations Manager must be supported by the Senior Trust leadership team to achieve this. ○ The Trust must ensure that the Patient Relations Team are aware of staff support services available to them and how to access these services.	The Patient Relations Manager Post is currently vacant (interviews scheduled 21 November 2023). A number of actions have been implemented which include: ○ Individual caseload reviews ○ Regular one to ones with case handlers ○ Weekly Meetings ○ Completion of Stress Risk Assessments ○ Occupational Health referrals completed as required. ○ Staff made aware of Occupational Health and Wellbeing support services available to them. ○ A daily call with case handlers is now in place to provide leadership and direction, fair distribution of workload and reduce the risk to business continuity and is working well. An OD proposal is being developed to support team building and cohesion and is planned for Q4.	Action 80% complete

6 - Resources	The Trust should undertake a targeted review of complaints which have breached the required timescales for completion and seek to obtain additional resources to assist in addressing this.	A target review of complaints has been completed of all breaches and cases with the potential to breach. A daily call with case handlers in now in place and these cases are reviewed to provide leadership, support, and the ensure the most effective use of resources to enable the staff to undertake their roles. The team are on track to have no complaints exceeding 6 months by 05 December 2023 and no complaints exceeding 5 months by the end of December 2023.	On Track
7 - Performance Management	Where there is a failure to meet the timescales, relevant teams must be held accountable with targeted action being taken by the senior leaderships team.	Complaints exceeding timescales are escalated though Care group weekly meeting and performance review meetings. In addition, the Trust has completed the review of the complaints module within Ulysses which has identified the need to implement the use of 'complaint stages' instead of a 'complaint status'. This will enable the Trust to report on key performance indicators to gain assurance that timescales are being met and for targeted action to be taken. The stages have now been built into the Ulysses system however the transfer over of 263 cases has been delayed due to ongoing staffing challenges within the department and the need to focus resource on cases exceeding 5 months and the PALS backlog.	Action 80% complete Delayed
8 - Quality Assurance of Complaints File	The Trust should ensure that all complaints are reviewed for quality and completeness throughout the complaints management process. This could include the implementation of key performance indicators at key milestones of the complaints management process	The Patient Relations Manager Post is currently vacant, and the recruitment process has commenced. Data quality SOP to be developed and to establish data quality prompts with Business Intelligence. The Trust will explore moving the submission all complaints to web-based system to improve data quality and ensure mandated fields are completed.	Deadline 30 November 2023 Not on track and postponed until Q4
9 - Monitoring the Completion and Sustainability of Lessons Learnt	○ The Trust should ensure there are robust monitoring and assurance processes in place for the	The Trust is reviewing its monitoring and assurance processes for the identification and monitoring of lessons learnt. The Trust has commenced the review of the complaints module within Ulysses which has identified the need to implement the use of 'actions tab'. This will	Deadline 30 November 2023 Postponed until Q4

	identification and monitoring of lessons learnt. ○ Documentation in which to provide assurance that lessons learnt have been actioned should be uploaded to the complaints file	enable lesson learnt to be clearly recorded and will provide oversight that lessons learnt have been implemented to reduce the recurrence of similar complaints in the future. This will enable evidence to be upload to the associated lesson learnt action on the complaint file. has been delayed due to ongoing staffing challenges (vacancies and absences)	
10 - Complaints responses	The Trust should explore the functionality of the complaints module within Ulysses and consider implementing this as the centralised record with editor access for staff who are required to contribute to the resolution of complaints. The data entry fields should dictate the information required to resolve the complaint.	The Trust is exploring the functionality of the complaints module within Ulysses and consider implementing a 'complaints response form' within Ulysses with editor access for staff outside of the Patient Relations Team. The Trust will implement Care Group complaints response leads who will be responsible for co-ordinating responses to ensure they are not disjointed and for populating the 'complaints response form'. This requires development within the Ulysses system and dedicated staff resource to lead and implement the Ulysses develop. This stream of work has been delayed due to ongoing staffing Challenges & PSIRF launch.	Deadline 30 November 2023 Postponed until Q4

NHS Lancashire and South Cumbria Integrated Care Board

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

NHS University Hospitals of Morecambe Bay NHS Foundation Trust

BOARD OF DIRECTORS

Date of Meeting	6 December 2023
Title	Patient Relations Annual Report 2022/23
Report of	Tabetha Darmon Chief Nursing Officer
Prepared by and contact details	Janet Garnett Patient Relations Manager

Confidentiality	Non-Confidential

Purpose of Report	**To Advise/Alert**	**To Assure**	**To Approve**	**To Update**
		x		
	This Annual report provides an overview of the compliments, complaints, comments and concerns cases handled during 2022/23 (data as at 31 May 2023).			

Summary of Key Issues / Concerns	The Patient Experience Group is responsible for the oversight and compliance with regards to the Trust's complaints, concerns, and comments. The Chairs report is presented at the Trust's Quality Governance and Patient Safety Group. The report also includes an overview of the outcome of the referrals to the Parliamentary Health Service Ombudsman – Formal Investigations. The report includes several impact statements where examples of lessons learned have been identified and addressed by Care Groups. All complaints are managed in accordance with the NHS Complaints Procedure and in line with the Trust's Policy for the Management and Resolution of Complaints.

Prior Discussions	Committee	Date	Recommendations/ Concerns
	Quality Committee	27 November 2023	

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

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

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

Acronyms	

UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST
ANNUAL PATIENT RELATIONS REPORT 2022/23

SUMMARY

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

2. Patient Advice Liaison Service (PALS) staff are available to provide local resolution to concerns as they arise, on the spot advice and support to 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. Each site has a dedicated PALS Officer who between them are currently dealing with an average of 250 concerns/enquiries per month, of which 2 to 3 per month become a formal complaint.

3. The Trust welcomes every complaint, and all complaints are managed in accordance with the NHS Complaints Regulations 2009, and in line with the Trust's Policy for the Management and Resolution of Complaints.

4. All new complaints are reviewed at the Trust's daily triage meeting which is attended by the Head of Patient Safety and Complaints, the Patient Relations Manager, the Governance Business Partners, representatives from the Patient Safety teams, Safeguarding team and Health and Safety team to ensure they are investigated through the correct process e.g. the complaints or the incident route. Each complaint is also reviewed at the Executive Review Group (ERG). ERG is convened weekly to oversee all incidents reviewed by the Care Group which have been validated as causing moderate or above harm. In addition to this the group may review other incidents which may trigger organisational concern. The group also reviews all complaints and claims received in the previous week; this enables Executive oversight and challenge, on how they are being managed and any immediate issues which need addressing.

5. Upon receipt of a complaint, a Senior Case Officer is allocated to the case who will make contact with the complainant either by a telephone call or in writing. On-going contact ensures complainants are kept up to date with progress. Care Groups are encouraged to have face to face meetings with complainants as early as possible to resolve issues quickly with the appropriate clinical staff attending the meeting.

6. Once opportunities for Trust resolution have been exhausted, the complainant is informed of their right to contact the Parliamentary and Health Service Ombudsman (PHSO) for a review of their complaint.

7. During 2022/2023, Patient Relations Department continued to provide a concerns and complaints handling service:

    - Information on how to complain is clearly advertised at the entrance to all wards and in patient areas such as Outpatients, etc. Information is also available on the UHMBT website.

- A staffed complaints helpline, Mon – Friday 9am – 5pm, with an out-of-hours answer machine service.
- PALS Officers are aligned to a site Complaints Officers are aligned to a Care Group
- On receipt of a formal complaint a designated Senior Case Officer will contact the complainant and where necessary agree the questions they would like answering.
- The Senior Case Officer informs each complainant at first contact of the complaints procedure, including how long it is likely to take, and advise of advocacy services available, if required
- Complainants are kept updated on the progress of their complaint.
- The Trust aims to provide response letters that are written in a way that complainants can understand and avoids, where possible, clinical terminology; if clinical terminology is used, a clear explanation in laymen's terms should also be given.
- A robust Quality Assurance process is in place whereby all complaints are reviewed by the Senior Management in the area where the complaint lies.

Organisational Learning

8. Care Groups and corporate teams report through to the Patient Experience Group, providing thematic analysis, examples and impacts from learning from complaints. Patient stories are now embedded into the organisation, acting as an excellent source of learning.

9. This report reflects the views of 4623 people who have taken the time to give the Trust feedback between 1 April 2022 to 31 March 2023.

10. A breakdown of this feedback is below:
    - 1397 Compliments
    - 394 Formal Complaints
    - 720 Comments
    - 2112 Concerns

COMPLIMENTS

11. During 2022/23, staff at the Trust have been commended for the care they have provided to patients and their relatives showing kindness, being respectful, helpful, attentive, calm, friendly and professional at all times.

Compliments	Cards/Letters	Verbal	NHS Choices	Website	Tweets
Quarter 1	222	88	0	6	1
Quarter 2	246	126	1	11	0
Quarter 3	206	110	0	11	1
Quarter 4	244	111	0	12	1
Annual Total	**918**	**435**	**1**	**40**	**3**

12. A breakdown and examples of the compliments received in the Care Groups and individual teams or areas in 2022/23 is listed in Appendix 1.

COMPLAINTS

13. The Patient Relations Department continues to provide a centralised approach to complaints which enables staff to better and more pro-actively manage negative patient experiences. There is guidance and support on how to handle a complaint at the point of origin or in a complaint investigation. There is now a real impetus in the Trust of 'getting it right the first time – every time.'

14. The number of complaints registered overall between April 2022 to March 2023, for investigation was 394, an increase of 57 when compared with the previous year. In this year there were 678,765 attendances compared to 539,862 for the same period in the previous financial year, to University Hospitals of Morecambe Bay NHS Foundation Trust. Of the 394 formal complaints received, this equates to 0.05% of hospital activity and attendances.

15. A breakdown of the number of formal complaints received per Care Group in this period is listed below.

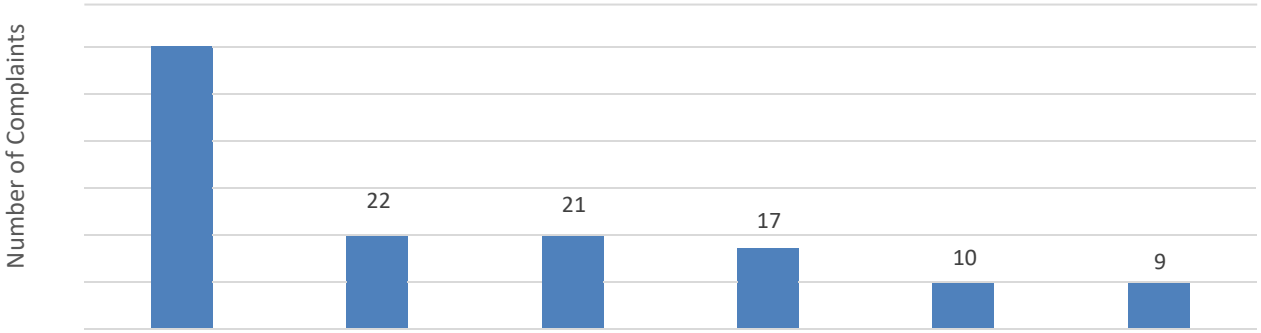
Number of Complaints Received	2020/21	2021/22	2022/23
Community Health	12	8	11
Core Clinical Care Group	17	16	21
Corporate Services	5	7	6
Estates & Facilities	1	1	2
Medicine Care Group	124	166	199
Surgery & Critical Care Group	79	90	108
Women & Children's Care Group	36	49	46
Non-UHMBT Healthcare Provider	0	0	1
Total	**274**	**337**	**394**
Number of Attendances	**438,936**	**643,225**	**678,765**
Percentage of Complaints	**0.06%**	**0.05%**	**0.05%**

Written formal complaints

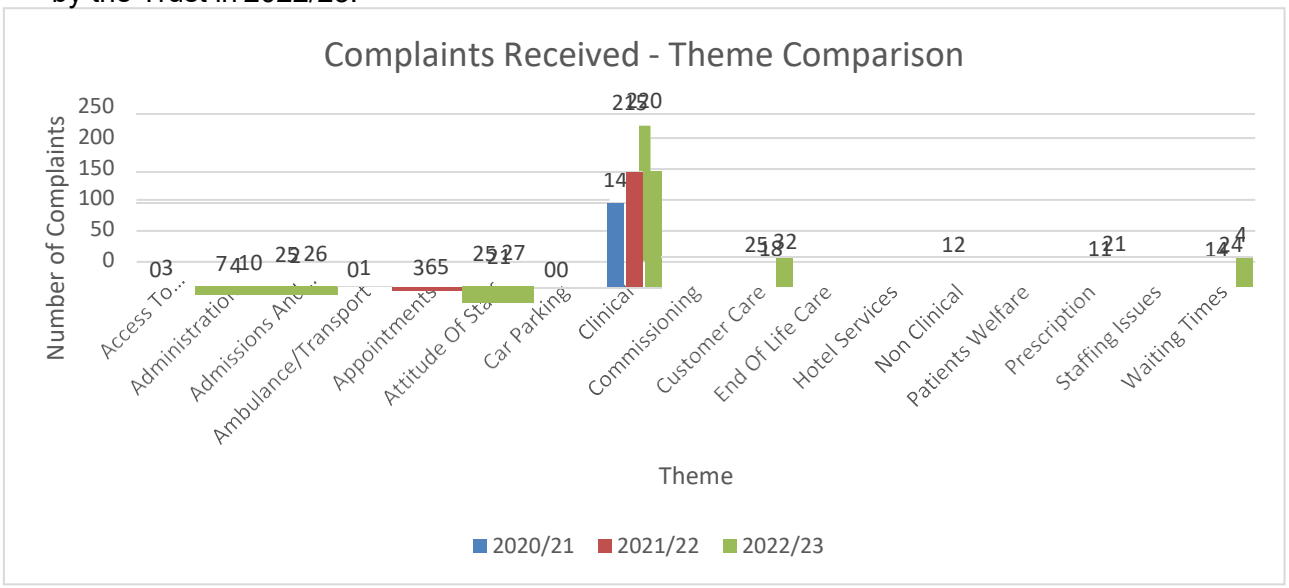
16. The Trust works in accordance with the NHS Complaint Regulations 2009 and operates an established and centralised complaints service, where all formal written requests are acknowledged and responded to within 35 working days or an agreed date, (National Regulations target is 6 months). All complaints received a written response signed by the CEO. In 2022/2023, 99% of complaints received were acknowledged within 3 working days and 337 out of the 352 received a written reply within 35 working days or agreed timescale.

	Number of complaints	Performance target	Performance achieved
Number of complaints due for response in 2022/2023	352		
Number of complaints received were acknowledged within 3 working days	394	100%	99%
Number of Complaints Closed within 35 days or agreed time	337	95%	95%

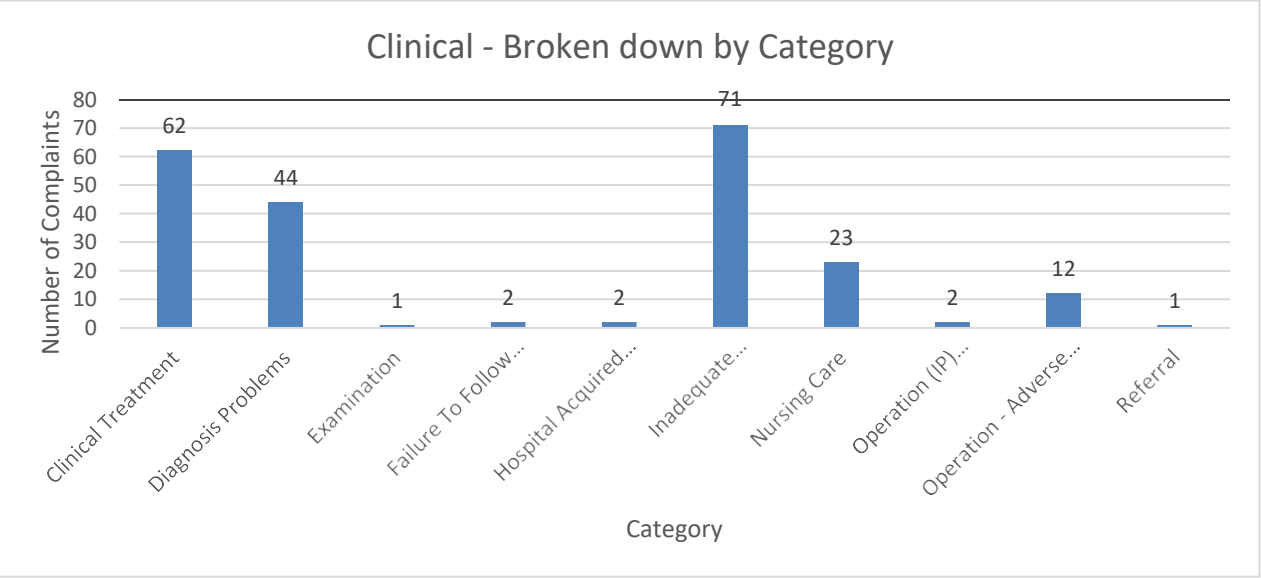
17. The top 6 areas which received the highest amount of formal written complaints in 2022/23 were:



18. Each complaint the Trust receives is often multi-faceted with concerns expressed about a number of aspects of the patient's experience of our Trust. This is particularly true of concerns which may involve a multi-disciplinary team and relate to events over a short or extended period of time. With this is mind a great deal of thought goes into how complaints are categorised to ensure it's appropriate to the concerns raised. The chart below shows that Clinical (220 cases) are by far the highest cause of complaint and represent 63% of all written complaints received by the Trust in 2022/23.



19. Within the category of Clinical there are sub-categories, the breakdown of which can be seen in the graph below, with the highest number reported relating to Inadequate care/treatment (71 cases)



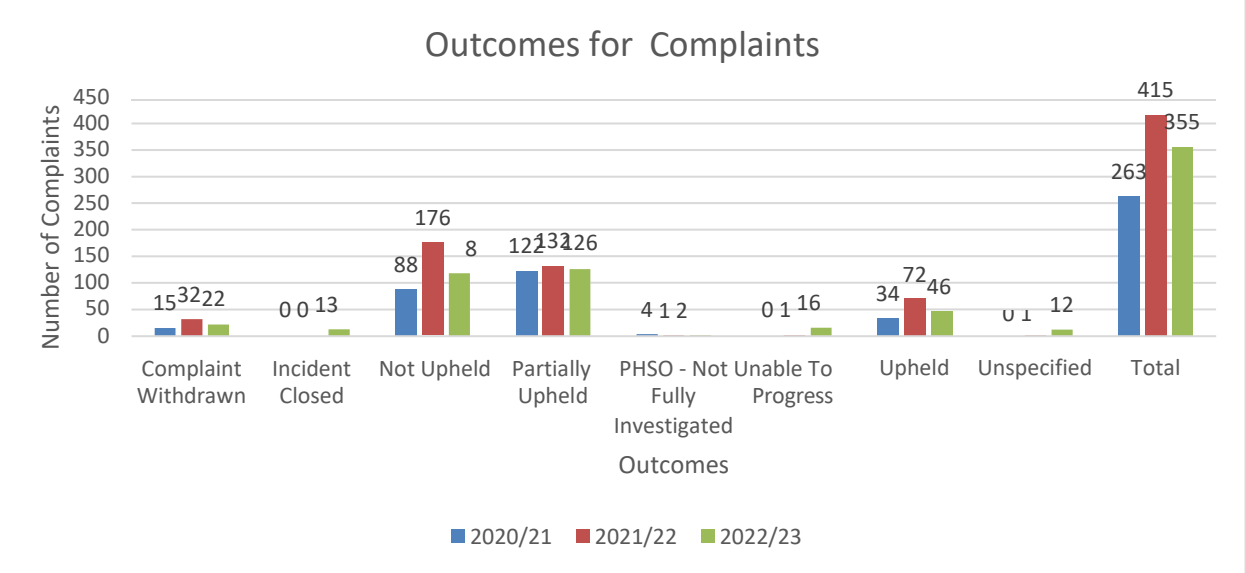
20. As part of the formal complaints process any actions identified resulting from a complaint are formally requested by the patient relations team along with any lessons learned. These are then logged along with the lessons learned.

21. During 2022/2023, the Trust received 50 requests from complainants to revisit their case after they had received their formal response. The table below demonstrates the number of Revisits by care group. A Revisited case is one where the complainant has come back to us following receipt of their Trust response. This may be for a variety of reasons e.g., they dispute the information; they have new questions, do not agree that all issues have been addressed or that they would like a local resolution meeting. The highest volume of revisits were received within Medicine. Medicine Care Group received the highest volume of complaints which is in line with their activity levels.

Care Group	No. of further correspondence after final response
Community Health	0
Core Clinical	3
Corporate	1
Medicine	27
Surgery & Critical Care	13
Women & Children's	5
Non UHMBT	1
Total	**50**

22. To see examples of some of the written complaint cases and lessons learned please see Appendix 3.

23. The outcomes for complaints closed over the last 3 years are detailed below.



PATIENT ADVICE LIAISON SERVICE (PALS) Comments and Concerns

24. The Trust received 2112 PALS Concerns and 720 PALS Comments at the point of service, a 6% decrease from the previous year. A PALS concern is an informal complaint that requires action from the PALS team rather than a formal investigation and a PALS comment is an enquiry or feedback.

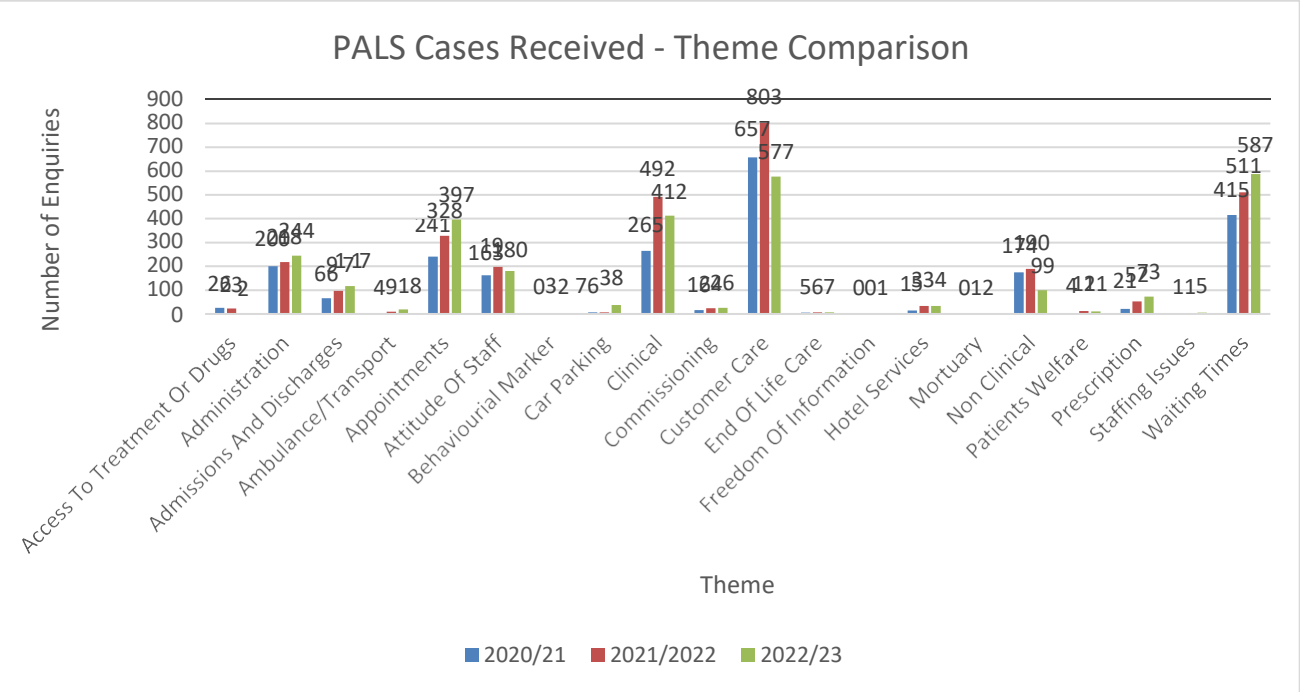
25. A breakdown of the number of PALS enquiries received per Care Group in this period is listed below.

Number of PALS Enquiries Received	2020/21		2021/22		2022/23	
	Comments	Concerns	Comments	Concerns	Comments	Concerns
Community Health	31	24	16	50	6	50
Core Clinical	215	98	308	186	149	258
Corporate	251	81	235	118	160	93
Estates & Facilities	24	13	28	22	31	48
Medicine	298	332	239	691	113	820
Non UHMBT Healthcare Provider	90	17	111	64	124	89
Surgery & Critical Care	459	229	279	505	111	626
Women & Children's	52	67	33	123	26	128
Total	**1420**	**861**	**1249**	**1759**	**720**	**2112**

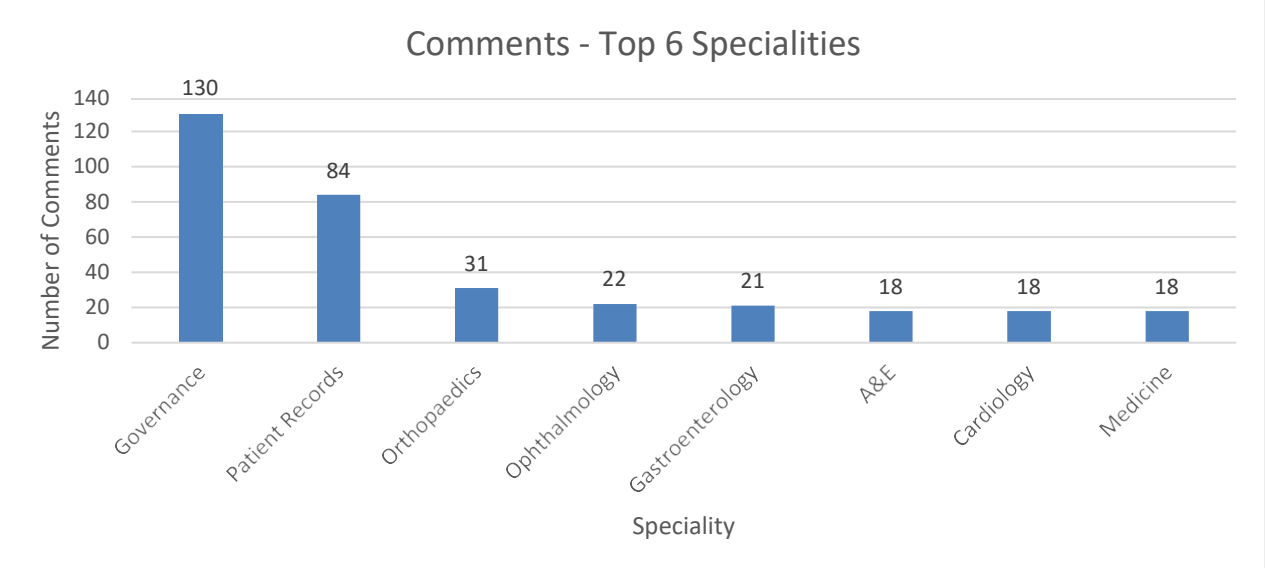
26. PALS are responded to within 5 or 20 working days. 45% of PALS were responded to within 5 working days with 83% within 20 working days, both below the performance target.

	Number of PALS	Performance target	Performance achieved
Number of PALS due for response in 2022/2023	2830	No target	No target
PALS responded to within 5 working days	1291	75%	45%
PALS responded to within 20 working days	2352	95%	83%

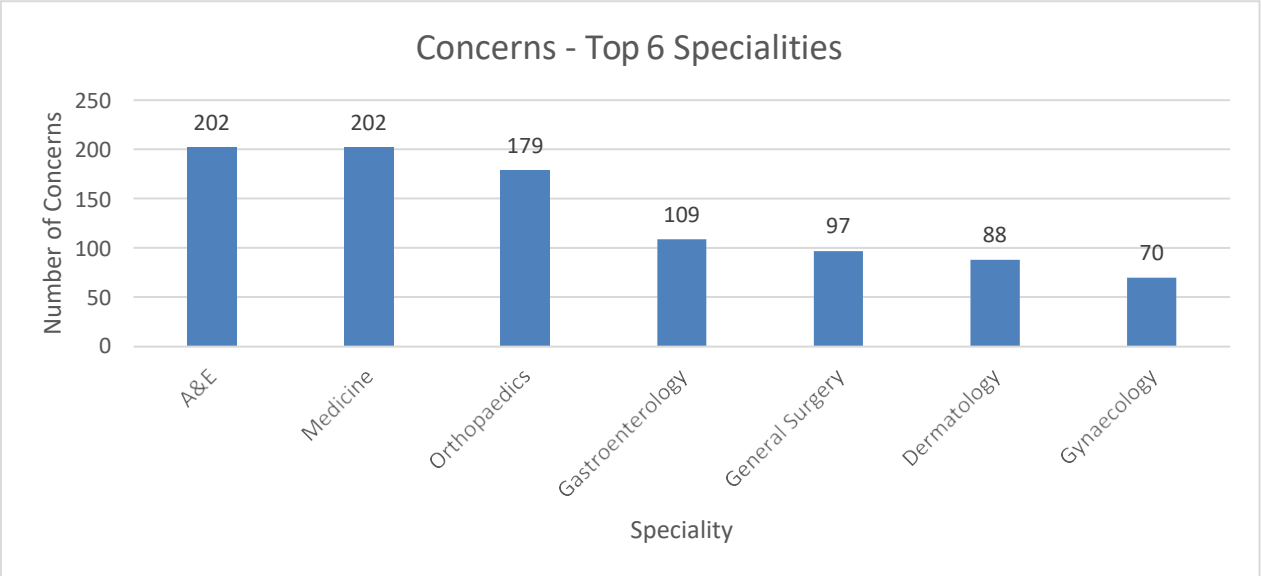
27. The chart below shows that waiting times (587 cases) are the highest cause of PALS, followed by customer care (577 cases) and Clinical (412 cases).



28. The top 6 specialities which received the highest amount of PALS Comments enquiries in 2022/23 were:



29. The top 6 specialities, which received the highest amount of PALS Concerns in 2022/2023, are detailed in the graph below.



REFERRALS TO THE PARLIAMENTARY HEALTH SERVICE OMBUDSMAN (PHSO) – FORMAL INVESTIGATION

30. Under the NHS complaints procedure, complainants dissatisfied with responses received at a local level can take their complaint to the Parliamentary and Health Service Ombudsman (PHSO). This is explained to all complainants in writing and on occasions, verbally by the Case Officer if required. If accepted for investigation by the PHSO, the Trust is then involved in providing the necessary information to the PHSO to enable them to make an informed decision.

31. The PHSO do an in-depth preliminary investigation to confirm the need for formal investigation. In the year 2022/2023 the trust was involved in ten of these cases.

32. During the year April 2022 to March 2023, the PHSO was involved with the Trust looking at one complaint from 2017; 2018 and two from 2019, twelve from 2020 and two from 2021. Decisions during this 12-month period resulted in two cases being partly upheld and closed; ten cases were not investigated by the PHSO; two cases closed and not upheld; two cases partly upheld and two cases currently awaiting the outcome of the PHSO's investigation.

Subject	2018/2019	2019/20	2020/21	2021/22	2022/23
Number of Complaints referred to the PHSO and reaching Stage 3	5	1	1	4	8
Currently (I.e as at 31 March of that year) being investigated by PHSO.	10	0	2	6	2
Upheld or Partially Upheld	4	5	0	2*	2
Not upheld	2	3	0	1	2
Complaints referred back to the Trust for local resolution	1	1	0	0	2
Assisted in possible PHSO Cases	13	10	3	4	10

* The Trust is currently awaiting one final report from the PHSO.

Lessons Learned from PHSO final reports received in 2022/23

33. There have been no lessons learned during 2022/2023

ONGOING REVIEW OF THE CONCERNS AND COMPLAINTS PROCESS

34. The Patient Relations Department encourages service users to speak up when the standard of care has not been acceptable within the organisation. The Patient Relations Team continues to work to signpost the concern and complaint process locally so that patients and carers know how or where to complain. As the predominant method for making a concern or complaint is via e-mail or letter, promoting other options such as the Trust's website, social media and third-party advocacy services is necessary to give patients and carers a choice, and to be personal and responsive to the needs of the individual.

Priorities for 2023/24

- Introduction of the new complaints handling procedure
- Ensure training is provided to all complaint leads and care group staff involved in complaint handling

- Continued focus on providing high quality compassionate responses whilst improving the timeliness of responses.
- Working towards and adopting the principles of the Parliamentary Health Service Ombudsman NHS Complaint Standards introduced in 2022.

Appendix 1: Number of compliments received per Care Group

Community Health			
Department	**Number**	**Department**	**Number**
Bladder And Bowel Service	11	ICC - Carnforth	1
Care Home Support Team - Lancs	1	ICC - Grange And Lakes	1
Case Manager-East ICC	1	IMSK - Carnforth	1
Case Manager-Grange	5	IMSK - Heysham	8
Case Manager-Grange & Lakes IC	1	Integrated Community Stroke Te	15
Community Health Monitoring	3	Integrated Community Stroke Te	11
Community Matrons - Lancaster	17	Integrated Rapid Response Serv	9
Community Matrons - Morecambe	1	Integrated Rapid Response Serv	3
Community Matrons - Morecambe	8	Integrated Rapid Response Serv	112
Community Therapeutic Service	24	Long Term Conditions - North L	5
District Nurses Furness - Alfr	5	Medical Records	1
District Nurses Furness - Barr	11	Night Nursing - North Lancashi	1
District Nurses Furness - Ulve	13	Outpatients Department FGH	2
District Nurses Lancs - Carnfo	16	Outpatients Department WGH	1
District Nurses Lancs - Castle	14	Palliative Care - RLI	8
District Nurses Lancs - Lancas	14	Palliative Care Furness	19
District Nurses Lancs - Moreca	6	Palliative Care South Lakes	6
District Nurses Lancs - Moreca	5	Physiotherapy Community - Furn	16
District Nurses Sth Lakes - Gr	35	Physiotherapy Community - Sout	10
District Nurses Sth Lakes - Ke	12	Podiatry - Furness	2
District Nurses Sth Lakes - Lu	6	Podiatry - South Lakes	1
District Nurses Sth Lakes - Mi	7	Pulmonary & Heart Failure Reha	100
District Nurses Sth Lakes - Wi	81	Respiratory Nurses - Furness	3
Evening & Night Nursing - Sout	1	Respiratory Nurses - South Lak	7
Heart Failure Team - Lancs	1	SaLT Adults	10
Heart Failure Team - South	4	Virtual Ward - North Lancs	1
		Total	**657**

Core Clinical			
Department	**Number**	**Department**	**Number**
Breast Unit Screening Admin In	1	Outpatients Department FGH	6
Breast Unit Screening Imaging	14	Outpatients Department QVH	1
Breast Unit Symptomatic Imagin	2	Outpatients Department RLI	2
Community Patient Contact Cent	8	Outpatients Department WGH	4
Community Patient Contact Cent	2	Pathology - Phlebotomy	2
Lloyds Pharmacy WGH	1	Physiotherapy Community - Sout	1
Medical Records	2	Physiotherapy FGH	2
Nutrition & Dietetics FGH	2	Physiotherapy QVH	1
Occupational Therapy FGH	1	Physiotherapy RLI	5
Occupational Therapy RLI	3	Physiotherapy WGH	12
Occupational Therapy WGH	3	X-Ray FGH	5
Orthotics FGH	1	X-Ray QVH	1
Orthotics RLI	2	X-Ray RLI	3
Orthotics WGH	1	X-Ray Ward RLI	1
		Total	**89**

Corporate			
Department	**Number**	**Department**	**Number**
Bereavement Office (FGH)	1	Patient Experience	1
COVID-19 Tactical Team	1	Patient Relations Department	1
PALS	4	Security	1
		Total	**9**

Estates & Facilities			
Department	**Number**	**Department**	**Number**
Catering WGH	1	Estates - Capital Services (QV	1
		Total	**2**

Medicine			
Department	**Number**	**Department**	**Number**
Acute Frailty Unit RLI	19	Morecambe Bay Cardiac Centre	9
Acute Medical Unit RLI	4	Oncology Unit FGH	2
Bowel Cancer Screening Unit	15	Oncology Unit WGH	5
Cardiac Care Unit RLI	3	Outpatients Department FGH	3
Clinical Investigations RLI	1	Outpatients Department QVH	1
Clinical Investigations WGH	1	Outpatients Department RLI	5
Complex & Coronary Care Unit F	77	Palliative Care - FGH	4
Dermatology OPD RLI	7	Palliative Care - RLI	3
Dunmail Day Hospital	4	Same Day Emergency Care (SDEC)	10
Emergency Department FGH	17	Urgent Treatment Centre	23
Emergency Department RLI	45	Ward 22 RLI (Temp Relocation O	1
Endoscopy Unit FGH	1	Ward 35 (Respiratory)	1
Endoscopy Unit RLI	4	Ward 6 FGH (Frailty)	33
Endoscopy Unit WGH	7	Ward 6 FGH (Stroke)	11
Huggett Suite	35	Ward 6 RLI	1
Lancaster Suite	32	Ward 9 FGH	3
Medical Secretaries	2	**Total**	**389**

Surgical & Critical Care			
Department	**Number**	**Department**	**Number**
Acute Surgical Unit RLI	11	Pre Op Assessment FGH	1
Audiology FGH	2	Pre Op Assessment WGH	3
Audiology RLI	1	Surgical Emergency Ambulatory	2
Audiology WGH	1	Surgical Emergency Ambulatory	3
Breast Unit Nursing Incidents	1	Theatres FGH	1
Day Surgery Unit FGH	5	Theatres RLI	4
Day Surgery Unit WGH	11	Theatres WGH	2
ENT WGH	1	Waiting List Office (RLI)	4
Intensive Therapy Unit FGH	1	Ward 10 WGH (Kendal Suite)	1
Intensive Therapy Unit RLI	3	Ward 2 FGH	3
Maxillo-Facial Department RLI	1	Ward 2 WGH	1
Ophthalmology FGH	1	Ward 33 RLI	6
Ophthalmology RLI	5	Ward 36 RLI	41
Ophthalmology WGH	16	Ward 37 (Surgical)	2
Orthoptists QVH	1	Ward 4 FGH	4
Outpatients Department FGH	2	Ward 5 FGH	1
Outpatients Department QVH	1	Ward 7 WGH	6
Outpatients Department RLI	3	Westmorland Surgical Centre	8
Outpatients Department WGH	9	**Total**	**169**

Women & Children's			
Department	**Number**	**Department**	**Number**
Antenatal Clinic RLI	1	Neonatal Unit RLI	42
Children's Outpatient Dept RLI	2	Outpatients Department FGH	1
Children's Ward FGH	2	Outpatients Department RLI	1
Children's Ward RLI	6	Outpatients Department WGH	1
Gynaecology OPD RLI	1	Ward 1 FGH	2
Helme Chase	2	Ward 16 RLI	3
Labour Ward RLI	9	Ward 17 RLI	7
Maternity Ward FGH	2	**Total**	**82**

Appendix 2 - Examples of compliments received during 2022/23

Community Health	
Community Matrons - Lancaster	Would like to thank the long term conditions team, we have been very thorough and are a competent service.
District Nurses Lancs – Carnforth	Thank you for the incredible support you have given to my husband and family, we could not have asked for more. You made him comfortable and we didn't have to worry about anything. The support was there when we needed it and the team responded quickly and effectively when needed. Thank you so much. We are so grateful for your support.
Heart Failure Team – South	Thank you for your time and help, was very impressed with your professionalism and the way you conducted the appointment, a credit to your profession, you have reassured me about my condition. I am so grateful for that. I am going to pass my thanks to the Hospital authorities again. Thank you.
Integrated Rapid Response Service	We just wanted to thank you for all the kindness and compassion you showed to my mum. You were there when she needed you and came when we called, and for that we will always be grateful. You made her last weeks happy and peaceful and helped us to keep her at home to the end. Thank You
Night Nursing - North Lancashire	Wanted to pass on her and the family's heartfelt thanks for the 2 'absolutely lovely ladies' who attended when Mum died. She said they were invaluable in your support to the family.
SaLT Adults	Thank you card received from patient. "It has been a privilege to see you at work - the care and personal attention and your dedication. Your approach has made so much difference to Ros and thank you also for the tips and communication cards you have given me."

Core Clinical	
Breast Unit Screening Imaging	Please record my heartfelt thanks to the lovely nurse who carried out my breast screening today. I really wasn't looking forward to it. She had a very efficient technique but was gently, kind & soothing throughout explaining everything. It was absolutely painless & a completely positive experience. A credit to the NHS & Breast Screening Service.
Medical Records	Thank you for your speedy response, in sending my mothers records through. I really appreciate your help.
Occupational Therapy WGH	Thank you very much for the talk we had about my hand. I've received the putty and band, and instructions. I also received the leaflet on looking after your joints. I truly appreciated your kindness and encouragement on the phone. Many smiles.
Physiotherapy WGH	Patient wanted to thank us for going above and beyond to offer them the best treatment for them. The patient has several other ongoing appointments and said everyone they had dealt with here had been very kind, patient, understanding and helpful for which they are very thankful.
X-Ray FGH	I recently had a CT (Computerised Tomography) and 2 MRI (Magnetic Resonance Imaging) scans, and I wanted to thank you all for the level of professionalism, kindness and caring that I received.

Corporate	
Bereavement Office (FGH)	My mum was recently treated on 11/01/2023 and unfortunately passed away on 13/01/2023 in Blackpool Victoria Hospital. I would like to thank Danielle Sadler who comforted my family at a traumatic time in all of our lives. Unfortunately I wasn't there at the time, but my grandmother speaks very highly of Danielle and the little knitted heart she gave to her and to my mum brought great comfort to us all in our time of need, especially to me who wasn't able to be with my mum in FGH but was with her in Blackpool. The little knitted heart was a very touching gesture and one that brings me comfort still to this day. So I would like to thank Danielle for being so compassionate and everything a nurse should be.
PALS	I would just like to thank you for for your help. I emailed around lunchtime and within a very short time had a call from a lovely lady at the waiting list office who helped me sort it out. Thank you.
Patient Experience	Patient rang to thank the volunteers on main reception at FGH and the Security Guard who helped her to try and find her glasses after had had attended an x-ray appointment. Yvonne (volunteer) wheeled the patient around various departments in a wheelchair trying to find her glasses. Patient was very appreciative of the help received.

Estates & Facilities	
Catering WGH	A lady approached the volunteer desk where I was talking with Volunteer Linda. She wanted to compliment Linda on the Costa who was friendly, professional and always smiling.
Estates - Capital Services (QVH	I would like to pass on my grateful thanks to the facilities and estates department for carrying out repairs in the car park, Queen Victoria hospital, Morecambe. I would especially like to give a special thankyou to ' Kenny' who inspected and carried out the work in an extremely professional and timely manner. He kept me informed and was as good as his word at all times. Please can you make sure his department receive this message.

Medicine	
Acute Frailty Unit RLI	To everyone on Acute Frailty Ward. Ward Clerk, Staff etc. Just a line to thank you all for your kindness and help whilst I was in your care. It is much appreciated
Bowel Cancer Screening Unit	Throughout the procedures I felt cared for. All staff were approachable and had a positive outlook. They made an unpleasant and worrying experience more than tolerable, in fact the staff make me smile. Especially Myles Daley.
Complex & Coronary Care Unit F	A Great Big Thank you for Everything - To all the amazing staff - Thank you for a lovely holiday!!! You have all been very supportive during my time here. Hopefully I will be back up in the Lakes again next year .... although you are so lovely I'm hoping not to be back here Many Thanks
Dermatology OPD RLI	I can't thank you enough for your kindness and doing the biopsy on my forearm. You all made me feel so relaxed, don't know what else to say except I think you are all wonderful. Thank you all so very much.
Emergency Department RLI	I attended A&E today with all the symptoms of a miscarriage in my first pregnancy. The nurses and HCSW's in A&E were the most friendly, reassuring and compassionate people I've ever met. I was seen quickly and offered a quiet space in the woman's centre where I was given a high standard of care and support. I cannot thank the staff enough for everything
Huggett Suite	A small thank you to all staff involved in my mum's care during her long stay here. What kindness, thoughtfulness and loving care I have seen given to my mum. Thank you to everyone.
Lancaster Suite	To the hospital. Thank you for looking after my grandma you are doing an amazing job at looking after her thanks you so much for looking after our relative. Thank you so much you are the best. Thank you
Oncology Unit WGH	I would like to add that the treatment and care I have received from all the staff at the Grizedale Unit has been exceptional, without exception. I was moved to a side room on AMU (Acute Medical Unit) and was relieved to receive excellent care from the two Nurse Consultants and nurses Rachel, Shellie and Nicky.
Urgent Treatment Centre	I just want to thank all the staff, who I saw, when I came in on the 14 December. I had a fall a few days earlier, and it was found that I had broken a bone connected to my pelvis. Unfortunately you were unable to do anything other than give me painkillers. Everyone, both doctor and nurses, were so kind and helpful. Thank you very much for your kind attention.
Ward 6 FGH (Stroke)	To all the wonderful staff of Ward 6. We just wanted to thank every single person for all the love and support we have received so far. Words really aren't enough but we wanted to say you are all doing an amazing job and I can't thank you enough. We are so lucky to have you all supporting us along the way.

Surgery & Critical Care	
Audiology FGH	Patient rang to express his thanks for the brilliant service he has received from Audiology and Clinical Investigations. He has received an excellent service from both departments. He really appreciates the pressure the NHS is under at the moment but he said he always gets a good service. He wanted to particular mention the receptionist who is so kind and understanding; promising to ring him back with the information if she does not have it hand, and always does.
Day Surgery Unit FGH	Further to the above email I am pleased to say my wife had her knee replacement operation on the 2nd Feb. The operation was a success and she is now on the road to recovery. I would like to congratulate the staff at FGH on the excellent care she received by one and all during her operation and short stay in the hospital.
Intensive Therapy Unit FGH	My mum was admitted to FGH on the evening of Tuesday 12 July 2022 after collapsing at home, unfortunately mum was seriously ill with Sepsis and a perforated bowel and was taken to theatre for major surgery on the Wednesday. Mum was in intensive care on a ventilator for a period of time but the doctors and nurses on ICU (Intensive Care Unit) were absolutely fabulous and kept my dad and myself up to date with all of my mum's care and gave her the best possible care they could. After a few weeks mum was moved onto PPU and again received 2nd to non-care, and she was making great progress. That evening my mum was rushed back into ICU where it was apparent, she was extremely poorly again and then the following day she was moved back into PPU where I believe she was witnessed having a seizure?, again I cannot fault the care she received on PPU and she remained there until the week of the 17th September. ICU and PPU have been amazing
Ophthalmology WGH	Patient has been to the Ophthalmology department WGH and says he had excellent service from Joanne on the 4th floor. Very professional with the various test that she did on his eyes and exceptionally pleasant. He wants to say how helpful Tony Lingwood was and charming to deal with on the reception.
Theatres RLI	I'd just to say thank you to everyone involved in my care from arrival at a very busy A&E until I was discharged. I can't name them all, but I'm grateful to them all, at a time when they are under so much pressure. I would like to say a particular thank you to Charlotte in Recovery who made it possible for me to speak to my wife by phone.
Ward 2 FGH	All the staff on ward 2, thank you for the support and care given to my dad during his long stay. Especially the support given to myself and my family love from family
Ward 33 RLI	Despite all of what has happened above I would like to say that during my time on ward 33 I was exceptionally well looked after..for the four nights I was in I was kept comfortable, my pain was managed and nothing was too much trouble for the nurses and CSW's. I was fortunate that I had the same nurses during my stay. I would like to thank Maria, Carolina, Emma and Allisia.

Women & Children's	
Antenatal Clinic RLI	Just wanted to thank Sandra and her Student Cerice (I think) for their good humour and how they treated my wife and I. we had a good appointment (13th Jan) and came out more informed.
Children's Ward RLI	She wants to say how brilliant, caring and hard working all the members of staff on the children's ward RLI are. Her son was in RLI in May. She wants the staff on the Children's ward RLI to know how fantastic they are.
Gynaecology OPD RLI	I visited the Colposcopy this clinic after referral from Gynaecology in Lancaster. I wanted to say both Dr Granger in Lancaster and the Colposcopy team I saw have been fantastic - really clear, caring and reassuring. Please pass on my compliments at what a fantastic job they are doing.
Labour Ward RLI	I was admitted into the Women's Unit to deliver our first child on 3rd December. I just wish to commend the staff who were there during my stay and made things really special and memorable for me and my husband. Going through delivery for the first time caused me a lot of anxiety but because of the care I received from the staff, we were given the guidance and assistance that we needed in order to make the experience a desirable one. Special thanks to Daisy and Rebecca (coordinator) of the Delivery Suite, you ladies were my heroes. The quality of care that I received from them was incomparable. They treated me with such compassion and care, I am tearing up now as I write this for I remember how caring they were. Thank you so very much to both of you! Also to Paula of Delivery Suite, her presence was so calming and comforting, she was very thoughtful that even though she wasn't there when I delivered, she made sure to check on me when she came back. To the rest of the team, the doctors, midwives, CSWs (Clinical Support Worker) both in Delivery Suite and Maternity Ward, I can't thank everyone enough. Everyone was so kind and compassionate. To end this, may everyone have a Merry Christmas and Happy New Year.
Maternity Ward FGH	This being said I would like to extend my upmost thanks and appreciation for the team at South Lakes Birth Centre. It is evident to see that the staff at the centre have care of their mothers and babies at the heart of all they do and they are a credit to the trust.
Ward 16 RLI	I had two lovely doctors who delivered my care this evening on ward 16 as an outpatient. They reassured me, listened to me and took my thoughts on board. Couldn't thank them enough! I can't remember their names but if you can find out please thank them again!

Appendix 3: Lessons Learned
Below are details of Lessons Learned from Upheld Complaints

Lessons Learned following a formal written complaint
CARE GROUP: Core Clinical Services
AREA INVOLVED: Pathology - Phlebotomy
MAIN ISSUES ARISING FROM A COMPLAINT/S: Patient had blood tests taken at FGH following request by GP (General Practitioner). GP has never received the results, even though pathology department state they have been sent electronically to the GP.
THEME/CATEGORY Waiting Time For Results
LESSONS LEARNED MADE/OUTCOME: A full review of booking in processes to take place to prevent reoccurrence. Improper requesting of investigations will also be flagged to the GP.

Lessons Learned following a formal written complaint
CARE GROUP: Core Clinical Services
AREA INVOLVED: Lloyds Pharmacy FGH
MAIN ISSUES ARISING FROM A COMPLAINT/S: Patient travelled to FGH to collect prescription from Lloyds Pharmacy which as not ready for collection. Patient ended up waiting 3+ hours before prescription was available due to Lloyds being unable to find on their system, oncology department having to check, prescription requiring further authorisation before it could be dispensed.
THEME/CATEGORY Prescription - Availability
LESSONS LEARNED MADE/OUTCOME: Our relief team have access to the group email address. We have given some additional training to the counter staff to recognise the medications that are accessible via the IQemo system so as they are aware to check in these instances.

Lessons Learned following a formal written complaint
CARE GROUP: Core Clinical Services
AREA INVOLVED: X-Ray QVH
MAIN ISSUES ARISING FROM A COMPLAINT/S: Parent raising concerns about missed/incorrect diagnosis following an x-ray at Queen Victoria Hospital, resulting in patient being in a lot of pain for several days.
THEME/CATEGORY Diagnosis Problems
LESSONS LEARNED MADE/OUTCOME: Radiographer reflected on family's experience. Reporting Radiographer reflected on need to review all areas not just those noted in request.

Lessons Learned following a formal written complaint
CARE GROUP: Core Clinical Services
AREA INVOLVED: X-Ray FGH
MAIN ISSUES ARISING FROM A COMPLAINT/S: Relative raising concerns on behalf of patient who was admitted to FGH recently having seizures. CT scan performed and referral for MRI made. MRI has been refused as the cyst found on CT scan was already present on scan carried out 10 years ago. Patient was not informed of cyst or received any follow-up treatment in the last 10 years.
THEME/CATEGORY Diagnosis Problems
LESSONS LEARNED MADE/OUTCOME: Missed reporting of cyst to be reviewed at REALM (Radiology Events and Learning Meetings).

Lessons Learned following a formal written complaint
CARE GROUP: Medicine
AREA INVOLVED: Dermatology OPD RLI
MAIN ISSUES ARISING FROM A COMPLAINT/S: Son is waiting for medication - disappointed that there has been a break in the course of treatment.
THEME/CATEGORY Prescription - Availability
LESSONS LEARNED MADE/OUTCOME: Secretarial team to double check prescriptions are not stuck together.

Lessons Learned following a formal written complaint
CARE GROUP: Medicine
AREA INVOLVED: Ward 35 (Respiratory)
MAIN ISSUES ARISING FROM A COMPLAINT/S: Relative raising concerns about patient's care and treatment whilst in RLI. Patient was on ward 35, Lancaster Suite and Ward 4. Relative unhappy about nursing care, care and treatment, cleanliness, staff hygiene on the wards. Concerns also raised about staff smoking on site and the mortuary arrangements for moving a body from a ward.
THEME/CATEGORY Nursing Care
LESSONS LEARNED MADE/OUTCOME: My learning was already answered in the first response around the room and door noise and preventing visitors up the stairs when a body is being taken from the ward.

Lessons Learned following a formal written complaint
CARE GROUP: Surgery And Critical Care
AREA INVOLVED: Ward 7 WGH
MAIN ISSUES ARISING FROM A COMPLAINT/S: Second day post-op nurse caring for patient did not provide adequate analgesics.
THEME/CATEGORY Inadequate Care/treatment
LESSONS LEARNED MADE/OUTCOME: I have undergone extra training with the nurse involved. She is aware of the pathway now and understands the importance of adequate analgesia and how this effects the patients recovery. She is going to undertake a reflective account on how she will improve her practise and any learning she needs which I will facilitate I will discuss this incident with the rest of the team to highlight the importance of training and guidance for new staff need when working on the ward.

Lessons Learned following a formal written complaint
CARE GROUP: Surgery And Critical Care
AREA INVOLVED: Ward 37 (Surgical)
MAIN ISSUES ARISING FROM A COMPLAINT/S: Incorrectly given information on a different patient with the same surname and date of birth. Cast was too tight and was replaced at local hospital.
THEME/CATEGORY Confidentiality
LESSONS LEARNED MADE/OUTCOME: The learning from the ward perspective is to ensure adequate clerking has been carried out prior to patients being admitted to the ward, if this has not been carried out to escalate immediately. The Ward Manager is going to send an email to all qualified staff to reiterate the importance of checking with patients if they take regular medications, and have they bought any into hospital with them.

Lessons Learned following a formal written complaint
CARE GROUP: Surgery And Critical Care
AREA INVOLVED: Acute Surgical Unit RLI
MAIN ISSUES ARISING FROM A COMPLAINT/S: Patient has several concerns regarding her recent admission to the Acute Surgical Unit at the RLI. Patient unhappy with the care and treatment herself and other patients received. Lack of information to the patient and confidentiality; staff shouted questions across the room at the patient, when other patients were present. Attitude of nursing staff was poor. Toilet facilities were dirty; patient cleaned the toilet/bathroom herself before using. Patient had to wait several hours for CT results when informed they would be available within the hour. Information/site map on the Trust's website is incorrect; patient had to ask the volunteer (whose appearance was untidy and slouching in a chair) and other staff for directions to the ward.
THEME/CATEGORY Inadequate Care/treatment
LESSONS LEARNED MADE/OUTCOME: To implement a monthly check of website to check maps and ward areas are up to date and make any amends that are needed. Following the complainants comments we have set up a rolling monthly feedback questionnaire which is sent to all patients who attend SEAC at RLI and FGH. This is providing us with some very positive comments, but also areas where we need to improve. Hopefully, she will be happy that we have acted on some of the concerns that she raised. Issue reported to the contractor who took appropriate action with the member of staff with uniform and operation standards reiterated and an up-to-date map issued.

Lessons Learned following a formal written complaint
CARE GROUP: Surgery and Critical Care
AREA INVOLVED: Breast Unit Surgery Incidents
MAIN ISSUES ARISING FROM A COMPLAINT/S: Patient says that she had to wait for reconstruction following breast cancer diagnosis. She says that there was a lack on care and support. She says that she has been left scarred and flat chested with loose skin. She would like to request reconstruction breast surgery.
THEME/CATEGORY Inadequate Care/treatment
LESSONS LEARNED MADE/OUTCOME: Each surgeon has been given a list of all patients that are awaiting follow-on surgery. We are in constant communication with the business unit and surgeons.

Lessons Learned following a formal written complaint
CARE GROUP: Surgery And Critical Care
AREA INVOLVED: Ward 33 RLI
MAIN ISSUES ARISING FROM A COMPLAINT/S: Patient had to wait 8 hours for medication on discharge.
THEME/CATEGORY Prescription - Availability
LESSONS LEARNED MADE/OUTCOME: When the team know a patient is planned to be discharged that day, the medication prescription should be completed at the earliest opportunity in the day, as there is always a time lag from that completion to Pharmacy dispensing the medications, which can lead to delays in patients being discharged home. In the event there is a change in circumstance (e.g. a wound problem after drain removal) or change to discharge medications, or need for additional medications then the prescription and discharge summary can be amended as required. Shared with individuals involved.

Lessons Learned following a formal written complaint
CARE GROUP: Women And Children's
AREA INVOLVED: Gynaecology OPD RLI
MAIN ISSUES ARISING FROM A COMPLAINT/S: Client is a Jehovah's Witness and is concerned at the consultant's attitude and using emotive rather than professional language.
THEME/CATEGORY Attitude Of Staff - Doctor
LESSONS LEARNED MADE/OUTCOME: Reflected on patient's experience for future practice. Obtaining guideline from another Trust which briefly details the origin of each non-blood component so that this information can be added to our own guideline for the benefit of clinicians and patients.

Lessons Learned following a formal written complaint
CARE GROUP: Women And Children's
AREA INVOLVED: Maternity Ward FGH
MAIN ISSUES ARISING FROM A COMPLAINT/S: Patient unhappy with the lack of care and treatment received following the birth of her first baby. Patient mentioned to staff on numerous occasions the extreme pain she was in following an episiotomy but was advised to take pain relief and it was normal; nobody examined the patient. Patient returned to South Lakes Birth Centre 6 days post labour and was admitted for the day with strong pain killers and antibiotics.
THEME/CATEGORY Nursing Care
LESSONS LEARNED MADE/OUTCOME: 1. Ask postnatal patients if they can examine the perineum prior to discharge home. If consent is not given, ensure the patients is given information on signs and symptoms to be aware of in order to detect early onset infection; as well as who and when to call for advice. All this must be documented within the postnatal management plan. 2. Completion of a medical discharge form by Obstetrician conducting review prior to discharge. 3. Document any phone call with patient/support person and what advice/information given. This will provide evidence of the advice provided. This can be referred to if subsequent calls are made with a similar issue. 4. Share Postnatal Care guideline section 4.6 Common health problems in women. This states to Document advice given over phone and what action has been taken. To be shared via 3 min brief on 28.11.22

NHS Lancashire and South Cumbria Integrated Care Board

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

NHS University Hospitals of Morecambe Bay NHS Foundation Trust

BOARD OF DIRECTORS

Date of Meeting	6 December 2023
Title	Maternity Safety Update
Report of	Tabetha Darmon, Chief Nursing Officer
Prepared by and contact details	Heather Gallagher, Director of Midwifery Heather.Gallagher@mbht.nhs.uk

Confidentiality	Non-Confidential

Purpose of Report	**To Advise/Alert**	**To Assure**	**To Approve**	**To Update**
		x		
	The Maternity update report is to advise/alert, to assure and to update. The Perinatal Quality Surveillance Data set out in this report seeks to provide a consistent and methodical oversight of maternity and neonatal services. It forms part of the long-term plan and revisions to the local, regional and national quality oversight model for the NHS. It is mandated that a monthly review of maternity safety and quality metrics is undertaken by the Trust Board. November Report, September Dashboard data.			

Summary of Key Issues / Concerns	Training compliance is improving. Compliance is expected to be over 90% by 1 December 2023. Entonox at homebirth has recommenced, following staff training, SOP development and NOD badges. HSIB has transitioned to Maternity and Newborn Safety Investigations (MNSI). The MSSP exit visit is planned for 29 November 2023 with a presentation to key stakeholders. Quality assurance visits continue with the LMNS for CNST MIS and SBLCBV3. The current trajectory for compliance for NHSR CNST MIS Year 5 currently remains at a possible 10/10. Maternity TNA is contained

	within reference pack for assurance. The Transitional Care action plan is being implemented since the business case approved. Maternity services are part of the national task and finish group asked to explore PSIRF implementation in Maternity following national concerns from maternity providers. Maternity services provided mutual aid to Blackpool Teaching Hospitals NHS Foundation Trust when a critical incident on 6 November-14 November 2023. Maternity services received a total of 14 women during the incident, 12 women were transferred to the RLI and 2 to FGH. We supported 6 births. Cultural improvement action plan are being reviewed and refreshed as the SCORE survey results (across the service) and the Good Vibes report for RLI have been received. Cultural conversations are currently being held across the service with all staff groups and with professionals who work in maternity. A formal request to participate in the Thirlwall statutory Inquiry was received on 2 November 2023, the deadline for responses is 18 December 2023, the trust is gathering evidence for the CMO and COO to respond, we have no concerns meeting the specified deadline.

Prior Discussions	Committee	Date	Recommendations/ Concerns
	Quality Committee	27 November 2023	

Action to be recommended to the Committee/Board	The Board of Directors is asked to receive and approve the report for assurance.

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

Impact on Board Assurance Framework or Trust Wide Risk Register	

Risk Impact Assessment	Is this required?	**Y**	If Yes, Date Completed	June 2023
Equality Impact Assessment	Is this required?	**Y**	If Yes, Date Completed	June 2023
Quality Impact Assessment	Is this required?	**Y**	If Yes, Date Completed	June 2023
Environmental / Sustainability Impact Assessment	Is this required?	**N**	If Yes, Date Completed	

Acronyms	
NHSE	NHS England
CNST	Clinical Negligent Scheme for Trusts
MIS	Maternity Incentive Scheme
LMNS	Local Maternity and Neonatal System
PMRT	Perinatal Mortality Review Tool
HSIB	Healthcare Safety Investigation Branch
MSSP	Maternity Safety Support Programme
ICB	Integrated Care Board
TC	Transitional Care
SBLCBV3	Saving Babies Lives Care Bundle Version 3
GAP/GROW	Fetal Growth Surveillance Tools
PROMPT	Practical Obstetric Multi Professional Training
NALS	Newborn Advanced Life Support
NHSR	NHS Resolution
MVNP	Maternity and Neonatal Voices Partnership
PPH	Postpartum Haemorrhage
NOD	Nitrous Oxide Detection Badge
BAPM	British Association of Perinatal Medicine
MNSI	Maternity and Newborn Safety Investigations programme (was HSIB)
PSIRF	Patient Safety Incident Response Framework
PSII	Patient Safety Incident Investigation
DKA	Diabetic Ketoacidosis
IG	Information Governance
DVT	Deep Vein Thrombosis
NICU	Neonatal Intensive Care Unit
ICU	Intensive Care Unit

UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST
Maternity Update Report

INTRODUCTION

1. This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety, as outlined in the NHSE document 'Implementing a revised perinatal quality surveillance model' (December 2020). The purpose of the report is to inform UHMBT Trust Board and LMNS Board of present or emerging safety concerns or activity to ensure safety with a two-way reflection of 'ward to board' insight across the multi-disciplinary, multi-professional maternity and neonatal services team.

PERINATAL QUALITY SURVEILLANCE MODEL

2. In line with the perinatal quality surveillance model, we are required to report the information outlined in the data measures proforma monthly to the Trust Board. Data is primarily for October 2023, except for where exceptions are highlighted. This has been included in the Board of Directors' Reference Pack.

PERINATAL DEATHS

3. 2 new PMRT cases. 1 Neonatal death of a 13-day old baby and 1 stillbirth of a multiple pregnancy.

MODERATE AND ABOVE HARMS IN SEPTEMBER

4. X7 Blood Loss >1500mls
   X1 ICU admission
   X1 Term Admission to NICU
   X1 Retained Suture
   X1 DVT

LEARNING FROM INCIDENTS IN OCTOBER

5. A suture was found to be retained for several months following a caesarean section. It was identified the surgeon used an absorbable suture interrupted on the skin, therefore the community midwife did not remove as it is standard/ best practise to not to remove absorbable sutures. A review has been undertaken and there are no other women affected.

6. There were 7 PPH, one DVT and one ICU admission for DKA, care has been reviewed and care was in accordance with guidance.

7. Following a review of a baby transferred out to a tertiary centre a Patient Safety Incident Investigation (PSII) was declared. There has been a theme around Information Governance (IG) breeches with the wrong child health book been given to the mother prior to discharge. A review of the process has been undertaken and the process changes so that these are now given after following the birth of the baby.

MATERNITY AND NEWBORN SAFETY INVESTIGATIONS (MNSI) (was HSIB) IN OCTOBER

8. 0 cases in month. One Healthcare Safety Investigation Branch (HSIB) report received identifying that the Trust must ensure that discussions with mothers about induction of labour, include the benefits, risks and alternatives to enable supported informed decision making.

TRAINING COMPLIANCE EXCEPTIONS

9. Doctors training compliance sits under 90% in the following subjects;
    - SBLCBv3 Doctors 82% (increase from 70%)
    - GAP/GROW Doctors 71.4% (increase from 62.9%)
    - PROMPT Doctors 82% (increase from 81.2%)
    - PROMPT Anaesthetists 82% (increase from 68.5%)
    - Care in labour Doctors 73% (decrease from 74%)
    - Personalised Care 83.3% (increase from 74.1%)

10. Training compliance for medical staff is increasing in alignment with improvement trajectories. Compliance has been achieved for 90%> for medical staff in Fetal Surveillance in Labour and Newborn life Support.

11. Midwives training is slightly below the 90% compliance standard for the following subjects.
    - GAP/GROW 82.5% (decrease from 84%)
    - Personalised Care 83.3% (increase from 86%)
    - Care during Labour 95.8% (decrease from 87.5%)

12. Improvements in midwifery training compliance seen, subjects which have met the 90%> target are SBLCBv3, PROMPT, Newborn Life Support and Fetal Surveillance in Labour.

13. The training compliance rates will continue to be monitored in the Clinical Business Unit meetings, Womens Quality Board and WACS Care Group Board. The risk for training compliance remains on the risk register. The improvement trajectories show expected compliance at 100% by 1st December for doctors including anaesthetists and midwives if the staff booked on the training attend.

STAFFING EXCEPTIONS

14. Fill rates for October remained above the 85% standard for RLI 89.9% and below for FGH 81.03%. The decline in fill rate at FGH is highlighting a drop in agency midwife availability. Acuity continues to be monitored and staffing managed in real time and staff moved according to need via staffing calls, safety huddles and the LMNS Gold calls daily. Birthrate is being commissioned to undertake the 3 yearly establishment review early 2024.

SERVICE USER FEEDBACK

15. Feedback has been received from a woman who was receiving consultant led care due to a raised BMI. She had needed to wait in clinic after her scan for a consultant appointment. She did not feel that the brief information in that appointment was sufficient to justify the wait.

STAFF FEEDBACK

16. A staff engagement event has been held to develop options to improve the on-call service for both women and midwives following complaints being received. Further development work is required prior to a decision being made in collaboration with the community midwifery team and service users.

17. Listening events are planned for the alignment with break times across the Trust, following midwives raising concerns regarding the changes to break durations.

MATERNITY DASHBOARD EXCEPTION REPORT

18. Please refer to Appendix 2 for the Maternity Dashboard for September data, which is included in the Board of Directors' Reference Pack.

MATERNITY SAFETY SUPPORT PROGRAMME (MSSP)

19. There is a planned MSSP exit presentation on 29th November 2023 to present our improvement journey and discuss exit out of the MSSP programme and transition of oversight of the sustainability plan. The presentation is to key stakeholders: the MSSP, Trust executives, the ICB Chief Nurse, regional Chief Midwife and the Director and Associate Director of the LNMS.

SAVING BABIES LIVES CARE BUNDLE VERSION 3 (SBLCBv3)

20. A quality improvement meeting was held with the LMNS in September and a review identified the maternity services are currently 69% compliant with all interventions across all 6 elements. In addition, there is an action plan to fully implement all 6 elements of SBLCBv3 by March 2024. Quarterly quality assurance meetings will continue to be held with the LMNS with the next one planned on the 23rd November 2023.

MATERNITY AND NEONATAL VOICES PARTNERSHIP (MNVP)

21. Co-production work with the MNVP has unfortunately been paused since August 2023 as the MVP was without a chair. The new MVNP chair Janet Gorry has been visiting the teams at the various sites, attended WACS Womens Quality Board and listened to the patient story and shared the MNVP workplan. The first MNVP bay wide meeting is being held on 27th November. Healthwatch hosted a Lancashire MNVP development day on Monday 30th October to support the new MNVP Chairs across the LMNS.

MATERNITY AND NEWBORN SAFETY INVESTIGATIONS (MNSI)

22. Healthcare Safety Investigation Branch (HISB) has transitioned into Maternity and Newborn Safety Investigations (MNSI) as of 1 October 2023. MNSI is now hosted by the

CQC. MNSI have published further details on how information sharing will occur between MNSI and the CQC.

PSIRF IMPLEMENTATION

23. Following concerns around the implementation of PSIRF in maternity a NHSE task and finish group has been set up, after NHSE recognition of the depth of feeling and concerns, given the national context of multiple governance failures and calls from parents asking for national Public Inquiry into Maternity Services, and the lack of parental or service user involvement in the evaluation of maternity PSIRF from the early adopter sites. Recommendations from the national task and finish Group are to be developed at pace and fast tracked in an attempt to have published before 1st April 2023 PSIRF launch. Both the Director of Midwifery and the Lead Midwife for Quality, Safety and Assurance are part of the national task and finish group.

BLACKPOOL CRITICAL INCIDENT

24. Blackpool Teaching Hospitals NHS Foundation Trust declared a critical incident on 6th November-14th November. WACS offered mutual aid for maternity, neonatal and CYP patients. Maternity services received from 7th-10th November a total of 14 women during the incident, 12 women were transferred to the RLI and 2 to FGH. We supported 6 births. Staff have been thanked for their care and professionalism, recognising the additional workload pressure they experienced during this time. Positive feedback received from Blackpool women transferred to us during this time has been shared with the teams.

MATERNITY INCENTIVE SCHEME (MIS) YEAR 5

25. The current trajectory for compliance for NHSR CNST MIS Year 5 currently remains at a possible 10/10 depending on achieving the >90% training compliance. See CNST paper.

26. The completed Training Needs Analysis (TNA) for the Maternity Core Competency Training Framework v2 (MCCFv2) is required to be shared with the Board as part of the minimum CNST requirement. Please refer to Appendix 3 for the TNA, which is included in the Board of Directors' Reference Pack. The TNA will also be shared with the LMNS on the 23rd November QA visit.

27. The Transitional Care action plan is being implemented since the business case approved.

CULTURAL IMPROVEMENT WORKSTREAMS

28. An action plan is in draft following the cultural diagnostics report for SLBC. The Quadrumvirate leadership team have also received the Good Vibes report from RLI and the SCORE survey results across maternity professionals this month. These reports and findings are being considered and will be incorporated into the cultural improvement plans.

29. Following receipt of the SCORE survey results, across the service cultural conversations with the maternity teams are progressing facilitated by Korn Ferry. This is part of the national NHSE Perinatal Culture and Leadership Programme.

30. The Maternity and Neonatal Safety Champions will discuss the cultural diagnostics and the SCORE survey findings and help the Quadrumvirate design and refresh the cultural improvement plans on 24th November, also identifying any Board support required.

ENTONOX SUSPENSION AT HOME BIRTH

31. Entonox has been reintroduced at home births from 13th November 2023, following robust risk assessment, the implementation of a SOP, staff safety training and Nitrous Oxide detection (NOD) badges for community midwives.

MATERNITY AND NEONATAL BOARD LEVEL SAFETY CHAMPIONS

32. The Maternity and Neonatal Board Level Safety Champions are asked as part of CNST MIS Year 5 to access the Future NHS Collaboration Platform, to explore the maternity resources and consider application to our local maternity services and to their role as Safety Champions. Below is a summary (Table 2) of the resources accessed by the Board level Maternity and Neonatal Safety Champions and the application to maternity services locally.

Table 2

Resource	**Learning and application**
Women and families advocating for systematic change in MatNeo care	Powerful advocacy for hearing and responding to the voices of women and families and for improving their ability to ask informed and empowered questions and to make appropriate and safe decisions about their care.
Seeing the Forest for the Trees: The Power of Systems Thinking in Healthcare	Particularly informative about the significance of emphasizing feedback loops: recognising that actions within the system can have feedback effects, and that outcomes can be influenced by previous actions. Really important for UHMBT in relation to current impacts of previous work and influence on making and sustaining improvement.
Women at risk	Prompting further questions relating to potential impact of staffing challenges on inductions and how these impact on women, families and staff.
Support for second victims	Highly relevant to the development of walkarounds to include neonatal services particularly in support and understanding the experiences of women, families and staff relating to the Letby trial aftermath and the forthcoming statutory inquiry

The Perinatal Culture and Leadership Programme	Helpful in establishing a clearer understanding of the PCLP, processes, opportunities, challenges and intended benefits. Enabling in preparing to effectively support and constructively challenge quadrumvirate colleagues.
Maternity & Neonatal Voices Partnerships area	The Kernow case study was especially relevant given the rural, coastal, isolated and coastal similarities with the UHMBT demography and geography.
Supporting a Learning Culture Maternity and Neonatal Summit, March 21st, 2023 – slide set	Ensuring that both visible and hidden factors are considered and 'noticed' and targeted in work to address cultural values. Helpful in promoting deeper insights into cultural factors and approaches to addressing these.
Three Year Delivery Plan for Maternity & Neonatal Services	Essential background reading particularly related to the four high level themes to be tackled over the next three years, addressing and reducing inequalities, and regional and national coproduction work with service users,
Maternity and Neonatal Safety Champions Toolkit	Background and context in preparation for the NED MatNeo Safety Champion role.
MatNeo Board Safety Champions – AQuA pilot workshops materials	Accessed as part of, and to follow up learning from the UHMBT MatNeo Safety Champions participation in the AQuA pilot programme. Particular focus on using data well and enhancing understanding and interpreting MatNeo data in relation to measuring and monitoring safety.

THIRLWALL INQUIRY

33. A formal request to participate in the Thirlwall statutory Inquiry was received on 2nd November 2023, the deadline for responses is the 18th December 2023, the Trust is gathering evidence for the CMO and COO to respond, we have no concerns meeting the specified deadline.

RECOMMENDATION

34. The Board of Directors is asked to receive and approve the report for assurance.

THIS PAGE IS INTENTIONALLY BLANK

NHS Lancashire and South Cumbria Integrated Care Board

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

NHS University Hospitals of Morecambe Bay NHS Foundation Trust

BOARD OF DIRECTORS

Date of Meeting	6 December 2023
Title	Trust Improvement Plan
Report of	Chris Adcock, Chief Finance Officer, Deputy Chief Executive and Executive Senior Responsible Officer for the Trust Improvement Plan
Prepared by and contact details	Rebecca Hogan, Assistant Director for Recovery Support and Improvement- rebecca.hogan2@mbht.nhs.uk

Confidentiality	Non-confidential

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

This report is to advise the Board of Directors on progress against the Trust's improvement priorities and:

- outcome of the first 6-month sustainability reports for the Recovery Support Programme (RSP) workstreams that have been transitioned to business-as-usual oversight arrangements; and
- Progress made to date in the establishment of the improvement programmes established under the refreshed Trust wide Improvement Plan.

Summary of Key Issues / Concerns	Previous reports to Trust Board outlined the process that will be used to ensure the improvements achieved under the remit of each of the RSP workstreams have been sustained, including a review of progress by the Trust Transformation and Improvement Board at 3 and 6 months' following their transition back to business-as-usual oversight arrangements. This report highlights that, in line with the agreed process, following a review of the 6-month sustainability reports for the first four RSP workstreams: • Two workstreams, Mortality and Freedom to Speak Up, have evidenced sustainability of the improvements achieved and ongoing oversight of sustainability has been concluded by the TIB. • Two workstreams, Clinical Effectiveness and Deteriorating Patient, have evidenced the improvements achieved have been sustained. However, further work to improve the visibility of data related to the audit element of clinical effectiveness and to the breadth of the deteriorating patient workstream that had been forecasted to be completed within the 6 months sustainability window have not yet been tested. Therefore, further sustainability

	reports will be considered by the TIB before formal closure of the ongoing oversight of sustainability by that forum. The report also highlights that with the exception of the digital programme, which is undertaking a review of its priorities following the identification of the digital requirements of the other programme areas, the recently established programme areas within the Trust's Improvement Plan are progressing from scoping and initiation into delivery of initial priority areas.

Prior Discussions	Committee	Date	Recommendations/ Concerns
	Transformation and Improvement Board	21 November 2023	1. Closure of FTSU/ Mortality oversight 2. Production of benefits realisation plans prior to Trust Board in February 2024.

Action to be recommended to the Committee/Board	The Board of Directors is asked to note: 1. The outcome of the 6 month sustainability report for the FTSU, Mortality, Deteriorating Patient and Clinical Effectiveness workstreams; and 2. The progress being made to establish the programmes of work under the Trust's refreshed Improvement Plan.

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

Impact on Board Assurance Framework or Trust Wide Risk Register				
Risk Impact Assessment	Is this required?	**N**	If Yes, Date Completed	
Equality Impact Assessment	Is this required?	**N**	If Yes, Date Completed	
Quality Impact	Is this	**N**	If Yes, Date	

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

Acronyms	
SOF	System Oversight Framework
ICB	Integrated Care Board
RSP	Recovery Support Programme
TIB	Transformation and Improvement Board
FTSU	Freedom to Speak Up

UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST

Trust Improvement Plan

INTRODUCTION

1. This report is intended to advise Trust Board of the activity that is ongoing to ensure:
   - the improvements achieved during the Trust's enrolment in the Recovery Support Programme are sustained, and
   - that the next phase of the Trust's Improvement Plan is established effectively to support the achievement of our ambition to progress towards segment 2 of the System Oversight Framework (SOF).

SUSTAINING THE IMPROVEMENTS ACHIEVED UNDER THE RSP

2. Previous reports to the Board outlined the process that would be used to ensure the improvements achieved under the remit of each of the RSP workstreams were sustained.

3. This included ongoing oversight of performance and quality via Business as Usual arrangements , including Board Assurance Committees, at pre-defined frequencies, as well as a review by the Trust's Transformation and Improvement Board (TIB) at 3 and 6 months' to ensure the maintenance of the original achievements, as well as progress made against any pre-planned additional improvements during those periods.

4. The first four workstreams have now undergone 6-month sustainability reviews via the TIB. A summary of the findings and outcome of the reviews is provided in Table 1 below:

Table 1: Overview of the outcome of 6-month sustainability reviews for the RSP workstreams:

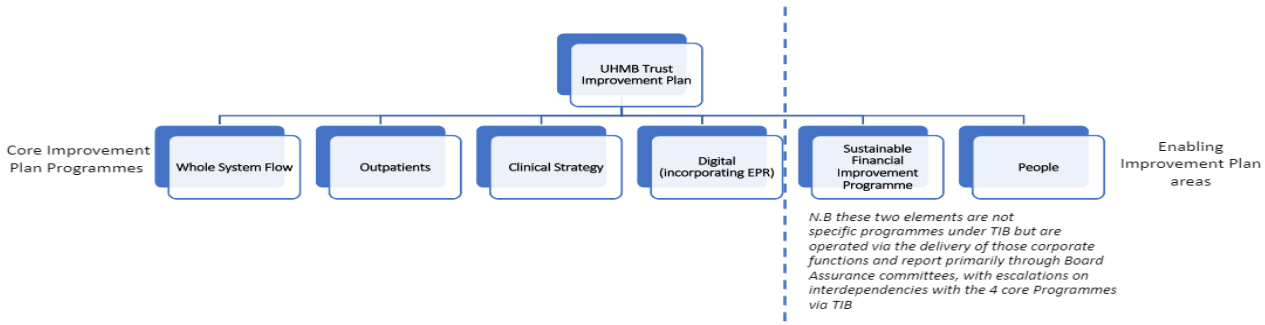
Workstream	Key findings	Outcome
Mortality	Evidence of maintenance of improvements including dissemination of learning from deaths, second review process, improved end of life care for patients with Learning Disabilities and triangulation of learning themes present. Planned further improvements to end of life pathways and implementation of uDNACPR achieved.	TIB has concluded its oversight of the programme and have now confirmed that sustainability and on-going progress in respect of this workstream has now been passed to the Quality Assurance Committee, reporting arrangements are established to support this.
Freedom to Speak Up	Evidence of maintenance of improvements including feedback from concerns raised, feedback on effectiveness and clarity of staff training, triangulation of themes raised across other routes including complaints present. Further improvements, including a PDSA	TIB has concluded its oversight of the programme and have now confirmed that sustainability and on-going progress in respect of this workstream has now been passed to the People

	review to ensure that issues raised are routed via the most appropriate route are ongoing but form part of planned continuous improvement cycles, not action required prior to oversight closure.	Committee, reporting arrangements are established to support this.
Deteriorating Patient	Evidence of maintenance of improvements such as the improved identification of deteriorating patients via the deteriorating patient alert system dashboard (DPAS) and response to deteriorating patients via the Critical Care Outreach Team (CCOT) present. Planned improvements to the reporting and visibility of metrics related to deteriorating patients via the Deteriorating Patient Group have not yet been tested via a cycle of business.	Oversight retained via the TIB until a cycle of reporting evidencing the effectiveness of the metrics is available.
Clinical effectiveness	Evidence of maintenance of improvements such as the use of GIRFT data to identify productivity and efficiency improvements and the alignment of audit plans with service risk profiles and business plans present. Further improvements related to the reporting of Audit effectiveness have not yet been tested via a cycle of business.	TIB ongoing oversight of sustainability of GIRFT and NICE guidance concluded. Oversight of audit retained via the TIB until a cycle of reporting evidencing the effectiveness of the metrics is available

5. The TIB will continue to oversee the sustainability of improvements achieved across the RSP workstreams until each workstream has evidenced the achieved improvements are sustained and any further pre-agreed improvements have been attained.

PROGRESS ACHIEVED IN ESTABLISHING THE PROGRAMMES UNDER THE CURRENT TRUST IMPROVEMENT PLAN

6. Focus over recent months has been on establishing the programmes of work under the next phase of the Trust's Improvement Plan. The configuration of the plan is shown in image 1 below:



7. In line with lessons learnt during the Trust's enrolment in the RSP emphasis has been placed on ensuring that the programmes and their associated infrastructure are mobilised effectively, including establishing leadership, oversight and reporting infrastructure, scoping the associated projects, defining the critical path for the delivery of associated improvements and ensuring a defined benefits realisation plan, against which progress can be measured, is in place.

8. With the exception of the digital programme, which is undertaking a review of its priorities following the identification of the digital requirements of the other programme areas, the programme areas have successfully mobilised the infrastructure associated with their programmes and are producing benefits realisation plans for initial delivery priorities, which will be considered for approval by the December TIB. An update on the workplan for the Digital programme will be provided to the February Trust Board.

9. Table 2 below provides an overview of some of the initial areas of improvement that are being prioritised by the Programmes.

Table 2: Initial areas of improvement by Programme

Programme	**Priority improvement areas**
Whole System Flow	- Clinical pathways, including Single point of access, Urgent & Emergency Care, Same Day Emergency Care pathway, Redesigned Urgent & Emergency Care: Barrow, Kendal Urgent Treatment Centre
Outpatients	- Patient Initiated Follow Up - Triage App - Advice and Guidance implementation - 100 day pathway reviews
Clinical Strategy	- Fragile Services: Three areas of priority have been defined at a Provider Collaborative level during November 2023 (Gastroenterology, Gynaecology, Haematology), work to define an internal workplan for the remaining P1 Trust level fragile services is now underway. - Integrated Models of Care: Vascular Access Collaborative and Shared Decision Making

10. Following the agreement of the benefits realisation plans at the December TIB future Board reports will report on progress made against the expected improvement trajectories.

11. The Trust is awaiting the provision of updated licence conditions following their exit from the RSP, it is expected these will be provided during December. An update on their contents and the associated oversight arrangements will be shared with Trust Board in February 2024.

CONCLUSION

12. The Trust continues to ensure the sustainability of the improvements achieved during the RSP, as well as ensure the next phase of its improvement programme is initiated in a way that enables the delivery of sustainable improvement. The current priority has been

to ensure that the intended benefits of the improvement activity are adequately defined during the scoping and initiation phase to ensure accountability for delivery can be achieved over the programme lifespan. The programmes related to WSF, Outpatients and Clinical Strategy have progressed through the scoping and initiation phase in line with the expected pace. The period between December and February will be critical in evidencing that the initial priority projects are delivering consistent outcomes in line with the benefits realisation plans. Progress against this critical path will be reported to the Trust Board in February 2024.

RECOMMENDATIONS

13. The Board of Directors is asked to consider the contents of the report and note:

- The outcome of the 6-month sustainability reports for the FTSU, Mortality, Deteriorating Patient and Clinical Effectiveness workstreams; and
- The progress being made to establish the programmes of work under the Trust's refreshed Improvement Plan.

THIS PAGE IS INTENTIONALLY BLANK

NHS Lancashire and South Cumbria Integrated Care Board

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

NHS University Hospitals of Morecambe Bay NHS Foundation Trust

BOARD OF DIRECTORS

Date of Meeting	6 December 2023
Title	Integrated Performance Report
Report of	Chris Adcock Chief Finance Officer / Deputy Chief Executive
Prepared by and contact details	Suzanne Hargreaves Associate Director Strategy (Planning & Performance)

Confidentiality	Non-Confidential

Purpose of Report	**To Advise/Alert**	**To Assure**	**To Approve**	**To Update**
		x		
	The Integrated Performance Report sets out the key performance indicators to show which KPIs achieved the standards in September and whether the KPIs will sustainably achieve the standard going forward using statistical process control methodology. Further detail provided in the pack includes associated actions, outcomes, dates and assurance.			

Summary of Key Issues / Concerns	The detailed report attached identifies the performance in September along with the actions and assurance, the key areas to highlight in relation to September report are: **Finance** – At month 6 the reported forecast deficit was £37m. This has since been mitigated and risk assessed at £29.9m for submission to the ICB and national team on 22 November. This forecast remains £11.6m adverse to plan. The validation and review of the forecast outturn continues with peer challenge across the Provider Collaborative, and this will form a continual process until the financial year end. Delivery against the CIP has been extremely positive with £11.9m of the £9m plan delivered at the end of September. The forecast for the year is currently £29m which is £1m adverse to the £30.4m plan. The recurrent value of the programme is £17m which is lower than the in-year amount achieved due to the UEC funding of £6m being received non-recurrently. The following targets whilst all identified as expected to **fail** are in **special cause improvement**: **65 Weeks –** performance against this target remains in special improvement and whilst flagging as a consistently fail – we are on

	track to deliver zero 65 week waits by end of March 2024. As previously reported there are a number of high-risk specialties which are being closely monitored and managed. **30 minute ambulance handover –** performance is now consistently above 70%, the improvement has been driven largely by improvement at FGH which was just under the 80% target at 77.8%. RLI remains in common cause variation at 68.3%. The ambition is to achieve the 80% target, an improvement trajectory is being agreed with the Care Group and will be included within the report from next month. **Appraisal –** whilst there is improving compliance overall with appraisals the figures continue to reflect that there is additional work to be done to win hearts and minds and the level of leadership appraisals is of concern. This was an area of discussion at the performance reviews and each of the Care Groups has an improvement trajectory in place. There is just one target that is flagging as **Fail – special cause concern** **RTT 18 weeks** – as expected Trust wide RTT performance is in special cause concern due a run of performance below the mean and is predicted to fail due to the distance away from the 92% standard. The RTT% will not substantially improve until the longest waiting patients have been treated, which is why the focus is on achieving the zero 65 week waits by March 24. Whilst this is the overall position it is important to note that several medicine specialties are now achieving the 92% standard and cardiology achieved for the first time since May 2022. **Hit & Miss** **There are no indicators in hit and miss that are currently indicating special cause concern.**

Prior Discussions	Committee	Date	Recommendations/ Concerns
	The relevant sections of the IPR have been taken through the Board sub committees.	November 2023	Identified through the Committee 3a reports

Action to be recommended to the Committee/Board	The Board of Directors is requested to note for assurance the integrated performance report for September 2023.

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

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

Acronyms	
ICB	Integrated care Board
NMC2R	Not meeting criteria to reside
RTT	Referral to treatment time
CIP	Cost improvement programme

THIS PAGE IS INTENTIONALLY BLANK

We are UHMBT

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

NHS
University Hospitals of Morecambe Bay
NHS Foundation Trust

Integrated Performance Report

September 2023 performance – Board (6 December 2023)

Contents

SECTION	PAGE
KEY TO KPI VARIATION & ASSURANCE ICONS	3
DATA QUALITY INDICATOR	4
EXECUTIVE SUMMARY	5
QUALITY & SAFETY	13
PEOPLE	22
FINANCE	27
OPERATIONAL PERFORMANCE	36
APPENDICES	51

Key to KPI Variation and Assurance Icons

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

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

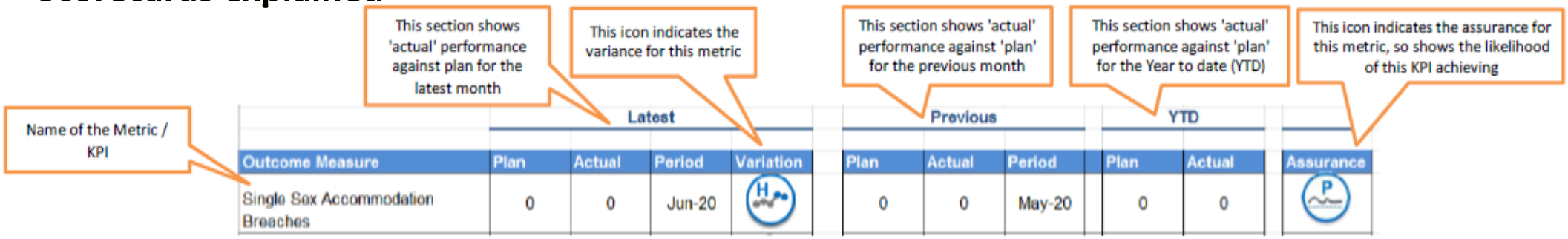
Special Cause Concern - this indicates that special cause variation is occurring in a metric, with the variation being in a favourable direction. Low (L) special cause concern indicates that variation is upward in a KPI where performance is ideally above a target or threshold e.g. ED or RTT Performance.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

Escalation Rules:

Areas are escalated for reporting if:

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

Scorecards explained



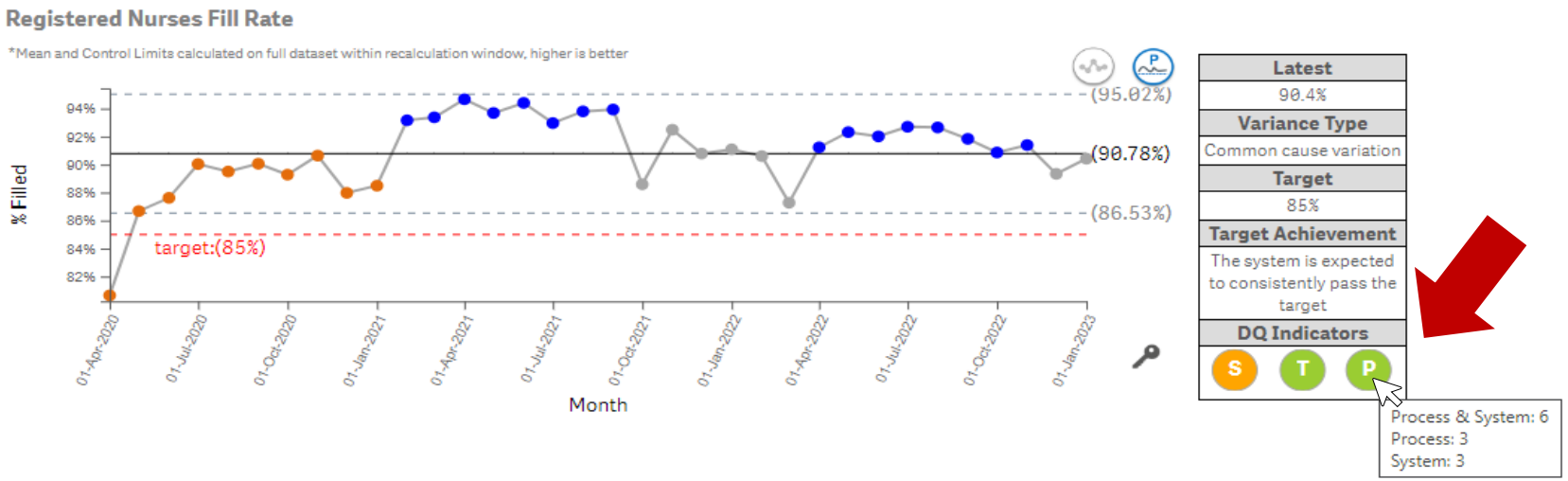
Further Reading / other resources

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

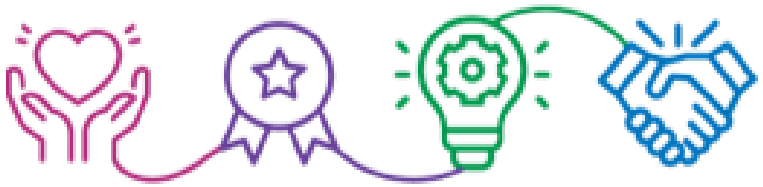
UHMB Data Quality Indicator - Overview

For the reporting of June 23 performance, the roll out of Data Quality Indicators is almost complete across the Performance, Quality & Safety and People & Organisational Development domains, with only a minimal number of metrics still awaiting scoring.
The Indicator provides an effective visual aid to quickly provide analysis of the collection, review and quality of the data associated with the metric. Each metric is rated against the 3 domains in the table below using the scoring matrix included within the appendices. The DQ Indicator is displayed within the SPC chart as per the chart below.

Symbol	Domain	Definition
S	Sign off and Review	Has the logic and validity of the data definition been assessed and agreed by people of appropriate and differing expertise? Has this definition been reviewed regularly to capture any changes e.g. new ways of recording, new national guidance?
T	Timely and Complete	Is the required data available and up to date at the point of reporting? Are all the required data values captured and available at the point of reporting?
P	Process and System	Is there a process to assess the validity of reported data using business logic rules? Is data collected in a structured format using an appropriate digital system?

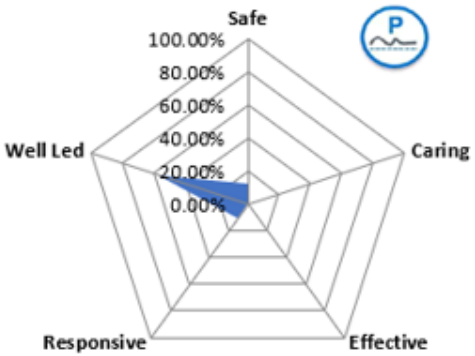


Executive Summary

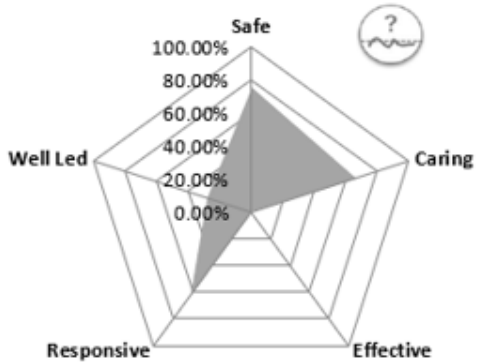


Executive Summary

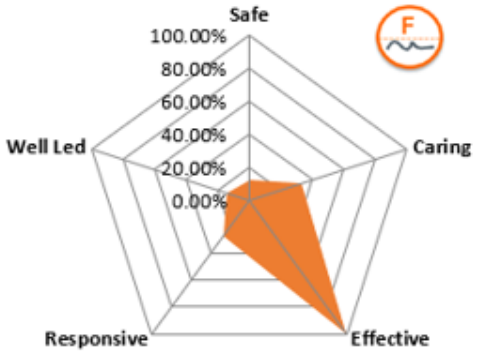
Consistently Passing



Hit and Miss



Consistently Failing



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

Safe:
- Registered Nurse Fill Rate

Well Led:
- Average time to hire
- Vacancy %
- Core Skills Framework
- Turnover %

Responsive:
- 2hr Community Crisis Response
- RTT total waiting list size

Effective:

Caring:

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

Safe:
- Hospital Falls per 1000 Bed Days – Moderate Harm or above, Total No. of MRSA Hospital Cases, Total Number of GNBIs, Total Number of c.Diff Infections, Inpatient Category 2,3 & 4 Pressure Ulcers per 1000 bed days, Total Number of MSSA Hospital Cases

Well Led:
- Absence FTE %, Bank & Agency Fill Rate

Responsive:
- % of ED attends > 12hrs, Cancer 2WW (%), Cancer 28-Day FDS (%), Cancer 31-day(%), Cancer 31-day subsequent drug(%), Cancer 31-day subsequent Surgery(%), No. of patients on Cancer PTL over 62 days (no.), Cancer 62-day (%), Cancer 62-day upgrade(%), RTT 52 weeks (no.), Diagnostic waits > 6 weeks, ED 4 hrs(%)

Effective:

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

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

Safe:
- StEIS Incidents Reported to CCG

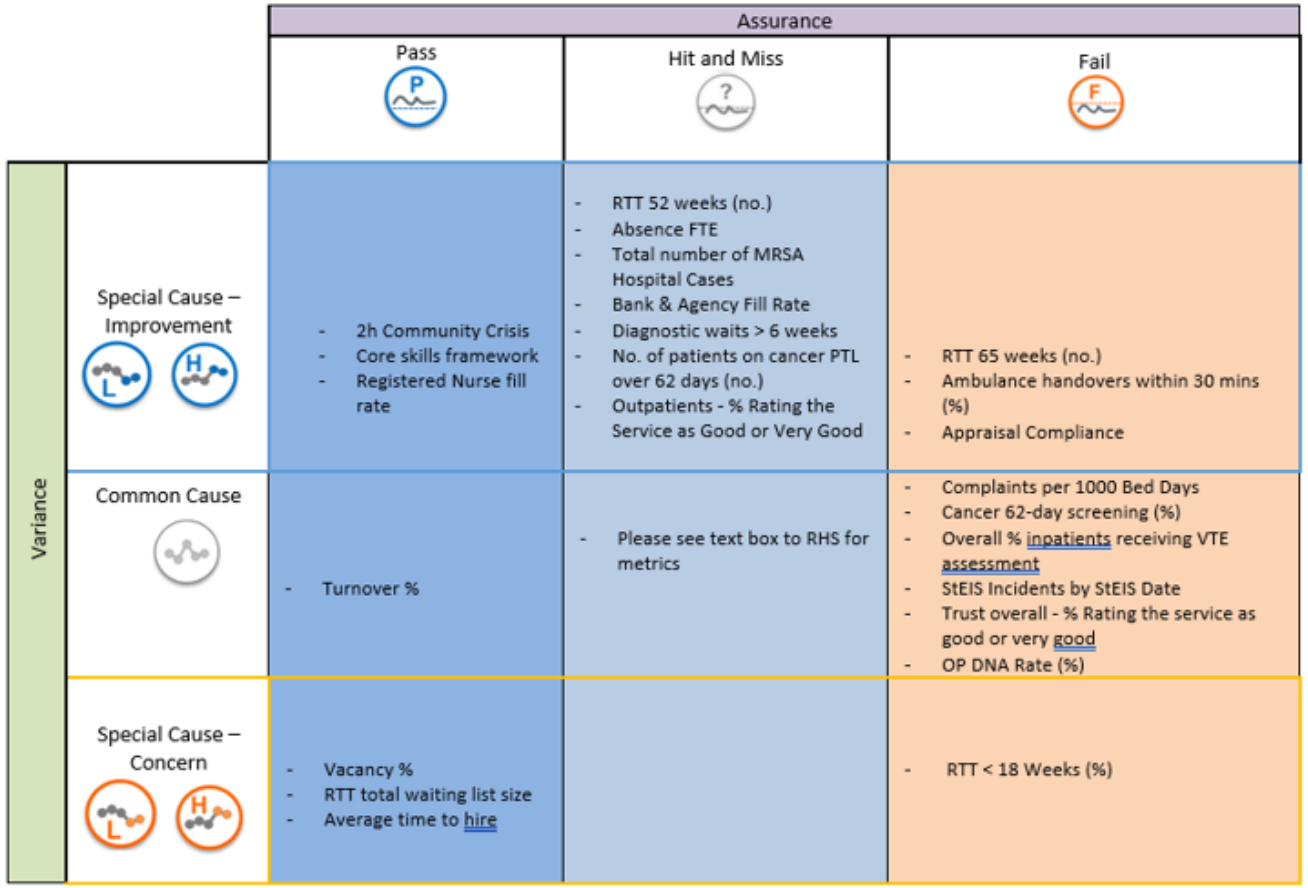
Well Led:
- Appraisal Compliance

Responsive:
- Ambulance Handovers within 30 mins (%)
- RTT <18 Weeks (%)
- RTT 65 weeks (no.)
- OP DNA Rate (%)
- Cancer 62-day screening (%)

Effective:
- Overall % of Inpatients Receiving a VTE Assessment

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

Executive Summary



Variance	Assurance: Pass	Assurance: Hit and Miss	Assurance: Fail
Special Cause – Improvement	- 2h Community Crisis - Core skills framework - Registered Nurse fill rate	- RTT 52 weeks (no.) - Absence FTE - Total number of MRSA Hospital Cases - Bank & Agency Fill Rate - Diagnostic waits > 6 weeks - No. of patients on cancer PTL over 62 days (no.) - Outpatients - % Rating the Service as Good or Very Good	- RTT 65 weeks (no.) - Ambulance handovers within 30 mins (%) - Appraisal Compliance
Common Cause	- Turnover %	- Please see text box to RHS for metrics	- Complaints per 1000 Bed Days - Cancer 62-day screening (%) - Overall % inpatients receiving VTE assessment - StEIS Incidents by StEIS Date - Trust overall - % Rating the service as good or very good - OP DNA Rate (%)
Special Cause – Concern	- Vacancy % - RTT total waiting list size - Average time to hire		- RTT < 18 Weeks (%)

Hit and Miss – Common Cause Metric List

Well Led

Safe

Inpatient Falls per 1000 Bed Days Resulting in Moderate Harm or Above, Total Number of c. Diff Infections, Inpatient Category 2, 3 & 4 Pressure Ulcers Per 1000 Bed Days, Total Number of MSSA Hospital Cases, Total number of GNBSI

Caring

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

Responsive

Cancer 28 Day FDS, Cancer 31 day (%), Cancer 31-day subsequent drug (%), Cancer 31-day subsequent surgery (%), Cancer 62 day (%), Cancer 62-day upgrade (%), % Of ED attends > 12hrs, ED 4 hrs (%), Cancer 2WW (%)

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

Safe:
Caring:
Effective:
Responsive: RTT < 18 Weeks %
Well-Led:

Executive Summary – Quality & Safety

Complaints - Revised metrics to be agreed and change to IPR implemented. As of 07/11, 129 open, 2 complaints over 6 months (not revisits) and 6 revisits. All with plans for closure ASAP (verbal update at QAC on current position with complaints) beyond 6 months.

Falls – 136 slips, trips and falls reported. 3 resulting in moderate harm. 66/136 incidents reported were due to recurrent fallers. • 1 dislocated hip where the patient had capacity and no lapses in care identified. • 2 fractured necks of femur 1 where the patient lacked capacity. Care group level thematic reviews reported to Learning response Group.

Pressure Ulcers – 53 reported category 2 pressure Ulcers (inpatients). Which is a consistent number to previous months. No category 3 reported. Work in progress to split the incidents into avoidable/unavoidable without having to do a manual trawl. Care group level thematic reviews reported to Learning response Group.

Family and Friends Test – The overall survey response rate was 13%. 6729 responses overall. Of 3934 IP surveys sent only 850 responses were received. QI project to bring the FFT in house with aim in Q4 to - Decrease the reliance solely on text messaging and increase face to face opportunity for real-time feedback.

Mixed Sex Accommodation Breaches – 8 breaches relating to delayed transfers from ICU to the ward due to lack of capacity.

Infection Prevention and Control - CDI figures are currently 2 above threshold, compared to last September when we were 10 over threshold

VTE – Overall VTE compliance remains below 95% at 87.7% (89.6%) VTE Assessment data for Inpatients in the last month by Care Group: • Surgery 80.4%. Medicine 95.6%. WACS 83.7% Snapshot audit showed most of the missed VTE assessments were in patients who had a GA. Work ongoing to deal with the LA exclusion criteria.

Mortality – SHMI – sustained green. Acute Cerebrovascular Disease SHMI remains red. The Stroke Mortality Review team and MEs are acutely aware of the red alert in acute Cerebrovascular disease and the MEs will refer to Mortality Reviewers for SJRs if they have any concerns in the delivery of care.

Executive Summary - People

Vacancy: Although overall vacancy rate (5.49%) is below trust target (6%), there are still hot spots of concern for the Trust, one of these is SAS vacancy position, which has increased by 2%. Vacancy Control Panel (VCP) is not currently impacting upon these areas of concern as these fall outside of the scope of VCP. Overall Trust WTE increased by 92 WTE, this is highlighted as the pressure from ICB is looking at all Headcount increases, even those which are funded externally.

Temporary Staffing: Nurse agency spend lowest point since this reporting commenced in 2021, with high fill rates achieved across the trust (only one ward didn't meet the trust target of 85% fill rate).

Core Skills Framework: All care groups are compliant with the Trust target. Overall trust compliance is at 93.7% and SPC shows that the target is expected to be constantly met. October data indicates there has been a 1.7% improvement overall due to work undertaken over the past two months.

Appraisal; Although improving, appraisal compliance figures continue to reflect that there is additional work to be done to win hearts and minds around the difference a good appraisal makes to a colleague experience, inclusion, growth and retention. The lack of leadership appraisals is the biggest concern. Leaders are responsible for supporting others and need to have their own quality appraisal.

Attendance: Absence is showing signs of steady increase and is failing to meet trust annual target but is under the winter target of 6.5%. As we move into the Autumn months, we will start to see a seasonal variation in reasons for absence which results in cough, cold and flu seeing more days lost. Highest number of referrals to Occupational Health within a month period to date received – 333 colleagues being referred in October 2023.

Staff Survey: Staff Survey response rates are ahead of average for Acute Trusts and ahead of where they were this time last year. With three weeks to go, at the end of October we were over 30% response rate.

Executive Summary - Finance

Finance		Month 6 (September) 2023/24	Forecast outturn 2023/24
	Income & Expenditure	• Actual **deficit of £16.0m** against a **plan of £15.6m** – a **variance of £0.4m**. • An adverse variance in month of £0.5m. • Includes £2m of unmitigated stretch income, plus £1.6m additional cost associated with the impact of industrial action	• Current risk assessed forecast outturn is a **deficit of £37.0m** against a **plan of £18.3m** which is **£18.7m adverse** to plan. • A deterioration of the risk rated forecast at month 5 of £4.0m which is under review. • This movement is predominantly due to an extension of agency staff due to vacancies in key posts, cost of pay award not funded and a slight reduction in variable income
	Agency	• **Agency expenditure is 4.24%** of the total pay budget, compared to the agency cap of £3.7% , a **variance of 0.54% which equates to £0.9m.** • Three of the care groups are above cap levels: Medicine 8.12%, CCS 4.19% & W & C 7.57%	• The Trust is forecasting to be below the 3.7% cap in the second part of the year overall. Although reducing, medical agency is forecast to remain above the cap all year.
	Financial Improvement	• The Financial improvement target is 5.5% which equates to £30.4m • 30% of plan phased in as at month 6 with 39% achieved – an **overachievement of £2.7m to month 6.**	• A full year value of £16.4m recurrent savings realised to month 6, £24.8m in year. • Roadmap of £42.6m to support £30.4m CIP plus £20.4m stretch
	Cash	• The trust holds a cash balance of £5.3m at the end of September 2023. • The value of cash held reduced in line with the deficit and the payment in month of the medical and dental pay award	• Cash will require to be topped up with revenue support in the form of Public Dividend Capital with effect from month 8 onwards.
	Capital	• Expenditure at Month 6 is slightly below profile.	• Ongoing efforts continue with the capital team in estates and facilities to ensure major refurbishments and new builds are progressing to plan and accruals for works undertaken but not yet invoiced are included.

Executive Summary – Operational Delivery

URGENT CARE

There remains a significant amount of focus on delivery of actions to make sustainable improvements to the urgent / emergency care metrics. Performance is considerably more challenged on the RLI site which is subject to specific and targeted actions. The Whole System Flow programme will also provide much needed to support to address some of the historical challenges that have faced our urgent care system.

Emergency Department (ED) 4-Hour performance – remains in common cause variation, overall performance including the Morecambe UTC was slightly under the national target of 76%. As in previous months the underperformance is driven by the RLI site with performance in month at 58.9%.

ED 12-hour performance – remains in common cause variation with overall delivery of 5.3% against a target of 2%. As with the 4-hour performance target there remains significant variation across the sites with almost 1:10 patients at RLI breaching this standard whilst 1;3 breach at FGH. Ensuring there is good patient flow within the hospital is a critical success factor of this standard which is why the actions not only identify improvements in assessment and streaming but equally focus on discharge.

Ambulance Handovers – performance overall is in special cause improvement driven largely by improvement a FGH which was at 77.8% in September. Performance at RLI remains is common cause variation at 68.3%

Not Meeting Criteria to Reside (NMC2R) – is included within the urgent care section of the OPR due to its impact on urgent care performance. As a Trust we remain a significant outlier at 19% against a target of 5%. We continue to seek to work collaboratively with system partners in resolving the barriers to support timely discharge.

The committee are reminded that as from the 25th September in line with national guidance, reporting against this metric is changing to include those patients who are not therapy fit, this will further increase our reported numbers and %.

CANCER

Another reminder to the committee is the change to the National Cancer Waiting Time Standards which took place on the 1st October 2023. The Board will see the change to reporting in the December meeting.

There are now 3 Consolidated targets :

- 28 day to Diagnosis (FDS) : Target 75%
- 31 Day Diagnosis to Treatment : Target 96%
- 62 Day Referral to Treatment : Target 85%

2ww & 62-day – the targets remain in common cause variation, there has been a slip in performance in month meaning that the standards weren't achieved for September. Details of the actions being taken are within the pack.

Executive Summary – Operational Delivery - 2

31-day diagnosis to treatment – the target was not achieved in September. Performance across the tumour groups for this standard is generally good. Only 4 tumour groups failed the standard with lower GI and breast narrowly missing the target. The challenge is within the skin service where performance was at 48%, there are a number of targeted actions identified in the pack that will improve this performance.

Cancer 62-day screening – continues to be highlighted as being expected to consistently fail – detailed pathway management and the specific backlog improvement work within breast screening is starting to see improvements against this target.

Cancer 28-day faster diagnosis – whilst performance for the above metrics is disappointing the trust consistently achieves the 28-day FDS target.

ELECTIVE CARE

Elective Care RTT (Referral to Treatment) – is in special cause for concern and is predicted to consistently fail the target. Improvement in and delivery of this target will not substantially improve until the longest waiters have been treated. Despite this performance we continue to perform well compared to peers and nationally.
65, and 52 week waiters are all continuing to demonstrate special cause improvement.

Total wait list size, New backlog & IRD performance – are all in special cause concern. We continue to focus on validation of our waiting lists and booking the front end of the pathway in a timely way; we are performing well against the national ask which set an ambition that all patients who will have waited 65 weeks by the 31/3/24 will have been offered their first appointment by 31st October 2023 – there were 31 patients that we were unable to find capacity for in October which equates to only 0.15% of the total patients waiting for their first OP appointment.

Patients waiting for a follow up appointment beyond their review date remains an issue and has increased as we have prioritised capacity for new, cancer and long waiting patients against a backdrop of industrial action. Our outpatient improvement programme will give this additional attention with priority workstreams focussed on referral optimisation, pathways aligned to GIRFT and increasing the use of patient initiated follow up.

Diagnostic 6-week - continues to demonstrate special cause improvement. Whilst non obstetric ultrasound performance continues to underperform at 10.48% in month, the actions described in last month's report have made a very positive impact and the latest performance as of end of October is demonstrating performance at 1.7%.
On another positive note endoscopy performance is reporting no patients waiting over 6 weeks which is the best performance since 2017.

NHS
University Hospitals of Morecambe Bay
NHS Foundation Trust

QUALITY & SAFETY

Scorecard

CQC Domain: Safe

Metric	Target	Actual	Variation	Assurance
Patient Safety Incidents per 1KBDs	N/A	88.0		
StEIS Incidents by StEIS Date	0	10		
Never Events	N/A	0		
Moderate and Above Harm Patient Safety Incidents	N/A	25		
Inpatient Falls (with Moderate & Above Harm) per 1000 Bed Days	0.1	0.2		
Inpatient Category 2, 3 & 4 Pressure Ulcers (Developed) Per 1000 Bed Days	1.5	1.9		
Patient Safety Alerts	N/A	2		
Infection Prevention - MRSA (HOHA & COHA)	0	0		
Infection Prevention - MSSA (HOHA & COHA)	3	5		
Infection Prevention - GNBSI (HOHA & COHA)	11	12		
Infection Prevention - CDiff (HOHA & COHA)	7	6		

CQC Domain: Caring

Metric	Target	Actual	Variation	Assurance
FFT A&E - % Rating the Service as Good or Very Good	84.00%	81.86%		
FFT Inpatients - % Rating the Service as Good or Very Good	94.00%	90.36%		
FFT Outpatients - % Rating the Service as Good or Very Good	94.00%	94.83%		
FFT Trust Overall (inc ED,OP & IP) - % Rating the Service as Good or Very Good	94.00%	91.90%		
Complaints per 1000 Bed Days	0.4	1.9		
Mixed Sex Accommodation Breaches	0	8		

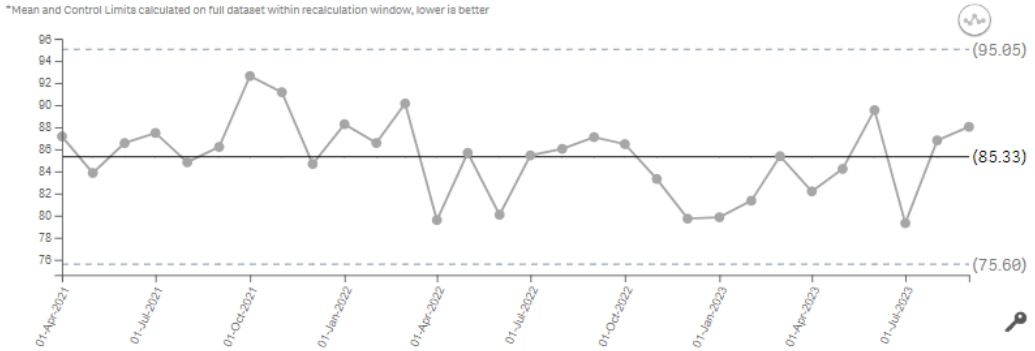
CQC Domain: Effective

Metric	Target	Actual	Variation	Assurance
VTE Assessment	95.00%	87.69%		

Patient Safety

Patient Safety Incidents per 1000 Bed Days

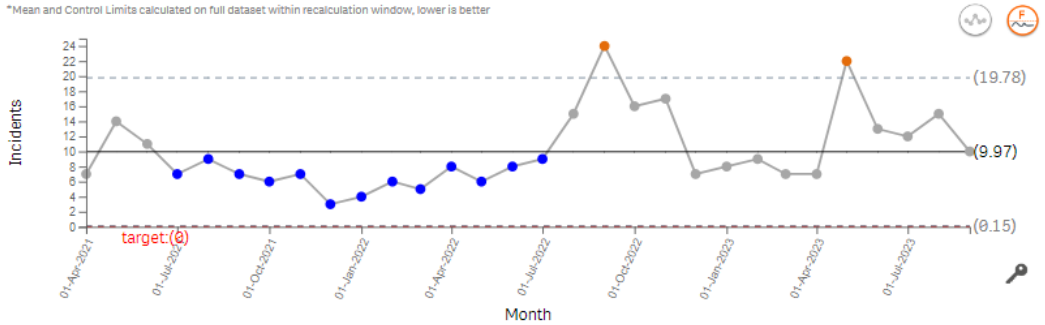
*Mean and Control Limits calculated on full dataset within recalculation window, lower is better



Latest
88.04
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A
DQ Indicators
S T P

StEIS Incidents by Month Reported to ICB

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

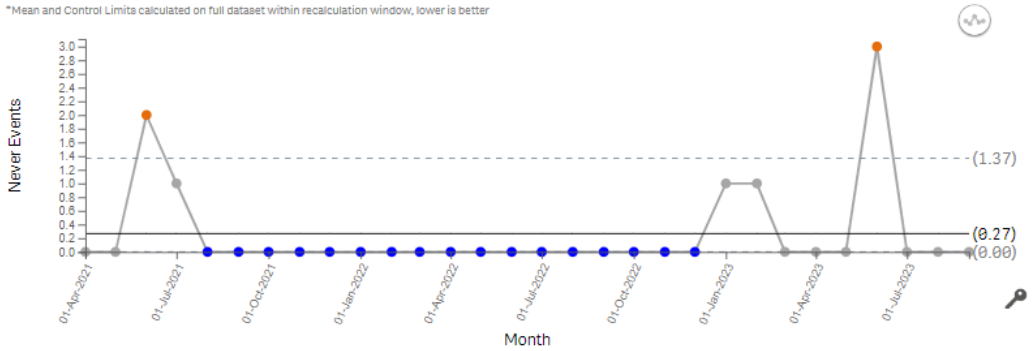


Latest
10
Variance Type
Common cause variation
Target
0
Target Achievement
The system is expected to consistently fail the target
DQ Indicators
S T P

Target under review with ICB colleagues

Never Events

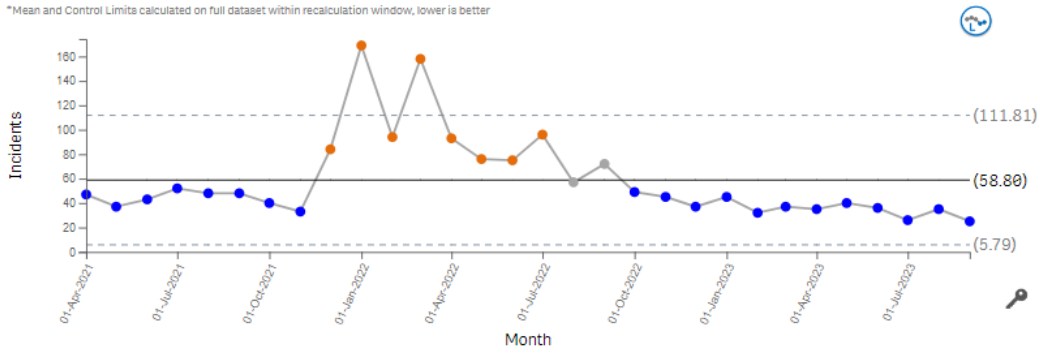
*Mean and Control Limits calculated on full dataset within recalculation window, lower is better



Latest
0
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A
DQ Indicators
S T P

Moderate and Above Harm Patient Safety Incidents

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



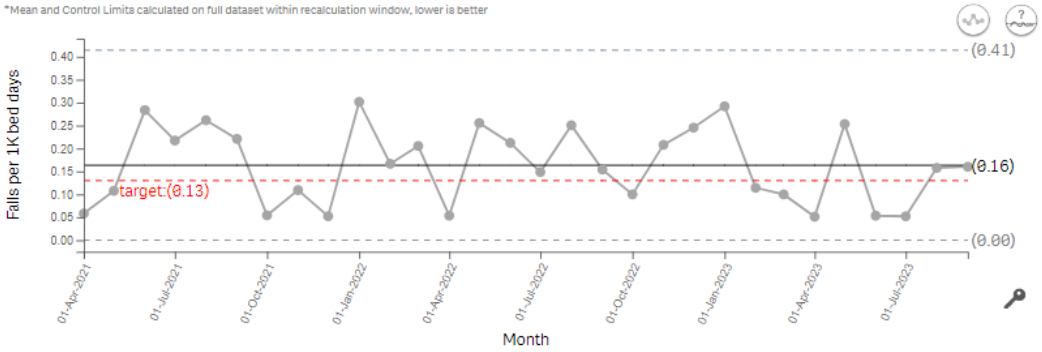
Latest
25
Variance Type
Special cause variation - improvement...
Target
N/A
Target Achievement
N/A
DQ Indicators
S T P

Metric	Summary	Actions	Assurance
Patient Safety Incidents per 1KBDs	-	-	-
StEIS Incidents by StEIS Date	10 incidents reported. 4 in Surgery and Critical Care, 4 in the Medicine Care Group, 1 in Women and Children's and 1 in Core Clinical Services. There were no noticeable themes identified in this month's data	-	The Trust continues to report a high volume of incidents which demonstrates a healthy reporting culture. The launch of PSIRF is going smoothly with teams navigating the processes together to maximise learning and patient/carer involvement.
Never Events	No Never Events reported Sept 23. 1 in Oct 23 in theatre at WGH. Reacted to incorrect screws being selected. No patient harm.	Significant focus on the 5th never event in theatres in 2023. Significant learning for the teams across the bay in relation to adherence to checklists, Locsips etc. Also working with the company to address the labelling - very little difference in the packaging.	-
Patient Safety Incidents: Moderate & Above Harm	In September, 25 moderate or above patient safety incidents were reported. Ten in the category off 'Clinical Assessment and Treatment' six related to Infection Prevention and Control incidents	-	-

Patient Safety

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

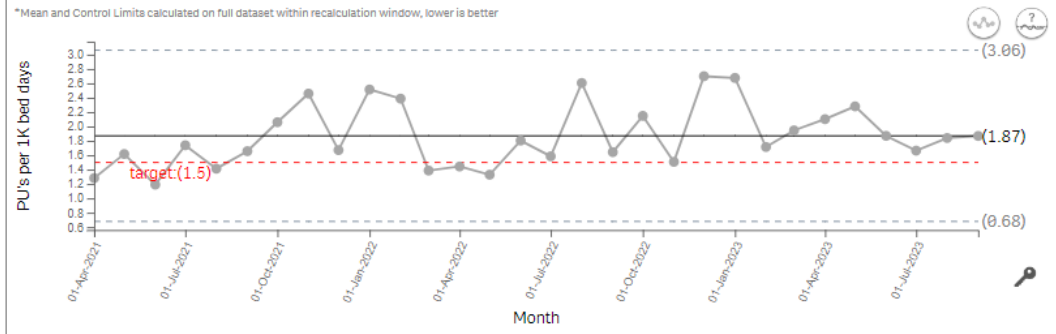
*Mean and Control Limits calculated on full dataset within recalculation window, lower is better



Latest
0.16
Variance Type
Common cause variation
Target
0.13
Target Achievement
The system may achieve or fail the target subject to random variation
DQ Indicators
S T P

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

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

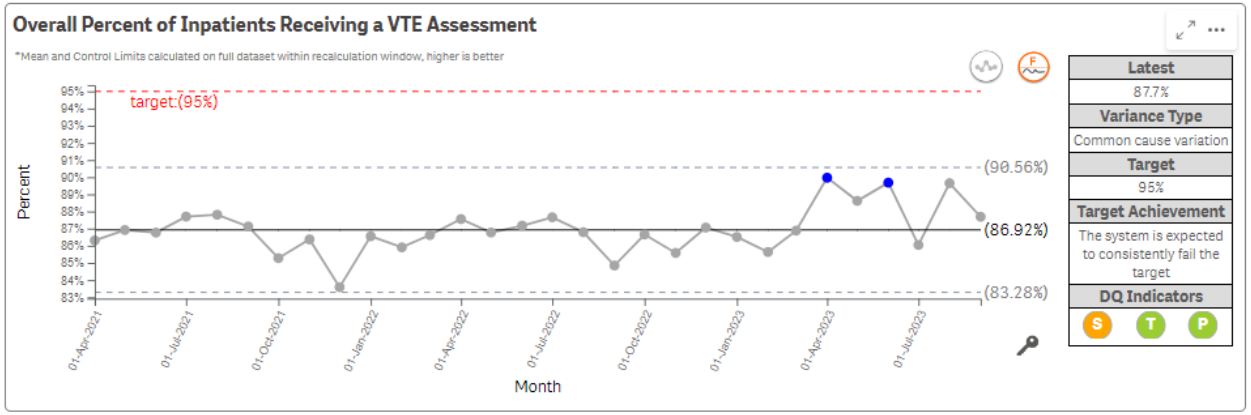


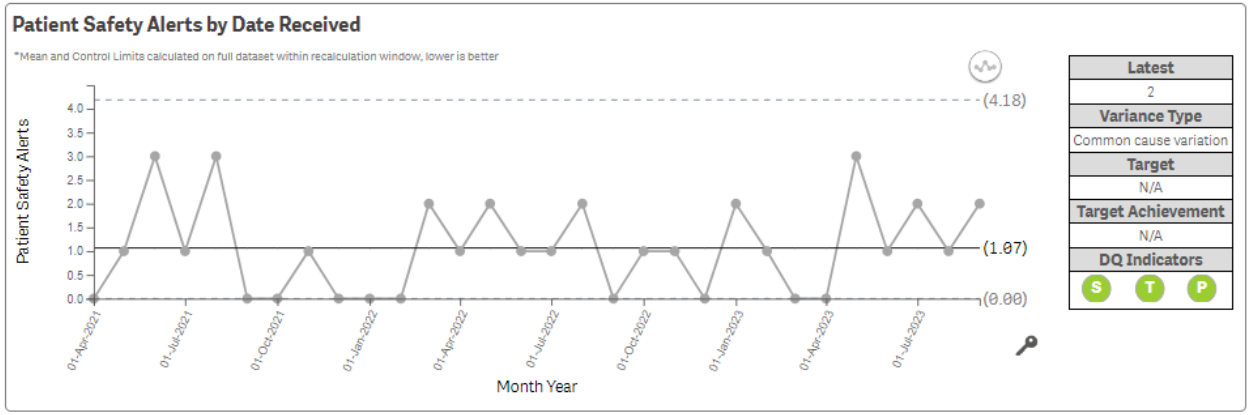
Latest
1.9
Variance Type
Common cause variation
Target
1.5
Target Achievement
The system may achieve or fail the target subject to random variation
DQ Indicators
S T P

Inpatient methodology: excluding PU incidents acquired in the community and non UHMB incidents | Target is local stretched improvement target

Metric	Summary	Actions	Assurance
IP Falls (Mod & Above Harm) P1KBD	136 slips, trips and falls reported. 3 resulting in moderate harm. 66/136 incidents reported were due to recurrent fallers. 1 dislocated hip where the patient had capacity and no lapses in care identified. 2 fractured necks of femur where the patient lacked capacity. No evidence of lying and standing BP or Mental Capacity Assessment in a patient with fluctuating capacity	Falls improvement group focusing on lying and standing BP recording and documentation. Continued focussed work with Fundamentals of Care Team regarding "deconditioning." Monitoring those patients who do not meet the criteria to reside	Falls with harm which are deemed avoidable with lapses in care/ lack of evidence of appropriate interventions, continue to be discussed at Harm Free Care Meeting to share lessons learned. Care group level thematic reviews reported to Learning response Group
IP Cat 2,3,4 Pressure Ulcers (Dev) P1KBD	53 reported category 2 pressure Ulcers (inpatients). Which is consistent. No category 3 reported. Work in progress to split the incidents into avoidable/unavoidable without having to do a manual trawl. The plan is that this will be reflected in the IPR from Q4	The oversite of category 2 pressure ulcers remains, through the Harm free care group. Agreed at Harm free care following quarterly thematic reviews to focus on pressure relieving interventions for those patient's sat out of bed. To always ensure access to pressure relieving equipment work is underway to create a central store	The Purpose T risk assessment tool generates a care plan that will support the intervention and prevention. Achievement of the Pressure Ulcer CQUIN picks up the completion of Purpose T assessment and associated interventions required. Compliance with the CQUIN is improving. The introduction of the revised electronic Care Plan will further. improve compliance. Care group level thematic reviews reported to Learning response Group

Patient Safety



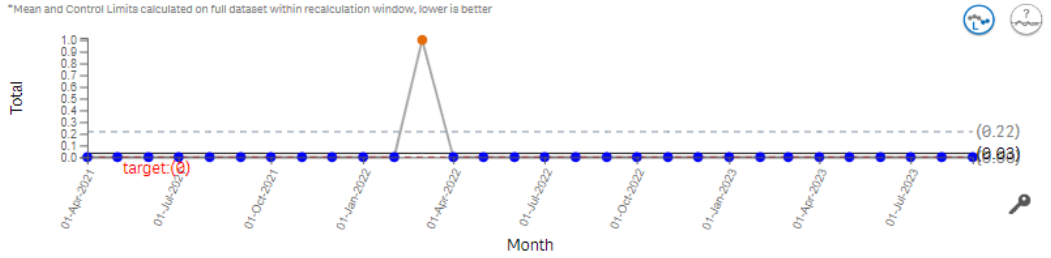


Metric	Summary	Actions	Assurance
VTE Assessment	VTE risk assessment overall 87.7% (89.6%) Surgery 80.4%. Medicine 95.6% WACS 83.7%	Day case low compliance has been highlighted in previous reports. Snapshot audit showed most of the missed VTE assessments were in patients who had a GA. Work ongoing to deal with the LA exclusion criteria. Gynae IP - VTE lead liaising with CD for gynaecology. Snapshot audit showed GAU/EPAU has low compliance. EPAU nurse not able to undertake assessments as a Registered Nurse.	Meeting with BI analyst and option to exclude immobilisation from LA exception criteria discussed. Has been presented and discussed at clinical leads meeting. Several suggestions have been made including removing LA criteria and making POA more robust to capture all requiring VTE assessment. Consider the role of non-medical prescribers in VTE assessment and prescribing
Patient Safety Alerts	-	-	Two issued: NatPSA/2023/012/DHSC - Shortage of verteporfin 15mg powder for solution for injection (Fully Compliant). NatPSA/2023/011/DHSC - Shortage of methylphenidate prolonged-release capsules and tablets, lisdexamfetamine capsules, and guanfacine prolonged-release tablets (Fully Compliant)

Infection Prevention

Infection Prevention - MRSA (HOHA & COHA)

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

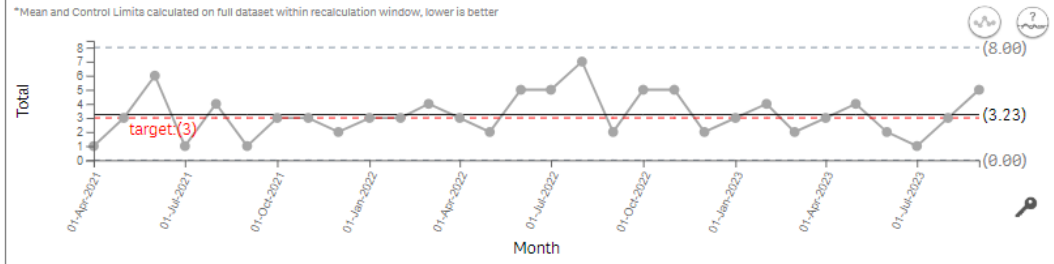


Latest
0
Variance Type
Special cause variation - improvement...
Target
0
Target Achievement
The system may achieve or fail the target subject to random variation

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

Infection Prevention - MSSA (HOHA & COHA)

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

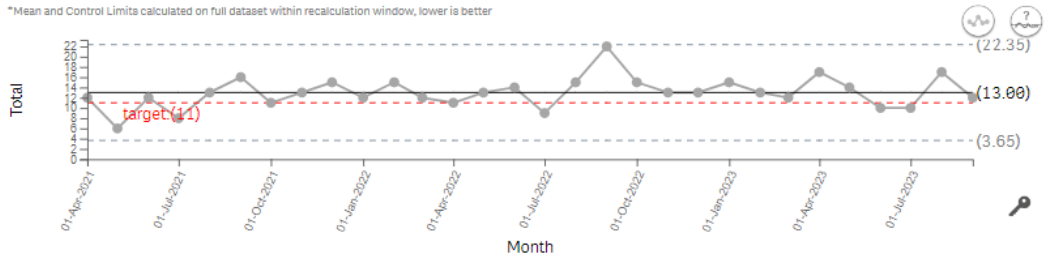


Latest
5
Variance Type
Common cause variation
Target
3
Target Achievement
The system may achieve or fail the target subject to random variation
DQ Indicators

Infections are Hospital Onset Healthcare Aquired & Community Onset Healthcare Aquired | Target is stretched improvement target

Infection Prevention - GNBSI (HOHA & COHA)

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

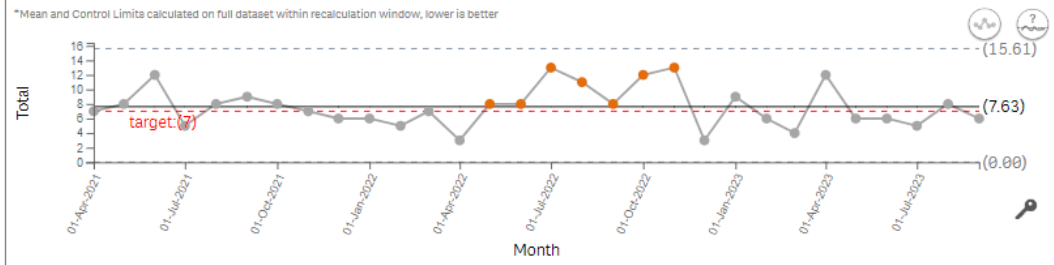


Latest
12
Variance Type
Common cause variation
Target
11
Target Achievement
The system may achieve or fail the target subject to random variation
DQ Indicators

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

Infection Prevention - CDiff (HOHA & COHA)

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



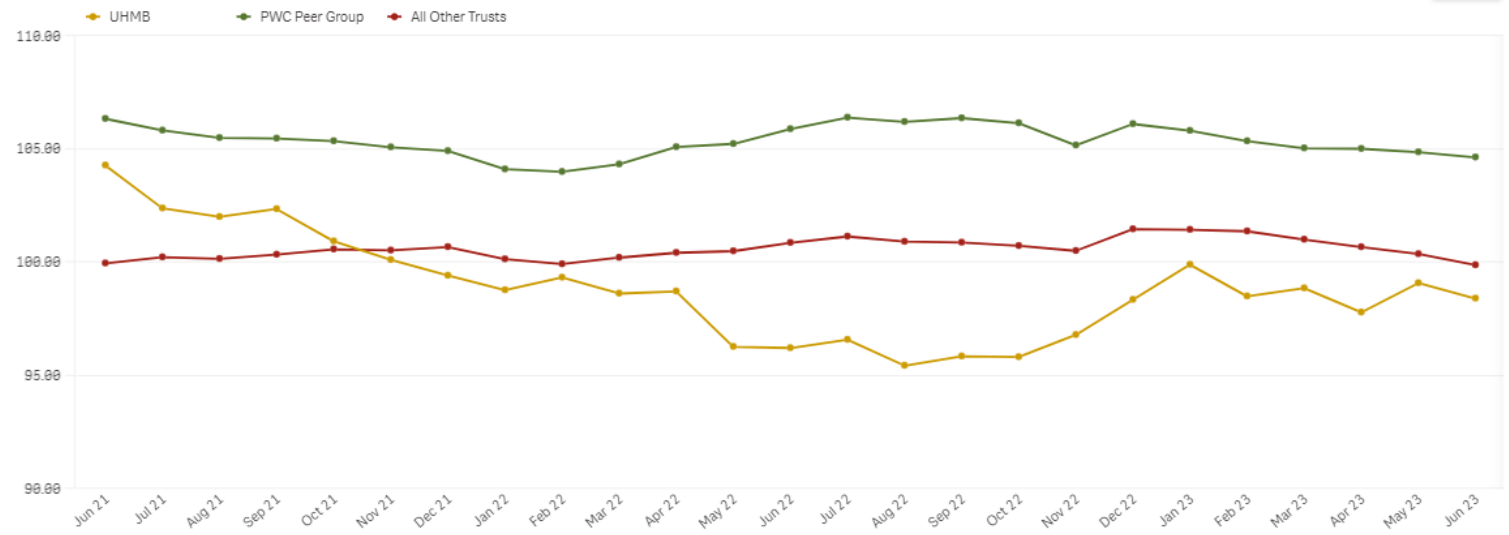
Latest
6
Variance Type
Common cause variation
Target
7
Target Achievement
The system may achieve or fail the target subject to random variation
DQ Indicators

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

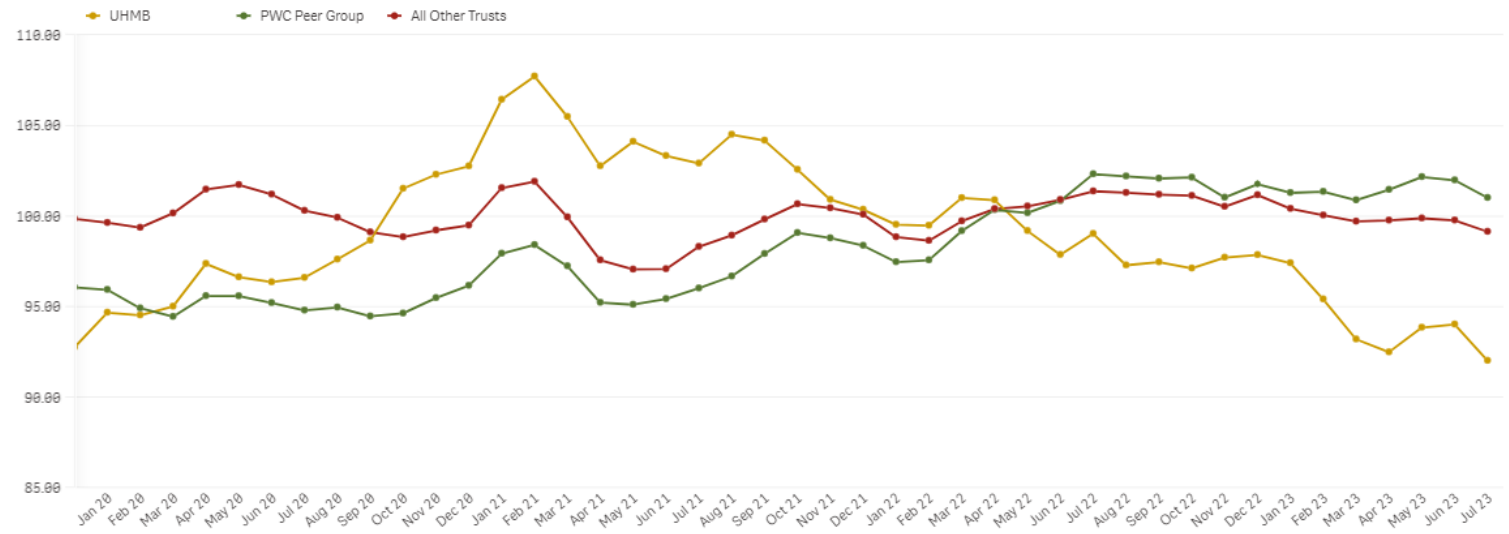
Metric	Summary	Actions	Assurance
Infection Prevention - CDiff (HOHA & COHA)	There were three periods of increased incidence (PII) in September/October, two within medicine care group and one within surgery care group. Ribotyping was requested and all were different in each of the PII's which gives assurance there wasn't any cross transmission. CDI figures are currently 2 above threshold, however, last year in September we were 10 over threshold, so improved from then	Further Hexiprep training has taken place across the trust, with a focus on ED's and AMU's Further resources are now available on the IP intranet site for blood culture training	Engagement has been good for the prescriber review process for CDI cases on the wards. CDI working group to be relaunched to improve attendance
Infection Prevention - GNBSI (HOHA & COHA)	The NW report shows that UHMBT is neither a low or high outlier for MSSA BSI's or for GNBSI's	GNBSI now form part of the care group reports to IPCC. There is currently a review of decontamination products, with a focus on 'fogging' equipment. A HPV product has been demonstrated to the trust and is awaiting a business case	Where there is a noted increase of GNBSI's in an area then a review will be undertaken by the IP team
Infection Prevention - MRSA (HOHA & COHA)	-	-	-
Infection Prevention - MSSA (HOHA & COHA)	-	-	-

Mortality

SHMI - Rolling 12 Month Figures - latest data: June 2023



HSMR - Rolling 12 Month Figures - latest data: July 2023



Summary

UHMB has a sustained position of a green alert for SHMI.

HED latest rolling 12-month position for SHMI is 98.41 (July 2022-June 2023).

SHMI, consistently been below 100 (since November 2021) and remains lower than PWC peer group and when compared with other Trusts. HSMR has also sustained its green alert and is 92.03 (previous 12 months was 93.66). UHMB (yellow) has shown a declining position since July 2022.

There is 1 red alerting group in SHMI: Acute Cerebrovascular disease (ACVD) SHMI-red ; HSMR amber.

UHMB SHMI score has seen a significant increase from August 2022. There has been a slight decrease in June 2023 to 98.41. We have observed 139 deaths in hospital or within 30 days of discharge against 111.03 expected.

Actions

ACVD (red) - the QA lead for Mortality and Morbidity has reviewed the139 cases - 89/123 -72% had a mortality review – 14 cases were in community and ICC group have undertaken MRs with no concerns.

Data shared at the Mortality Steering Committee and with the stroke team.

2 cases were non-strokes.

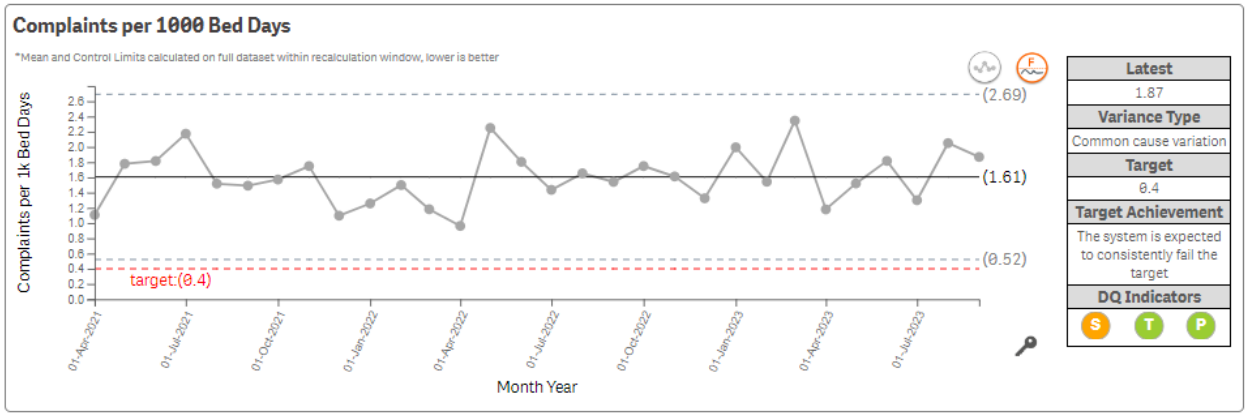
A thematic review of lessons learnt included poor documentation, poor discharge summary, delay in stroke specific diagnoses after CT/completion of NIHSS data /dysphasia, late/delay in DNAR discussions, lack of timely admission to stroke ward, better palliation and advice should have been sought from hospice and 2 areas of excellent practice in End-of-life care and excellent and timely review by stroke nurses.

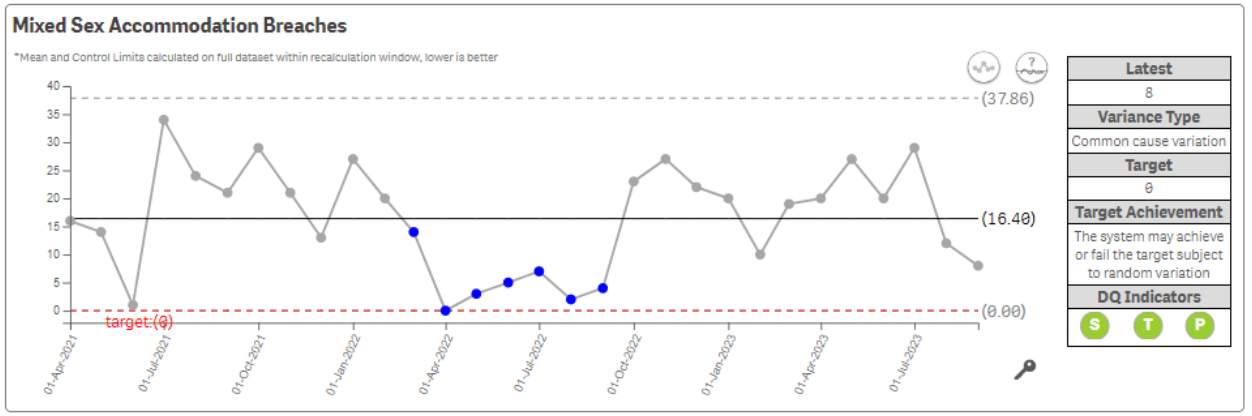
Assurance

Superficial Injury: contusion – the alert has reduced to an amber alert and hopefully in January will no longer be an alert.

The Stroke Mortality Review team and MEs are acutely aware of the red alert in acute Cerebrovascular disease and the MEs will refer to Mortality Reviewers for SJRs if they have any concerns in the delivery of care.

Patient Relations



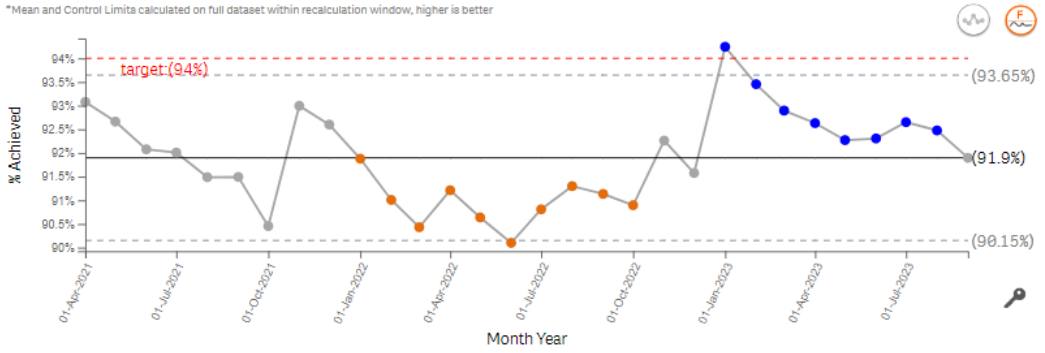


Metric	Summary	Actions	Assurance
Complaints P1KBD	129 open, 2 over 6 months (not revisits) and 6 revisits. All with plans for closure ASAP. The metric for complaints is no longer consider relevant and will require formal amendment	Need agreement to to bring online the revised metrics which will provide meaningful oversight	A review of gaps in staffing has been requested following Trust Board
Mixed Sex Accommodation Breaches	8 breaches related to delayed transfers to ward from ICU FGH. No RLI breaches reported which is an error due to an local change in process	-	Change in local practice at RLI ICU has been amended

Friends and Family

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

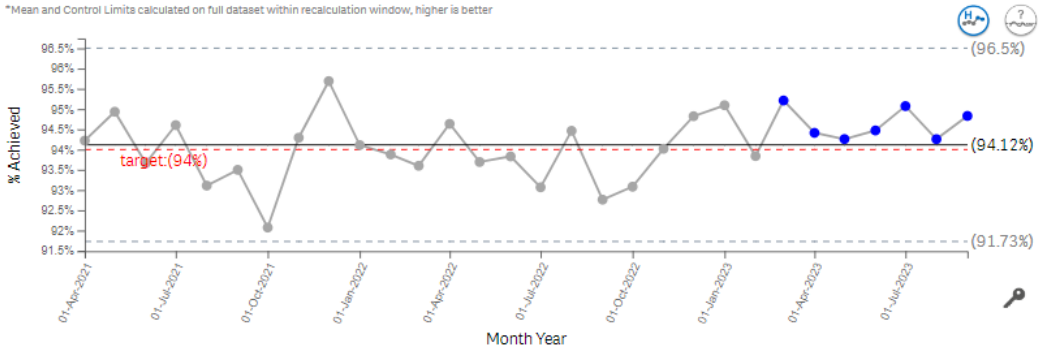
*Mean and Control Limits calculated on full dataset within recalculation window, higher is better



Latest
91.9%
Variance Type
Common cause variation
Target
94%
Target Achievement
The system is expected to consistently fail the target
DQ Indicators
S T P

Outpatients - % Rating the Service as Good or Very Good

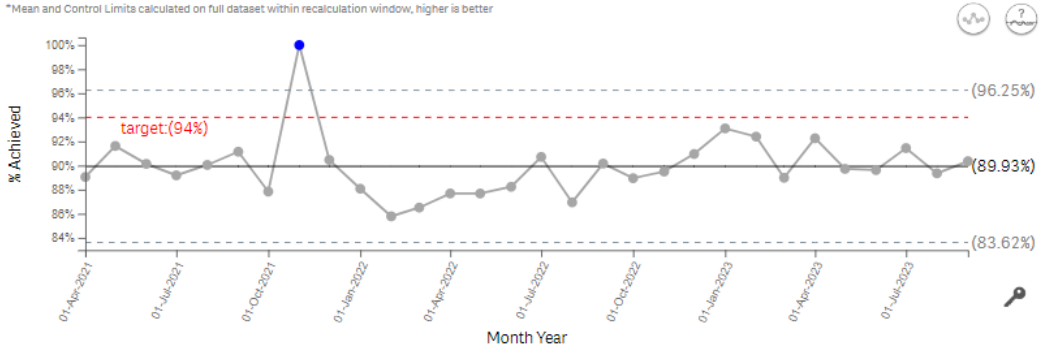
*Mean and Control Limits calculated on full dataset within recalculation window, higher is better



Latest
94.8%
Variance Type
Special cause variation - improvement...
Target
94%
Target Achievement
The system may achieve or fail the target subject to random variation
DQ Indicators
S T P

Inpatients - % Rating the Service as Good or Very Good

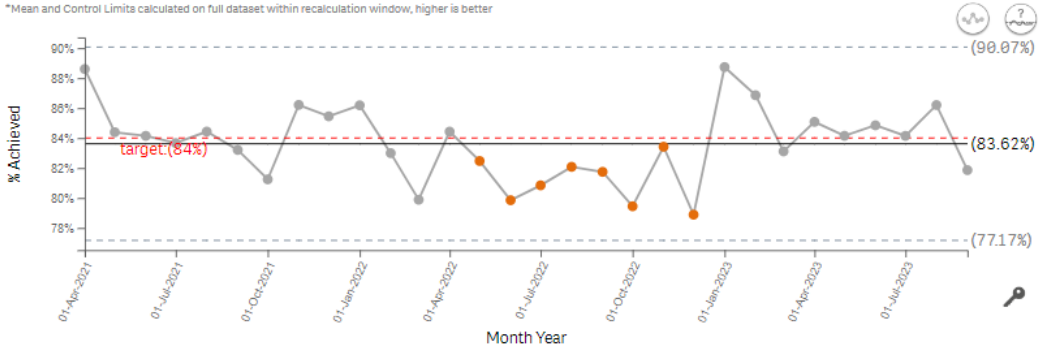
*Mean and Control Limits calculated on full dataset within recalculation window, higher is better



Latest
90.4%
Variance Type
Common cause variation
Target
94%
Target Achievement
The system may achieve or fail the target subject to random variation
DQ Indicators
S T P

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

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



Latest
81.9%
Variance Type
Common cause variation
Target
84%
Target Achievement
The system may achieve or fail the target subject to random variation
DQ Indicators
S T P

Metric	Summary	Actions	Assurance
FFT Trust Overall (ED,OP,IP) - % Good & Very Good	The overall survey response rate was 13%. 6729 responses overall. Of 3934 IP surveys sent only 850 responses were received. 92% of respondents rated the experience as positive. 4.24% of respondents rated their patient experience as poor or very poor 3.76% of respondents rated their experience as neither good nor poor or no rating provided	Current QI project to bring the FFT in house with aim in Q4 to - Decrease the reliance solely on text messaging Increase the opportunities to gather face to face/real time feedback while the patient is still in hospital Increase the opportunity to put things right (if necessary) following feedback, Provide more meaningful feedback to wards and depts, to allow them to focus improvements, celebrate positive feedback.	The Experience team have developed a rota utilising volunteers to collect FFT feedback face to face rather than just relying on text messages after discharge. The aim is to increase responses and more accurately assign satisfaction to a specific area.
FFT OP - % Good & Very Good	-	-	-
FFT IP - % Good & Very Good	-	-	-
FFT ED - % Good & Very Good	-	-	-

PEOPLE

Metric Scorecards by CQC Domain

CQC Domain: Well Led

Metric	Target	Actual	Variation	Assurance
ESR Absence FTE Data	5.00%	5.68%	L	?
ESR Vacancy FTE of filled posts	6.00%	4.08%	H	P
ESR Turnover FTE Data	8.00%	0.65%		P
Bank & Agency Fill Rate	75.00%	82.56%	H	?
Average time between vacancy creation and offer letter	50.0	41.2	H	P
Core Skills Framework	85.00%	93.69%	H	P
Appraisal Compliance	85.00%	82.14%	H	F

CQC Domain: Safe

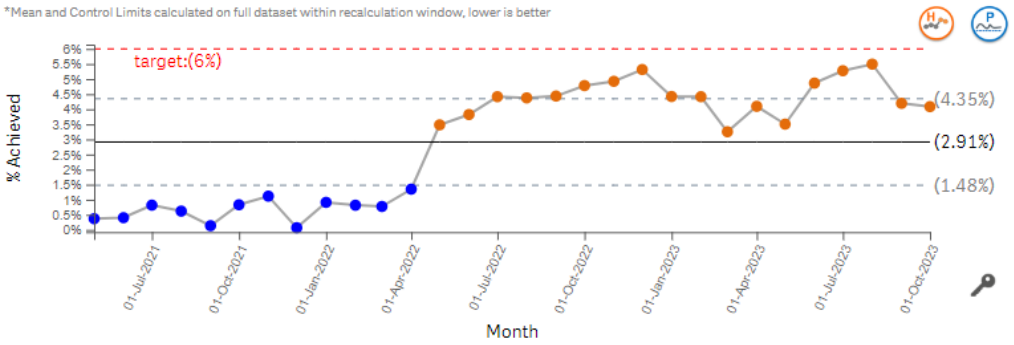
Metric	Target	Actual	Variation	Assurance
Registered Nurse Fill Rate	85.00%	93.65%	H	P

Workforce

People & OD: Recruitment

Vacancy Rate %

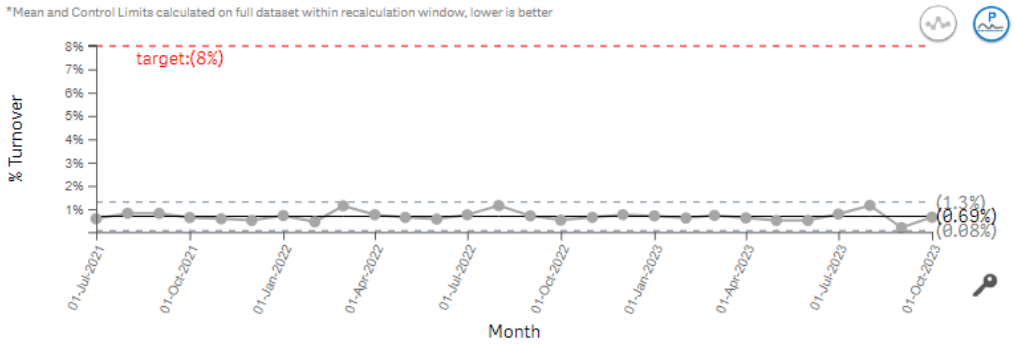
*Mean and Control Limits calculated on full dataset within recalculation window, lower is better



Latest
4.08%
Variance Type
Special cause variation - cause for concern...
Target
6%
Target Achievement
The system is expected to consistently pass the target
DQ Indicators
S T P

Turnover %

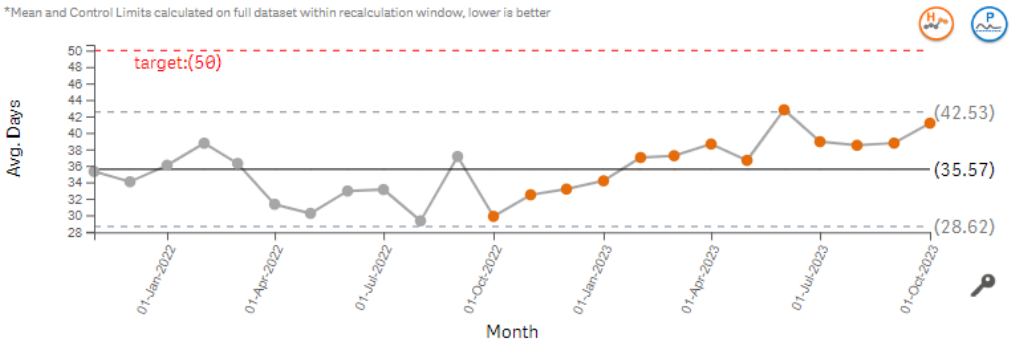
*Mean and Control Limits calculated on full dataset within recalculation window, lower is better



Latest
0.65%
Variance Type
Common cause variation
Target
8%
Target Achievement
The system is expected to consistently pass the target
DQ Indicators
S T P

Average time: vacancy creation to offer letter

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



Latest
41.2
Variance Type
Special cause variation - cause for concern...
Target
50
Target Achievement
The system is expected to consistently pass the target
DQ Indicators
S T P

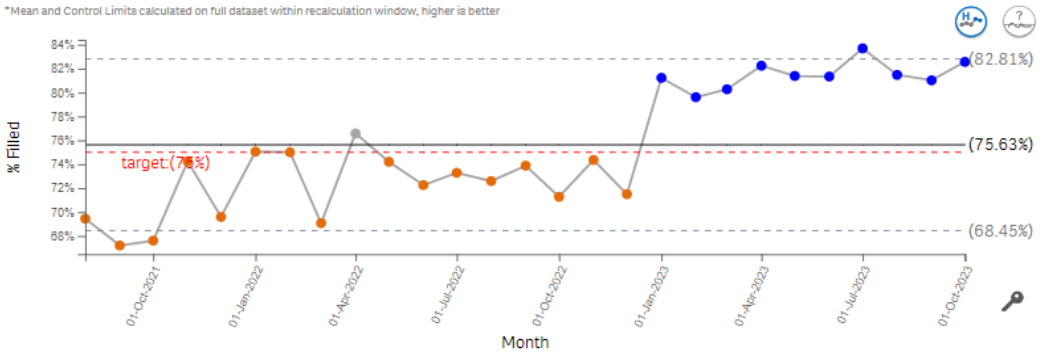
Metric	Summary	Actions	Assurance
Average time between vacancy creation and offer letter	A new financial incentives framework is in final draft. This will provide a clear framework for recruiting managers to work within to aid recruitment strategies for hard to fill posts, helping with attracting talent to UHMB.	Interviews are taking place for a Medical Workforce Operations Manager which will be a key appointment for the Medical Workforce team. Work continues to review the end-to-end recruitment journey, including more robust timelines in relation to shortlisting and securing dates for interview in a timely manner.	The recruitment review is on track. The next key phase will be the team attending on site to meet with each member of the recruitment team and testing of the process.
ESR Turnover FTE Data	Turnover has constantly remained lower than the national average, with both monthly and annual tu8rnover figures lower than forecast.	Care Group BP's continue to support Retention work based upon the NHS employers retention framework, which is having a positive impact within departments.	BPs completed NHS Employers Retention Framework training in October – actions will result and form part the refreshed strategy for Retention.
ESR Vacancy FTE of filled posts	Overall Trust WTE increased by 92 WTE, although overall vacancy position remains below target (4.08%) but still cause for concern in some areas. SAS vacancy has increased by 2%, now at 17.3%.	New Exit Guidance launching November which will help to understand what is driving our vacancy position..	BPs completed NHS Employers Retention Framework in Oct – actions will result and form part the refreshed strategy for Retention. Overall vacancy decreased by 1.41%

Workforce

People & OD: Fill Rates & Attendance

Bank & Agency Fill Rate

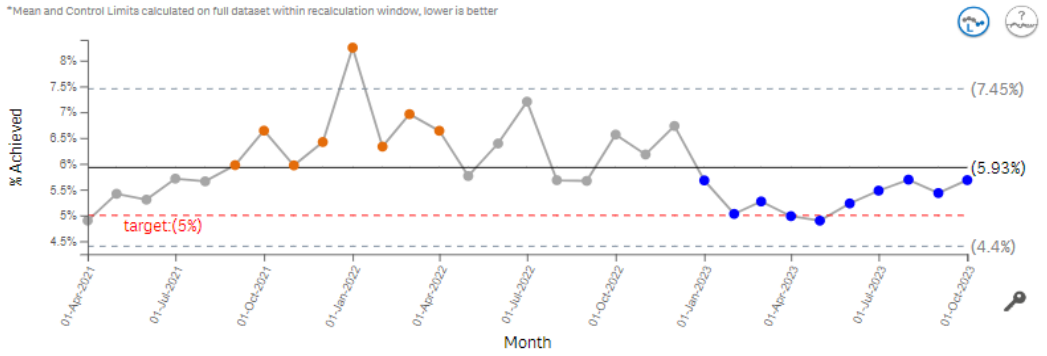
*Mean and Control Limits calculated on full dataset within recalculation window, higher is better



Latest
82.6%
Variance Type
Special cause variation - improvement...
Target
75%
Target Achievement
The system may achieve or fail the target subject to random variation
DQ Indicators
S T P

Absence FTE %

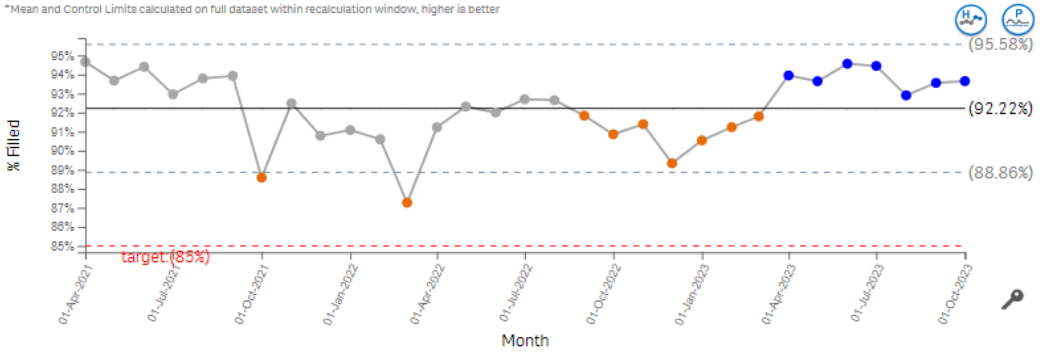
*Mean and Control Limits calculated on full dataset within recalculation window, lower is better



Latest
5.68%
Variance Type
Special cause variation - improvement...
Target
5%
Target Achievement
The system may achieve or fail the target subject to random variation
DQ Indicators
S T P

Registered Nurses Fill Rate

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



Latest
93.65%
Variance Type
Special cause variation - improvement...
Target
85%
Target Achievement
The system is expected to consistently pass the target
DQ Indicators
S T P

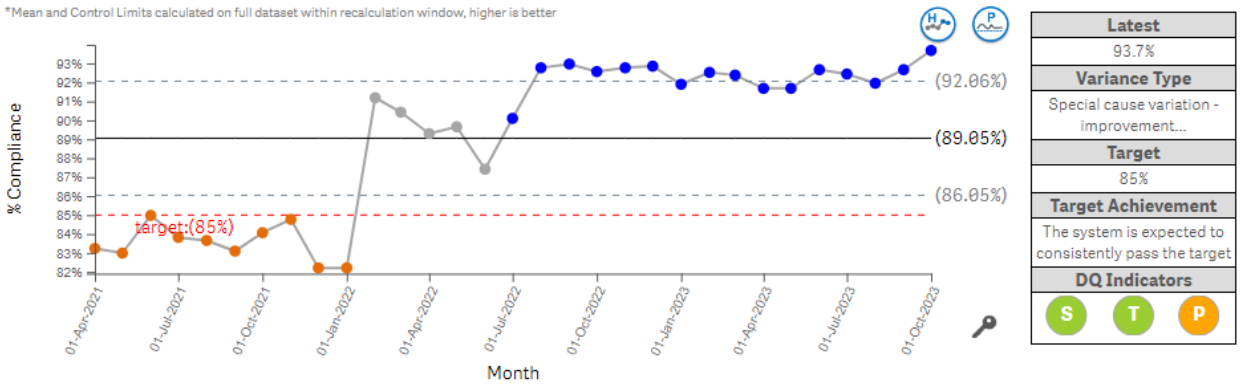
Metric	Summary	Actions	Assurance
ESR Absence FTE Data	Time lost due to total sickness continues to decline, although as we move into the Autumn months, we will start to see a seasonal variation in reasons for absence which results in cough, cold and flu seeing more days lost. This will see absence above trusts overall target of 5%, but below the agreed 6.5% winter target for period Nov 23 - Feb 24.	Care Groups have assurance meetings in place to review and monitor absences. MDT approach to all OH Consultant referrals to support a reduce waiting time. this has seen an improvement in waiting time to see the OHP and is helping reduce long term absence.	Absences attributed to MSK and mental health are showing an improving position. This will be monitored over the coming months including a review of any contributing factors. Infectious disease management effective to reduce spread of scabies amongst patients and staff after a breakout, prevent large absences from a department.
Bank & Agency Fill Rate	A safe staffing report is sent monthly to QA Committee which provides a detailed report on staffing "fill rates" (actual staffing levels match against planned) with nurse sensitive indicators and workforce metrics at a granular ward level. Nursing agency spending is the lowest it has ever been for UHMB. 14.09% of total demand hours were from bank and 0.38% from agency with 14.59% of filled hours from bank and 0.39% from agency.	Fill rates sign off meetings continue with all care groups to understand any ward level issues with fill. Check and balance meetings continue- a focus on bank shifts filled by elevated grades is underway and a benefits realisation report has been drafted to review the progress made since check and balance was introduced in February.	Only 1 department had an RN fill rate below 85%, which is vast improvement from 6 moths ago, 2 departments had CSW fill rates below 85%, again a significant improvement.
Registered Nurse Fill Rate	The nursing and midwifery vacancy rate has reduced again, along with a reduction in agency expenditure, this has not seen any impact upon Nursing fill rates which remains above trust target.	Bank/additional staffing and "red flags" data and other roster metrics will be reviewed, once accurate data sources have been accessed. This will then help to provide further assurance and have a positive impact upon fill rates.	Staff turnover and absence for nursing and midwifery was an improving picture, which has helped to maintain high fill rates on all wards, except 1 which did not meet the trust target.

Workforce

People & OD: Staff Development

Core Skills Framework

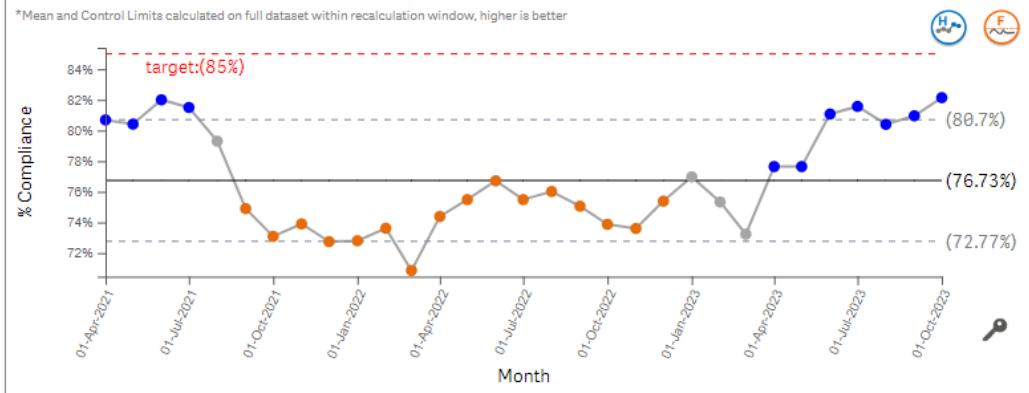
% of staff fully Compliant as start of month



Latest
93.7%
Variance Type
Special cause variation - improvement...
Target
85%
Target Achievement
The system is expected to consistently pass the target
DQ Indicators
S T P

Appraisal Compliance

% of staff compliant as start of month



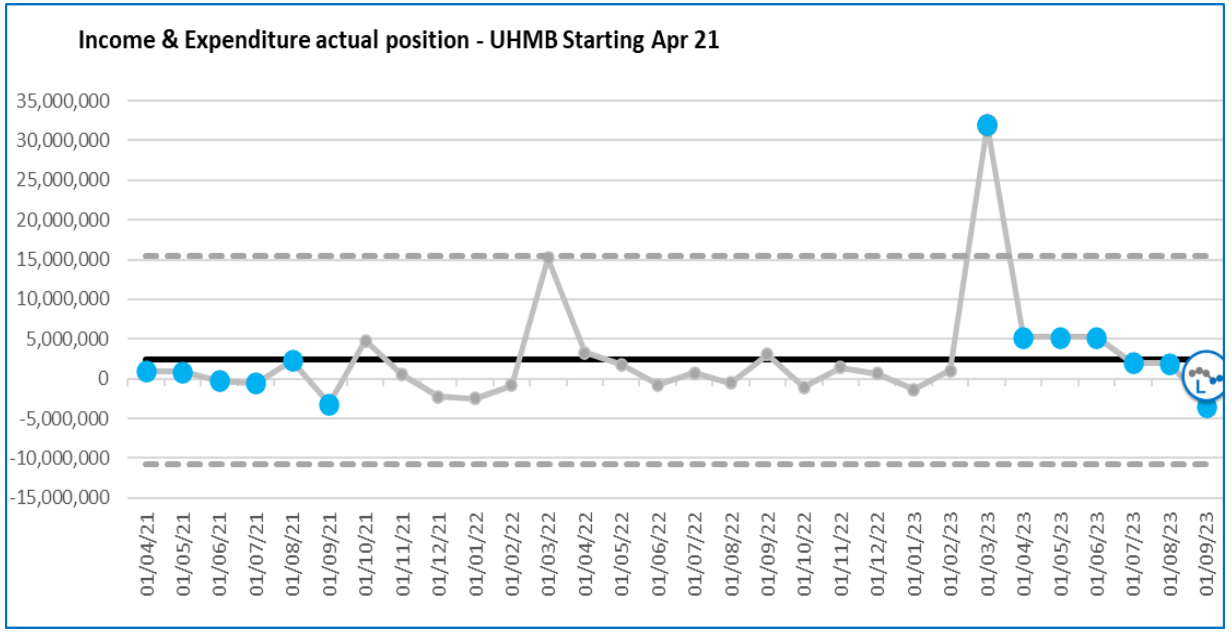
Latest
82.1%
Variance Type
Special cause variation - improvement...
Target
85%
Target Achievement
The system is expected to consistently fail the target
DQ Indicators
S T P

Metric	Summary	Actions	Assurance
Appraisal Compliance	Although improving, appraisal compliance figures continue to reflect that there is additional work to be done to win hearts and minds around the difference a good appraisal makes to a colleague experience, inclusion, growth and retention. The lack of leadership appraisals is the biggest concern. Leaders are responsible for supporting others and need to have their own quality appraisal	An appraisals hub has been launched. The new appraisal system makes the conversation and completion easier for colleagues and leaders and is live – receiving good feedback.	The appraisals refresh pilot landed very positively; feedback included: 'I've learnt to empower the staff that I manage and allow them to lead on their development' "'To use open honest and compassionate communication to get the best outcome from an appraisal', 'using smart objectives and active listening', 'To be using appreciative enquiry during appraisal and ensure positive AND constructive feedback is given'
Core Skills Framework	October data indicates there has been a 2% improvement overall due to work undertaken over the past two months. Manual handling (module F 2019) remains below the 85% target in 4 care groups. Advanced Life Support has decreased to 76.3%. Non-compliance sits with three areas: •Corporate 81.5% (5 staff) •Medicine 70.9% (55 staff) •Surgical 83% (18)	Advanced Life Support - Emails were sent out and colleagues responded promptly and positively. We believe that further data cleanse is needed as a brief investigation has highlighted names of GPs and STs wrongly included in data. There needs to be additional clarity around 'completion' as this appears to be an issue. Further investigation needed.	Overall, for combined core skills we are collectively reaching the 85% target. Manual handling (module F 2019) - activity to individuals to increase compliance has helped, further action to contact Deputy Chief Nurse and WACs planned to get course above 85%. Advanced Life Support – work will be done with Resus to see how training is completed and if extra sessions can be added to ensure staff are able to complete this training as it is essential for us to deliver outstand care.

FINANCIAL PERFORMANCE

Finance: Income & Expenditure (SoCI – Statement of Comprehensive Income)

Table 1 - Income & expenditure	Annual Plan £'000	In Month Variance £'000	Year To Date Plan £'000	Year To Date Actual £'000	Year To Date Variance £'000	Forecast Outturn Plan £'000	Forecast Outturn Actual £'000	Forecast Outturn Variance £'000
Income from Patient Activities	496,198	4,545	245,500	244,537	(963)	496,198	484,172	(12,026)
Other Income	31,708	(834)	16,528	17,920	1,392	31,708	34,648	2,941
Subtotal income	527,905	3,712	262,028	262,458	430	527,905	518,820	(9,085)
Pay	(363,760)	(2,021)	(183,615)	(194,789)	(11,174)	(363,760)	(390,557)	(26,797)
Non Pay	(176,947)	(2,526)	(91,251)	(82,006)	9,245	(176,947)	(161,841)	15,106
Subtotal Expenditure	(540,707)	(4,548)	(274,865)	(276,795)	(1,929)	(540,707)	(552,399)	(11,692)
Operating Total	(12,802)	(836)	(12,837)	(14,337)	(1,500)	(12,802)	(33,578)	(20,776)
Financing Costs	(5,819)	292	(2,910)	(1,964)	945	(5,819)	(3,812)	2,007
Operating Surplus / (deficit)	(18,621)	(544)	(15,747)	(16,302)	(555)	(18,621)	(37,391)	(18,770)
Donated Assets Adjustment	343	(14)	171	243	71	343	343	0
NHSE Monitored Surplus / (deficit)	(18,278)	(558)	(15,576)	(16,059)	(483)	(18,278)	(37,048)	(18,770)



Summary

- Table 1 summarises the financial position at Month 6, a deficit of **£16m** against a planned deficit of **£15.6m**. A variance to plan of **£0.4m** adverse.
- The current year end forecast risk assessment is a deficit of £37.05m, £18.77m adverse to plan.
- £6.8m of the stretch income target phased into the plan, with £4.4m of mitigations recognised
- £1.6m of additional costs associated with industrial action are included, with the loss of income estimated to be c£800k

Actions

- All care groups asked to have recovery plans for their top ten overspending cost centres on the WAVE system be the end of October
- In depth review of all forecasts carried out by the Director of Finance with care groups asked to produce robust action plans.
- On going monitoring is in place to account for the impact of industrial action of both income and expenditure

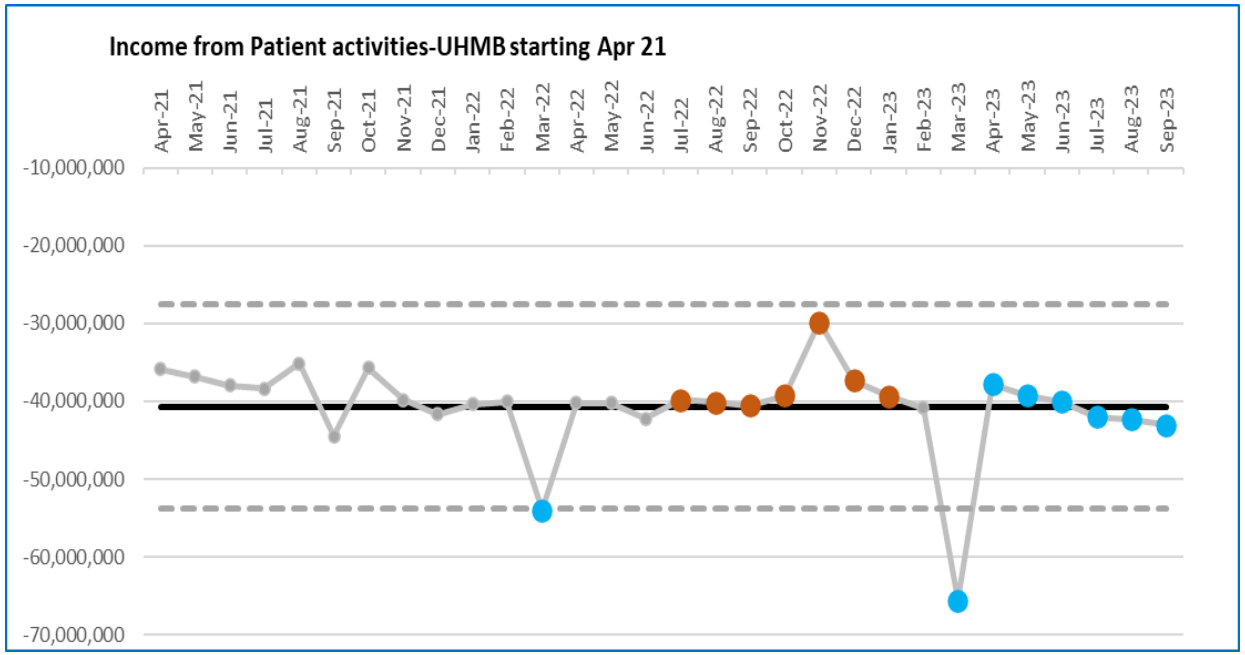
Assurance

- Oversight of progress will be carried out within the FIP calls with slippage on recovery actions escalated as appropriate
- New Finance metrics have been launched . With a weighted score applied

Performance & Accountability Framework Levels	
Outstanding	1
Good	2
Concerns requiring investigation	3
Immediate concerns	4
Material issue	5
Intensive support	6

- Additional senior financial support has been aligned to each care group with a PAF score higher than 3

Finance: Income run rate



2023/24	Annual Activity Plan	YTD Activity Plan	YTD Activity Actual	YTD Activity Variance	Annual £'000 Plan	YTD £'000 Plan	YTD £'000 Actual	YTD £'000 Variance
Variable								
Daycase & Elective	47,774	23,693	23,681	(12)	50,579	25,084	25,476	392
Outpatient Firsts	155,674	77,204	76,469	(735)	30,261	15,007	14,671	(336)
Outpatient Procedures	109,938	54,522	58,595	4,073	18,485	9,167	9,821	653
Other Variable	135,660	67,280	65,911	(1,369)	11,894	5,899	5,864	(35)
Variable High Cost Drugs & Devices	-	-	-	-	31,843	15,921	15,668	(254)
Total Variable Income	**449,046**	**222,699**	**224,656**	**1,957**	**143,061**	**71,079**	**71,499**	**420**
Fixed								
Accident & Emergency	135,241	69,036	69,063	27	25,775	13,158	13,448	290
Non Elective	50,869	25,300	24,869	(431)	116,702	58,042	55,960	(2,082)
Non Elective Excess Bed Days	24,887	12,377	10,567	(1,810)	7,749	3,854	3,277	(577)
Outpatient Follow ups	300,883	149,218	147,361	(1,857)	25,821	12,806	12,556	(249)
Other Fixed	4,649,093	2,305,781	2,420,146	114,365	141,815	74,541	78,205	3,664
Fixed High Cost Drugs & Devices	-	-	-	-	2,026	1,013	719	(295)
Adjustment to Fixed Value	-	-	-	-	-	-	(751)	(751)
Total Fixed Income	**5,160,973**	**2,561,712**	**2,672,006**	**110,294**	**319,889**	**163,414**	**163,414**	**0**
Other Patient Care Income					8,427	4,200	4,897	696
Other Income	-	-	-	-	8,841	4,421	4,727	306
Stretch Income Target	-	-	-	-	15,979	2,386	-	(2,386)
Total Clinical Income	5,610,019	2,784,411	2,896,662	112,251	496,198	245,500	244,537	(963)

Summary

Income from Patient Activities – includes all patient income contracts, ERF, CQUIN etc.

- The patient care income is paid under an aligned payment and incentive (API) contract in 2023/24. £140m of the contract will be paid on a variable basis, with payments increased where activity is above plan and reduced when below plan.
- The variable income for the Day case and Elective patient care in September was £291k below plan, and Outpatient activity was £69k under. These figures include the reduced activity resulting from the industrial action in month. Year to date variable activity is £670k above target due to increased activity in previous months. This has been partially offset by lower than anticipated cost and volume high-cost drugs and devices

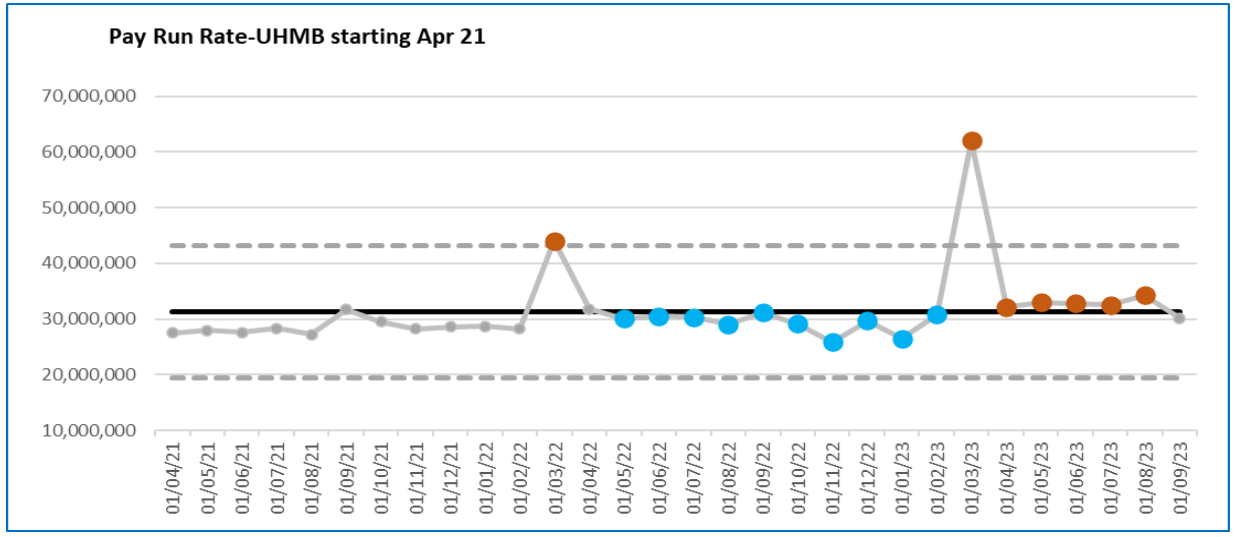
Actions

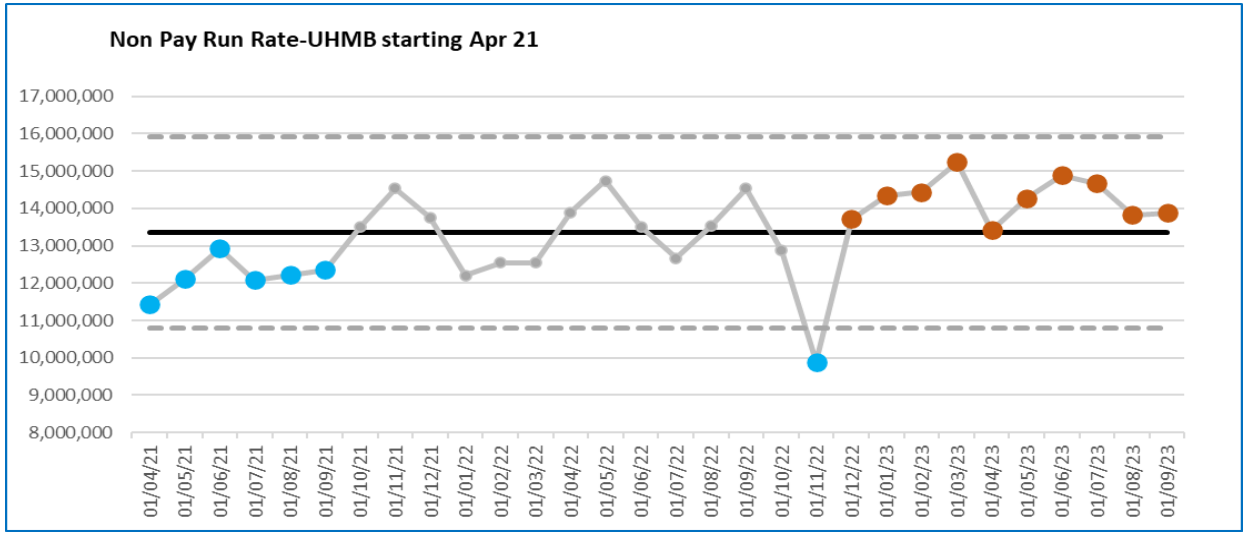
- Review of activity attracting elective recovery funding
- Continued Assessment & reconciliation of contract offer for 2023/24 with a focus on the constituent elements of the block contract.
- Partnerships work stream under SFIP to review and implement commercial and other income opportunities.
- Follow up review of non-clinical and non-NHS income sources to determine the location and reasons for the reducing balances.

Assurance

- Recent review of elective recovery fund associated activity and income provided assurance that internal assumptions are in line with NHSE.
- The model associated with the review has been validated against NHSE calculations and used to validate the 23/24 ERF potential.

Finance: Pay & Non-pay run rate





Summary

Pay run rate

- A4C pay award paid in month 3, fully funded with care groups.
- 6% Medical and Dental pay award paid in month, impact to month 5 recognised last month
- £2.2m of mitigations were released in to the position as set out in the roadmap.
- The spike in March run rate above includes 6.3% pension contribution and 22/23 non-consolidated pay award

Non-Pay run rate

- September costs remain static despite a drop seen in activity .

Actions

- The Pay Control Group established as part of the Sustainable Financial Improvement Programme (SFIP) commenced review of pay controls and non-clinical agency has been updated and presented to Trust Management Group for implementation
- Follow up review of WTE changes since 2019/20 to be completed which, whilst being good practice, also supports NHSE assurance requirements.
- Planning 23/24 -Triangulation between workforce WTE and finance £'s to ensure plans are congruent to delivering Trust priorities
- Enhanced control process now in place, for non patient facing roles and orders over £10,000.

Assurance

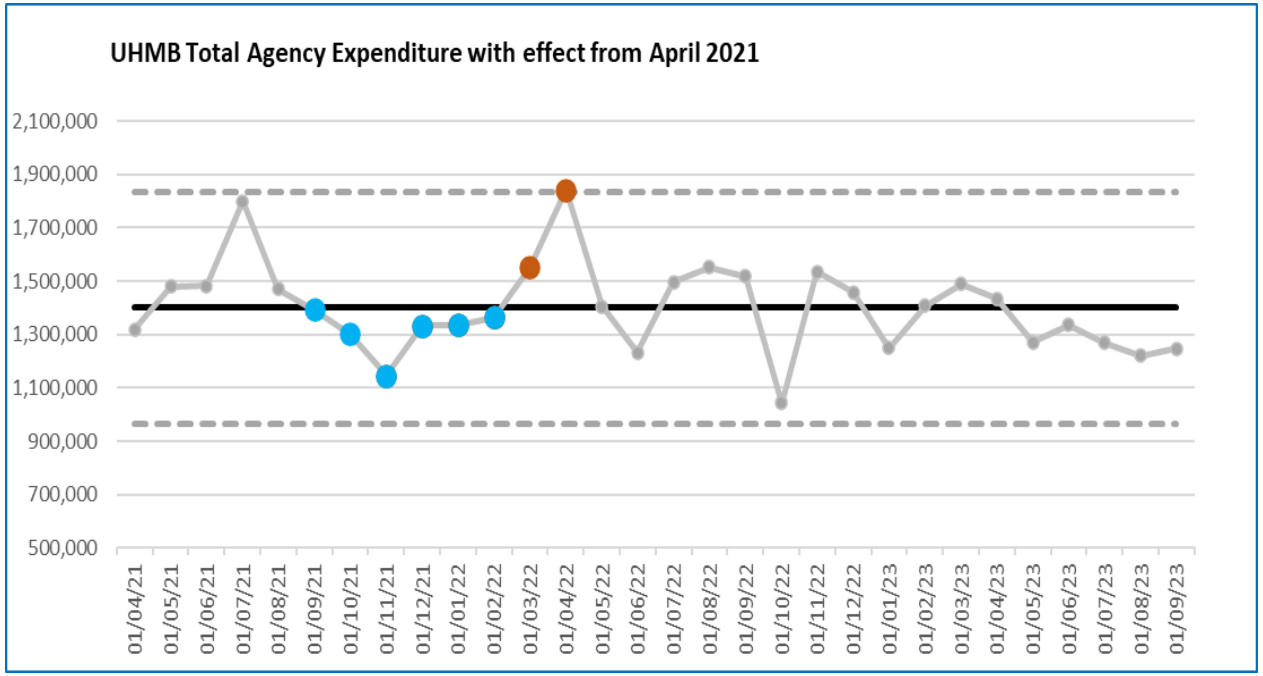
Current non-clinical agency posts in process have been approved by NHSE and include;

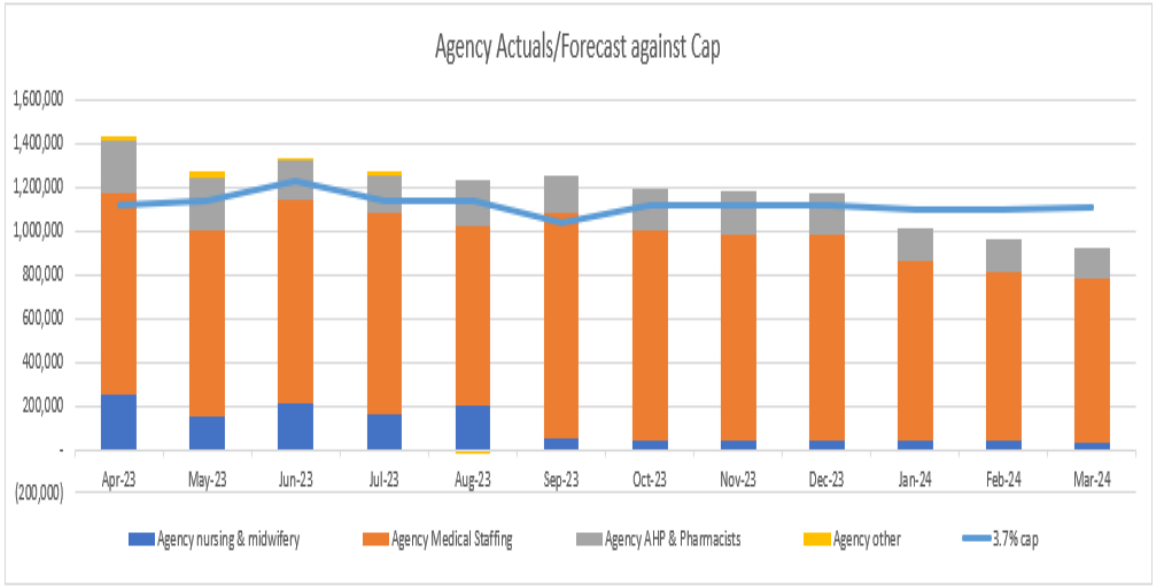
- Finance - Ledger implementation backfill
- I3 - ED clinical coder

Energy contract renewal in progress. Procurement team spot checking daily prices.

Additional senior finance support offered to those care groups with the largest deficit

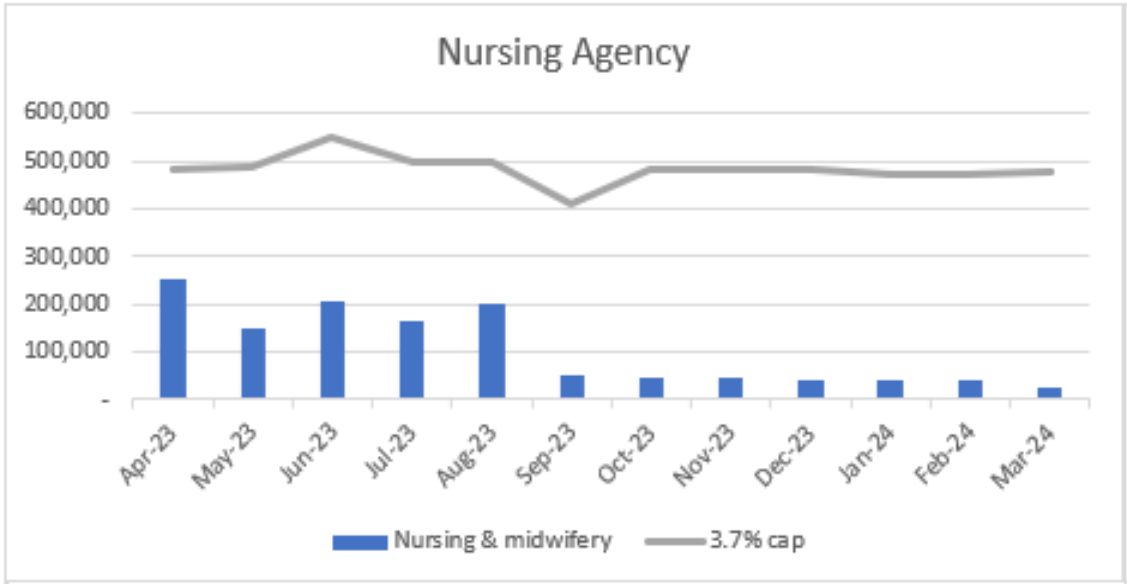
Finance: Agency expenditure – run rate & performance against cap

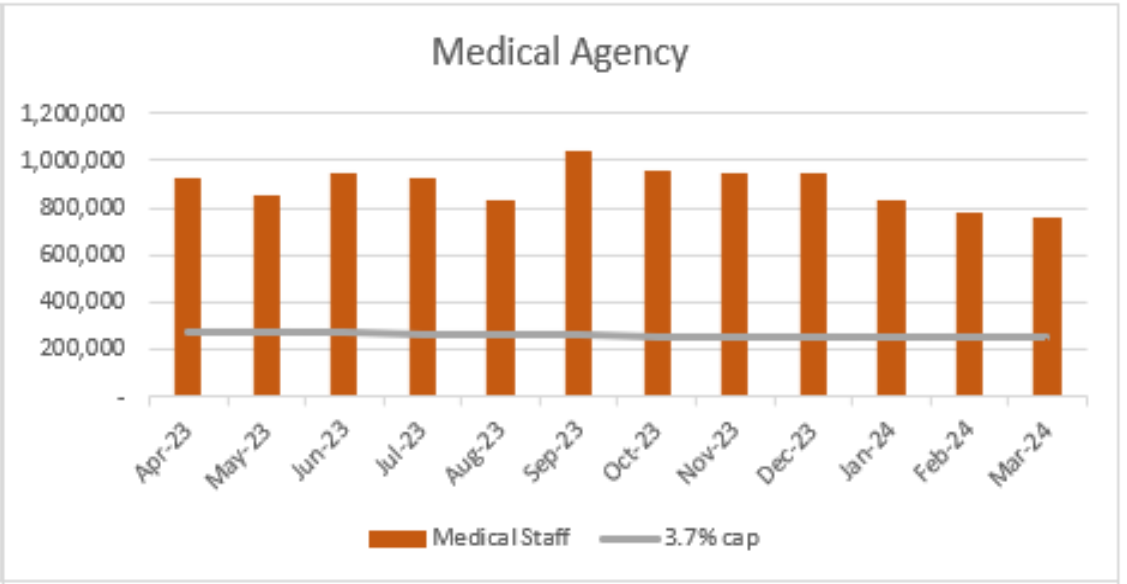


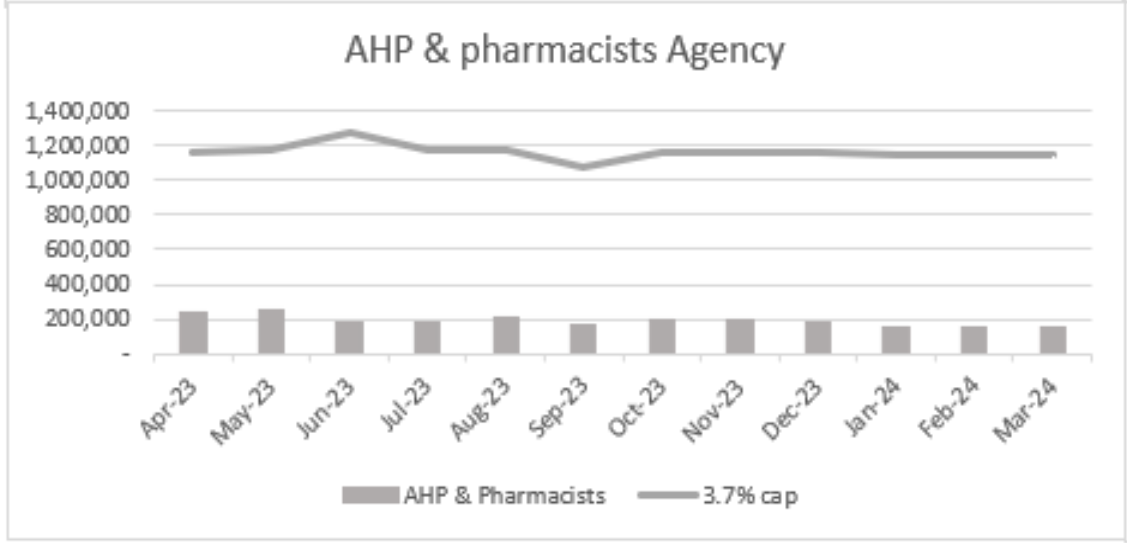


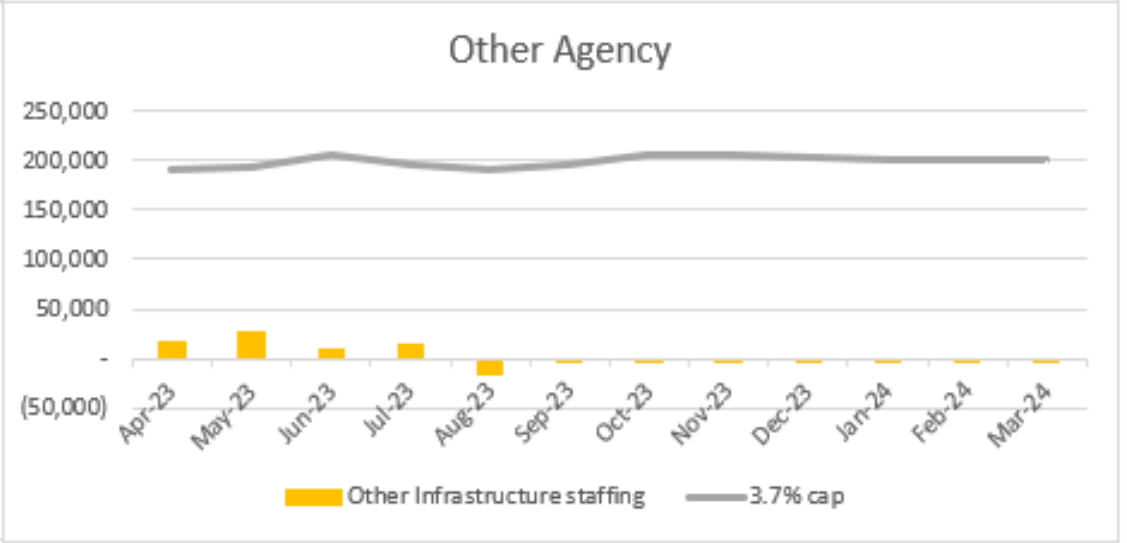
Summary	Actions	Assurance
• The cap to the end of September was exceeded by 0.54% or £986k for the Trust. • Medicine , CCS and W&C giving cause for concern against the new 3.7% price cap for their agency spend. • Funding for agency premium now sits in reserves	• Care Group budgets for 23/24 set in line with agreed establishment, removing agency and bank funding from their base budgets. • As part of recovery actions to deliver breakeven, Care groups are required to create action plans to reduce agency to within the 3.7% cap.	• Although over the cap , overall agency spend is remaining stable, despite increased use due the industrial action taking place . • The forecast to the end of the year does show that from January the Trust should be below the cap.

Finance: Agency expenditure by staff group









Finance: Financial Improvement Programme

Annual Plan (£000's)	Annual Forecast (£000's)	Annual Variance to Plan (£000's)	Annual Recurrent %
30,439	25,330	(5,109)	75%
M6 YTD Plan (£000's)	**M6 YTD Actuals (£000's)**	**M6 YTD Variance to Plan (£000's)**	**M6 YTD Recurrent %**
9,132	11,834	2,702	74%

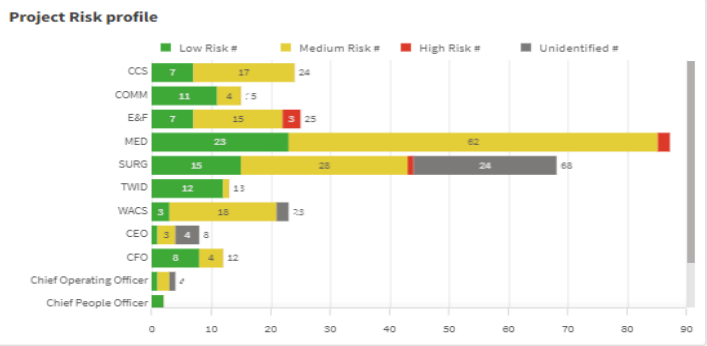
Month: 6 | Year: FY 23/24 | Care Group: Chief Executive Officer, Chief Finance Officer, Chief Medical Officer, Chief Nursing Officer | Project Level | Recurrent/Non-Recurrent

Performance by Care Group | Performance for NHSI

CareGroupParent | CG | Service | Values

	Annual Target	L0-L2 Plan	L3 F'Cast	L4-L5 Actuals	Annual Plan	L3-L5 Var to Target	% L3-L5 to Target	Full Year Effect (L4&L5)	No. Projects	Zero value Projects	No. Projects L0-L2	No. Projects L3-L5	% Recurrent (£)
Grand Total	**£30,439**	**£4,806**	**£546**	**£24,784**	**£30,135**	**(£5,109)**	**83.2%**	**£19,570**	**294**	**93**	**197**	**97**	**79%**
⊕ Community	£1,838	£12	£2	£1,516	£1,530	(£320)	82.6%	£1,518	15	3	6	9	100%
⊕ Core Clinical	£2,533	£534	£53	£1,070	£1,657	(£1,410)	44.3%	£1,078	24	4	13	11	100%
⊕ Corporate	£2,260	£52	£183	£876	£1,111	(£1,201)	46.9%	£1,076	39	12	16	23	100%
⊕ Estates & Facilities	£1,630	£126	£0	£1,969	£2,095	£339	120.8%	£2,727	25	0	18	7	100%
⊕ Medicine	£5,639	£1,506	£12	£418	£1,936	(£5,209)	7.6%	£316	87	54	71	16	100%
⊕ Surgery & Critical Care	£4,710	£1,152	£296	£368	£1,815	(£4,047)	14.1%	£400	68	19	52	16	100%
⊕ Trustwide	£10,089	£1,100	£0	£18,380	£19,480	£8,291	182.2%	£12,150	13	0	1	12	68%
⊕ Women & Children	£1,740	£324	£0	£188	£512	(£1,552)	10.8%	£304	23	1	20	3	100%

CIP Delivery Profile | CIP by Project Level | Project List



Summary

- Financial Improvement Programme Target is **£30.4m** plus the trust has a stretch target of a further £20.4m. The distribution across Care Groups and Corporate Directorates is shown in the table above.
- Phasing of the plan is 10% Q1, 20% Q3, 30% Q4 and 40% Q4.
- At month 6 only 30 % of the plan has been phased in . With 39% delivered
- At month 6 (September) the plan of **£9m has overachieved by £2.9m**.
- The **in-year effect of this is £24.8m** of which £16m is recurrent.

Actions

- **Financial Assurance Panel** established in Medicine Care group
- Fortnightly meetings with Care groups and Corporate Directorates take place every 2 weeks to progress 23/24 schemes and opportunities.
- Corporate directorates key focus on CIP identification

Assurance

- Surgery Medicine and Women & Children's care groups have held **finance summits and CIP development sessions** to generate and progress new ideas.
- Budget holder training being undertaken
- Finance awareness training now on TMS
- All care groups have had training on the CIP monitoring and tracking system (Wave).

Finance: Capital Programme

Capital Programme	Annual Plan	Cumulative to 30 September 2023			Year end Forecast	Actual breakdown	
		Plan	Actual	Variance to Plan		Invoices	Accruals
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Medical Equipment	2,678	600	374	226	2,678	374	-
IT Baseline Hardware, Software, Security	1,500	790	1,160	-370	1,500	855	305
PDC Funded	3,531	118	-	118	3,531	-	-
Backlog	2,000	700	598	102	2,000	578	20
Clinical Improvements	8,376	6,124	2,281	3,843	8,376	1,193	1,088
Charity Funds	200	80	32	48	200	32	-
New Hospital Programme (NHP)	1,523	420	444	-24	1,523	186	258
Major Refurbishments / New Build							
RLI - Theatre 1 & 2 refurbishment + Shared infrastructure	1,048	500	507	-7	1,048	190	317
TIF ERF Theatres	5,384	1,550	1,701	-151	5,384	1,228	473
CDC - Community Diagnostic Centres	9,484	4,000	832	3,168	9,484	478	354
Total	**35,724**	**14,882**	**7,929**	**6,953**	**35,724**	**5,114**	**2,815**

Summary

Capital programme allocation is £35.7

- Expenditure at Month 6 is below spending profile but with commitments through current contracts the full year allocation will be expended.

Actions

- Work is underway with the capital team in estates and facilities to ensure major Refurbishments and New Builds are progressing to plan and accruals for works undertaken but not yet invoiced are processed.

Assurance

- Rigorous time limited appraisal processes are being put into place to ensure any bids are necessary and can be delivered without increasing revenue commitments.

Finance: Cash Flow (SOCF – Statement of Cash Flow)

	31 Mar 23 £'000	30 Sep 23 £'000
Operating surplus/(deficit)	(36,493)	(14,357)
Non-cash revenue and expenses		
Depreciation and amortisation	22,729	11,366
Impairments	25,839	0
Income recognised in respect of capital donations	(181)	(32)
(Increase)/decrease in Inventories	(660)	(240)
(Increase)/decrease in Trade and Other Receivables	(16,628)	4,177
Increase/(decrease) in Trade and Other Payables	4,013	(10,503)
Increase/(decrease) in Provisions	(1,942)	(1,188)
Increase/(decrease) in Other Liabilities	(822)	1,874
Net cash generated from operating activities	**(4,145)**	**(8,903)**
Cash flows from investing activities		
Interest received	1,024	991
Purchase of Intangible assets	(1,792)	0
Purchase of Property, Plant and Equipment	(35,947)	(5,652)
Cash received to purchase donated assets	181	32
Net cash used in investing activities	**(36,534)**	**(4,629)**
Cash flows from financing activities		
PDC received	19,659	0
PDC repaid	0	0
Finance lease payments	(3,111)	(1,619)
Other loans repaid	(507)	(254)
Interest paid	(30)	(15)
PDC dividends paid	(5,470)	(2,347)
Net cash used in financing activities	**10,541**	**(4,235)**
Increase/(decrease) in cash	**(30,138)**	**(17,767)**
Opening cash	**53,211**	**23,073**
Closing cash	**23,073**	**5,306**

COMMENTARY

This report covers the period from 1 April 2023 to the 30 September 2023 and reflects the format utilised in the monthly NHSE Returns.

This figure reflects cash donations received to purchase assets. Items are in progress.

There has been increase in deferred income due to income received from NHS Lancashire and South Cumbria ICB.

Interest rates on Government bank accounts have increased. The Trust benefits from high average cash balances.

This figure reflects the purchase of donated assets utilising the income shown above.

Finance lease payments relate to RoU assets.
This relates to the repayment of the Salix loan.

Dividend payments are made in M6 and M12.

Cash surpluses had built up as a result of the revised funding regimes. Cash has reduced due to payment of outstanding accruals and the deficit position.

Summary

- Cash held at end of September is £5.3m
- Cash in respect of contract income continues to be received early in the month which contributes to the achievement of additional interest receivable as this is based on average cash balances.
- Cash support will be required from month 8.

Actions

- Long term cash forecast model to be reviewed and implemented for Q1 24/25
- Cash forecast being submitted to ICB on a fortnightly basis to monitor bank balance and requirement for cash support.

Assurance

- Average cash balances remain high due to early receipt of monthly contract income.
- As at end of September no cash support required.
- Daily cash reconciliation
- % of bad debt to be included in care group PAF metrics

Finance: Balance Sheet (SOFP – Statement of Financial Position)

	Opening Balance 01 Apr 23 £m	Prev Mth Balance 31 Aug 23 £m	Curr Mth Balance 30 Sep 23 £m
NON CURRENT ASSETS			
Property Plant & Equipment	204.3	199.9	201.1
Right of Use Assets	30.4	29.0	29.0
Intangible Assets	1.7	2.9	2.9
Other Assets	1.1	1.2	1.2
Total Non Current Assets	237.5	233.0	234.2
CURRENT ASSETS			
Inventories	4.4	4.5	4.7
Trade & Other Receivables	27.0	20.3	22.2
Non Current Assets Held for Sale	0.1	0.1	0.1
Cash & Cash Equivalents	23.1	11.0	5.3
Total Current Assets	54.6	35.9	32.3
CURRENT LIABILITIES			
Trade & Other Payables	(51.3)	(48.5)	(43.1)
Current Borrowings	(0.3)	-	-
RoU Finance Lease Liabilities	(3.0)	(1.9)	(1.5)
Current Provisions	(1.9)	(0.6)	(0.6)
Other Liabilities	(6.8)	(8.7)	(8.7)
Total Current Liabilities	(63.3)	(59.7)	(53.9)
Net Current Assets/(Liabilities)	(8.7)	(23.8)	(21.6)
Total Assets less Current Liabilities	228.8	209.2	212.6
NON CURRENT LIABILITIES			
RoU Finance Lease Liabilities	(27.5)	(27.5)	(27.5)
Provisions	(2.0)	(2.1)	(2.1)
Total Non Current Liabilities	(29.5)	(29.6)	(29.6)
TOTAL ASSETS EMPLOYED	199.3	179.6	183.0
TAXPAYERS EQUITY:			
Public Dividend Capital	515.9	515.9	515.9
Revaluation Reserve	63.0	63.0	63.0
Retained Earnings (Prior Years)	(339.2)	(379.6)	(379.6)
Retained Earnings (In Year)	(40.4)	(19.7)	(16.3)
TOTAL TAXPAYERS EQUITY	199.3	179.6	183.0

Summary

Non-current assets

Property plant and equipment additions of £4.9m plus depreciation charged of £1.6m in the month.
Right of use assets recognised from 01/04/2023 in accordance with implementation of International Financial Reporting Standard (IFRS) 16.

Current assets

Prepayments amount to £3.5m and NHS debtors £13.9m. Overdue items from other NHS bodies is high due to cash pressure across the system.
Cash balances are reducing due to increased deficit position and settlement of payables

Current liabilities

Payables balance has reduced by £11.9m predominantly due to payment of the pay award. Trade payables, however, have increased by £3.6m since April mainly due to delayed invoice authorisations.
Current borrowings (Salix energy loan) outstanding at March 2023 have been repaid in full.
Other liabilities relate to deferred income which has increase in the 2nd quarter with receipt of income from Health Education England.

Non-current liabilities

Include finance lease liabilities on right of use assets under IFRS16.

Actions

- The trust has applied for revenue cash support from October 2023
- Work is ongoing to recover overdue income and mitigate support requirements

Assurance

- Application for cash support submitted in September 2023
- Cash position is being monitored and reconciled on a daily basis

OPERATIONAL DELIVERY

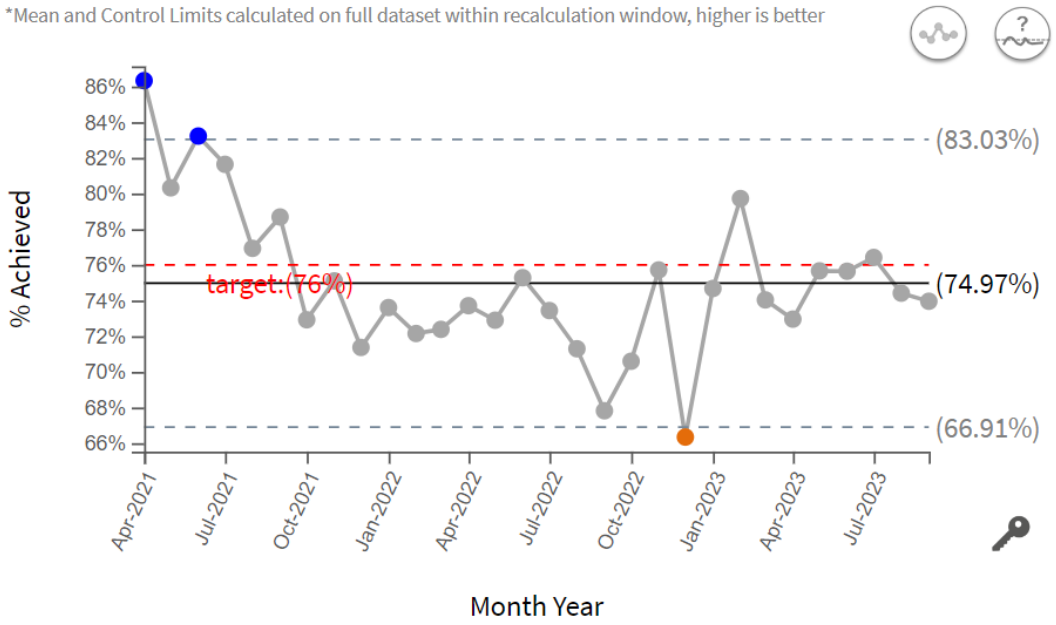
Trust Level Scorecard

Outcome Measure	Target	Actual	Period	Variation	Assurance
ED 4 Hours (%)	76%	74.0%	Sep-23		
% of ED Attends >12 hrs	2%	5.3%	Sep-23		
Ambulance Handovers within 30 mins (%)	80%	71.8%	Sep-23		
Not Meeting Criteria to Reside (Daily Average)	N/A	115	Sep-23		N/A
% of Open G&A Beds Occupied by NMC2R	N/A	19.0%	Sep-23		N/A
Cancer 2WW (%)	93%	87.9%	Sep-23		
Cancer 28 Day FDS (%)	75%	80.2%	Sep-23		
Cancer 31 Day (%)	96%	87.6%	Sep-23		
Cancer 31 Day Subsequent Drug (%)	98%	98.4%	Sep-23		
Cancer 31 day Subsequent Surgery (%)	94%	100.0%	Sep-23		
Cancer 62 Day (%)	70%	60.9%	Sep-23		
Number of Patients on Cancer PTL over 62 Days (no.)	54	59	Sep-23		
Total Patients on Cancer PTL (All)	N/A	1873	Sep-23		N/A
Cancer 62 Day Screening (%)	90%	60.7%	Sep-23		
Cancer 62 Day Upgrade (%)	85%	84.9%	Sep-23		
Cancer Treatments Beyond 62 Days (no.)	N/A	38.0	Sep-23		N/A
Diagnostic Waits > 6 weeks	5%	4.8%	Sep-23		
RTT <18 Weeks (%)	92%	68.1%	Sep-23		
RTT 65 Weeks (no.)	0	106	Sep-23		
RTT 52 Weeks (no.)	1150	773	Sep-23		
RTT Total Waiting List Size	32003	33880	Sep-23		
New Backlog	N/A	27140	Sep-23		N/A
Follow-Ups Past IRD	N/A	43082	Sep-23		N/A
OP DNA Rate (%)	4%	7.2%	Sep-23		
2 Hour Urgent Community Response	70%	94.2%	Sep-23		

Urgent Care Performance

ED 4hr Performance - Trust

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



Latest
74.0%
Variance Type
Common cause variation
Target
76%
Target Achievement
The system may achieve or fail the target subject to random variation
DQ Indicators
S T P

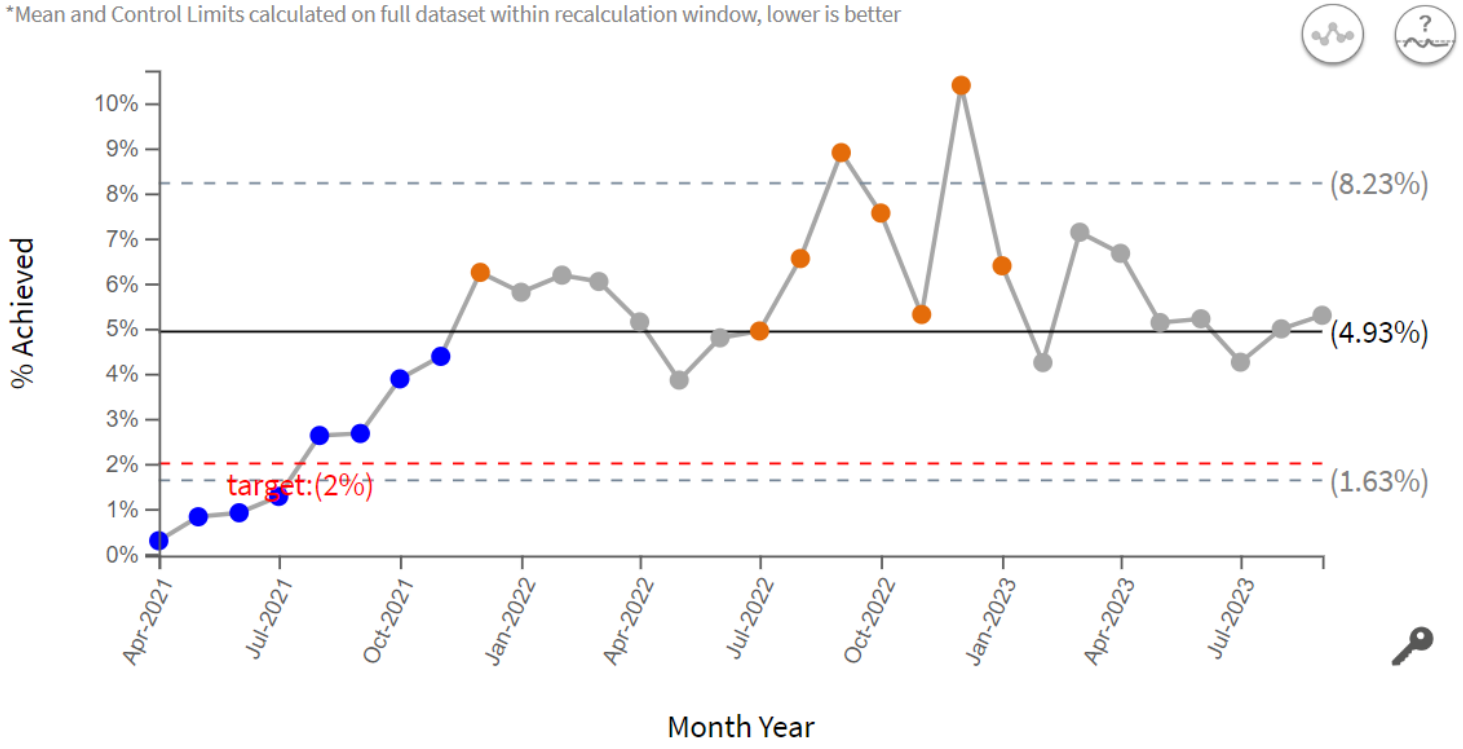
	Numerator	Denomina...	% Achieved
	9,559	**12,798**	**74.7%**
Furness General Hospital	2,767	3,743	73.9%
Morecambe UTC	1,233	1,263	97.6%
Royal Lancaster Infirmary	3,080	5,226	58.9%
Westmorland General Hospital	2,479	2,566	96.6%

Summary	Actions	Assurance
ED Four Hour Performance remains in common cause concern – performance in month including Morecambe UTC is just under the target at 74.7%. The underperformance is predominantly driven by poor performance at RLI which is expected to fail the 76% (performance in September was58.9%).	• Focus on timely assessment and triage looking at times of deterioration, secondary triage team during high demand. • Reducing delays in ambulance handover. Working with North West Ambulance Service (NWAS) to improve direct streaming, limit cohorting and reduce delays outside ED. • Trial to improve flow – Frailty patients to be taken for assessment on the acute frailty unit (AFU) where possible (Nov). • Same Day Emergency Care (SDEC) unit – focus on enabling easier referrals into the service should a patient attend the emergency department under one of these pathways • Trialling a better way to bring patients back into an appointment rather than attend and then wait to be seen at RLI Emergency Department.	• Benchmarking - ED 4 Hr (Type 1 performance) - 41st out of 122 national Trusts in September. UHMB is 1st out of the 9 trusts within our peer group.

Urgent Care Performance

ED 12hr Performance - Trust

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



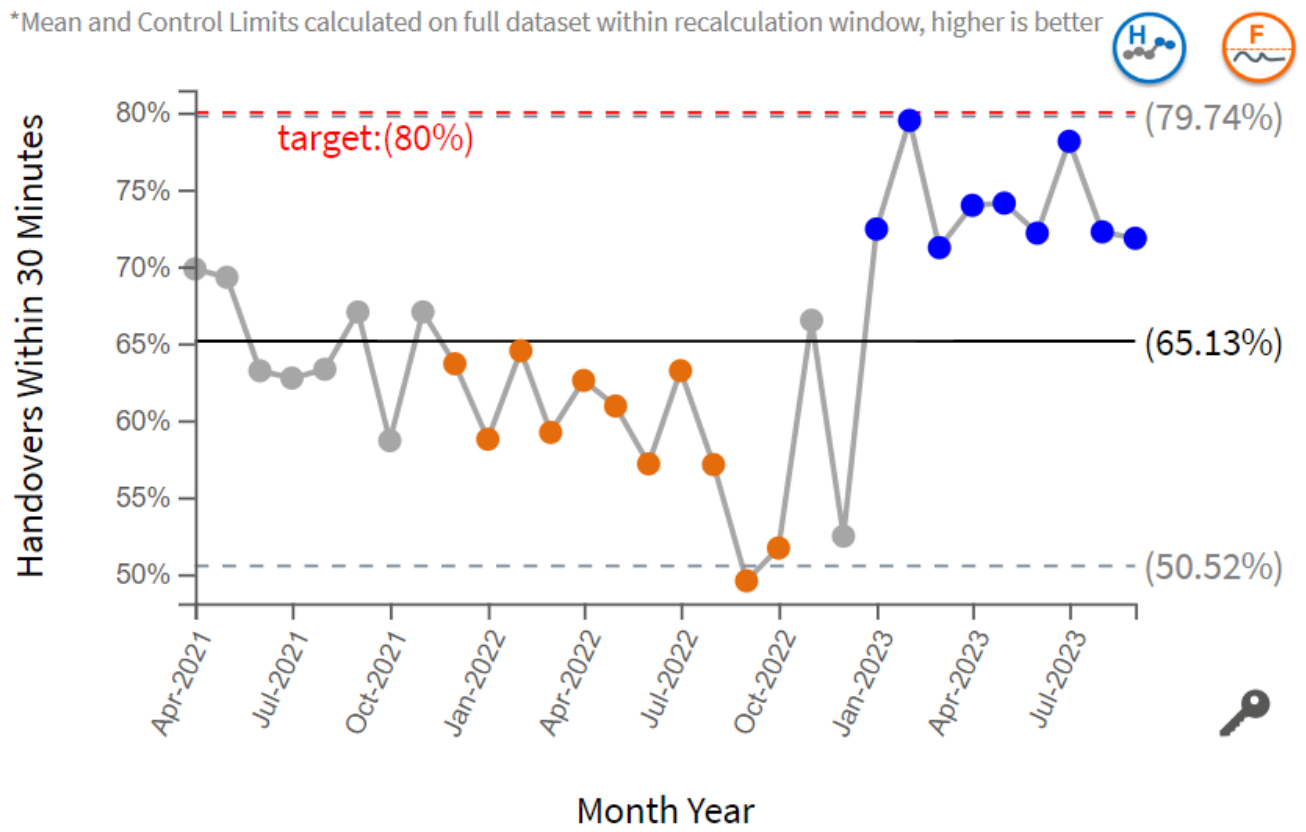
Latest
5.3%
Variance Type
Common cause variation
Target
2%
Target Achievement
The system may achieve or fail the target subject to random variation
DQ Indicators
S T P

Summary	Actions	Assurance

12-hour performance remains in common cause variation.
 	
As with the 4-hour performance there is a different picture across the 3 sites:
• RLI almost 1:10 patients breached this standard in September and they are expected to consistently fail the standard going forward.
• FGH failed the 2% target this month with performance just above at 3%
• WGH had zero 12-hour breaches
	• 12-hour performance remains a challenge for both Emergency Departments', with RLI the worst performer.
	• Key actions within this domain:
	  • Frailty Assessments being trialled on the acute frailty unit alongside the focus to improve patient flow (noted on previous slide)
	  • Direct streaming to SDEC from ED and accepting direct ambulance arrivals to SDEC.
	  • Daily position provided to care groups and challenges to increase discharges.
	  • Increased use of Priority Assessment Discharge Unit (PADU) to improve flow through ED.
		• Benchmarking - 89th out of 125 national Trusts in September. UHMB is 6th out of the 9 trusts within our peer group.

Ambulance Handover Performance

Percentage of Ambulance Handovers within 30 Minutes - Trust

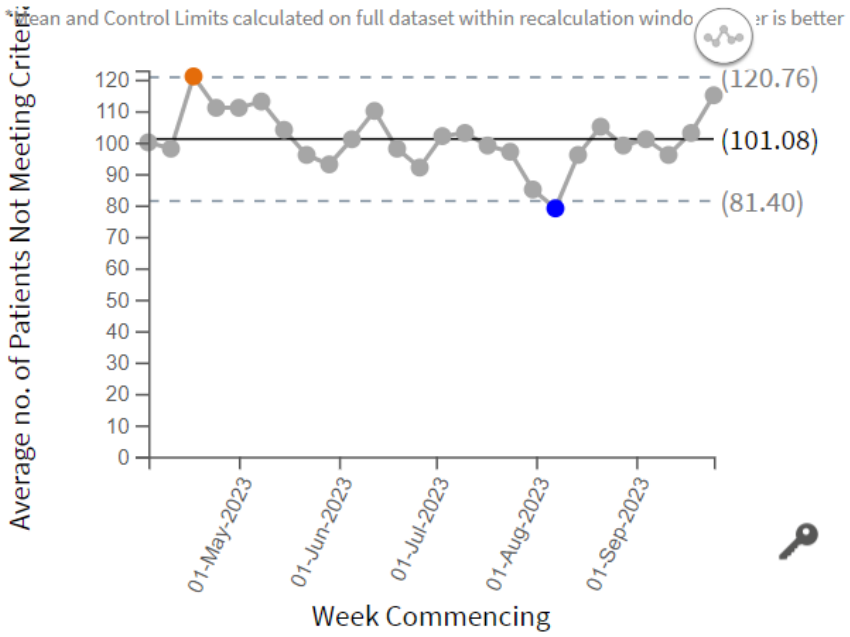


Latest
71.8%
Variance Type
Special cause variation - improvement...
Target
80%
Target Achievement
The system is expected to consistently fail the target
DQ Indicators
S T P

Summary	Actions	Assurance
Performance overall is in special cause improvement, driven largely by improvement at FGH which was at 77.8% in September. Performance at RLI is in common cause variation at 68.3%	• Whilst some improvement noted, there is still ongoing variation in this metric. • The acute teams are working closely with North West Ambulance Service to improve the number of patients going directly to SDEC – this will improve the 30-minute handover target. • Inpatient bed delays are key to this improvement. Work is being undertaken with frailty intervention team (FIT) on plans to move patients from ED to the acute frailty unit in a timely fashion (PDSA starts 6/11/23). • Direct streaming to minor treatment unit and same day emergency care unit remain a key focus to support decongestion of the emergency department at RLI.	In September UHMB's 30-minute handover performance was the highest of the 4 local trusts.

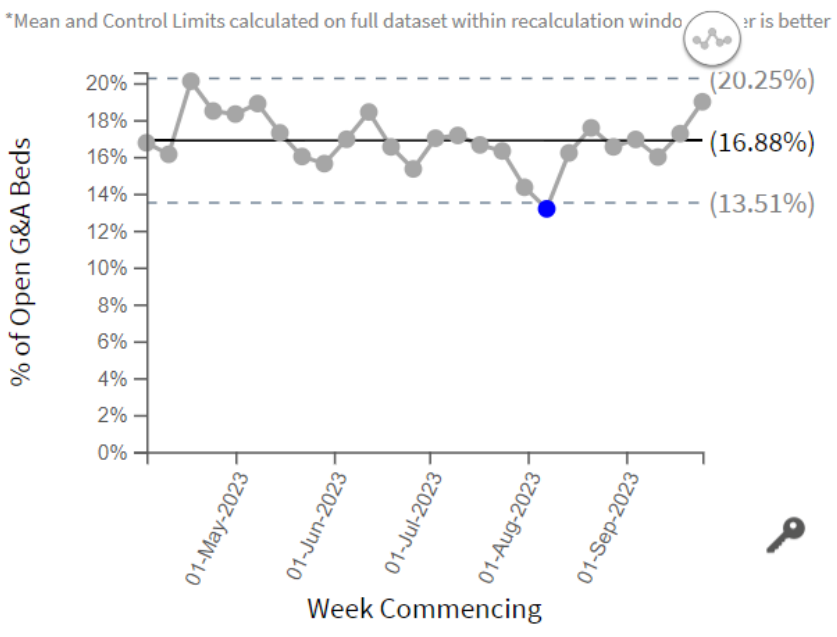
Not Meeting Criteria to Reside (NMC2R)

Daily Average of Complex Patients Who Did Not Meet Criteria to Reside



Latest
115
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

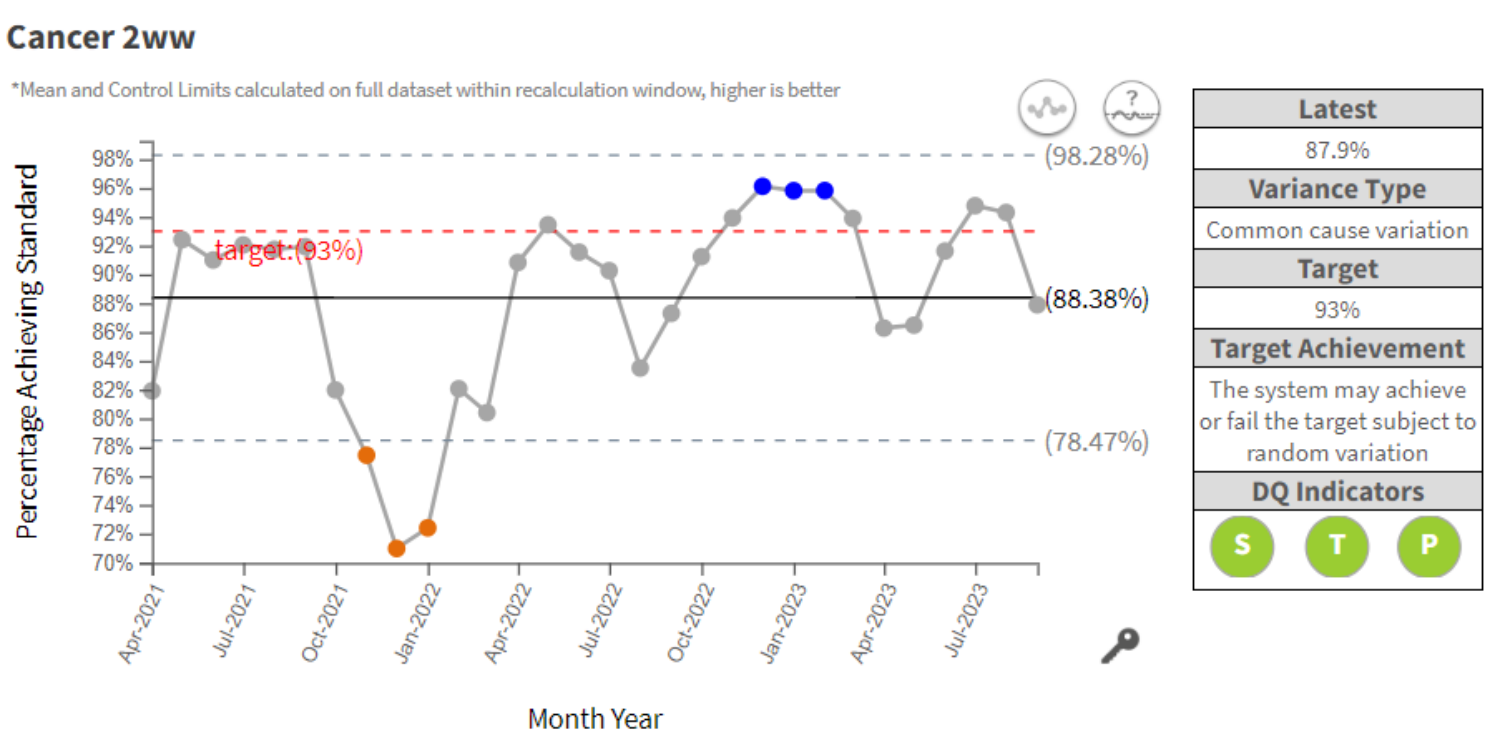
% of Open G&A Beds Occupied by Complex Patients Who Did Not Meet C2R



Latest
19.0%
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Summary	Actions	Assurance
Nationally the NMC2R target is 5% of occupied G&A beds. NMC2R continues to provide a significant challenge to the Trust and continues to be in common cause variation. Current number of NMC2R patients is 19.0%. In line with national requirements from the 25th September this figure will also include those patients who are not therapy fit and will therefore see a further increase to the current reported figures.	• Continued collaborative working with local authority's • Weekly length of stay review meetings • Daily calls with the transfer of care hub • Move to having virtual and physical presence on sites from social workers to encourage joint working and expedite discharge • Tabletop reviews of patients not therapy fit with community and hospital teams to consider alternative solutions – which has resulted in a reduction of approximately 30 patients.	System Discharge Steering Group provide oversight of key performance indicators and track of any actions. Benchmark in LCS ICB LTH – 7.6% BVH – 11.4% ELHT – 6.7%

Cancer 2WW Performance



Latest
87.9%
Variance Type
Common cause variation
Target
93%
Target Achievement
The system may achieve or fail the target subject to random variation
DQ Indicators
S T P

Cancer 2 Week Wait Performance Sep 2023

Tumour Group	Percentage Achieving Standard	Total Patients Receiving First Appointment	Breaches
Clinical Haematology	100.0%	17	0
Other	100.0%	28	0
Lung	98.3%	58	1
Lower GI	97.8%	320	7
Breast	96.4%	252	9
Upper GI	96.4%	55	2
Head and Neck	87.5%	160	20
Skin	83.2%	561	94
Urology	81.7%	115	21
Gynaecology	55.6%	108	48
Paediatrics	50.0%	2	1

Summary

The Cancer 2 Week Wait (C2WW) standard was not achieved in September at 87.9%. C2WW performance is in common cause variation.

The highest number of breach patients were in Skin (94 patients) and Gynaecology (48 patients).

Skin has experienced a 23% increase in referrals whilst Consultant vacancies and sickness has impacted Gynaecology cancer waiting times.

Actions

Skin:

- community dermatology now with different provider with enhanced triage from November - Detailed work being undertaken to establish a start date and the expected impact on demand. Expected that this service will be meeting target from December.

Gynae:

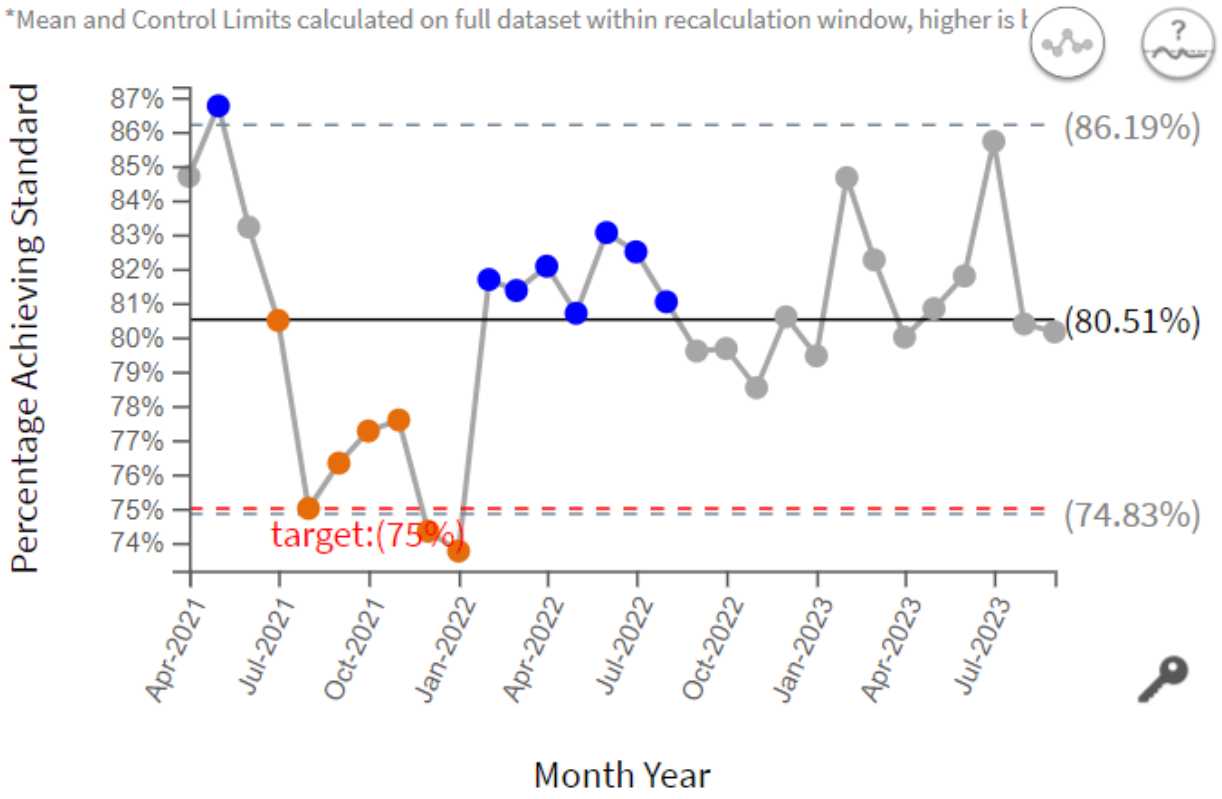
- Revised Post Menopausal Bleed (PMB) referral protocols to reduce demand being established for Implementation December.
- Mutual aid from other Lancashire and South Cumbria providers has been requested via DMAS (national capacity request tool).
- Increased Hysteroscopy clinic capacity due to clinic moves within RLI Gynaecology Outpatients.
- Clinician is planned to return from long term sickness clinician in November – which will improve performance. Expected compliance from December.

Assurance

- Benchmarking - 50th out of 140 national Trusts in September. UHMB is 2nd out of the 9 trusts within our peer group.

Cancer 28 Day Performance

Cancer 28 Day Faster Diagnosis Standard



Latest
80.2%
Variance Type
Common cause variation
Target
75%
Target Achievement
The system may achieve or fail the target subject to random variation
DQ Indicators
S T P

Cancer 28 Day Faster Diagnosis Performance Sep 2023

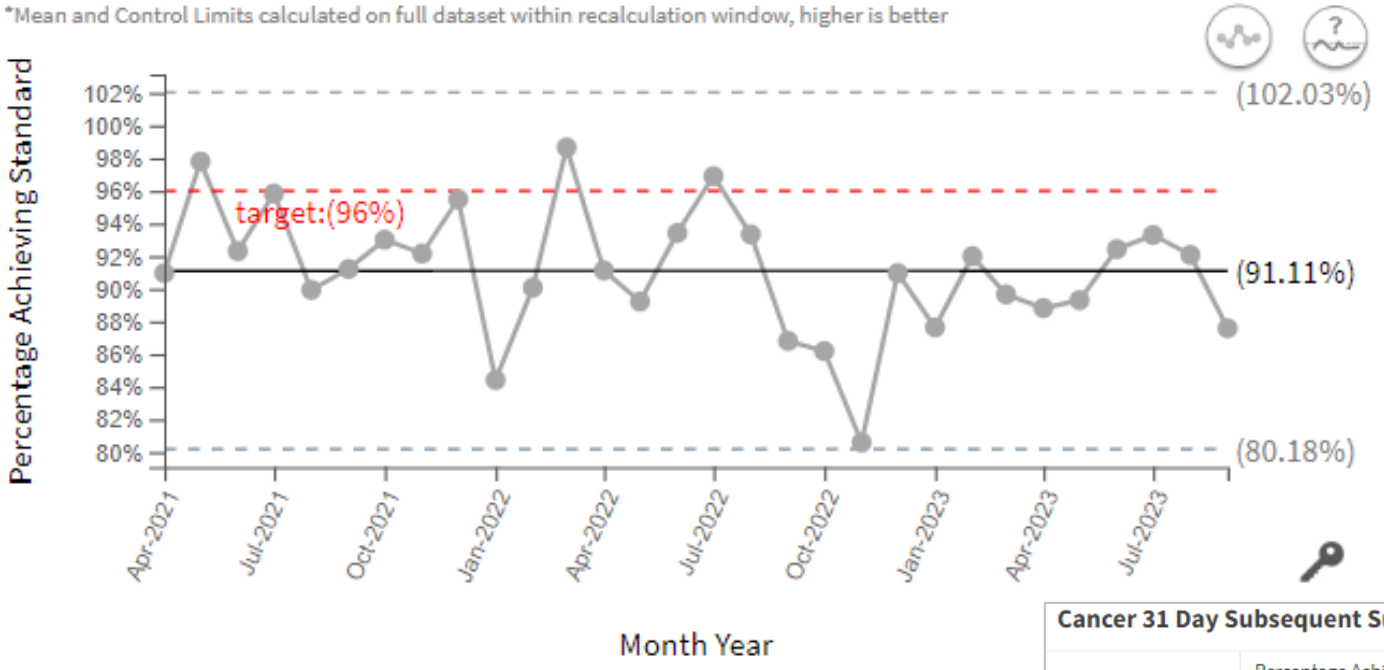
Tumour Group	Percentage Achieving Standard	Patients Informed	Breaches
Totals	**80.2%**	**1,577**	**313**
Paediatrics	100.0%	2	0
Breast	95.9%	242	10
Skin	91.5%	480	41
Upper GI	90.8%	65	6
Head and Neck	75.2%	157	39
Lower GI	72.9%	292	79
Lung	66.7%	48	16
Urology	60.0%	105	42
Gynaecology	57.4%	129	55
Other	56.4%	39	17
Clinical Haematology	55.6%	18	8

Summary	Actions	Assurance
The target has been achieved for 20 consecutive months and further improvement in performance will see a pass icon as the lower control limit rises above the target. **TO NOTE:** As of the 1st October the National Cancer Waiting Time Standards have changed and will be reported in December. 3 Consolidated targets : **-28 day to Diagnosis (FDS) : Target 75%** **-31 Day Diagnosis to Treatment : Target 96%** **-62 Day Referral to Treatment : Target 85%**	**Gynae & Urology** – Breach Analysis of all 28 day breach patients undertaken Key Theme : Long waits for benign letters, (letters informing patients that Cancer has been ruled out) awaiting dictation. This letter stops the Faster Diagnosis Standard clock and expedites communications with patients– process to be fast tracked and in place November Additional Radiology and Histology capacity funded from Cancer Alliance has been put in place to reduce diagnostic turnaround times and meet Best Practice Timed Pathway milestones. **Skin** has experienced a 23% increase in referrals whilst Consultant vacancies and sickness has impacted **Gynaecology** cancer waiting times.	• Benchmarking - 29th out of 140 national Trusts in September. UHMB is 1st out of the 9 trusts within our peer group. • Initial unvalidated level for October is 81%

Cancer 31 Day Performance

Cancer 31 Day First Treatment

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



Latest
87.6%
Variance Type
Common cause variation
Target
96%
Target Achievement
The system may achieve or fail the target subject to random variation
DQ Indicators
S T P

Cancer 31 Day Subsequent Surgery Performance Sep 2023

Tumour Group	Percentage Achieving Standard	Patients Treated	Breaches
Totals	**100.0%**	**8**	**0**
Breast	100.0%	7	0
Lower GI	100.0%	1	0

Cancer 31 Day Subsequent Drugs Performance Sep 2023

Tumour Group	Percentage Achieving Standard	Patients Treated	Breaches
Totals	**98.4%**	**124**	**2**
Clinical Haematology	100.0%	8	0
Gynaecology	100.0%	9	0
Lower GI	100.0%	8	0
Lung	100.0%	7	0
Other	100.0%	1	0
Upper GI	100.0%	9	0
Urology	100.0%	54	0
Breast	92.9%	28	2

Cancer 31 Day First Treatment Performance Sep 2023

Tumour Group	Percentage Achieving Standard	Patients Treated	Breaches
Totals	**87.6%**	**153**	**19**
Clinical Haematology	100.0%	8	0
Gynaecology	100.0%	2	0
Head and Neck	100.0%	5	0
Lung	100.0%	15	0
Other	100.0%	5	0
Upper GI	100.0%	7	0
Lower GI	95.5%	22	1
Breast	94.1%	34	2
Urology	90.0%	30	3
Skin	48.0%	25	13

Summary

Cancer 31 Day 1st Treatment - was not achieved in September at 87.6% (96% standard).

Cancer 31 Day Subsequent Drugs - standard was achieved in September. The standard may or may not be met due to the small numbers (124 total treatments in September).

Cancer 31 Day Subsequent Surgery - was achieved at 100.0% (94% standard). The standard may or may not be met due to the small numbers.

Actions

- **Skin** : AI software implemented from September. This will free up Consultant time to deliver treatments within 31 days. Monitoring of initial impact ongoing. Expected impact to release treatment capacity in November
- **Skin** : Bid for national funding submitted October (254k) additional insourcing
- **Breast** : Pain Pathway to be implemented with the national best practice timed pathway.

Assurance

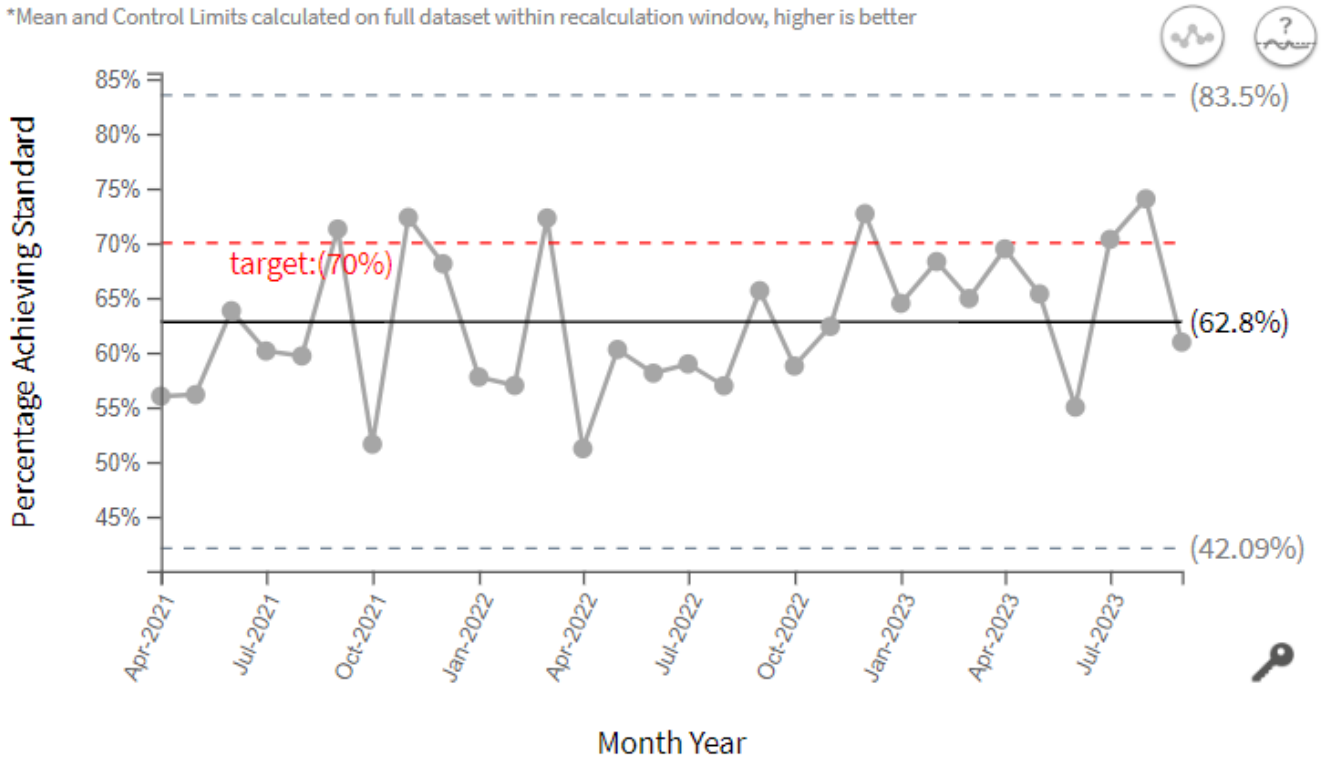
Benchmarking - 107th out of 140 national Trusts in September. UHMB is 4th out of the 9 trusts within our peer group.

Skin service are meeting 62 day referral to treatment standard currently (only service to do so at present)

Cancer 62 Day Performance & 104 Day breaches

Cancer 62 Day

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



Latest
60.9%
Variance Type
Common cause variation
Target
70%
Target Achievement
The system may achieve or fail the target subject to random variation
DQ Indicators
S T P

Cancer 62 Day Reallocated Performance Sep 2023

Tumour Group	Percentage Achieving Standard	Patients Treated	Breaches
Totals	**60.9%**	**96.0**	**37.5**
Clinical Haematology	100.0%	2.5	0.0
Upper GI	71.4%	3.5	1.0
Breast	70.8%	24.0	7.0
Urology	70.0%	20.0	6.0
Skin	58.8%	17.0	7.0
Head and Neck	55.6%	4.5	2.0
Lung	55.6%	9.0	4.0
Lower GI	36.4%	11.0	7.0
Gynaecology	22.2%	4.5	3.5

104 Day Breaches		
Tumour Group	**UHMB**	**Tertiary**
Colorectal	2	
Head and Neck		
Gynaecology		0.5
Lung		1.5
Sarcoma		
Skin		
Upper GI		1
Urology	1	1

Summary

The confirmed position for September is 60.9% against a national target of 70% for March 2024.

Breast, Skin and Colorectal shared over half of the breaches.

Performance is in common cause variation.

Actions

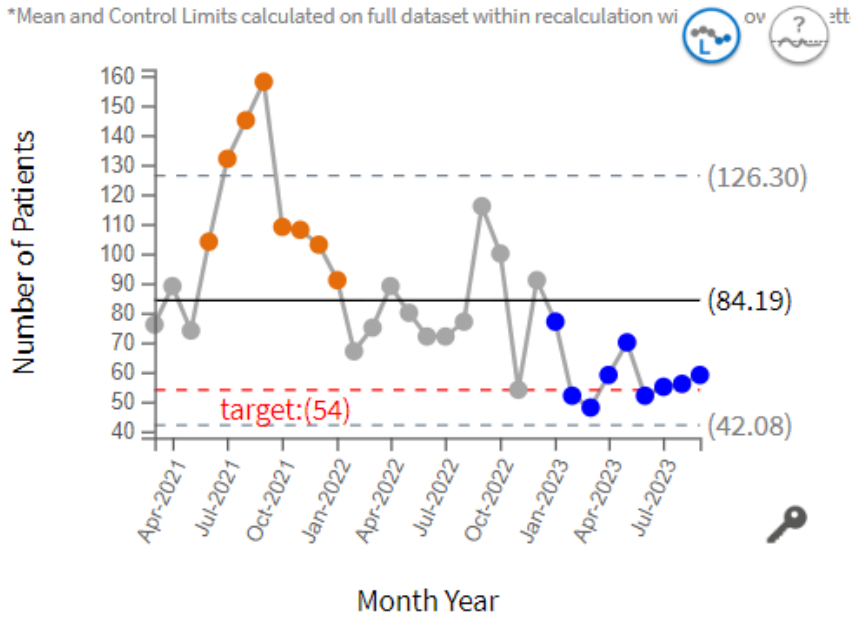
- 2ww, FDS and 31 day actions will all contribute to improve the % of patients we are able to treat within 62 days

Assurance

- Benchmarking 62 Day Performance - 71st out of 139 national Trusts in September. UHMB is 3rd out of the 9 trusts within our peer group.
- October 62 day treatment % (unvalidated position) : **66%**
- 104 day breaches reducing and at a comparatively low level

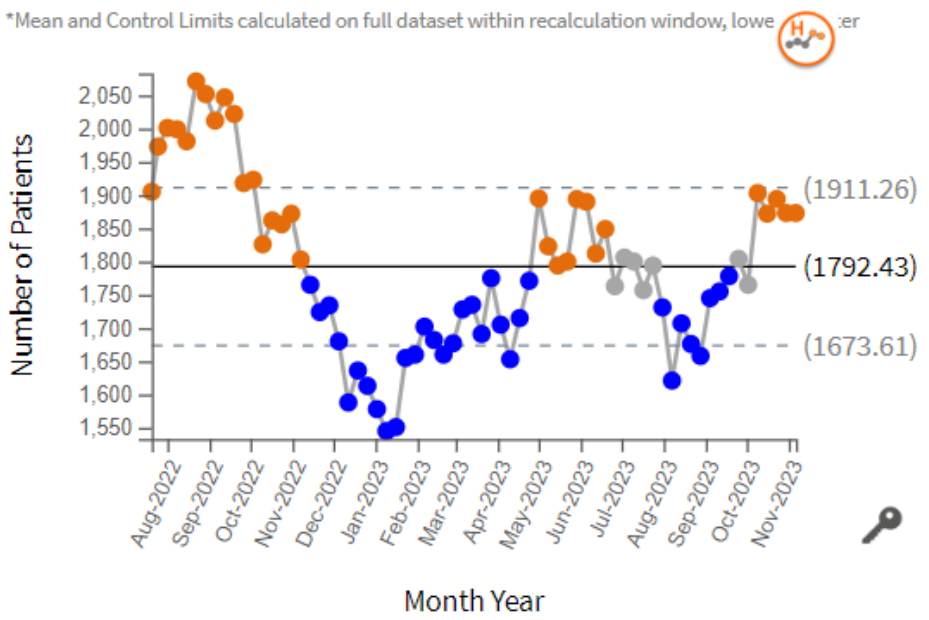
Cancer Patient Tracking List (PTL) Performance

Patients on Cancer PTL Over 62 Days (Classic)



Latest
59
Variance Type
Special cause variation - improvement...
Target
54
Target Achievement
The system may achieve or fail the target subject to random variation
DQ Indicators
S T P

Total Patients on Cancer PTL (All)



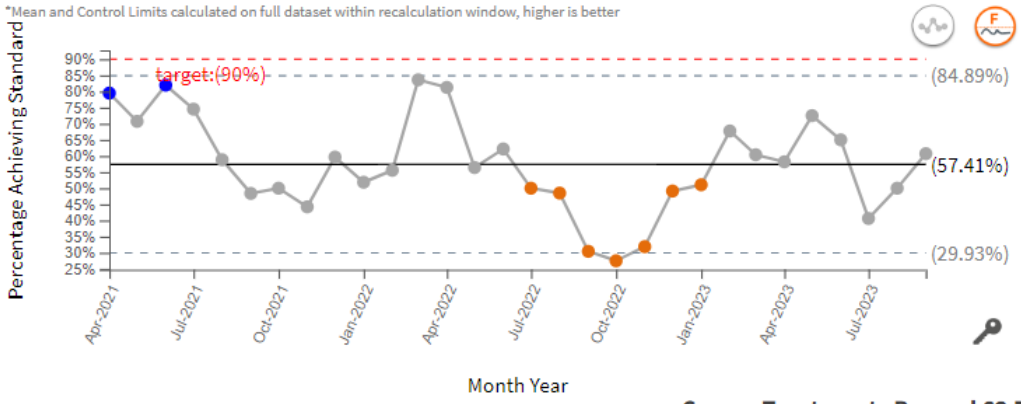
Latest
1873
Variance Type
Special cause variation - cause for concern...
Target
N/A
Target Achievement
N/A
DQ Indicators
S T P

Summary	Actions	Assurance
A patient tracking list (PTL) is an established management tool that enables proactive planning and management of patient waiting lists. The PTL contains the data required to manage patient's pathways by showing clearly which patients are approaching the maximum waiting time so that operational staff can offer dates according to clinical priority and waiting times. The number of patients on the PTL over 62 days measure is in special cause improvement but the number of patients on the PTL for over 62 days remains slightly above the target at 59 against a target of 54. The total number of patients on the PTL is in special cause improvement.	• Every patient waiting > 62 days given focussed attention in clinically attended weekly PTL meeting calls to proactively progress the outstanding next step of their pathway • Continuous Improvement : Cancer Primary Target List meetings being refreshed to focus of ensuring the next appointment / test / treatment has a booked future date. • All actions identified in earlier 'cancer standards slide' will contribute to the delivery of this target going forward.	• 3.11.23 Over 62 day number stands at : **49**

Cancer 62 Day Performance

Cancer 62 Day Screening

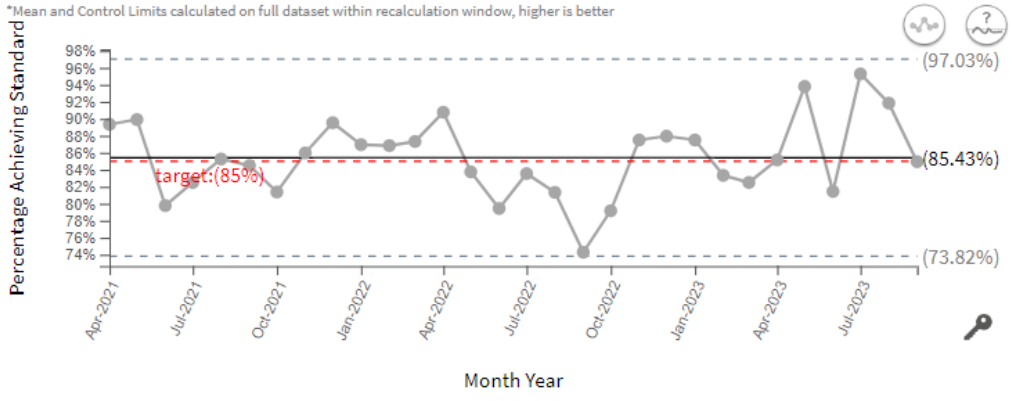
*Mean and Control Limits calculated on full dataset within recalculation window, higher is better



Latest
60.7%
Variance Type
Common cause variation
Target
90%
Target Achievement
The system is expected to consistently fail the target
DQ Indicators
S T P

Cancer 62 Day Upgrade

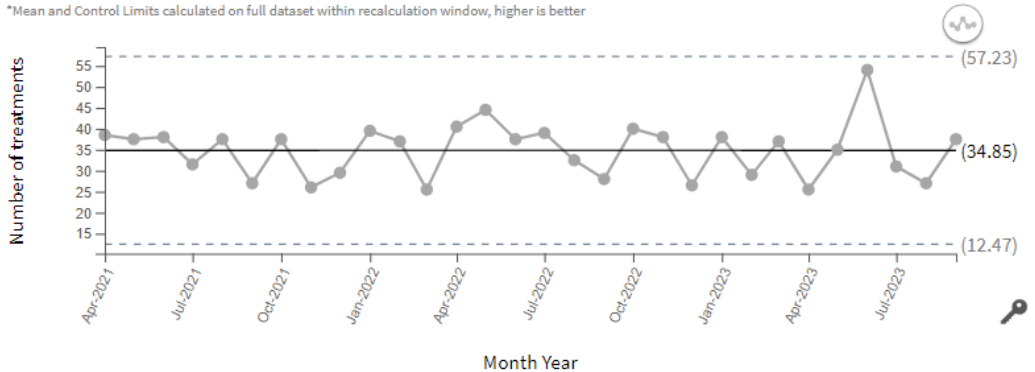
*Mean and Control Limits calculated on full dataset within recalculation window, higher is better



Latest
84.9%
Variance Type
Common cause variation
Target
85%
Target Achievement
The system may achieve or fail the target subject to random variation
DQ Indicators
S T P

Cancer Treatments Beyond 62 Days

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



Latest
38
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A
DQ Indicators
S T P

Summary

Cancer 62 Day Screening - The mean has fallen from 85% pre-pandemic to 57.4%. The standard is likely to fail going forward.

Cancer 62 Day Upgrade - The mean has declined from 90% to 85.4% since before the pandemic, the standard was not achieved in September at 84.9% (85% target). The standard may or may not be achieved due to the small numbers involved and is in common cause variation.

Cancer Treatments >62 days - performance directly mirrors the cancer 62 day % achievement chart on the previous slide.

Actions

- Additional capacity put in place by screening service to reduce backlog : Sept 57%, further improvement expected going forward as backlog is cleared ; Expectation of improvement month on month to achieve by 31.3.24.
- National KPI's now being met by screening service.
- Revised Cancer Upgrade process in place from October to ensure patients that do not begin as a Cancer referral, but are internally upgraded are treated with equity and seen within 14 days.

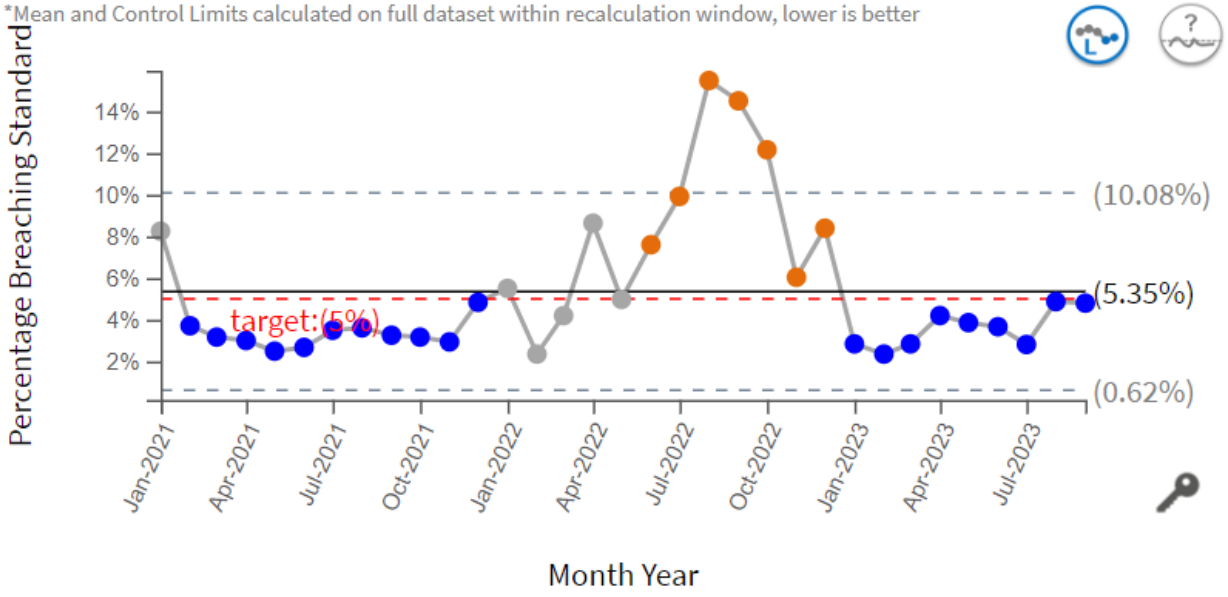
Assurance

- Breast screening :57% - backlog (assessment within 3 weeks of recall dates) is now being met with an improvement trajectory in place.
- Bowel Screening :70% - from date of recall to treatment

Diagnostic Performance

Diagnostics 6 Week Standard

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



Latest
4.8%
Variance Type
Special cause variation - improvement...
Target
5%
Target Achievement
The system may achieve or fail the target subject to random variation
DQ Indicators
S T P

Diagnostic Performance by Modality

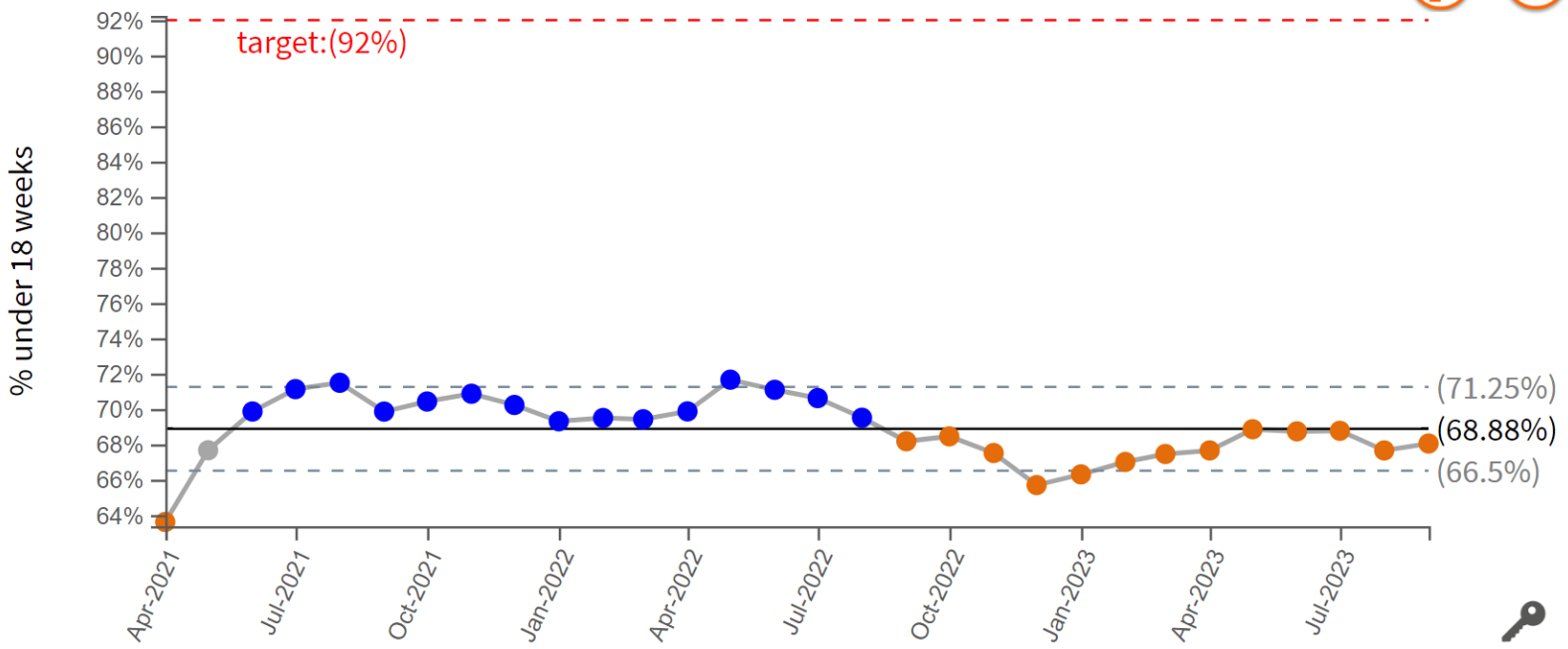
Modality	Number of Breaches	Breaches as a proportion of patients waiting
Totals	**329**	-
Non-obstetric ultrasound	280	10.48%
DEXA Scan	10	2.36%
Magnetic Resonance Imaging	9	0.87%
Audiology - Audiology Assessments	8	2.68%
Computed Tomography	8	1.01%
Urodynamics - pressures & flows	4	6.56%
Flexi sigmoidoscopy	3	3.16%
Cystoscopy	2	4.17%
Gastroscopy	2	0.94%
Cardiology - echocardiography	1	0.16%
Colonoscopy	1	0.52%
Neurophysiology - peripheral neurophysiology	1	0.76%

Summary	Actions	Assurance
Diagnostic performance is in a run below the mean and September's performance was 4.8% against a target of 5%. Most of the breaches were in non-obstetric ultrasound with the performance for that modality above target at 10.5%. The most challenged modalities by number of patients are; Imaging, with 297 breaches (6.6%), of which 280 of the patients were waiting for Non-Obstetric Ultrasound (10.5%)	• Ultrasound – performance against non-obstetric ultrasound has been affected by sickness in the service which has resulted in reduced capacity. At 30/09/23, the total waiting list was 2672 patients, under the planned number of 2837. 10.5% of patients waited >6 weeks. Expediting patients at risk of breaching 78 RTT weeks may have resulted in other routine patients with shorter RTT waits waiting longer for their tests. Latest performance, as at 29/10/23, is 1.7% and only 39 breaches, so when assessing performance on a weekly basis, Ultrasound service is now in special cause improvement.	Benchmarking - 202nd of 433 providers in September. UHMB is 1st out of the 9 trusts within our peer group. Endoscopy performance is currently at 0% with 0 patients waiting over 6 weeks, which is the best performance since 2017 and is in special cause improvement.

RTT Incomplete Performance

RTT Incomplete Performance - Trust

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



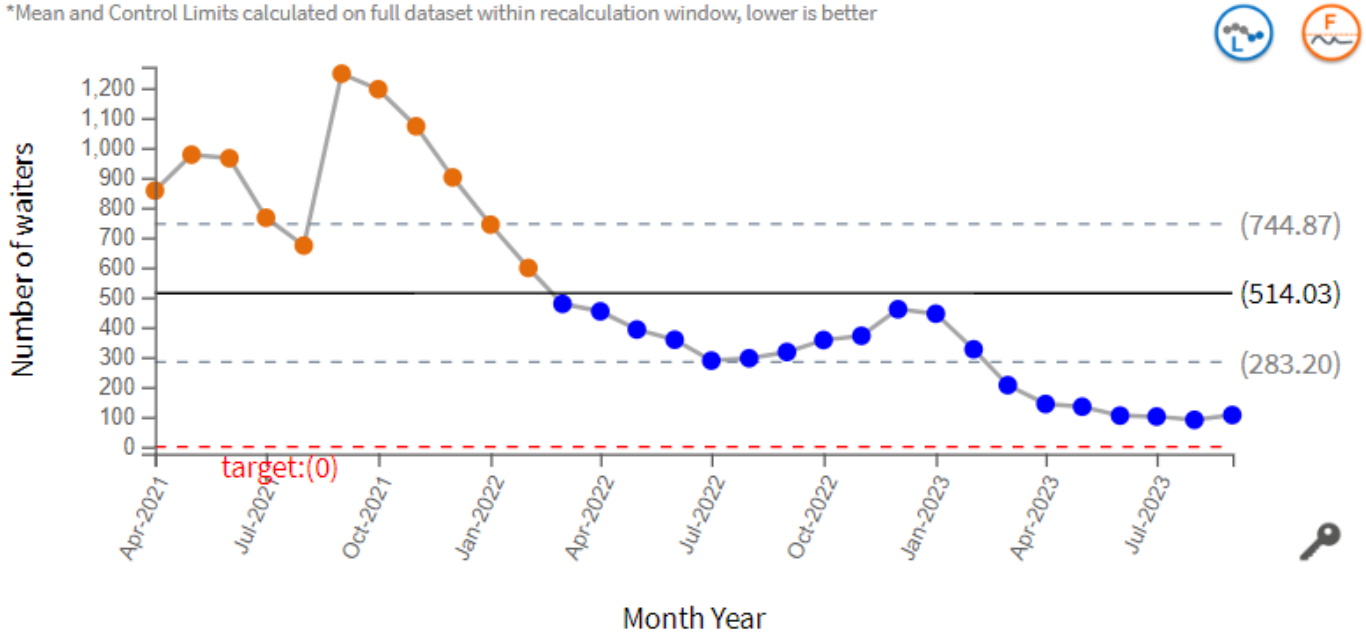
Latest
68.05%
Variance Type
Special cause variation - cause for concern...
Target
92%
Target Achievement
The system is expected to consistently fail the target
DQ Indicators
S T P

Summary	Actions	Assurance
Trust wide RTT performance is in special cause concern due a run of performance below the mean and is predicted to fail due to the distance away from the 92% standard. The RTT% will not substantially improve until the longest waiting patients have been treated (as per national maximum wait time standards). Every care group with the exception of core clinical and community are predicted to fail, with WACS, S&CC and Medicine all in special cause concern. Several Medicine Specialties are now achieving the 92% standard; Cardiology achieved for the first time since May 2022.	• Utilisation of mutual aid to access capacity across Lancashire and South Cumbria (more than 2,870 patients as an ICS to date), plus use of the independent sector across the North West Region. • New national guidance around Patient Choice implemented on 30/01/23, with 241 patients being deferred to date, as per their preference (as at 03/11/23). • 31/10/23 launch of Patient Initiated Choice/Mutual Aid (PIDMAS), where patients opt in to seek transfer to other local/national providers to receive their care sooner. 35 UHMB patients registered for PIDMAS in the first 3 days, out of 494 patient invited, and the ICB is currently sourcing transfer options.	RTT- in September UHMB had the 39th highest performance out of all 170 Trusts and was 1st out of 9 trusts in our peer group.

RTT 65 Week Performance

RTT 65 Week Waits

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



Latest
106
Variance Type
Special cause variation - improvement...
Target
0
Target Achievement
The system is expected to consistently fail the target
DQ Indicators
S T P

RTT 65 Week Waits by Specialty Sep 2023

Treatment Function	Patients Waiting Over 65 Weeks
TRAUMA AND ORTHOPAEDICS	49
ORTHODONTICS	15
GENERAL SURGERY	11
Oral and Maxillofacial Surgery Service	6
COLORECTAL SURGERY	5
PAIN MANAGEMENT	5
GYNAECOLOGY	4
RESTORATIVE DENTISTRY	3
GASTROENTEROLOGY	2
PHYSIOTHERAPY	2
UROLOGY	2
ENT	1
PAEDIATRIC OPHTHALMOLOGY	1

Summary

65-week performance has been in special cause improvement for over a year, with over half of the count being Trauma & Orthopaedics and Orthodontics patients.

Actions

The majority of the longest waiting patients are in T&O. Analysis of the capacity and demand gap within T&O is complete; improvement plan for T&O actions include:

- Patients still waiting for their first appointment, who choose to go, will be transferred to 2 x independent sector (IS) providers from 31/07/23. To date 485 patients have been accepted by the IS.
- From 13/10/23, referrals to be transferred to another local hospital within the ICB. To date, 24 patients have been chosen and been accepted for transfer.

The Orthodontic service did not achieve the internal 65-week trajectory (+14 patients). A system level action plan is under development to ensure the provision of sufficient capacity. Internally we have insourced additional Restorative Dentistry activity to see the MDT patients that sit under Orthodontics.

Assurance

3 patients waited longer than 78 weeks for treatment. Their correct wait times were found late in September through business-as-usual validation, where incorrect clock stops earlier in the pathway and incorrect activity coding were discovered. These occurrences were reported as clinical incidents, which generated a range of actions to help prevent a recurrence.

The following Specialties achieved their internal September 65 weeks trajectories:

- Trauma & Orthopaedics (including Paediatrics); Breast Surgery; Urology; General Surgery; Gynaecology; Ophthalmology

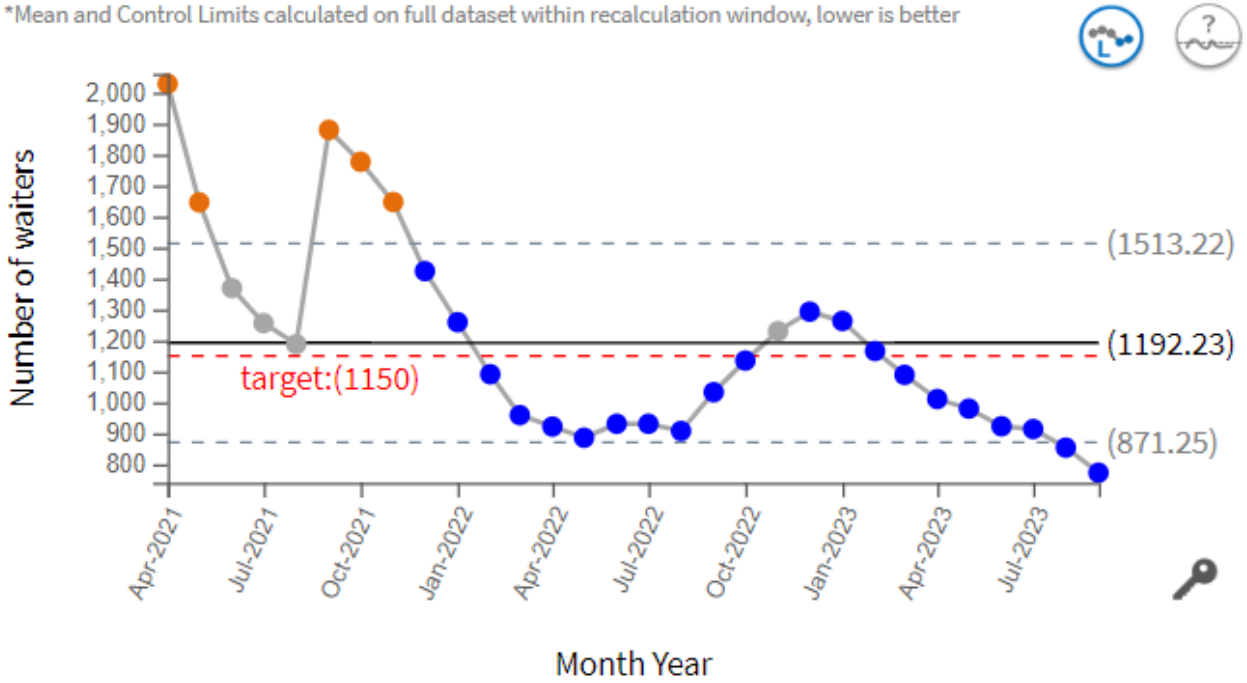
With the exception of Orthodontics all other services are within 5 patients of their trajectory.

At 03/11/23, there were only 1080 patients without confirmed treatment dates left to treat between now and 31/03/24 in order to hit the 65-week maximum wait time. Most Specialties have minimal patients left (low risk), with higher risks for complex/subspecialty T&O (489 patients and Orthodontics/Restorative Dentistry fragile services (88 patients).

RTT 52 Week Performance

RTT 52 Week Waits

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



Latest
773
Variance Type
Special cause variation - improvement...
Target
1150
Target Achievement
The system may achieve or fail the target subject to random variation
DQ Indicators
S T P

RTT 52 Week Waits by Specialty Sep 2023

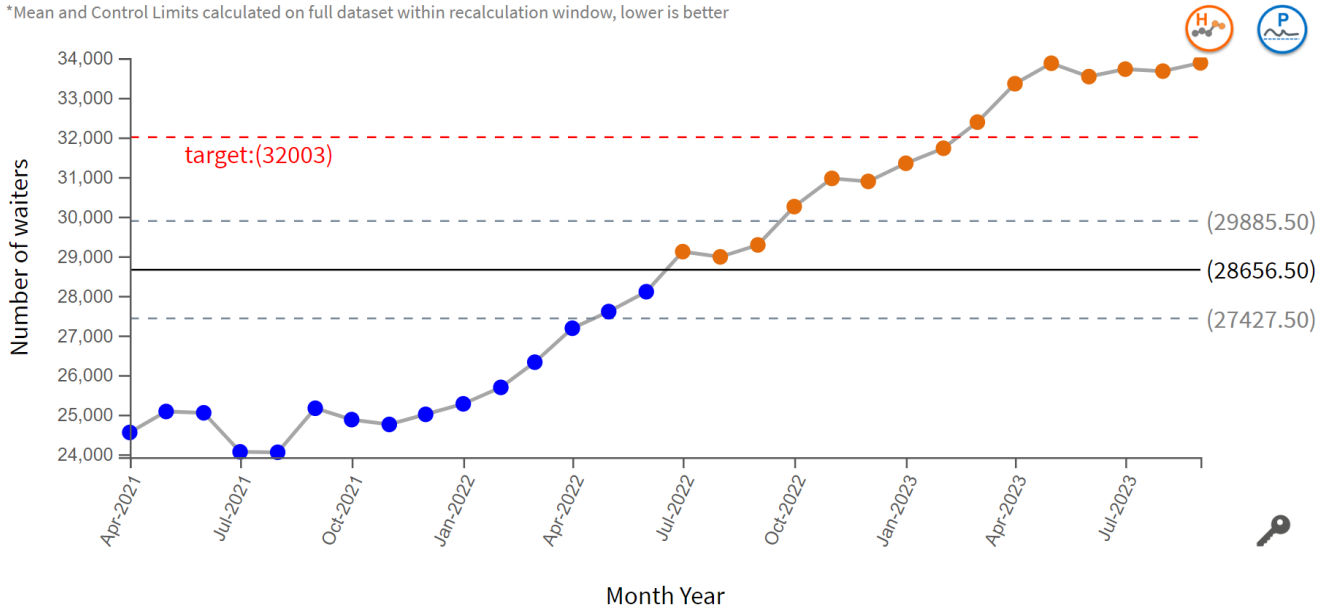
Treatment Function	Patients Waiting Over 52 Weeks
TRAUMA AND ORTHOPAEDICS	340
UROLOGY	91
GENERAL SURGERY	74
COLORECTAL SURGERY	68
GYNAECOLOGY	54
ORTHODONTICS	42
PAIN MANAGEMENT	38
PAEDIATRIC SURGERY	13
Oral and Maxillofacial Surgery Service	12
PAEDIATRIC TRAUMA AND ORTHOPAEDICS	8
ENT	6
RESTORATIVE DENTISTRY	6
BREAST SURGERY	5
DERMATOLOGY	3
GASTROENTEROLOGY	3
PAEDIATRICS	2
PHYSIOTHERAPY	2
RHEUMATOLOGY	2
AUDIOLOGY	1
ENDOCRINOLOGY	1
OPHTHALMOLOGY	1
PAEDIATRIC OPHTHALMOLOGY	1

Summary	Actions	Assurance
In SPC terms, performance is in special cause improvement and may or may not achieve the agreed target, although the 52-week trajectory has now been met for 7 months. The internal stretch target for September of 1171 patients waiting over 52 weeks was achieved, with 773 patients. (The chart shows the Mar 24 target). S&CC account for the majority of 52-week waiters with almost half in T&O.	Paediatric Surgery: Additional clinics set up in October with visiting Consultants to see the backlog of patients waiting. There are currently 7 patients waiting over 52 weeks and all have TCI/appointment dates.	In September UHMB ranked 71st out of all 169 Trusts and was 1st out of 9 trusts in our peer group for patients waiting over 52 weeks. On 29/10/23, 690 patients were waiting >52 weeks. This is the lowest number since 09/08/20 and bodes well for achieving the maximum waiting time of 52 weeks for March 2025. The following Specialties achieved their internal September 52 weeks trajectories: Audiology, Breast Surgery; Colorectal; Trauma & Orthopaedics (including Paediatric); General Surgery; Gynaecology; Urology; Gastroenterology; Pain Management; ENT; Physiotherapy No Specialties under achieved their internal September 52 weeks trajectories by more than 10 patients.

Waiting List Size Performance

RTT Total Waiting List Size

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

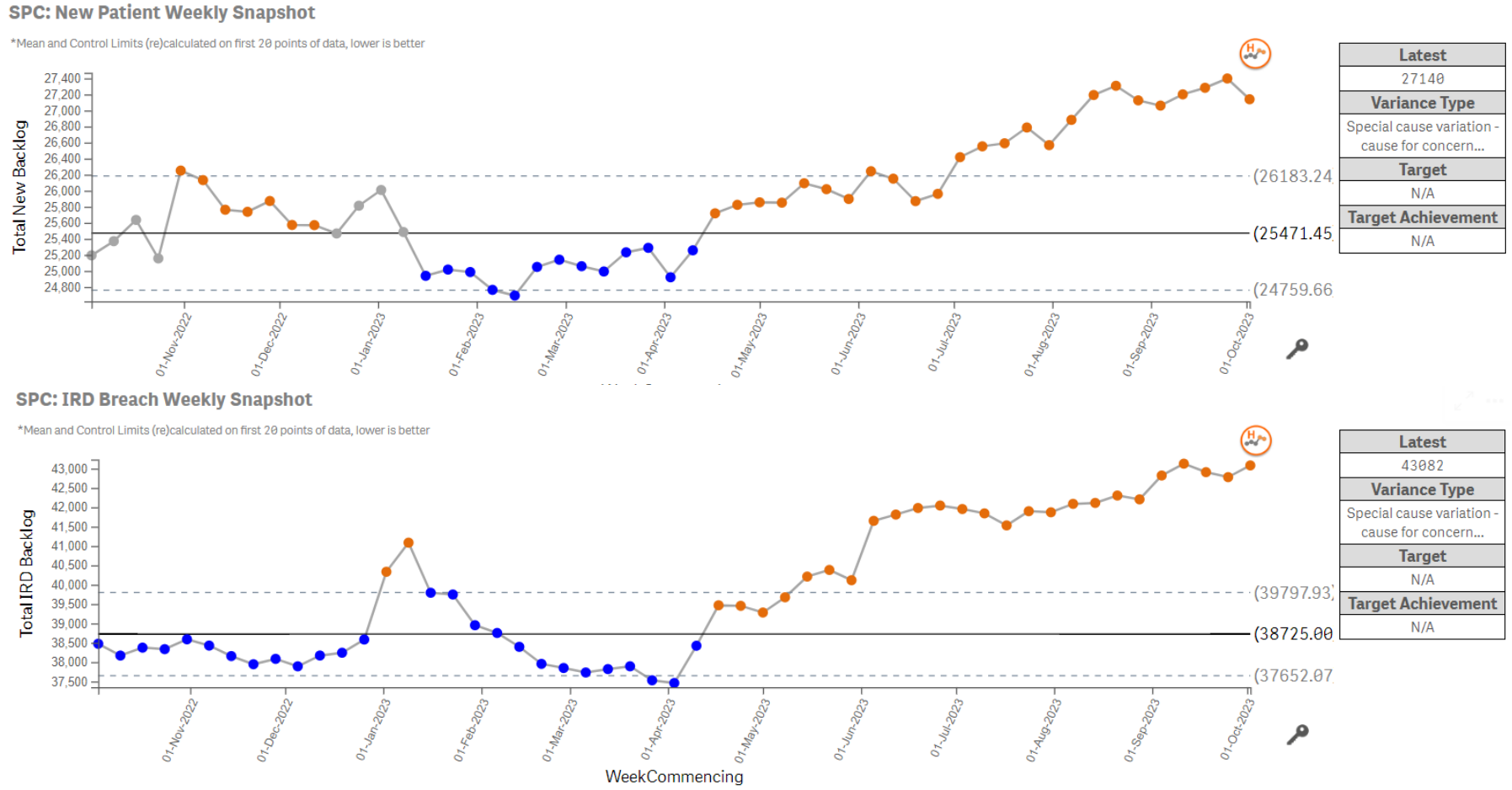


Latest
33,880
Variance Type
Special cause variation - cause for concern...
Target
32003
Target Achievement
The system is expected to consistently pass the target
DQ Indicators
S T P

Care Group	September Performance	September Trajectory	Current Waiting List Size (29/10/23)	October Trajectory
Surgery	23,107	22,960	23,127	22,617
Medicine	7,519	7,436	7,228	7,325
WACS	3,153	3,086	3,161	3,041

Summary	Actions	Assurance
Waiting list size continues to be in special cause concern, with over two thirds being Surgery patients. Surgery, Medicine and WACS Care Groups are all in high cause for concern variation.	• Developing an in-house digital validation solution via a new "Patient Portal" communication platform. Successful pilot in Gynaecology, where 50% of the patients responded within 2 days and 4 patients let us know that they no longer required their appointments. This will enable us to contact patients every 12 weeks, which is the national requirement. • One of the ambitions from the Protecting and Expanding Elective Capacity letter was for all patients waiting over 12 weeks to be validated by 31/10/23. Latest performance puts UHMB at 71.1% coverage, and 82.7% for patients waiting over 26 weeks.	• The total number of patients waiting in September, 33,880 was above the month's trajectory of 33,498; and the current waiting list size of 33,539 (as at 29/10/23) is also over October's trajectory of 32,999. The Trust and all Care Groups waiting list sizes are in high cause for concern. The 12-week rolling patient contact validation programme will remove patients who no longer need or want their appointments which will reduce the number of patients waiting from October. • Validation coverage is the best in L&SC ICB

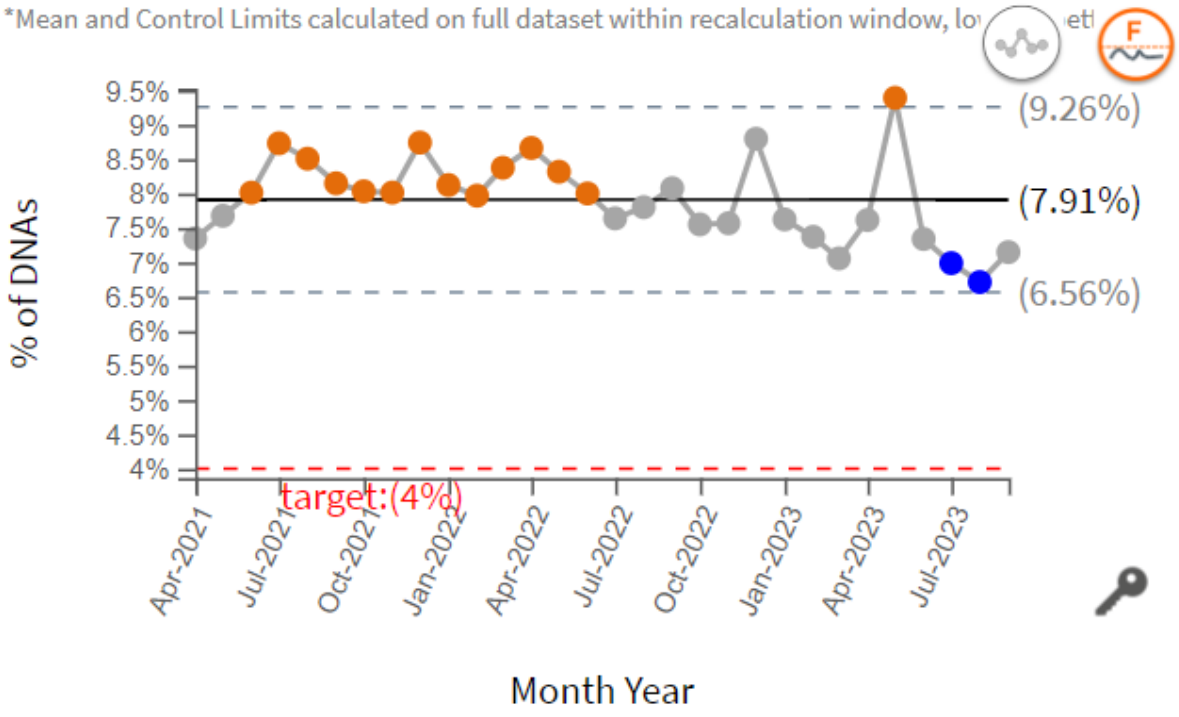
New Backlog and IRD Performance



Summary	Actions	Assurance
New patient backlog is in a period of special cause for concern. Follow ups past IRD are in a period of special cause concern, with latest number of 43,082. The mean has increased from 31,000 pre pandemic to 38725 from October 2022.	New patient backlog: National ask via the Protecting and Expanding Elective Capacity letter with the ambition that all patients who will have waited 65 weeks on 31/03/24, will have been offered their first appointment by 31/10/23. This would lower the maximum wait time to first appointment to 43 weeks and will mean that patients are seen for their first appointments in time to allow possible tests, follow-up and surgery within the maximum waiting time of 65 weeks on 31/03/24. On 11/08/23 there were 1525 patients outstanding for appointments; at 31/10/23 this has reduced to 141 patients. Of these patients, 110 either declined appointments at UHMB or were offered the opportunity to be seen at a local IS or neighbouring Trust in October. That left 31 patients that we were unable to find capacity for in October, which equates to only 0.15% of the total patients waiting for their first appointment.	• Continued focus on booking the front end of the patient pathway in a timely way. • In mid-October, UHMB were the 3rd best performing Trust for the booking of first appointments by 31/10/23 in the Northwest region.

DNA Performance

Did Not Attend Percentage



Latest
7.15%
Variance Type
Common cause variation
Target
4%
Target Achievement
The system is expected to consistently fail the target
DQ Indicators
S T P

DNAs by Treatment Function Sep 2023

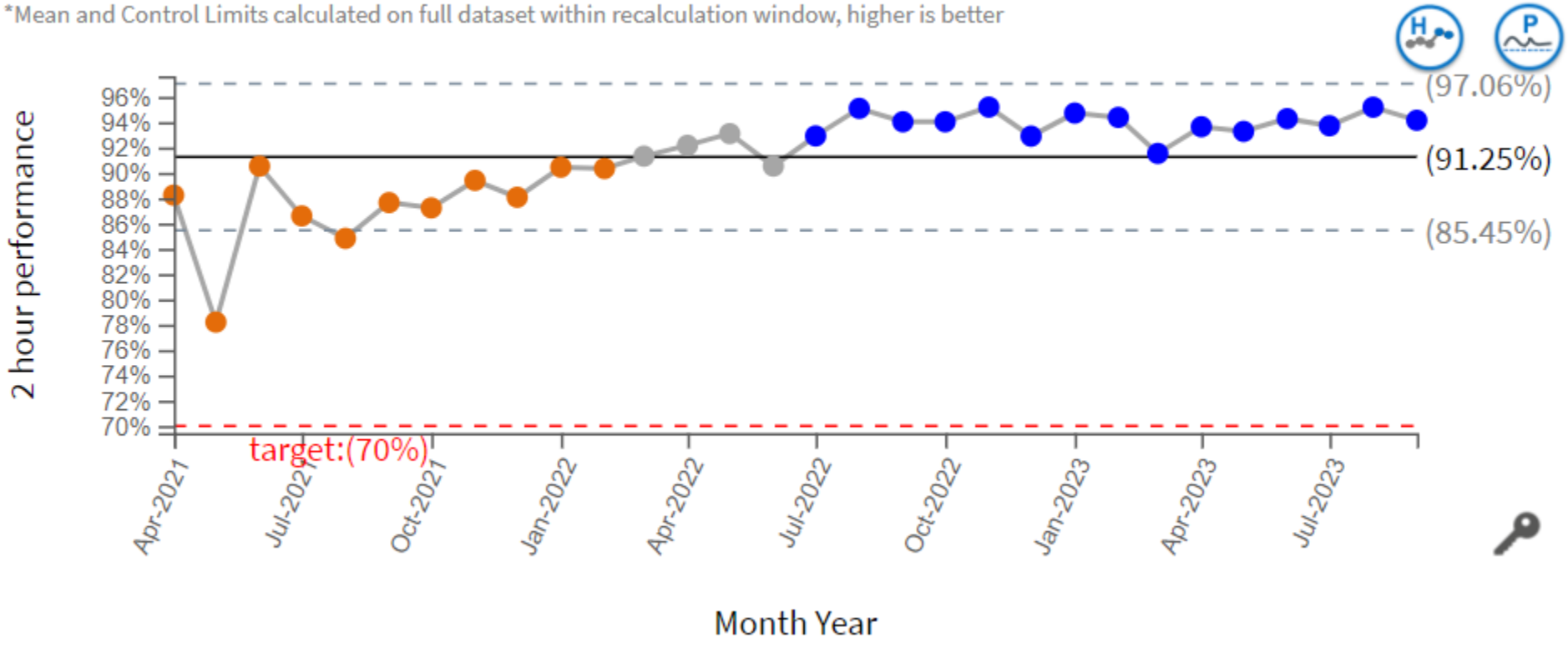
Treatment Function	Number of DNAs	DNAs as a proportion of patients seen
Totals	**3,277**	**7.15%**
PHYSIOTHERAPY	347	9.06%
TRAUMA AND ORTHOPAEDICS	290	7.07%
OPHTHALMOLOGY	259	5.08%
ENT	234	10.65%
DERMATOLOGY	159	6.29%
GASTROENTEROLOGY	158	9.30%
MIDWIFE EPISODE	145	7.81%
AUDIOLOGY	134	5.73%
CARDIOLOGY	120	10.46%
UROLOGY	111	7.42%
PAEDIATRICS	104	12.35%
RHEUMATOLOGY	96	6.32%
ORTHOPTICS	91	18.50%
Oral and Maxillofacial Surgery Service	83	7.35%
Cardiac Physiology Service	80	4.73%
GYNAECOLOGY	78	7.05%
CLINICAL HAEMATOLOGY	77	6.03%

Summary	Actions	Assurance
This standard is in common cause variation but will continue to fail the 4% standard without a step change in performance. Every care group except Core Clinical is expected to fail the standard going forward, surgery is in special cause improvement, though as with the trust level figure, is some way from the target	The reduction in Did not Attend and Was Not Brought Rates (Children & Young Adults service) is a key deliverable of the Outpatient Transformation Programme. Patient Initiated Follow-Up will be extended across further specialties and cohorts with ambitious trajectories set for existing specialties. The Delivery Plan will be presented to the first Outpatient Transformation Board on 28/11/23. As part of business-as-usual validation of outpatient new and follow-up lists will continue as per national requirements.	UHMB DNA % is the lowest out of the 3 ICS Trusts where data is in Model Hospital (September data). UHMB use of Patient Initiated Follow-up (PIFU) is the highest in the ICS by over nine percentage points (September data).

Community Urgent Response Performance

2 Hour Urgent Community Response

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



Latest
94.15%
Variance Type
Special cause variation - improvement...
Target
70%
Target Achievement
The system is expected to consistently pass the target
DQ Indicators
S T P

Summary	Actions	Assurance
The standard remains in special cause improvement and comfortably achieving a pass icon. This is the 15th consecutive month above the post-Covid mean of 91.3%.	• Communications shared with care homes to encourage direct referrals into 2 hour UCR • Ongoing engagement with NWAS to support utilisation • Advanced Care Practitioner cover 7 days per week from November 2023 • Reviewing of DOS profile and ongoing work with ICB to support 111 referrals	• The target threshold continues to be met

Operational Performance: SSNAP Stroke Audit – Quarter 1

Action- Weekly breach meetings identify target areas to improve. Actions follow with training identified and opportunities for process improvement

Performance- **Quarter 1 SSNAP data-** FGH has declined from 89 to 86 and remained at level A. The RLI has improved from 73 to 76 and remained at level B – FGH remain the only A rated Unit in the L&SC Network.

Patient-centred SSNAP scores by site:

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

1) Good consistent performance- delays identified at the weekly breach meetings.
2) **KEY FOCUS AREA – out of hours performance.**
3) **KEY FOCUS AREA – out of hours performance.**
4) Slight deterioration due to staffing.
5) Good performance but recruitment at risk.
6) Recruitment ongoing but maintaining well.
7) RISK! - due to national shortages in SALT specialists.
8) Good consistent performance noted.
9) Maintaining standards & looking for improvements.
10) Now improved due to changes in recording.

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

1) No major issues – maintaining good work.
2) **KEY FOCUS AREA - Ensuring protected beds a priority**.
3) **KEY FOCUS AREA – ongoing training needs assessed.**
4) First line assessments maintaining the improvement.
5) Good performance since therapy space opened end Q3.
6) Improving trajectory albeit ongoing recruitment.
7) RISK! - Recruitment ongoing – national shortfall in specialists.
8) Improvements made and continue to remain a focus.
9) **KEY FOCUS AREA –** improvements in documentation actioned.
10) Now improved due to changes in recording.

Key to SSNAP Scoring

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

APPENDICES

Operational Performance-Glossary of Metrics

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

Operational Performance-Glossary of Terminology

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

REPORT TO BOARD OF DIRECTORS

DATE OF MEETING: 6 December 2023

University Hospitals of Morecambe Bay NHS Foundation Trust

CHAIR'S REPORT

Reporting Group/Committee:	Finance and Performance Committee			
Data and time:	20 November 2023 at 11:30			
Chairperson	Amin Kamaluddin Non-Executive Director			
Attendance:	**Quorate:**	Yes	**Not Quorate:**	
If not quorate, state reason:				
Key items discussed:	1. Chief Financial Officer's Report			
	2. Integrated Care Board Block Contract Review			
	3. Investment and Priorities Group 3A Report			
	4. Community Diagnostic Centres Business Case			
	5. Month 7 Financial Performance Report			
	6. Overview of EVO (engagement, value and outcome) Framework			
	7. Elective Activity Monitoring – October 2023			
	8. Operational Performance Report			
	9. Performance Accountability Framework Output Report – October 2023			
	10. Annual Plan 2024/25 Update			
	11. Sustainable Financial Improvement Programme Update			
	12. National Cost Collection 2022/23 – Planned Submission Report			
	13. Lancashire and South Cumbria New Hospitals Programme Flash Report			
	14. Finance and Performance Committee Quarterly Risk Report			
	15. Peer Review of Corporate Governance Arrangements at UHMB			

Alert: (where a matter needs sharing with another committee/Board in relation to areas of non-compliance or matters that need addressing urgently with details of actions taken to address the matter.)	1. The Committee was updated on the Trust's current financial position and was assured by the mitigations in place.
	2. The Committee was alerted to the impact of the number of patients not meeting criteria to reside. The Committee noted the executive team were discussing a response to this with the ICB. The Committee and Board would be kept briefed.
	3. After deferring a decision to approve the business case for Community Diagnostic Centres to seek assurance and establish an audit trail regarding approvals to date, risks and mitigations considering the wider financial picture, the Committee noted this work had been completed and approved the business case.
	4. The Committee considered its risk report and agreed a review of the risk relating to the Trust financial position be undertaken to reflect discussions by the Committee regarding the forecast outturn position.
Advise: (where there is a matter that has on-going monitoring and any new developments need sharing to the committee/Board)	5. The Committee received a report on the lessons learnt from the business case benefits realisation process following establishment of the Investment and Priorities Group and how this had informed the process for the development of future business cases.
	6. The Committee was updated on the EVO (engagement, value and outcome) framework. It was agreed the Head of Income and Costing, Director of Governance and Associate Director of Strategy review the EVO framework in the context of Trust arrangements to understand how they could be calibrated for maximum efficiency of time commitment of corporate and Care Group colleagues and agree the forum to present at for consideration ahead of the Finance and Performance Committee.
	7. The Committee approved the submission of the National Cost Collection.
	8. The Committee considered the outcome of the corporate governance peer review and noted further work would be undertaken before presentation to the Board of Directors on 6 December 2023.
Assure: (where an update has been provided to the Committee and assurance has been received)	9. The Committee was assured of the work relating to a detailed review of the Trust's block contract arrangements. A report on next steps would be considered by the Committee in December 2023.
	10. The Committee was assured on the annual planning process for 2024/25.
Name of committee for escalation: (parent committee)	Board of Directors

Chair's Narrative on the meeting: (if applicable, covering points otherwise not discussed elsewhere in the template)
Date, Time & Location of next meeting:
Monday 18 December 2023 at 11.30am via Microsoft Teams.

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

THIS PAGE IS INTENTIONALLY BLANK

REPORT TO: BOARD OF DIRECTORS

DATE OF MEETING: 6 DECEMBER 2023

University Hospitals of Morecambe Bay NHS Foundation Trust

CHAIR'S REPORT

Reporting Group/Committee:	Quality Assurance Committee			
Data and time:	27 November 2023 at 2pm			
Chairperson	Hugh Reeve Non-Executive Director			
Attendance:	**Quorate:**	Yes	**Not Quorate:**	
If not quorate, state reason:				
Key items discussed:	1. CNO/CMO Update			
	2. Integrated Quality & Safety IPR			
	3. Maternity Assurance Reports			
	4. The Impact of Not Meeting Criteria to Reside on Fundamentals of Care			
	5. Monthly Safe Staffing Report			
	6. Quarterly Update – Surgery & Critical Care Group			
	7. Quarterly Update – Medicine Care Group			
	8. Quarterly Clinical Audit Update			
	9. Outcome of Peer Review of Corporate Governance Arrangements at UHMB			
	10. Continued Quality Improvement Strategy			
	11. Patient Relations Process & MIAA Update Paper			
	12. Patient Relations Annual Report			
	13. Monthly CQC and Niche Sustainability Assurance Paper			
	14. Quarterly Risk Register			
	15. Lessons Learned Newsletter			

	16. Chair's Report from reporting groups
Alert: (Where a matter needs sharing with another committee/Board in relation to areas of non-compliance or matters that need addressing urgently with details of actions taken to address the matter.)	The final report outlining our performance in this year's Maternity Incentive Scheme (CNST) requires Board sign off in January 2023. There is no public Board meeting taking place in January 2024. Action: The maternity leadership team will investigate how we can best handle this and will report to December's Board.
Advise: (Where there is a matter that has on-going monitoring, and any new developments need sharing to the committee/Board)	The Committee considered an initial report on any adverse effects on those patients who are experiencing a prolonged stay in hospital while not meeting the criteria to reside there. The initial report considered falls and pressure ulcers. It is recognised this was a rapid review and a further detailed report will be presented in February 2024 reviewing the wider quality issues covered by Fundamentals of Care.
	The Peer Review of Corporate Governance Arrangements was considered. The recommendation that Board Committees should be supported by the Company Secretary's team was discussed. This recommendation was supported by the Committee, which at present is supported by the PA to the Chief Nursing Officer.
	The draft Continuous Quality Improvement Strategy was discussed, prior to its submission to the Board. Several points were raised including: Greater emphasis should be made on the responsibility of everyone in the organisation to continuously improve their own work and that of their team. Everyone has two jobs – to do their work and to improve how this work is done. Involving patients and their families/carers in our improvement and transformation work needs further development within the strategy. The delivery plan for the strategy was not available for our discussions – without this we were unable to comment on the practicalities of delivering this vital piece of work. Concerns were voiced about the capacity of the team that will be tasked with supporting the strategy's delivery. In addition, more detail was needed regarding how we would know/measure that the key elements of the strategy were on track. The outcomes described in the main strategy paper felt rather broad and non-specific.
	Progress with addressing the backlog with complaints and PALS concerns was discussed. The team has been hampered by long term illness and delays in recruiting to vacant positions. This situation should improve significantly in the New Year. Despite this significant progress has been made with reducing the number of complaints unresolved after 6 months.
Assure:	A detailed update was received regarding progress with the audit programme for 2023/24, which at the

	end of Quarter 2 was on track to deliver most of the planned audits, despite the ongoing pressures due to industrial action. Some suggestions were made as to how the report could provide greater assurance regarding those audits that had been removed from the programme in year.
Name of committee for escalation: (Parent committee)	Board of Directors
Chair's Narrative on the meeting: (If applicable, covering points otherwise not discussed elsewhere in the template)	
Date, Time & Location of next meeting:	
Monday 18 December 2023 at 2pm via MS Teams	

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

THIS PAGE IS INTENTIONALLY BLANK

NHS Lancashire and South Cumbria Integrated Care Board

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

NHS University Hospitals of Morecambe Bay NHS Foundation Trust

BOARD OF DIRECTORS

Date of Meeting	6 December 2023
Title	Provider Collaboration Board (PCB) Update
Report of	Aaron Cummins Chief Executive
Prepared by and contact details	Paul Jones Company Secretary

Confidentiality	Non-Confidential

Purpose of Report	**To Advise/Alert**	**To Assure**	**To Approve**	**To Update**
				x
	The purpose of this paper is to present an update on the most recent meetings of the PCB.			

Summary of Key Issues / Concerns	The Provider Collaboration Board (PCB) met on 19 October 2023. It received updates on the following standing items: system pressures and performance updates within urgent/emergency care and elective care; mental health and learning disabilities, and finances. The next meeting of the PCB will take place on 16 November 2023 and an update will be provided at the Board of Directors' meeting on 7 February 2024.

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

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

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

Impact on Board Assurance Framework or Trust Wide Risk Register	This report is a source of assurance on progress on Working in Partnership.			
Risk Impact Assessment	Is this required?	**N**	If Yes, Date Completed	
Equality Impact Assessment	Is this required?	**N**	If Yes, Date Completed	
Quality Impact Assessment	Is this required?	**N**	If Yes, Date Completed	
Environmental / Sustainability Impact Assessment	Is this required?	**N**	If Yes, Date Completed	

Acronyms	

UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST

Provider Collaboration Board (PCB) Update

Introduction

1. The Provider Collaboration Board (PCB) met on 19 October 2023.

2. It received updates on the following standing items: system pressures and performance updates within urgent/emergency care and elective care; mental health and learning disabilities, and finances.

3. The Joint Committee has been established to give the PCB a mechanism via which to make decisions on a number of key programmes of work as agreed with Trust Boards. Updates on Central Services, Outpatient Dispensing Services, clinical programmes and funding, and the Elective Recovery Programme were discussed under Joint Committee Working items.

System pressures – acute

4. LSC A&E attendances had increased significantly across the system in September. Although 4- hour performance fell slightly below the 76% March 2024 target this still compares well against the averages for England and all North- West trusts.

5. After doubling in August, over 60-minute ambulance handover delays remained high in September.

6. LSC's overall bed occupancy rose to a peak in week ending 1st October, matching the previous high in mid-December 2022. This impacted flow out of the Emergency Department (ED), leading to delays and worsened performance.

7. The proportion of Adult G&A beds occupied by patients Not Meeting Criteria to Reside (NMC2R) (complex case patients only) remains significant and have begun to rise. Plans were being explored with Place to mitigate these figures.

8. As is the case nationally, the total number of patients waiting for treatment across LSC is increasing and an update on the hard work taking place to address this was provided later on in the agenda.

9. Within Cancer Service, reducing long waits remains a priority. A number of specialties were particularly challenged in terms of meeting the 31-day standard which is driven by surgical capacity.

System pressures – mental health and learning disabilities

10. While the bed request rate remains within normal range for patients with mental health, learning disabilities and autism (MHLDA), A&E bed requests continue to show fluctuation, reflecting bed availability rather than increases in overall demand.

11. Accident and Emergency 12-hour breaches were higher in September than August but still reduced from May peak. Overall bed demand has been in established range for last

3 months with discharge rates improving with weekly average discharge rate higher in 2023 compared to 2022.

12. There are early signs of a positive impact from the Super Stranded Incident Management Group, working alongside Local Authorities to create a direct link to consultants and support patients who have been in hospital for a significant period to be discharged.

13. There is a focus on reducing the number of patients in inappropriate Spot Purchased Out of Area Placements. On 13th November 2023 a 32-bed facility will open in Whalley to primarily take people from out of area.

14. There are currently long waits for children and young people with autism or attention deficit hyperactivity disorder (ADHD) and work is underway with the ICB to undertake significant assessment between now and 31 March 2024.

15. A CQC Well Led review took place in mid-October with plans being scrutinised to mitigate waits and assess young people who are waiting.

16. Fylde Coast Initial Response Service launched in September 2023 meaning there is now a service in place across Lancashire and South Cumbria. The telephone triage service means people can call the service to be directed to urgent care or third sector organisations.

Financial Update

17. LSC has the 2nd largest deficit in the Country in both financial and percentage terms. At month six in-year the system had spent significantly more than projected.

18. At provider level, cost improvement plan (CIP) delivery progresses steadily, with a further £20m of CIP delivered between month 5 and month 6.

19. Year to date Agency spend was significantly above plan and the forecast had been changed to reflect this.

20. Work was taking place on revised deficit protocols to help Boards to prepare for the 2024/25 planning round and maximise potential improvement and delivery over the second half of the financial year.

Central Services Portfolio Update – Outpatient Dispensing Services for Lancashire and South Cumbria

21. In May 2023, L&SC Provider Trusts established a Pharmacy Collaborative Steering Group reporting to the Central Services Portfolio Board of the Provider Collaborative.

22. The Pharmacy Collaborative Steering Group have been considering potentially viable delivery models for future delivery of outpatient dispensing services based on the principle of improving collaboration. A number of options have been considered and were discussed at PCB.

23. The PBC endorsed the recommendation of an Alternative Delivery Model (ADM) as the preferred future operating model for outpatient dispensing. The Pharmacy Steering

Group would now proceed to commercial and operational planning, and preparation of an NHSE Subsidiaries Business Case.

Clinical Programme Board Update and Funding Decision

24. Work to reconfigure clinical services is ongoing. Networks across the system are working to design and implement new models of care with a single network of provision. This is approach is currently being undertaken in: Vascular; Head and Neck Cancer; Urology; and Cardiac.

25. Cross system specialty networks are delivering pathway level improvement and tackling the issues identified as most important to them, including a constant cycle of improvements in quality and efficiency. These services include Stroke; MSK; T&O; Haematology; Dermatology; Ophthalmology; Integrated Physical and Mental Health; and Frailty.

26. Providers are also currently undertaking an assessment which will highlight their most fragile services with a view to establishing and focusing on those services which would benefit from taking a collaborative approach to developing rapid solutions.

27. An initial workshop held on 4th August would be followed by another on 17th November with PCB and ICB executive representation to review potential configurations in further detail.

28. The 23/24 budget for Clinical Programmes was smaller budget than previous years. Although possible to say within the initial budget, this would severely impact and delay the programme described above.

29. PCB agreed to resource the clinical programme correctly in line with our other system change portfolios. Further work is required on specific allocations of support to specialty areas - this will be completed once we have the outcome from the fragile services assessment.

Elective Recovery Programme Group Update

30. The Elective Recovery Programme focuses on eliminating long waits and reducing waiting times through restoring and transforming elective care to maximise and optimise capacity and manage demand.

31. In line with the national position and primarily driven by the impact of industrial action, the number of patients awaiting treatment in Lancashire and South Cumbria is continuing to increase. There is also an increase in both 65-week waiters and 52-week waiters. Modelling work at both a system and Provider level has been undertaken to forecast the impact of- industrial action continuing, with this suggesting the waiting list size and number of long waiters continuing to grow throughout the second half of the financial year.

32. This shared issue has been discussed within the COO's Network and a view that a more 'radical' mitigation is required, with significant support to develop and then consider a cost per case remuneration model for LSC to both increase the uptake of additional activity and increase the throughput in sessions.

33. Both the issue and potential solution have been shared with the Provider Director of Finance (DPF) Group who are supportive of work commencing to consider this as an option. Once developed, the option will be brought back to the Provider Collaborative Board for a decision on whether to pilot this.

34. The ICS Vacancy Control Panel did not endorse the proposal to utilise available budget to engage the NHS Transformation Unit to support the Surgical Hub programme. whilst waiting on the programme team capacity being in place. Consequently, there was an estimated 3-month delay to the programme.

35. Aside from this, the Lancashire and South Cumbria Elective Recovery Programme continues to perform and benchmark well across a range of key metrics on both a regional and national footprint, with day case rates at 82.6% which is in the second top quartile within the latest reporting period.

36. The Westmorland Surgical Hub has been accepted into Cohort 3 of the national accreditation programme, with Burnley Surgical Hub expressing an interest to be considered for Cohort 4.

37. Work is also progressing to create an Independent Sector Strategy for LSC. Rich data has now been obtained from all acute Trusts to inform future strategic intentions and the main IS providers now being met with to obtain the same level of insight. This is important to gauge the ability of the IS to increase capabilities in pressurised services in LSC and opportunities to widen acceptance criterions.

Recommendation

38. The Board of Directors is asked to consider the contents of the report.

NHS Lancashire and South Cumbria Integrated Care Board

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

NHS University Hospitals of Morecambe Bay NHS Foundation Trust

BOARD OF DIRECTORS

Date of Meeting	6 December 2023
Title	Provider Collaborative Board Joint Committee – Revised Terms of Reference
Report of	Paul Jones Company Secretary
Prepared by and contact details	Paul Jones Company Secretary

Confidentiality	Non-Confidential

Purpose of Report	**To Advise/Alert**	**To Assure**	**To Approve**	**To Update**
			x	
	At its meeting on 25 November 2022, the Board approved the terms of reference (TORs) for the establishment of the PCB as a joint committee. In March 2023 these TORs were revised further to allow for the pathology network board to be constituted as a sub-committee of the joint committee. The TORs have been subject to a further review and the proposed revised TORs (as attached to the report) are presented to all constituent Trust Boards in December 2023 for consideration. Christian Dingwall, Partner - Browne Jacobsen, will be present at the meeting to answer questions on the revisions.			

Summary of Key Issues / Concerns	The success of individual NHS and NHS Foundation Trusts will increasingly be judged against their contribution to the objectives of the integrated care system. Engaging consistently in shared planning and decision-making together with delivery of improvement and decisions are key elements of good collaboration. The PCB was created to provide a platform to achieve these objectives. Keeping the TORs under review will help achieve effective integration. The review has been undertaken by the PCB supported by the Angela Bosnjak-Szekeres, Senior Responsible Officer for Governance and Legal Services - Lancashire & South Cumbria PCB, and Christian Dingwall.

	The PCB has held workshops and the TORs have been circulated to the provider Company Secretaries for review. Following the last PCB workshop, the final revised TORs are now ready for presentation at constituent Boards for their consideration. An advice Note has been published that explains the changes being proposed. Two changes are highlighted to the Board. The first change is to Appendix A and the work plan of the Committee. This is extended and more defined. In approving the workplan, the Board is giving authority for the PCB to set strategic priorities in these areas. In respect of pathology, authority is being given for site selection. A further report on this will be taken to the Finance and Performance Committee on 18 December 2023 so that each provider is clear on the process. The second change is reference is now made to Sub-Committees, Programme Boards and Professional Networks and their role and remit as they relate to the work of the PCB. Further details are set out in Appendix C. In the next phase, the PCB will be considering its role in relation to the ICB and reviewing the operating model of the JCPCB in terms of Trust Boards assurance and how joint decisions are being made. Under this model, each provider retains authority for achieving the strategic priorities as set out by the PCB. The PCB will need a strong corporate governance framework to ensure due diligence is followed and that there is transparency and accountability in shared planning and decision-making together.

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

Action to be recommended to the Committee/Board	The Board of Directors is asked to consider the revised terms of reference and if so minded approve them before ratification by the PCB at its meeting on 18 January 2024.

Link to Key Priorities	Delivering outstanding	Create the culture and	Make the best use of our	Working in partnership

	care and experience	conditions for colleagues to be the very best they can be	physical and financial resources	
	x	x	x	x

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

Acronyms	

THIS PAGE IS INTENTIONALLY BLANK

Terms of Reference for L&SC Joint Committee Provider Collaboration Board

November 2023 - DRAFT ~~v006-3~~ v006-4

Title	Terms of Reference for L&SC Joint Committee Provider Collaboration Board
Author(s)	
Version	Draft ~~v006-3~~v006-4
Target Audience	Lancashire and South Cumbria NHS Trust Providers
Created – date	
Date of Issue	
Date ratified	
Review date	
Document Status	Draft
Description	Updated Terms of Reference for Lancashire and South Cumbria Joint Committee Provider Collaboration Board
File name and path	

Document History:

Date	Version	Author	Notes
20 Feb 2023	003-1	Angela Bosnjak-Szekeres, SRO for Governance & Legal Services – Lancashire & South Cumbria PCB Christian Dingwall, Browne Jacobson	Previous versions of the PCB ToR were: Version 001 – original ToR approved July 2020 to constitute the PCB as a working group Version 002 – updated ToR approved Nov 2022 to reconstitute the PCB as a joint committee The purpose of this updating to version 003 is to confer delegated additional functions on the PCB for pathology services
07 Jul 2023	004-1	Angela Bosnjak-Szekeres, SRO for Governance & Legal Services –	The purpose of this updating to version 004 is to update the PCB's workplan to include centralized corporate services in accordance

		Lancashire & South Cumbria PCB Christian Dingwall, Browne Jacobson	with the PCB's decision at its meeting on 21 June 2023
19 Sep 2023	005-1	Angela Bosnjak-Szekeres, SRO for Governance & Legal Services – Lancashire & South Cumbria PCB Christian Dingwall, Browne Jacobson	The purpose of this updating to version 004 is to update the PCB's workplan to include functions relating to new site location for a central facility for pathology services
20 Sep 2023	005-2	Angela Bosnjak-Szekeres, SRO for Governance & Legal Services – Lancashire & South Cumbria PCB Christian Dingwall, Browne Jacobson	Amended to take account of comments of Tim Bennett
11 Oct 2023	006-0	Christian Dingwall, Browne Jacobson	
12 Oct 2023	006-1	Angela Bosnjak-Szekeres, SRO for Governance & Legal Services – Lancashire & South Cumbria PCB Christian Dingwall, Browne Jacobson	Amended for review by LSC CoSecs.
02 Nov 2023	006-2	Angela Bosnjak-Szekeres, SRO for Governance & Legal Services – Lancashire & South Cumbria PCB Christian Dingwall, Browne Jacobson	Amended following review by LSC Trust Secs 13 Oct 2023
09 Nov 2023	006-3	Angela Bosnjak-Szekeres, SRO for Governance & Legal Services – Lancashire & South Cumbria PCB Christian Dingwall, Browne Jacobson	Amended following review by LSC Trust Secs 03 Nov 20223
23 Nov 2023	006-4	Angela Bosnjak-Szekeres, SRO for Governance & Legal Services – Lancashire & South Cumbria PCB Christian Dingwall, Browne Jacobson	Amended following review by LSC Trust Secs 23 Nov 20223

Approval	

Lancashire and South Cumbria

Joint Committee Provider Collaboration Board Terms of Reference Version ~~006-3~~006-4

1. Introduction

Lancashire and South Cumbria Joint Committee Provider Collaboration Board (JCPCB) is a formal joint working and delegation arrangement between

- Blackpool Teaching Hospitals NHS Foundation Trust (BTHT)
- East Lancashire Hospitals NHS Trust (ELHT)
- Lancashire Teaching Hospitals NHS Foundation Trust (LTHT)
- Lancashire and South Cumbria NHS Foundation Trust (LSCT)
- University Hospitals Morecambe Bay NHS Trust (UHMBT)

(the Trusts) who are NHS providers within NHS Lancashire and South Cumbria Integrated Care System (ICS). The Trusts have agreed that the JCPCB should continue to be constituted as a joint committee of them to enable increased collaboration and to commit to collective, binding decisions.

2. Name

Lancashire and South Cumbria Joint Committee Provider Collaboration Board (JCPCB).

3. Establishment

Each Trust Board has formally approved constituting the JCPCB as a joint committee with delegated functions in accordance with these terms of reference.

4. Aims and Objectives

The JCPCB aims to enable greater collaboration between the Trusts to:

- Improve the pace of decision making to enable better patient outcomes and quality of patient care
- Provide NHS Lancashire and South Cumbria Integrated Care Board (the ICB), NHS England, local authorities and the wider ICS with a single, collective view of the Trusts on proposals for service change
- Develop, implement manage and oversee shared clinical, corporate and other services on behalf of the Trusts across Lancashire and South Cumbria including the associated operating delivery and governance models which they may agree to adapt, and
- Support financial stability and sustainability through reduced duplication and better use of existing resources.

5. Delegated Duties and Responsibilities

Each of the Trusts has agreed to delegate to the JCPCB the exercise of its functions for:

- Key strategic service transformation priorities as defined by the ICS and commissioners;
- Key priorities for provider productivity improvement
- Key opportunities for developing standardised approaches to service change and delivery
- Shared clinical services including but not limited to community services and pharmacy services
- Shared corporate services including but not limited to: bank and agency workers; procurement; centralised corporate services and financial transactions including a single financial ledger and payroll.

Additionally BTHT, ELHT, LTHT and UHMBT have agreed to delegate to the JCPCB the exercise of functions for shared pathology services that are set out in Appendix A.

The JCPCB's exercise of functions shall be limited to matters set out in the workplan that is set out in Appendix A. The JCPCB shall review its workplan as often as it considers necessary and at least annually with a view to agreeing updates to Appendix A in accordance with section 7 of these terms of reference and always subject to being within its delegated authority.

The JCPCB shall exercise such further functions as the Trusts may delegate to it from time to time.

In exercising delegated functions the JCPCB shall provide a single, collective view of the Trusts at all levels of the ICS through an agreed annual work programme relating to the delegated functions that promotes the best interests of the whole population.

6. Accountabilities and reporting lines/governance structure

The JCPCB is one part of an overall public sector service transformation programme within the ICS led by the ICB. The JCPCB will work within the existing structure of organisations and existing legal frameworks.

The principle of subsidiarity will be applied to the work programme of the JCPCB; issues will be addressed at the most appropriate level of decision making.

The JCPCB is accountable to each of the Trusts.

Each of the Trusts will remain fully accountable for its functions that the JCPCB exercises for it.

7. Decision Making

The JCPCB will operate as a joint committee. Each Board has delegated decision making authority to the JCPCB so the JCPCB may make collective decisions that bind the Trusts in relation to its delegated duties and responsibilities.

All JCPCB Members will have the right to vote regardless of whether the service or issue was 'relevant' to them. An inclusive arrangement will enable a greater sense of collaboration and reciprocity – and where dispassionate views and opinion may assist in decision making.

Whilst it is expected that decisions will be achieved through the usual processes of consensus, it will be necessary for proposals to be put to be put to a vote in default of consensus. In the event of a vote, decisions will be approved if a qualified majority of votes is in favour. The required qualified majority will be as follows:

No. of Member Trusts participating in decision	Qualified voting majority % greater than or equal to (≥)
5	≥80%
4	≥75%
3	≥66%

Any dispute about voting may be escalated in accordance with the Dispute Resolution as described.

8. Membership

Membership of the JCPCB shall comprise the Chief Executive and Chair of each of the Trusts (the Members).

	The Trusts	Member
1	Lancashire Teaching Hospitals NHS Foundation Trust	Chief Executive & Chair
2	University Hospitals of Morecambe Bay NHS Foundation Trust	Chief Executive & Chair
3	East Lancashire Hospitals Trust	Chief Executive & Chair
4	Blackpool Teaching Hospitals NHS Foundation Trust	Chief Executive & Chair
5	Lancashire and South Cumbria Mental Health NHS Foundation Trust	Chief Executive & Chair

Each Trust shall designate a deputy (Deputy Member) for each of its Members. The Deputy Member for a Chief Executive must be an Executive Director with voting rights or for a Chair must be a Non-Executive Director with voting rights. In these terms of reference 'Member' shall include a Deputy Member who attends a meeting for a Member.

It is each Trust's responsibility to consider its approach to authorise its Members for the purpose of JCPCB participation.

There will be a total of 10 votes available. Each Member may exercise one vote on behalf of each organisation that the Member represents.

A governance professional with appropriate qualifications will act as the JCPCB Secretary on behalf of the JCPCB in a support and secretariat role, and will attend its meetings but without voting rights.

8A. Associate Members

The Members may appoint up to three Associate Members of the JCPCB who may attend its meetings but without voting rights or counting towards the quorum. An Associate Member's term of office shall be two years from the date of appointment. An Associate Member shall be eligible for reappointment to a second term of office on expiry of their initial term of office subject to a maximum tenure of four years.

9. Chair

The Chair of the JCPCB will be one of the Trusts' Chairs whom the Members appoint by consensus. The Chair shall preside at meetings of the JCPCB. In the absence of the Chair at a meeting or part of a meeting, and with the Chair's prior agreement, the Members may agree that one of them should deputise for the Chair.

The JCPCB Chair's term of office shall be two years from the date of appointment. The JCPCB Chair shall be eligible for reappointment on expiry of their term of office, subject to a maximum tenure of four years.

9A. Lead Chief Executive

The lead Chief Executive of the JCPCB will be one of the Trusts' Chief Executives whom the Members appoint by consensus.

The lead Chief Executive's term of office shall be two years from the date of appointment. The lead Chief Executive shall be eligible for reappointment to a second term of office on expiry of their initial term of office subject to a maximum tenure of four years.

10. Meetings

The JCPCB shall meet at such times and places as the Chair may direct on giving reasonable written notice to members. Meetings will be scheduled to ensure that they do not conflict with Trust Board meetings and are synchronised so that JCPCB members can properly engage their organisations ahead of JCPCB meetings.

On occasion it may be necessary to arrange extraordinary meetings at short notice. In these circumstances the Chair will give as much notice as possible to members.

Meetings of the JCPCB shall not be open to the public.

Papers for the meeting will be issued one week in advance of the date the meeting is due to take place.

11. Costs and support functions

Costs incurred by and provision of support functions to the JCPCB will be borne equally by all Trusts, unless there are material grounds (agreed in advance by all members) to allocate specific costs on a different basis. Examples of costs likely to be incurred include the JCPCB Director, secretariat and consultancy support where it is appropriate and agreed by members.

12. Quorum

The quorum for a meeting of the JCPCB shall be:

- For a meeting at which a Category 1 decision will be made, all of the Members must be in attendance or able to participate virtually by using video, telephone, web link or other live and uninterrupted conferencing facilities.
- For a meeting at which no decisions on Category 1 issues will be made, **80%** (in terms of whole numbers) of the Members are required to be in attendance or able to participate virtually by using video, telephone, web link or other live and uninterrupted conferencing facilities.

13. Attendees

The JCPCB can request additional attendees at meetings to provide specialist advice or information and can call for the attendance of others, such as clinicians.

The Chair can permit other persons to attend JCPCB meetings, including individuals or representatives of organisations who request to attend.

Any additional attendees shall not count towards the quorum or have the right to vote at meetings.

14. JCPCB Subcommittees

The JCPCB may appoint one or more subcommittees and sub-delegate to them the exercise of any of the JCPCB's delegated functions. Eligibility for membership of a subcommittee shall be restricted to Members or Deputy Members. JCPCB Subcommittees shall be recorded in Appendix C.

14A JCPCB Programme Boards

The JCPCB may appoint one or more Programme Boards to assist the JCPCB and its subcommittees with their work. Each JCPCB Programme Board shall be chaired by a Member or Deputy Member. Eligibility for membership of a JCPCB Programme Board shall

be within the discretion of the Members. JCPCB Programme Boards shall be advisory or enabling only and have no delegated authority to exercise any of the JCPCB's delegated functions, but may make recommendations to the JCPCB for the purpose of its decision-making. JCPCB Programme Boards shall be recorded in Appendix C.

14B. Professional working groups

JCPCB Subcommittees and JCPCB Work Groups may be assisted by professional working groups which are advisory only.

15. Conflict of interest

All Members and attendees should declare any conflicts of interest at the start of each meeting. Any declared interests should be recorded in the register of interests of the Member's or attendee's employing organisation.

Should any Members have concerns regarding an actual or perceived conflict of interest of the Chair, they should report these to the JCPCB Secretary in the first instance.

16. Dispute Resolution

The agreed L&SC dispute resolution process shall apply and is attached at appendix B.

17. Collective Responsibility

Once decisions are made, all members will have a responsibility to ensure achievement of the JCPCB's objectives and delivery of the work programme. Externally, members will be expected to represent the JCPCB's views and act as ambassadors.

18. Communications

Following each JCPCB a summary of actions and decisions will be sent to Members. A briefing on key discussions and decisions will be provided through the LSC governance.

19. Review of the performance of the JCPCB

The JCPCB shall review its own performance annually (led by the Chair) and implement and/or recommend any necessary changes. These changes will be reported to members' Boards.

20. Review of the Terms of Reference

The Terms of Reference will be reviewed annually in conjunction with the wider review of the JCPCB.

The JCPCB has no other powers than those in the Terms of Reference.

Appendix A - Workplan

Shared clinical services for community services

Shared corporate services including but not limited to: bank and agency workers; procurement; and financial transactions including a single financial ledger and payroll

Shared pathology services

The JCPCB is responsible for strategic priorities for pathology services which comprise:

- Oversight and Leadership of the Implementation of Digital Solutions for Pathology including laboratory information management systems (LIMS), digital pathology, informatics and management reporting.
- Agreement of an appropriate clinical model for all pathology services including development and agreement of a delivery model.
- Coordination of all equipment procurement leading to common automation platforms across the network.
- Responsibility for managing the response to Pathology related GIRFT (Getting it Right First Time) across the network including standardisation and harmonisation of practices.
- Developing and implementation a programme for rolling out Point of Care Testing across the network.
- Coordination and delivery of the Cancer restoration plans with regards to Pathology services.
- Agreement to a network wide workforce strategy.
- Establishing a network wide approach to QMS and coordinating all aspects of pathology related clinical governance.
- Implementation and roll out of the genomics programme across the network.
- Oversight and management of all pathology related research and development across the network.
- Agreeing the Terms of Reference for the Pathology Network Board as a sub-committee of the PCB.

The JCPCB is further responsible for:

- Undertaking all steps required to prepare and (subject to the Trusts agreeing to amend section 5 of the core ToR) to approve the capital business case of BTHT, ELHT, LTHT and UHMBT for development of the Lancashire and South Cumbria central facility for pathology services including option appraisal, recommendation and selection of the preferred site location
- Amending the Pathology Network Board's Terms of Reference so that they shall include responsibility for:
    - Agreeing a set of criteria for determining the preferred site location for a central facility for pathology services

- Identifying potential sites
- Ranking each site option against the criteria.
- Making a recommendation to the PCB for site selection

Central corporate services

BTHT, ELHT, LSCT, LTHT and UHMBT, in partnership with the Integrated Care Board, have a joint vision for more collaborative central services – removing duplication and improving efficiency and effectiveness of the services to better support patient care and create a great place to work where our colleagues are supported to excel. As well as closer collaboration across functions, the PCB has agreed in principle that transactional operational central services should be brought together into one 'umbrella' service hosted by one of the NHS Trusts. This is known as a 'Host Trust Model'.

The programme focuses on a model for delivering collaborative corporate services. These are non-clinical services and include HR and OD, procurement, strategy, estates and facilities, communications, digital, finance, and legal and governance.

At its meeting on 21 June 2023 the PCB agreed to update its Workplan (as appended to its Terms of Reference) by including responsibility for its central corporate services programme set out in the paper for its meeting titled *Corporate Services Update – next steps for decision*.

The following phases have been completed:

- Phase 0 Preparation and visioning
- Phase 1 Scoping and Programme launch
- Phase 3 Defining the future Target Operating Model (TOM)

Accordingly the PCB has agreed that its functions should include responsibility for the following further phases to establish the Host Trust Model, being:

- Phase 4 Transition Planning
- Phase 5 Implementation of Transition
- Phase 6 Transformation
- Phase 7 Optimisation, improvement, and review

Community services

Outpatient Dispensing Service

At its meeting on [INSERT DATE] the PCB agreed to update its Workplan so that its functions include responsibility for developing and implementing an Alternative Delivery Model (ADM) to manage the outpatient dispensing service for Lancashire and South Cumbria, following options appraisal recommendation. This has materialised from the objectives of the Provider Collaborative Central Services Programme and the drivers to improve services via collaboration across the Lancashire and South Cumbria 'footprint'.

Appendix B - Lancashire and South Cumbria Provider Collaboration Board – Dispute Resolution Process

1.0 INTRODUCTION

1.1 A formal dispute resolution process is a last resort; organisations should do all they can to avoid disputes and, when they do occur, the aim should be to resolve them swiftly. Formal involvement in a dispute is a sign that the parties have failed in their duty to work together effectively for the benefit of the 1.7 million population of the region. This document sets out the dispute process and, to reduce the number and scale of these failures, it also outlines how organisations can be supported in resolving disputes before they require any formal process.

2.0 PRINCIPLES OF THE DISPUTE RESOLUTION PROCESS

2.1 The following principles are to be adhered to for any dispute resolution:

- The resolution agreement must be in the best interests of the population. It must maintain the quality of health and social care now and in the future, deliver the best possible outcomes for our population, support innovation where appropriate, make care more cost-effective, and allocate risk fairly
- The resolution agreement must promote transparency and accountability. It should hold the members of the PCB accountable to each other and to patients and citizens, and facilitate the sharing of information to achieve the transformation objectives across Lancashire and South Cumbria
- The parties to the PCB must engage constructively with each other within the dispute resolution process when working to reach agreements. This should involve agreeing a framework for negotiations, the sharing of relevant information, engaging appropriate stakeholders where applicable, and agreeing appropriate joint objectives for service improvement and delivery.

3.0 SCOPE AND APPLICATION OF THE DISPUTE RESOLUTION PROCESS

3.1 This dispute resolution process is intended for application to disputes arising beyond the geography of a single organisation or locality.

3.2 In the absence of any other such arrangements all localities are encouraged to adopt the policy to ensure wherever possible that a swift and satisfactory conclusion for all parties of any dispute is reached in compliance with the disputes resolution process.

3.3 The dispute resolution process applies to disputes arising from the following:

- Any non-compliance with decisions agreed through the formal PCB and ICB governance processes of both Boards and their associated governance, and specific approved minutes detailing specific decisions made at such meetings, and
- Actions that are in breach of the decisions of the PCB.

4.0 OUTLINE OF THE DISPUTE RESOLUTION PROCESS

4.1 This dispute resolution process operates in three stages:

- Stage One - Mediation: The first stage involves advice and/or mediation which must be taken by agreement solely between the disputed parties. It is expected that this process will be concluded within a two-week period. If the disputed parties reach an agreement this will be binding upon all parties and the dispute will be considered as settled

- Stage Two - Negotiation: The second stage involves formal negotiation between the disputed parties with the aim of reaching a negotiated position which is acceptable to all parties. It is expected that this process will be concluded within a two-week period. If the disputed parties reach an agreement this will be binding upon all parties and the dispute will be considered as settled

- Stage Three - Panel Negotiation: The third stage involves a more formal negotiation which will be facilitated by the Accountable Officer of the ICB (or their nominated deputy). It is expected that this third stage process will be concluded within a four-week period. This is the end of the dispute resolution process.

4.5 It is acknowledged that the Parties involved in any formal dispute have recourse to existing legal processes for dispute resolution. It is hoped that the process outlined here will support the local resolution of disputes.

Appendix C – Subcommittees and Work Groups

Part 1 – Subcommittees

The JCPCB has appointed the following subcommittees under section 14 of the JCPCB terms of reference

Subcommittee name	Date ratified	Review date	ToR version no.
Pathology Subcommittee	TBA	TBA	TBA

Part 2 – Programme Boards

The JCPCB has appointed the following Programme Boards under section 14A of the JCPCB terms of reference. NB Programme Boards do not have delegated authority but are only advisory or enabling groups.

Name of Programme Board	Date ratified	Review date	ToR version no.
Clinical Programme Board	18 Jan 2023	18 Jan 2024	V0.3
Elective Recovery Programme Board	03 Feb 2023	Jan 2024	V0.4
Central Services Programme Board	TBA	TBA	TBA

Browne Jacobson

Legally privileged and confidential

Notes on LSC JCPCB Terms of Reference v006-4

1. We have drafted updated LSC JCPCB Terms of Reference v006-4 (ToR v006-4).

2. All changes have been discussed at meetings with LSC Trust Secretaries.

3. ToR v006-4 will require approval of each Trust Board participating in the JCPCB.

4. Our notes on ToR v006-4 are as follows.

Clause	**Notes**
§1.	Name of the joint committee updated from 'Provider Collaboration Board (PCB)' to 'Joint Committee Provider Collaboration Board (JCPCB)'
§2.	No material change
§3.	Confirmation that JCPCB continues to be constituted as a joint committee.
§4.	Broaden JCPCB's remit for clinical, corporate and other services from '*develop'* to '*develop, implement, manage and oversee'*.
§5.	Clarify that the JCPCB's remit for shared clinical services is '*including but not limited to community services and pharmacy services'* Clarify that the JCPCB's remit for shared corporate services is *'including but not limited to bank and agency workers; procurement; centralised corporate services and financial transactions including a single financial ledger and payroll'* Clarify that that the *'JCPCB's exercise of functions shall be limited to matters set out in the workplan that is set out in Appendix A'*
§6	Clarify that, '*The JCPCB is accountable to each of the Trusts,'* and, '*Each of the Trusts will remain fully accountable for its functions that the JCPCB exercises for it.*'
§7.	Remove requirements for initiation and categorisation so that all JCPCB

Clause	Notes
	Members have the right to vote on all issues regardless of strict relevance to their respective Trust.
§8.	Clarify designation of Deputy Members so that Deputy Member for a Chief Executive must be an Executive Director with voting rights or for a Chair must be a Non-Executive Director with voting rights. Clarify that each Member may exercise one vote on behalf of each organisation that the Member represents. Amend qualification provision for JCPCB Secretary.
§8A.	New provision for the appointment of up to three Associate Members.
§9.	New provision that the maximum tenure for the JCPCB Chair is four years.
§9A.	New provision for the appointment and tenure of the lead Chief Executive.
§10-§13.	No material changes.
§14.	Clarify that the JCPCB Subcommittees (which have delegated functions) will be recorded in Appendix C.
§14A.	New provision for JCPCB Programme Boards to assist the JCPCB but do not have delegated functions.
§14B.	New provision for JCPCB Professional Working Groups to assist JCPCB Subcommittees and JCPCB Work Groups
§15.	Clarify that, *'Any declared interests should be recorded in the register of interests of the Member's or attendee's employing organisation.'*
§16-§20	No material changes.
Appendix A	For the JCPCB to approve changes, ie there are no changes that require Trusts Boards' approval.
Appendix B	No material changes.

Clause	Notes
Appendix C	New appendix for the JCPCB to update with information about Subcommittees and Workgroups ie there are no changes that require Trust Boards' approval.

Browne Jacobson

30 November 2023

THIS PAGE IS INTENTIONALLY BLANK

NHS Lancashire and South Cumbria Integrated Care Board

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

NHS University Hospitals of Morecambe Bay NHS Foundation Trust

BOARD OF DIRECTORS

Date of Meeting	6 December 2023
Title	Guardian of Safe Working Hours Annual Report 2022/23
Report of	Jane McNicholas Chief Medical Officer
Prepared by and contact details	Dr Alan Minchom. Contact via Jessica Kirby (PA to the Guardian) Alan.michom@mbht.nhs.uk; jessica.kirby@mbht.nhs.uk

Confidentiality	Non-Confidential

Purpose of Report	**To Advise/Alert**	**To Assure**	**To Approve**	**To Update**
		x		
	The attached annual report provides asurance to the Board that the junior doctors training is being safely rosterd and their working hours are compliant with the terms and conditions stipulated in the 2016 contract and contractual requirements for the year ending 31 March 2023.			

Summary of Key Issues / Concerns	For the period 1 April 2022 – 31 March 2023 a total of 409 exception reports were submitted, of which, the vast majority were from juniors at FY1 and FY2 level during their placements at RLI and primarily in General Medicine. The focus of the exception reports was largely regarding an inability to obtain mandated breaks, having to stay late due to work intensity and short staffing. The lack of appropriate rest facilities was also highlighted in these reports. An audit using the BMA Fatigue and Facilities Charter was undertaken and the findings and recommendations are now being taken forward via medical workforce / HR with input from estates.

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

Action to be recommended to the Committee/Board	Support is requested from the Trust Board to escalate the implementation of the recommendations from the audit of the BMA Fatigue and Facilities Charter.

Link to Key Priorities	Delivering outstanding care and experience	Create the culture and conditions for colleagues to be the very best they can be	Make the best use of our physical and financial resources	Working in partnership
	Responding to new challenges	Belonging in the NHS and looking after our people	New ways of working	Growing for the future
		x	x	

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

Acronyms	
GoSW	Guardian of safe working

UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST

Guardian of Safe Working Hours Annual Report
1 Aprill 2022 – 31 March 2023

Summary

1. This annual report provides assurance to the Board that progress has been made in ensuring that the requirements of the 2016 Junior Doctors Contract are being met.

2. For the period 01/04/2022 – 31/03/2023, a total of 132 exception reports were submitted.

3. The Guardian levied a total of 10 new fines during this period.

4. The lessons learned have now been implemented and systems are running more smoothly.

5. An audit using the BMA Fatigue and Facilities Charter was undertaken, findings presented, and recommendations agreed which are now required to be progressed via medical workforce / HR with input from estates.

Background

6. In meeting the Junior Doctors 2016 terms and conditions of service (TCS), the Guardian oversees the work schedule review process and seeks to address concerns relating to hours worked and access to training opportunities.

7. The system of exception reporting outlined in the 2016 contract assists to ensure that departures from planned working hours, working pattern or access to planned training opportunities are recorded and where this happens, the work schedules are reviewed and the reasons investigated and appropriate action taken.

8. The main role of the GoSW is to monitor and address the exception reports from doctors in training (as defined in the 2016 Junior Doctor's contract).

9. The Guardian supports safe care for patients through protective and prevention measures to stop doctors working excessive hours.

10. The Guardian can levy financial penalties where safe working hours are breached.

Junior Doctor's Data

11. The breakdown of the junior doctor trainee capacity within UHMB is set out in table 1 below.

Table 1: UHMB junior doctor trainee capacity

Total junior doctor trainee capacity within UHMB	229
Actual number of doctors / dentists in training for the period	214
Foundation doctors in post during the period	125
Highers (Employed by St Helens & Knowsley NHS Trust) for the period	89

Exception Reports

12. As part of the new contract, doctors are entitled to report deviations from their contractual expectations for working hours and education. The reports help to identify any trends which can then be referred to the rota coordinators and discussed with the clinical leads.

13. The Guardian or a member of the medical staffing team, have attended the Junior Doctors Forums (both sites) and the Pediatric Doctors meetings and attendance has improved on last years. The Guardians office also attends both the shadow inductions and formal full induction.

14. The Guardian has run sessions for educational supervisors to explain the exception reporting process together with the Trust's expectations and these will be repeated for the next intake of juniors.

Analysis of the Exception Reports

15. For the period 01/04/2022 – 31/02/2023 a total of 409 reports compared to 286 in the previous year were submitted by the junior doctors, of which 37 related to education, 399 for rest hours. Note, some reports are submitted for both education and rest hours.

16. A summary of the analysis of the exception reports is as follows:

- Majority of reports were from junior doctors based at the Royal Lancaster Infirmary;
- Majority of reports were from Foundation Year 1 doctors;
- 37 reports had an impact on education;
- 10 of the exceptions met the criteria for a Guardian fine; and
- Covering too many clinical areas, lack of locums, TTO's, handing over at the end of shift, lack:
    - of dedicated time for junior doctors appraisal, continuing lack of appropriate rest facilities
    - were the reasons cited.

Table 2: Department reporting

April 2022- March 2023	RLI	FGH	Total
A & E	10	0	10
General Medicine	185	6	191
General Surgery	145	16	161
Obs & Gynae	23	0	23
General Pathology	4	0	4
General Practice		4	1
Paediatrics	1	0	1
Psychiatry		3	0
Oncology		3	0
T&O		8	0
TOTALS	**386**	**23**	**409**

Table 3: Level of doctor who submitted an exception report

April 2022- March 2023	RLI	FGH	Total
F1	247	17	264
F2	98	4	102
CT 1-2 / St1-2	26	2	28
ST3-8	15	0	15
TOTALS	**386**	**23**	**409**

Table 4: Reasons sighted

Education	Rest / hours
37	399

Table 5: Hospital site of

RLI	Cross Bay	FGH
386	N/A	23

17. As of 31st March 2023, all reports were closed compared to the previous year where there was a total of 4 were closed.

18. All education related exception reports are escalated to the director / deputy of education in support of them having an overview and raising the exceptions with the education teams.

19. No exceptions were encountered in the reporting year and the Guardian held discussion with those concerned including the trainee involved, educational supervisor, clinical lead and HR and a resolution was achieved.

Guardian Fines

20. A total of 10 exceptions have resulted in Guardian fines in this year.

21. For this reporting year, the Guardian funds were used and will be rolled over. Agreement of how these funds is to be spent will be in full consultation with the junior doctors.

Lessons Learnt from Reports

22. As the work of the Guardians team has evolved, so to have the process for dealing with the Reports and harvesting lessons for learning.

23. Examples of lessons learned as follows:

- An agreement for HR / workforce to address rota gaps to prevent comprising junior doctor;
- A need to educate juniors on the importance of logging into the bye bye bleeps system for junior doctors;
- An agreement for HR / workforce to take steps to improved communication and allocation of senior nurse triage for the allocation of job requests on wards; and

- An agreement for HR / workforce to take steps to improved work structure to ensure that non urgent jobs are completed by the in hours teams.

Improving Rest Facilities

24. In response to a request to investigate rest facilities for Junior doctors, the Guardian undertook an audit of both acute sites against the BMA fatigue and facilities charter. The findings of this report highlight areas for escalation in some significant areas and are mainly focused at RLI.

25. The findings of the audit were presented to representatives of estates and medical workforce and included trainee representation. Solutions to the findings were identified and are now required to be progressed by medical workforce / HR with input from Estates.

Recommendation

26. Support is requested from the Trust Board to escalate the implementation of the recommendations from the audit of the BMA Fatigue and Facilities Charter.

NHS Lancashire and South Cumbria Integrated Care Board

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

NHS University Hospitals of Morecambe Bay NHS Foundation Trust

BOARD OF DIRECTORS

Date of Meeting	6 December 2023
Title	Thirlwall Inquiry
Report of	Paul Jones Company Secretary
Prepared by and contact details	Paul Jones Company Secretary

Confidentiality	Non-Confidential

Purpose of Report	**To Advise/Alert**	**To Assure**	**To Approve**	**To Update**
	x	x		
	The purpose of the report is to share: 1. The Terms of Reference of the Inquiry; and 2. The internal governance arrangements for overseeing the Trust response to the Inquiry.			

Summary of Key Issues / Concerns	The Thirlwall Inquiry has been set up to examine events at the Countess of Chester Hospital and their implications following the trial, and subsequent convictions, of former neonatal nurse Lucy Letby of murder and attempted murder of babies at the hospital. The government has published the terms of reference for the Thirlwall Inquiry. This follows an engagement process led by the inquiry's independent chair, Lady Justice Thirlwall, with the affected families and other stakeholders. The terms of reference cover 3 broad areas: • the experiences of the parents of the babies named in the indictment; • the conduct of clinical and non-clinical staff and management, as well as governance and escalation processes in relation to concerns being raised about Lucy Letby and whether these

	structures contributed to the failure to protect babies from her; and • the effectiveness of governance, external scrutiny and professional regulation in keeping babies in hospital safe, including consideration of NHS culture. The inquiry will play an important role in identifying learnings following events at the Countess of Chester Hospital. Further details about the inquiry, including how to contact it, are available on the Thirlwall Inquiry website. The Inquiry has sent a questionnaire to every Trust providing neonatal services in England in order to gain an understanding of the reality of how neonatal units work. This includes UHMB. The Chair of the Inquiry has requested a copy of this questionnaire is completed by both the Trust Chief Medical Officer and a non-clinical Director with responsibility for the Trust's neonatal services. For UHMB this will be the Chief Medical Officer and Chief Operating Officer. Each respondent must give their answers without line of sight of each other's given responses. Responses to the questionnaire are to be returned to the Inquiry by 18 December 2023. The Trust has established a working group, chaired by the Director of Governance, that is currently co-ordinating the evidence required to enable the Chief Medical Officer and Chief Operating Officer to make their responses. We have no concerns currently and the collated response will be shared with the Thirlwall Inquiry by 18 December 2023.

Prior Discussions	Committee	Date	Recommendations/ Concerns

Action to be recommended to the Committee/Board	That the Board of Directors note the contents of the report.

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

	X	X	X	X

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

Acronyms	

THIS PAGE IS INTENTIONALLY BLANK

NHS Lancashire and South Cumbria Integrated Care Board

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

NHS University Hospitals of Morecambe Bay NHS Foundation Trust

BOARD OF DIRECTORS

Date of Meeting	6 December 2023
Title	Policy and Publications Report
Report of	Aaron Cummins – Chief Executive
Prepared by and contact details	Maria Caparelli – Business Manager to Chief Executive maria.caparelli@mbht.nhs.uk

Confidentiality	Non-Confidential

Purpose of Report	**To Advise/Alert**	**To Assure**	**To Approve**	**To Update**
				x
	The purpose of this report is to provide the Board of Directors with information on recent policy developments and relevant information issued from the Department of Health, NHS England / Improvement, NHS Providers, NHS Confederation, Care Quality Commission (CQC) and Healthwatch. This report also provides a view as to any upcoming External Agency Visits, Inspections and Accreditations that are expected in month.			

Summary of Key Issues / Concerns	This report highlights a number of current policies, guidance or publications, as follows: • New Care Quality Commission (CQC) Methodology • Covid-19 Public Inquiry Update • External Agency Visits, Inspections and Accreditations

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

Action to be recommended to the Committee/Board	

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

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

Acronyms	

UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST

Policy & Publications Report

NEW CARE QUALITY COMMISSION (CQC) METHODOLOGY

1. The CQC have announced they will be introducing a new regulatory approach for health and care providers, integrated care systems and local authorities.

2. This will include a new single assessment framework for providers. They intend to make all areas in England live by April 2024, with implementation in the North in February 2024.

3. The Trust Compliance and Assurance Team continue to work towards the full implementation of this methodology and already have the following in place:

    - Fortnightly task & finish group updated on latest CQC rating change
    - Breakdown of key areas of assessment identified for review and sources of data / data quality processes are continuing to be compiled and reviewed

4. We continue to monitor updates from the CQC and their implications for us as a provider Trust and will respond accordingly.

5. A Board Workshop has been arranged on 3 January 2024 to present the CQC new methodology including implications for Board and wider-Trust.

COVID-19 PUBLIC INQUIRY UPDATE

6. The UK Covid-19 Inquiry (the Inquiry) public hearings for module 2 began on 3 October 2023 and will conclude on 14 December 2023.

7. Module 2 is focused on core political and administrative governance and decision-making for the UK. It will examine the initial response, central government decision making, political and civil service performance as well as the effectiveness of relationships with governments in the devolved administrations and local and voluntary sectors. It will also assess decision-making about non-pharmaceutical measures and the factors that contributed to their implementation.

8. The Inquiry heard from witnesses including Lord Simon Stevens, former chief executive of NHS England (NHSE); Sir Christopher Wormald, permanent secretary of the Department of Health and Social Care (DHSC); Dominic Cummings, former adviser to the prime minister; Lord Mark Sedwill, former cabinet secretary and head of the civil service; Lord Edward Udny-Lister, a senior advisor to then prime minister; Rt Hon Boris Johnson; Simon Ridley, who was director general of the Covid-19 Taskforce; Sir Patrick Vallance; Professor Sir Chris Whitty and Professor Sir Jonathan Van Tam.

9. The Inquiry heard that the lack of diversity in the Cabinet Office and Number 10 directly impacted policy decisions, that NHS leaders were not consulted on the “stay home, protect the NHS, save lives” campaign, and that data indicating that the NHS was in danger of being overwhelmed in March 2020 led to the first lockdown.

10. The Inquiry heard evidence about the concerns that the NHS was going to be overwhelmed, the discharge of patients into care homes, decisions about lockdowns, and the Department of Health and Social Care's (DHSC) role in drafting regulations.

11. The Inquiry heard evidence on the timing of lockdowns, difficulties in getting data on NHS capacity, and the interactions between government and its scientific advisors.

12. During week commencing 27 November 2023, the Inquiry will hear from Rt Hon Matt Hancock MP, former secretary of state for health and social care; Rt Hon Michael Gove MP, now secretary of state for levelling up, housing and communities, and Professor Dame Jenny Harries, former deputy chief medical officer and now chief executive of the UK Health Security Agency (UKHSA).

13. Module 3 of the Inquiry opened on 8 November 2022 and will look into the governmental and societal response to Covid as well as dissecting the impact that the pandemic had on healthcare systems, patients and health care workers. A preliminary hearing for Module 3 took place on 27 September 2023. Further preliminary hearings will be announced in 2024. It is expected that hearings for this module will begin in Autumn 2024.

EXTERNAL AGENCY VISITS, INSPECTIONS AND ACCREDITATIONS

14. The Trust Compliance and Assurance team maintain a database of all external agency visits, inspections and accreditations.

15. This contains overview of any external visits, inspections or accreditations the Trust is expecting.

16. A SEND mock audit was planned by OFSTED for the ICS. This was cancelled by OFSTED with a plan that a SEND inspection will take place a date to be notified. There are no further external visits expected this month.

Aaron Cummins
Chief Executive

December 2023

1 April 2023 – 31 March 2024
Trust Board Members' Attendance Monitoring

Public Board of Directors' Meetings

MEMBERS	03/05/2023	07/06/2023	05/07/2023	02/08/2023	06/09/2023	04/10/2023	01/11/2023	06/12/2023	03/01/2024	07/02/2024	06/03/2024
Mike Thomas, Chair (Chair)											
Aaron Cummins, Chief Executive											
Chris Adcock, Chief Financial Officer / Deputy Chief Executive											
Alison Balson, Chief People Officer											
Tabetha Darmon, Chief Nursing Officer											
Karen Deeny, Non-Executive Director											
Amin Kamaluddin, Non-Executive Director (wef 03/07/2023)											
Adrian Leather, Non-Executive Director											
Scott McLean, Chief Operating Officer											
Jane McNicholas, Chief Medical Officer											
Tony Oakman, Non-Executive Director											
Sarah Rees, Non-Executive Director											
Hugh Reeve, Non-Executive Director											
Members who have resigned / term of office ended during 2023/24											
Liz Sedgley, Non-Executive Director (Term of Office ended 03/09/2023)											

Attended	Apologies	Deputy	Not commenced in post

University Hospitals of Morecambe Bay NHS Foundation Trust
Board of Directors’ Forward Plan 2023/24

	Quarter 1 2023/24		Quarter 2 2023/24			Quarter 3 2023/24			Quarter 4 2023/24		
	3 May 2023	7 June 2023	5 July 2023	2 August 2023	6 September 2023	4 October 2023	1 November 2023	6 December 2023	3 January 2024	7 February 2024	6 March 2024
Board Core Items	Minutes	Minutes	Minutes	Minutes	Minutes	Minutes	Minutes	Minutes	Minutes	Minutes	Minutes
	Action Tracker	Action Tracker	Action Tracker	Action Tracker	Action Tracker	Action Tracker	Action Tracker	Action Tracker	Action Tracker	Action Tracker	Action Tracker
	Patient Story	Patient Story	Patient Story	Patient Story	Patient Story	Staff Story	Patient Story	Patient Story	Patient Story	Patient Story	Patient Story
	Chair’s Report	Chair’s Report	Chair’s Report	Chair’s Report	Chair’s Report	Chair’s Report	Chair’s Report	Chair’s Report	Chair’s Report	Chair’s Report	Chair’s Report
	CEO Report inc ICB Update	CEO Report inc ICB Update	CEO Report inc ICB Update	CEO Report inc ICB Update	CEO Report inc ICB Update	CEO Report inc ICB Update	CEO Report inc ICB Update	CEO Report inc ICB Update	CEO Report inc ICB Update	CEO Report inc ICB Update	CEO Report inc ICB Update
	Head Governor Report	Head Governor Report	Head Governor Report	Head Governor Report	Head Governor Report	Head Governor Report	Head Governor Report	Head Governor Report	Head Governor Report	Head Governor Report	Head Governor Report
	CQC Improvement Plan										
	Maternity Update including perinatal quality surveillance model, maternity dashboard, quarterly SBLCB and 6 monthly maternity self-assessment	Maternity Update including perinatal quality surveillance model, maternity dashboard, quarterly SBLCB and 6 monthly maternity self-assessment	Maternity Update including perinatal quality surveillance model, maternity dashboard, quarterly SBLCB and 6 monthly maternity self-assessment	Maternity Update including perinatal quality surveillance model, maternity dashboard, quarterly SBLCB and 6 monthly maternity self-assessment	Maternity Update including perinatal quality surveillance model, maternity dashboard, quarterly SBLCB and 6 monthly maternity self-assessment	Maternity Update including perinatal quality surveillance model, maternity dashboard, quarterly SBLCB and 6 monthly maternity self-assessment	Maternity Update including perinatal quality surveillance model, maternity dashboard, quarterly SBLCB and 6 monthly maternity self-assessment See separate list of maternity reports	Maternity Update including perinatal quality surveillance model, maternity dashboard, quarterly SBLCB and 6 monthly maternity self-assessment See separate list of maternity reports	Maternity Update including perinatal quality surveillance model, maternity dashboard, quarterly SBLCB and 6 monthly maternity self-assessment See separate list of maternity reports	Maternity Update including perinatal quality surveillance model, maternity dashboard, quarterly SBLCB and 6 monthly maternity self-assessment See separate list of maternity reports	Maternity Update including perinatal quality surveillance model, maternity dashboard, quarterly SBLCB and 6 monthly maternity self-assessment See separate list of maternity reports
	Maternity Perinatal Mortality Review Tool (Private)	Maternity Continuity of Care (6 monthly)	Maternity Serious Incidents and HSIB (quarterly) (Private)	Maternity Perinatal Mortality Review Tool (Private)	Ockenden Review Update (quarterly)	Maternity Serious Incidents and HSIB (quarterly) (Private)					
	Maternity Serious Incidents and HSIB (quarterly) (Private)		Maternity East Kent – Kirkup Report (6 monthly)	Women’s Experiences Report (Includes FFT, CQC inpatient survey action plan) (6 monthly)							
			Ockenden Review Update (quarterly)	Maternity Voices Partnership Report							
	Avoiding Term Admissions into Neonatal Units (ATAIN) / Transitional Care (quarterly)	Integrated Performance Report	Avoiding Term Admissions into Neonatal Units (ATAIN) / Transitional Care (quarterly)								
		Assurance Committee 3A Report									
	Midwifery workforce (6 monthly)			Mortality Review Update							
	Neonatal workforce and medical workforce (6 monthly)										
			Recovery Support Programme - Final Report		Transformation and Improvement Update		Transformation and Improvement Update	Transformation and Improvement Update		Transformation and Improvement Update	
	Integrated Performance Report		Integrated Performance Report	Integrated Performance Report	Integrated Performance Report	Integrated Performance Report	Integrated Performance Report	Integrated Performance Report	Integrated Performance Report	Integrated Performance Report	Integrated Performance Report

University Hospitals of Morecambe Bay NHS Foundation Trust
Board of Directors' Forward Plan 2023/24

	Assurance Committee 3A Report		Assurance Committee 3A Report	Assurance Committee 3A Report	Assurance Committee 3A Report	Assurance Committee 3A Report	Assurance Committee 3A Report	Assurance Committee 3A Report	Assurance Committee 3A Report	Assurance Committee 3A Report	Assurance Committee 3A Report
									Mortality Review Update		
									UHMB Strategy (6 monthly update)		
	PCB Update	PCB Update	PCB Update	PCB Update	PCB Update	PCB Update	PCB Update	PCB Update	PCB Update	PCB Update	PCB Update
	Policy and Publications		Policy and Publications		Policy and Publications		Policy and Publications		Policy and Publications		Policy and Publications
	Patient Safety and Other Alerts / RO Update	Patient Safety and Other Alerts	Patient Safety and Other Alerts / RO Update (Private)	Patient Safety and Other Alerts	Patient Safety and Other Alerts	Patient Safety and Other Alerts / RO Update (Private)	Patient Safety and Other Alerts	Patient Safety and Other Alerts	Patient Safety and Other Alerts / RO Update (Private)	Patient Safety and Other Alerts	Patient Safety and Other Alerts
Board Quarterly Items	New Hospitals Programme Update Q4			Q1 Quarterly Review of priorities including improvement work and Q1 finance review and Board Assurance Framework 2023/24			Q2 Quarterly Review of priorities including improvement work and Board Assurance Framework 2023/24			Q3 Quarterly Review of priorities including improvement work and Board Assurance Framework 2023/24	Draft Board Assurance Framework 2024/25
	End of year Review of priorities	BAF 2023/24	Chief Medical Officer Update including Guardian of Safe Working Annual Report, Annual Appraisal & Revalidation Report	Chief Medical Officer Update Annual Appraisal & Revalidation Report		Chief Medical Officer Update including Research & Guardian of Safe Working				Chief Medical Officer Update including Research & Guardian of Safe Working	
			Freedom to Speak Up Annual Report	New Hospitals Programme Update Q1			New Hospitals Programme Update Q2			New Hospitals Programme Update Q3	
		Freedom to Speak Up Update (6 monthly update)								Freedom to Speak Up Update (6 monthly update)	
Board Annual / Statutory Items		Board and Committee TORs / Outcome of Effectiveness Review	Urgent Care Improvement Plan inc review of winter		Equality, Diversity and Inclusion Annual Report including Workforce Race Equality Standard / Workforce Disability Equality Standard / Gender Pay Gap Report / Equality Delivery System 2	Operational Resilience / Winter Plan	Safeguarding Adults and Safeguarding Children and Young People statutory report			Safe Staffing	Annual Plan 2024/25
	NHSI Submission of Annual Self-Declarations		Safe Staffing				Emergency Planning Resilience and Response (EPRR) Annual Assurance Return				NHS Staff Survey (public)
	CQC Single Assessment Framework		Annual Report and Accounts 2022/23 (via Audit Committee 3A Report)			Progress against UHMB Green Plan					Annual Report from the Director of Infection Prevention and Control

	Mortuary Assurance Return	Assurance Committee Annual Reports									Safeguarding Maternity Services and Safeguarding Children in care and care leavers statutory report
	Annual Report from the Director of Infection Prevention and Control										
Extra Board Sessions	5 April 2023 – RSP										

Items for further discussion to be added to the Board Forward Plan:			
Other Items Reserved for Board	**Board Workshops**	**Strategies and Enabling Strategies Reserved for Board**	**Strategies delegated to Assurance Committees**
	See Board Development Programme 2023/24 for further details.	• Clinical Strategy – approved by Trust Board in February 2023 • Finance Strategy • Quality Strategy • People Strategy • Leadership Strategy • Continuous Improvement Strategy • Patient Experience Strategy • Estates Strategy • EDI Strategy	• Clinical Strategy – implementation will be overseen via the Transformation and Improvement Board