University Hospitals of Morecambe Bay NHS Foundation Trust

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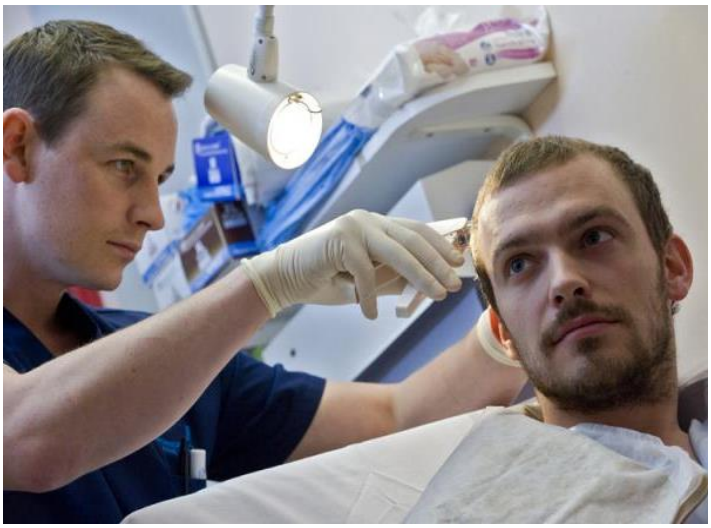
Annual Report and Accounts 2017-18



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Annual Report and Accounts 2017-18

Presented to Parliament pursuant to Schedule 7, Paragraph 25 (4) (a) of the National Health Service Act 2006

Contents

Chairman's and Chief Executive's Welcome

Preparing for Change – Moving Towards Transformation

At the end of 2017/18 it was with a tinge of sadness that the Trust bid farewell to Jackie Daniel, our former Chief Executive and Pearse Butler our former Chairman.

Both took the decision to stand down at the end of the last financial year but both went out on a high with so many achievements taking place during the year.

We thank them for their leadership and vision and wish them every success in the future.

We are both delighted to have been given the opportunity to continue the journey of improvement for the Trust.

In this Annual Report we will reflect on the past year and the legacy created by Jackie and Pearse.

We have once again grouped our activities into the framework we use to help us deliver our objectives. We call it our 'Strategic Pillars for Improvement'.

These pillars are made up of five key elements:

- Strategy;
- Engagement;
- Quality and Safety;
- Partnership; and
- Performance.

Strategy

During the year, we continued to make great progress in developing the vision shared across the health and care services to see a network of communities across Morecambe Bay enjoying great physical, mental and emotional well-being.

This success was demonstrated through delivery of the Better Care Together strategy and the work we are doing with clinical and other work streams as part of our Vanguard funding:

- Developing care closer to people through our work with the twelve Integrated Care Communities (ICCs);
- Bringing the organisations providing health and care to our population closer together as Bay Health and Care Partners which will prevent duplication and ensure seamless care; and
- Continuing to modernise services to ensure they are provided with the public at the centre.

The second point has been most evident in the work we have been carrying out to bring community services in south Cumbria and north Lancashire together, rather than be provided by separate organisations. In the past, this has led to patients in Morecambe Bay experiencing different services depending on where they live, which is something we wanted to ensure was eradicated.

We are therefore acting as a host organisation for community services comprising south Cumbria services who joined us on 1 April 2018 and those services in north Lancashire that are due to join us later in 2018/19. This will allow us to develop an integrated, seamless service across the area that will help to keep people at home safely and only bring them to hospital when they absolutely need to be there.

By services integrating together we will also help ensure people get out of hospital and back to their own homes more quickly, which is where people want to be.

There is more about the successes of our partnership working in the Performance Section of this Annual Report.

Engagement

Engagement is vital for the future success of services. Our Better Care Together strategy was launched in 2015 on the back of extensive public and staff engagement, and at the end of the year – and braving the late snow we had, we (with our Bay Health and Care Partners) took the Healthwatch "Chatty Van" out to our communities to talk to them further about what they want from their health services and how we should tackle some of the challenges we face.

We visited a number of locations over a two and a half week period and the feedback was really valuable so thank you to all those who came to see us. We also made an online version of the survey available for those unable to see us, and will theme the responses to ensure the valuable feedback is used when planning services in the future.

Our NHS Staff Survey results were also published in March and these showed that staff experience and engagement continues to improve year on year. Feedback from staff showed big improvements in a number of areas, when compared to the previous year's results, including:

- Staff feeling that the Trust takes positive action on health and wellbeing;
- Staff recommending the Trust as a place to work or receive treatment; and
- Staff believe the quality of appraisals has improved.

We scored above average in 18 areas this year – compared to 14 areas in the previous year. This includes being in the top 20% of all Acute Trusts in England in six areas, including:

- Staff feeling confident in the fairness and effectiveness of procedures for reporting unsafe clinical practice;
- Staff feeling satisfied in the opportunities for flexible working; and
- Staff reporting incidents of violence, bullying and harassment or abuse.

We also had the highest ever number of responses (more than 2,000!), and we want to thank all staff who took part – your views really do count.

Our Flourish at Work campaign continued during the year aiming to improve employee health and well-being. During the year, there were three main themes that were the focus of our efforts.

Our staff's mental health is as important as their physical health and we invested in Headspace – a gymnasium for your mind. The Headspace application has helped to encourage over 350 Trust staff to look after themselves through mindfulness - a scientifically proven way of improving physical and mental health without having to put medication into our bodies.

Mindfulness is a way of paying attention to the present moment, using techniques like meditation, breathing and yoga. It helps us become more aware of our thoughts and feelings so that, instead of being overwhelmed by them, we're better able to manage them.

We also helped groups of staff across our Trust to take part in the Couch to 5k challenge – training them from being novice runners to completing a 5k run. During the eight week programme, staff covered about 60 miles each.

We also wanted to encourage every member of staff to eat a healthy and well-balanced diet and encouraged staff to commit to having a healthy breakfast three or four times a week. We gave away 200 reusable lunch bags to encourage staff to take part in this scheme and publicised their efforts on social media. We are hopeful that their commitment to a healthy start to the day will continue into the future.

While we are on the subject of staff engagement, our staff-led improvement programme has gone from strength to strength during the year, with a total of 34 groups of staff, from across Bay Health and Care Partners, making real changes for patients and staff. Some of the highlights include:

- A collaborate scheme between the Trust and Kendal Integrated Care Community (ICC) to achieve a reduction in Emergency Department (ED) attendances and prolonged admissions for the Kendal population identified as severely frail;

- A Facilities Helpdesk Web Portal to avoid duplication and improve communication and efficiency – this was shortlisted for a Health Service Journal (HSJ) Value Award;
- Produced an End of Life Communication Diary for patient and family / friends to aid and improve communication between them and health care professionals during the early stages of bereavement; and
- Introduced a more streamlined approach to Bank Staff recruitment resulting in a reduction of 21 days, introduced weekly pay for bank shifts, and supported bank workers to complete their mandatory training including appraisals.

In December 2017, we were also named as the eighth most inclusive employer in the UK in the Inclusive Top 50 UK Employers List – which was both a great honour and an achievement. The achievement recognises the outstanding efforts of our staff to make our Trust a better place to work in and be treated, regardless of who you are and what you believe. Our ambition is to keep attracting and retaining a truly diverse workforce and this achievement helps to show us that we are on the right track.

Quality and Safety

Quality and safety continue to be of vital importance to the Trust Board and our staff. This year, we have backed this up with the introduction of the Behavioural Standards Framework. We think it's vital that no-one should come to work and feel that they are not valued and the introduction of these standards show how we expect each staff member to behave with each other and our patients.

Despite the difficult economic climate within the NHS, we have continued to invest in our facilities, ensuring that we have a more modern healthcare estate and can offer better services and experience for the people of Morecambe Bay.

This investment has resulted in:

- A £1 million revamp of the Cardiac Centre at Westmorland General Hospital (WGH), which included new specialised cardio-vascular imaging equipment and a full refurbishment of the Cardiac Catheter Lab Theatre Suite;
- A new Diabetes Centre at the Royal Lancaster Infirmary (RLI), supported by investment from the Trust and fundraising efforts from the public. The Centre opened in July 2017 and saw 2,000 patients in the first four months;
- A £1 million investment in a new Acute Stroke Unit (the Huggett Suite) at the RLI with six acute stroke beds and an assessment bay to improve stroke services across the Bay. This was backed up in August with the launch of an ambitious programme to reduce preventable strokes across Morecambe Bay;
- A new £1.2 million integrated Therapies Unit opened at the RLI; and
- The crowning glory was the opening of the £12 million South Lakes Birth Centre at Furness General Hospital (FGH). We are the guardians of the unit but it really belongs to the communities it serves. Women, families that lost loved ones in our services, the general public and staff were involved from the very start so that we could be confident that the unit was exactly what local people and staff wanted and rightly deserved.

To protect our staff and patients, we promoted the national flu vaccination and ended the year having protected 89.4% of our frontline staff – one of the highest levels achieved in the country. We certainly view this as testament to the importance our staff place on safety.

Quality shines throughout the Trust, and the awards that the Trust Care Groups or individuals have either won, or been shortlisted for, show the achievements are being recognised at a national level.

There are too many nominations to outline in full here – they almost need their own section – but suffice to say they include:

- Shortlisted in four Nursing Times award categories;
- Shortlisted in three HSJ award categories;
- Winning in one and shortlisted in another HSJ Value award category;
- Shortlisted in two Personnel Today Awards categories;
- Winning a North West Health and Care Award;
- Shortlisted in the Patient Safety Awards; and
- Winning in one and shortlisted in another Academy of Fabulous Stuff Awards.

We come to the end of 2017/18 not complacent, but with the immense pride of knowing we have performed very well as an organisation against many of our key quality targets:

The Trust set a number of goals and targets in 2016, with the aim of achieving a culture of continuous improvement and learning. Those quality targets were thought to be aspirational when set, but the Trust can now look forward to the next three years, having achieved their targets 12 months ahead of schedule.

Some of those targets and achievements include:

- The 2019 target for harm free care was 98%. By November 2017, the Trust was delivering 97.87% of harm free care. Even more importantly, data suggests that the level of harm is also reducing;
- With mortality an important indicator of a learning organisation, the Trust has continued to learn through consultant-led reviews and mortality is consistently below the national average and is often on the best 10% nationally; and
- A focus on patient safety was an important element of the goals and targets. The number of complaints received in 2017/18 was 427, which is a 17.1% decrease on the 515 recorded in 2016/17 and 12.2% below the target level of 486 complaints for 2017/18.

As with most years there are a number of challenges we have needed to address.

Partnership

As we mentioned above, the engagement with families and staff during the planning and build of the South Lakes Birth Centre is a fantastic example of how working together can result in something special for many years to come. This partnership working has been shown in many other areas during the year - both as a Trust and as Bay Health and Care Partners.

The partnership working as Bay Health and Care Partners has seen a number of successes, including:

- Our innovative Advice and Guidance scheme that means GPs can have an 'electronic' conversation about a patient, has resulted in 1,670 people being treated in the community rather than having to attend hospital;
- Almost 6,000 people who would previously have been treated at hospital were able to access care in our community opticians – at a time to suit them, and without having to travel to hospital;
- We have created 12 Integrated Care Communities (ICCs) across our area which continue to grow from strength to strength. For example in Garstang, the ICC worked closely with elderly and frail residents; Barrow ICC is making great progress with respiratory care; in Kendal, they have reduced admissions to hospital and in Millom they have worked to reduce travel out of the area;
- The launch of the Better with You Careers and Engagement Hub – a partnership across the health community to promote healthcare as a career. This culminated in the Hub winning the Outstanding Contribution to Widening Participation award from Health Education England;
- A new service for people referred to the orthopaedic service which has seen 1,550 people in community physiotherapy clinics rather than in hospital. Patients have been very positive about the new service with a 96% satisfaction rate reported; and
- The extension of the Patient Initiated Follow Up service. It began as a pilot in rheumatology and now has 900 people across four specialties covered by the scheme. This means they have access to clinical expertise quickly if they require it but avoids them having costly repeated trips to hospital while they are well – releasing their time and the time of clinical teams.

Performance

During the year, we have seen hundreds of thousands of people come through our doors from across Morecambe Bay and beyond. It is fair to say that the health service across the country is under a great deal of pressure. Whilst we have not met the Emergency Department 4 hour standard, we are not alone with Trusts across the region and country as a whole struggling under the pressure. We have put in place a number of plans to keep our patients safe.

Finances are also under pressure both within our Trust and other Trusts across the country. Our plans are built on the Better Care Together ethos of partnership working and engagement and we won't sacrifice quality and safety for money. However, we do recognise that we need to build our service so they are sustainable now and into the future to allow them to flourish.

Despite the pressures we have been facing, our staff have worked exceptionally hard to make savings in their services. Our approach with our sustainability programme has to be to encourage staff to come up with ideas on how we can work differently to improve the services we offer to patients and save money at the same time. By the end of Quarter Four, our sustainability programme has seen £17.44 million saved throughout the year, against a target of £17.4 million – the biggest cost improvement target the Trust has ever achieved.

Some of the areas outlined above, and in the following pages, show that 2017/18 was a year where we moved towards transforming the local health services - not just in the hospital but across primary, community and social care as well. This has seen us all work together in an unprecedented way to provide a platform not just for the coming year but for decades to come.

It was also a year when we faced enormous operational pressures. Our teams have continued to manage these pressures magnificently, ensuring that we continue to provide the best care possible across all our hospitals. We want to thank everyone – doctors, nurses and other healthcare professionals but also the staff supporting those services, such as our porters, caterers, cleaners and our administrative teams. Each and every one of you has played a valuable role in keeping our services safe for our patients. In addition to the contribution of our staff, it would be wrong of us not to mention the magnificent contribution of our volunteers, who do so much across our organisation. Without each of you, the organisation would not be where it is today and we therefore thank each and every one of you.

In May 2017, the NHS, as well as other global organisations, was impacted by a large-scale cyber-attack that disrupted hospital and GP appointments across the country. Although our services were affected, the impact of the disruption was lessened due to the investments made into our IT infrastructure. As always with large scale incidents, our staff responded magnificently; in many cases, going above and beyond 'the call of duty' to restore systems to enable patients to be safely cared and treated. We again saw the same level of dedication and commitment following the heavy snow storms in early 2018, which saw some of Cumbria cut-off. Staff and local partners got together and overcame Mother Nature to ensure services were maintained as well as they could be for our patients.

2018/19 will be a year when our shared vision of Bay Health and Care Partners working together begins to take shape. The Trust will grow by around 700 staff as community services staff join and begin to work together with the hospital services to make a truly integrated service for our patients. We will also continue to prepare for the Care Quality Commission to return to the Trust for a large scale inspection, and hope to build on our current rating of 'Good' overall with 'Outstanding' care. We hope that you enjoy reading about all the achievements and challenges in more detail in the pages which follow.

We would like to again thank the entire workforce at the Trust, our governors, volunteers and partners for their incredible support and hard work to support the Trust to continually improve for the benefit of our local communities.

Ian Johnson
Chairman

Date: 25 May 2018

Aaron Cummins
Chief Executive

Date: 25 May 2018

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Performance Report

The purpose of the Performance Report is to give you a short summary that provides you with sufficient information to understand the organisation, its purpose, the key risks to the achievement of its objectives and how it has performed during the year.

Driven By Safety – Guided By Performance

The scale of the challenge for this Trust to meet increasing demand for services within current financial constraints has never been more critical. During the winter period more than 10% of patients were waiting longer than four hours in Accident and Emergency (A&E), and delays in discharging patients were experienced at both Royal Lancaster Infirmary and Furness General Hospital.

This increase in demand puts pressures on services across the Trust and means we are operating with very high bed occupancy which makes it difficult to respond to unexpected fluctuations in admissions. In response we have made positive changes to urgent care provision to ensure we continue to provide safe levels of care.

We are very proud that we have a dedicated and committed workforce, and our teams across the Trust continue to deliver improvements and compassionate care.

The Quality Improvement Strategy 2016/19 made a commitment to protect patients and provide care which is free from avoidable harm. Over the past 12 months the corporate nursing team have continued to make significant progress with improvements in the quality and safety of the care we provide.

The table below shows how we progressed in 2017/18 and sets out targets for 2018/19.

Quality Improvement Metric	Progress in 2017/18	Target for 2018/19
% of patients receiving harm-free care	97.87% (Nov Safety Thermometer)	98%
Audit of e nursing documentation	Ongoing process now collected monthly during matron audits and Quality Assurance Accreditation Scheme	98%
Summary Hospital-level Mortality Indicator (SHMI)	Achieved	90-95
Stroke mortality	Achieved	<75 per year
Care bundles implemented	Acute admission, AKI and sepsis now on EPR; stroke remains paper	4 (stroke, frailty, AKI, sepsis)
Quality Assurance Accreditation Scheme	2 exemplar, 4 more being assessed, on a rolling programme	50% of impatient wards to have exemplar status
Lesson learned bulletins	Achieved	12 per year
Complaints	Target – 486 Actual – 427	Reduce by 5%
Public engagement	Achieved	6 quality events per year
Staff survey	56% of result areas better than average	60% of result areas better than average

Further details can be found in the Trust's Quality Improvement strategy here.

Overview of the Trust

University Hospitals of Morecambe Bay NHS Foundation Trust was established on 1 October 2010, as a public benefit corporation authorised under the Health and Social Care (Community Health and Standards) Act 2003.

We are a provider of acute hospital and community services from three main hospital sites:

- Furness General Hospital (FGH), Barrow;
- Royal Lancaster Infirmary (RLI), Lancaster; and
- Westmorland General Hospital (WGH), Kendal.

In addition, we provide outpatient services at Queen Victoria Hospital (QVH) in Morecambe, Ulverston Community Health Centre (UHC) and in a range of community facilities.

On 1 April 2018, adult community services in South Cumbria transferred to the Trust from Cumbria Partnership NHS Foundation Trust. Later on in 2018/19, adult community services in North Lancashire are scheduled to transfer to the Trust from Blackpool Teaching Hospitals NHS Foundation Trust.

We serve a dispersed population of around 365,000 covering South Cumbria, North Lancashire and surrounding areas, with services commissioned by Morecambe Bay Clinical Commissioning Group.

Furness General Hospital is situated on the outskirts of Barrow with around 260 beds. It provides a wide range of services including Accident and Emergency, surgery, maternity, outpatients, critical care, oncology and a special care baby unit.

Westmorland General Hospital is located on the edge of the stunning Lake District. It has around 45 beds and provides a midwifery-led unit, elective surgery, chemotherapy unit and a wide range of outpatient services. It is also home to a minor injuries unit; GP led medical wards, mental health wards and a renal unit, all of which are provided by other NHS Trusts.

Royal Lancaster Infirmary is situated in the centre of the historic city of Lancaster and has around 425 beds. It provides a wide range of services including Accident and Emergency, surgery, maternity, critical care, oncology, outpatients and a special care baby unit.

Ulverston Health Centre, situated between Barrow and Kendal provides a range of outpatient services.

Queen Victoria Hospital is a few miles from the main hospital in Lancaster and is home to a range of outpatient services.

The Trust has undergone a significantly challenging period of change following the formal intervention of NHS Improvement (NHSI), the regulator of Foundation Trusts.

Following authorisation as a Foundation Trust, the organisation experienced a number of high profile failures, including the launch of several investigations looking into the tragic deaths of a number of babies and mothers following care received at Furness General Hospital.

The Care Quality Commission carried out a number of inspections across the Trust and imposed sanctions to ensure improvements were made.

In February 2012 NHSI determined that enforcement action was required and conditions were attached to the Trust's Provider Licence to secure the necessary improvements.

The Trust has continued to make significant progress in its recovery, following a three stage programme of stabilisation, transition and transformation.

The Board of Directors has continued to deliver the changes and improvements required and following the CQC re-inspection in July 2015 the Chief Inspector of Hospitals recommended that the Trust should come out of Special Measures.

In February 2017 the Care Quality Commission (CQC) rated the Trust as 'good' overall and outstanding for 'care'.

In March 2017 NHSI agreed that the enforcement conditions in relation to Quality of Care could be lifted. Enforcement in relation to Financial Sustainability remains. A revised enforcement notice in respect Financial Sustainability was received in May 2018. Plans are in place to complete the required actions.

The Board of Directors is not complacent and there are still significant challenges facing not only the Trust but the wider health economy. Through Bay and Health Care Partners, plans have been made to respond to the risks around health inequalities, patient safety and financial and workforce sustainability.

System Leadership and Integrated Models of Care

Lancashire and South Cumbria Integrated Care System (ICS)

The NHS is now under more pressure than ever because of people living longer and the growing population of the country. In the Five Year Forward View, NHS England has asked primary care, community health, mental health and hospital services to work together better.

At a regional level we are part of the Lancashire and South Cumbria Integrated Care System (ICS).

Back in March 2017, NHS England announced that groups of NHS and local government partners, would develop their roles and relationships to implement the NHS Five Year Forward View and other key national priorities. Initially, these arrangements were to be known as Sustainability and Transformation Partnerships or STPs.

In February 2018, the latest NHS planning guidance renamed Sustainability and Transformation Partnerships (STP) and restated the importance of partners working together to create what is now termed an **integrated care system or ICS**. The guidance states that this will happen as systems demonstrate their ability to take collective responsibility for financial and operational performance and health outcomes.

Healthier Lancashire and South Cumbria intends to become a shadow integrated care system during 2018/19. An integrated care system is a collaboration in which NHS, Local Authority, voluntary and other public sector partners will need to demonstrate how we will work effectively with the communities we serve. In doing so, this will bring together commissioners, providers and regulators to work in more cohesive ways.

The Lancashire and South Cumbria integrated care system covers a region made up of five local areas (Central Lancashire, West Lancashire, Pennine Lancashire, Fylde Coast, and Morecambe Bay). We are calling these areas **integrated care partnerships** or ICPs as the basis for local organisations and groups involved in health and care to join up their priorities and resources. The partnership is known as Healthier Lancashire and South Cumbria.

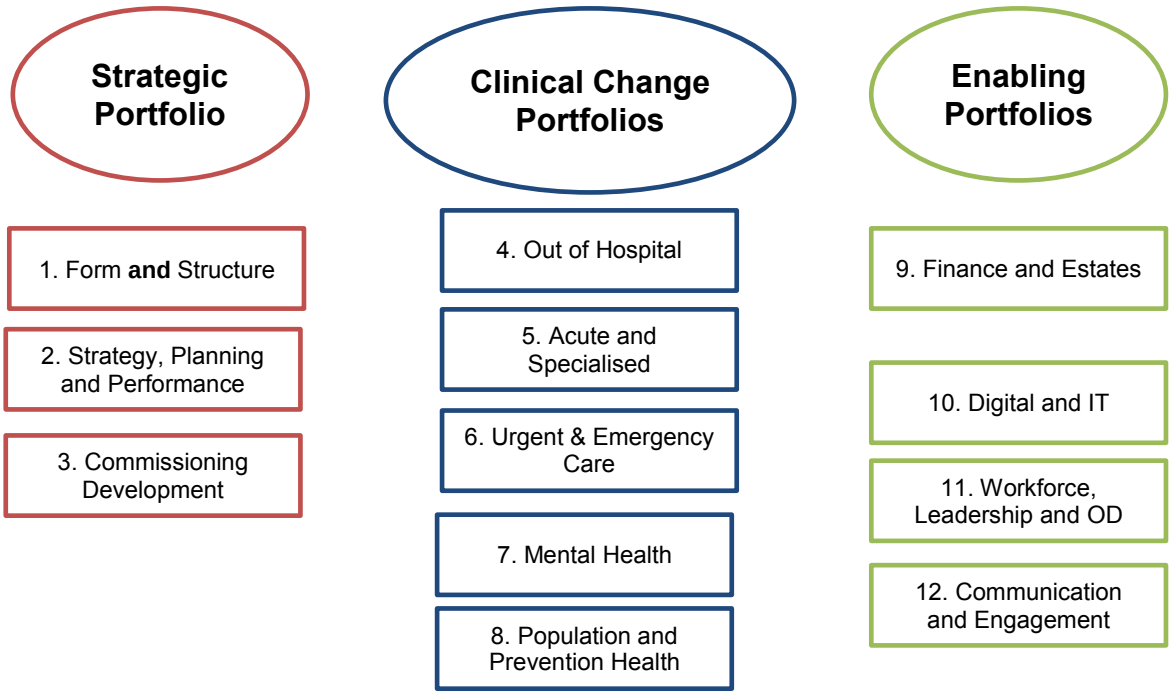
The Lancashire and South Cumbria integrated care system has a clinical leader in Dr Amanda Doyle, a GP from Blackpool with significant national and local leadership experience. As Chief Officer, Amanda is working with the support of senior clinicians and managers from every part of Lancashire and South Cumbria.

An ICS Board (formerly called the STP Board) was established in December 2017. The role of the ICS Board is to provide leadership and development of an overarching strategy for Lancashire and South Cumbria, taking oversight of the partnership between organisations and ensuring there is a Strategic Framework in place to deliver more sustainable models of health and care for the future. The purpose of the Lancashire and South Cumbria Strategic Framework is to clarify and coordinate the decisions and activities across the whole system to ensure the most effective and efficient use of resources.

The Strategic Framework has three Levels:

- What should be undertaken once (across Lancashire and South Cumbria);
- What should be undertaken five times consistently (at a local integrated care partnership level); and
- What should be undertaken uniquely (at a local integrated care partnership level or neighbourhood / place level).

The ICS Board approved a Strategic Framework to design, mobilise and lead transformation and improvement work across key areas in Lancashire and South Cumbria. These are shown below:



Bay Health and Care Partners

At a local level we have established Bay Health and Care Partners (BHACP) to improve the delivery and outcomes of health and care for our communities. This is the ICP for Morecambe Bay.

More information on Bay Health and Care Partners can be found here.

Bay Health and Care Partners developed a shared plan for our population called 'Better Care Together'. It set out a bold ambition for the future of the local NHS and care services. Our ambition was to make integrated care a reality for the communities of North Lancashire and South Cumbria. This strategy identified many of the opportunities set out at the same time by national leaders in the NHS Five Year Forward View.

Integrated care means taking a shared view of the care someone needs, rather than dealing with problems or conditions separately; it means looking at the health and wellbeing of whole communities rather than only the 'sick' people within them. Increasingly communities wish to take the initiative for their own health and wellbeing rather than becoming dependent on overstretched health and care services.

BHACP has already made significant progress and tackled some difficult issues together. Local doctors and care professionals from partner organisations have begun to implement the new models of care set out in Better Care Together. BHACP has used its vanguard status to establish Integrated Care Communities which will provide more joined up NHS and social care services closer to people's homes. Senior clinical and organisational leaders have worked closely together over a sustained period of time, improving the quality of clinical services and taking action to develop the workforce.

BHACP would like to use the best evidence available so that the care offering is proactive rather than reactive and is effective for those receiving it. Partners want to work as one team without walls, looking at ways to address the variation in health outcomes and inequalities across the Bay area. The intention is also to be as cost-effective as possible and to reduce duplication to make the value of the 'Morecambe Bay pound' go further. This will enable the development of services that are better placed to meet people's health and care needs, now and in future.

The financial pressure faced in Morecambe Bay is one of the main reasons for acting now. It is no longer an option to continue doing things the way they have always been done.

The fact that health and local authority organisations are pulling together to do something about this is a spur to think and work very differently; and this creates an opportunity to radically improve the services and care provided.

The key deliverables for BHACP area for the next 3 years are to:

- Improve individual and population health, promoting primary, preventative and self-care and reducing the requirement for more costly care. This will require a strong public health and health promotion component to be effective in this area;
- Improve the quality, safety and effectiveness of care provision thus improving clinical outcomes;
- Enhance people's experience of care by providing transformed and integrated pathways of care with minimal hand offs between different parts of the system; and
- Make substantial progress towards returning the system to financial balance.

These key deliverables will be achieved through:

- Agreed system goals and targets for which all system partners are accountable. These include targeted reductions in non-elective admissions and outpatient follow up appointments, reduced delayed transfers of care, fewer beds and outpatient clinics;
- A system-wide governance mechanism which brings together providers and commissioners, with clear decision-making rights, including the ability to shift resources;
- An agreed set of system-wide work programmes that support delivery of the system goals;
- Continued implementation of our new Integrated Care Communities models based on redesigning our primary and community care system and enabling us to shift resources, capacity and capability;
- A system-wide financial control total that enables the leadership to manage the whole NHS budget for the population that it serves. Further opportunities will be identified to combine NHS and local authority resources, building on established arrangements such as the Better Care Fund;
- Financial incentives linked to system-wide goals that operate across providers and commissioners; and
- A system-wide integrated care record which enables the partners to ensure "knowledge follows the patient/person" as they receive care in our services.

Our Future Business Plans – look forward for 2018/19

As an organisation we continue to work through the 2017/19 Operational Plan which has been refreshed for 2018/19. This explains our priorities and the key actions to enable the delivery of our strategic approach and our corporate objectives.

Under the Plan our objectives are:-

- Continuously improve the patient experience - becoming the provider of choice for excellence with safe and effective patient care;
- Support and develop all staff to take responsibility for what they do and help them to do their best;
- Getting staff truly engaged in how the Trust works;
- Encourage staff to be innovative when delivering and planning high quality and sustainable services;
- Achieving long term financial sustainability;
- Work with our partners to provide an integrated health service that meets the needs of the local population; including developing strong relationships with third sector organisations to enable services to work together, rather than in 'competition';
- Providing local access, including to specialist services wherever that is feasible; and
- Positively contribute to the well-being of the local community.

The priorities are:-

- Better Care Together: Implementing the strategy to transform health and care across "the Bay", including the creation of an Integrated Care Partnership with Bay Health and Care Partners;
- Leadership: Continuing to roll out our leadership development programme at all levels of the organisation;
- Integration of Community Services: Focus on the Integration of Community services staff and supporting the development of Community Services Care Group;
- Flourish: Helping to improve the Health and Wellbeing of our staff;
- Having the right staff, in the right place, with the right skills and experience to deliver high quality services;
- Inclusion: Focus on our Towards Inclusion journey, working collaboratively with our regional health and public sector partners to ensure the population we serve experiences the same inclusive approach in both work and services;
- Responsive: Ensuring timely access to high quality care through sustained improvement in national standards such as the urgent care four hour standard, 18 weeks and cancer referral to treatment times; Improving patient flow and rapid response to urgent safety concerns through a dedicated Patient Safety Unit;
- Engaged: Listening to the experience of our patients and staff to continually improve recruitment and retention of our staff and improving the employee experience;
- Building on our achievement of a Care Quality Commission rating of 'Good and outstanding for care';
- Our quality targets will be stretching to enable us to achieve our ambition to be an 'outstanding' organisation and to deliver quality standards across acute, primary and community health and social care.

Further details can be found in the Trust's Operational Plan here.

To deliver the priorities in the Operational Plan the Trust has identified a number of risks that it needs to manage and mitigate.

Top 4 Strategic Risks

People Risk: Ensure the Trust has a motivated and engaged workforce, in sufficient numbers and appropriately trained, to deliver the Trust's vision, values and objectives to be a "great place to be cared for, great place to work".

Risks being mitigated through:

- Workforce Plan (sustainable workforce across Bay Health and Care Partners' footprint);
- Recruitment and Retention Strategy;
- Towards Inclusion Strategy;
- Listening into Action;
- Embedding Behaviour Standards Framework; and
- Employee Health and Wellbeing Plan (Flourish).

Finance Risk: Deliver the 2018/19 financial plan and continued development of the Sustainability and Transformation Plans to 2020/21.

Risks being mitigated through:

- Sustainability Programme and Cost Improvement Plans are in place. Plans to address the financial challenges and risks form part of the Two Year Operational Plan and Care Groups' Business Plans;
- Submission of a Sustainability and Transformation Plan (STP) on a Lancashire and South Cumbria footprint; and
- Ongoing negotiations to agree a deliverable Cost Control Total with our Regulators.

Urgent Care Performance Risk: Ensuring the Trust achieves its trajectories on the NHS Constitution Access Standards for Urgent and Emergency Care, Elective Care and Cancer Care.

Risks being mitigated through:

- Improved analysis of cause and effect of patient flow through the whole system with corresponding Emergency Department Improvement Plan focusing on Front Door (triage, coordination and mental health);
- In Hospital and Out of Hospital improvement plans including improved patient flow, admission prevention and avoidance projects; and
- Implementation of Advice and Guidance, Patient Initiated Follow Up.

Change and Transition Risk: Ensure the Trust leads the system change and retains delivery of safe services.

Risks being mitigated through:

- System-wide Programme Management Office including project and programme management;
- Bay Health and Care Partners' Senior Leadership Team Development; and
- Trust and Primary Care Interface programme.

Top 4 Corporate Risks

Robust Sustainable Safe Staffing Levels: Inability to meet agreed safe staffing levels may lead to poor standards of care, increased complaints, demotivated and fatigued staff and loss of organisational reputation as well as the inability to deliver the Trust's visions, values and objectives to be a "great place to be cared for, great place to work".

Risks being mitigated through:

- Safe staffing levels agreed;
- Staffing levels and skill mix monitored 4 times a day through safety/flow meetings and staff moved to meet patient need;
- National and international recruitment continues in line with recruitment plan;
- Return to practice promoted widely with effect;
- Modern apprenticeship scheme in place to deliver longer term workforce needs; and
- Different models of care have been implemented in several specialties including radiology and gastroenterology to deliver services with a diversified workforce, for example through the use of nurse endoscopists and advanced nurse practitioners to reduce the impact of national shortages in particular staff groups.

Patient Flow: Inability to maintain flow through the hospital may result in poor patient experience through delays in the emergency departments and delays in discharge and transfer of care, increased complaints, fatigued staff and poor compliance against the agreed trajectories for the NHS Constitution access standards, particularly in urgent and emergency care and elective care.

Risks being mitigated through:

- System resilience delivery plan;
- Implementation of integrated care models through the Better Care Together strategy;
- Implementation of Discharge to Assess pathways; and
- Implementation of best practice processes and pathways e.g SAFER Care Bundle, EndPJParalysis.

Bullying and Harassment: Inability to provide workplaces free of bullying, harassment and discrimination will lead to a deterioration in employee experience and a subsequent increase in patient quality and safety harms.

Risks being mitigated through:

- Organisational Development Strategy;
- Improved Policies and procedures;
- Freedom to Speak up Guardian;
- Respect Champions;
- Behavioural Standards Framework;
- Training and development; and
- Inclusion and Diversity worksteams.

Quality of Environment and fabric of our estate and its implications for patient safety and experience: Inability to provide fit for purpose clinical areas will lead to deterioration in patient and employee experience and a subsequent increase in patient quality and safety harms.

Risks being mitigated through:

- Estate Strategy;
- Capital Planning Group;
- Assessment and prioritisations of programmes/projects;
- Risk assessments of backlog maintenance; and
- Capital Expenditure Monitoring Group.

Throughout all of our plans, our priority remains that of delivering high quality, safe services that meets the needs and expectations of our patients.

Going Concern Basis

As part of the Accountability Report I am required to give a statement that the Accounts in this report can be prepared on a Going Concern Basis.

The going concern basis assumes that the Trust will be able to realise its assets and liabilities in the normal course of business and that it will continue in business for the foreseeable future. The future should be at least, but is not limited to a period of twelve months from the end of the reporting period. For Foundation Trusts there is no automatic presumption that they will always be a going concern, particularly where difficult economic conditions and/or financial difficulties prevail.

After making enquiries, the directors have a reasonable expectation on the basis of a recommendation from its Audit Committee that the NHS foundation trust has adequate resources to continue in operational existence for the foreseeable future.

The Trust is forecasting a planned deficit before impairments of £69.4 million which is after a cost improvement programme of £14 million and sparsity funding of £5.8 million. No Sustainable Transformation Funding has been assumed as the Trust has not agreed its control total. The directors recognise that should this level of operating deficit continue, this introduces significant risk to future years' financial standing, and the Trust is working to mitigate this risk. However, the overall Financial Plan ensures a cash flow forecast for the coming twelve months demonstrates that the Trust will be able to meet its liabilities as they fall due. The Trust has agreed the financial baseline position on its main contracts for the year 2018/19 which represents a significant percentage of total budgeted income. The financial plan for 2018/19 takes into account our capital plans, service development plans and our cost improvement programme for the year, the delivery of which partly relies on work we are doing with our partners in the regional health economy around system transformation. Our sensitivity analysis of the financial plan demonstrates the maintenance of positive cash balances for the coming year even under foreseeable downside scenarios.

For this reason, the Directors continue to adopt the going concern basis in preparing the accounts.

Aaron Cummins
Chief Executive

Date: 25 May 2018

Performance Analysis

In the previous section we explained how we planned to improve our Health Services. To help us understand how well we are doing the Trust measures its effectiveness in delivering its priorities by monitoring and reporting performance data in four main areas:-

- National Quality Standards;
- Local Quality and Governance Standards;
- Financial Performance; and
- Value Creation

The Trust requires accurate, timely, relevant patient information in order to support:

- The safe delivery of patient care; including on-demand real-time reporting and analytics;
- The delivery of the Trust's core business objectives;
- Clinical governance and clinical audit;
- Accurate clinical coding;
- Service Level Agreement monitoring and contract management;
- Business planning; and
- Accountability and transparency.

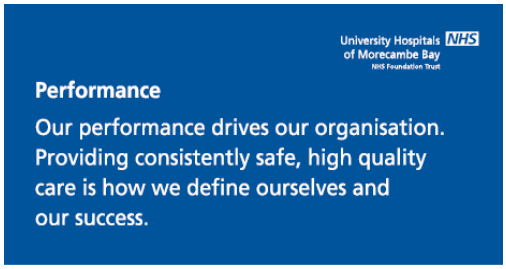
Data quality and data security risks are managed by the Informatics, Information and Innovation (I^3) Steering Group and Risk Management Forum with information generated through the risk management system. A Data Quality Group has been established to set; steer and performance manage the implementation of a data quality policy. The policy ensures robust management information and business intelligence based upon accurate patient data is essential for the delivery of patients care and to maximise the utilisation of resources for the benefit of patients and staff.

This policy focuses on the Trust's Electronic Patient Record (EPR) system, which helps clinical and medical staff deliver in-hospital patient care, including the management of patient pathways and care decisions.

The Trust's data warehousing and business intelligence framework provides management information in the corporate dashboards, Care Group reporting, and self-service analytics to support national and local data submissions and to analyse Trust performance.

National Quality Standards

There are a several standards set by the Government that hospitals are measured against. These are reported to the Board of Directors on a monthly basis so that the Board can assure themselves of how the Trust is performing and ensure that mitigating actions are taken when areas of concern arise.



2017/18 has been an extremely busy and challenging year with a key focus on recruiting to key medical, nursing and leadership roles, the system wide approach to improving access to urgent care services through the achievement of the 4 hour standard, the management of additional demand for diagnostic services within Core Clinical Services, the planning for the transfer of community services from Cumbria Partnership Trust and the Blackpool Victoria Trust, the development of future pathways within Bay Health and Care Partners and a root and branch review of the activity and leadership structure within the Critical Care and Surgery Care Group.

The Trust achieved Cancer 62 Day Standard in Quarters 2 and 3 and the Cancer 31 Day and Cancer 14 Day Standard in Quarters 1 to 4. In Quarter 3, all eight cancer standards were met, bucking the national trend of declining performance. In Quarter 4 six of the eight Cancer standards were met. The Immediate Discharge Summary communication within 24 hours standard was met in 11 of 12 months in 2017/18. The Diagnostic 6 week standard was achieved in 9 of the 12 months in 2017/18.

Tables 1 and 2 show the results from the Trust's assessment of performance against the healthcare targets and indicators over the past 3 years, as currently reported in section 5a of the Integrated Board

Performance Report and/or the Executive Dashboard which is submitted to the Board of Directors at each of its meetings.

Table 1: Performance against Quality Standards and Indicators- Quarterly Key Performance Indicators												
	2015/16				2016/17				2017/18			
Standard	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
A&E: maximum waiting time of four hours from arrival to admission/ transfer/ discharge	Failed to Meet	Met	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet
All cancers: 31-day wait for second or subsequent treatment - surgery	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
All cancers: 31-day wait for second or subsequent treatment- drug treatment	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
All cancers: 62-day wait for first treatment from urgent GP referral for suspected cancer	Met	Met	Met	Met	Met	Failed to Meet	Met	Failed to Meet	Failed to Meet	Met	Met	Failed to Meet
All cancers: 62-day wait for first treatment from NHS Cancer Screening Service referral	Met	Met	Met	Met	Met	Met	Met	Met	Failed to Meet	Met	Met	Failed to Meet
All cancers: 31-day wait from diagnosis to first treatment	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Cancer: two week wait from referral to date first seen- all urgent referrals	Failed to Meet	Failed to Meet	Failed to Meet	Met	Met	Met	Met	Met	Met	Met	Met	Met
Data Source: Unify Data												

Table 2: 2017/18 Performance against Quality Standards and Indicators- Quarterly Key Performance Indicators												
Standard	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Maximum time of 18 weeks from referral to treatment–incomplete	89.39%	89.49%	89.19%	88.72%	88.29%	87.60%	87.96%	87.50%	86.08%	85.53%	85.40%	84.75%
Diagnostic waits over 6 weeks	0.90%	0.95%	0.73%	0.92%	1.18%	0.73%	0.57%	0.57%	0.95%	1.09%	0.77%	1.89%
Urgent Operations cancelled for the second or subsequent time	0	0	1	0	0	0	0	0	0	1	0	4
Ambulance Handover Time	17.10	17.10	17.20	17.75	16.20	16.20	16.50	16.50	19.60	19.90	19.00	26.10
Data Source: Unify Data												

Other Quality Indicators
Referral to Treatment (RTT) Data

The Sustainability and Transformation trajectory for RTT was met in April and May 2017; however, the national standard of 92% has not been achieved in 2017/18. Nine out of 17 specialties within the Care Groups of Medicine and Women's and Children's and the specialty of urology within the Critical Care and Surgery Care Group are sustainably exceeding the national standard of 92%; thus, supporting the overall Trust position. However, six surgical specialties are consistently underperforming against the national standard: anaesthetics, ophthalmology, ear, nose and throat, oral surgery, general surgery and trauma and orthopaedics. Due to the high numbers of patient activity in the majority of the underperforming specialties, a downturn in individual specialty performance has a high impact on the Trust total.

RTT performance has been affected throughout 2017/18 due to the ongoing impact of the cancellations in 2016/17 due to the series of scheduled industrial action planned by junior doctors. In 2017/18 winter pressures, medical staffing vacancies, unavailability of theatres due to planned and unplanned maintenance and a further NHS Improvement instruction to cancel all non-urgent surgery between December 2017 and early February 2018 have further impacted upon performance, with a 4.6% reduction in performance between April 2017 and January 2018.

The recent refresh to the NHS Plan states that the national minimum expectation is that the number of patients on the incomplete waiting list in March 2019 will be no higher than the number on the waiting list in March 2018 and where possible the waiting list size should be reduced. However the ongoing consistent message is that all efforts should be made to meet the RTT standard by specialty in line with the NHS Constitution. In addition the number of patients waiting greater than 52 weeks for first definitive treatment should be halved by March 2019 and eliminated where possible. Up to January 2018, 10 patients have waited greater than 52 weeks for first treatment.

Risks to the achievement of the standards going forward include: the ongoing impact of the NHS Improvement cancellations, medical and theatre staff vacancies, bed pressures due to emergency admissions, and planned and unplanned theatre downtime for maintenance.

Actions taken to improve patient experience through the achievement of the 18 week standard in 2018/19 include:

- Programme of work supported by the NHS Improvement Intensive Support Team to develop timed 18 week patient pathways, gain greater learning from the pathways of longer waiting patients through formal breach analysis;
- Updated and automated capacity and demand analysis by specialty from April 2018 to facilitate balanced demand and capacity;

- As part of the Bay Health and Care Partners' plan, to focus on reducing the wait to first appointment through clinically appropriate use of outpatient capacity; and
- Maximising the reutilisation of outpatient clinics and theatre sessions for consultant leave.

Table 3 details month on month RTT performance for 2016/17. Table 4 details month on month RTT performance for 2017/18 against the Sustainability and Transformation Fund trajectory and the national standard of 92%.

Table 3: Month on Month RTT Performance for 2016/17

RTT Performance 2016/17	Apr -16	May -16	Jun -16	Jul -16	Aug -16	Sep -16	Oct -16	Nov -16	Dec -16	Jan -17	Feb -17	Mar -17	Average for 2016/17
RTT Incomplete Standard 92%	92	92	92	92	92	92	92	92	92	92	92	92	92
STF Trajectory %	88.6	89.1	89.7	90.0	90.2	91.8	91.7	92	92	92	92	92	90.92
<18 weeks against STF Trajectory	89.5	89.7	89.71	90.08	88.82	87.99	87.99	88.49	87.75	87.78	88.26	89.75	88.82%
<18 weeks against National Standard	89.5	89.7	89.71	90.08	88.82	87.99	87.99	88.49	87.75	87.78	88.26	89.75	88.81%
Data Source: Unify Data													

Table 4: Month on Month RTT Performance for 2017/18

RTT Performance 2017/18	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Average 2017/18
RTT Incomplete Standard 92%	92	92	92	92	92	92	92	92	92	92	92	92	92.00
STF Trajectory %	88.76	89.31	89.70	90.00	89.80	89.60	90.00	90.30	90.10	90.00	90.40	90.76	89.90
<18 weeks against STF Trajectory	**89.39**	**89.49**	**89.19**	**88.72**	**88.29**	**87.6**	**87.96**	**87.5**	**86.08**	**85.53**	**85.40**	**84.75**	**87.49**
<18 weeks against National Standard	**89.39**	**89.49**	**89.19**	**88.72**	**88.29**	**87.6**	**87.96**	**87.5**	**86.08**	**85.53**	**85.40**	**84.75**	**87.49**
Data Source: Unify Data													

Accident and Emergency Department 4 hour standard for 2016/2017 and 2017/18

As shown in Table 5 and 6 below, the Trust achieved the 4 hour Accident and Emergency standard between May 2015 and August 2015, but from September 2015 the Trust did not achieve the standard.

Table 5: Trust wide Accident and Emergency Department 4 hour standard for 2016-17

A&E Performance 2016/17	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17
A&E standard 95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Trust 95% performance	86.55 %	90.54 %	91.67 %	86.24 %	83.02 %	81.91 %	87.35 %	84.19 %	81.04 %	79.45 %	81.18 %	83.39 %
>4 hours	86.56 %	90.54 %	91.67 %	86.24 %	83.02 %	81.91 %	87.35 %	84.19 %	81.04 %	79.45 %	81.18 %	83.39 %
STF Trajectory	85.00 %	90.50 %	93.00 %	95.00 %	95.00 %	94.00 %	93.01 %	93.00 %	92.50 %	91.00 %	92.00 %	95.00 %

Data Source: Unify data: the indicator is in relation to the percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge

Table 6: RLI and FGH Accident and Emergency Department 4 hour standard for 2016/17

A&E Performance 2016/17	Apr -16	May -16	Jun -16	Jul -16	Aug -16	Sep -16	Oct -16	Nov -16	Dec -16	Jan -17	Feb -17	Mar -17	Average 2016/17
A&E Standard 95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
FGH	88.59%	91.36 %	91.86 %	87.57 %	85.31 %	87.62 %	91.82 %	86.38 %	83.10 %	75.38 %	74.24 %	79.57 %	85.23%
RLI	81.85%	87.28 %	89.31 %	80.29 %	76.45 %	72.89 %	80.12 %	77.77 %	74.48 %	74.48 %	79.29 %	80.58 %	79.56%
Average RLI and FGH *(Type 1)*	85.22%	89.32 %	90.59 %	83.93 %	80.88 %	80.26 %	85.97 %	82.08 %	78.79 %	74.93 %	76.77 %	80.08 %	82.14%

Data Source: Unify data: the indicator is in relation to the percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge

As shown in Table 5, and in Table 6 and Table 7 below, the Trust has failed to meet the 95% 4 hour Accident and Emergency Standard in 2017/18, but met the Sustainability and Transformation Fund trajectory in October 2017.

Table 7: Trust wide Accident and Emergency Department 4 hour standard for 2017-18

A&E Performance 2017/18	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
A&E standard 95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Trust 95% performance	86.63%	85.46 %	88.67 %	85.19 %	86.65 %	89.41 %	90.49 %	87.64 %	84.79 %	79.41 %	82.48 %	76.33 %
>4 hours	86.63%	85.46 %	88.67 %	85.19 %	86.65 %	89.41 %	90.49 %	87.64 %	84.79 %	79.41 %	82.48 %	76.33 %
STF Trajectory	90.01%	90.00 %	90.01 %	90.01 %	90.00 %	90.00 %	90.01 %	90.00 %	90.00 %	88.01 %	88.00 %	95.00 %

Data Source: Unify data: the indicator is in relation to the percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge

Table 8: Site & Trust Wide Accident and Emergency Department 4 hour standard for 2017-18													
A&E Performance 2017/18	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Average 2016/17
A&E standard 95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
RLI Performance	84.05 %	83.04 %	87.70 %	80.76 %	83.10 %	87.35 %	87.19 %	81.36 %	79.79 %	75.06 %	75.63 %	69.07 %	81.08 %
FGH Performance	81.03 %	82.75 %	84.83 %	83.49 %	87.23 %	87.75 %	90.64 %	93.13 %	83.73 %	76.26 %	83.98 %	77.13 %	84.12 %
Average RLI and FGH *(Type 1)*	82.8%	82.9%	86.5%	81.9%	84.8%	87.5%	88.3%	85.5%	81.1%	75.2%	78.5%	71.8%	82.28 %
Data Source: Unify data: the indicator is in relation to the percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge													

The following factors have contributed to us not achieving the standard:

- Increased levels of Delayed Transfers of Care;
- Continued increases in the high number of patients who are not in the optimal place, but remain in an acute hospital bed;
- Inability to gain timely access to community services including care homes (Nursing and Elderly Mentally Impaired) and social care packages of care including reablement, particularly in South Cumbria;
- Ability to recruit registered nurses;
- High numbers of patients requiring an in-patient mental health bed attending the Emergency Departments;
- Impact of pressures upon social care; and
- Lack of community based non-'bed based' services to avoid unnecessary admission and facilitate early appropriate discharge.

The plan to improve performance against the standard in 2017/18 was based on a strategy to reduce medical bed occupancy on each acute site to 85%. A number of actions have been implemented throughout the year to improve patient flow, including:

- Implementation of the Accident and Emergency (A&E) Delivery Board which has developed a single A&E Improvement Plan which is a whole system plan designed to improve care and coordination across the spectrum of primary community, acute and social care;
- Further reductions in the numbers of patients who are medically fit for discharge; and
- The pull back of medical outliers from the surgical bed base into the medicine bed base resulting in more timely care and shorter lengths of stay.

External assistance to assist with more timely care home placements was intended to reduce medical bed occupancy, improving patient flow and supporting the delivery of improved performance of the Emergency Department 4 hour standard.

In addition to the National Quality Standards the Trust has adopted its own key performance indicators which include local quality and governance standards, workforce standards and financial standards. All standards are reported on a monthly basis to the Board of Directors through an Integrated Performance Report.

The key focus of the Trust has been to improve the quality of care for our patients and to increase the number of permanent medical and clinical staff within the resources available to the Trust.

The Trust believes the safety of its patients is at the centre of everything we do and uses a large number of indicators to assess how well it is doing. A summary of the performance for the year is given below.

During 2017/18 over 112,000 patients attended our Emergency Departments, 108,000 previous year. In 2017/18, 31,554 ambulances arrived at our Emergency Departments; a 2.79% increase over the same period in 2016/17.

The Trust has seen a significant and sustained reduction in the number of falls resulting in patient harm during the past few years. For 2016/17 the number of avoidable harms was 11 cases. The figure for 2017/18 is 10 cases.

The Trust has a zero tolerance policy to infections and we are working towards eradicating them; part of this process is to set improvement targets. The Trust limit for 2017/18 cases of *Clostridium difficile* infection has been set at 44 cases. This remains unchanged from 2016/17. The aim is that no patient is harmed by a preventable infection and this is a maximum number of cases and not a target. A Post Infection Review is completed for each case of *Clostridium difficile* infection to identify if there is a lapse in care such as, but not limited to:

- Non-compliance in cleaning or hand hygiene standards on the ward during previous audits;
- Poor antimicrobial prescribing practices;
- Poor compliance regarding commode and environmental cleaning or labelling;
- Poor compliance to policy regarding isolation of patients with loose stools; and
- Transmission of *Clostridium difficile* (two cases with links by the same ribotype and evidence suggestive of cross infection).

Reduction of e-coli infections has been a focus across the UK over the last year. Nationally, there is a requirement to reduce these infections by 50% by March 2021. The majority of these infections are associated with urinary tract (catheter acquired) infections, of which, 80% are acquired in the community. The Director of Infection Prevention and Control received a letter in March 2018 from Ruth May, National Director of Infection Prevention and Control to congratulate Trust staff on being one of 59 Trusts nationally to achieve a reduction of 10% or greater in 2017. Our reduction of 23.4% is a tribute to the Trust's front line staff who continue to deliver high standards or care in very challenging NHS environment. Opportunities to support a healthcare economy reduction over the next year are significant and will be one of the Trust's key infection prevention goals.

The Department of Health developed guidance in conjunction with the NHS Commissioning Board to facilitate delivery of a zero tolerance objective towards MRSA blood infections. The Trust continues to follow this guidance through the use of the post-infection review process and supports the implementation of the modified admission MRSA screening guidance for NHS (2014). During 2017/18, there were no further MRSA infections acquired in the Trust.

The bulk of the harms have been continually caused by grade 2 Hospital Acquired Pressure Ulcers (HAPU) since April 2014. Whilst steady progress was made in reducing HAPU grade 2 between April 2014 and April 2017, there has now been a slow increase in prevalence again during 2017/18. There is a full action plan in place in order to assist in reduction of these consistently high numbers during 2018/19, with each Care Group taking responsibility for their own learning. Positively, HAPU grade 3 and Grade 4 remain extremely low in number, with only one grade 4 HAPU being recorded since April 2014. The categories of "HAPU unstageable" and "HAPU Deep Tissue Injury" have begun to rise during 2017/18 which is a cause for concern; action plans are in place to reduce prevalence.

A more detailed report on our clinical performance is given in our Quality Report at Annex A.

Financial Performance

The Trust's accounts for 2017/18 have recorded a deficit of £67.6 million which is after a cost improvement programme of £17.44m and impairments of £2.715m.

For 2018/19 the Trust is forecasting a planned deficit before impairments of £69.4 million which is after a cost improvement programme of £14 million and sparsity funding of £5.8 million. No Sustainable Transformation Funding has been assumed as the Trust has not agreed its control total. The Directors recognise that should this level of operating deficit continue, this introduces significant risk to future years' financial standing, and the Trust is working to mitigate this risk. However, the overall Financial Plan ensures a cash flow forecast for the coming twelve months demonstrates that the Trust will be able to meet its liabilities as they fall due. The Trust has agreed the financial baseline position on its main contracts for the year 2018/19 which represents a significant percentage of total budgeted income. The financial plan for 2018/19 takes into account our capital plans, service development plans and our cost improvement programme for the year, the delivery of which partly relies on work we are doing with our partners in the local health economy around system transformation.

The Trust recognises it has loans which are due for repayment in 2019/20 and as part of our refresh of long term financial strategy, we will, in 2018/19, agree with the regulators how the repayment terms will be managed. The Trust will work within the policy guidance issued by the Department of Health and Social Care in relation to this issue.

A more detailed reported on our financial performance is given in our Accounts for the Period 1 April 2017 to 31 March 2018 at Annex G.

Innovation and Informatics

Our Information, Innovation and Informatics strategy (I^3) is integral in supporting clinicians to deliver high quality services to our patients and to improve our performance.

This year was the fifth of the six year strategy which is based on eight themes; an integrated innovation, informatics and information service, complete the Lorenzo Patient Record deployment and rollout, the need for business intelligence, governance, eHospital, develop and maintain a project portfolio, interoperability and infrastructure.

Progress has been made across all of the eight themes, with a demonstrable impact as the Trust 'Digital Maturity' was ranked above the national average in all twelve areas of the national assessment.

Significant progress has been made through a programme to optimise the Trust's Electronic Patient Record (EPR), which has extended the 'width' of the EPR to new areas in and out of the hospital and the 'depth' of the EPR with the deployment of new forms to capture structured clinical content. In an average month our doctors, nurses and other health professionals record over 140,000 electronic forms which allow us to share more easily patient information between clinical colleagues and analyse the information to understand how we can further improve patient care.

Nurses on all wards now use hand held devices to record some assessments at the bed side and we are currently rolling out an application which links the ward electronic whiteboards to the catering department and reduces waste whilst allowing patients more time to choose their meals. In the future we can link the food patients eat to the EPR to inform an accurate nutritional assessment.

We are working with Digital Leaders from Bay Health and Care Partners to develop a new vision, so far known as the 'Digital Offer' to take maximum benefit from the development and integration of existing systems within the Bay footprint. A cross-bay workshop was held to explore options for a new model of consent to support direct patient care. An output of the workshop was a framework of recommendations to change practice to much wider sharing of health and social care records than is currently practiced within Morecambe Bay. This is based on principles of confidentiality, sharing with "no surprises" and based on implicit consent. This will be underpinned by a much wider definition of "Direct Care" developed by the National Data Guardian and will need clinical design of systems and tools and methods of auditing and assurance.

I^3 have established a bay-wide business intelligence platform, underpinned by a Health Community Data Warehouse, which provides a combined view of patient data from GPs and the hospital. Visual and interactive 'dashboards' of up-to-date information allow managers and clinicians in the hospital and integrated care communities to have a tailored view of the same information to better understand their business.

The 'Advice and Guidance' (A&G) application, which has been developed locally, allows a GP and a hospital specialist to discuss the care of a patient using a secure instant messaging service. Once the conversation is complete it can be stored as part of the patient's record both in primary care and in the hospital. A&G is well established within the Bay and this year with the support of I^3 has been extended to more clinicians in North Cumbria and Lancashire.

Projects are in place to move the incoming community staff to the same common informatics platform as colleagues in the hospital and GPs across the Bay. I^3 are working closely with the Bay Digital Leads and clinical colleagues across the system to plan the best way to consolidate community information systems and integrate staff and patient records.

As I^3 look to the future we are developing a new framework of governance to shift from the current 'push' mode of functionality to one of 'pull' where priorities are set by the hospital Care Groups and ultimately by clinical leaders across the integrated care system.

Cyber Attack 12 May 2017 and the Response of the Trust

On Friday 12 May 2017 reports of a virus, now known as 'WannaCry', were reported to the Trust Service Desk. The virus was unknown to the Trust Antivirus Shield and PC's and Servers targeted by the virus were therefore unprotected. Shortly after the virus attack NHS Digital communicated that the virus was exploiting a known Microsoft vulnerability which would be corrected with patch MS-017. As part of this testing and approval schedule the March 2017 Security patch was tested and released to all live PCs, but – unusually – had a very high installation failure rate, over 2,500 failures and only 25 successful installations with the remaining computers awaiting installation. Other organisations seemed to be having the same experience with this update. At this point Microsoft withdrew the superseded March update and replaced it with the April security-only update, so this was released to the test computer collection as part of the normal verification process. The April update was therefore in test, and almost ready for deployment to all live computers when the virus struck.

Shortly after the virus was reported servers began to be attacked and the decision was made to take off line the Trust File Servers, which were a particular target for the virus. At this point the Trust position was not to close down servers running clinical applications unless at risk of immediate attack and to switch off non-clinical and non-essential computers. The Trust established a command and control structure across the three main sites, with floorwalkers reporting in roughly every two hours with updated communications released thereafter.

A rota was prepared to keep the I^3 Service Desk running 24/7 throughout the crisis, to operate as a single point of contact. McAfee the supplier of the Trust Antivirus Shield released a patch for the virus and as soon as the patch for the antivirus shield became available the IT team began steps to release it to all servers and computers. Similarly, as soon as the IT team became aware of the dependency on the MS-017 patch they began to deploy the patch to PC's and Servers, which was a lengthy process and was completed early morning on 14 May 2017.

During the containment phase staff were notified to leave PC's turned off. During this period the IT team began to restore corrupted servers from backup. At the worst point of the crisis out of 40 Priority 1 and 2 information systems only three systems were available; Lorenzo, Digital Telephony and CRIS (Radiology Information System). At approximately 09:30 on 14 May 2017 all computers and servers were patched with the Microsoft and McAfee patches and the virus was contained and recovery process begun. During this period I^3 also provided support to Primary Care and liaised with lead GPs and practices to open and turn on their computers for patching. IT Engineers were also dispatched to turn on and patch computers at Queen Victoria Hospital, Ulverston Community Health Centre and Care Quality Committee buildings in South Cumbria and Lancashire.

On 15 May 2017 systems returned to normal. During the incident 50 computers were reported as infected out of a total of 8000. These computers were immediately isolated from the network to prevent the virus spreading. All of the infected computers were replaced by 16 May 2017.

Our Environment and Sustainability Report

The Trust is committed to providing sustainable healthcare to the people of the Morecambe Bay and the wider community. We have a Sustainable Healthcare Strategy, which provides a framework for waste minimisation, the impacts of transport, energy and resource use, use of water, and environmental emissions. In addition, we acknowledge the significance of the indirect impacts that we influence through procurement and our choice of contractors and suppliers.

It is the Trust's objective to act in a responsible manner to control and reduce any negative impacts on the environment whilst continuing to provide high quality patient care.

Policy and strategy are developed and reviewed by the appropriate governance committees. Public Governors are given the opportunity to attend key decision making forums to ensure that the views of patients, carers and the local community are considered.

Day to day responsibility for implementing most aspects of the Sustainability Strategy is delegated to the Estates and Facilities Division. The Trust employs a Waste Officer with specific responsibility to reduce waste, and thereby contribute to a reduction in the Trust's environmental footprint.

In 2017/18, the Trust generated overall a lower volume of waste in the region of 125 tons per month which is, lower than the previous year. This is despite the move to seven day working and increased clinics and the volumes moving through the hospitals.

Due to the new clinical waste contract, greater recycling is being achieved. We are particularly proud of our progress in respect of non-hazardous healthcare waste, improved segregation and better training within the Trust.

The Trust has a new domestic waste contract which separately recycles cardboard, waste is segregated at the plant and materials are now going as “refuse derived fuel” reducing the landfill capacity element. Waste food is also being re-cycled and produces energy which is fed back into the National Grid through anaerobic digestion by the contractor, “Re-Foods Ltd”.

This has removed food waste from the drainage system and has generated renewable energy. The Trust has trained 1900 staff last year in waste management, an increase of 600 staff over the previous 12 months.

The most substantial single improvement will arise from the major energy-saving investment programme to which the Trust is committed. It will reduce annual energy costs by over £1 million after scheme completion, and reduce carbon usage by 3,800 tonnes a year. There have been delays whilst we sought Department of Health loan finance, but the scheme can be self-financing from revenue saving on energy costs. Working with an external partner we intend £5 million investment in a package of measures, including combined heat and power engines at our two main hospitals.

The following table details environmental performance in key areas.

Environmental performance		**2014-15**		**2015-16**		**2016-17**		**2017/18**	
		Tonnes	*Cost £000s*	*Tonnes*	*Cost £000s*	*Tonnes*	*Cost £000s*	*Tonnes*	*Cost £000s*
Production of waste	Total waste	1,352	378	1,580	425	1692	431	1620	439
	Clinical	481	172	315	157	613	201	638	258
	Landfill	349	51	566	90	427.2	92	86	16
	Recycled	433	49	375	39	640.8	138	896	165
	Energy produced	548	202	295	103	TBC	TBC		
	Electrical/electronic	6	4	7	3	9	2		
Use of resources (water, electricity & gas)			4,103		3,844		3,652		

Value Creation

The Trust's improvement journey is beginning to realise significant benefits.

Through our enterprise and utilisation of our capacity, capital, staff and other resources, value is being created not only for our patients but our partners and the wider health economy.

Central to this is the Better Care Together strategy. Historically the provision of health and social care in the Morecambe Bay area has always been a challenge. The commissioning and provider landscape has always been complex and has not always operated as efficiently as it could.

Through Better Care Together commissioning and provider organisations are working together for their mutual benefit to solve individual and collective problems not only at a local level but also on a regional basis. By reviewing the collective position of the local heath economy opportunities for new and innovative ways of working have been identified that will improve care for patients. This ambition has already yielded further benefits through Vanguard Status and access to a national £200million fund to support our work.

Through our principle activities we are also beginning to play a central role in society as we focus more on population and public health

An example of this is the Millom Project. The Trust, Cumbria Partnership and the local community have all worked together to develop services in the town - involving patients, families and carers to make sure that they truly put the patient at the centre.

The Millom model of healthcare was developed following historical frustrations by the community in Millom which culminated in a march by hundreds of people through the town. They demanded better healthcare services. What followed was incredible.

The new model was formed with input from the community, patients, staff, the third sector and representatives from all NHS organisations and included: a community led GP recruitment campaign, 3 doctors recruited, a new newspaper full of health promotion messages, a detailed clinical model developed including: the first advanced community paramedic in the North West, a nurse linked to community group mobilising the population for health and wellbeing, school plays on using the health services properly, healthy eating initiatives, a pharmacy minor illness scheme, care homes support scheme, new access system in general practice, a community hospital reopened and a significant reduction in length of stay was seen.

The Millom model shows just how much can be achieved when everyone works together to achieve a shared goal and is the ethos behind Better Care Together – our shared strategy to make healthcare services in the Morecambe Bay area fit for a sustainable future.

Millom has shown how Integrated Care Communities can be formed and others are now developing in Garstang and Kirkby Lonsdale. In total there will be 12 Integrated Care Communities.

The Trust is playing its part in promoting health and well-being and developing a range of services with the aim of reducing the need for hospital admissions. These include alcohol and smoking services.

The Trust continues to invest in its estate and staffing levels creating wealth and opportunities for local people and contributing to the prosperity of the local economy.

Through our Volunteer work we offer a variety of opportunities for different sectors of our community.

The Be Inspired Project - is aimed at students considering an NHS career pathway, and embedding micro volunteers from schools and further education and the wider community in activities for example fundraising.

Community Partnership Network - is aimed at developing our partnership working with third sector voluntary and charity organisations while bringing people together who want to help generate strong community partnerships that work to make a difference within their local healthcare services. The focus is on supporting community voluntary partners to be fully involved in mutually beneficial partnerships.

Volunteer Academy - This project is aimed at those returning to work, those having second careers, and people who may have been out of work for some time or are thinking of returning to employment. The scheme is an interim development activity to re-build their confidence or perhaps moving towards the end of their core career pathways or who simply wish to give something back to their local hospital services.

A trial that saw the Trust become one of the first Trusts in the UK to work in partnership with Parish Nursing Ministries UK to support patients to recover in their own homes will continue.

The parish nurse pilot project launched on the surgical wards at Furness General Hospital (FGH) and it focused on providing care for those patients that were medically well enough to be discharged from FGH but who may benefit from a period of extra support and monitoring in their own home. All parish nurses are registered nurses and are appointed through the local church. Patients of any or no faith are eligible for parish nursing. The main aim of the service is to further support patients in their own home to enable them to recover from their operation fully, potentially regain their independence and confidence in their home, and prevent re-admission to hospital.

The success of the pilot project can be contributed to the team working together to set the inclusion criteria, strong team relationships and commitment to do the best for our patients and offer this quality service provided by the Parish Nurse. It works so well because a parish nurse is able to provide the time required to assess a person holistically in the home setting, and is not bound by the time restrictions of other services.

The Community Eyecare Service is an example of collaborative working between the Trust and local opticians in South Cumbria and North Lancashire which looks to improve patient experience and provide increased access to local care. Over the last year, this service has made appointments for suitable patients much more accessible. In addition, it has led to hospital staff, community optometrists and other people involved in eye health working much closer together. This is helping partners to look at further new and innovative ways of providing services in the community in the future. Prior to the launch of the service, optometrists in the community saw approximately 30 patients with minor eye conditions each month. Following the launch of the new system, they now see approximately 500 patients per month in the community. Currently there are 24 optical practices actively participating in the scheme increasing the choice of locations for patients to receive their care. The Community Eyecare Service has provided patients with the appropriate treatment and advice quickly and at a time and place convenient to them. In January 2018, the Trust launched two apprenticeship schemes. The nurse degree apprenticeship, in partnership with University of Cumbria, offers individuals the opportunity to train as a registered nurse. The Trust is the first Trust nationally who have registered nurse degree apprentices in post in this way. This approach is the Trust's first step in developing "home grown" registered nurse workforce and this strategy will be an essential component in ensuring a sustainable nursing workforce in the future.

The second apprenticeship scheme, the healthcare science associate apprenticeship, in partnership with Kendal College, enables learners to qualify as a healthcare science associate who will take up posts within the Trust's pathology services.

These schemes demonstrate the commitment of the Trust to promote opportunities for young people supporting learning and development and strengthening the local economy

During 2018/19 the Trust will be looking at further opportunities to develop its stakeholder relationships and create further value.

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Accountability Report

Director's Report

Management Commentary and Principal Activities

The business of the Foundation Trust is managed by the Board of Directors which is collectively responsible for the exercise of the powers and the performance of the NHS Foundation Trust subject to any contrary provisions of the National Health Service Act 2006 as given effect by the Trust's Constitution. These have changed slightly after the Health and Social Care Act 2012, which was introduced on 27 March 2012.

The Board of Directors is responsible for providing strong leadership to the Trust. Responsibilities include:

- Setting strategic aims and objectives, taking into account the views of the Council of Governors;
- Ensuring robust assurance, governance and performance management arrangements are in place to ensure the delivery of identified objectives;
- Ensuring the quality and safety of healthcare services, education, training and research and applying the principles and standards of robust clinical governance;
- Ensuring that the Trust complies with its License, its Constitution, mandatory guidance as laid down by NHS Improvement and other relevant contractual or statutory obligations; and
- Ensuring compliance with the Trust's Constitution which sets out the types of decisions that are required to be taken by the Board of Directors. The Corporate Governance Manual identifies those decisions that are reserved by the Board of Directors and those that can be delegated to its Trust Managers. The Constitution describes which decisions are to be reserved for the Council of Governors.

The Board of Directors comprises seven Non-Executive Directors (excluding the Chairman) and seven Executive Directors (including the Chief Executive). The voting balance therefore lies with the Non-Executive Directors. The Non-Executive Directors and the Chairman are appointed by the Trust's Council of Governors and, under the terms of the Trust's Constitution, they must form the majority of the Directors.

The decision making structures within the Trust provide Non-Executive Directors with the ability to make decisions and provide challenge on an informed basis. Non-Executive Directors have access to independent professional advice at the Trust's expense to enable them to discharge their responsibilities as directors. For example external support was sought to provide the Trust with expertise to support its Sustainability Programme.

Each Director has a shared and equal responsibility for the corporate affairs of the Trust both in terms of strategic direction and for promoting the success of the Trust.

As a self-governing Foundation Trust, the Board of Directors has ultimate responsibility for the management of the Trust, but is accountable for its stewardship to the Trust's Council of Governors and Foundation Trust Members. In addition, the Trust is regulated by NHS Improvement and inspected by the Care Quality Commission.

In order to understand the roles and views of the Council of Governors and the Foundation Trust Members, members of the Board of Directors undertake the following:

- Attend Council of Governors meetings;
- Hold four joint meetings with the Council of Governors;
- Hold two joint Non-Executive Director and Council of Governors meeting;
- The Head Governor attends all Public and Private Board Meetings;
- Invite Governors to attend Assurance Committees;
- The Chairman and the Trust regularly update the Council of Governors with information from Board meetings and invite them to events and briefings; and

- Support and attend engagement events organised by the Trust and the Better Care Together Engagement Team.

The Chairman is committed to spend a minimum three days per week on Trust business. The Chairman's other significant commitments are outlined later in this Director's Report. There have been no material changes to these commitments during the past 12 months. The Non-Executive Directors are committed to spend a minimum of four days per month on Trust business. Both the Chairman and the Non-Executive Directors routinely spend in excess of their commitment of three days per week and four days per month respectively on Trust business.

The Board of Directors meet formally on a bi-monthly basis and the Board Agenda is produced to ensure that the Board has sufficient time to devote to matters relating to patient safety and quality, finance and workforce. The Board takes strategic and informed decisions based on high quality information and monitors the operational performance of the Trust, holding the Executive Directors to account for the Trust's achievements and performance. The Board receives an Integrated Performance Report covering patient safety and quality, finance and workforce. This enables the Board to monitor the Trust's financial, operational, quality and workforce performance against national and contractual standards. This is supported through a series of dashboards giving more detailed analysis of performance.

There is a clear division of responsibilities between the Chairman and the Chief Executive. The Chief Executive ensures that the Board has a strategy which delivers a service which meets and exceeds the expectations of our patients and the wider population and an Executive Team with the ability to execute the strategy. The Chairman facilitates the contribution of the Non-Executive Directors and constructive relationships between Executive and Non-Executive Directors. To that end the Chairman routinely holds meetings with the Non-Executive Directors prior to meetings of the Board without the Executive Directors present to co-ordinate the Non-Executive Directors' contribution.

The Chairman also leads the Council of Governors and facilitates its effective working. The effectiveness of both the Board and the Council, and the relationships between the Board and Council, are the subject of regular review, led by the Chairman. In the event of a dispute between the Board of Directors and the Council of Governors the Trust has adopted a procedure which is set out in Annex 8 of the Constitution.

The Chief Executive is responsible for executing the Board's strategy for the Trust and the delivery of key targets, for allocating resources and management decision making. The Chief Executive is also responsible for the effective running of the hospital on a day to day basis. The Chief Executive is the Accounting Officer and must operate in accordance with the "NHS Foundation Trust Accounting Officers Memorandum April 2008". Specific responsibilities are delegated by the Chief Executive to the Executive Directors comprising the Director of Finance, the Medical Director, the Executive Chief Nurse, the Chief Operating Officer, the Director of Workforce and Organisational Development and the Director of Governance. The Constitution and the Corporate Governance Framework provide additional information on the types of decisions that are taken by the Board and its Committees and which are delegated to the Executive Directors.

Composition of the Board

The Executive Directors are appointed by the Non-Executive Directors. The Non-Executive Directors are appointed by the Council of Governors' Nomination Committee.

The Board is of sufficient size and the balance of skills and experience is appropriate for the requirements of the business and the future direction of the Trust. Arrangements are in place to enable appropriate review of the Board's balance, completeness and appropriateness to the requirements of the Trust.

The backgrounds, experiences and qualifications of the Non-Executive Directors are varied. They include public and private sector backgrounds, financial, legal, project management and clinical knowledge and expertise.

The balance and composition of the Board of Directors is regularly reviewed by the Chairman. In the light of the changes that have taken place since 2012, the composition of the Board of Directors has been reviewed on numerous occasions.

As the term of office of four Non-Executive Directors was expiring the Chairman took the opportunity to consider the issues facing the Trust and to review the skills, knowledge and background of Non-

Executive Directors and to consider changes to their terms of office This has ensured stability at this important time but put in place arrangements to ensure that Board membership does not become stale and is refreshed on a regular basis.

One Non-Executive Director was appointed for a further term of office. Two Non-Executive Directors will see their term of office expire in 2018 and the Chairman will review the knowledge and experience of new candidates with the Governors to ensure the future needs of the Trust are met as the integrated care partnership proposals develop during 2018/19.

The Terms of Office of the Non-Executive Directors are set out below:-

Name	Post	Appointment Date	Term of Office	End Date
Mr Pearse Butler	Chairman	1 November 2014	3 years	31 March 2018*
Mr Peter Armer	Non-Executive-Director	25 June 2015	2 years	31 August 2017*
Mrs Helen Bingley	Non-Executive Director	1 September 2017	3 years	31 August 2020
Ms Helen Denton	Non-Executive-Director	25 June 2015	3 years	24 June 2018
Professor Neil Johnson	Non-Executive-Director	1 July 2016	3 years	30 June 2019
Mr M Jassi (known as Bruce Jassi)	Non-Executive-Director	24 February 2018	3 years	23 February 2021
Mr Denis Lidstone	Non-Executive-Director	25 June 2016	2 years	24 June 2018
Ms Elizabeth Sedgley	Non-Executive Director	1 September 2017	3 years	31 August 2020
Ms Jacqueline Telfer	Non-Executive-Director	1 April 2017	2 years	31 March 2019
Ms Melanie Weeks	Non-Executive-Director	25 June 2015	2 years	24 June 2017

*It was agreed to extend the Chairman's term of office to 31 March 2018 and Peter Armer's term of office until 31 August 2017. This was skills and knowledge of the Trust and to ensure a degree of continuity during this period of change in Board Membership. Process followed by the Council in relation to appointments of the Chairperson and Non-Executive Directors.

The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the Chairman of the Trust and the other Non-Executive Directors in accordance with the provisions in Annex 5 of the Constitution.

Board Diversity

Board Diversity - Trust Board - Voting Members					
Ethnicity	Number	%	Sex	Number	%
White - British	13	86.67%	Male	7	46.7%
BME	2	13.33%	Female	8	53.3%
Total	15	100.00%	Total	15	100%

Board Development and Review of Effectiveness

Informal Board meetings are held at least bi-monthly to ensure that sufficient time is devoted to strategic issues and to developing an effective Board. The Chair agrees the content of the Informal Board to help the Board consider the strategic challenges and risks facing the Trust.
Informal sessions ensure that the Board have the opportunity to reflect on their collective and individual performance and use external support to undertake development activities and assessments.

NHS Improvement's Oversight Framework requires that NHS Foundation Trusts should carry out an external review of their governance every three years. This was last undertaken during 2015/16. A Well Led Review will be undertaken in 2018/19

Grant Thornton UK LLP was appointed as the independent reviewer to undertake the review.

The reviewer has made an assessment of the Trust's quality governance arrangements. Their report followed the format of the four domains within the framework of:

- Strategy,
- Capabilities and Culture,
- Process; and
- Structure and Measurement.

Under these four domains sit 10 key high-level questions.

The ratings given by Grant Thornton agreed with the Trust's self-assessment in four of the ten areas and in the other six areas they rated the Trust as Green/Amber rather than Green. The difference between the Trust's self-assessment and the reviewer's assessment was that they have applied the test of "established and embedded" whereas the Trust has applied the NHS Improvement risk rating against the evidence presented. It was notable that no assessment scores were Amber/Red or Red.

The reviewers confirmed there were "no glaring gaps" and "a lot of good practice" in their summary of findings which echoed the Trust allocation of green ratings; referring to NHS Improvement risk rating Green as having "no major omissions" and "many elements of good practice".

However, to embed the significant progress already made the amber/green ratings and associated recommendations provided the Trust with the opportunity to further refine and consolidate governance and focus resources to ensure systems and processes are truly embedded.

In the Care Quality Commission (CQC) report under the Well Led Domain the CQC Inspectors noted the following

- There was a clear vision and strategy for delivering high standards of patient care with quality and safety as a key focus;
- There were effective reporting arrangements and governance systems up to the Board;
- There were good levels of clinical engagement and leadership across the Trust. Staff were proud of the organisation as a place to work. The NHS Staff Survey 2016 demonstrated many areas of improvement including staff recommending the Trust as a place to work or receive treatment, staff feeling supported, and staff making effective use of patient and service-user feedback;
- The Trust valued and encouraged public engagement. There were many examples of public engagement in the development and delivery of maternity services, such as co-designing the new maternity unit, interviews for recruitment of new staff, including midwives and matrons, and the development of guidelines and strategies;
- There were many examples of innovation and improvement, for instance, the Trust was one of only two NHS trusts in the country to launch a new quality ambassador scheme to help improve the quality of care provided across its services;
- The senior executive team had been stable since the last inspection and had been strengthened by the appointment of two deputy chief operating officers. The senior team members were strong, visible and accessible;

- The triumvirate management arrangement had also been changed and strengthened and was continuing to be embedded at the time of the inspection; and
- There was a positive and challenging relationship with the Non-Executive Directors.

Board Activity

There have been seven formal Board of Directors' meetings in 2017/18.

There were five Committees of the Board as follows:

- Finance Committee;
- Quality Committee;
- Audit Committee;
- Remuneration Committee; and
- Workforce Committee.

The Board of Directors also acts as Trustees for the Charity Corporate Trustees Committee.

Independence of Non-Executive Directors

The Trust undertakes an annual review of the independence of its Non-Executive Directors. It determines whether each Director is independent in character and judgement and whether there are relationships or circumstances which are likely to affect, or could appear to affect, the Director's judgement. The Trust considers all Non-Executive Directors to be independent on the grounds that they meet the independence requirements set out in the NHS Improvement Code of Governance. Each of the Non-Executive Directors has passed the Trust's Fit and Proper Persons Test.

Code of Conduct

The Board of Directors operates a Code of Conduct that reflects high standards of probity and responsibility in discharging their duties. All Directors have read and signed the Trust's Code of Conduct which includes a commitment to actively support the NHS Foundation Trust's Vision and Values and to uphold the Seven Principles of Public Life, determined by the Nolan Committee.

Statement as to Disclosure to Auditors

The Board of Directors is not aware of any relevant audit information that has been withheld from the Trust's auditors. Each individual member of the Board has taken all necessary steps they ought to have taken, as a director, in order to make themselves aware of any relevant audit information and to establish that the Trust's auditor is aware of said information, by making such enquiries of their fellow directors and the Trust's auditors for said purpose and exercising reasonable care, skills and diligence.

Material Interests and the Register of Directors

The Trust undertakes an annual review of its Register of Declared Interests. At each meeting of the Board of Directors a standing agenda item also requires all Executive and Non-Executive Directors to make known any interest in relation to the agenda, and any changes to their declared interests. The Register of Declared Interests for the Board of Directors is available for public inspection by contacting the Company Secretary. The following interests have been declared. Sue Smith has declared she is a Director of Transform Healthcare Cambodia (registered charity) and a Non-Executive Director for St. John's Hospice, Bruce Jassi has declared he is a Non-Executive Director with New Charter Housing Trust, Chairman for New Charter Homes and AKSA Homes Housing Association. Neil Johnson has declared that he is employed by Lancaster University. Ian Johnson has declared he is Chair of Lancaster University Health Innovation Campus Board and member of Lancaster University Council.

Contacting the Board of Directors

Any member of the public wishing to make contact with a member of the Board should, in the first instance, contact Paul Jones, the Company Secretary.

Address: Trust Headquarters
Westmorland General Hospital
Burton Road
Kendal
LA9 7RG

Telephone: 01539 715314

Email: paul.jones4@mbht.nhs.uk

Profile of the Board

Pearse Butler (Chairman)
Appointed – 1 November 2014

Pearse Butler has eighteen years' experience as an NHS Chief Executive in a variety of organisations including Royal Liverpool Children's Hospital (Alder Hey), the former Cumbria and Lancashire Strategic Health Authority, and Royal Liverpool and Broadgreen University Hospitals.

His previous role with the Computer Sciences Corporation (CSC) will help support the Trust as we continue to develop modern, digital systems that help ensure joined-up patient care across multiple NHS and social care organisations.

He has a track record of developing a sustainable, loyal workforce through attracting and training young people; during his time at Royal Liverpool and Broadgreen, the Trust became one of the city's largest employers of apprentices.

Helen Denton (Non-Executive Director)
Re-appointed – 25 June 2015

Recently retired from Lancashire County Council, Helen held the role as Chief Officer for Children's Services. Helen led a significant and rapid change management initiative under the scrutiny of Ofsted, and was responsible for administering a multi-million pound central budget in a role which requires strong leadership and enhanced partnership working.

Helen has also undertaken leadership roles with large multinational company, Serco. As Operations Director of Education and Children's Services within Serco Solutions division, she was responsible for around 1,500 employees and contract budgets in the region of £100 million.

Helen made a strong contribution to Serco's global top 200 leaders and managers initiative and twice picked up Chairman's awards for outstanding performance. During this period she also served as a director on the board of a New Deal Regeneration Board in Walsall, and as non-executive director for a Serco defence contract at RAF Cosford.

Whilst Managing Director of Education Walsall, she managed her own company board, chaired by one of the founding partners of Serco, who took a personal interest in the developing education and children's services. This was an important demonstration contract for Serco, as one of the first major government interventions that was managed through outsourcing to the private sector.

Helen Bingley (Non-Executive Director)
Appointed – 1 September 2017

Helen qualified as a nurse in Lancaster in 1979 and took up her first management post in the NHS in 1984 and reached the position of Chief Executive in 1996. NHS roles have included Chief Executive, Executive Director, and Non-Executive Director roles and have involved managing substantial change in the NHS.

After leaving the NHS in 2002, Helen worked for a period as Head of Teaching and Learning at the University of Central Lancashire designing an Undergraduate and Masters Programme designed to achieve organisational change.

Helen has been Managing Director of Bingley Consultancy for 15 years, a business that she and others established to support senior managers in the public, private and voluntary sectors with strategic change.

Helen has several voluntary sector roles, she is a founder member and Chief Executive of a UK Registered Charity The Abaseen Foundation UK, set up almost 20 years ago; the charity has recently gained a Queen's Award for Voluntary Services. Helen is also the Treasurer and a Trustee of Mind in Barrow in Furness. She is part of the Bereavement Support Team at St John's Hospice in Lancaster and is a Queen's Awards Assessor.

Bruce Jassi (Non-Executive Director)
Re-appointed – 24 February 2018

Bruce is a former Assistant Police and Crime Commissioner for Lancashire and previous to that was Chair of the Lancashire Police Authority.

He has also been Strategic Director of Salford City Council, and he joined our Trust Board as a Non-Executive Director in March 2015.

Bruce's extensive experience in public sector leadership, which has included the delivery of major change programmes and multi-million pound efficiency projects, is brought to his key roles in overseeing safety, quality and finance as part of our Trust Board.

He has previously held Board positions for Salford's Healthy City Executive Forum, Crime and Disorder Executive and Urban Vision Partnership, and has pledged to focus on patients in everything he does here at University Hospitals of Morecambe Bay.

Neil Johnson (Non-Executive Director)
Appointed – 1 July 2016

Neil completed his initial medical education at Cambridge and Oxford, he trained as a General Practitioner. Alongside work as a GP he also took on a series of academic roles, starting as a Research Fellow in Oxford in 1990. Over time his research focused increasingly on medical education and in 1997 he moved into the leadership and management of medical training - initially as Director of GP Education in Oxford and then as Postgraduate Medical Dean in Leicester. After a period as a Director of NHSU he moved to Warwick in 2006 where he became Professor of Medical Education in 2008 and Pro Dean in 2010. He then moved to Lancaster as Dean of the Faculty of Health and Medicine and Professor of Medical Education in 2014. His research focuses on aspects of medical education. Recent work includes the measurement of teaching and the use of role modelling.

He has served on a wide range of health-related committees at regional and national level. He is also currently Chair of the General Medical Council's Medical Licensing Assessment Expert Reference Group, Chair of the Medical School's Council Assessment Alliance Board, and a member of the GMC's Assessment Advisory Board, the UK Health Education Advisory Council and the Academy of Medical Royal Colleges Specialty Training Consultative Committee. He is also a member of the Council of Lancaster University.

Denis Lidstone (Non-Executive Director and Senior Independent Director)
Re-appointed – 25 June 2016

Denis, from Barrow, is an experienced practitioner in programme and change management in both the public and private sector. In addition to being one our Non-Executive Directors, Denis is also the Senior Independent Director.

Previous roles include Partnering Director at BAE Systems, Director of the UK Council for Electronic Business, and Non-Executive Director at NHS North of England.

He started his career as an apprentice electrical fitter at Devonport Dockyard, and went on to work at all levels in the ship building and air defence industries, from the shop floor to the board. In a career focused on programme management, he was involved in rationalisation of the shipyard at Barrow. Later he became Partnering Director of BAE Systems, where he stayed until his retirement in 2005. Since then he has been working as a business consultant, particularly as an accredited Gateway Reviewer for the Government on projects at key stages in their progress. Beyond the working arena, Denis has a passion for mountains and fell-walking and has trekked in the Everest and Annapurna areas of Nepal and the Atlas Mountains in Morocco.

Elizabeth Sedgley (Non-Executive Director)
Appointed – 1 September 2017

Liz is a qualified certified accountant who trained in general practice and then moved to what was in 1994 the fastest growing accountancy practise in the U.K. as an audit Manager. This role provided her with an insight into providing excellent customer service alongside exposure to the workings of multinational organisations and rapidly expanding entrepreneurial businesses.

After starting a family, Liz set up her own business providing accountancy services to OMBs across the North West where she acts as accountant, Finance Director and counsellor.

She was a Non-Executive Director at East Lancashire Hospitals Trust for 8 years where she developed an interest in understanding and improving the patient's experience and helping to develop seamless care between hospital and community settings for the benefit of patients.

After a lifetime of inactivity Liz had been converted to running via the NHS Couch to 5k programme.

Jacqueline Telfer (Non-Executive Director)
Re-appointed – 1 April 2017

In a career which has spanned 30 years, Jacqueline has a proven track record, which takes in health and social care leadership at Board level, and includes leadership and governance roles within an NHS Foundation Trust and the Police Service.

She is an experienced Foundation Trust Non-Executive Director and has held numerous high level appointments. Jacqueline has significant experience when it comes to contributing to business improvement and helping to manage change.

Jacqueline started her career as a social worker, where she developed her passion for caring for people, something she has remained committed to throughout her career.

Peter Armer (Non-Executive Director)
Term of Office Ended on 31 August 2017

Peter's experience at board level comes from both the public and private sectors. He was one of seven directors at European Metal Recycling, taking a leading role in acquisitions to help grow the business from an original turnover of £1.5 billion, to a size which saw it rank among the largest private companies in the UK.

His experience in the public sector came via the University of Cumbria where he carried out the role of Finance and Estates Director from 2005 to 2009, helping to acquire and draw down the substantial investment necessary to develop the University. Earlier in his career Peter was Finance Director of Customer Support within BAE Systems, before becoming Managing Director of the division.

His experience at BAE Systems included several change initiatives, including a business process re-engineering project that resulted in a multi-million pound reduction in debt, as well as an award for innovation.

A former rugby player and footballer, Peter still enjoys a game of squash and cricket, and has recently turned his hand to clay shooting. He is also a keen walker with a passion for the Lake District.

Melanie Weeks (Non-Executive Director)
Term of Office Ended on 24 June 2017

Melanie Weeks is a fully qualified solicitor from the Carnforth area. She came to the Law later in life after a career in the health service, having practised as a registered general nurse, registered midwife (where she worked at the Trust and clinical nurse manager in the NHS).

Melanie is a Private Client solicitor with a special interest in Court of Protection matters under the Mental Capacity Act 2005. Melanie's strong NHS background has provided her with a keen insight into the day to day workings of a large NHS organisation and the drive to contribute towards shaping the vision and strategic direction of the Trust.

Dame Jackie Daniel (Chief Executive)
Appointed – 1 August 2012

Dame Jackie was appointed as the Chief Executive in August 2012. Jackie has overseen the turnaround of the organisation, with the appointment of a complete new Board and clinical leadership team as well as the development and launch of an ambitious, clinically- led strategy to transform health and care services to its local population – Better Care Together. This work has been recognised nationally, with Better Care Together being amongst the first wave of NHS England's 'vanguards' in the country. In addition, the Trust was the first Trust to successfully apply to NHS Improvement for a Local Price Modification, resulting in a tariff improvement in the region of £20m-£25 million a year. Jackie also led the beginning of cultural change following the publication of the Kirkup Report into the Trust's maternity services. The final recommendation of the Kirkup Report was completed in December 2017 with the construction of the new maternity unit at Furness General Hospital. The unit became operational at the beginning of February 2018 and was officially opened by Bill Kirkup and John Woodcock, MP for Barrow, on 14 February 2018.

As a Chief Executive for the last 14 years, Jackie has led acute, mental health and specialist trusts. Jackie holds a Master's Degree in Quality Assurance in Health and Social Care and is a qualified business and personal coach.

Jackie is a member of the HSJ Women Leaders Board and also sits on the Board of Trustees for Alcohol Concern. Jackie was recently selected as one of the leading NHS Chief Executives in the HSJ 2016 Top 50 Chief Executives Awards list.

At the end of December 2017, it was announced that Dame Jackie Daniel had been made a Dame in the New Year's Honours list.

In January 2018 Jackie confirmed she had decided to step down from her role as Chief Executive at the end of March 2018.

Aaron Cummins (Director of Finance / Deputy Chief Executive)
Appointed – 1 January 2014

Aaron joined the Trust in January 2014 as Director of Finance / Deputy Chief Executive.

Most recently, Aaron was the Director of Finance / Deputy Chief Executive of Mid-Staffordshire NHS Foundation Trust – a role he was appointed to in June 2012. Prior to that, he was Director of Finance at Liverpool Heart and Chest Hospital NHS Foundation Trust (LHCH).

Aaron started his career in the NHS as a National Graduate Trainee in 2000 and has held a number of senior management positions in the finance function before being appointed as Director of Finance at LHCH in August 2009.

Aaron also chairs the Foundation Trust Network Finance Directors' Forum and the Government Procurement Services (GPS) Customer Board, as well as being a member of the National Procurement Council.

In March 2018, it was confirmed Aaron had been appointed as the Trust's next Chief Executive following Jackie's decision to step down from this role. Aaron will take up the post as Chief Executive on 1 April 2018.

Foluke Ajayi (Chief Operating Officer)
Appointed – 30 March 2015

Foluke is our Chief Operating Officer and started in post in April 2015. She provides strategic leadership to the operational teams and is instrumental in driving and leading improvements in clinical care and performance right across the Trust.

Foluke, a former clinical scientist joined the Trust from Leeds Teaching Hospitals, where she began work in 2008, first as a Directorate Manager, then progressing to lead the Trust's internationally-renowned cancer centre as General Manager.
Before working in Leeds, Foluke held senior positions with NHS Employers and the Department of Health, where she was deputy to the Chief Scientific Officer.

Mary Aubrey (Director of Governance)
Appointed – 30 September 2013

Mary is our Director of Governance, and started in post in October 2013. Mary is a registered nurse, midwife and health visitor, and has an outstanding knowledge base including the attainment of a Bachelor of Science (Hons.) Public Health nursing degree. This was followed by the attainment of a Master's Degree in Health Services Management. Mary has also attained the prestigious Fellowship in Leadership and Management award.

Mary has over thirty years varied health service experience - the last eight years having gained Board and strategic managerial and leadership experience working at a senior management level within the Acute and Primary Care setting. Mary has a strong track record in the development and modernisation of governance activities

Sue Smith (Executive Chief Nurse)
Appointed – 2 December 2013

Sue took up her role as Executive Chief Nurse in December 2013. Sue 'came home' to Morecambe Bay after starting her career here as a Registered General Nurse.

Sue has held a number of posts on the wards, as well as specialist roles in diabetes and recruitment. She has also operated at Board level in a number of very well respected Trusts, with specific responsibility for patient safety and infection prevention.

David Walker (Medical Director)
Appointed – 1 January 2015

David is our Medical Director, and started in post in January 2015.

David has been a medical consultant since 1996. He is a member of the Royal College of Physicians and the Faculty of Public Health.

He has excellent knowledge and experience of the UK health system from working at a senior level across different regions of the country. David has additional insight into international healthcare after working on four different continents.

David worked as an executive director in the NHS for 12 years, eight of those as a Medical Director.

He holds a number of academic appointments and was a visiting scientist at the Centers for Disease Control in Atlanta, Georgia, USA. David has been widely published in the fields of health protection and disease surveillance methodology.

David Wilkinson (Director of Workforce and Organisational Development)
Appointed – 1 July 2013

David is our Director of Workforce and Organisational Development, and started in post in July 2013.

David has over 20 years HR experience in the NHS, working in acute, mental health and community settings in London and the North West. He was a member of the national project group that introduced the annual NHS Staff Survey, was involved in the piloting and testing phases of both the Consultant Contract and the Job Evaluation system, and is currently a member of the North West Regional Clinical Excellence Awards Subcommittee.

He is committed to embedding the NHS Constitution's Staff Pledges into every aspect of employees' working lives and in creating the right conditions for staff to flourish and give their best for patient care.

Note: The Terms of Office of both Pearse Butler and Jackie Daniel concluded on 31 March 2018 when both resigned from their respective roles as Chair and Chief Executive Officer. Ian Johnson took up the role of Chair on 1 April 2018. Aaron Cummins was appointed as Chief Executive Officer in March 2018 and commenced post on 1 April 2018. Adrian Leather was appointed as a Non-Executive Director to replace Jacqueline Telfer and commenced post on 1 May 2018. The contract of Denis Lidstone was extended for a further period of 12 months meaning he will step down from this role on 24 June 2019.

Board Attendance 2017/18

MEMBERS	31/05/2017	26/07/2017	27/09/2017	25/10/2017	29/11/2017	31/01/2018	28/03/2018
Pearse Butler, Chair							
Jackie Daniel, Chief Executive							
Foluke Ajayi, Chief Operating Officer							
Peter Armer, Non-Executive Director (Term of Office ended on 31 August 2017)							
Mary Aubrey, Director of Governance							
Helen Bingley, Non-Executive Director (from 1 September 2017)							
Aaron Cummins, Director of Finance							
Helen Denton, Non-Executive Director							
Bruce Jassi, Non-Executive Director							
Neil Johnson, Non-Executive Director							
Denis Lidstone, Non-Executive Director							
Elizabeth Sedgley, Non-Executive Director (from 1 September 2017)							
Sue Smith, Executive Chief Nurse							
Jacqueline Telfer, Non-Executive Director							
David Walker, Medical Director							
Melanie Weeks, Non-Executive Director (Term of Office ended on 24 June 2017)							
David Wilkinson, Director of Workforce and OD							

Attended	Apologies	Deputy	Not commenced in post

Enhanced Quality Governance Reporting

In this part of the annual report the Trust must report on its arrangements for having robust systems of governance to assure itself of the quality of care it provides.

It is requirement of the NHS Improvement (NHSI) licence under which the Trust operates that it must have strong governance – this is how a Foundation Trust oversees care for patients, delivers national standards, and remains efficient, effective and economic.

From 1 October 2016, NHSI changed the way it assessed these criteria. It introduced the Single Oversight Framework.

The Single Oversight Framework is designed to help NHS providers attain, and maintain, Care Quality Commission ratings of 'Good' or 'Outstanding'. The Framework will help NHSI identify NHS providers' potential support needs across five themes:

- quality of care;
- finance and use of resources;
- operational performance;
- strategic change; and
- leadership and improvement capability.

The Trust is expected that it will have in place a number of mechanisms through its own assurance framework to test its own effectiveness against each of these themes. Further details can be found in the Quality Account of this Annual Report and Accounts.

The Trust has used the NHSI Quality Governance Framework to assess quality governance systems and help in the preparation of the Annual Report and Accounts, the Annual Governance Statement and the Corporate Governance Statement.

The Annual Reporting Requirements for 2017/18 have been amended. References to the former quality governance framework have been updated to refer to NHS Improvement's broader well-led framework, which effectively incorporates the quality governance framework.

The Executive Team has undertaken an assessment against the Framework and this has been presented to the Audit Committee and the Quality Committee. In this first assessment there are there are no significant gaps in any of the areas.

This is as a result of the clinical and corporate governance improvements that have been made across the Trust which have been validated by the outcomes of the Well led Governance review and the CQC Inspection process.

A summary of the Assessment is set out below.

Key Questions	Summary Assessment
1. Is there the leadership capacity and capability to deliver high quality, sustainable care?	The Trust Board will be undertaking a Board Development Programme in 2018 to ensure capability and capacity is maintained
2. Is there a clear vision and credible strategy to deliver high quality sustainable care to people, and robust plans to deliver?	The Trust's vision and strategy is clearly articulated in its Operational Plan. This also aligns to the Better Care Together (BCT) strategy
3. Is there a culture of high quality, sustainable care?	The Trust has delivered on the targets in the Quality Improvement Strategy 2016/19. Revised targets are being discussed
4. Are there clear responsibilities, roles and systems of accountability to support good governance and management?	The Board of Directors has approved a new Governance and Assurance Strategy for 2018/21
5. Are there clear and effective processes for managing risks, issues and performance?	The Board of Directors has approved a new Risk Management Strategy for 2018/19
6. Is appropriate and accurate information being effectively processed, challenged and acted on?	The Trust has developed a robust assurance and escalation framework that provides for reporting from 'Ward to Board'
7. Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?	In February 2018 the Trust launched a new Patient and Public Involvement Strategy
8. Are there robust systems and processes for learning, continuous improvement and innovation?	The Care Quality Commission found that there was a strong culture of reporting, investigating and learning from incidents throughout the Trust

As a result of using these different frameworks, the Trust has improved its governance framework to support delivery of priorities for quality improvement and to demonstrate its impact on improved patient and staff experience:

- Each of the three outcomes Better - Care that is safe; Care - Care that is clinically effective; Together - Care that provides a positive experience for patients, their families and our staff will have a nominated Board Executive Director lead;
- The Quality Committee and the Workforce Committee will be responsible for monitoring and reporting on-going progress to the Board of Directors regarding patient safety, clinical effectiveness, patient experience, staff surveys and front line engagement activities;
- Each Divisional Management Team will be responsible for delivery, monitoring and reporting of progress against the key outcomes;
- Each work-stream will have a nominated lead to champion and ensure delivery of the improvements as agreed, supported by monitoring through the Project Management Office;

- Task and finish groups will be used to support any work-streams that are failing to achieve the improvement outcomes and the Executive Director leads will ensure that adequate support and training are available to deliver these; and
- Governors will contribute to the oversight of the Quality Improvements.

The overall progress will be reported on a monthly basis though the Quality Committee which will be responsible for providing the Board of Directors with assurance that the improvements are being delivered. The priorities for Quality Improvement in 2018/19will continue to be monitored and measured and progress reported to the Board of Directors by exception at each of its meetings as part of the updated performance quality reports and the Executive Dashboard. For priorities that are calculated less frequently, such as the staff survey, local staff survey and frontline engagement measures, these will be monitored at the Workforce Committee and will be monitored by the Board of Directors by the submission of an individual report. The Trust has well-embedded delivery strategies already in place for all the quality priorities, and will track performance against improvement targets at all levels from ward level to Board level on a monthly basis using the integrated performance report and dashboard at the Quality Committee. This will be augmented by and triangulated with soft-intelligence from stakeholders. Risks that arise through the day to day working towards the delivery of quality improvements will be monitored through the Corporate Risk Register and Divisional Risk Register process.

The Trust will also report on-going progress regarding implementation of the quality improvements for our staff, patients and the public via our performance section of our website which can be accessed here.

The Trust is required by NHS Improvement to report data on our Patient Safety Incidents to the National Reporting and Learning Service (NRLS). In early in 2018 NRLS commenced the monthly publication of a national data set of the provisional patient safety incident data submitted by all NHS Trusts in England during the previous 12 months.

As the Trust's NRLS data is now in the public domain, the Patient Safety Team believed it was appropriate that we should also be self-publishing this data on the Trust's external website, as this would support our 'Open and Honest' culture around learning from Incidents and would also demonstrate our openness and transparency to our Patients and other stakeholders.

The Clinical Governance Team have completed the new patient safety incident data web page which can be found here.

We are confident that we may be the one of the first Trusts, if not the first Trust, to self-publish this data.

Freedom to Speak Up Guardian

The Freedom to Speak Up Guardian for the Trust is Heather Bruce who is supported by Bruce Jassi, Lead Non-Executive Director and David Walker, Medical Director.

Following the publication of the NHS Employers review into Raising Concerns in the Trust in March 2015, the organisation has continued to promote the culture of speaking up for our patients to improve and maintain the patient and staff experience. As one of the first Trusts in the country to appoint a Freedom to Speak Up Guardian, we are seen as exemplar in our approach and we continue to closely follow the recommendations from Robert Francis' 'Freedom to Speak Up' report while now being supported by the National Guardian's Office.

The Trust is recognised for its work on Raising Concerns and our Freedom to Speak Up Guardian is asked to speak nationally and regionally on a regular basis so that learning from the Trust is shared. Innovative approaches have been taken to facilitate speaking up as everyday practise and the rate of concerns being raised is increasing. The Trust won the first National Guardian's communications award in October 2017.

Raising concerns for patient safety and staff well-being is underpinned by our Behaviour Standards Framework, created through the Listening into Action programme in 2015, clearly outlining the behaviours that we all expect to see every day at work. The framework describes acceptable and unacceptable behaviours within the organisation and encourages staff to speak out and 'have a conversation' where behaviours fall short of expectations. Supporting the Framework are a team of trained Respect Champions who can be contacted to help advise, coach and mediate where behaviours are creating tension and difficulties between parties.

The framework is promoted through various forums in order that it continues to be embedded and becomes core business, and the way we do things. The promotion of this has further encouraged and empowered staff to speak up, and it is a valuable tool to support our culture of openness and transparency.

The Behaviours Standards Framework has been shared nationally through the National Guardian's Office network as it is seen as an example of good practice.

The Freedom to Speak Up campaign can never stand still as we continually promote 'Raising concerns as business as usual' which involves the Freedom to Speak Up Guardian taking a high profile across the Trust, and being proactive in advertising this support for all who work in the Trust, including staff, volunteers, governors and students.

Patient Relations

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

The Patient Advice and Liaison Service (PALS) handle an average of 3000 concerns/enquiries per year across the three sites. The PALS service has improved significantly over the last 3 years and have seen a 60% increase in the number of patients and relatives that they have been able to help with enquiries and concerns since 2014 and the re-establishment of the PALS service. PALS staff are available to provide resolution to concerns as they arise, on the spot advice and support patients and their relatives to navigate NHS services or signpost them to appropriate voluntary or public sector services. Early identification of concerns enables the Trust to respond to those enquiries in a timely and efficient manner which in turn reduces patients and relatives anxieties and formal complaints. The Patient Relations Case Officers handled 427 formal complaints in 2017/18.

Information on how to complain is now clearly advertised at the entrance to all wards and inpatient areas such as the Outpatient Departments. Information is also available on the Trust's website. We were commended for our forward thinking, patient focused approach when handling complaints. The Patient Relations Team have been recognised nationally as a best practice site in the handling of complaints and incorporating the following:

- A staffed complaints helpline Monday to Friday, 9am to 5pm;
- A dedicated PALS Officer based on each of the three main sites for any "walk-in" patients, inpatients, or relatives who have any concerns they wish to discuss;
- A dedicated Complaints Officer informs each complainant at first contact of the complaints procedure, including how long it is likely to take and provide details of advocacy services available, if required;
- All complainants receive a dedicated case officer who assist the complainant in confirming what they think went wrong with their care and the questions they would like answering;
- Courtesy calls are now a mandatory part of the complaints process with the dedicated Complaints Officers regularly updating the complainant with progress of their complaint;
- Response letters are written in a way that complainants can understand and avoid, where possible, clinical terminology; however, if used, a clear explanation in layman's terms is also given; and
- A 'complaint's handling' questionnaire, which incorporates the 'I statements' as questions, as recommended by the Parliamentary and Health Service Ombudsman (PHSO), is sent to each complainant one month following the closure of their complaint.

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

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

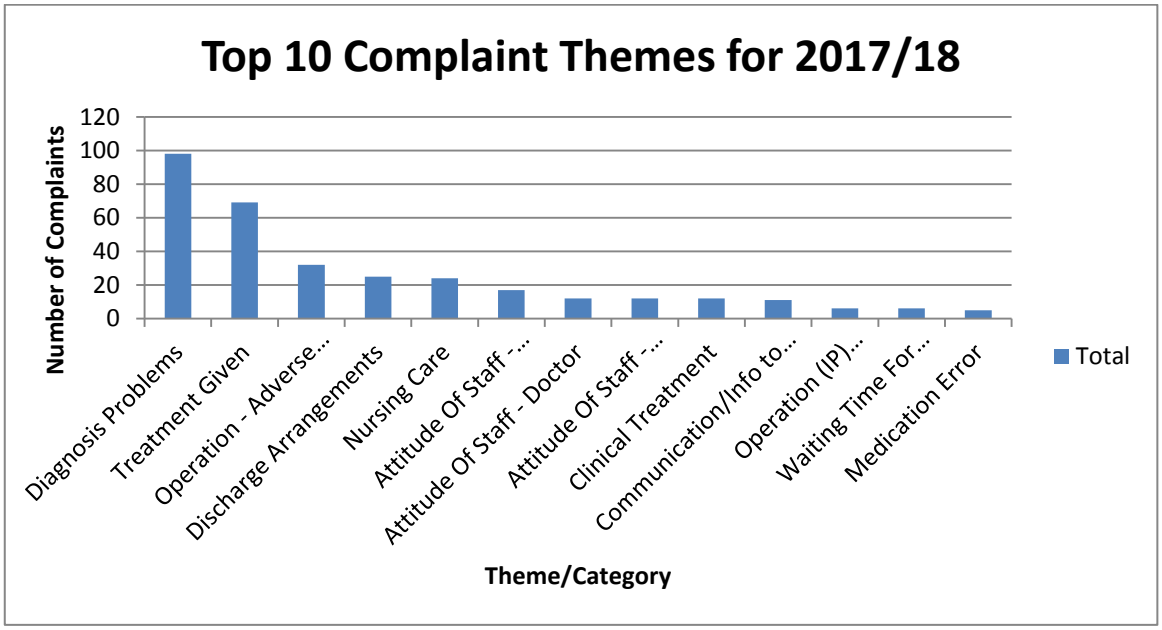
The number of complaints received in 2017/18 was 427 and the number of PALS cases was 2502.

Analysis of Number of Complaints		
Year	**Concerns/Comments PALS Received**	**Complaints Received**
2013/14	1463	481
2014/15	2480	560
2015/16	2659	488
2016/17	2662	516
2017/18	2502	427

For 2017/18, 15 cases have been accepted for review by the PHSO. Of these 15, 6 cases were not upheld, 7 cases were partly upheld and 2 are awaiting a PHSO report.

Parliamentary Health Service Ombudsman Complaints – Analysis of Number of Complaints					
Date – Financial Year	**PHSO Complaints**	**Not Upheld**	**Partly Upheld**	**Upheld**	**Awaiting report**
2013/14	11	3	4	4	
2014/15	14	7	5	2	
2015/16	8	4	2	1	
2016/17	14	6	7	2	9 plus 1 referred back to Trust by the PHSO for further investigation
2017/18	15	6	7	0	1 plus 1 referred back to the Trust by the PHSO for further investigation

Themes of Complaint



Patient Experience

Friends and Family Test

The Friends and Family Test (FFT) is a national government initiative, introduced to inpatient, accident and emergency services, maternity services and outpatient services.

All NHS providers are required to give their patients the opportunity to feedback about their experience. We ask patients how likely they would be to recommend the service to their friends and family if they needed similar care or treatment. Patients are also given the opportunity to answer some additional questions to provide more general feedback about their experiences if they wish to do so.

A variety of methods are used to capture feedback. There is a selection of paper forms available to suit different user groups (including children and young people), iPads are also used to collect real time feedback and SMS messages and Interactive Voice Messaging (IVR) are also methods used to collect valuable feedback.

FFT results are published nationally on the NHS England and NHS Choices websites and are displayed locally in wards and departments across the Trust. Each month all wards and departments receive a report which indicates their Friends and Family test score, and how they have performed against other wards and departments within the Trust. All patient comments are also fed back to the appropriate wards and departments for them to consider, and where necessary, act on. There is an escalation process in place to deal with any lower rated reviews. Alerts are sent to the relevant Governance leads for them to action accordingly. The Trust works hard to ensure we learn from what our patients are telling us.

The table below shows a summary of our performance over recent years.

Measure	2014/15	2015/16	2016/17	2017/18
Number of Reviews	37,005	55,423	61,346	66,875
% Likely to Recommend	91.59%	93.65%	93.91%	94.24%
% Unlikely to Recommend	3.21%	2.24%	2.37%	2.41%

The vast majority of comments are very positive and we share those comments with staff and celebrate complimentary feedback, as well as learning lessons from feedback that highlights poor experience.

It is clear that the Trust is making good progress. Overall patient satisfaction remains high, with the percentage of patients who are likely to recommend our services increasing. The overall number of

patient reviews continues to grow. All feedback is good and important lessons can often be learnt from negative feedback as well as positive feedback.

The Trust recognises the importance of collecting and acting on patient feedback. The FFT reviews provide the Trust with vital information in terms of patient experiences when accessing services provided by UHMBT. Feedback can provide assurance, and issues raised can also provoke the need for change. The Trust uses reviews to support our learning to improve initiatives along with engaging with our patients and co-designing services to meet their needs.

Patient-Led Assessments of the Care Environment (PLACE)

Between February 2017 and May 2017, the Trust participated in the established Patient-Led Assessment of the Care Environment (PLACE) inspections; all assessments were concluded by 3 May 2017.

All assessments were undertaken using a standard assessment format issued by NHS England; at least 25% of each site was assessed and included, where available, the accident & emergency department. Over the last four years the patient assessment teams have assessed all areas on each site.

The aim of the PLACE assessments is to provide a snapshot of how an organisation is performing against a range of non-clinical activities which impact on the patient experience of care – cleanliness, the condition, appearance and maintenance of healthcare premises, the extent to which the environment supports the delivery of care with privacy, dignity and wellbeing, dementia friendly, disability, accessibility, hand hygiene and the quality and availability of food and drink.

The assessment covered:

- Cleanliness of all items commonly found in healthcare premises including patient equipment, baths, toilets and showers, furniture, floors, beds, bed tables and other fixtures and fittings;
- The condition of appearance and maintenance of all the above items as well as a range of other aspects of the general environment including décor, tidiness, signage, lighting (including access to natural light), linen, access to car parking (excluding the costs of car parking), waste management and the external appearance of buildings and the tidiness and maintenance of the grounds;
- All aspects of privacy, dignity and wellbeing includes infrastructural / organisational aspects such as provision of outdoor / recreation areas, changing and waiting facilities, access to television, radio, computers and telephones and practical aspects such as appropriate separation of sleeping and bathroom / toilet facilities for single sex use, bedside curtains being sufficient in size to create a private space around beds and ensuring patients are appropriately dressed to protect their dignity;
- Dementia friendly environments, reviewing floors, decor and signage. Whilst this section has been an information gathering exercise for the last 2 years, this section has been expanded to include a scoring mechanism this year; and
- An overview of food and hydration which includes a range of questions relating to the organisational aspects of the catering service (e.g. choice, 24-hour availability, meal times, access to menus) as well as an assessment of the food service at ward level and the taste and temperature of food.

Cleanliness

The scores reflect the high standards of cleanliness that have been maintained across the Trust's inpatient areas within Furness General Hospital, Westmorland General Hospital and the Royal Lancaster Infirmary.

Ward Food

Overall the scores for food and hydration are very pleasing, the recent developments by the catering team to increase food sampling, observation and review ward comments, complaints and compliments is clearly working.

Organisational Food

This is a sub section of the main food domain and is an area for development. All sites scored lower than expected, the results are also much lower than the national average.

- To appear in the upper quartile the organisation needs to operate an 'à la carte' menu, provide a daily choice at breakfast of 6 or more different items including at least 3 different cereals and 2 hot or cooked options (for example porridge / oat-based, boiled egg, beans on toast), and have available a salad (with protein accompaniment) at both the lunch and evening meal service; and
- Each menu course needs to be served separately, at the time of assessment this was only observed taking place at Westmorland General Hospital.

Privacy Dignity and Wellbeing

Overall this section scored higher than the national average. There is now an emphasis on wellbeing such as the provision of onsite day room facilities which the wards have worked hard to develop while offering supportive meaningful patient activity; this has helped maintain compliance for this core domain.

Condition Appearance & Maintenance

This domain scored well across all assessment sites; the assessment team noted the good work around maintaining the building, new signage internal and external and ongoing evidence of build developments, creating great patient environments. The Furness General Hospital assessment team were pleased to see the ambulance parking area at the main entrance.

Dementia

This standard was updated last year to look at the extent to which environments support the care of people with dementia. Our hospitals scored very well against the national average score for this domain.

- There is clear evidence that our hospitals are thinking about the environment for people with dementia when planning ward and department refurbishment;
- The assessment was undertaken across all assessed hospital wards, including the communal areas, Emergency Departments, Outpatient Departments and clinics; and
- There are a lot of questions in the dementia section, but they feature a Yes or No answer with the evidence being clear and unambiguous.

Disability

From 2016 the disability domain has been introduced to PLACE. The standard looks at the needs of those with disabilities and how well hospital environments meet them. In the main this is addressed through existing questions rather than new / specific ones – the only specific ones are those relating to audio-visual appointment alert systems, hearing loops, braille lift buttons and lift floor announcements.

- The data return asked for the number of patient assessors per team who may have a disability. The Trust recruited diverse ranges of patient assessors to ensure fair and equal assessments took place over a number of days; and
- This is the first year for the availability of national average data attached to this domain. The Trust Equality of Access Group in early 2017 reviewed the assessment outcomes and supported the development of a local action plan. Examples of development work include the new changing place location at Furness General Hospital.

In conclusion staff within Estates and Hotel Services continue to work extremely hard to maintain positive patient environments. However our main challenges going forward are to ensure the standards are maintained. The patient assessors have completed mini-PLACE assessment since the main assessment.

For more information and to view our scores, please click here.

Volunteers

In 2014 the Trust made a commitment to support and encourage voluntary activity, which not only enhances the care offered to patients but also supports staff across the Trust's hospitals, improving the lives of those within the local community.

Currently, the Trust has 450 volunteers working in over 30 different areas across the Trust in roles such as meet and greet reception information desk, patient support, gardening, hospital radio and chaplaincy. This is compared with 115 volunteers back in 2013.

Volunteers bring a wealth of experience, time, and commitment to our hospital services. They make a unique contribution to patients, carers, and staff at the Trust. We recognise that volunteers are an essential resource that help us achieve our vision while supporting and enhancing the patients' and public experience and perception of our hospitals. As an organisation we value the time, energy, and enthusiasm which our volunteers give to us and we recognise the important contribution volunteers make to our organisation.

We have reviewed our key achievements and detail our future plans to grow and develop volunteering with the Trust. Over the next two years we aim to build on the foundations to develop and extend our volunteer programme, the experience of our volunteers and ways of engaging the wider community allowing the Trust to 'leapfrog the average' and become a nationally recognised leader for creating volunteer opportunities and community engagement.

Some of our Key Volunteers' Celebrations

The North West Blood Biker volunteers transport life-saving items for the Trust at evenings and weekends. During 2017 our Blood bikers won the Trust's Star of the Quarter. Steve Dunstan, North West volunteer blood biker said; "We all joined the volunteer blood bikes to give something back to the unique institution that is the NHS. Our reasons for joining may vary but not one of us joined for recognition or reward."

The Trust is fortunate to work with the Royal Voluntary Service who has achieved their Investing in Volunteers award. Staff, governors and volunteers raised a teacup to local couple, Phyl and Roy Harrison, who retired from the Royal Voluntary Service (RVS) shop at Furness General Hospital (FGH) after volunteering for the last 23 years.

Phyl first started volunteering in the Furness Court's tea bar, and when that closed, she moved to support the RVS at Furness General Hospital. Supporting the shop soon became a joint venture when her husband Roy also joined the team as a volunteer. Phyl said: "Over the past 23 years, I have done all sorts of volunteer roles and met all sorts of lovely people from all walks of life. I have found the whole team of staff and volunteers friendly, approachable, efficient and passionate about their work. I really have loved every minute of it."

The Royal Voluntary Service is continually developing, and helping the Trust to bring people together who want to help generate strong community links that work to make a difference within their local healthcare services.

The 'Move it or Lose It!' programme, run by one of our third sector partners, The Royal Voluntary Service, has been introduced across our main hospitals and within the wider community at the Hind Pool Centre in Barrow-in-Furness and at community locations in Lancaster. There are plans to deliver further community programmes which are due to start in spring 2018 at Ulverston Health Centre and Queen Victoria Hospital in Morecambe. This programme was developed because of local people wishing to access chair-based exercise, which aims to help our frail citizens and patients to improve their level of physical functioning through targeted resistance based exercises.

This work is not only helping with physical wellbeing, but also with social interaction, confidence and peer support. We also utilise these sessions to share and collect the thoughts from older people with regards to health and care services.

Entertainment is provided by two hospital radio stations, Radio Lonsdale at Furness General Hospital and the Bay Trust Radio for Westmorland General Hospital and Royal Lancaster Infirmary. Social interaction via hospital radio comes from providing listeners with a virtual friend and through face to face interaction with volunteers from the station to the bed side. We know that hospital radio helps create a positive sense of belonging by familiarising patients with the hospital and allowing them to maintain a connection with their lives and people outside. Our radio stations have the potential to increase awareness of health and wellbeing by delivering information and advice in an appropriate and sensitive way.

Our Objectives 2017/18

Building on the foundations of our Volunteer Programme

- Improve the profile, quality and range of volunteer opportunities and community engagement with a focus on social action through health improvement initiatives eg Dementia Friends for volunteers and FT members
- Provide flexible volunteering opportunities that consider individual's needs and overcome barriers to getting involved for individuals and organisations.
- Constantly improve the volunteering experience and greater community engagement
- Develop a volunteer community that is responsive, engaged, enthusiastic and can be mobilised to support the needs of the Trust, our patients and community
- Have a robust and interactive volunteer programme which works with other partners to support the engagement of volunteers across the community, wrapping care around the patient and co-ordinates preventative care
- Create a flexible learning and development programme to meet the needs of our volunteers and community to create meaningful engagement and to support our staff so they have the skills they need to more effectively engage and manage volunteers in their area.

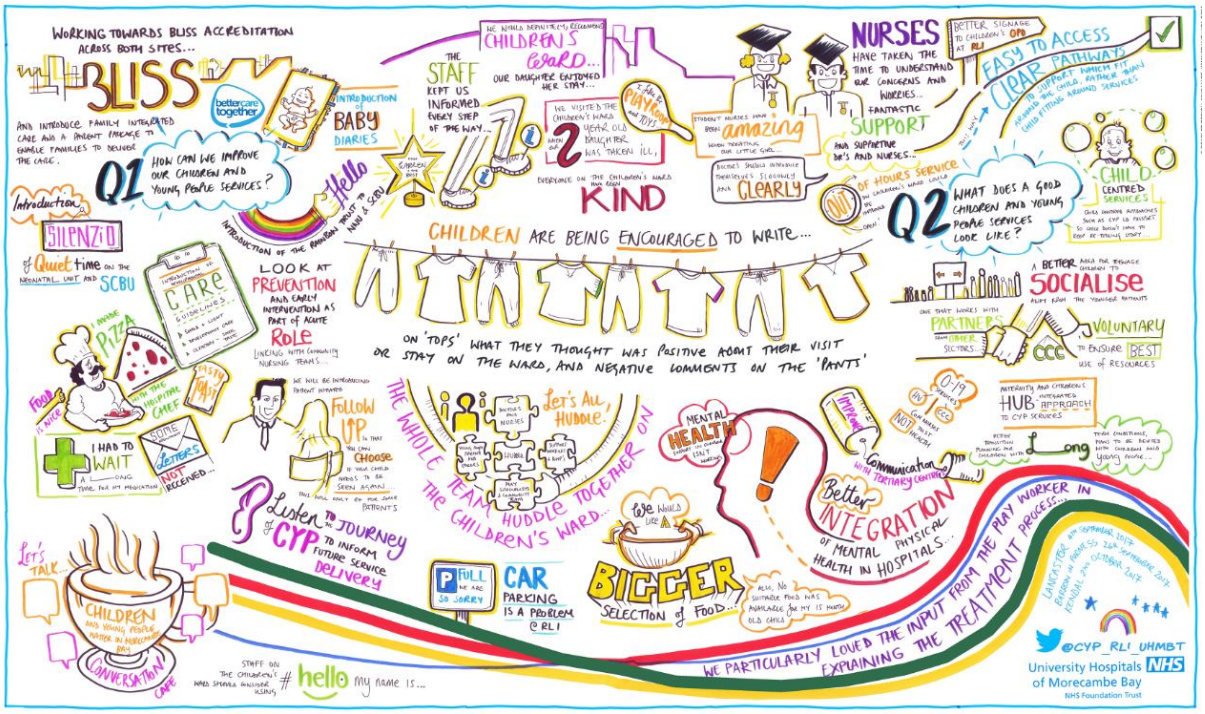
Relationship with Commissioners and Stakeholders, the Wider Community and our Patients and Patient Representative Groups

The Trust continues to have strong working relationships with its commissioners and stakeholders building on the significant work undertaken in developing the Better Care Together Strategy and the two year delivery plan. These include our Morecambe Bay Clinical Commissioning Group and our Regional NHS Team which commission specialised services, public health screening and secondary dental services.

In year, the Trust has been working with commissioners to look at new and innovative ways of delivering services in an integrated way with key stakeholders including community provider services, local authorities and social services to deliver integrated ways of working in line with the principles of Better Care Together.

Our Maternity and Young People Matters community conversion cafe events have been so valuable to us – not only in terms of giving us the opportunity to hear directly from women and families about their experiences of our maternity services, but also allowing us to really listen to their ideas and suggestions on what we can do to make things even better for local communities.

We have made lots of improvements in our maternity services over the last two years or so but we are always looking for new ideas on how we can change even further to give local women and families the services they want and deserve.



In February 2018 we launched our new Patient and Public Involvement Strategy along with our ten point action plan to involve patients and the public in their local hospitals. The strategy is a public facing document and continues to provide a supportive and developmental direction of intent for putting patients and the public at the heart of our quality improvement work. You can view the Patient and Public Involvement Strategy here.

The Trust has continued to build strong partnerships and developed key relationships with patient representative groups, while involving these groups in a diverse range of the Trust activity. We continue to see these links as essential to ensuring the patient voice is heard and that as a Trust we act and are responsive to patients' needs.

Community engagement and patient experience involvement has benefited the Trust during 2017/18 by using a comprehensive range of opportunities and methods for the public to get involved, from

Information sharing, focus groups and public events to partnership and co-production techniques over the last 12 months. For example new approaches have been demonstrated through the involvement of patients and the public in co-production activities, some examples of these include:

Partnership Working with Macmillan

We are in the progress of creating three Macmillan Information and Support Centres situated near the main entrances of Furness General Hospital (FGH), Westmorland General Hospital (WGH) and Royal Lancaster Infirmary (RLI). The RLI centre is now built and ready to be stocked creating a drop-in centre, which aims to offer practical and emotional support to anyone affected by cancer. We have recruited one specialist qualified staff and have a current recruiting programme in place to secure a number of volunteers to help welcome patients and citizens to the service.

The aims of the service is to assist people by providing time to talk and offer high quality information and support within a quiet, relaxed, comfortable environment. The services will include general and or specific information with guidance, complementary therapies, counselling, benefits and financial advice, end of life and bereavement support, hair loss / regrowth advice, support groups, signposting and referral to additional support services and much more besides.

Chatty Van

In early 2018 Bay Health and Care Partners engaged with staff, stakeholders and the public about what we are calling our hard truths. To help us speak to as many members of the public as possible, we teamed up with Healthwatch and jumped aboard their 'chatty van' to visit nine locations around Morecambe Bay. This was also supported by an online survey for those that couldn't attend but wanted to give their feedback.

Initial feedback from team members who supported the chatty van tour was really positive and we are pleased that so many people stopped to talk about their experiences of healthcare, their understanding of the challenges the NHS faces and their feedback on our ideas for addressing these challenges. The final report published by Healthwatch will be used to help shape any future proposals.

Aaron Cummins
Chief Executive
Date: 25 May 2018

Remuneration Report

The Role of the Remuneration Committee

The Committee establishes pay ranges, progression and pay uplifts for the Chief Executive, Executive Directors and other Senior Manager posts including their terms of employment.

Membership of the Remuneration Committee

The membership of the Trust's Remuneration Committee comprises all Non-Executive Directors, plus the Chairman and Chief Executive (accept when the matter under discussion relates to the Chief Executive).

The membership of the Committee during the 2017/18 financial year was as follows:

Membership of the Remuneration Committee 2017/18	
Pearse Butler	Chair (Chair of the Committee)
Peter Armer (until 31 August 2017)	Non-Executive Director
Helen Bingley (from 1 September 2017)	Non-Executive Director
Helen Denton	Non-Executive Director
Bruce Jassi	Non-Executive Director
Neil Johnson	Non-Executive Director
Denis Lidstone	Non-Executive Director
Liz Sedgley (from 1 September 2017)	Non-Executive Director
Jacqueline Telfer	Non-Executive Director
Melanie Weeks (until 24 June 2017)	Non-Executive Director

Jackie Daniel (Chief Executive) attended as a non-voting member.

Committee Attendance 2017/18

MEMBERS	28/06/2017	27/09/2017	31/01/2018	28/02/2018
Pearse Butler, Chair				
Peter Armer, Non-Executive Director (Term of Office ended on 31/08/2017)				
Helen Bingley, Non-Executive Director (wef 01/09/2017)				
Helen Denton, Non-Executive Director				
Bruce Jassi, Non-Executive Director				
Neil Johnson, Non-Executive Director				
Denis Lidstone, Non-Executive Director				
Elizabeth Sedgley, Non-Executive Director (wef 01/09/2017)				
Jacqueline Telfer, Non-Executive Director				

Attended	Apologies	Deputy	Not commenced in post

Annual Statement on Remuneration from the Chair of the Remuneration Committee

During the course of 2017/18, the Committee:-

- Reviewed Executive Directors salaries;
- Received a report on quarterly settlement agreements;
- Received a report on equal pay;
- Received reports on the appointment process of the Chief Executive;
- Ratified the appointment of the Chief Executive; and
- Reviewed the Committee's Terms of Reference and Schedule of Business.

Senior Managers Remuneration Policy

Senior Managers Remuneration is determined by the Remuneration Committee with reference to national guidance, pay awards made to other staff groups through national awards and by obtaining intelligence from independent specialists in pay and labour market research.

Since the direction from the Secretary of State relating to the level of the remuneration and benefits packages of Executive Directors (£142500), Executive Directors have been appointed in excess of this level and the Trust is satisfied that for those Executive Directors with salaries in excess of this amount these are necessary and publicly justifiable to ensure the Board retains the skills, knowledge and capacity for the efficient running of the Trust and the safety and care of patients. The appropriate consent from NHS Improvement has been secured.

All Executive Directors are on permanent contracts. Notice and termination payments are made in accordance with the provisions set out in the standard NHS conditions of service and NHS pension scheme as applied to all staff in accordance with Agenda for Change.

Jackie Daniel, Chief Executive of the Trust, left the Board on 31 March 2018. Aaron Cummins was appointed as the Trust's new Chief Executive from 1 April 2018. There were no early termination payments made in the year. When the Committee undertakes the recruitment and appointment of the Executive Team it uses external recruitment companies to support the recruitment process; it reviews the structure, size and composition of the Board making recommendations for changes where appropriate.

The Committee has agreed that it will undertake further work in relation to reviewing the performance of the Chief Executive and Executive Directors and undertake a review of the remuneration, terms of service and allowances for Senior Managers.

The following disclosures in respect of Executive and Non-Executive remuneration are made in accordance with the Annual Reporting Manual for Foundation Trusts.

Executive Directors' Remuneration 2016/17	Salary	Benefits in Kind	Pension Benefits	Total
	Bands of £5000	Rounded to nearest £100	Bands of £2500	Bands of £5000
Name and Title	**£000**	**£**	**£000**	**£000**
Ms J Daniel - Chief Executive	200 - 205	0	n/a	200 - 205
Mr A Cummins - Director of Finance & Deputy Chief Executive	170 - 175	0	n/a	170 - 175
Dr D Walker - Medical Director	215 - 220	0	10 - 12.5	225 - 230
Ms S Smith - Executive Chief Nurse	145 - 150	7,900	62.5 - 65	215 - 220
Ms M Aubrey - Director of Governance	105 - 110	4,100	50 - 52.5	165 - 170
Ms F Ajayi - Chief Operating Officer	120 - 125	3,200	35 - 37.5	160 - 165
Mr D Wilkinson - Director of Workforce & Organisational Development	105 - 110	4,000	55 - 57.5	165 - 170

Pension related benefits represent the benefit in year from participating in the NHS Pension Scheme. The amount is calculated by taking the full pension due to the Director upon retirement if they were to retire at 31 March 2017 and deducting the equivalent value from the amount due at 31 March 2016. This includes lump sum and annual pension entitlement and uses a factor of 20 for grossing up purposes in accordance with the HMRC method (derived from section 229 of the Finance Act 2004). Where no figures are calculated for 2016/17 the Director was not a member of the NHS Pension Scheme

Executive Directors' Remuneration 2017/18	Salary	Benefits in Kind	Pension Benefits	Total
	Bands of £5000	Rounded to nearest £100	Bands of £2500	Bands of £5000
Name and Title	**£000**	**£**	**£000**	**£000**
Ms J Daniel - Chief Executive	205 - 210	0	n/a	205 - 210
Mr A Cummins - Director of Finance & Deputy Chief Executive	180 - 185	0	n/a	180 - 185
Dr D Walker - Medical Director	220 - 225	0	n/a	220 - 225
Ms S Smith - Executive Chief Nurse	145 - 150	8,000	20 - 22.5	175 - 180
Ms M Aubrey - Director of Governance	110 - 115	5,000	15 - 17.5	130 - 135
Ms F Ajayi - Chief Operating Officer	120 - 125	4,100	27.5 - 30	155 - 160
Mr D Wilkinson - Director of Workforce & Organisational Development	110 - 115	4,100	12.5 - 15	125 - 130

Pension related benefits represent the benefit in year from participating in the NHS Pension Scheme. The amount is calculated by taking the full pension due to the Director upon retirement if they were to retire at 31 March 2018 and deducting the equivalent value from the amount due at 31 March 2017. This includes lump sum and annual pension entitlement and uses a factor of 20 for grossing up purposes in accordance with the HMRC method (derived from section 229 of the Finance Act 2004).

Where no figures are calculated for 2017/18 the Director was not a member of the NHS Pension Scheme.

Pension Benefits Values	Real increase in pension at pension age	Real increase in lump sum at pension age	Total accrued pension at pension age at 31 March 2018	Total accrued lump sum at pension age at 31 March 2018	Cash Equivalent Transfer Value at 31 March 2018	Cash Equivalent Transfer Value at 31 March 2017	Real increase in Cash Equivalent Transfer Value *
	(bands of £2500)	(bands of £2500)	(bands of £5000)	(bands of £5000)			
Name and Title	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Mr A Cummins - Director of Finance & Deputy Chief Executive	0	0	20 - 25	60 - 65	294	294	0
Dr D Walker - Medical Director	0	0	70 - 75	210 - 215	1,392	1,392	0
Ms S Smith - Executive Chief Nurse	0 - 2.5	5 - 7.5	50 - 55	155 - 160	1,084	982	70
Ms M Aubrey - Director of Governance	0 - 2.5	2.5 - 5	40 - 45	125 - 130	889	808	58
Ms E Ajayi - Chief Operating Officer	0 - 2.5	0 - 2.5	40 - 45	65 - 70	564	501	40
Mr D Wilkinson – Director of Workforce and Organisational Development	0 - 2.5	0 - 2.5	35 - 40	90 - 95	630	576	35

Trust employees are covered by the provisions of the NHS Pension Scheme which is a defined contribution scheme and provides pensions related to final salary. Details of the scheme can be found on the NHS Pensions website here. No payments are made to any other pension scheme on behalf of Executive Directors.

The table above details the current pension benefits of the Trust's senior managers. As Non-Executive Directors do not receive pensionable remuneration, there are no entries in respect of Non-Executive Directors. Where the Executive Director in post at 31 March 2018 is not a member of the NHS Pension Scheme, there are no pension benefits to be disclosed.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the Scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the NHS Pension Scheme, not just their service in a senior capacity to which the disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS Pension Scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the Scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

* The Real Increase in CETV does not include the effects of inflation or contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Non-Executive Directors' Remuneration 2016/17 and 2017/18	2017/18	2016/17
	Salary Bands of £5000	Salary Bands of £5000
Name and Title	**£000**	**£000**
Mr J P Butler – Chair	40 - 45	40 - 45
Mr P Armer – Non-Executive Director	5 - 10	10 - 15
Ms H Bingley – Non-Executive Director (from 01/09/17)	5 - 10	n/a
Ms H Denton – Non-Executive Director	10 - 15	10 - 15
Prof A Garden – Non-Executive Director (to 30/06/16)	n/a	0 - 5
Mr M Jassi – Non-Executive Director	10 - 15	10 - 15
Prof N Johnson – Non-Executive Director (from 01/07/16)	10 - 15	5 - 10
Mr D Lidstone – Non-Executive Director	10 - 15	10 - 15
Ms J Telfer (Pratt) – Non-Executive Director	10 - 15	10 - 15
Mrs E Sedgley – Non-Executive Director (from 01/09/17)	5 - 10	n/a
Ms M Weeks – Non-Executive Director	0 - 5	10 - 15

There are no benefits in kind or pension related benefits in respect of Non-Executive Directors.

Director Expenses 2017/18

Name and Title	2017/18
Non-Executive Directors	**(£)**
Mr J P Butler – Chair	9,529.38
Mr P Armer – Non-Executive Director	414.99
Ms H Bingley – Non-Executive Director	981.88
Ms H Denton – Non-Executive Director	514.25
Mr M Jassi – Non-Executive Director	3,067.11
Mr Neil Johnson – Non-Executive Director	163.50
Mr D Lidstone – Non-Executive Director	1,548.66
Mrs E Sedgley – Non-Executive Director	1,261.90
Mrs J Telfer (Pratt) – Non-Executive Director	388.38
Ms M Weeks – Non-Executive Director	257.14
Executive Directors	**(£)**
Ms J Daniel – Chief Executive	13,138.13
Mrs F Ajayi – Chief Operating Officer	2,086.08
Ms M Aubrey – Director of Governance	643.58
Mr A Cummins – Director of Finance & Deputy Chief Executive	5,328.44
Ms S Smith – Executive Chief Nurse	2,247.29
Mr D Wilkinson – Director of Workforce and Organisational Development	5,241.39
Mr D Walker – Medical Director	3,344.48
Total Sum of Expenses	**50,156.48**

Directors Expenses 2017/18

Total number of Directors in office	Number of Directors receiving expenses	Total Sum of Expenses
17	**17**	**50,156.48**

Fair Pay Multiples

The Trust is required to disclose the relationship between the remuneration of the highest paid director and the median remuneration of the workforce.

The mid point of the banded remuneration of the highest paid director in the financial year 2017/18 was £207,500. This was 7.9 times the median remuneration of the workforce, which was £26,400. In 2016/17 the mid point was £202,500 which was 7.9 times the median remuneration of £25,800.

Calculations are based on the full time equivalent of all staff in post at 31 March and salaries have been annualised. Total remuneration of the highest paid director includes salary and benefits in kind. It does not include employer pension contributions or the cash equivalent transfer value of pensions and also excludes any severance payments.

During the year 9 employees received remuneration in excess of the highest paid director. A total of 9 employees received higher remuneration during 2016/17.

Remuneration ranged from £15,000 to £291,000 for 2017/18. The range of remuneration for 2016/17 was between £14,000 and £264,000.

Aaron Cummins
Chief Executive

Date: 25 May 2018

Staff Report – Creating a Great Place to Work

The Workforce & OD service plays an essential role in helping to achieve the strategic priorities of our Trust. Striving to continuously modernise and improve, developing a truly employee centric culture will enable the function to lead the way in making the Trust a 'Great Place to be Cared for; Great Place to Work'.

Our function has evolved considerably over the last 12 months and has seen a number of changes to improve the service we deliver. Specific examples of our achievements over the last 12 months include the onward development of our employee engagement and involvement systems, such as the re-launch of our **Behavioural Standards Framework;** our **Improvement and Listening into Action** approach, further developing the improvement capabilities of our frontline staff; our **staff recognition** programme (including Star of the Month/Quarter/Year and Staff Wonder Walls). For the second year running, we opened 2017's **staff survey** to all staff rather than a sample to gain greater understanding of current employee experience.

We have made significant progress with our approach to **recruitment,** including collaboration with **Choose Cumbria campaigns** and the on-going development of our **Bay Health and Care Partners** recruitment portal **#Betterwithyou**. Our approach has seen significant volumes of applicants and appointments, resulting in a residual vacancy rate of 8.7% registered nurses; 8.5% midwives; 9.6% consultants (as at 12th March 2018). The residual vacancy figures do not take account of our overseas recruitment campaigns as we continue to have those nurses join us. Our innovative approaches have resulted in us winning the **Healthcare People Management Association (HPMA) Award for Strategic Recruitment in 2016, winning** the **Health Education England Outstanding Contribution to Widening Participation Award** and **being shortlisted for HPMA Recruitment Team of the year in 2017**.

We have developed a **leadership development** programme for senior and middle managers in partnership with Lancaster University and have delivered the **Kirkup action plan** for education, training & development. In addition we have moved closer to providing leadership development as part of the modern apprenticeships scheme. 2017 also saw the launch of the registered nurse and healthcare science apprenticeships at UHMB.

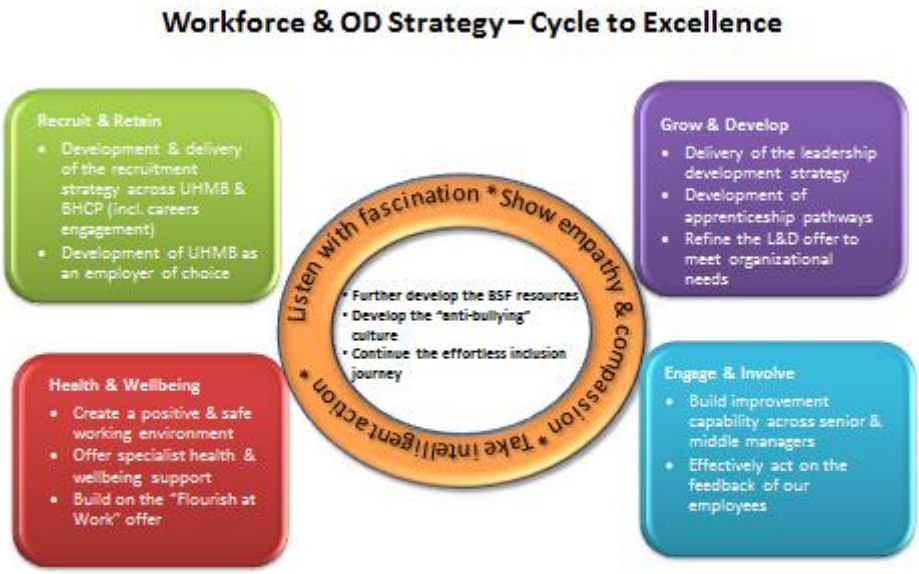
Our **Towards Inclusion** activity has received national recognition including being named the **8th most inclusive employer in the UK** Top 50 list (top NHS Trust), and shortlisting for **HPMA, Chartered Institute of Personnel and Development and Health Service Journal Awards**.

Partnership working with staff side, inclusions networks, Improvement Champions, Respect Champions and our Personal Fair Diverse network has enabled effective leadership at all levels. It is through this that we have achieved so much, and the continuation of working in partnership with staff is key to the on-going effective implementation of our strategy.

Workforce & OD Strategy

The Trust is committed to creating a performance-driven culture focused on safety and quality, underpinned by strong and effective leadership, empowerment, involvement and continuous improvement. The Workforce Strategy is based on a Cycle of Excellence that leads to individualised employee-centric support for our staff that truly makes UHMBT 'a great place to work' and through an engaged and motivated workforce creates a 'great place to be cared for'.

Workforce Strategy – Cycle of Excellence



Our progress in relation to a 'Great Place to Work' is measured by staff experience, driven through a culture of improvement, inclusion and empowerment and underpinned by Behavioural Standards.

The Workforce & OD priorities fall into the following strategic focus areas:

Recruit & Retain

- We will attract, hire & retain the best people based on our shared values;
- We will be clear about who we are as an employer and what we are trying to achieve; and
- We will be clear about our expectations of all employees.

Grow & Develop

- We will ensure that organisational training and development plans support staff to develop and maintain the relevant skills to deliver Trust priorities;
- We will provide the training, development and support for employees to do their job effectively;
- We will provide opportunities and support for the continuous development of all employees; and
- We will give employees feedback on how they are doing and support them to do it better.

Engage & Involve

- We will involve employees in decisions that affect them and the services they provide;
- We will empower employees to speak up;
- We will listen to employees' ideas, experiences and concerns;
- We will work with employees to take action; and
- We will become an "effortlessly inclusive" employer.

Health & Wellbeing

- We will create a positive and safe working environment;
- We will offer specialist health & wellbeing support to access when employees need it;
- We will support and empower employees to take responsibility for their own health and well-being; and
- We will provide guidance to employees on maintaining a quality work/life balance.

A fifth area of **Service Modernisation and Redesign** is threaded through all four strategic priority areas.

Recruit & Retain

Recruitment is a key strategic priority for the Trust; with many hard to fill vacancies, particularly in shortage occupations, but due to its geography, recruitment is a greater challenge than many urban Trusts. Following significant investment in both nursing and medical establishments, recruitment requirements have been at extraordinary levels in 2017 and the Workforce team has responded to this with support in all aspects of recruitment for managers at UHMBT, but also in the wider health economy. Whilst the Trust has been successful over the past twelve months, closing the gap remains a challenge.

The Trust has recruited at unprecedented levels over the last 12 months. These are demonstrated in our vacancy rates and recruitment levels but the work has been much more than that. Working with managers on both recruitment and retention strategies, reviewing staffing levels in conjunction with acuity and dependency is key to using the workforce more efficiently and reducing agency and temporary staffing costs. Whilst recruitment has been the significant focus, 2017 saw the development and approval of a Trust wide Retention Strategy.

At the start of 2017/18 the Trust reviewed its recruitment strategy, in particular the Nurse Recruitment Strategy. The strategy set a target of recruiting 275 WTE nurses. This factored in the then residual gap, predicted turnover and predicted maternity leave. There were two strands to the strategy, domestic and international recruitment. The primary focus was on domestic recruitment recognising the challenge with the timescales associated with international recruitment. Although we did not achieve the very challenging target of 275 WTE, the team was successful in recruiting 171.29 WTE registered nurses who joined UHMBT in 2017/18. Recognising our geographic challenges and the national changes impacting on nurse recruitment, such as uncertainty over Brexit and, changes to the nursing Bursary, this level of recruitment is cause for celebration, in particular we have seen our highest number of student nurses start in 2017/18.

Recognising the national challenge and shortage of nurses, the Trust embarked on developing a 'grow our own' approach and a brand new Registered Nurse Apprenticeship has launched. The first cohort of 27 started in February 2018 with a plan to have a cohort each year.

The "betterwithyou.co.uk" recruitment site has been further developed. Alongside the work of the Virtual Recruitment Hub, the website brings opportunities for organisations across Bay Health and Care Partners to work collaboratively to address the key recruitment challenges.

The domestic recruitment strategy included the development of a new approach to recruitment for the Trust, including social media campaigns via Facebook. The pilot campaign went live for two months in July 2017.

- Reached 228,821 people;
- Received 42 direct enquiries; and
- 4 recruits were offered.

Through Health Education England the Trust became an early implementer of the Global Health Exchange programme, the ethos of which is 'Earn, Learn, Return.'

Specific Medical recruitment campaigns have been commissioned. Appointments have been made to Speciality doctors with a support route for them to obtain entry to the specialist register to become Consultants. It is also extremely positive that the Trust has continued to recruit into traditionally hard-to-recruit consultant posts in specialities such as Radiology.

Career engagement is a core element of our long-term strategic approach to recruitment – recruiting local people and growing our own. Over the past year, the Careers & Engagement Hub has engaged directly with 11, 895 people at 74 events throughout Cumbria and North Lancashire. This brings the total number of people directly engaged with up to more than 28,000 since the creation of the Hub in January 2016. The Careers & Engagement Hub has also organised 104 work experience placements for students aged over 16 years in 2017; this is an increase of 185% on the number of placements organised in 2016.

Many of the careers engagement projects and events that the Hub organises empower members of the public by enabling them to develop skills and gain knowledge which can help them to make decisions to improve their own health or understand options for career pathways.

- Skills Clubs;
- Bespoke school visits;
- Healthcare Careers Weekends;
- Healthcare & Blue Light events; and
- Traineeships.

The Hub worked collaboratively with Morecambe Bay Clinical Commissioning Group, the Trust and the Furness Education and Skills Partnership (FESP) to develop the Happy and Healthy Lifestyles Project in primary schools in Barrow. This project aims to empower year 5 students in a number of primary schools to design innovative ways to improve the health and lifestyles of their peers and families.

The Hub in conjunction with the University of Cumbria and Kendal College were successful in a bid to build a mobile education unit. The mobile education unit will visit schools and colleges to provide interactive and practical sessions to showcase the skills required by many jobs within the Health and Social Care sectors.

Resourcing – Contingent Staffing

Throughout 2017/18 contingent staffing has remained a key element of our workforce plan, and the Trust has continued to ensure that optimum use is made of contingency staffing arrangements in terms of cost efficiency and effectiveness. The Agency Use Programme Board and Operational Meetings have continued to play a fundamental role in ensuring that the Trust was effectively balancing quality, safety and finance in complying with the NHS Improvement agency capping rules.

The Workforce team have played a pivotal role in the development of the strategic interventions achieved through the Agency Use Programme which has over the past year seen a significant reduction in agency spend across all staff groups. Working closely with the finance and procurement teams the following successes have been achieved;

- Continued Check & Challenge and Exec Sign off approval process;
- Development of bespoke divisional action plans;
- Review of all high cost agency;
- Review of all long term agency;
- Continued focus on increasing Rostering 6-week lockdown;
- Continued development of Bank options;
- Introduction of Weekly Bank pay;
- Tier Zero Supplier engagement to support rate reduction;
- Development and introduction of a Trust-wide Rate Card for Medical Locums; and
- Review internal medical bank rates.

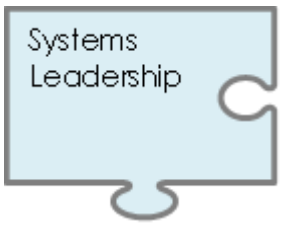
In the two years the Agency Use Programme had been running the interventions put in place have reduced agency spend by just short of £10 million. Work continues to maximise opportunities to manage agency spend, either through agency management such as the Rate Care and Tier Zero Preferential Supplier options or increasing internal supply such as the introduction of the weekly pay or the proposal to review internal medical bank rates.

The Trust has also committed to working collaboratively on a project across the integrated care system to explore options of shared medical bank and medical agency spend. This project is in its initial stages and will continue to develop over the coming 12 months.

Grow & Develop

The Trust's OD Strategy: Shaping the Future; Developing People; Improving Care was approved by the Board in May 2017 and set out a framework to build the "Bay Way" to leadership and improvement to develop four critical capabilities:

- systems leadership for staff who are working with partners in other local services on 'joining up' local health and care systems for their communities;
- established quality improvement methods that draw on staff and service users' knowledge and experience to improve service quality and efficiency;
- inclusive and compassionate leadership, so that all staff are listened to, understood and supported, and that leaders at every level of the health system truly reflect the talents and diversity of people working in the system and the communities they serve; and
- talent management to support NHS-funded services in growing its own talent pipeline to fill current and future senior leadership roles through the right numbers of diverse and appropriately developed people.



Bay Learning and Improvement Collaboration (BLIC) purpose over the last 12 months has been to implement an organisational development work stream that enables the growth of a clinical community across Morecambe Bay area that significantly advances the closer working of primary and secondary care. A number of approaches have been used such as coaching, facilitation, Insights and networking events.

In response to the new strategy the Trust identified that it required a more systematic and far reaching approach to increasing capacity and capability. Over the last 12 months a full review of resources and capability for delivering Improvement has been undertaken and the output had been a co-designed framework ratified at December's Trust Management Board that gives clear structure to building improvement capability.

To deliver the resources element we will continue to deliver Listening into Action (LiA) and Improvement for all staff to access. This enables two things:

- Staff engagement; and
- Realising small/ medium scale improvements from the front line.

The LiA and Improvement team, along with a cohort of key delegates across the Trust, have undertaken Quality, Service, Improvement and Redesign (QSIR) training, which includes a wide breadth of service improvement skills providing participants with the skills and ability to design and implement more efficient patient-centered services. This practitioner level training will enable the team to delivery QSIR training in-house over the coming year to support ongoing improvement activity and embed improvement into everything we do.

Great Leaders – Great Care

The Trust recognises the value of investing in leadership to develop a culture where staff at all levels are empowered as individuals and in teams to act to improve care within and across our health economy.

The leadership ethos developed at Morecambe Bay is both simple and effective – treat your staff well, look after them, nurture them and they will respond in kind, getting involved to improve things and ensure the highest levels of patient care are maintained going forward.

The Trust has heavily promoted Leadership Development opportunities from the NHS Leadership Academy with some success across a number of prestigious programmes, including Nye Bevan, Ready Now and the Directors Programme. Alongside the Leadership Academy development opportunities, the Trust has collaborated with Lancaster University Management School (LUMS) to devise a Leadership Development Programme for senior and middle managers. Cohort 3 of this programme commenced in July 2017 with 24 senior leaders from across divisions taking part. Occasional master-classes with LUMS run alongside this programme with access for staff from across Bay Health and Care Partners who are not on the programme, which have included prestigious speakers such as Michael West.

In collaboration with Lancaster University's CETAD, the Trust has delivered a PgC Professional Practice (Clinical Leadership) qualification across three cohorts of AHP, nursing and midwifery, junior and middle managers. The third cohort completed in November 2017. It is notable that this approach has been written up as a best-practice case study on the national E-WIN reference library.

Following a successful pilot of e-appraisal for staff 8a and above with line management responsibilities, the system has been rolled out for all staff during 2017/ 18. The design of this new electronic appraisal documentation includes a 'Talent Management' section enabling the recording of career aspirations. This also allows us to collect and report on the data captured to support future development plans of these staff. In our appraisal process, talent management is not specific to leadership / management roles, it recognises succession planning covering all roles therefore adopting the approach advocated by the NHS Leadership Academy i.e.:

- Leadership and management;
- Clinical Specialist roles; and
- Support Specialist roles.

The next stage of this is to further develop this section to link with the Talent Management Strategy, which will be a focus for 2018/19.

Growing Our Own to Provide Great Care – Trust's Apprenticeship Programme

The Trust's apprenticeship programme has gone from strength to strength over the past year with the ground breaking introduction of Nurse Degree Apprenticeships and Clinical Health Scientist Apprenticeships. In conjunction with University of Cumbria the Trust is among the first in the country to introduce Nurse Degree Apprentices. February 2018 saw 27 existing Clinical Support Workers / administrative staff start a 4 year programme to become registered nurses. Also, working with Kendal

College, in January 2018, 6 internal members of staff started a Healthcare Scientist Apprenticeship. Both are great examples of “Growing Our Own to Provide Great Care.”

The Trust’s 8th cohort of 24 apprentice Clinical Support Workers commenced with us in June 2017. We see our Apprenticeship Programme as a positive approach to supporting local people to develop and take on careers in the Health Service whilst also helping the Trust in developing a workforce for the future. 86% of Clinical Support Worker apprentices finishing the programme either started on a degree programme or secured a permanent post within the Trust.

The Trust also agreed its Apprentice Strategy in 2017 which enables us to maximise the opportunities provided by the Apprenticeship Levy. The strategy includes the developing and dissemination of information resources to support departments to promote and develop apprentice posts across the Trust.

Continuous Improvement through E–appraisal

2017 saw the continued development of the Trust’s bespoke developed E-Appraisal system, with it being successfully rolled out for all staff. This has provided greater access to the appraisal system, linking the records to the individual member of staff’s Training Management System. The Training & Development team have also sought to improve the appraisal process; good appraisals depend on high quality conversations. The quality of appraisals is based on how staff feel after their appraisal, i.e. did they feel valued, and was it worthwhile. The Trust was cognisant of the fact that the 2016 Staff Survey showed our quality of appraisals as being in the worst 20% nationally. We therefore developed an evaluation process via Wave 8 Listening into Action to gather information which is helping understand the issues and develop appropriate support mechanisms. This activity will be used over the coming year to improve our appraisal experience, which should see an improvement in the staff survey response rates.

Human Factors

Human factors examines the relationship between human beings and the systems with which they interact by focusing on improving efficiency, creativity, productivity and job satisfaction, with the goal of minimizing errors. A failure to apply human factors principles is a key aspect of most adverse events in health care. The Trust believes it is important, therefore that all our staff have a basic understanding of human factors principles.

The Trust has taken an embedded approach to maximise staff exposure to Human Factors by including Human Factors training within the already existing training programmes. For example, Human Factors training has been successfully incorporated into the Nurse Preceptorship Programme. This approach provides an opportunity to empower staff to use the knowledge of Human Factors with the examples and activities related to their target group to make the understanding of this science accessible and relatable.

In addition to embedding Human Factors into current training, we have developed the Human Factors website, providing resources that enable staff to expand their knowledge about Human Factors and learn how they can apply Human Factors within their own work processes and environments. The Trust has introduced an integrated approach to Human Factors Awareness Training which is open to all staff, with training being delivered via key staff training and team meetings. We have also developed a clinically focussed more advanced Human Factors e-learning module, which is available on the Trust website for those who have completed the initial awareness session.

Improving Systems and Governance

A key focus for the Learning and Organisation Development through 2017 has been the development of Educational Governance and improving our systems to support this. The Education Governance Group has now been established, as a sub-committee of the Workforce Assurance Committee, with cross divisional representation working in partnership to establish a template and reporting mechanism for “job essential” training as recommended within the Morecambe Bay Investigation.

The Trust is proud of its Training Management System (TMS) “My Learning & Development” which is user friendly and gives each member of staff access to their own training record. Over the last year a module for nurse revalidation and the Care Certificate have been developed. Responding to staff requests TMS@Home was also launched meaning staff could access their record from a non-trust device such as a home PC or smart phone. The Trust has received very positive feedback about the

increased flexibility and support this increased accessibility has enabled for staff, particularly our contingent staff, which has enabled better compliance Core Skills Framework rates for our Bank staff.

Engage & Involve

Behavioural Standards Framework

The **Behavioural Standards Framework** (BSF) was developed through one of the initial Listening into Action schemes by our employees, for our employees. It describes how the vision and values were to be embedded within everyone's role through their behaviours and actions. October 2017 saw the re-fresh of the BSF, as a critical element to our continued ambition is to further embed and mainstream the BSF, keeping it fresh, relevant and prominent.

We want the Trust to be 'A great place to be cared for;a great place to work'. An organisation that provides quality, compassionate care and supports its staff and everyone who works for the Trust plays a part in achieving this.

The Framework sets out the behaviours and attitudes expected of all staff which are not explicitly described in our job descriptions, the personal skills and attributes around 'how' we are expected to approach our work and should combine with the professional and technical skills to inform every action we take.

These behaviours and attitudes underpin our vision and values and also link to the Trust's Customer Care Commitment, the NHS Values and the Department of Health Compassion in Practice Strategy which includes providing care using the 6Cs:

The relaunch focused on a 12-month programme that focused on the BSF Behaviours, lead each month by a different leadership trio who shared their insights, advice and experiences. In addition, new information boards were put in place across the Trust as a visual and daily reminder of the BSF. An e-learning training module was developed which was seen as a critical step in the progression of the BSF. Not only will the e-learning module raise awareness of the BSF, it will further embed the BSF by requiring each employee to set a personal ambition based on the BSF. This will link into the Training Management System and will trigger a conversation about the pledge/ambition at their next appraisal, supporting on-going cultural transformation.

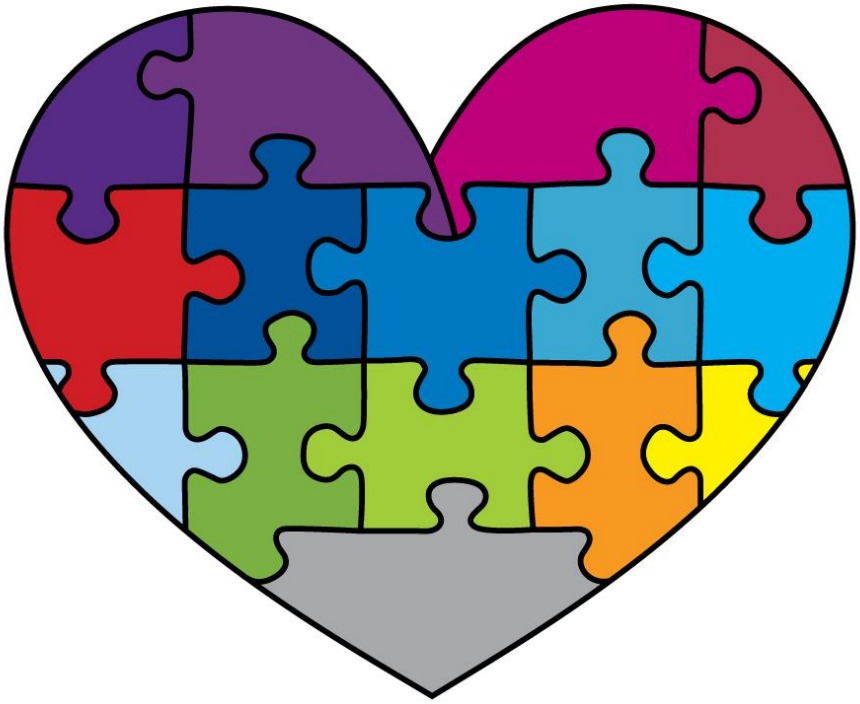
The Plans for 2017/18, as originally set out in the Organisational Development strategy, were to develop and further embed the BSF through the following actions:

- Continuing to raise awareness of the Behavioural Standards Framework at all stages of the employee lifecycle;
- Introduction of specific employee training on the behavioural standards (e-learning module);
- Introduction of specific leadership development training on behaviours and impact of others (through e-learning and taught modules);
- Promotion of Freedom to Speak Up, Respect Champions and the Inclusion Networks;
- Creating a social movement of collaborative partners across the Trust, in order to promote positive behaviours and to eradicate bullying and harassment in all its forms; and
- Embedding the BSF within an Accountability Framework.

A key area of challenge for the Trust is the ambition to deliver a bullying and harassment free organisation. A co-ordinated programme of activity is currently being worked up between trade union colleagues, workforce colleagues, Staff Inclusion Networks, Respect Champions and staff governors.

Set out in detail is our Behavioural Standards Framework giving details of the 15 standards which all staff follow and promote.

Behavioural standards are the heartbeat of UHMB



Introduce yourself with #hello my name is…

Be friendly and welcoming

Respect shown to everyone

Put patients at the centre of all we do

Show support to both staff and patients

Value the contribution of everyone

Team working across all areas

Seek out and act on feedback

Be open and honest

Communicate effectively: listen to others and seek clarity when needed

Share learning with others

Recognise diversity and celebrate this

Ensure all our actions contribute to safe care and a safe working environment

For those who supervise / manage teams: ensure consistency and fairness in your approach

Be proud of the role you do and how this contributes to patient care

#TeamUHMBT

Inclusion

The Trust's Equality Objectives for 2015-2019 are:

- To eliminate unlawful discrimination, harassment and victimization;
- To improve year on year the reported patient experience for protected groups;
- To improve year on year the reported employee experience for protected groups; and
- To reduce health inequalities for protected groups by improving access to all services.

The first annual update of the Trust's 5 year Towards Inclusion strategy took place in 2017. This highlighted the areas where the Trust needed to work on developing a better awareness of our workforce, so that we can better understand any workforce needs.

Significant work and actions have taken place to improve our patient experience which has been supported largely by our Equality of Access Group. Highlights have included:

- Site Accessibility Plans;
- Better Services for Children at A&E;
- Utilisation of the Readers Panel; and
- New interactive patient ID panels.

The significance of the staff network contribution was noted with this work. The Trust's staff networks provide an opportunity to develop equality of opportunity, provide opportunity for social interaction, peer and personal support and contribute to the development of policies and working practices. The more established networks cover the needs and support for our Black and Minority Ethnic staff, Lesbian Gay Bisexual and Transgender (LGBT) staff and staff with Disabilities provided through their respective individual Staff Networks. As part of the Behavioural Standards commitments an Age Network was launched in October and a Religion & Belief network was launched during Interfaith Week in November. Twelve month action plans have been agreed for each of the networks.

As part of the newly developed Forces Network action plan the Trust has signed the Step Into Health (SiTH) pledge. Following our pledge to champion the SiTH campaign the Trust was honoured to be invited to attend the national public launch which was officially launched by His Royal Highness, The Duke of Cambridge. The Trust has pledged support to service leavers and the wider Armed Forces community, recognising the benefits that serving personnel, veterans and military families bring to the workforce. The programme offers a route into apprenticeships, employment and career development opportunities.

In terms of building on the successful inclusion foundations the Trust is part way through its annual action plan which includes:

- Promoting Trust Beyond Boundaries – Towards an Inclusive Bay, which will involve an annual Towards Inclusion conference in May 2018;
- Collaboration with our public sector partners so we can deliver improvements together for our collective workforce and services users;
- Cross Fertilise network progress by developing a network for our networks, an opportunity to replicate and share the current good practice;
- Celebrate the ongoing successes and achievements through a week-long festival of fun and awareness raising; and
- Further alignment of the Trust's strategic links across the various staff engagement initiatives.

Further areas of positive progress include the Trust recent accreditation as a **Disability Confident Employer** for a further 2 year period.

Being a Disability Confident organisation enables the Trust to play a leading role in changing attitudes, behavior and culture for the better and helps demonstrate that we treat all employees fairly. The scheme has three levels and we are now working towards level 3 to become a Disability Confident Leader.

The Trust has also contributed to the **Stone Wall Equality Index**, the first submission since becoming a Stonewall Diversity Champion. The in-depth, tailored feedback and scores the Trust has received will enable a better understanding of our LGBT employee experience and where the Trust and the Network need to focus their efforts, as well as an opportunity to benchmark against other organisations within our sector and region.

The Trust has also committed to support the **Time to Change - Time to Talk Campaign** a national campaign to end mental health stigma. One of the recommended ways of reducing mental health stigma is to get the nation talking about mental health. National Time to Talk day was officially 1 February 2017, however, the Trust committed to focusing on having conversations about mental health, awareness raising and experience sharing throughout the entire month with a programme of Time to Talk events and roadshows across all 3 sites.

Alumni Event

Following the successful completion of the NHS Employers national development Diversity and Inclusion Partners programme in both 2015/16 and 2016/17, the Trust is now termed as an Alumni partner and there is an expectation that we will help other organisations by sharing our experiences both good and bad. In November 2017, the Trust hosted it's first national Inclusion and Diversity NHS Employers Alumni event, and in recognition of the fact that much of our success has been attributable to our networks, the theme of the event was Beyond Boundaries - A network focus. The session was very well attended, with positive feedback from delegates.

Inclusive Top 50

In late 2017 UHMB was named as the **eighth most inclusive employer** in the UK, in the Inclusive Top 50 UK Employers list.

The Inclusive Top 50 UK Employers showcases leading organisations working across all strands of diversity, and provides a definitive list of UK based organisations that promote inclusion across all protected characteristics, throughout each level of employment within an organisation.

Listening into Action and Improvement

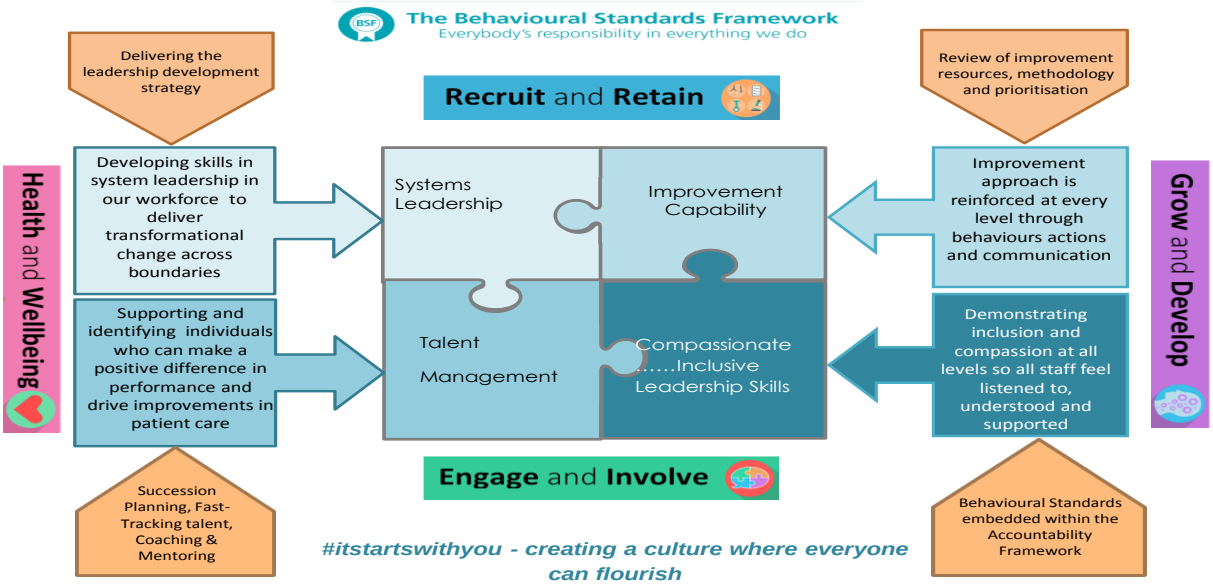
2017/18 has been a year of consolidation in the delivery of Listening into Action (LiA) with a further 4 waves taking the Trust to a total of 11 waves of improvements over 3 and half years resulting in 132 completed schemes - a fantastic achievement showing the commitment to improvement of the Trust's staff.

Wave 8 saw the Trust open applications to Cumbria Partnership NHS Foundation Trust (CPFT) colleagues, making it one of the most successful waves to date with 20 applications submitted from across both the Trust and CPFT. Working together across both Trusts in the workshops helped forge new understanding, developed collaboration and built relationships.

The celebration event in November 2017, "**Brilliant Bay Day**", was timed to coincide with the visit from broadcaster Roy Lilley and Dr Terri Porrett from the Academy of Fabulous NHS Stuff. Roy Lilley, a health policy analyst and commentator on the National Health Service, said:

> "*UHMBT has a massive amount to be proud of and it is great at sharing what it does with the academy. You are definitely now the envy of the NHS. The Trust has been through the mill but it hasn't stopped staff coming to work and wanting to do the right thing and it hasn't stopped staff making improvements. You are now and forever magic Morecambe Bay!"*

The publication of Developing People – Improving Care in December 2016 provided the opportunity to refresh the Organisational Development strategy, re-energise the leadership and improvement support for our people whilst ensuring that it remains congruent with the wider Workforce Strategy and its underpinning model of the Workforce Cycle of Excellence.



Staff Survey

Staff experience at the Trust continues to improve year on year, according to the results of the 2017 annual NHS National Staff Survey. Feedback from staff showed big improvements in a number of areas, when compared to the previous year's results, including:

- Staff feeling that the Trust takes positive action on health and wellbeing;
- Staff recommending the Trust as a place to work or receive treatment; and
- Staff believe the quality of appraisals has improved.

The Trust scored above average in 18 areas this year – compared to 14 areas last year. This includes being in the top 20% of all Acute Trusts in England in six areas, including:

- Staff feeling confident in the fairness and effectiveness of procedures for reporting unsafe clinical practice;
- Staff feeling satisfied in the opportunities for flexible working; and
- Staff reporting incidents of violence, bullying and harassment or abuse.

Spread of Key Findings (by number)

	2017	2016	2015	2014	2013	2012
Best 20%	6	8	4	3	4	2
Better than average	12	6	9	4	2	3
Average	7	5	3	7	3	3
Worse than average	5	11	9	10	12	8
Worst 20%	2	2	7	5	7	12
Total	32	32	32	29	28	28

[1] A national framework for action on improvement and leadership in NHS-funded services, developed by a collaboration of arms-length bodies

Spread of Key Findings (by percentage)

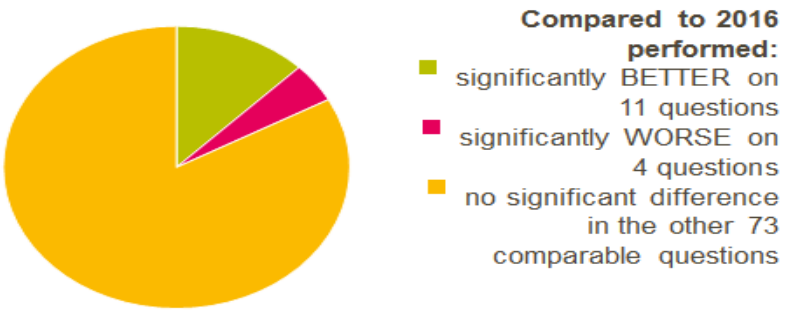
	2017	2016	2015	2014	2013	2012
Best 20%	19%	25%	13%	10%	14%	7%
Better than average	38%	19%	28%	14%	7%	11%
Average	22%	16%	9%	24%	11%	11%
Worse than average	15%	34%	28%	34%	43%	29%
Worst 20%	6%	6%	22%	17%	25%	43%
Total	100%	100%	100%	100%	100%	100%

It is clear that the Staff Survey show further improvements this year. The Trust may take a number of positive assurances from the survey, such as the increase in staff feeling that the Trust is taking positive action on health and wellbeing, and that fact that overall, staff don't feel pressured to come into work when they are sick.

The Trust has always recognised that a key priority is to support staff and give staff the knowledge, support and tools to look after themselves. The Trust Flourish programme has been running for two-years, with the aim of supporting staff in four key areas of health and wellbeing, namely physical activity, nutrition, mindfulness and healthy heart. The survey also highlighted areas where the Trust needed to make further improvements, including:

- Staff feeling able to contribute towards improvements at work;
- Communication between senior management and staff;
- Effectiveness of team working;
- The quality of non-mandatory training, learning or development; and
- The level of staff reporting having experienced harassment, bullying or abuse from other staff.

For the second consecutive year our Trust took the decision to issue the survey to all staff, as the benefits from an all staff survey were significant in 2016. The overall response rate was 40.3% with 2181 employees completing the survey.



Staff Engagement as supported by NHS Employers is defined as "a positive attitude held by the employee towards the organisation and its values" The NHS Staff survey includes a methodology for calculating levels of staff engagement based on 9 key questions, covering themes of advocacy, involvement and motivation.

Despite the aforementioned statistically significant improvement in staff recommending the Trust as a place to work or receive treatment, the Trust has maintained an overall moderately static position with an increase from 3.78 in 2016 to 3.79 in 2017.

It is worth noting however, that this staff engagement score now aligns to the 2017 national average.

Staff Survey – Comparison to 2016 Responses

The table below identifies the areas which have significantly improved and those which have deteriorated since 2016.

QUESTION AREA	2016 results	2017 results	BETTER/ WORSE
Motivation and Job Satisfaction			
Satisfied with recognition for good work	49%	53%	**Better**
Satisfied with support from immediate manager	63%	67%	**Better**
Would recommend organisation as place to work	60%	63%	**Better**
Satisfied with level of pay	39%	35%	**Worse**
Management			
Immediate manager can be counted upon to help with difficult tasks	65%	70%	**Better**
Immediate manager takes a positive interest in my health & well-being	64%	67%	**Better**
Immediate manager values my work	68%	71%	**Better**
I know who senior managers are	77%	80%	**Better**
Health, Wellbeing & Safety at Work			
Organisation definitely takes positive action on health and wellbeing	36%	41%	**Better**
Training			
Training helped me stay up-to-date with prof. requirements	84%	86%	**Better**
Appraisals			
Clear work objectives definitely agreed during appraisal	28%	31%	**Better**
Had appraisal/KSF review in last 12 months	90%	87%	**Worse**
Patient, Service User Care			
If friend/relative needed treatment would be happy with standard of care provided by organisation	65%	70%	**Better**
Feedback from patients/service users is used to make informed decisions within directorate/department	62%	57%	**Worse**
Bullying, Harassment and Whistleblowing			
Not experienced discrimination from patients/service users, their relatives or other members of the public	97%	96%	**Worse**

Next Steps

It is evident from the results, based on both in-year and longer-term changes, that the interventions and approaches deployed are reinforcing an organisational culture that is patient-centred, safety-focussed and supports employees in giving their very best every day.

The journey is not complete and there are a number of areas that need further consideration and focussed attention throughout 2018/19. The staff engagement domains will continue to be a priority for divisional teams and provide some indication of where a designated focus needs to be over the coming months.

On a wider Trust basis work will continue with a number of initiatives already underway to support those areas of the staff experience which require the most urgent attention, including collaborative working with our Trade Union partners to address bullying and harassment by creating positive working environments.

Health & Wellbeing

Occupational Health & Wellbeing

The Occupational Health & Wellbeing service is a multi-disciplinary team with a Consultant Physician and nurse led service. The service includes Physician interventions, Specialist Occupational Health Nurses/Advisers, Physiotherapist who specialise in Muscular Skeletal (MSK) conditions, Psychotherapist that specialise in Person Centred Counselling/Hypnotherapy, Cognitive Behaviours Therapy. The service is offered to Trust support staff across all 3 sites.

The services offered range from pre-employment screening and assessment of fitness to work following illness or injury, healthy lifestyle checks to supportive therapeutic interventions and physiotherapy. The Occupational Health & Wellbeing services continues to develop their service and constantly strives to offer staff more ways to take care of their health and be empowered to make healthy choices.

The Occupational Health and Well-being service have continued over 2017/18 to move forward in delivering an excellent, quality Occupational Health (OH) service for both the Trust and employees individually. Some examples of improvement are listed below:-

- Maintained Key Performance Indicators (KPIs), linked to the Commissioning for Quality and Innovation standards (CQUIN);
- Development and growth of the MSK team, working towards more preventative measures addressing the needs of staff specifically by visiting more work places and performing ergonomic assessments;
- Proactive approach and improved links with Health and Safety and Infection Prevention;
- Improved usage of the OH System Cohort, has enabled improved reporting and the implementation of the dashboard, facilitating better work planning and prediction of possible problematic areas;
- Introduced an OH technician, therapy coordinator, and a new phone system;
- Continued development of proactive health and wellbeing initiatives, focused in line with Trust initiatives such as the Flourish Campaign and The Bay Stroke Prevention Campaign;
- Development of new courses and development of existing courses, such as; man shed, women's health, menopause course, on line CBT training, back care course, work out at work sessions;
- Recognition of sickness absence trends, through statistical gathering via dashboard link to in house clinical coding and ESR; and
- Recent implementation of the PHQ 9 pre and post therapy to improve the accountability of therapy provision and its effectiveness.

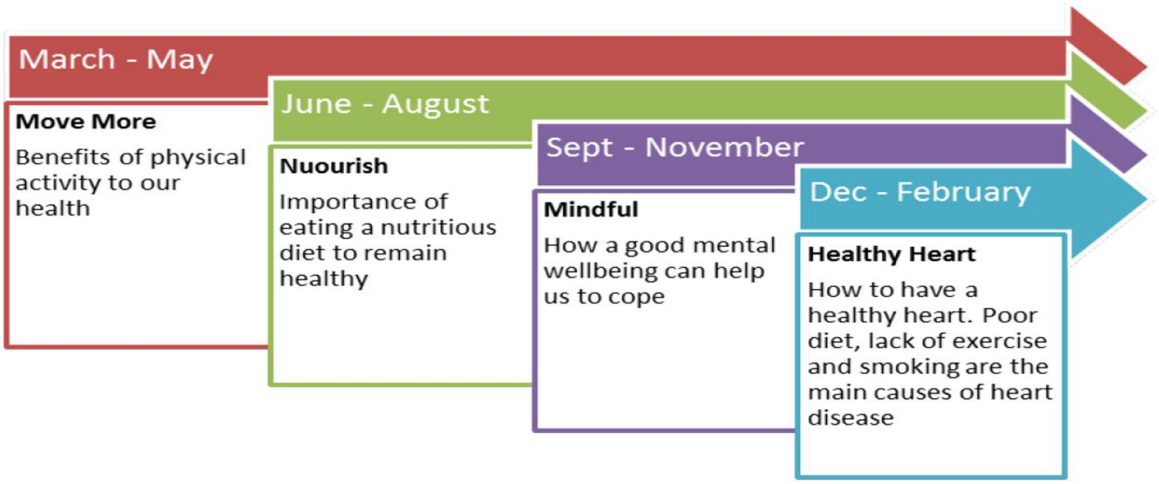
The Department has also maintained its SEQOHS - Safe Excellent Quality Occupational Health Service accreditation in year. The Trust gained accreditation initially in 2014 and has successfully renewed it each year since, with the most recent assessment having taken place in January 2018. It is very positive to note that the SEQOHS assessors provided the Occupational Health service with excellent feedback, in particular complementing the team on their ability to collate and report information.

The Trust has for the 4th year running achieved the national target for 75% of front line staff to be vaccinated against flu. This has improved year on year and currently to date we stand at 89.4% of front line staff vaccinated and 81.7% total staff vaccinated. The Trust achieved the 4th highest vaccination rate in the country which is a hugely successful result for a well-led campaign.

Flourish

The Occupational Health & Well-being team has continued to support the Trust's #Flourish Campaign in 2017/18, which aimed to:

- Create exciting initiatives throughout the year that informed, educated and encouraged our staff to get involved and make a change;
- Support and build on the existing services provided by our Occupational Health services to deliver a Trust Health and Wellbeing strategy;
- Provide the leadership and support to help staff make changes which will help each other, such as in catering and active travel schemes;
- Take a 'population health approach' to improving the health and wellbeing of local people as part of Better Care Together;
- Create opportunities for staff to get involved, and through new ways of working like Listening into Action, make the change needed in these areas; and
- The #FlourishatWork campaign was a four phase programme running throughout the year.



Attendance Management

The Trust continues to implement a supportive, proactive and employee-centric approach to managing attendance, shifting the focus away from merely tackling sickness absence. It is positive to note that the Trust's approach has led to improving levels of attendance, although performance is slightly below the KPI target of 95.7% the Trust has been able to maintain high levels of attendance through the year.

The Trust's position is significantly better than the NHS North West average (95.1%) and the development and delivery of the Occupational Health and Well-being Service and the Flourish campaign in 2017/18 saw the Trust's position maintained and improved.

The Trust provides monthly updates to the Board outlining work within the divisional teams, focusing on increasing attendance and a number of interventions, including the development of joint case reviews between Occupational Health and Workforce to support our managers, improved reporting and information for our Care Group teams and the agreement and launch of a new policy which set a new

approach to attendance management the training for which was developed in partnership with our staff side colleagues.

Overall Trust Sickness Absence & Attendance rates	
Year	Attendance Rates
2012/13	95.4%
2013/14	95.5%
2014/15	95.1%
2015/16	95.7%
2016/17	95.5%
2018 year to date	95.3%

Staff sickness absence (HSCIC data) and Average working days lost			
Staff sickness absence (HSCIC data)	**2017**	**2016**	**2015**
	Number	**Number**	**Number**
Total days lost	49,577	50,954	47,534
Total staff years	4,703	4,559	4,439
Average working days lost	10.5	11.2	10.7
Sickness absence data is based on the calendar year. This is considered to be a reasonable proxy for financial year equivalents.			
Sickness absence data is published by the Health & Social Care Information Centre (HSCIC) based on monthly extracts from the Trust's ESR payroll system.			

There has been a focused drive to improve the health of our employees and create a culture which supports individuals at times of difficulty, rehabilitating and making adjustments wherever possible to keep people in work.

Service Modernisation and Redesign

The workforce team have continued to develop the Staff and Management Information System (AskSAMI) originally introduced in 2016/17. SAMI has been very well received by managers across the Trust and has received positive feedback. This advisory service supports staff by providing responses to workforce queries within one working day. In addition to efficiency, accessibility is also at the forefront of this service with contact made through Twitter @AskSamiUHMBT, email Ask.Sami@mbht.nhs.uk and phone 49700. The service was designed to support staff across the Trust's five sites, therefore ease of access and systems which are geographically flexible are key to understanding the success of SAMI. Working on modernising, retention and developing new talent was key to developing an Employee Centric service that gave value to the organisation.

A number of helpful management resources and tools have been developed by the SAMI team as well as improving the intranet site. Whilst there is further modernisation work to undertake, particularly of the intranet, to make it a modern fully interactive support tool the activity undertaken over the past year has started to provide an excellent foundation for onward development.

Average number of people employed	2017/18		
	Permanently Employed	Other	Total
	Number	Number	Number
Medical and dental	490	75	565
Administration and estates	1,127	34	1,161
Healthcare assistants and other support staff	1,090	159	1,249
Nursing, midwifery and health visiting staff	1,388	93	1,481
Scientific, therapeutic and technical staff	455	29	484
Healthcare science staff	197	6	203
Total	4,747	396	5,143

Average number of people employed	2016/17		
	Permanently Employed	Other	Total
	Number	Number	Number
Medical and dental	453	90	543
Administration and estates	1,081	37	1,118
Healthcare assistants and other support staff	1,006	131	1,137
Nursing, midwifery and health visiting staff	1,417	80	1,497
Scientific, therapeutic and technical staff	468	14	482
Healthcare science staff	170	5	175
Total	4,595	357	4,952

Of the above there were 14 staff (Whole Time Equivalent) engaged on capital projects during 2017/18 (16 WTE staff engaged on capital projects during 2016/17).

The Trust employs bank staff and engages agency staff for temporary assignments and these are shown within the appropriate staff categories under the other staff heading. A total of 263 bank staff and 133 agency staff (2016/17, 210 and 147 respectively) were employed on average during the year.

As part of the Staff Report in the Annual Report the Trust is required by the Annual Reporting Manual to report on:-

- Off Pay Roll Engagements;
- Exit packages; and
- Consultancy Expenses.

Off Pay Roll Engagements

As part of the annual Review of Tax Arrangements of Public Sector Appointees published by the Chief Secretary to the Treasury on 23 May 2012, Foundation Trusts are required to publish information in relation to the number of off- payroll engagements.

Off-Payroll Engagements	
The Table below covers for all off-payroll engagements as at 31 March 2018, for more than £220 per day and that last for longer than six months:	
No. of existing engagements as at 31 March 2018	1
Of which…	
No. that have existed for less than one year at time of reporting	0
No. that have existed between one and two years at time of reporting	1
No. that have existed between two and three years at time of reporting	0
No. that have existed between three and four years at time of reporting	0
No. that have existed for four or more years at time of reporting	0
**All existing off-payroll engagements highlighted above have been subject to a risk based assessment to establish whether the Trust needed to seek assurance that the relevant individuals were paying the right amount of tax. Where necessary that assurance was sought and received.	
The Table covers for all new off-payroll engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018, for more than £220 per day and that last for longer than six months.	
No. of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	0
No. of the above which include contractual clauses giving the Trust the right to request assurance in relation to income tax and National Insurance obligations	1
No. for whom assurance has been requested	1
Of Which…	
No. for whom assurance has been received	1
No. for whom assurance has not been received	0
No. that have been terminated as a result of assurance not being received.	0
The Table below covers for any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018	
No. of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.**	0
No. of individuals that have been deemed “board members and/or senior officials with significant financial responsibility” during the financial year. This figure should include both off-payroll and on-payroll engagements.	17

Exit Packages

Exit packages	2017/18		2016/17	
	Number	Costs	Number	Costs
		£000		£000
Exit package cost band <£10,000	0	0	0	0
Exit package cost band £10,001 to £25,000	0	0	0	0
Exit package cost band £25,001 to £50,000	1	27	0	0
Exit package cost band £50,001 to £100,000	0	0	0	0
	1	27	0	0
Contractual redundancy	1	27	0	0
National MARS	0	0	0	0
	1	27	0	0
During 2017/18 the Trust agreed a departure with 1 employee. This departure was paid in line with contractual redundancy. There were no termination benefits paid to Directors in 2017/18. There were no termination benefits paid to employees or Directors during 2016/17.				

Consultancy Expenditure

Consultancy Services Expenditure	Value
Design and re-implementation of the Trust's Reference Cost system"	£69,000
Investigations etc	£94,000
Electronic Patient Record system	£60,000
Better Care Together	£193,000
Total	£416,000

Audit Committee Report

The Role of the Audit Committee

It is a requirement for every NHS Board to establish an Audit Committee which reflects not only established best practice in the public and private sectors, but also the constant principle that the existence of an independent Audit Committee is a central means by which a Board of Directors ensures effective internal control arrangements are in place. In addition the Audit Committee provides a form of independent check upon the executive arm of the Board.

The Audit Committee of the Foundation Trust operates in accordance with the Terms of Reference set by the Board which were reviewed in March 2018, to reflect the latest edition of the NHS Audit Committee handbook.

The key responsibilities are set out in the Terms of Reference, but the main priorities of the Committee are:

- Governance, Risk Management and Internal Control;
- Oversight of the work of Internal Audit;
- Oversight of the work of External Audit;
- Financial reporting;
- Oversight of the work of the Anti-Fraud Service; and
- Other functions delegated by the Board.

Membership of the Committee

The Audit Committee membership includes a Non-Executive Director as the Chair; and all other Non-Executive Directors on the Board of Directors (excluding the Chair of the Board of Directors). All members have full voting rights at the Committee.

The membership of the Committee during the 2017/18 financial year was as follows:

Membership of the Audit Committee	
Peter Armer (until 31 August 2017)	Non-Executive Director (Chair)
Helen Bingley (from 1 September 2017)	Non-Executive Director
Helen Denton	Non-Executive Director
Bruce Jassi	Non-Executive Director
Neil Johnson	Non-Executive Director
Denis Lidstone	Non-Executive Director
Liz Sedgley (from 1 September 2017)	Non-Executive Director (Chair)
Jacqueline Telfer	Non-Executive Director
Melanie Weeks (until 24 June 2017)	Non-Executive Director

The Chair of the Committee until 31 August 2017 was Peter Armer who is a qualified accountant and has extensive experience as a Financial Director in large complex organisation. Elizabeth Sedgley took over as Chair of the Committee from 1 September 2017. Elizabeth is a qualified accountant. Neil Johnson, Helen Bingley and Melanie Weeks have clinical experience and Helen Denton and Jacqueline Telfer have social care experience. Bruce Jassi is an experienced public sector director and Denis Lidstone is an experienced programme director. Please see Board Profiles for further information.

Standing invitations to attend Audit Committee meetings have been extended to the:

- Director of Finance;
- Director of Governance;
- Head of Financial Services;
- Internal Audit representatives;
- Local Anti-Fraud Specialist;
- External Audit representatives;
- Head of Finance Services; and
- Company Secretary.

In addition, the Chief Executive and other officers from within the organisation have been invited to attend Audit Committees or meet with Audit Committee members where it was felt that to do so would assist the Audit Committee to effectively fulfil its responsibilities.

In the current year the Committee specifically invited attendance from the Executive Chief Nurse and the Divisional General Manager for the Critical Care and Surgery Care Group.

Overview of the Work of the Committee

The work of the Committee during the year has covered a wide range of areas and topics in order that it can provide assurance to the Board of Directors. The main aspects of this work are outlined in the following paragraphs.

Annual Accounts and Annual Report 2016/17

Through the NHS Foundation Trust Annual Reporting Manual 2016/17, NHS Improvement advised that the submission deadline for the production of NHS Foundation Trust Annual Report and Accounts for 2016/17 was 31 May 2017. As the Board of Directors' meeting was scheduled to take place on 31 May 2017, the Audit Committee sought delegated authority from the Board of Directors for the Committee to undertake the document approval process of the Annual Accounts and Report 2016/17 on behalf of the Board of Directors. The Board of Directors' approved this process.

The Committee at its meeting on 26 May 2017, on behalf of the Board of Directors, considered the Annual Report and Accounts including the Quality Report and was satisfied with the content and formally adopted them.

Internal Control & Risk Management Systems

At each meeting the Audit Committee considered reports from its internal and external auditors, and the Anti-Fraud Specialist.

The Director of Governance and the Company Secretary provided regular updates on corporate governance and risk management.

External Audit

The Audit Committee reviewed the work and findings of external audit by:

- discussing and agreeing the nature and scope of the Annual Plan, and the letter of engagement;
- discussing and agreeing the audit fee; and
- receiving and considering reports derived from the Annual Plan.

In July 2017, the Committee approved the recommendation by the Council of Governors to appoint Grant Thornton as the Trust's external auditors for a further period of 3 years with the option of an additional 2 years.

Internal Audit

The Audit Committee reviewed and considered the work and findings of internal audit by:

- discussing and agreeing the nature and scope of the Annual Plan;
- receiving and considering progress reports throughout the year from the internal auditor at each Audit Committee meeting;
- receiving and considering reports derived from the Annual Plan; and
- receiving the Head of Internal Audit's annual opinion on the Trust's system of internal control.

Set out below is the 2017/18 work programme delivered by Internal Audit:

REVIEW TITLE	ASSURANCE LEVEL High/Significant/Limited/No
Combined Financial Systems	Significant Assurance
Cost Improvement Programme	High Assurance
VTE – Follow Up	Significant Assurance
Discharge Planning – Follow Up	Significant Assurance
Information Governance Toolkit	Significant Assurance
Local Security Management Specialist (LSMS) Quality Assurance	High Assurance
Clinical Audit Effectiveness	Significant Assurance
5-Steps to Safer Surgery	Limited Assurance
Maintenance of Equipment	Limited Assurance
Payroll: High-Level Spend	Significant Assurance
Appraisals	Significant Assurance
Sickness Absence: Return to Work Interviews	Significant Assurance
NMC Registration	No Assurance
Complaints Management	Significant Assurance
Whistleblowing	Significant Assurance
Surgery and Critical Care Division – Patient Flow	Limited Assurance
Business Continuity Follow Up	Limited Assurance
Compliance with Standards	High Assurance

The Clinical Audit Effectiveness Audit received Significant Assurance. The overall objective of this review was to provide assurance on the Trust's ability to demonstrate the value realised as a result of carrying out clinical audit and its effectiveness. The Audit found that the Trust had a Clinical Audit Strategy supported by a detailed Clinical Audit Policy; together they define the strategic profile of clinical audit, how it should be operationally prioritised, monitored and reported. Clinical audit was managed through the development and implementation of an annual programme which concludes with an annual report; the 2016/17 report and programme for 2017/18 were received and approved by the Quality Committee in line with policy. The Clinical Audit and Effectiveness Group maintained operational oversight monitoring delivery of the clinical audit programme.

Central monitoring of the programme was undertaken by the Clinical Audit Department; each clinical audit project was found to be identifiable by a unique number and recorded/ contained information such as the standards that were being reviewed, the current status of the review, key leads and key documentation. Reporting of the programme was found to be very detailed and robustly implemented throughout the specialities of the Trust.

On review of the documentation supporting the implementation of action plans, differing practices were identified; three of five projects with action plans had either fewer actions than that detailed in presentations or actions that identified that the audit simply needed to be presented to peers. The Trust agreed with the recommendation to provide a consistent approach to the development and delivery of clinical audit plans. A review of existing practice was undertaken to develop guidance to provide a 'gold standard' for staff to work towards. The agreed implementation date was 1 December 2017.

Anti-Fraud

The Trust's anti-fraud service is provided by the Mersey Internal Audit Agency. The Anti-Fraud Specialist is required to attend the Committee and during the year the Committee received regular progress reports.

Managing Conflicts of Interest in the NHS

The Committee received several reports on how the Trust had adopted guidance from NHS England on managing conflicts of interest in the NHS.

In February 2017, NHS England issued new guidance on managing conflicts of interest in the NHS. The guidance:

- introduced common principles and rules for managing conflicts of interest;
- provided simple advice to staff and organisations about what to do in common situations; and
- supported good judgement about how interests should be approached and managed.

The guidance came into force on 1 June 2017 and applied to the following NHS organisations:

- Clinical Commissioning Groups (CCGs) via the statutory guidance to CCGs issued by NHS England;
- NHS Trusts and NHS Foundation Trusts which included secondary care trusts, mental health trusts, community trusts, and ambulance trusts; and
- NHS England (through the Standards of Business Conduct).

To make implementation easier, NHS England released a model policy which included the content of the guidance. Organisations were encouraged to adopt this policy or use parts of it to update their current policies and procedures. The Trust's model policy was considered by the Audit Committee and Workforce Operational Meeting in April 2017. In light of the positive feedback at both meetings, the model policy was adopted with minor amendments by the Procedural Documents and Information Leaflet Group.

The Trust policy covered a number of common situations which could give rise to risk of conflicts of interest, being:

- Gifts;
- Hospitality;
- Outside employment;
- Shareholdings and other ownership interests;
- Patents;
- Loyalty interests;
- Donations;
- Sponsored events;
- Sponsored research;
- Sponsored posts; and
- Clinical private practice.

The Trust policy outlined the risks and issues posed in these situations and the principles and rules that staff should adopt to manage them. The new policy was circulated via the Trust's internal communications system. A dedicated webpage was created for staff to access.

As part of this work, the declarations which were recorded on the UK Disclosure website (pharmaceutical companies' declarations) would be reviewed to ensure congruence with Trust records.

During 2017/18, a review of Conflicts of Interest was conducted by Mersey Internal Audit Agency in accordance with the 2017/18 internal audit plan. The overall objective of the audit was to evaluate the design and operating effectiveness of the arrangements that the Trust had in place to manage conflicts of interest and gifts and hospitality, including compliance with NHS England's statutory guidance on Managing Conflicts of Interest in the NHS.

The auditors concluded that although their analysis demonstrated that the Trust was fully compliant with the systems in place for the register of interests, gifts and hospitality and identifying and managing breaches, there were areas of the review that were not fully compliant. A number of recommendations were made to ensure full compliance at all levels of the review. All recommendations, except the

recommendation in relation to staff training, have been implemented. The Trust will be fully compliant when NHS England release the training modules which will be embedded across the organisation.

Working with Other Committees

The Audit Committee works closely with the Quality Committee. This approach has ensured that the Audit Committee obtains assurance on key clinical and safety issues.

Committee Effectiveness and Looking Ahead to 2018/19

As the development of an integrated care partnership in Morecambe Bay progresses during 2018/19, the Audit Committee will play a significant role in supporting the governance arrangements of partnership working.

Looking ahead into 2018/19, the Committee will continue to carry out its duties to provide the necessary assurance to the Board of Directors. The role of the Audit Committee will continue to evolve by supporting the development of an integrated care partnership.

The Committee's Terms of Reference were reviewed in March 2018 to ensure that it met its purpose to provide assurance to the Board of Directors.

Compliance with UK Corporate Governance Code and Disclosure Set Out in the NHS Foundation Trust Code of Governance

The creation of Foundation Trusts led to the introduction of a framework for corporate governance, applicable across the Foundation Trust Network.

To ensure compliance NHS Improvement has produced the NHS Foundation Trust Code of Governance. This code consists of a set of Principles and Provisions to ensure that Boards operate to the highest levels of corporate governance.

The Board of Directors has taken actions to comply with the Code, and where appropriate established governance policies that support the delivery of corporate governance.

Further information is contained in the Constitution of the Trust and throughout this Annual Report

Foundation Trusts are required to report against this Code each year in their Annual Report on the basis of either comply with the Code provisions or an explanation where there is non-compliance.

The Board of Directors considers that, throughout the 2017/18 reporting year, the Trust has applied the principles and met the provisions and the requirements of the Code of Governance with no exceptions.

Full details can be found at Annex I

NHS Improvements' Single Oversight Framework

Performance against NHS Improvement (NHSI) Single Oversight Framework

NHS Improvement is the Independent Regulator of Foundation Trusts. It is requirement of the NHS Improvement licence under which the Trust operates that it must have strong governance – this is how a Foundation Trust oversees care for patients, delivers national standards, and remains efficient, effective and economic.

From 1 October 2016, NHS Improvement changed the way it assessed these criteria. It introduced the Single Oversight Framework

The Single Oversight Framework is designed to help NHS providers attain, and maintain, Care Quality Commission ratings of 'Good' or 'Outstanding'. The Framework will help NHSI identify NHS providers' potential support needs across five themes:

- quality of care;
- finance and use of resources;
- operational performance;
- strategic change; and
- leadership and improvement capability (well-led).

Under the Single Oversight Framework (SOF), NHSI segment providers based on the level of support each provider needs.

NHSI segments trusts according to the level of support each trust needs across the five themes above.

Each trust is segmented into one of the following four categories:

Segment	Description
1	Providers with maximum autonomy: no potential support needs identified. Lowest level of oversight; segmentation decisions taken quarterly in the absence of any significant deterioration in performance.
2	Providers offered targeted support: there are concerns in relation to one or more of the themes. We've identified targeted support that the provider can access to address these concerns, but which they are not obliged to take up. For some providers in segment 2, more evidence may need to be gathered to identify appropriate support.
3	Providers receiving mandated support for significant concerns: there is actual or suspected breach of licence, and a Regional Support Group has agreed to seek formal undertakings from the provider or the Provider Regulation Committee has agreed to impose regulatory requirements.
4	Providers in special measures: there is actual or suspected breach of licence with very serious and/or complex issues. The Provider Regulation Committee has agreed it meets the criteria to go into special measures.

Care Quality Commission Hospital Inspection

The Care Quality Commission (CQC) carried out a re-inspection of the Trust in October 2016 with the report being published on Thursday 9 February 2017.

The Trust was extremely pleased that our rating improved to that of GOOD, with OUTSTANDING for Caring. The outcome was terrific news for staff, our partners in the Bay, and most importantly for the patients and the people who use our services.

This means we have continuously improved over three successive hospital inspections over the last three years moving from 'Inadequate' and in special measures to today's rating of 'Good' and 'Outstanding' for caring. It also means we are among the top rated NHS hospitals in the country.

During the inspection, inspectors found that we had made significant progress across most services since the last Inspection in July 2015, particularly in maternity and gynaecology and end of life services. Inspectors also noted improvements in culture and engagement, staffing levels, strategy and plans for the future, leadership, governance and risk management, and a more positive approach to inclusion and diversity.

This result is a remarkable achievement and reflects the hard work our staff have done to change our culture and focus on patient safety and quality of care. We feel enormously proud to work with such committed and talented staff.

The full reports from our latest inspection can be viewed on the CQC's website at: CQC Report.

The Report highlighted a number of areas where further work was needed to meet required standards, and these have begun to be addressed.

Details of Improvement Plan can be found on line: CQC Improvement Plan.

There were no unannounced visits from the CQC.

NHSI Provider Licence

Following publication of the Chief Inspector of Hospitals Report on the CQC re-inspection of the Trust's hospitals NHSI agreed that the number and level of conditions on the Trust's Provider Licence should be reduced.

The Enforcement Notice attached to the Trust's Licence required the Board to address the concerns raised in previous CQC Inspections, together with actions to complete the Action Plan in relation to the Morecambe Bay Investigation report. Following the CQC report the Trust was judged to be fully compliant with the requirements of these licence conditions and they were removed from the Licence.

The only licence condition remaining relates to finance and sustainability. A revised enforcement notice in respect of Financial Sustainability was received in May 2018. Plans are in place to complete the required actions.

The Licence Condition in relation to finance and sustainability is being dealt with through the Trust's Sustainability Plan and Cost Improvement Programme and through the Better Care Together Strategy and programme and the Two Year Operational Plan.

Other Statements and Notes

External Auditors

During 2017/18 the Trust's audit contract was undertaken by Grant Thornton UK LLP.

The planned audit fees are £46,000 in respect of the Annual Accounts and £7,000 for the audit of the Quality Report.

Grant Thornton UK LLP is also engaged to provide external audit for Morecambe Bay Hospitals Charity. Fees of £2,000 will be paid by the Charity in relation to this service for 2017/18.

The items that are audited by the External Auditor in this Annual Report are:

- salary single total figure table for each director (audited);
- pension benefits table (CETV disclosures) (audited);
- payments for loss of office (if relevant) (audited);
- payments to past directors (if relevant) (audited);
- fair pay disclosures (audited);
- exit packages (if relevant) (audited); and
- the analysis of staff numbers and staff cost (audited).

Counter Fraud

NHS Protect (formerly The NHS Counter Fraud and Security Management Service) has set out the framework within the NHS plans to minimise losses through fraud. The Trust's local policy complements the national and regional initiatives and sets out the arguments for the reporting and the elimination of fraud.

The Director of Governance is nominated to make sure that the Trust's requirements are discharged and is aided by a Local Counter Fraud Specialist (LCFS). The LCFS developed a plan that aimed to proactively reduce fraud and create an anti-fraud culture supported by appropriate deterrence and prevention measures. Progress against the plan is regularly reported to the Audit Committee.

Principal Risks and Uncertainties

NHS is changing rapidly and for the Trust this gives many opportunities as well as risk and uncertainty. The Board of Directors has identified the strategic risks facing the Trust. These risks are formally reviewed on a quarterly basis by the Board of Directors. Current strategic risks are identified in the Annual Governance Statement (Annex F) and appropriate risk management and mitigation plans are in place for each.

Insurance Cover

The Trust has a contract in place with Royal & Sun Alliance Insurance Plc to provide appropriate insurance to cover the risk of Director's and Officer's Liability.

Political Donations

No Political donations have been made.

Modern Slavery Act 2015 – Statutory Statement

University Hospitals of Morecambe Bay NHS Foundation Trust is a large acute hospital organisation serving the population of South Cumbria and North Lancashire. The Trust operates from three main hospital sites, Royal Lancaster Infirmary (RLI) in Lancaster, Furness General Hospital (FGH) in Barrow and Westmorland General Hospital (WGH) in Kendal serving a population of circa 363,000 spread across an area of over 1,000 square miles.

Each hospital has a range of 'General Hospital' services, with full Accident and Emergency Departments, Critical / Coronary Care units and consultant led beds at Barrow and Lancaster plus a Primary Care Assessment Service with GP led inpatient beds in Kendal. All three sites provide a range of planned care, including outpatients, diagnostics, therapies, day case and inpatient surgery. In addition a range of local outreach services and diagnostics are provided from a number of community facilities.

The Trust is fully aware of the responsibilities it bears towards patients, employees and the local community and as such, we have a strict set of ethical values that we use as guidance with regard to our commercial activities. We therefore expect that all suppliers to the Trust adhere to the same ethical principles.

In compliance with the consolidation of offences relating to trafficking and slavery within the Modern Slavery Act 2015, the Trust is currently reviewing its supply chains with a view to confirming that such behaviour is not taking place.

To date we have:

- Reviewed our supply chain and identified general potential areas of risk including:
  - Provision of Food
  - Construction
  - Cleaning
  - Clothing (work wear)
- We have contacted the suppliers within these Supply Chains and have asked them to confirm that they are compliant with the Act; and
- Contacted our key suppliers and requested confirmation from them that they too are compliant with the Act.

We will also be:

- Introducing a 'Supplier Code of Conduct' and asking all existing and new suppliers to confirm their compliance; and
- Adding evidence gathering questions into our tendering procedures.

Advice and training about slavery and human trafficking is available to staff through the Safeguarding Team.

Statement of Accounts Officer's Responsibilities

The Statement of the Chief Executive's Responsibilities as the Accounting Officer of University Hospitals of Morecambe NHS Foundation Trust is given in Annex D.

Annual Governance Statement

The Annual Governance Statement is given in Annex F.

Council of Governors' Report

Under the National Health Service Act 2006 Foundation Trusts must make arrangements to establish a Council of Governors. The Council of Governors is responsible for representing the interests of NHS Foundation Trust members and partner organisations in the local health economy.

The Council has the following three main roles:-

i) **Advisory** – to communicate with the Board of Directors the wishes of members of the Trust and the wider community;
ii) **Guardianship** – to ensure that the Trust is operating in accordance with its Constitution and is compliant with its authorisation; and
iii) **Strategic** – to advise on a longer-term direction to help the Board effectively determine its policies.

The essence of these roles is elaborated on within NHS Improvement's document entitled "*Your Statutory Duties – A reference guide for NHS Foundation Trusts Governors".* This document is provided to all Governors.

The specific statutory powers and duties of the Council of Governors, which are to be carried out in accordance with the Trust's Constitution and the Foundation Trust's Provider Licence, are as follows:-

- To agree with the Nominations Committee a clear process for the nomination of a new Chairperson and Non-Executive Directors;
- To appoint or remove the Chairman and other Non-Executive Directors;
- When considering the appointment of a Non-Executive Director the Council takes into account the views of the Board and the Nominations Committee on the qualifications, skills and experience required for each position;
- To approve the appointment (by the Non-Executive Directors) of the Chief Executive;
- To decide the remuneration and allowances, and the other terms and conditions of office, of the Non-Executive Directors;
- To appoint or remove the Foundation Trust's External Auditor;
- To appoint or remove any other External Auditor appointed to review and publish a report on any other aspect of the Foundation Trust's affairs;
- To be presented with the Annual Accounts, any report of the External Auditor on the Annual Accounts and the Annual Report;
- To provide their views to the Board of Directors when the Directors are preparing the documents containing information about the Foundation Trust's forward planning;
- To respond as appropriate when consulted by the Board of Directors in accordance with the Constitution;
- To undertake such functions as the Board of Directors shall from time to time request;
- To prepare and, from time to time, review the Foundation Trust's Membership Strategy and its policy for the composition of the Council of Governors and of the Non-Executive Directors and, when appropriate, to make recommendations for the revision of the Trust's Constitution;
- Hold the Non-Executive Directors, individually and collectively, to account for the performance of the Board of Directors;
- Represent the interests of the members of the Trust as a whole along with the interests of the public,
- Approve "significant transactions", (As defined in the current Constitution);
- Approve an application by the Trust to enter into a merger, acquisition, separation or dissolution;
- Decide whether the Trust's non-NHS work would significantly interfere with its principal purpose, which is to provide goods and services for the health service in England, or performing its other functions,
- Approve amendments to the Trust's Constitution; and
- Periodically assess the collective performance of the council and communicate to members and the public how their responsibilities have been discharged.

The Council of Governors and the Board of Directors continue to work together to develop an appropriate and effective working relationship. Board members regularly attend Council of Governors Meetings to ensure that the Board achieves an understanding of the Governors' and Members' views about the Trust.

The Council of Governors comprises a total of 31 Governors as follows:-

Elected Governors Constituency / Class to be elected	Number of Governors to be elected
Public Constituency	
Area 1 – Barrow and West Cumbria	4
Area 2 – Lancashire and North West of England and North Yorkshire	7
Area 3 – South Lakeland and North Cumbria	6
Staff Constituency	
Class 1 – Registered medical practitioners and dentists	1
Class 2 – Registered nurses, midwives and operating department practitioners	2
Class 3 – Allied Health Professionals	1
Class 4 – Estates and Ancillary	1
Class 5 – Management and administration	1
Total Elected Governors	**23**

Appointed/Partner Governors Sponsoring Organisation	Number of Governors to be appointed
Healthwatch Groups	
Healthwatch Lancashire	1
Healthwatch Cumbria	1
Local Authority	
Cumbria County Council	1
Lancashire County Council	1
Partnership Organisations	
Local Universities	
The University of Lancaster	1
Community Organisations	
Cancer Care	1
Age UK	1
Cumbria Partnership NHS FT	1
Total Appointed/Partner Governors	**8**

Total Membership Of Council of Governors
Appointed/Partner Governors – 3 (currently five vacancies)
Staff Governors (elected) – 6
Public and Patient Governors (elected) - 17
Total membership of Council of Governors – 26 (currently five vacancies)

In August 2017, the Council of Governors agreed to extend governors' terms of office due to end on 30 September 2017 until 31 March 2018, when the review of the trust Constitution had been completed.

Membership of the Trust's Council of Governors is set out below:

Name	Constituency/Organisation	Date of Appointment and Term of Office
Public Governors		
Shahnaz Ashgar	Barrow & West Cumbria	1 October 2015 for 3 Years
Dave Waddington	Barrow & West Cumbria	1 October 2015 for 3 Years
Leslie Hall	Barrow & West Cumbria	1 October 2016 for 3 Years
Peter Taylor	Barrow & West Cumbria	22 February 2016 for 3 Years
Jim Wood	Lancashire & North Yorkshire	1 October 2016 for 3 Years
Janet Hamid	Lancashire & North Yorkshire	1 October 2014 for 3 years (extended until 31 March 2018)
Philip Hodge	Lancashire & North Yorkshire	1 October 2014 for 3 years (extended until 31 March 2018)
Val Richards	Lancashire & North Yorkshire	1 October 2016 for 3 Years
John Pearson	Lancashire & North Yorkshire	1 October 2016 for 3 Years
Arthur Jones	Lancashire & North Yorkshire	1 October 2016 for 3 Years
Colin Hartley	Lancashire & North Yorkshire	1 October 2014 for 3 years (extended until 31 March 2018)
David Stamp	South Lakeland & North Cumbria	1 October 2016 for 3 Years
George Butler	South Lakeland & North Cumbria	1 October 2016 for 3 Years
Colin Ranshaw	South Lakeland & North Cumbria	1 October 2014 for 3 years (extended until 31 March 2018)
Roger Titcombe	South Lakeland & North Cumbria	1 October 2015 for 3 Years
Annette Miller	South Lakeland & North Cumbria	1 October 2015 for 3 years
David Wilton	South Lakeland & North Cumbria	12 April 2016 for 3 years
Staff Governors		
Steve Cvijanovic	Allied Health Practitioners	1 October 2015 for 3 years
Glyn Davies	Estates & Ancillary	1 October 2015 for 3 Years
Ben Hignett	Management & Admin	1 October 2015 for 3 Years
Karnad Krishnaprasad	Medical Practitioner	1 October 2014 for 3 Years (extended until 31 March 2018)
Peter Taylor	Registered Nurses, Midwives & Operating Department Practitioners	24 April 2015 for 3 years
Chris Norman	Registered Nurses, Midwives & Operating Department Practitioners	1 October 2016 for 3 years
Appointed/Partner Governors		
Cllr Anne Burns	Cumbria County Council	1 June 2016 for 3 Years
Alison Dixey	Cancer Care	1 October 2015 for 3 years
Hugh Tomlinson	Age UK South Lakeland	1 October 2015 for 3 years

Resignations

Public Governors: None

Appointed/Partner Governors: Sonya Clarkson, Lancaster University (ceased employment)
Darren Clifford, Lancaster County Council

Staff Governors: None

There have been no removals of any Governors from the council within the last financial year.

Meetings of the Council of Governors

Meetings of the Council of Governors took place on the following dates in 2017/18:-

23 May 2017
8 August 2017
3 October 2017
20 December 2017
23 January 2018

Attendance at Council of Governors Meetings

Governor Attendance	
Governors	**Number of Meetings (5)**
Shahnaz Ashgar	5
Dave Waddington	3
Leslie Hall	1
Peter Taylor, Public Governor	3
David Wilton	5
Jim Wood	5
Janet Hamid	5
Philip Hodge	5
Val Richards	4
John Pearson	5
Arthur Jones	4
Colin Hartley	4
David Stamp	3
George Butler	4
Colin Ranshaw	5
Roger Titcombe	5
Annette Miller	5
Steve Cvijanovic	2
Glyn Davies	2
Karnad Krishnaprasad	3
Chris Norman	1
Peter Taylor, Staff Governor	0
Ben Hignett	4
Cllr Anne Burns	1
Alison Dixey	5
Hugh Tomlinson	0
Sonya Clarkson (end date – 19 January 2018)	0

As requested by the Council of Governors, the above governors with poor attendance have been contacted by the Chair. The Council will continue to monitor attendance.

Governor Expenses

The total expenses claimed by Governors are as follows:-

Year	Total number of Governors as at 31 March	Number of Governors receiving expenses	Total Sum of Expenses
2016/17	28	17	£12,469.40
2017/18	28	15	£12,212.14

Overview of the Work of the Council of Governors

Governors

The Head Governor is Colin Ranshaw. The Deputy Head Governor is George Butler.

The Council of Governors met on a bimonthly basis with two joint meetings with the Board of Directors, two joint meetings with Non-Executive Directors, and extra meetings where required.

The Council of Governors was supported by the following Sub Groups and Committees:

- Finance and Planning Group;
- Quality and Patient Experience Group;
- Foundation Trust Membership and Communications Group;
- Nominations Committee; and
- Auditor Appointments Committee.

The Chief Executive, Deputy Chief Executive, Director of Governance, Non-Executive Directors and Trust staff regularly attend meetings of the Council of Governors and its Sub Groups to present appropriate reports and provide information on the Trust's performance to enable the Council of Governors to discharge its duties effectively.

During 2017/18, the Council of Governors and its Sub Groups and Committees received and considered reports on a number of issues including:-

- The Trust's Transition Plan and Two year Operational Plan;
- Annual Report and Accounts;
- Quality Account and Extended Audit Report on the Quality Accounts;
- Budget and Financial Information;
- Performance Information;
- Open and Honest Care;
- Communications and Membership reports;
- Membership Strategy;
- Trust Constitution;
- Serious Untoward Incidents Update;
- Patient Relations Update (PALS, Compliments and Complaints); and
- Accountable Care Organisation / Better Care Together.

Governors have also been involved in or attended the following meetings/events:-

- Annual Members' Meeting 2017;
- Trust Board as observers;
- CQC Mock Inspections;
- Governors' Informal Meetings;
- Infection Prevention & Control Committee;
- Quality Committee as observers;
- Finance Committee as observers;
- Workforce Committee as observers;
- Membership and Recruitment – talks/governor presentation;
- Senior management recruitment focus groups; and
- Estates and Facilities Committee;

In addition, Governors have participated in external events as organised by the Foundation Trust Network and the North West Governors' Forum.

The Council of Governors provide Membership Talks and hold engagement events across public, voluntary and commercial sectors. This enables Governors to consult with and understand the views of members and the public.

Code of Conduct

All Governors have read and signed the Trust's Code of Conduct which includes a commitment to actively support the NHS Foundation Trust's Vision and Values and to uphold the Seven Principles of Public Life, determined by the Nolan Committee.

Material Interests and the Register of Governors

All Governors have declared their relevant and material interests and the Register of Interests is available for inspection by members of the public via the Trust's website here or the Company Secretary at the following address:-

Address: Trust Headquarters
Westmorland General Hospital
Burton Road
Kendal
LA9 7RG

Telephone: 01539 715314

Email: paul.jones4@mbht.nhs.uk

Any member of the public wishing to make contact with a member of the Council of Governors should, in the first instance contact the Company Secretary.

Council of Governors' Nominations Committee

Role of the Nominations Committee

The Nominations Committee has the following responsibilities:-

Recruitment and Appointment of Non-Executive Directors:-

- To agree the skill mix and process for the appointment of Non-Executive Directors, in accordance with the Trust's Terms of Authorisation and NHS Improvement's requirements;
- To draw up person specifications for each of these posts to take account of general and specific requirements in terms of roles and responsibilities;
- To determine a schedule for advertising, shortlisting, interview and appointment of candidates with requisite skills and experience. This will include identification of appropriate independent assessors for appointment panels; and
- To recommend suitable people for appointments to be ratified by the Council of Governors.

Terms and Conditions – Chair and Non-Executive Directors:-

- To recommend salary arrangements and related terms and conditions for the Chairman and Non-Executive Directors for agreement by the Council of Governors based upon the time commitments and responsibility of their role and having regard to external professional advice.

Performance Management and Appraisal:-

- To agree a mechanism for Non-Executive Directors appraisal by the Trust Chairman and feedback to the Council of Governors; and
- To agree a mechanism for the evaluation of the Trust Chairman, led by the Senior Independent Director.

Membership of the Nominations Committee

The membership of the Nominations Committee comprises the Chairman, the Senior Independent Director and six Governors:

Pearse Butler (Chair of the Committee)
Denis Lidstone (Senior Independent Director)
Shahnaz Asghar Public Governor,
George Butler Public Governor,
Steve Cvijanovic, Staff Governor,
Janet Hamid Public Governor,
Philip Hodge Public Governor,
Colin Ranshaw, Head Governor

Meetings of the Nominations Committee:-

There have been several meetings of the Nominations Committee during 2017/18.

The Committee undertook the review of the process for appointment of two Non-Executive Directors and the re-appointment of one Non-Executive Director, Jacqueline Telfer.

Chairman and Non-Executive Director Appraisals

The Committee established a mechanism for Non-Executive Directors appraisal by the Trust Chairman and a mechanism for the evaluation of the Trust Chairman, led by the Senior Independent Director and the Head Governor. The Committee received the 2016/17 reports from the Chairman.

The overall average assessment for the Chair and Non-Executive directors was 4, resulting in all non-executive members meeting the expected requirements, if not exceeding requirement. There were no significant areas of concern. Individual Development Plans and Objectives were agreed.

Membership Report

Membership Strategy

The Trust is required under the Foundation Trust Code of Governance to keep under review its Membership Strategy to establish, develop and maintain an active membership. The Trust must also establish relations with stakeholders and create a dialogue with members, patients and the local community.

The specific requirements are:-

- The board of directors should appropriately consult and involve members, patients and the local community;
- The council of governors must represent the interests of Trust members and the public; and
- Notwithstanding the complementary role of the governors in this consultation, the board of directors as a whole has responsibility for ensuring that regular and open dialogue with its stakeholders takes place.

A new Membership Strategy was approved by the Council of Governors on 3 October 2017 and by the Board of Directors on 29 November 2017.

The revised Strategy seeks to support the Council of Governors in achieving these requirements.

The delivery of the Strategy will be achieved through the integration of the specific actions into the core business of the Trust.

Recruitment of Members

In order to maintain our membership level and in order to recruit new public members, we have implemented various initiatives over the past year. These include:

- Membership information displayed at entrances to hospitals and in outpatient departments;
- Membership Talks;
- Governor presentations in the community;
- Recruitment Stands at key locations across the Trust;
- Distribution of recruitment posters and leaflets to GP surgeries;
- Continue to use the Trust's Facebook social network site to engage and inform members and the wider public of developments and events at the Trust; and
- The Trust has a Membership Officer who acts as link between the members and the Trust.

Retention of Members

The Trust recognises the importance and value of a representative membership and has continued to focus on and progress opportunities for the engagement and retention of existing members.

It is particularly important to the Trust to not only build its membership, but to ensure that the membership is being fully utilised.

Numerous and varied initiatives have taken place over the last year to retain our existing members.

- Introduction of a new electronic Newsletter;
- All members were invited to the Public Governor Meetings throughout the year and to the Annual Members' in September 2017; and
- Continue to keep members up-to-date with events at the hospital, such as the health seminars which included a talk on stroke prevention and using the Emergency Department, official openings of new facilities which included the new maternity unit at Furness General Hospital and fundraising activities via email and social media.

Over the next 12 months we will continue to look at new and fresh ways of promoting the benefits of membership in order to maintain and increase our total membership in accordance with the plans set out in the Membership Strategy.

Public Members

The Public Constituency consists of the electoral wards that have been grouped into three areas as follows:-

Area 1 - Barrow and West Cumbria

Area 2 - Lancashire, North West of England and North Yorkshire

Area 3 - South Lakeland and North Cumbria.

Membership is open to all members of the public who are aged 16 or over and who live within these boundaries

Staff Members

An individual who is employed by the Trust under a contract of employment with the Trust will automatically become or continue as a member of the Trust, unless they choose to opt out.

Trust volunteers are eligible to become members under the public constituency.

Further Information on Membership

The membership office can be contacted:

How to contact the Membership Office

By email: FTmembershipOffice@mbht.nhs.uk

By phone: 01229 404 473 (Please leave a voice mail message if the administrator is away)

By post: Foundation Trust Office, Admin Block, Furness General Hospital, Dalton Lane, Barrow-in-Furness, LA14 4LF

Membership Profile

The membership of the Trust as at 31 March 2018 was as follows:-

Age	Public	Staff	Total
0-16	0	0	0
17-21	33	224	257
22+	4,310	6,517	10,827
Not stated	1,510	0	1,510
Total	5,853	6,741	12,594

The Trust is required to have a memberhsip which is representative of the area which it serves.

Gender	Public	Staff	Total
Unspecified	62	2,393	2,455
Male	2,173	792	2,965
Female	3,618	3,556	7,174

Ethnicity	Public	Staff	Total
White - English, Welsh, Scottish, Northern Irish, British	4,193	3,883	8,076
White - Irish	20	9	29
White - Gypsy or Irish Traveller	0	0	0
White - Other	33	97	130
Mixed - White and Black Caribbean	0	5	5
Mixed - White and Black African	10	5	15
Mixed - White and Asian	12	22	34
Mixed - Other Mixed	15	8	23
Asian or Asian British - Indian	19	64	83
Asian or Asian British - Pakistani	7	17	24
Asian or Asian British - Bangladeshi	0	2	2
Asian or Asian British - Chinese	12	6	18
Asian or Asian British - Other Asian	15	17	32
Black or Black British - African	5	6	11
Black or Black British - Caribbean	0	2	2
Black or Black British - Other Black	1	3	4
Other Ethnic Group - Arab	0	0	0
Other Ethnic Group - Any Other Ethnic Group	10	18	28
Not stated	1,501	2,577	4,078

Acorn Socio-Economic Category	Public	Staff	Total
Lavish Lifestyles [A]	24	30	54
Executive Wealth [B]	718	724	1,442
Mature Money [C]	1,125	1,013	2,138
City Sophisticates [D]	16	15	31
Career Climbers [E]	78	196	274
Countryside Communities [F]	737	585	1,322
Successful Suburbs [G]	373	520	893
Steady Neighbourhoods [H]	453	743	1,196
Comfortable Seniors [I]	467	360	827
Starting Out [J]	146	339	485
Student Life [K]	60	123	183
Modest Means [L]	584	791	1,375
Striving Families [M]	253	356	609
Poorer Pensioners [N]	224	157	381
Young Hardship [O]	336	537	873
Struggling Estates [P]	70	118	188
Difficult Circumstances [Q]	93	102	195
Not Private Households [R]	34	20	54
Not available [NA]	62	12	74

Office for National Statistics NHSI Classifications	Public	Staff	Total
AB	1,617	1,797	3,414
C1	1,686	2,004	3,690
C2	1,255	1,476	2,731
DE	1,226	1,451	2,677

Part 1: Statement on Quality from Aaron Cummins, Chief Executive

Introduction

I am pleased to present to you our Quality Account for 2017/18, which is an annual review of the quality of NHS healthcare services provided by University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBFT) during 2017/18. It also outlines the key priorities for improvement to be undertaken in 2018/19. The Quality Report incorporates all of the requirements of the *Quality Accounts Regulations* as well as including a number of additional reporting requirements set by NHS Improvement as detailed below.

Part 1: Statement on quality from the Chief Executive of the NHS Foundation Trust
This section includes a statement by the Chief Executive explaining the importance of quality to the Trust, and provides an overview of achievements in quality.

Part 2: Priorities for improvement and statements of assurance from the Board
This section includes a review of the Trust's performance against the priorities set for the 2017/18 Quality Account; the priorities for improving the quality of services in 2018/19 that were agreed by the Board of Directors in consultation with stakeholders; and the legislated statements of assurance from the Board of Directors.

Part 3: Other information
This section contains an overview of the quality improvement work which has taken place across the organisation during 2017/18. The section provides detailed information and commentary on a selected range of improvement areas relating to patient safety, clinical effectiveness and patient experience.

Part 4: Appendices
This section contains details of formal feedback from local organisations and stakeholders; Statement of Directors' Responsibilities and a glossary of abbreviations and terms.

Statement on Quality

The University Hospitals of Morecambe Bay NHS Foundation Trust aims to be one of the safest organisations within the NHS with our staff committed to providing safe, high quality care to patients all of the time. This Quality Account highlights some of the work that has been undertaken in 2017/18. It includes an overview of the quality improvements and achievements we have made in 2017/18 and sets out our priorities for quality improvement for 2018/19.

2017/18 has been a challenging year as demand for our services continued to place pressure on our services and staff and this has meant financial and operational targets have not been met consistently. However, it is testament to the hard work and dedication of all our staff that we have continued to deliver safe, effective quality care.

We continue to make improvements in performance against the quality indicators with monthly reporting to the Trust's Quality Committee and details of performance against these priorities is referenced at Part 2, page 111 of this document. Over the last 6 months, both Hospital Standardised Mortality Ratio (HSMR) and Standardised Hospital Mortality Indicator (SHMI) have showed significant improvements and also in other indicators of

Methicillin-Resistant Staphylococcus Aureus (MRSA), Clostridium Difficile Toxin (CDT), falls and pressure ulcers.

Whilst we continue to receive and learn from complaints about our services, we are delighted that, taking into account agreed extension that is in line with Trust policy, the average complaint response time is 31.34 days against a target of 35 days. The Trust responded to 98.6% of complaints within 35 working days in 2017/18.

The weekly Patient Safety Summit continues to be recognised regionally and nationally and the Good Governance Institute commended it as an exemplar Patient Safety Initiative. The process ensures that all moderate and above harms are reviewed at the earliest possible juncture by senior medical, nursing and others to identify and mitigate further risk.

Our risk profile remains healthy. The Trust has systems and processes in place to protect people from harm with robust reporting, feedback and learning from incidents. This is something that the Trust has worked hard to achieve and, as an organisation, we produce monthly organisational Learning to Improve Bulletins, special edition Learning to Improve Bulletins and divisions also produce service specific Learning to Improve Bulletins. The CQC quality reports also acknowledged the improvement in staffing since the last inspection, although noting there are still nursing and medical vacancies throughout the Trust.

"Providers of acute services are asked to include a statement regarding how they are implementing the priority clinical standards for seven day hospital services: *https://improvement.nhs.uk/resources/seven-day-services/* "

The Trust was one of the first acute trusts to appoint a Freedom to Speak up Guardian and has also launched a telephone App to support the raising of concerns. Details of the concerns raised and actions can be found in the section 'Other Additional Information in Relation to The Quality of NHS Services' within this document.

Our Quality Improvement Strategy 2016-19 outlines a 3 year plan and reiterates the Board of Directors commitment to delivering high standards of safe, quality care to our patients, as well as providing a working environment and culture which promotes and welcomes honesty, safety first, openness and compassion in everything we do.

2018/19 will be another challenging year for the University Hospitals of Morecambe Bay NHS Foundation Trust as we focus on delivering the best in care and achieving outcome and access targets alongside ever increasing demand for our services coupled with tighter financial constraints. The Trust will continue working with regulators, commissioners, healthcare providers and other organisations to influence future models of care delivery and deliver further improvement to quality during 2018/19.

The areas we have chosen as our quality improvement priorities for 2018/19 have been set following consultation with our Governors, local health scrutiny committees, local Healthwatch, healthcare user groups, our Commissioners and importantly, by talking to staff, patients and carers.

Progress described within this document is based on data and evidence collected locally and nationally, much of which is presented as part of our performance framework each month and in our public board meetings, Council of Governors meetings and to our Commissioners.

To the best of my knowledge the information in the document is accurate and provides a balanced account of the quality of services we provide.

Aaron Cummins
Chief Executive

Date: 25 May 2018

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

2.1 Priorities for improvement
Quality Achievements in our 2017/18 priorities as set out in the 2016/17 Quality Account

In this section, the Trust's performance in 2017/18 is reviewed and compared to the priorities that were published in the Trust's Quality Account in 2016/17.

This section tells you about the quality initiatives we progressed during 2017/18 and how we performed against the quality improvement priorities we set ourselves last year.

A programme of work was established that corresponded to each of the quality improvement areas we targeted. Each individual scheme within the programme has contributed to one, or more, of the overall performance targets we have set. Considerable progress and improvements have been delivered through staff engagement and the commitment of our staff through 'Listening into Action' schemes to make improvements.

Wherever applicable, the report will refer to performance in previous years and comparative performance benchmarked data with other similar organisations. This will assist you to understand progress over time and is a means of demonstrating performance compared to other Trusts. Therefore, this will enable you to understand whether a particular number represents good or poor performance. Wherever possible, references to the data sources for the quality improvement indicators will be stated within the body of the report or within the Glossary of Abbreviations and Glossary of Terms, including whether the data is governed by national definitions.

Please note that some 2016/17 comparators may differ than the Quality Accounts 2016/17 dated 26 May 2017 due to national and local Trust data not being finalised.

We are pleased to report the significant progress made against our priorities. An overview of performance targets in relation to the priorities for quality improvement that were detailed in the 2016/17 Quality Account is provided in Table 1, below. A more detailed description of performance against these priorities for patient safety, clinical effectiveness and the patient experience will be reported on in detail in Part 3, Section 3.4.

Table 1: Performance Against Trust Priorities 2017/18							
Key	Target Achieved / On Plan	Close to Target	Behind Plan	2014/15	2015/16	2016/17	Target 2017/18
Priority 1: Patient Safety							
Improvement Outcome 1 – Care that is safe							
Reducing Harm							
Achieve at least 98% of patients receiving Harm Free Care, consistent across every ward by 2019		Achieve 98% Harm Free Care 2017/18 to 2018/19		Not reported in 2014/15	92.71%	93.61% At Mar 17 93.37% 2016/17 Average	April 2017 to March 2018 was 97.8% (January data for new harms)
Reduction in variation of observations leading to better outcomes		Embed the National Early Warning Score (NEWS) and monitor through audit tools		Not reported in 2014/15	Not reported in 2015/16	Not reported in 2016/17	NEWS embedded and audited
Reducing Clinical variation in identified areas		Develop data systems to help to review a variation by site, specialty and clinician level which will be monitored through Trust dashboards.		Not reported in 2014/15	Not reported in 2015/16	Not reported in 2016/17	Dashboards developed
The use Remembrance as a tool to improve patient safety and experience		Bring together, through the Patient Safety Unit, key partners to ensure that learning and remembrance underpin all events and awards throughout the year.		Not reported in 2014/15	Not reported in 2015/16	Not reported in 2016/17	Completed: Remembrance events held, remembrance garden created.
Improving Documentation							
Delivery of E-Nursing Documentation across all In-Patient Wards		E-Nursing Documentation implemented in all In-patient Wards		Not reported in 2014/15	Not reported in 2015/16	100%	100%
Reducing Avoidable Mortality							
Maintain scores consistently in the 'statistically as expected' range, or better, for both the HSMR and SHMI measures		HSMR of 98 or less		92	90	97 (As at Feb 2017)	77 (to Dec 2017)
		5-10 % better than National Average		Not reported in 2014/15	Not reported 2015/16	2-5 better than National Average	5-10% better than National Average: 98.77
		SHMI within expected statistical range		101	99	123 (As at Dec 2016)	86.85
		2-5 better than National Average		Not reported in 2014/15	Not reported 2015/16	2-5 better than National Average	5-10% better than National Average 90.4
Stroke mortality reduced to 75 or fewer deaths per annum (as a result of admissions for stroke as a primary diagnosis)		75 Deaths or fewer in 2017/18 and 2018/19		Not reported in 2014/15	Not reported in 2015/16	115	94
Priority 2: Clinical Effectiveness							
Improvement Outcome 2 – Care that is clinically effective							
Deliver Effective and Reliable Care							
Introduction of Care bundles		Two of the four Care Bundles to be established		Not reported in 2014/15	Not reported in 2015/16	AKI and Stoke Care underway	Care Bundles: AKI Frail Elderly Unit Sepsis Stroke established and operational
Development of a Patient Safety Unit		Patient Safety Unit established and operational		Not reported in 2014/15	Not reported in 2015/16	Unit established and fully operational in Oct 2016	Unit established and fully operational in Oct 2016
Ward Accreditation scheme		The Trust will scope and develop a programme plan to support implementation of the Ward Accreditation scheme in 2017/18. Ward Accreditation takes at least 2 years to implement • Implementation roll out 2017/18		Not reported in 2014/15	Programme plan completed Quality Assurance Matron appointed and in post	Accreditation Scheme now active in 25 Inpatient Depts. /Wards and 5 Outpatient Depts. 22 wards at 'Green' Standard. 8 at 'Amber' Standard 10 wards have maintained 'Green' Standard for two assessments	Accreditation Scheme now active in 50 Inpatient Depts. /Wards and 5 Outpatient Depts. 21 wards at 'Green' Standard. 13 at 'Amber' Standard 10 wards have maintained 'Green' Standard for two assessments 2 wards have achieved exemplar standard

Table 1: Performance Against Trust Priorities 2017/18							
Key	Target Achieved / On Plan	Close to Target	Behind Plan	2014/15	2015/16	2016/17	Target 2017/18
Ward Accreditation scheme cont.							
		5% of inpatient wards at Exemplar standard by 2017/18		Not reported in 2014/15	Not reported in 2015/16	Not reported in 2016/17	4% (2 of 50) wards achieved
		Quality Assurance & Assessment System in progress in all Outpatient areas.		Not reported in 2014/15	Not reported in 2015/16	Not reported in 2016/17	5 Outpatient areas implemented
Sharing Lessons Learned from Patient Safety Incidents		12 Standard Bulletins		Not reported in 2014/15	Not reported in 2015/16	12 Standard Bulletins	12 Standard Bulletins
		6 Themed Bulletins per annum		Not reported in 2014/15	Not reported in 2015/16	7 Bulletins	6 Bulletins
		Safe incidents: Audit of Lessons Learned		Not reported in 2014/15	Not reported in 2015/16	Audit of Lessons Learned completed	Audit of Lessons Learned completed
Commissioning for Quality and Innovation (CQUIN)		Develop and maintain 95% delivery as a minimum for 2017/18		94%	76%	92%	98%
Priority 3: Patient Experience							
Improvement Outcome 3 – Care that provides a positive experience for patients							
Improvement in Patient Flow and Experience							
Re-alignment of services for Stroke Patients		Integrated stroke unit to be established and operational		Not reported in 2014/15	Not reported in 2015/16	Building and 'fit out work' completed in Jan 2016, recruitment underway, expected to be operational in Q1 2017/18	Integrated Stroke Unit established and operational
The Trust is described as provider of choice for Consultants under 'I Want Great Care'		Inpatient areas to maintain Healthcare Communications (HCC) (previously IWGC)		Not reported in 2014/15	Achieved 100% (IWGC)	Achieved 100% (HCC)	Achieved 100% (HCC)
		IWGC introduced in to Consultant experience feedback in at least one speciality		Not reported in 2014/15	IWGC introduced to Consultant experience feedback	95% of Consultants registered on IWGC. 23% of Consultants Active on IWGC. Used in Ophthalmology Reviews.	Achieved
		Embed IWGC in to Consultant experience feedback		Not reported in 2014/15	Not reported in 2015/16	Not reported in 2016/17	Reviews for all clinicians are now accessible under clinic titles and departments
Reduce Formal Complaints and improve complaints response timescales		Maintain complaint levels below a ratio of 1 Complaint per 1,000 patient attendances (Equivalent to 0.1%)		Not reported in 2014/15	Not reported in 2015/16	0.73 complaints per 1,000 patient attendances	0.52 complaints per 1,000 patient attendances
		100% of complaints acknowledged within 3 days		100%	100%	100%	100%
		95% of complaints to be responded to within 35 days		97.1%	97.2%	97.7%	98.6%
Increase the scope and depth of public engagement		6 public engagement events 2017/18 to 2018/19		Not reported in 2014/15	Not reported in 2015/16	13 Events held	15 Events held
Integration of Physical and mental health pathways		Quarter 4 of 16/17 will see development		Not reported in 2014/15	Not reported in 2015/16	Not reported in 2016/17	Achieved
		April 2017 7 day Child and Adult Mental health Service (CAMHS) support		Not reported in 2014/15	Not reported in 2015/16	Not reported in 2016/17	6 day service achieved
		A Mental Health Matron working across The Orchard and the Emergency Department at the Royal Lancaster Infirmary		Not reported in 2014/15	Not reported in 2015/16	Not reported in 2016/17	Achieved
		Baseline outcomes measured reported to ENACT		Not reported in 2014/15	Not reported in 2015/16	Not reported in 2016/17	Complete
Advice and Guidance for Nursing Homes		Agreement on early priorities that incorporate local need with high service pressure further collaboration and development of patient pathways to improve safety and experience. Measure to be developed to demonstrate the impact of the service.		Not reported in 2014/15	Not reported in 2015/16	Not reported in 2016/17	Achieved

Table 1: Performance Against Trust Priorities 2017/18							
Key	Target Achieved / On Plan	Close to Target	Behind Plan	2014/15	2015/16	2016/17	Target 2017/18
Building relationships and improve participation by the people who use and care about our NHS services		Develop a strategy to involve service users in service planning and delivery. Monitor staff and user satisfaction via survey.		Not reported in 2014/15	Not reported in 2015/16	Not reported in 216/17	Engagement Strategy developed
Improve Staff Experience							
Increase voice for staff in how their organisation can be improved		60% of key result areas in the better than average/best 20%		Not reported in 2014/15	Not reported in 2015/16	Not reported in 2016/17	56%
		Staff ability to contribute to improvements at work (65%)		67%	65%	69%	69%
		Staff recommendation of the Trust as a place to work or receive treatment (3.39 out of 5)		3.47 out of 5	3.72 out of 5	3.73 out of 5	3.79 out of 5
		Staff motivation at work (3.76 out of 5)		3.81 out of 5	3.95 out of 5	3.90 out of 5	3.90 out of 5
		Overall Staff Engagement Figure		3.65 out of 5	3.78 out of 5	3.78 out of 5	3.79 out of 5

2.1.2 Selected Priorities for Quality Improvement in 2018/19

This section tells you about how we prioritised our quality improvements for 2018/19. This section also includes the reason for the selection of these priorities and how the views of patients, the wider public, and staff were taken into account. Information on how progress to achieve the priorities will be monitored, measured and reported is also outlined in this section.

2.1.3 How we prioritised and consulted on our selection of Quality Improvements for 2018/19

On 19 February 2018, the Trust published a timetable for the process of developing the Quality Account for 2018/19, including consultation with stakeholders, our Governors and importantly, by talking to staff, patients and carers.

A draft Annual Quality Account was produced in March 2018 and circulated to stakeholders and Governors with a request to help identify quality improvement areas based on the Trust's Quality Improvement Strategy and Plan for 2016-19.

The Trust has taken the views of patients, relatives, carers and the wider public into account, for the selection of priorities for quality improvement, through the completion of feedback forms which are available from the Trust's website. The Governors were consulted during meetings of the Strategy Subgroup.

Other methods of obtaining the views of patients, public, staff and governors included feedback from local and national patient and staff surveys, information gathered from formal complaints, comments received through the Patient Relations Team and various local stakeholder meetings and forums.

Governors also obtained the views of patients, public and staff by obtaining feedback through monthly patient safety walkabout visits and monthly local Corporate Quality Reviews.

Listening to what our staff, governors, patients, their families and carers tell us, and using this information to improve their experiences, is a key part of the Trust's work to increase the quality of our services.

2.1.4 Rationale for the Selection of Priorities in 2018/19

In November 2015, the Trust published a three-year Quality Improvement Strategy 2016-19. The Quality Improvement Strategy described the Trust's quality vision and outcomes that the Trust must deliver in line with the NHS Outcomes Framework.

The priorities chosen link closely to the Trust's work with commissioners and are closely aligned to the Care Quality Commission (CQC) five domains of Safe, Effective, Caring, Responsive and Well Led organisations. They also link to work relating to improvements in patient safety and Commissioning for Quality and Innovation (CQUIN) priorities and are aligned to the Trust's Annual Plan.

The Trust's priorities for improvement encompass three equally important quality improvement elements. These are:

- **Better – Care that is safe**
  Working with patients and their families to reduce avoidable harm and mortality.

- **Care – Care that is clinically effective**
  Not just in the eyes of clinicians but in the eyes of patients and their families

- **Together - Care that provides a positive experience for patients, their families and our staff**
  As evidenced by the Friends and Family Test and Staff Surveys

The Trust has taken into account the feedback received from staff, governors and stakeholders when developing its priorities for quality improvement for 2016-19 and based on what it believes will have maximum benefits for our patients. The following quality improvement priorities referred to in our Quality Improvement Strategy 2016-19 was endorsed by the Board of Directors on 25 November 2015. The outcomes described in the Strategy will be those that will be used to provide assurance to the Board of Directors; commissioners; regulators; and to patients and staff, that the improvement goals we set are being achieved.

Please note, six Key Quality Improvement Priorities for 2018/19 have been taken from the Quality Improvement Strategy 2016-19, and an additional six Key Quality Improvement Priorities for 2018/19 were agreed through consultation with staff and stakeholders to be included in the Quality Accounts and approved by the Quality Committee on 19 March 2018 and subsequently on 16 April 2018 and these are detailed in Table 2 in bold italics.

Table 2: Priorities for Quality Improvement for 2018-19 detailed in Quality Improvement Strategy and Plan 2016-2019

Quality Goal	Key Priority	Measurable Outcome
Improvement Outcome 1 – Care that is safe		
Reducing Harm	Achieve at least 98% of patients receiving Harm Free Care, consistent across every ward as measured through analysis of incidents within the incident reporting system within 5 years.	***Achieve at least 98% Harm Free Care 2017/18 to 2018/19***
	Reduction in combined number of slips trips and falls in all harm categories. This is an overall reduction in the combined number	***Reduction in slips trips and falls in all harm categories Baseline taken from the past 12 months 2017/18 of data reported through NRLS rates of all harms by bed day broken down by harm category and ward***
	Reduction in variation of observations leading to better outcomes	Embed the revised (2018) National Early Warning Score (NEWS2) and monitor through audit tools to achieve 95% standard
		Reduction in StEIS reportable incidents that identify a failure in clinical escalation taken from 2016/17 baseline
Improving Documentation	Delivery of E-Nursing Documentation across all In-Patient Wards	***2017/18 to 2018/19 98% improving documentation. Improvement in e-nursing documentation quality outcomes***
Reducing Avoidable	Reducing the Summary Hospital-level Mortality Indicator	2017-18 to 2018-19 Mortality ratio to be 5-10% better than the national average

Table 2: Priorities for Quality Improvement for 2018-19 detailed in Quality Improvement Strategy and Plan 2016-2019		
Quality Goal	**Key Priority**	**Measurable Outcome**
Mortality	for HSMR & Summary Hospital-level Mortality Indicator (SHMI)	2017/18 to 2018/19 Stroke mortality reduced to 75 or fewer deaths per annum as a result of admissions for stroke as a primary diagnosis
Improvement Outcome 2 – Care that is clinically effective		
Deliver Effective and Reliable Care	Reduce E-coli infection rates in hospital wards.	***25% reduction in hospital E-coli infections against baseline data from 2016/17 by the end of 2018/19*** 2019/20 Target - 50% reduction of hospital *E-coli infections by 2020/21 from the 2016/17 baseline*
	Ward Accreditation scheme	***50% of Inpatient Wards at Exemplar Standard by 2017/18 to 2018/19***
		15% of Outpatients areas to achieve exemplar status by 2017/18 to 2018/19
	Sharing Lessons Learned from Patient Safety Incidents	2017/18 to 2018/19 12 Standard Bulletins and 6 Themed Bulletins per annum
	Safety Incidents	Audit of lessons learned at 6-12 months following publication of themed bulletins to measure lessons being learned
	Commissioning for Quality and Innovation (CQUIN)	Develop and maintain 95% delivery as a minimum for 2018/19
Improvement Outcome 3 – Care that provides a positive experience for patients		
Improvement in Patient Flow and Experience	Reduce Formal Complaints and continue to Improve complaints response timescales and commitment in handling complaints in a sensitive and professional manner from which learning is made and implemented across the divisions	Maintain complaint levels below a ratio of 1 Complaints per 1,000 patient attendances
		100% of complaints acknowledged within 3 days
		95% of complaints to be responded to within 35 days
	Increase the scope and depth of public engagement	6 public engagement events per annum
	Delivery of the SAFER Care Bundle which is fundamental to optimising flow and requires clinical leadership.	***The first two elements (S &A) needs to be delivered by doctors and ANPs, with the F & E being dependent on actions of the ward team.*** ***S – Senior Review. All patients will have a senior review before midday by a clinician able to make management and discharge decisions.*** ***A – All patients will have an Expected Discharge Date and Clinical Criteria for Discharge. This is set assuming ideal recovery and assuming no unnecessary waiting.*** ***F – Flow of patients will commence at the earliest opportunity from assessment units to inpatient wards. Wards that routinely receive patients from assessment units will ensure the first patient arrives on the ward by 10am.*** ***E – Early discharge. 33% of patients will be discharged from base inpatient wards before midday.*** ***R – Review. A systematic MDT review of patients with extended lengths of stay (> 7 days – 'stranded (>7 days – 'stranded patients') with a clear 'home first' mind-set.***
	Reduce avoidable referrals into hospital through increased uptake in advice and guidance to GPs	***10% reduction in avoidable referrals: this relates to absolute number of admissions avoided through advice and guidance in 2018/19 compared to 2017/18***

Table 2: Priorities for Quality Improvement for 2018-19 detailed in Quality Improvement Strategy and Plan 2016-2019		
Quality Goal	**Key Priority**	**Measurable Outcome**
	Work with local GP's and community nursing staff to reduce the number of patients who die in hospital against their wishes:	***Quarter 1 and Quarter 2: Develop a dataset to support delivery of admission reduction of people who have a wish to die in their care home and avoid admission to hospital through targeted support in homes.***
	Work with local nursing homes to reduce the number of patients who die in hospital against their wishes:	***Quarter 3 and Quarter 4: A decrease in the proportion of patients on the End of Life pathway who die in hospital when they expressed a wish to die at home***
	Integration of physical and mental health pathways	7-day CAMHS support for Cumbria and Lancashire North
	Healthcare Communications (was IWGC) embedded in to Consultant experience feedback	***Healthcare Communications embedded in to Consultant experience feedback in 5 specialities***
Improve Staff Experience	Increased voice for staff in how their organisation can be improved, monitored by the overall staff engagement figure identified in the Staff Survey	***Achievement of 60% on key result areas in the better than average/best 20% 2017/18 to 2018/19***

2.1.5 Commissioning for Quality and Innovation (CQUIN) Schemes in 2018/19

Working closely with our Commissioners, we have developed a comprehensive CQUIN programme for 2018/19 and beyond focusing on delivering key quality outcomes for patients, rather than process outcomes. The delivery of schemes will be via teams from across our Clinical Divisions supported by colleagues in Information Technology and Governance so that improvements are fully embedded in a sustainable way.

There are currently 15 CQUIN Schemes proposed for 2018/19. These are across a number of commissioning organisations including Morecambe Bay Clinical Commissioning Group (CCG), North Cumbria CCG, Specialist Commissioning and Public Health England.

Table 3 below lists the selected CQUIN schemes for 2018/19 that will be reported on in the Quality Account 2019/20.

Table 3: CQUIN Schemes for 2018/19	
National CQUIN Scheme	**Target**
Staff Health and Wellbeing	Improvement of health and wellbeing of NHS staff
Staff Health and Wellbeing	Healthy food for NHS staff, visitors and patients
Staff Health and Wellbeing	Improving the uptake of flu vaccinations for front line staff within Providers
Reducing the impact of serious infection	Timely identification of sepsis in emergency departments and acute inpatient settings
Reducing the impact of serious infection	Timely treatment for sepsis in emergency departments and acute inpatient settings
Reducing the impact of serious infection	Antibiotic Reviews
Reducing the impact of serious infection	Reduction in antibiotic consumption per 1,000 admissions
Improving service for people with mental health needs who present to A&E	Sustain the reduction in the number of attendances to A&E for those within the selected cohort of frequent attenders identified in 2017/18 who would benefit from mental health and psychosocial interventions Reduce total number of attendances to A&E by 10% for all people with primary mental health needs
Preventing Ill Health (Tobacco and Alcohol) Acute	All patients admitted for >1 day are screened, given brief advice, receive medication (if required) and offered referral onto specialist services.

Table 3: CQUIN Schemes for 2018/19	
Preventing Ill Health (Tobacco and Alcohol) Community	All patients admitted for >1 day are screened, given brief advice, receive medication (if required) and offered referral onto specialist services.
Offering Advice and Guidance	Implement Advice and Guidance services to cover a group of specialties responsible for at least 75% of GP referrals
Improving the Assessment of Wounds Community	Increase the number of full wound assessments for wounds which have failed to heal after 4 weeks
Personalised Care and Support Planning Community	Embedding personalized care and support planning for people with long term conditions
Regional CQUIN Scheme	**Target**
None identified	
Local CQUIN Schemes	**Target**
None applicable to the Acute Trust	
NHS England CQUIN schemes	**Target**
Adult Intravenous Anticancer Therapy (SACT)	Standardisation of chemotherapy doses
Medicines Optimisation	Support the procedural and cultural changes required to fully optimize the use of medicines commissioned by specialised services
Public Health England	**Target**
None identified	

The Trust will strive to maintain and improve upon its year on year significant improvement of CQUIN achievement. Our ambition for 2018/19 is to achieve a 95% delivery as a minimum, carrying this through into 2019/20.

2.1.6 Rationale for the Selection of Priorities to be removed in 2018/19

This section includes a list of areas that the Board of Directors have chosen to remove from the quality improvement priorities for 2018/19. The rationale for the de-selection of these priorities is that considerable progress and improvements have been delivered / put in place and other improvements have become a priority.

Information regarding the improvements made to demonstrate evidence for their removal is outlined in Part 3. It has been agreed to remove the following:

- Reducing clinical variation in identified areas
- The use of remembrance as a tool to improve patient safety and experience
- Introduction of Care bundles: Stroke, Specialist Elderly Frail Unit, Acute Kidney Injury, Sepsis
- Development of a Patient Safety Unit
- Re-alignment of services for Stroke Patients
- Advice and guidance for nursing homes
- Building relationships and improve participation by the people who use and care about our NHS services

2.1.7 How we will Monitor, Measure and Report on-going progress to achieve our priorities for quality improvement 2018/19

When identifying the quality improvement priorities for 2018/19 for the Trust, we do so with the expectation of reporting on them in future.

There will be a Governance Framework in place to support delivery of priorities for quality improvement and to demonstrate its impact on improved patient and staff experience:

- Each of the three outcomes: Better - Care that is safe; Care – Care that is clinically effective; Together - Care that provides a positive experience for patients, their families and our staff) will have a nominated board Executive Director lead.

- The Quality Committee and the Workforce Committee will be responsible for monitoring and reporting on-going progress to the Board of Directors regarding patient safety, clinical effectiveness, patient experience, staff surveys and front line engagement activities.
- Each Divisional Management Team will be responsible for the delivery, monitoring and reporting of progress against the key outcomes.
- Each work-stream will have a nominated lead to champion and ensure delivery of the improvements as agreed, supported by monitoring as required through the Project Management Office.
- Task and finish groups will be used to support any work-streams that are failing to achieve the improvement outcomes and the Executive Director leads will ensure that adequate support and training is available to deliver these.
- Governors will contribute to the oversight of the Quality Improvements.

The overall progress will be reported though the Quality Committee at each of its meetings which will be responsible for providing the Board of Directors with assurance that the improvements are being delivered. The priorities for quality improvement in 2018/19 will continue to be monitored and measured and progress reported to the Board of Directors by exception at each of its meetings as part of the updated performance quality reports and the Executive Dashboard. For priorities that are calculated less frequently, such as the staff survey, local staff survey and frontline engagement measures, these will be monitored at the Workforce Committee and will be monitored by the Board of Directors by the submission of an individual report.

The Trust has well-embedded delivery strategies already in place for all the quality priorities, and will track performance against improvement targets at all levels from Ward level to Board level on a monthly basis using the integrated performance report and dashboard at the Quality Committee. This will be augmented by and triangulated with soft-intelligence from stakeholders. Risks that arise through the day to day working towards the delivery of quality improvements will be monitored through the Corporate Risk Register and Divisional Risk Register process.

The Trust will also report on-going progress regarding implementation of the quality improvements for 2018/19 to our staff, patients and the public via our performance section of our website which can be accessed at the following link: http://www.uhmb.nhs.uk/about-us/key-publications/. You can visit our website and find up-to-date information about how your local hospitals are performing in key areas. We believe that the public have a right to know about how their local hospitals are performing in the areas that are important to them.

We are keen to build on the amount of data we publish, but we want to make sure that the information is what you want to see and that it is easy to understand. Please have a look at the web pages and let us know if there are any areas that could be improved http://www.uhmb.nhs.uk/about-us/key-publications/

2.2 Statements of Assurance from the Board of Directors

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

2.2.1 Information on the Review of Services

During 2017/18 the University Hospitals of Morecambe Bay NHS Foundation Trust provided and/or subcontracted 45 relevant Health Services.

The University Hospitals of Morecambe Bay NHS Foundation Trust has reviewed all the data available to them on the quality of care in 45 of these relevant Health Services.

The income generated by the relevant Health Services reviewed in 2017/18 represents 99% of the total income generated from the provision of relevant Health Services by the University Hospitals of Morecambe Bay NHS Foundation Trust for 2017/18.

The data reviewed on various activities enable assurance that the three dimensions of quality improvement for Patient Safety, Clinical Effectiveness and Patient Experience is being achieved through the following:
The introduction of the local Corporate Quality Reviews and patient safety walkabout visits are undertaken by the Executive Directors, Non-Executive Directors, Governors and Stakeholders who continue to help in communication with patients, visitors and ward staff. These initiatives have been of great value and aid our understanding of what we do well and where we can improve.

2.2.2 Participation in Clinical Audits and National Confidential Enquiries

During 2017/18, 51 national clinical audits and 3 national confidential enquiries covered relevant Health Services that University Hospitals of Morecambe Bay NHS Foundation Trust provides.

During 2017/18, University Hospitals of Morecambe Bay NHS Foundation Trust participated in 96.9% of national clinical audits and 100% of national confidential enquiries which it was eligible to participate in. These are detailed in Tables 4 and 5.

The national clinical audits and national confidential enquiries that University Hospitals of Morecambe Bay NHS Foundation Trust participated in, and for which data collection was completed during 2017/18 are listed below, in Column A of Tables 4 and 5, alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry identified, in Column B and C of Table 4 and 5.

Table 4: List of National Clinical Audit in which University Hospitals of Morecambe Bay NHS Foundation Trust was eligible to participate in and participated in during 2017/18

Number	Title of National Clinical Audit	Column A Participate	Column B Cases Submitted	Column C Cases submitted (% of cases required)
1	Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP) - NICOR	Yes	FGH (160) RLI (216)	100% 100%
2	RCEM Neck of Femur	Yes	FGH (51) RLI (50)	100% 100%
3	RCEM Procedural Sedation	Yes	FGH (50) RLI (46)	100% 92%
4	RCEM Pain in Children	Yes	FGH (52) RLI (49)	100% 98%
5	Bowel Cancer (NBOCAP)	Yes	X-Bay (258)	100%
6	Cardiac Rhythm Management (CRM) - NICOR	Yes	304	100%
7	Case Mix Programme (CMP) ICNARC	Yes	FGH (309) RLI (559)	100% 100%
8	Diabetes (Paediatric) (NPDA)	Yes Data to be submitted early May.	Anticipated submissions = 170	
9	Elective Surgery (National PROMs Programme)	Yes	X-Bay (1291)	Unknown %
10	Endocrine and Thyroid National Audit	Yes	RLI (60)	Unknown %
11	Falls and Fragility Fractures Audit programme (FFFAP): • National Hip Fracture database	Yes	RLI (232) FGH (110)	100% 100%
12	Inflammatory Bowel Disease (IBD) programme	Yes	138	100%
13	Major Trauma Audit (TARN)	Yes	FGH (133) RLI (289)	77-90% 77-100%
14	National Cardiac Arrest Audit (NCAA)	Yes	FGH (29) RLI (30)	100% 100%
15	National Chronic Obstructive Pulmonary Disease Audit programme (COPD) : Secondary Care - RCP	Yes	FGH (324) RLI (365)	100% 100%
16	National Comparative Audit of Blood Transfusion programme: • Transfusion Associate Circulatory Overload (TACO)	Yes	Trust (76)	100%

Table 4: List of National Clinical Audit in which University Hospitals of Morecambe Bay NHS Foundation Trust was eligible to participate in and participated in during 2017/18				
Number	**Title of National Clinical Audit**	**Column A Participate**	**Column B Cases Submitted**	**Column C Cases submitted (% of cases required)**
	• 2017 National Comparative Audit of Red Cell and Platelet Transfusion in Adult Haematology patients • Audit of Patient Blood Management in Scheduled Surgery		RLI (14) FGH (9) WGH (3) FGH (3) & RLI (5) WGH (2)	100% 100%
17	National Diabetes Inpatient Audit (NaDia)	Yes	FGH (40) RLI (60)	100% 100%
18	National Emergency Laparotomy Audit (NELA)	Yes	FGH (65) RLI (119)	100% 100%
19	National Heart Failure Audit	Yes	FGH (134) RLI (134)	100% 100%
20	National Joint Registry (NJR)	Yes	FGH (381) RLI (371)	Unknown %
21	National Lung Cancer Audit (NLCA)	Yes	X-bay283	100%
22	National Ophthalmology Audit	Yes	X-bay (31)	11%
23	National Prostate Cancer Audit	Yes	X-bay (265)	100%
24	National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care)	Yes	FGH (5) RLI (16)	100% 100%
25	Oesophago-gastric Cancer (NAOGC)	Yes	Trust (60)	100%
26	National Maternal and Perinatal Audit (NMPA)	Yes	3,151	100%
27	Sentinel Stroke National Audit programme (SSNAP)	Yes	RLI (405) FGH (373)	100% 100%
28	Nephrectomy Audit (BAUS)	Yes	(RLI) 99 Not done at FGH	Unknown %
29	National Parkinson's Disease Audit	Yes	FGH (20) RLI (25) WGH (25)	100% 100% 100%
30	Cystectomy (BAUS)	No Not eligible	--	--
31	Percutaneous Nephrolithotomy (BAUS)	No Not eligible	--	--
32	Radical Prostatectomy (BAUS)	No Not eligible	--	--
33	Urethroplasty (BAUS)	No Not eligible	--	--
34	Female Stress Urinary Incontinence (BAUS)	No Eligible but non-participant	Trust does not take part in this audit	Non-participant
35	Congenital Heart Disease (CHD)	No Not eligible	--	--
25	Oesophago-gastric Cancer (NAOGC)	Yes	Trust (60)	100%
36	Coronary Angioplasty / National Audit of Percutaneous Coronary Interventions (PCI)	No Not eligible	--	--

Table 4: List of National Clinical Audit in which University Hospitals of Morecambe Bay NHS Foundation Trust was eligible to participate in and participated in during 2017/18				
Number	**Title of National Clinical Audit**	**Column A Participate**	**Column B Cases Submitted**	**Column C Cases submitted (% of cases required)**
37	Adult Cardiac Surgery	No Not eligible	--	--
38	Head and Neck Cancer Audit (HANA)	Yes	151	100%
39	Learning Disability Mortality Review Programme (LeDeR)	Yes	Unknown as UHMB cases submitted by neutral Trust	
40	Mental Health Clinical Review Outcome Programme	No Not eligible	--	--
41	National Audit of Breast Cancer in Older Patients (NABCOP)	Yes	Unknown number – all cases submitted	100%
42	National Audit of Dementia	No data collection, report only	--	--
43	National Audit of Intermediate Care (NAIC)	No Not eligible	--	--
44	National Audit of Psychosis	No Not eligible	--	--
45	National Bariatric Surgery Registry (NBSR)	No Not eligible	--	--
46	National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs Following Major Injury (NCASRI)	No Not eligible	--	--
47	National Vascular Registry	No Not eligible	--	--
48	Neurosurgical National Audit Programme	No Not eligible	--	--
49	Paediatric Intensive Care (PICANet)	No Not eligible	--	--
50	Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	Yes	0 cases occurred	100%
51	Prescribing Observatory for Mental Health (POMH-UK)	No Not eligible	--	--
Data source: Clinical Audit Programme and final reports. This data is governed by standard national definitions				

Table 5: List of National Confidential Enquiries that University Hospitals of Morecambe Bay NHS Foundation Trust was eligible to participate in and participated in during 2017/18.				
Number	**Title of National Confidential Enquiries**	**Column A Participate In**	**Column B Cases submitted**	**Column C Cases submitted (% of cases required)**
1	Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE)	Yes	Ongoing Apr 2017 - Mar 2018	
2	Medical and Surgical Clinical Outcome Review Programme (NCEPOD) • Cancer in children, teens and young adults • Heart Failure	Yes	No Cases, 2 Organisational Questionnaires sent. 9 cases included - 8	

	• Peri-operative diabetes		returned. Ongoing	
3	Child Health Clinical Outcome Review Programme • Chronic Neurodisability • Young People's Mental Health	Yes	 FGH (3) & RLI (7) FGH (5) & RLI (2)	
Data source: Clinical Audit Programme and final reports. This data is governed by standard national definitions				

The reports of 4 National Clinical Audits were reviewed by the provider in 2017/18, and University Hospitals of Morecambe Bay NHS Foundation Trust intends to take, or has taken, the following actions to improve the quality of healthcare provided, examples of which are shown in Table 6.

The full list of actions can be found in the Annual Clinical Audit Report on the Trust's website at http://www.uhmb.nhs.uk/about-us/key-publications/.

Table 6: Details of actions taken or being taken to improve the quality of local services and the outcomes of care.

No.	Title of National Clinical Audit reports received in 2017/18	Details of actions taken or being taken to improve the quality of local services and the outcomes of care.
1	Intensive Care National Audit and Research Council (ICNARC)	• Improve the number of nurses so to avoid one nurse looking after more than one patient • Transferring to other unit or managing the patient in the Theatres recovery area to avoid premature patient discharge and Intensive Care Unit lead should be informed
2	National Emergency Laparotomy Audit (NELA)	• Remind staff that pPOSSUM & NELA risk prediction should be done for all cases pre-op and documented in NELA • To present findings and highlight the need for elderly medicine input into relevant patients at Quality Committee, Clinical Audit & Effectiveness Steering Group and Divisional Governance Assurance Group as this will shortly be attached to a tariff • Emlap boarding cards should now be used to book theatre slots now for all emergency laparotomies and demonstrate to staff where they are located within Lorenzo
3	Non-Invasive Ventilation (NIV) NCEPOD	• Gap analysis of the existing service against recommendations, particularly for recommendations 1,2,6-8,14-15,17-21 • Data to be added to the national National Chronic Obstructive Pulmonary Disease Audit programme (COPD(audit database
4	National Neonatal Audit Programme	• Ensure any lessons learned from reviews are disseminated to staff • Complete Multi-Disciplinary Team review of any preterm infant admitted with temperature below 36C • Explore possibility of tick box on Lorenzo for MgSO4 administration • Work with the NWNODN Special Interest Group for Breastfeeding to support Network strategy • Review Infants feeding on discharge alongside intention to Breastfeed in light of term Breastfeeding rates for area • Continue to provide Breastfeeding training as part of PANDA for all Children and Young People Nursing staff • Ensure positive benefits of Breastmilk is communicated to Mums • Work with Maternity to encourage early expression of breastmilk
5	National Asthma Audit	• Alert Respiratory nurse team when Asthma patient attends for care bundle and follow up to be arranged. • Placebo inhaler boxes to be provided on each ward and team will start to provide education. • Pre and post Nebuliser Peak Expiratory Flow (PEF) Needs to be encouraged • Intensive care review/pathway • Introduce Asthma care bundle to A&E/AMU and Ward 37
6	National Dementia Audit	• Ensure that structured pain assessments are in use and properly

Table 6: Details of actions taken or being taken to improve the quality of local services and the outcomes of care.		
No.	**Title of National Clinical Audit reports received in 2017/18**	**Details of actions taken or being taken to improve the quality of local services and the outcomes of care.**
		recorded including an evaluation option • Ensure all staff receive training on delirium and its relationship with dementia, manifestations of pain, and behavioural and psychological symptoms of dementia • Safeguarding lead to ensure all staff are trained in Mental Capacity Act (MCA) including consent and Best interest decisions, the use of Lasting Power of Attorney (LPA) and Advanced Decision making • Ensure that structured pain assessments are in use and properly recorded including an evaluation option • The executive lead to ensure there is a dementia champion available at all times to support staff 24/7 with expertise in dementia care e.g. clinical site managers out of hours • Identify key themes from audit in line with kings fund recommendations
7	NBOCAP Bowel Cancer Audit	• Cancer Service team to ensure Somerset Cancer Registry updated with Clinical Nurse Specialist review • M stage to be added in all pathology reports • Data to be circulated bi-monthly to all colo-rectal consultants in order to correct own data prior to submission • Performance status to be recorded at each MDT weekly • Height of rectal tumour to be recorded
8	Falls and Fragility Fractures Programme: National Hip Fracture Database	• Log issues around theatre space and Orthogeriatrician review on Risk Register
Data source: Clinical Audit Programme and final reports. This data is governed by standard national definitions		

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

The reports of 195 local clinical audits were reviewed by the provider in 2017/18 and a sample of improvements made to the quality of healthcare provided as a result of audit findings are detailed in Table 7 below. Staff undertaking the clinical audit must report any actions needed to improve service delivery and clinical quality.

Find out more in the Annual Clinical Audit Report 2017/18 at www.uhmb.nhs.uk/about-us/key-publications/ or you can request a copy of the report.

Table 7: Details of actions taken to improve the quality of local services and the outcomes of care	
Local Clinical Audits presented for assurance to the Board of Directors 2017/18	**Details of actions taken to improve the quality of local services and the outcomes of care**
FGH - Are Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions easily accessible?	• Evaluate whether decisions are recorded on Discharge summary • Encourage use of yellow folders on wards • Work with wards with poor compliance to encourage correct practice
17/18 Snapshot Audit of Glucose Meter Internal Quality Control (IQC) Record	• Contribute to Trust Lessons Learned Bulletin to remind staff of the necessity to include the serial number on each page of the log book • Add item to e-learning teaching where and how to record serial number in log book.
17/18 Auditory Brainstem Response (ABR)	• Members of Audiology staff to attend ABR refresher course to ensure department is up to date with national standards

Table 7: Details of actions taken to improve the quality of local services and the outcomes of care	
Local Clinical Audits presented for assurance to the Board of Directors 2017/18	**Details of actions taken to improve the quality of local services and the outcomes of care**
	• Audiology department to purchase external peer review vouchers
17/18 Record Keeping Re-audit in Dietetics	• Finish domiciliary visits earlier (end of day) to allow time to return to base to complete records as electronic system not reliable enough to always complete on site. • Contact Lorenzo team to request this is added to all staff smartcard profiles • To be addressed with individual dietitians. • If appropriate template not available for specialist need they will need to develop one
Potential infection control risks associated with inpatients wall electronic touch screens at FGH	• To discuss with the Infection Control Team regarding the possible introduction of a guideline
17/18 Audit of In-house Dispensing Errors	• Develop new dispensing standards across UHMBFT pharmacy • To produce error log collection for aseptic unit and identify a dedicated person for reviewing errors. • Produce a new delivery sheet to allow more accurate audit trail of items from leaving the department • Produce logbooks for staff in dispensary and purchasing when training on dispensing procedures.
17/18 Audit of the Safe and Secure Storage of Medicines	• Produce a policy regarding refrigerated storage of medicines to support compliance with these standards within the audit.
Surgical Handover System in Furness General Hospital	• To implement a handover whiteboard
Audit of Fine Needle Aspiration Cytology (FNAC) for Salivary Gland Lumps	• Agreement to be reached for staff to perform FNA on all salivary gland lumps in one stop clinic
Pre-operative assessment for infection risk in urology at FGH	• Discussion to take place with microbiology re antibiotic use • Discussion with pre-op staff to ensure urine dips are taken appropriately
Urodynamics audit.	• Produce new patient information leaflet
Intermittent Auscultation	• Develop a sticker system to provide simple documentation • Provide a teaching package to improve and update intermittent auscultation
17/18 Audit of Adherence to Antimicrobial Guidelines	• Share results with microbiologists for action • Develop an action plan to address the excess usage of co-amoxiclav identified • Share results at the pharmacist meeting for dissemination and action
FGH - Quality Improvement Strategy and Plan (QIP) Emergency Oxygen Audit	• Contact the Lorenzo Electronci Pation Record (EPR) manager regarding adding details about prescribing oxygen, to try and improve prescription rate
Transient Ischaemic Attack (TIA) audit	• Review method of reviewing referrals - requires discussion within stroke team • I3 services to establish access for inclusion of referrals on Lorenzo
Data source: Annual Clinical Audit Report 2017/18	

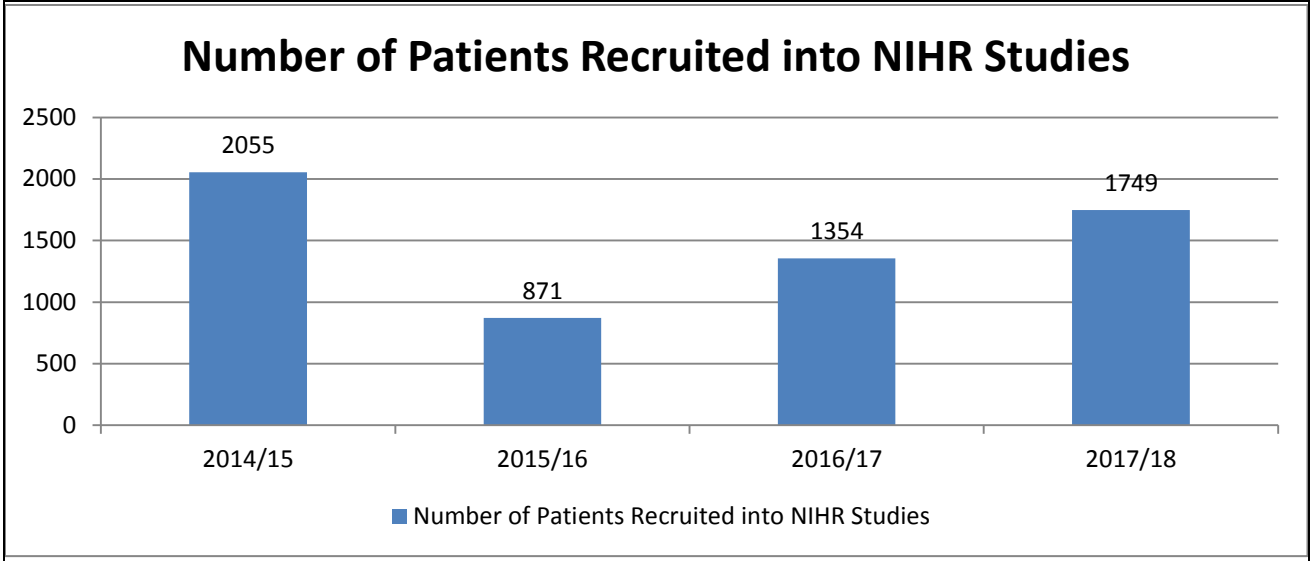
2.2.3 Participation in Clinical Research in 2017/18

The number of patients receiving relevant Health Services provided or sub-contracted by University Hospitals of Morecambe Bay NHS Foundation Trust in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee was 1749.

This information is identified in Graph 1, and all are on the National Institute of Health Research (NIHR) Portfolio. In addition, we have a small body of work for educational awards. This figure shows an increase in the number of people taking part in research compared to 2016/17, although the number of research active specialities has decreased. We continue to have a balanced portfolio including higher recruiting simpler studies up to more complex randomised controlled trials, involving lower numbers of patients. The research portfolio continues to cover a broad spectrum of medical and healthcare specialties. This year we have continued to work collaboratively with Lancaster University to recruit to locally led studies in Radiology and Orthopaedics.

It should be noted that in 2017/18, NIHR Portfolio Study data is not signed off nationally until 30th June 2018 and the patient participation figure is, therefore, un-validated at this time.

Graph 1 - Participation in Clinical Research



Data source: NIHR Portfolio Database of studies. *This data is governed by standard national definitions.*

The National Institute of Health Research (NIHR) portfolio studies are high quality research that have full funding and have undergone a rigorous peer review in order for them to be adopted onto the portfolio. In England, studies included in the NIHR portfolio have access to infrastructure support via the NIHR Clinical Research Network. This Trust receives this infrastructure support which supports the salaries of a team of Research Practitioners who are employed by the Trust and take responsibility for the set-up of research studies, recruitment of patients to research and their subsequent follow up. Funding is also given to our clinical support services, laboratories, imaging and pharmacy to facilitate the delivery of the research.

Participation in clinical research demonstrates UHMBFT's commitment to improving the quality of care offered and to making our contribution to wider health improvement. Our clinical staff keep up to date with the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

University Hospitals of Morecambe Bay NHS Foundation Trust was involved in conducting 63 clinical research studies during 2017/18. There were over 100 clinical staff supporting research activity at University Hospitals of Morecambe Bay NHS Foundation Trust during 2017/18. These staff assisted with research covering 14 healthcare specialties as outlined in Table 8 below.

Table 8: Research Activity at UHMBFT per Healthcare Specialty

No.	Specialty	No. of patients recruited 2017/18
1	Health Services Research	701
2	Reproductive Health	223
3	Gastroenterology	191
4	Children	173
5	Cancer	166
6	Anaesthesia, Perioperative Medicine and Pain Management	105
7	Cardiovascular Disease	73
8	Musculoskeletal Disorders	54

9	Respiratory Disorders	38
10	Injuries and Emergencies	10
11	Ophthalmology	8
12	Dermatology	3
13	Surgery	2
14	Diabetes	2
Total		**1749**
Data Source: : *NIHR Open Data Platform*		

In addition, over the last five years, collaborations with the University of Lancaster on Cochrane systematic reviews of medical and healthcare related topics have increased and these reviews are beginning to be published, which demonstrates a clear commitment to increase the wealth of knowledge in health and medical fields to improve patient outcomes and experience across the NHS. The improvement in patient health outcomes in UHMBFT demonstrates that a commitment to clinical research leads to better treatment for patients.

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

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

A proportion of University Hospitals of Morecambe Bay NHS Foundation Trust's income in 2017/18 was conditional on achieving quality improvement and innovation goals agreed between University Hospitals of Morecambe Bay NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant Health Services, through the Commissioning for Quality and Innovation Payment Framework payment framework. Further details of the agreed goals for 2017/18 and for the following 12 month period 2018/19 are available electronically via our performance section of our website which can be accessed via the following link: http://www.uhmb.nhs.uk/about-us/key-publications/.

For 2017/18, the baseline value of the CQUIN was £5.6m. If the agreed quality indicators were not met during the year or the outturn contract value was lower than the baseline contract, then a proportion of the monies would be withheld.

The planned monetary total value for income of CQUIN in 2017/18, conditional upon achieving quality improvement and innovation goals, is £5.6m; however, it is estimated that the Trust will achieve a monetary total value of £5.5m (currently projected value) for the associated payment in 2017/18 (compared to 2016/17, the Trust achieved a monetary total value of £4.4m). This is a provisional sign off based on achievement to date as, for a few indicators, the final results will not be known until later in the year.

Further details of the agreed goals for 2017/18 are detailed in Table 28; in addition, further details of the 15 agreed CQUIN schemes 2018/19 are detailed in Table 3.

2.2.5 Registration with the Care Quality Commission and Periodic/Special Reviews

Statements from the Care Quality Commission

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

The Care Quality Commission has not taken enforcement action against University Hospitals of Morecambe Bay NHS Foundation Trust during 2017/18.

Special Reviews/Investigations/Planned Reviews

- **Planned Reviews**

University Hospitals of Morecambe Bay NHS Foundation Trust has participated in planned reviews or investigations by the Care Quality Commission relating to the following areas during 2017/18.

The Trust participated in a CQC Health and Social Care review for Cumbria 12-16 February 2017. A CQC quality summit was held 21 May 2018 to discuss the outcome of the review with agencies involved.

University Hospitals of Morecambe Bay NHS Foundation Trust intends to take the appropriate action to address the conclusions or requirements reported by the CQC and these actions will be detailed in a joint CQC Health and Social Care Cumbria Improvement Plan.

- **Special Reviews**

University Hospitals of Morecambe Bay NHS Foundation Trust has not participated in any special reviews by the Care Quality Commission in 2017/18.

Unannounced visits

The Care Quality Commission has not carried out any unannounced visits during 2017/18.

Advisory requirement

The Trust's CQC ratings grid for the outcome of the CQC re-inspection undertaken in October 2016 is detailed below in Table 9.

Table 9: Overall Trust Summary– CQC Quality Report published 9 February 2017						
Acute Services	**Safe**	**Effective**	**Caring**	**Responsive**	**Well-Led**	**Overall**
RLI	Requires Improvement	Good	Outstanding	Good	Good	Good
FGH	Requires Improvement	Good	Outstanding	Good	Good	Good
WGH	Good	Good	Good	Good	Good	Good
Trust	Requires Improvement	Good	Outstanding	Good	Good	Good

You can look at our latest CQC Hospital Improvement Plan and progress made to address areas that require improvement via the following link http://www.uhmb.nhs.uk/patients-and-visitors/cqc where you can also find out more about the developments and milestones we are reaching every month.

2.2.6 Information on the Quality of Data

Quality information that is "Fit for Purpose" underpins safe patient care. There are potentially serious consequences if information is not correct and timely.

Robust management information and business intelligence based upon accurate patient data is essential for the delivery of patients' care and to maximise the utilisation of resources for the benefit of patients and staff.

The Trust requires accurate, timely, relevant patient information in order to support:

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

- Accountability and transparency

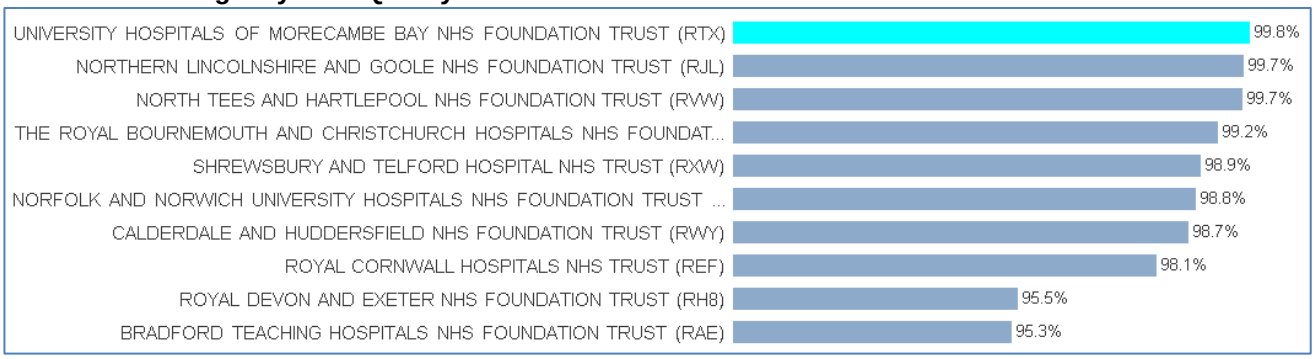
The obligations upon all Trust staff to maintain accurate records are:

- Legal (Data Protection Act 1998)
- Contractual (Contracts of employment)
- Ethical (Professional codes of practice)

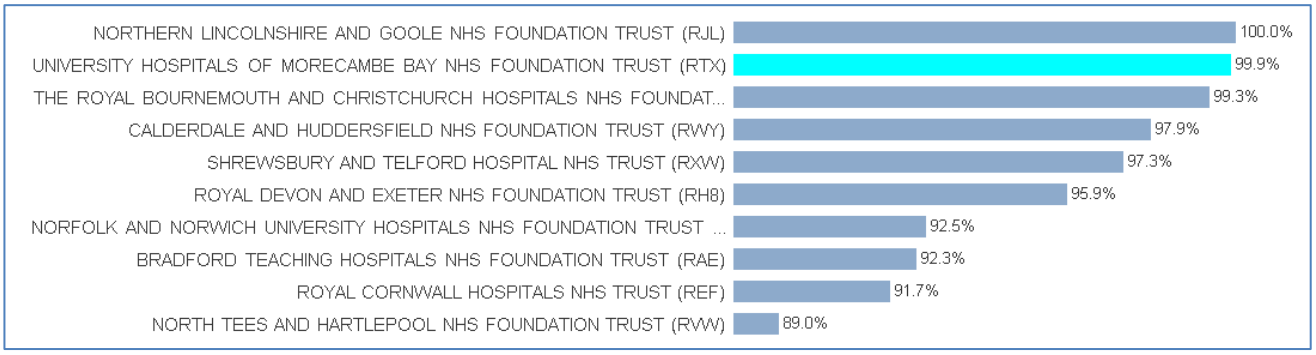
Improving data quality requires effort, resources and commitment at all levels in the Trust and requires a focus on user behaviour and improving how staff interact with the Trust's Electronic Patient Record and core systems. The Trust will be taking the following actions to improve data quality:

The Trust is monitored internally, locally and nationally on the clinical data it generates and publishes. The following indicators are monitored by both local Health Service Commissioners, as well as by NHS England. The information below shows the Trust's performance for 2017/18 against its peer group:

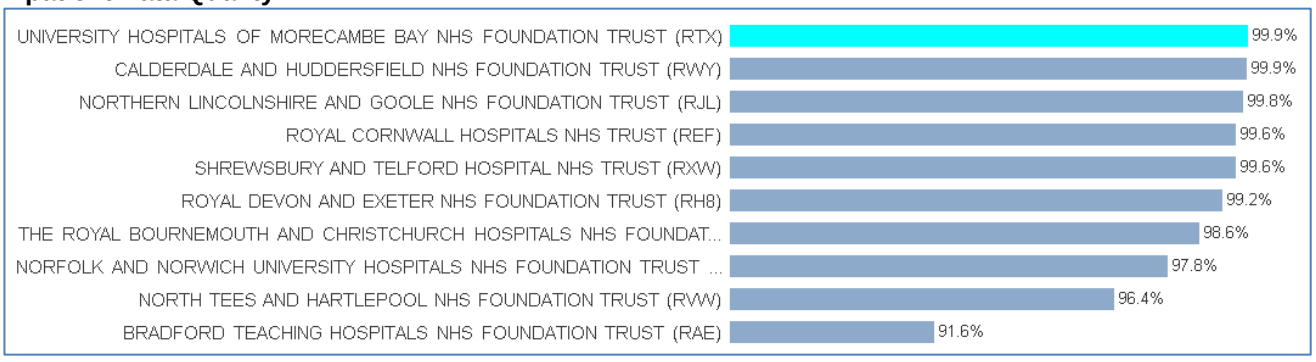
Accident & Emergency Data Quality:



Outpatient Data Quality:



Inpatient Data Quality:



NHS Number and General Medical Practice Code Validity

University Hospitals of Morecambe Bay NHS Foundation Trust submitted records during 2017/18 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. 2.2.62.2

The percentage of records in the published data (latest available December 2017):

which included the patient's valid NHS Number was:

- 99.7% for Admitted Patient Care;
- 99.9% for Outpatient Care; and
- 98.6% for Accident and Emergency Care.

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

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

Information Governance Assessment Report 2017/18

The Information Governance Toolkit (IGT) is an online system which allows NHS organisations and partners to assess themselves against Department of Health Information Governance policies and standards. It is fundamental to the secure storage, transfer, sharing and destruction of data both within organisations and between organisations.

University Hospitals of Morecambe Bay NHS Foundation Trust Information Governance Assessment Report overall score for 2017/18 was 82% and was graded green (satisfactory). This reflects a sustained satisfactory rating as the score for 2016/17 was 80%.

This rating links directly to the NHS Operating Framework which requires organisations to achieve Level 2 or above in all requirements. A list of the types of organisations included, along with compliance data, is available on the NHS digital website www.digital.nhs.uk

UHMBFT will continue to work towards maintaining and improving compliance standards during 2018/19 monitored by the Trust's Information Governance Group which reports to the Innovation, Information and Informatics (I^3) Operations and Performance Group and the Trust's Finance Committee.

The Data Quality and Records Management attainment levels assessed within the Information Governance Toolkit provide an overall measure of the quality of data systems, standards and processes within an organisation.

Payment by Results (PbR) Clinical Coding Audit

University Hospitals of Morecambe Bay NHS Foundation Trust was not subject to the Payment by Results (PbR) clinical coding audit during 1st April 2017 – 31 March 2018. It is expected that the Trust will undertake a PbR Audit during 2018/19; however, this has not yet been confirmed by the Regulator, NHS Improvement.

2.2.7 Learning from Deaths [27]

The Trust has a Mortality Review Process procedure in keeping with the National Learning from Death Policy. The Patient Safety Unit reports to the Quality Committee quarterly with mortality review data and action plans. This includes data from both hospital sites. The monthly mortality reviews are also discussed in each divisional department to share learning and to act on areas of improvement.

The Trust publishes their quarterly Report on Mortality Reviews on the Trust's website: www.uhmb.nhs.uk/about-us/data-patient-safety-incidents/.

From a patient's and family experience point of view, bereavement staff are supporting families through the difficult time and have had very good feedback. All cases where care quality could have been better are discussed in mortality reviews and also in divisional meetings. The near misses or any potential harm is discussed through the Weekly Patient Safety Summit and Serious Incident Requiring Investigation (SIRI) panel, as appropriate. Over the last 6 months, both HSMR and SHMI have showed significant improvements and also in other indicators of Methicillin-resistant Staphylococcus aureus (MRSA), Clostridium difficile toxin (CDT) and falls. The Trust has appointed a Venous thromboembolism (VTE) lead and a sepsis lead who are undertaking regular audits on those areas to ensure the quality and standard of care is improved.

The Trust assesses quality of care and preventability though Hogan and National Confidential Enquiry into Peri-operative Outcomes and Death (NCEPOD) scoring.

During the period 1 April 2017 to 31 March 18, 1314 of University Hospitals of Morecambe Bay NHS Foundation Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

329 in the first quarter;
239 in the second quarter;
323 in the third quarter;
423 in the fourth quarter.

By 31st March 2018, 761 case record reviews and 64 investigations have been carried out in relation to 761 of the deaths included in the item above.

In 64 cases, a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

190 (Averaged) in the first quarter;
190 (Averaged) in the second quarter;
190 (Averaged) in the third quarter;
190 (Averaged) in the fourth quarter.

*7 representing 0.5% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of:

0 representing 0% for the first quarter;
3 representing 0.23% for the second quarter;
2 representing 0.15% for the third quarter;
2 representing 0.15% for the fourth quarter.

*Based on those assessed with a HOGAN score of 3 or above.

These numbers have been calculated using the Mortality Review Process procedure and a standard pathway and process by which the site based mortality leads conduct mortality reviews and this is documented in the system in the bereavement folder in excel format. Since January 2018, the Trust have introduced a much finer software where we are documenting all the mortality reviews in a standard template along with NCEPOD and HOGAN scores. There is a site based mortality report submitted to divisional meetings on a mortality/patient safety agenda for discussion and lessons learnt every month. From the Patient Safety Unit, we report to the Quality Committee every 3 months with avoidable deaths and HOGAN and NCEPOD scores. We also take account of the clinical incidents which are raised during the mortality reviews and also any clinical incidents raised during the patient's stay in hospital before the mortality review. Depending on the severity, these go through a rapid review, a Root Cause Analysis (RCA) and the Weekly Patient Safety Summit with closure after reflection and action plan from the clinical team/person.

The Trust documents all learning, not only from mortality reviews, but also from the Patient Safety Summit and this gets circulated to the divisional teams and Divisional Governance Assurance Groups (DGAG) for lessons learnt. Depending on the themes, we also do themed reviews (for example: include falls, missed fractures, radiology reporting, PEG/RIG review, radiology results tracking and acting upon, stroke mortality audit, coding audit etc.). Depending on the findings from these, we have implemented new policies and stipulated processes within the Trust and divisions wherever it was required.

The Trust introduced a result and action policy of test in relation to the Trust's Mortality Review Process procedure. This also includes divisional learning on all those cases where the HOGAN and mortality scores were high. This is monitored at the Quality Committee on a quarterly basis.

To ensure the Trust is compliant with the Trust's Mortality Review Process procedure, we have assessed the impact of the implementation of the procedure and in order to improve the assessment process the Trust has introduced an electronic system to undertake mortality reviews. This has allowed for improved communication and sharing of information between departments resulting in a reduction of clinical incidents and harm to patients.

*0 case record reviews and 7 investigations completed after 31/03/2017 which related to deaths which took place before the start of the reporting period. * Estimated

0 representing 0% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been determined by reviewing all 7 investigations for avoidability by our organisation.

0 representing 0% of the patient deaths during 2016/17 are judged to be more likely than not to have been due to problems in the care provided to the patient.

2.3 Reporting Against Core Quality Indicators

Since 2012/13, all NHS Foundation Trusts have been required to report performance against a core set of Quality Indicators using the standardised statement set out in the NHS (Quality Accounts) Amendments Regulations 2012.

To ensure consistency in understanding of these indicators, NHS England has published a "data dictionary" for the quality accounts (see the quality accounts area of the NHS Choices website) http://www.nhs.uk/Pages/HomePage.aspx. The data dictionary includes a definition for each indicator.

Set out in Table 10 are the Core Quality Indicators that trusts are required to report performance in their Quality Accounts. In addition, where the required data is made available to the trust by NHS Digital, a comparison of the numbers, percentages, values, scores or rates of the Trust (as applicable) are included for each of those listed in Table 10 with:

a) the national average for the same; and

b) with those NHS Trusts and NHS Foundation Trusts with the highest and lowest for the same, for the reporting period.

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

Table 10: Core Quality Indicators – Prescribed Information

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

	SHMI				Palliative Care Coding			
Period	Trust	England Average	England Highest	England Lowest	Trust	England Average	England Highest	England Lowest
Jan 15 to Dec 15	0.99 Band 2	1.00	1.17	0.67	The Palliative Care Coding data is no longer available			
Apr 15 to Mar 16	0.98 Band 2	1.00	1.18	0.68				
Jul 15 to Jun 16	0.99 Band 2	1.00	1.17	0.69				
Oct 15 to Sep 16	1.00 Band 2	1.00	1.16	0.69				
Jan 16 to Dec 16	1.03 Band 2	1.00	1.19	0.69				

Data includes the most recent publication on the NHS Digital, published in December 2016

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

- The data shows that there was a slight increase in SHMI for the period January 2016 to December 2016.

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

- The Trust has included mortality reduction in its *Sign up to Safety* programme for 2015-18 to improve this rate and it is anticipated to improve when 2017 data is published.

The data made available to the Trust by the NHS Digital with regard to the Trust's patient reported outcome measures scores for the following during the period reported:

(i) groin hernia surgery;
(ii) varicose vein surgery;
(iii) hip replacement surgery; and
(iv) knee replacement surgery.

Groin Hernia – Percentage of patients with improvement in EQ-5D health scores			
Year	Eligible Episodes	Trust	National Average
2012/13	72	45.8%	50.2%
2013/14	142	45.1%	50.6%
2014/15	201	48.8%	50.7
2015/16	186	54.8%	50.9%
2016/17	100	53.0%	51.3%
2017/18	2017/18 Data will not be available until November 2018		

Varicose Veins – Percentage of patients with improvement in EQ-5D health scores			
Year	Eligible Episodes	Trust	National Average
2012/13	34	47.1%	52.8%
2013/14	32	56.3%	51.6%
2014/15	26	46.2%	52.0%
2015/16	The Trust has not had any eligible patients within PROMS since 2014/15 following the transfer of Vascular services to Lancashire Teaching Hospitals NHS Foundation Trust.		
2016/17			
2017/18			

Hip Replacement – Percentage of patients with improvement in EQ-5D health scores			
Year	Eligible Episodes	Trust	National Average
2012/13	201	91.5%	88.3%
2013/14	235	87.7%	87.3%
2014/15	288	87.5%	89.5%
2015/16	277	90.6%	89.7%
2016/17* Provisional Data finalised in Q3 of 2018/19	288	90.60%	90.0%
2017/18	2017/18 Data will not be available until November 2018		

Knee Replacement – Percentage of patients with improvement in EQ-5D health scores			
Year	Eligible Episodes	Trust	National Average
2012/13	243	79.4%	81.7%
2013/14	285	81.1%	81.3%
2014/15	348	77.9%	81.0%
2015/16	318	78.6%	81.6%
2016/17* Provisional Data finalised in Q3 of 2018/19	304	80.6%	81.5%
2017/18	2017/18 Data will not be available until November 2018		

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

- There were 1952 procedures carried out in 2016/17. 1324 (67.8%) patients completed the pre-operative questionnaire. This is a significant drop in patient participation from 2015/6's rate of 82.7%
- Subsequently, 1286 post-operative questionnaires were distributed and 848 (65.9%) were completed. This is in line with return rate experienced across the past 5 years within the Trust, and in line with national performance.
- The percentage of modelled records remains an area where improvement could be made by a review to the pre-operative questionnaire process, and will have been negatively affected by the reduction in patient participation.

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

- Will continue to work with patients to improve information on knee replacement surgery which will enable them to make more informed and appropriate choices.
- Will engage with patients at discharge to ensure they understand the value of completing the six month post-operative survey and the value that gives to the Trust and can help shape future services.

The data made available to the Trust by the NHS Digital with regard to the percentage of patients aged (i) 0 to 15; and (ii) 16 or over, readmitted to a hospital within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.

Year	Categories	16 or over	0 to 15
2010/11	Trust	10.88	11.53
	England Average	11.45	Not recorded
	England Highest	22.76	16.05
	England Lowest	0	0
2011/12	Trust	10.5	10.2
	England Average	11.08	11.45
	England Highest	19.36	41.65
	England Lowest	0	0
2012/13	Trust	6.7	10.7
	England Average	5.8	8.3
	England Highest	Not yet published by NHS Digital – Scheduled publication date not available	
	England Lowest		
2013/14	Trust	6.9	6.9
	England Average	5.5	5.5
	England Highest	Not Reported by HSCIC	Not Reported by HSCIC
	England Lowest	Not Reported by HSCIC	Not Reported by HSCIC
2014/15	Trust	Last Data release was December 2013	
	England Average		
	England Highest		
	England Lowest		
2015/16	Trust		
	England Average		
	England Highest		
	England Lowest		
2016/17	Trust		
	England Average		
	England Highest		
	England Lowest		
2017/18	Trust		
	England Average		
	England Highest		
	England Lowest		

Please note that this data is no longer a reporting requirement with NHS England/Monitor/NHS Digital; therefore, it is not possible to supply peers comparison due to its granularity.

0-15			
Discharge period	Admissions	Re-admitted	Readmission Rate
2016/17	**9,054**	**1158**	**12.79%**
2016-Apr	765	99	12.94%
2016-May	775	85	10.97%
2016-Jun	725	96	13.24%
2016-Jul	755	101	13.38%

16+			
Discharge period	Admissions	Re-admitted	Readmission Rate
2016/17	**31,505**	**3629**	**11.52%**
2016-Apr	2,639	296	11.22%
2016-May	2,790	350	12.54%
2016-Jun	2,809	327	11.64%
2016-Jul	2,770	319	11.52%

2016-Aug	679	77	11.34%	2016-Aug	2,662	312	11.72%
2016-Sep	712	78	10.96%	2016-Sep	2,647	291	10.99%
2016-Oct	754	99	13.13%	2016-Oct	2,583	300	11.61%
2016-Nov	900	122	13.56%	2016-Nov	2,583	284	10.99%
2016-Dec	833	108	12.97%	2016-Dec	2,610	316	12.11%
2017-Jan	713	104	14.59%	2017-Jan	2,490	272	10.92%
2017-Feb	624	82	13.14%	2017-Feb	2,271	238	10.48%
2017-Mar	819	107	13.06%	2017-Mar	2,651	324	12.22%
2017/18	**8,288**	**1159**	**13.98%**	**2017/18**	**28,452**	**3332**	**11.71%**
2017-Apr	704	95	13.49%	2017-Apr	2,470	282	11.42%
2017-May	727	107	14.72%	2017-May	2,653	300	11.31%
2017-Jun	690	92	13.33%	2017-Jun	2,663	300	11.31%
2017-Jul	731	89	12.18%	2017-Jul	2,587	307	11.53%
2017-Aug	655	89	13.59%	2017-Aug	2,621	324	12.36%
2017-Sep	784	110	14.03%	2017-Sep	2,636	302	11.46%
2017-Oct	783	91	11.62%	2017-Oct	2,730	315	11.54%
2017-Nov	897	138	15.38%	2017-Nov	2,548	300	11.77%
2017-Dec	829	114	13.75%	2017-Dec	2,593	328	12.65%
2018-Jan	794	127	15.99%	2018-Jan	2,524	311	12.32%
2018-Feb	674	113	16.77%	2018-Feb	2,443	284	11.63%
2018-Mar	879	109	12.40%	2018-Mar	2700	234	8.67
Data source: UHMBT Electronic Patient Record - Lorenzo Data shown: Apr 17-Mar 18.							

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

- The data shows that the work being undertaken across the health economy has started to impact on the percentage of readmissions seen at the Trust, with a small reduction in the total number of readmissions.
- The higher percentage return rate within paediatrics reflects the service offered to parents whereby they are encouraged to return to the ward if further problems are encountered. This is a service that is highly valued by parents.

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

- An action plan, led by the Clinical Directors is in place to review the level of emergency readmissions.

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

Year	Trust	England Average	England Highest	England Lowest
2011/12	65.3	67.4	85	56.5
2012/13	66.6	68.1	84.4	57.4
2013/14	70.6	76.9	87.0	67.1
2014/15	77.8	76	82.2	59.0
2015/16	79.7	77.3	88.0	70.6
2016/17	69.5	68.1	85.2	60.0
2017/18	The 2017/18 information is not currently available and will be published by NHS Digital in August 2018.			

The University Hospitals of Morecambe Bay NHS Foundation Trust considers that this data is as described

for the following reasons:

- The data shows that the Trust maintains within England Average scores. The Trust considers patients' feedback to be pivotal in ensuring our services continue to develop in order for the Trust to meet individual patient needs.

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

- We continue to focus energy and efforts on improvements to patient outcomes, quality care and patient experience.
- The Trust has continued to focus on the importance of the Friends and Family Test and has made the information available to staff, patients and visitors on ward boards.
- Additional monies have been identified to support increased nurse recruitment to enhance patient experience.

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

Year	Trust	England Average	England Highest	England Lowest
2014/15	56%	77%	100%	45%
2015/16	64%	79%	100%	51%
2016/17	65%	79%	98%	44%
2017/18	70%	71%	100%	46%

Please note: Figures for 2017/18 are complete to the end of September 2017 – updated data will be available in May 2018

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

- The year on year improvements seen in staff recommending the Trust as a place to receive treatment signals a continuing increase in staff advocacy. The correlation between staff engagement levels and improved patient outcomes is strong and this particular factor is one key domain which contributes to overall staff engagement levels.

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

- The year on year improvements seen in staff recommending the Trust as a place to receive treatment signals a continuing increase in staff advocacy. The correlation between staff engagement levels and improved patient outcomes is strong and this particular factor is one key domain which contributes to overall staff engagement levels.

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

Year	Trust	England Average	England Highest	England Lowest
2012/13	98.4%	94.2%	100%	84.6%
2013/14	99.4%	95.97%	100%	76%
2014/15	93.3%	96.00%	100%	86.4%
2015/16	94.3%	95.76%	100%	75.00%
2016/17	93.7%	95.62%	100%	77.84%
2017/18	94.8%	95.11%	100%	66.44%

Please note: Figures for 2017/18 are complete to the end of September 2017- these will be updated as March 2018 data becomes available in September 2018

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

- Data has been collected from a combination of Trust NHS safety thermometer, from EPR data and from

monthly auditing. This is because we have both moved from paper to electronic assessment for all emergency admissions and reviewed the method of data collection to streamline the process and improve accuracy. Data quality will further improve once all admissions assessments are completed within the EPR.

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

- Launch of the electronic VTE assessment form, currently active for all emergency admissions with elective admissions to follow.
- Clinical indicators being developed in the EPR to flag any unassessed patients to ward staff.
- Regular review of VTE prevention guidance including maternity and outpatients with lower limb casts.
- Establishment of VTE e-learning for all clinical staff.
- Teaching slot for all foundation year doctors established in their annual education programme
- Inclusion of VTE in Foundation Year Quality Improvement projects by VTE champions specifically aimed at improving education and performance of clinical teams
- Development of system for capture and investigation of all cases of hospital-acquired thrombosis for assurance and wider learning
- Annual trust-wide VTE audit for ongoing engagement and education of medical and surgical departments

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

Rate per 100,000 bed days of cases of Clostridium Difficile Infection				
Year	**Trust**	**England Average**	**England Highest**	**England Lowest**
2013/14	64.4	38.9	81.8	0
2014/15	69.8	40.8	74.0	0
2015/16	63.4	40.8	67.4	0
2016/17	43.6	36.7	147.5	0
2017/18	Please note: The 2017/18 information will be published by Public Health England in July 2018.			

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

- The Trust has continued to embed measures to reduce levels further within the organisation.

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

- Ensured that all staff are re-trained annually in hand hygiene.
- Maintained a high profile campaign on beating bugs.
- Maintained surveillance teleconferences every month to support the monitoring of cases and continue a thorough review of all cases.
- The reduction in infections has been identified as a priority in the Trust's Better Care Together and the Quality improvement Plan.
- Establish the prevalence of Clostridium Difficile in the community by the Clinical Commissioning Groups and work closely with them and Public health to take a whole healthcare system approach.
- Clostridium Difficile Root Cause Analysis meetings are undertaken for all Clostridium Difficile cases attributed to UHMBFT.

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

	Rate per 1000 bed days				Percentage of incidents			
	Incidents				Resulting in severe harm or death			
Period	**Trust**	**England**	**Highest**	**Lowest**	**Trust**	**England**	**Highest**	**Lowest**
Oct 2014 to Mar 2015	40.91	N/A	82.21	3.57	0.3	0.4	5.2	0
Apr 2015 to Sep 2015	39.65	N/A	74.67	18.07	0.5	0.4	1.7	0
Oct 2015 to Mar 2016	37.85	N/A	75.91	14.77	0.2	0.4	2.0	0

Apr 2016 to Sep 2016	35.88	N/A	71.81	21.15	0.1	0.1	0.5	0
Oct 2016 to Mar 2017	38.9	N/A	69.0	0.1	0.1	0.2	0.5	0
Apr 2017 to Sep 2017	48.77	N/A	111.69	23.47	0.3	0.6	0.5	0
Oct 2017 to Mar 2018	The figures for Oct 2017 to Mar 2018 will be published in September 2018.							
The NRLS discontinued the use of the large Acute Trust cohort at its publication in April 2015.								

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

- There has been a steady increase in the number of incidents over the last 5 years and the Trust now has an excellent reporting culture.

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

- The Trust will continue to encourage and maintain a strong reporting culture.
- The Trusts RCA (face to face training programme) has been reviewed and was launched with the CISU team in September. Initial feedback has been incorporated into the training. We are currently scoping the possibility of working with local hospitals to become an approved centre for investigation training delivery.
- The Governance Hub has launched a central investigation support unit (CISU) for staff completing RCAs reported through StEIS and Riddor. One of the risks associated with its success is capacity. Cases are currently being prioritised as able.
- Fresh eyes has been established with improved engagement from the divisional teams
- Weekly senior manager review of all incidents causing moderate or greater harm has been maintained
- Review of serious incidents by the Serious Incident Requiring Investigation (SIRI) Panel has strengthened throughout the year and lessons learned are identified.
- The learning to improve group is moving into the next phase of work. This means that the lessons will continue to be monitored as previously; however, there is now greater focus on measuring the outcomes and providing evidence of improvement
- Duty of candour is applied and monitored.

Further details on incidents and risks can be found in the Annual Governance Report 2017/18 which is published on the Trust's website at http://www.uhmb.nhs.uk/about-us/key-publications/. A copy of the report is available on request.

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

Part 3: Other Information - Review of Quality Performance

The Quality Account has provided an overview of the Quality Improvement work which has taken place across the organisation. There are a number of projects which we will be taking forward into the coming year and focusing our attention upon. We would, however, like to highlight the following projects as key priorities for 2017/18:

3.1 An Overview of the Quality of Care Based on Performance in 2017/18 with an Explanation of the Underlying Reason(s) for Selection of Additional Priorities

Table 1 in Part 2 of this document sets out the priorities for improvement which were identified in the 2016/17 report. Additional information regarding the rationale for the priority selection is detailed in 2.2.2 and 2.2.3.

Section 2.2.3 included a list of priorities that have been chosen to be removed by the Board of Directors from the quality improvements priorities for 2018/19. The rationale for the de-selection of the following priorities is that considerable progress and improvements have been delivered or put in place and other improvements have become a priority. It has been agreed to remove the following:

- Reducing clinical variation in identified areas
- The use of remembrance as a tool to improve patient safety and experience
- Introduction of Care bundles: Stroke, Specialist elderly frail unit, Acute kidney injury, Sepsis
- Development of a Patient Safety Unit
- Re-alignment of services for Stroke Patients
- Advice and guidance for nursing homes
- Building relationships and improve participation by the people who use and care about our NHS services

Information regarding the improvements made to demonstrate evidence for their removal is described in Part 3 – Section 3.4.1, 3.4.2 and 3.4.3.

3.2 Performance against Key National Priority Indicators and Thresholds

The NHS Outcomes Framework for 2017/18 sets out high level national outcomes which the NHS should be aiming to improve. The Board of Directors monitors performance compliance against the relevant key national priority indicators and performance thresholds as set out in the NHS Outcomes Framework 2017/18. This includes performance against the relevant access targets and outcome objective and performance thresholds set out in Appendix A of the NHS Improvement's Risk Assessment Framework 2017/18 which can be accessed via the following link: https://www.gov.uk/government/publications/risk-assessment-framework-raf.

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

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

Part 3, Section 3.2, and detailed in Table 10 section 2.3.7 *Reporting Against Core Quality Indicators* sets out the relevant indicators and performance thresholds outlined in Appendix A of NHS Improvement's *Risk Assessment Framework*. Unless stated in the supporting notes, these are monitored on a quarterly basis.

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

indicators which have not already been reported in Part 2 will be reported here to avoid duplication of reporting.

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

3.2.1 Our Performance- National Quality Standards

2017/18 has been an extremely busy and challenging year with a key focus on: recruiting to key medical, nursing and leadership roles; the system wide approach to improving access to urgent care services through the achievement of the 4 Hour Standard; the management of additional demand for diagnostic services within Core Clinical Services; the planning for the transfer of community services from Cumbria Partnership Trust and the Blackpool Victoria Trust; the development of future pathways within Bay and Healthcare Partners; and a root and branch review of the activity and leadership structure within the Division of Surgery and Critical Care.

The Trust achieved Cancer 62 Day Standard in Quarters 2 and 3, and the Cancer 31 Day and Cancer 14 Day Standard in Quarters 1 to 3. In Quarter 3, all eight cancer standards were met, bucking the national trend of declining performance. . In Quarter 4, six of the eight Cancer standards were met. The Immediate Discharge Summary communication within 24 hours standard was met throughout 2017/18. The Diagnostic 6 week standard was achieved in 9 of the 12 months, with breaches predominantly related to equipment failure.

Table 11 and 12 shows the results from the Trust's assessment of performance against the healthcare targets and indicators over the past 3 years, as currently reported in section 5a of the Integrated Board Performance Report and/or the Executive Dashboard which is submitted to the Board of Directors at each of its meetings.

Table 11: Performance against Quality Standards and Indicators- Quarterly Key Performance Indicators

	2015/16				2016/17				2017/18			
Standard	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
A&E: maximum waiting time of four hours from arrival to admission/ transfer/ discharge	Failed to Meet	Met	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet
All cancers: 31-day wait for second or subsequent treatment - surgery	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
All cancers: 31-day wait for second or subsequent treatment- drug treatment	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
All cancers: 62-day wait for first treatment from urgent GP referral for suspected cancer	Met	Met	Met	Met	Met	Failed to Meet	Met	Failed to Meet	Failed to Meet	Met	Met	Failed to Meet
All cancers: 62-day wait for first treatment from NHS Cancer Screening	Met	Met	Met	Met	Met	Met	Met	Met	Failed to Meet	Met	Met	Failed to Meet

Service referral												
All cancers: 31-day wait from diagnosis to first treatment	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Cancer: two week wait from referral to date first seen- all urgent referrals	Failed to Meet	Failed to Meet	Failed to Meet	Met	Met	Met	Met	Met	Met	Met	Met	Met
Data Source: Unify Data												

Table 12: 2017/18 Performance against Quality Standards and Indicators- Quarterly Key Performance Indicators

Standard	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Maximum time of 18 weeks from referral to treatment– incomplete	89.39%	89.49%	89.19%	88.72%	88.29%	87.60%	87.96%	87.50%	86.08%	85.53%	85.40%	84.75
Diagnostic waits over 6 weeks	0.90%	0.95%	0.73%	0.92%	1.18%	0.73%	0.57%	0.57%	0.95%	1.09%	0.77%	1.89
Urgent Operations cancelled for the second or subsequent time	0	0	1	0	0	0	0	0	0	1	0	4
Ambulance Handover Time	17.10	17.10	17.20	17.75	16.20	16.20	16.50	16.50	19.60	19.90	19..00	26.1
Data Source: Unify Data												

3.2.2 Other Quality Indicators

Referral to Treatment (RTT) Data

The Sustainability and Transformation trajectory was met in April and May; however, the national standard of 92% has not been achieved in 2017/18. Nine out of 17 specialties within the Division of Medicine and the Women and Children's Division plus the specialty of Urology with the division of Surgery and Critical care are sustainably exceeding the national standard of 92%; thus, supporting the overall Trust position. However, six surgical specialties are consistently underperforming against the national standard: Anaesthetics, Ophthalmology, ENT, Oral Surgery, General Surgery, and Trauma and Orthopaedics. Due to the high numbers of patient activity in the majority of the underperforming specialties, a downturn in individual specialty performance has a high impact on the Trust total.

RTT performance has been affected throughout 2017/18 due to the ongoing impact of the cancellations in 2016/17 due to the series of scheduled industrial action planned by Junior Doctors; prolonged unavailability of theatres due to air handling unit breakdowns and the instruction by NHSI to cancel all non-urgent elective surgery in December to February 2017. In 2017/18, winter pressures, medical staffing vacancies, unavailability of theatres due to planned and unplanned maintenance and a further NHSI instruction to cancel all non-urgent surgery between December and early February have further impacted upon performance, with a 4% reduction in performance between April 2017 and January 2018.

The recent refresh to the NHS Plan states that the national minimum expectation is that the number of patients on the incomplete waiting list in March 2019 will be no higher than the number on the waiting list in March 2018 and where possible to the waiting list size should be reduced. However, the ongoing consistent message is that all efforts should be made to meet the RTT standard by specialty in line with the NHS Constitution. In addition, the number of patients waiting greater than 52 weeks for first definitive treatment should be halved by March 2019 and eliminated where possible. In 2017/18 to January, 10 patients have waited greater than 52 weeks for first treatment.

Risks to the achievement of the standards going forward include: the ongoing impact of the NHSI cancellations, medical and theatre staff vacancies, bed pressures due to emergency admissions, and planned and unplanned theatre downtime for maintenance.

Actions taken to improve patient experience through the achievement of the 18 week standard in 2018/19 include;

- Programme of work supported by the NHS Improvement Intensive Support Team to develop timed 18 week patient pathways, gain greater learning from the pathways of longer waiting patients through formal breach analysis.
- Updated and automated capacity and demand analysis by specialty from April to facilitate balanced demand and capacity.
- As part of the Bay and Healthcare Partners plan, focus on reducing the wait to first appointment through clinically appropriate use of outpatient capacity.
- Maximising the reutilisation of outpatient clinics and theatre sessions for Consultant leave.

Table 13a details month on month RTT performance for 2016/17. Table 13b details month on month RTT performance for 2017/18 against the Sustainability and Transformation Fund trajectory and the national standard of 92%.

Table 13a: Month on Month RTT Performance for 2016-17

RTT Performance 2016/17	Apr -16	May - 16	Jun -16	Jul -16	Aug -16	Sep -16	Oct -16	Nov -16	Dec -16	Jan -17	Feb -17	Mar -17	Average for 2016/ 17
RTT Incomplete Standard 92%	92	92	92	92	92	92	92	92	92	92	92	92	92
STF Trajectory %	88.6	89.1	89.7	90.0	90.2	91.8	91.7	92	92	92	92	92	90.92
<18 weeks against STF Trajectory	89.5	89.7	89.71	90.08	88.82	87.99	87.99	88.49	87.75	87.78	88.26	89.75	88.82%
<18 weeks against National Standard	89.5	89.7	89.71	90.08	88.82	87.99	87.99	88.49	87.75	87.78	88.26	89.75	88.81%

Data Source: Unify Data

Table 13b: Month on Month RTT Performance for 2017/18

RTT Performance 2015/16	Apr -17	May -17	Jun -17	Jul -17	Aug -17	Sep-17	Oct -17	Nov -17	Dec -17	Jan - 18	Feb -18	Mar -18	Average 2017/18
RTT - Incomplete standard 92%	92	92	92	92	92	92	92	92	92	92	92	92	92.00
<18 weeks	88.76	89.31	89.70	90.00	89.80	89.60	90.00	90.30	90.10	90.00	90.40	90.76	89.90
<18 weeks against STF Trajectory	89.39	89.49	89.19	88.72	88.29	87.6	87.96	87.5	86.08	85.53	85.4	84.75	87.49
<18 weeks against National Standard	89.39	89.49	89.19	88.72	88.29	87.6	87.96	87.5	86.08	85.53	85.4	84.75	87.49

Data Source: Unify Data

Accident and Emergency Department 4 hour standard for 2016/2017 and 2017/18

As shown in Table 14a and 14b below, the Trust achieved the 4 hour Accident and Emergency standard between May 2015 and August 2015, but from September 2015 the Trust did not achieve the standard.

Table 14a: Trust wide Accident and Emergency Department 4 hour standard for 2016-17

A&E Performance 2016/17	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17
A&E standard 95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Trust 95% performance	86.55 %	90.54 %	91.67 %	86.24 %	83.02 %	81.91 %	87.35 %	84.19 %	81.04 %	79.45 %	81.18 %	83.39 %
>4 hours	86.56 %	90.54 %	91.67 %	86.24 %	83.02 %	81.91 %	87.35 %	84.19 %	81.04 %	79.45 %	81.18 %	83.39 %
STF Trajectory	85.00 %	90.50 %	93.00 %	95.00 %	95.00 %	94.00 %	93.01 %	93.00 %	92.50 %	91.00 %	92.00 %	95.00 %

Data Source: Unify data: the indicator is in relation to the percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge

Table 14b: RLI and FGH Accident and Emergency Department 4 hour standard for 2016/17

A&E Performance 2016/17	Apr -16	May -16	Jun -16	Jul -16	Aug -16	Sep -16	Oct -16	Nov -16	Dec -16	Jan -17	Feb -17	Mar -17	Average 2016/17
A&E Standard 95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
FGH	88.59%	91.36 %	91.86 %	87.57 %	85.31 %	87.62 %	91.82 %	86.38 %	83.10 %	75.38 %	74.24 %	79.57 %	85.23%
RLI	81.85%	87.28 %	89.31 %	80.29 %	76.45 %	72.89 %	80.12 %	77.77 %	74.48 %	74.48 %	79.29 %	80.58 %	79.56%
Average RLI and FGH *(Type 1)*	85.22%	89.32 %	90.59 %	83.93 %	80.88 %	80.26 %	85.97 %	82.08 %	78.79 %	74.93 %	76.77 %	80.08 %	82.14%

Data Source: Unify data: the indicator is in relation to the percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge

As shown in Table 11, and in Table 15a and Table 15b below, the Trust has failed to meet the 95% 4 hour Accident and Emergency Standard in 2017/18, but met the STF trajectory in October 2017.

Table 15a: Trust wide Accident and Emergency Department 4 hour standard for 2017-18

A&E Performance 2017/18	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
A&E standard 95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Trust 95% performance	86.63%	85.46 %	88.67 %	85.19 %	86.65 %	89.41 %	90.49 %	87.64 %	84.79 %	79.41 %	82.48 %	76.33 %
>4 hours	86.63%	85.46 %	88.67 %	85.19 %	86.65 %	89.41 %	90.49 %	87.64 %	84.79 %	79.41 %	82.48 %	76.33 %
STF Trajectory	90.01%	90.00 %	90.01 %	90.01 %	90.00 %	90.00 %	90.01 %	90.00 %	90.00 %	88.01 %	88.00 %	95.00 %

Data Source: Unify data: the indicator is in relation to the percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge

Table 15b: Site & Trust Wide Accident and Emergency Department 4 hour standard for 2017-18

A&E Performance 2017/18	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Average 2016/17
A&E standard 95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
RLI Performance	84.05 %	83.04 %	87.70 %	80.76 %	83.10 %	87.35 %	87.19 %	81.36 %	79.79 %	75.06 %	75.63 %	69.07 %	81.08 %

FGH Performance	81.03 %	82.75 %	84.83 %	83.49 %	87.23 %	87.75 %	90.64 %	93.13 %	83.73 %	76.26 %	83.98 %	77.13 %	84.12 %
Average RLI and FGH *(Type 1)*	82.8%	82.9%	86.5%	81.9%	84.8%	87.5%	88.3%	85.5%	81.1%	75.2%	78.5%	71.8%	82.28 %
Data Source: Unify data: the indicator is in relation to the percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge													

The strategy for patient flow and winter planning in 2017/18 was to achieve an 85% average occupancy within the current bed base by a combination of working with system partners to limit what comes in the front door, reducing length of stay through improving processes in the acute phase and a reconfiguration of medical and surgical beds and by reducing delays in discharge, again working with system, partners through a number of whole system initiatives – specifically Discharge to Assess (D2A).

Unfortunately, implementation of the Discharge to Assess model has been slow to implement, for a variety of reasons, and bed occupancy has a result been very high and suboptimal for patient flow. The ED standard, a barometer of flow across the system, has therefore not been achieved throughout 2017/18 with significant variance of between 79.4% in December 2017 to 90.49% in October 2017.

Looking forward, the strategy of delivering and embedding 85% bed occupancy to support effective patient flow will be continued through 2018/19.

Implementation of the D2A model remains key to delivering this and is planned to commence in late 2017/18.

In Morecambe Bay, system partners have agreed to develop a model of three pathways under D2A – pathway 1 Home First, pathway 2 – interim residential care and pathway 3 24/7 supported nursing care.

The model follows the Home First principle i.e. if the patient can be supported at home whilst longer term assessments are undertaken then this will be the pathway. For some patients this is not possible and they need a period of supported rehabilitation in an interim care facility and for others they have greater care needs and require support in a 24/7 nursing home whilst the assessment is completed.

The aim is to minimise the time a patient stays in hospital by facilitating an earlier discharge through one of these pathways 1, 2 and 3 under D2A once the patient is medically fit. Patients will then be discharged either directly home, or to a residential or nursing placement for a further period of re-ablement and then assessment for long-term care needs.

In order to support this new model a range of services will be in place and some short term funding has been secured to support implementation of the model whilst strategic analysis of benefits and longer term funding arrangements is undertaken.

Capacity planned is as follows:

- For pathway 1 Home First, this is an expanded UHMB Hospital Home Care service.
- For pathway 2, Intermediate Care, this is primarily Altham Meadows supporting the RLI locality and Park View Gardens, supporting the FGH locality.
- For pathway 3, a block of care home beds in each acute locality will be commissioned.

In addition to implementation of this model focus will also be on supporting the development of the out of hospital respiratory and Frailty models together with the Integrated Care Community development.

Emergency Readmissions within 28 days

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

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

Table 16: Inpatient readmissions within 28 days									
Division	Number of Monitor Readmissions < 28 Days			Percentage (%) of Monitor Readmission Rate < 28 Days			Number of Spells		
	2015/16	2016/17	2017/18	2015/16	2016/17	2017/18	2015/16	2016/17	2017/18
Acute Medicine Elective Medicine	2528	2345	2244	13.75%	13.57%	13.05%	18387	17285	17192
Women's and Children's	1381	1183	1436	12.58%	12.29%	13.92%	10980	10656	10318
Core Clinical Services	1	1	1	11.11%	10.00%	14.29%	9	10	7
Surgery	1221	1131	1272	9.27%	8.97%	9.95%	13174	12613	12782
TRUST TOTAL	**5131**	**4787**	**4953**	**12.06%**	**11.80%**	**12.29%**	**42550**	**37091**	**40299**
Data Source: UHMBFT Data Warehouse Readmissions Model (please note Monitor readmission rate calculation applies exclusion criteria). The definitio for this indicator is in relation to emergency re-admissions within 28 days of discharge from hospital. (Period 01/04/2017 – 31/03/2018)									

Cancer 62 day Waiting Time Standard for first treatment

As shown in Table 11, the Cancer 2 week wait standard has been consistently met since January 2016.

In Tables 17a and 17b below, the Cancer 62 Day standard has been consistently met in 9 of the last 12 months with the standard achieved in Quarters 2 (July- September) and Quarter 3 (October to December).

In December and Quarter 3, all eight cancer standards were achieved. Our Cancer 62 Day Standard has consistently bucked the national trend of worsening performance and again in Quarter 3, we achieved the standard at 86.05% as compared to the failing national average of 82.8%.

In Quarter 4, we achieved the standard at 84.74% against the 85% standard, failing January and February, but achieving March.

Table 17a: Performance against Cancer 62 day waiting time standard for first treatment- Quarterly Key Performance Indicators													
	2015/16				2016/17				2017/18				
Standard	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Average 2017/18
All cancers: 62-day wait for first treatment from urgent GP referral for suspected cancer	Met	Met	Met	Met	Met	Failed to Meet	Met	Failed to Meet	Failed to Meet	Met	Met	Failed to Meet	84.72%
All cancers: 62-day wait for first treatment from NHS Cancer Screening Service referral	Met	Met	Met	Met	Met	Met	Met	Met	Failed to Meet	Met	Met	Failed to Meet	86.78%
Data Source: Unify Data													

Table 17b: Performance against Cancer 62 day waiting time standard for first treatment- Quarterly Key Performance Indicators													
A&E Performance 2017/18	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	
62 day standard 85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	Average 2017/18
All cancers: 62-day wait for first treatment from urgent GP referral for suspected cancer	85.79 %	87.20 %	78.03 %	87.77 %	85.71 %	86.11 %	82.42 %	89.73 %	89.67 %	82.88 %	79.62 %	85.56 %	84.71 %

All cancers: 62-day wait for first treatment from NHS Cancer Screening Service referral	88.14 %	85.07 %	86.27 %	68.52 %	88.06 %	94.87 %	92.11 %	85.45 %	93.94 %	95.74 %	80.00 %	86.05 %	86.85 %
Data Source: Unify Data													

Key national expectations for 2018/19 include:

- The delivery of all eight cancer standards, with the release of cancer transformational monies being linked to the achievement of the 62 day standard.
- Ensuring the delivery of the nationally agreed rapid assessment and diagnostic pathways for lung, Prostate and Lower and Upper GI tumour groups.
- Progress towards the 2020 diagnosis by Day 28 standard.
- Roll out of Faecal Immunochemical Test (FIT) testing to guide referral for suspected colorectal cancer in people without rectal bleeding who have unexplained symptoms but do not meet the criteria for a suspected cancer pathway referral outlined in NICE's guideline on suspected cancer.

Other local developments include the roll out of electronic referral for suspected cancer referrals from 1st April 2018.

Risks to delivery include:

- Patients not wishing to accept offered dates, resulting in delayed diagnosis and treatment.
- Lack of diagnostic capacity including Endoscopy, Radiology and network wide capacity shortfalls such as Endoscopic Ultrasound.
- Service pressures such Clinical Nurse Specialist and Medical vacancies.

Actions in 2018/19 include:

- Contribution to the design of and implement the Cancer Alliance wide pathways for lung, Upper and Lower Gastrointestinal (GI) and Prostate
- Enhanced learning through breach analysis
- Roll out of FIT testing
- Improvement trajectories to be agreed by tumour group to be agreed.
- Programme of continuous capacity and demand for cancer 2 week wait slots to assist capacity planning.

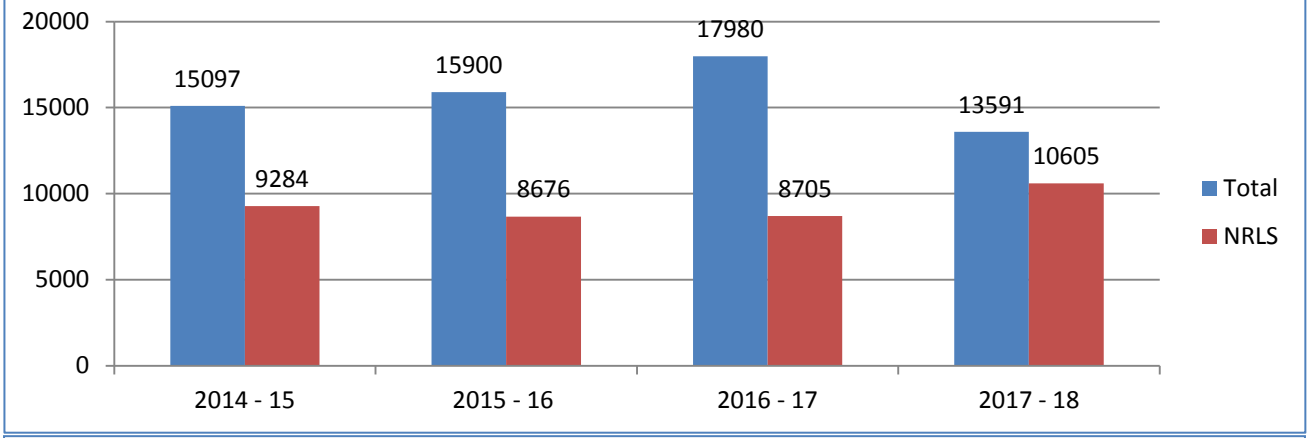
A detailed improvement and delivery plan is overseen by the Cancer Quality Group, which meets bi-monthly to drive forward improvements in cancer services.

3.3 Other Additional Information in Relation to the Quality of NHS Services

3.3.1 Learning from Patient Safety Incidents

Learning from patient safety incidents is a key feature of the Trust's Risk Management Strategy and staff endeavour to use the knowledge gained from their investigation to improve care. The Trust has a good reporting culture and staff reported 10,605 patient safety incidents in 2017/18 to date (31.03.2018). The National Reporting and Learning System (NRLS) helps the NHS to understand why, what and how patient safety incidents happen, learn from these experiences and take action to prevent future harm to patients. National data can be found at: www.nrls.npsa.nhs.uk/patient-safety-data/. Graph 2 below shows the total number of incidents reported and the number reported to the national patient safety agency.

Graph 2 – Patient Safety Incidents by Year



Data source: NPSA and Trust Incident Management System. This data is governed by standard national definitions

Lessons to be learnt are identified as part of the investigation process. These are discussed at ward governance meetings and cascaded to relevant staff. There is a monthly 'Learning to Improve' meeting that shares lessons which are then distributed throughout the Trust in monthly divisional and organisational newsletters. The following example topics were included in bulletins in 2017/18:

- Deprivation of Liberty Services (DoLS)
- Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) communication
- Infection Prevention
- Sepsis
- Falls
- Labelling of test samples & expiry dates on blood bottles
- Situation Background Assessment Recommendation (SBAR) communication
- Inappropriate use of mobile phones by staff and patients

Table 18a and 18b below shows the number of incidents reported to the National Reporting and Learning System (NRLS) each month for the year. The NRLS then use the numbers reported and calculate a standardised ratio of incidents reported per 1000 days patients are in hospital beds. This is then published nationally with comparisons to other hospitals in the NHS (see Table 10).

Table 18a: Patient Safety Incidents by year 2016-2017

	2016 04	2016 05	2016 06	2016 07	2016 08	2016 09	2016 10	2016 11	2016 12	2017 01	2017 02	2017 03
1 No Injuries	469	505	473	550	524	463	476	462	393	519	500	546
2 Minor	179	193	167	183	173	161	177	187	181	201	174	198
3 Moderate	11	22	20	18	15	24	21	17	11	10	17	22
4 Major	3	0	2	2	0	1	3	0	0	1	1	0
5 Catastrophic	2	0	1	0	0	0	1	0	2	1	1	0
6 Near Miss	90	79	40	30	50	35	45	37	29	34	30	50
Grand Total	**752**	**801**	**702**	**784**	**762**	**684**	**722**	**704**	**614**	**767**	**723**	**817**

Data source: Trust Incident Management System. This data is governed by standard national definitions

Table 18b: Patient Safety Incidents by year 2017/18

	2017 04	2017 05	2017 06	2017 07	2017 08	2017 09	2017 10	2017 11	2017 12	2018 01	2018 02	2018 03
1 No Injuries	479	541	556	652	688	606	610	611	593	671	654	719
2 Minor	178	196	221	237	249	202	203	207	223	230	194	218
3 Moderate	15	15	17	24	24	19	17	18	13	23	25	26
4 Major	2	0	1	2	0	1	2	1		1		1
5 Catastrophic	0	1	1	1	2	1		1				
6 Near Miss	30	36	39	46	37	41	44	27	29	35	17	32
Grand Total	**704**	**789**	**835**	**962**	**1000**	**870**	**876**	**865**	**858**	**960**	**890**	**996**

Data source: Trust Incident Management System. This data is governed by standard national definitions

3.3.2 External Incidents Reported

Our staff also report incidents that relate to events occurring outside our Trust. These are summarised and discussed with colleagues outside the Trust. Table 19 below shows the number of external incidents that have been reported between 2012/13 and 2017/18.

Table 19: External Incidents Reported						
Incident Group	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**
Tissue Viability – In community	944	1121	1378	1339	1539	1448
Safeguarding - (Children)	134	956	1362	2316	4023	4650
Other Incidents	12	81	385	486	377	295
Safeguarding - (Adults)	65	169	289	550	983	668
Data source: Trust Incident Management System. This data is not governed by standard national definitions						

3.3.3 How Duty of Candour is being implemented

Duty of Candour is required if any patient suffers moderate harm as a result of an incident.

The implementation of this is firstly supported within the computerised incident management system. When any Patient Safety Incident is submitted by a member of staff, they are asked if the patient or family have been informed of the incident, how they were informed, and any reason for not informing. This happens for all incidents and promotes good practice with regard to openness and transparency. They are also required to grade the incident for patient harm. If the incident is graded as moderate harm the investigating manager is informed and has to identify a lead person to complete the Duty of Candour, who will then record details of the completion.

All incidents that are thought to cause moderate harm are reviewed and discussed at the Weekly Patient Safety Summit which is led by the Executive Chief Nurse or the Medical Director. The actual harm caused by the incident triggers a need for a Duty of Candour and the Duty of Candour letter that is sent to the patient is appended to the Patient Safety Summit Meeting minutes.

Information on the completion of a Duty of Candour is also included in the monthly Trust Executive and Quality Dashboards.

The Patient Safety Team monitor all incidents that have caused moderate harm and they ensure that supporting evidence of completion of a Duty of candour is attached to the incident record on the computerised incident management system. Each quarter the information is collated and an audit of Duty of Candour is presented to the Serious Incident Review and Investigations (SIRI) Panel as part of the Quarterly Incident Report. This Quarterly Incident Report is then presented to the Quality Committee which reports to the Board of Directors. The current duty of candour status is under review by the Divisional Governance Business Partners in order to review, validate and update the incident reports against those progressing. A live compliance report has now been developed and a new monitoring process will be put in place.

3.3.4 Sign up to Safety

The Sign up to Safety was launched in 2014 as a new national patient safety campaign with its mission to strengthen patient safety in the NHS and make it the safest healthcare system in the world. The campaign aims to listen to patients, carers and staff, learn from what they say when things go wrong and take action to improve patients' safety helping to ensure patients get harm free care every time, everywhere. As part of the UHMBFT response to improving safety for patients, the Trust committed to take part in the 3 year *Sign up to Safety* campaign. This will run parallel to *Our Quality Improvement Plan 2016- 2019.*

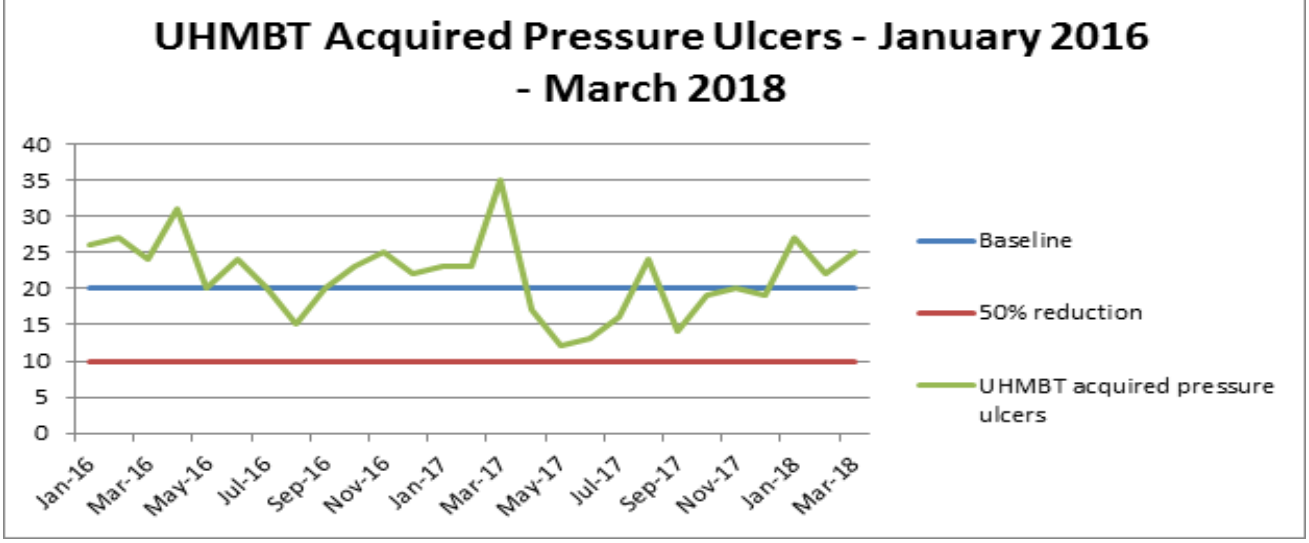
The following information details the scope of the campaign in UHMBFT, which focuses on four change programmes:

Reduce the incidence of hospital acquired pressure ulcers by 50% by April 2018 from a baseline April to September 2014.

Graph 3 shows current performance for this indictor. The graph has a differing baseline and reduction target to that reported previously, as grade 1 pressure damage is no longer externally reported. A recalculation of the April to September 2014 figures, excluding the grade 1's, gives a new baseline of 122 cases or 20 per month meaning that a 50 % reduction over the same time period would be a ceiling of around 10 per month by April 2018.

Although a great deal of good work has been undertaken, the Trust is struggling to meet this target. This is due to rising demand of the Tissue Viability Service, and the increasing pressures seen across UHMBT. Work is continuing to reduce UHMBFT acquired pressure ulcers, but it is unlikely that the target will be met without further input of resources.

Graph 3: Total Pressure Ulcers

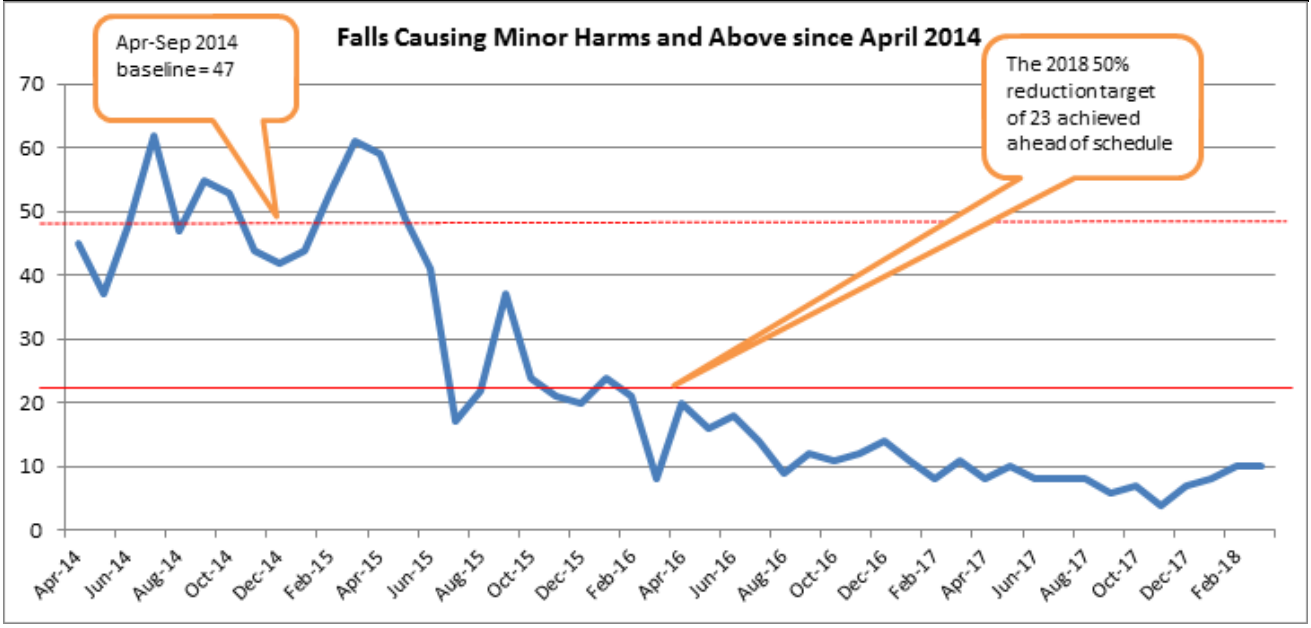


Reduce harm caused by patient falls by 50% by April 2018 from a baseline April to September 2014.

During the reference period April to September 2014, a total of 284 patient falls were reported to have caused harm which is a baseline of 47 cases per month. A 50% reduction from the baseline of 47 harms per month was, therefore, identified to reduce the number of cases to 23 or less per month, by April 2018.

The Trust has consistently delivered against this target and reached the April 2018 target ahead of schedule in October/November 2015. Actual harms continue below the target in single figures, as shown in Graph 4 below every two months to March 2018.

Graph 4: UHMBFT Falls With Harm Apr 2015 to Mar 2018



Reduce the harm caused by medication incidents causing harms by 50% by April 2018 from a baseline April to September 2014.

The initial task in relation to reducing the harm caused by medication incidents was to establish a range of measures that can be used to monitor progress and improve Medication Safety. Following a review of reducing harms by 50%, it is felt that without taking into consideration the increase in activity within the Trust this target does not reflect the true picture of safety in relation to reported medication incidents.

Table 20: Progress with Medication Safety within UHMBFT since April 2014				
Number of Medication Incidents Reported				
Year	All Incidents	Incidents resulting in Harm	Incidents resulting in Moderate or above Harm	Bed Days Used
2014-15	1295	233	21	351,913
2015-16	1338	222	12	353,914
2016-17	1214	208	9	355,178
2017-18	1238	390	17	349,105
Ratio of Medication Incidents per 1000 Bed Days Used				
Year	All Incidents	Incidents resulting in Harm	Incidents resulting in Moderate or above Harm	Bed Days Used
2014-15	3.680	0.662	0.060	351,913
2015-16	3.781	0.627	0.034	353,914
2016-17	3.418	0.586	0.025	355,178
2017-18	3.546	1.117	0.049	349,105
% Reduction in Medication Incidents per 1,000 Bed Days Used from 2014/15 to 2017/18				
Year	All Incidents	Incidents resulting in Harm	Incidents resulting in Moderate or above Harm	Bed Days Used
2014-2017/18	-3.63	68.73	-18.40	1410,110

The ratio of Medication Incidents per 1,000 Bed Days that result in Moderate or Above Harm have decreased by 18.4% from 2014/15 to 2017/18.

The percentage reduction has fluctuated significantly over the past four years. In 2016/17, the Trust had achieved a 50% reduction in moderate harm or above Incidents, and was on target for this to remain until the April 2018 target. However, 2017/2018 data has reflected a reduced reduction.

The following actions continue to contribute to reduction of medication incidents:

- Deep dive into the data to understand the reduced reduction and implement supportive actions- led by the Medication Safety Officer
- Introduction of a UHMBFT Medication Safety Officer from September 2014. This role is part of both the National and Regional Networks of Medication Safety Officers to share learning and good practice from Medication incidents.
- Learning from Medication Incidents themes and trends shared with all Trust Staff via the Trust Wide 'Learning to Improve' process and in some cases the learning from serious incidents formally distributed to Department and Ward Managers as Trust Wide internal Alerts requiring acknowledgment and completion of mitigating actions.
- Changes in remit of the Medication Safety Group to concentrate of cross divisional areas of concern and implement clear action plans for improvement and associated monitoring.
- Increased use of access to GP records via the local Medical Inter-operability Gateway (MIG) system and the national Summary Care Records (SCR) system to improve quality of drug history taking on admission.
- Implementation of UHMB Hospital Pharmacy Transformation Programme; Key development to ensure hospital pharmacies achieve their benchmarks such as increasing pharmacist prescribers, e-prescribing and administration, accurate cost coding of medicines and consolidating stock-holding by April 2020, in agreement with NHS Improvement and NHS England so that their pharmacists and clinical pharmacy technicians spend more time on patient-facing medicines optimisation activities. A Board approved UHMB HPTP (Hospital Pharmacy Transformation Plan) is in implementation. The project is reviewed against all national 'The Model Hospital Metrics' for Pharmacy and Medicine including medicines reconciliation compliance.

- Plans to increase the number of Medicines Reconciliations completed within 24 hours following release of pharmacy staff for in-patient work. This is following outsourcing of out-patient dispensing to Lloyds Pharmacy.
- Introduction of Daily Safety Huddles within all Pharmacy departments with a Pharmacy Governance team which reviews medication incidents and produces internal trend reports and a monthly lessons learned bulletin concentrating on Medication safety. This is shared via Divisional Governance and the UHMBFT Learning to Improve group.

Reduce deaths from Stroke for patients with a primary diagnosis of stroke by 30% by April 2018 from a 2013/14 baseline.

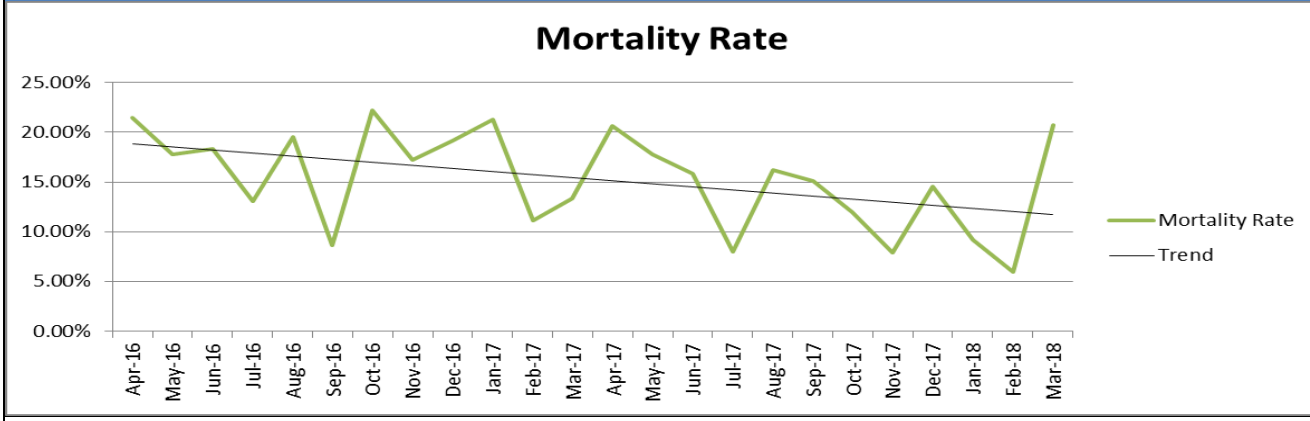
Table 21, below, shows a significant reduction against the 2013/14 baseline and this is in line with the target of reducing stroke related deaths by 30% by April 2018.

Table 21: Stroke data

Fiscal Year	Number of Stroke cases	Number of Mortalities	Mortality Rate %	% Reduction against 2013/14 Baseline
2013/14 - Baseline	677	151	22.30%	
2014/15	605	134	22.15%	0.70%
2015/16	669	109	16.29%	26.95%
2016/17	682	115	16.86%	24.39%
2017/18	671	93	13.86%	37.85%

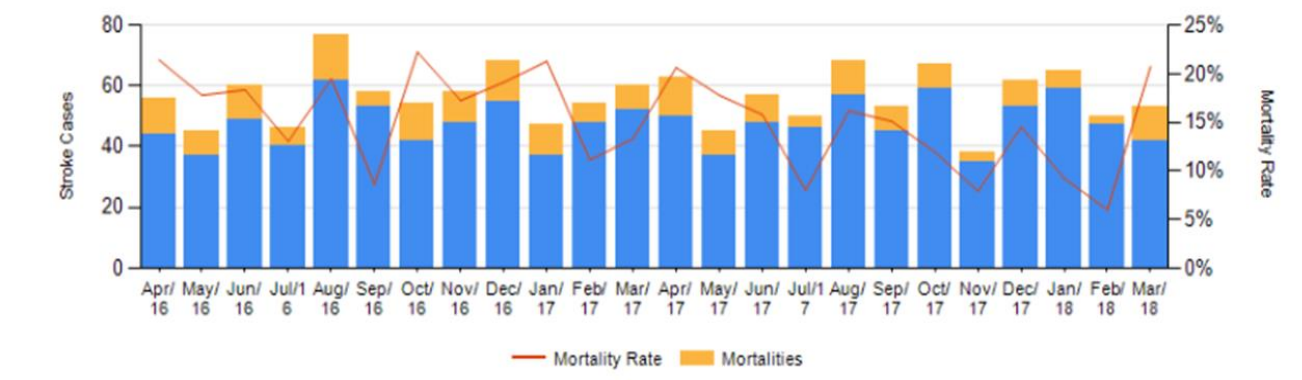
Data Source: UHMBFT Data Warehouse

Graph 5: Stroke Mortality Rate



Data Source: UHMBFT Data Warehouse

Graph 6: Stroke Cases showing number of Mortalities



Data Source: UHMBFT Data Warehouse

Additional Sign up to Safety information

In addition, the Women's and Children's Division developed a Sign up to Safety proposal to reduce harm and the associated costs of litigation with improvements in the provision of Cardiotocography (CTG) interpretation, viewing and archiving. They were successful in a bid to secure £259,000 of funding from the Sign up to Safety campaign. The bid included purchase of additional 11 CTG machines and recruitment to two specialist midwives for safer and active birth. The 11 CTG machines have been purchased and are now in use at both the RLI and FGH sites, and two Safe and Active Birth Midwives have been recruited and have been in post for 9 months at the time of writing.

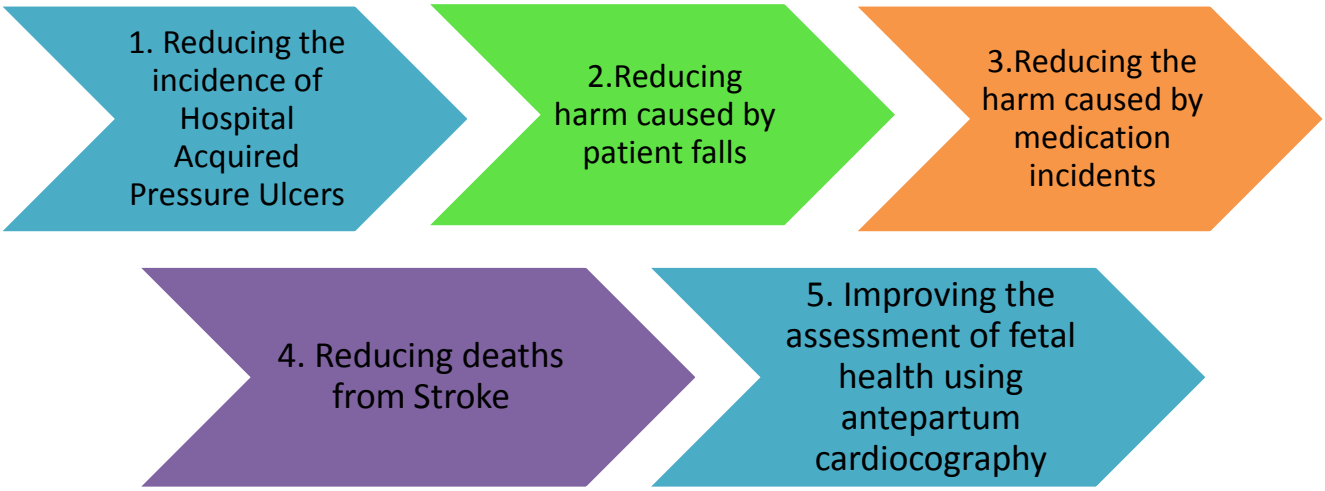
To enable the Trust to meet and deliver the 'sign up to safety' priorities, a Patient Safety Unit was developed in 2016/17 - see section 3.4.2 *Priority 2: Clinical Effectiveness* of this document for the full information.

An improved patient experience has been created by the Safe Active Birth Midwives recruited from the Sign up to Safety successful bid. A reduction in unexpected Neonatal admissions for incorrect CTG interpretation has also been seen alongside improved clinical outcomes in general.

Following the distribution of the maternity safety training funds last year, in which we were successful in securing £80,000, maternity services received significant funding to support essential training to improve areas of training and education for all members of the multi-professional teams in maternity services. This has ranged from robust Cardiotocography training, the implementation of prompt across services as well as other training around perinatal mental health, emergencies in community settings and communication across maternity services. The importance of team based multi-professional training is key to reducing harm with emphasis on the impact of human factors and the ability to support staff to improve continually

The opening of the new FGH Maternity Unit-South Lakes Birth Centre has incorporated a new skills drill lab and 'Sim Mum' which allows staff to have hands on training in a more realistic and safe way to maintain staff competencies.

To ensure that mortality issues are considered across treatment pathways and that patient safety is embedded in clinical education and research programmes. The 'sign up to safety' priorities for 2018/19 are detailed below:



3.3.5 Improvement in 2016 staff survey Key Result outcomes, including KF26 and KF21

For the second year running, the Trust has run an all-census survey giving 5408 eligible staff the opportunity to take part in the national staff survey. The overall return rate was 40.3% which, whilst slightly lower than the 41.9% in 2016, more staff actually took part in the survey with 2181 returning a survey this year compared to 2160 in 2016.

The key findings continue to show an improving trend with double the number of areas being better than average and a reduction from 11 to 5 of the findings in the worse than average area. Like last year, there remain 2 findings in the worse 20% and those in the best 20% have fallen slightly from 8 to 6.

There are three statistically significant improvements in:

KF12 – Quality of appraisals
KF 19 - organisational and Management interest in health and wellbeing
KF1 – staff recommendation of the organisation as a place to work

There are two statistically significant deteriorations in:
KF11 - % appraised in last 12 months
KF20 - % experiencing discrimination at work in the last 12 months

The staff engagement score has stayed fairly static at 3.79 compared to 3.78 in 2016. Whilst this movement has not been significant, it does mean we are reporting the same as the national average.

The following areas are within the best 20%:

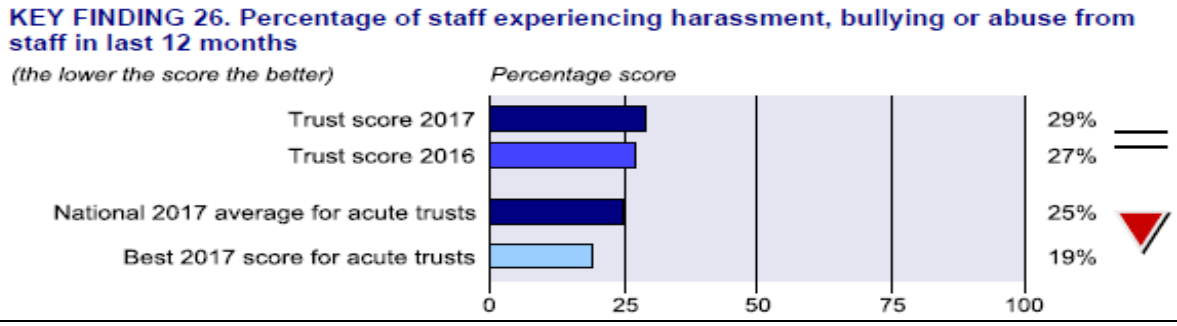
- KF15 Staff satisfied with the opportunities for flexible working patterns
- KF16 Staff working extra hours
- KF 24 Reporting most recent experience of violence
- KF27 reporting most recent experience of harassment, bullying or abuse
- KF30 Fairness and effectiveness of procedures for reporting errors, near misses and incidents
- KF19 Organisational management interest in and action on health and wellbeing

Areas of concern which staff are reporting and upon which the Trust can build foundations for improvement are:

- Quality of appraisals
- Quality of non-mandatory training, learning or development
- Able to contribute to improvements at work
- Effective team working
- Reporting good communication between senior management and staff
- Agreeing their role makes a difference to patients/service users
- Experiencing harassment, bullying or abuse from staff in last 12 months

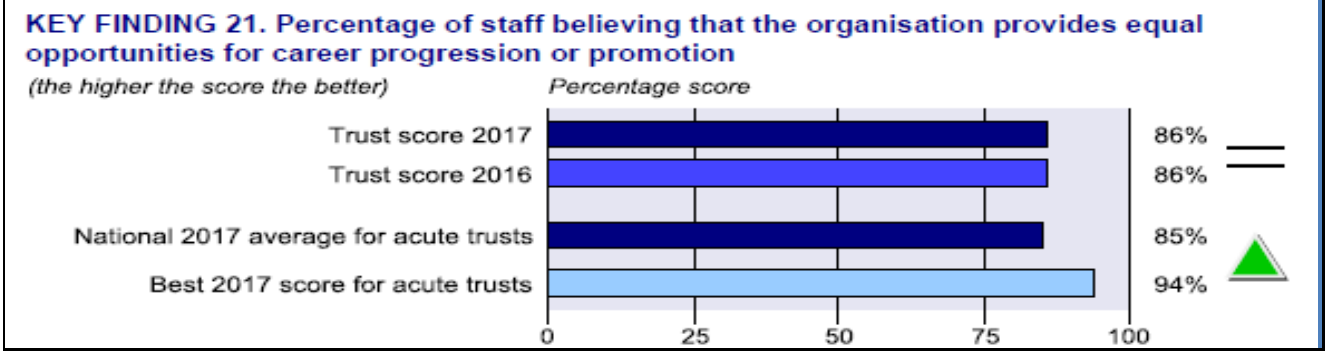
The Trust has seen a slight increase in the numbers of staff reporting bullying and harassment and this year this has put the Trust in the worst 20% for this key finding (Graph 7a: KF26)

Graph 7a: KF26 Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months



There has been no change in the findings for equal opportunities for career progression or promotion with the Trust being above average in this factor (Graph 7b: KF21)

Graph 7b: KF21 Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion



3.3.6 National Inpatient Survey

All Acute NHS Trusts are required by the Care Quality Commission (CQC) to undertake an annual inpatient survey. The Picker Institute was commissioned by 81 trusts to undertake the 2017 Inpatient Survey (which is 55% of all eligible trusts in England). The Inpatient Survey is due to be published in May 2018. A total of 1232 patients from UHMBFT were sent a postal questionnaire in September 2017. 1199 patients were eligible for the survey, of which 521 returned a completed questionnaire, giving a response rate of 43.5%. The average response rate for the 81 'Picker' trusts was 38.3%.

Key facts about the 521 inpatients who responded to the survey:

- 34% of patients were on a waiting list/planned in advance and 62% came as an emergency or urgent case.
- 59% had an operation or procedure during the stay.
- 47% were male; 53% were female.
- 5% were aged 16-39; 15% were aged 40-59; 19% were aged 60-69 and 61% were aged 70+.

The survey has highlighted the many positive aspects of the patient experience:

- Overall: 89% rated care 7+ out of 10.
- Overall: treated with respect and dignity 87%.
- Doctors: always had confidence and trust 86%.
- Hospital: room or ward was very/fairly clean 98%.
- Care: always enough privacy when being examined or treated 91%.

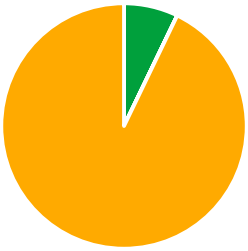
In the 2016 survey, there were 2 particular areas that highlighted concern, and results for both have improved in the 2017 results:

Table 22: UHMBFT has improved on the following questions:			
* Low scores are better *			
Questions	**2015**	**2016**	**2017**
Admission: Had to wait a long time to get a bed on a ward	24%	40%	33%
Nurses: sometimes, rarely or never enough on duty	32%	40%	31%

Overall has UHMBFT improved since the 2016 survey?

A total of 56 questions were used in both the 2016 and 2017 surveys.

Graph 8a: How have we Improved since the 2016 survey?



Of the 56 questions that were used in both the 2016 and 2017 surveys, UHMBT is:

- Significantly BETTER on 4 questions
- Significantly WORSE on 0 questions
- The scores show no significant difference on 52 questions

Table 23: UHMBFT has improved significantly on the following questions:

*** Low scores are better ***

Questions	2016	2017
9. Admission: had to wait long time to get to bed on ward	40 %	33 %
29. Nurses: sometimes, rarely or never enough on duty	40 %	31 %
50. Discharge: was delayed	43 %	35 %
63+. Discharge: family not given enough information to help care	56 %	47 %

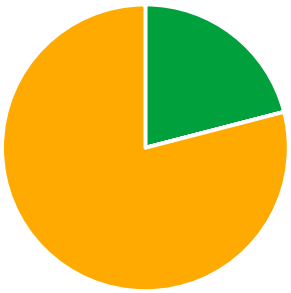
Table 24: The Trust has worsened significantly on the following questions:

*** Lower scores are better ***

	2016	2017
The Trust has not worsened significantly on any questions this year		

In comparison to the other 80 Picker Trusts, how did UHMBFT perform for the 2017 survey?

Graph 8b: Comparison to other Trusts



Of the 62 problem scored questions, UHMBT is:

- Significantly BETTER on 13 questions
- Significantly WORSE on 0 questions
- The scores show no significant difference on 49 questions

Table 25: UHMBFT Results (Better than Picker Average)		
UHMBFT results were significantly better than the 'Picker average' for the following questions:		
*** Lower scores are better ***		
Questions	**UHMBT**	**Picker Average**
11. Hospital: shared sleeping area with opposite sex	5 %	8 %
18+. Hospital: not always able to take own medication when needed to	28 %	34 %
22. Hospital: did not get enough to drink	2 %	6 %
26+. Nurses: did not always get clear answers to questions	25 %	29 %
27. Nurses: did not always have confidence and trust	15 %	20 %
29. Nurses: sometimes, rarely or never enough on duty	31 %	40 %
30. Nurses: did not always know which nurse was in charge of care	41 %	49 %
43+. Care: staff did not help within reasonable time when needed attention	28 %	37 %
50. Discharge: was delayed	35 %	40 %
65+. Discharge: staff did not discuss need for additional equipment or home adaptation	13 %	19 %
67. Overall: not always treated with respect or dignity	13 %	16 %
68. Overall: rated as less than 7/10	11 %	14 %
71+. Overall: not always well looked after by non-clinical hospital staff	11 %	15 %

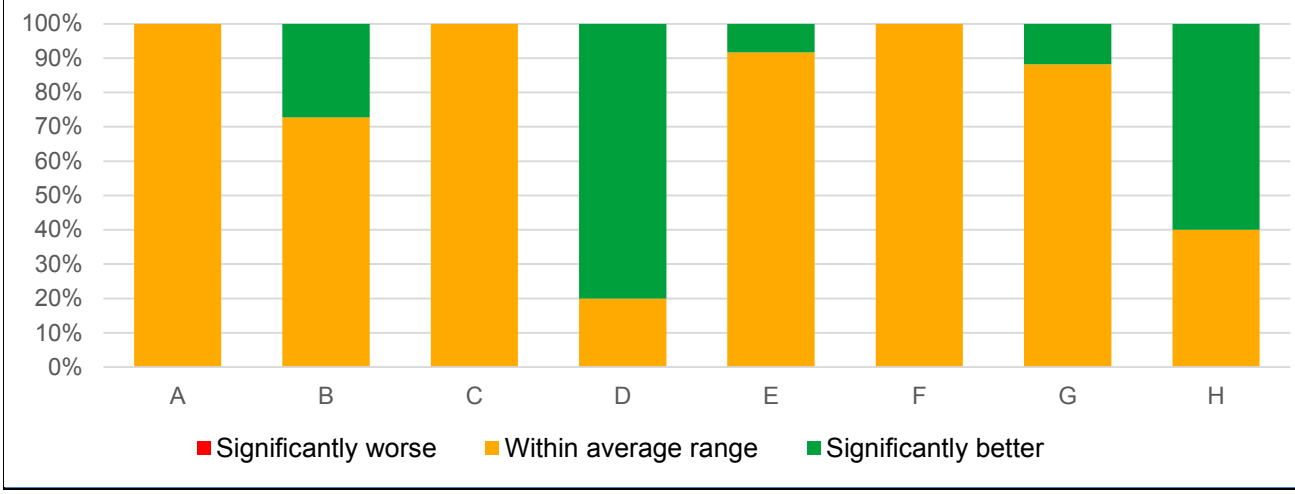
Table 26: UHMBFT Results (Worse than Picker Average)		
UHMBFT results were significantly worse than the 'Picker average' for the following questions:		
*** Lower scores are better ***		
Questions	**UHMBT**	**Picker Average**
No questions were significantly worse than the Picker average		

3.3.6.1 Comparison between sections

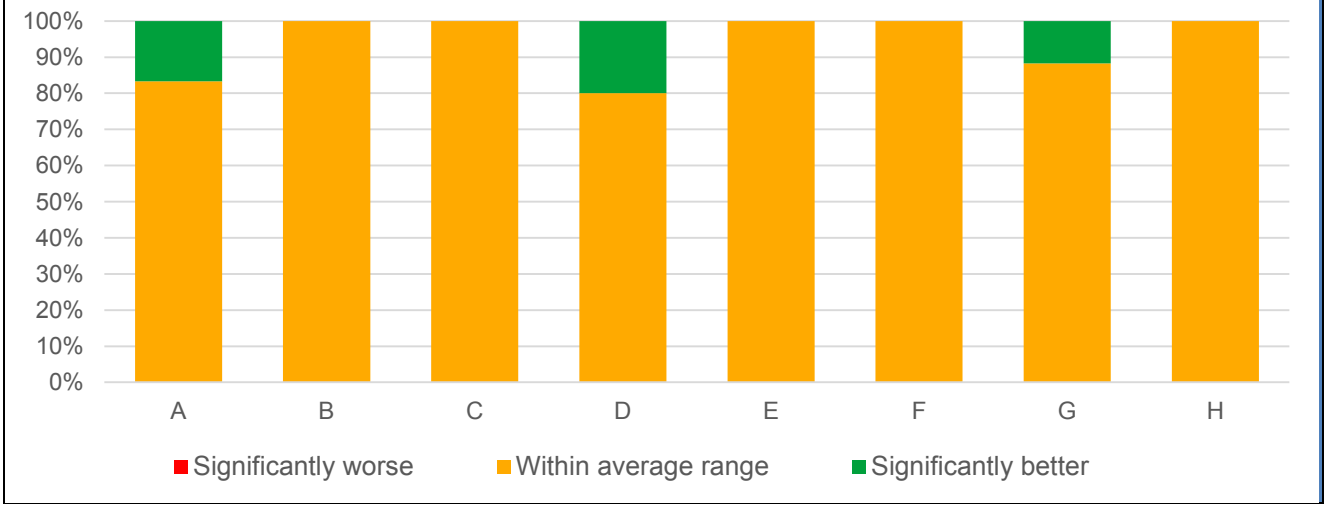
The sections of the Inpatient questionnaire are designed to mirror the patient journey. The significant differences in UHMBFT's performance compared to the average, and compared to the Trust's performance last year, are shown by section. It is easy to see which parts of the trust are performing best and which parts may require improvement.

Table 27: Sections of the Inpatients Questionnaire	
A. Admission to Hospital	E. Your Care & Treatments
B. The Hospital and Ward	F. Operations and Procedures
C. Doctors	G. Leaving Hospital
D. Nurses	H. Overall

Graph 9a: Comparison with the Picker average



Graph 9b: Comparison with the Trust's own performance from the previous survey



The results of the survey need to be communicated and priorities for service improvement need to be identified and agreed across the organisation. The key stages are as follows:

- Compare results within the Trust to help identify problem areas and examples of best practice.
- Target areas where improvements are most needed.
- Look at the actual patient comments for details and suggestions.
- Develop action plans.
- Raise awareness about the patient surveys – publish results and action plans.

It is necessary to maintain the high standards that have been recorded for this survey round and, even though there were no significant areas of a decrease in performance (either reported when measuring historical performance for UHMBFT, or when comparing the most recent 2017 results against other Picker Trusts), it is necessary to remain focussed and to continue to monitor and aim to improve on aspects of care where minor dips in performance have been identified in the survey outcomes.

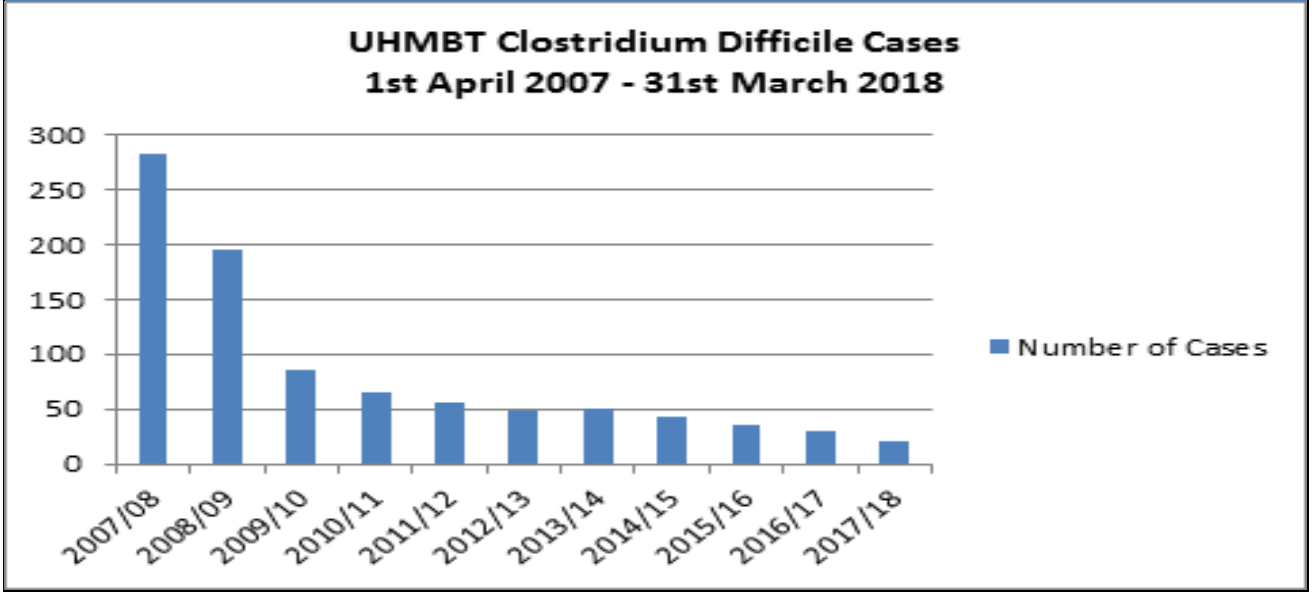
UHMBFT will continue to work hard to ensure that patient experience targets are met and that standards are high across the Trust.

3.3.7 Hospital Acquired Infections

Since 2007, UHMBFT has achieved a year on year reduction in Clostridium Difficile infection (CDI) cases. UHMBFT will continue to commit to the reduction in Health Care Acquired Infection (HCAI) by reducing the avoidable CDI cases in line with the annual trajectory given to us by NHS England.

The annual trajectory for 2017/18 was set at 44 cases for UHMBT. This was the same as the previous year 2016/17. During the year 2017/2018 there were 20 cases of post 72 hour CDI cases identified. 10 of these cases were deemed as having lapses in care identified; 5 cases were deemed as unavoidable as there were no lapses in care identified; 5 cases are currently awaiting a discussion with the relevant CCG. It is nationally recognised that there has been a significant reduction in CDI cases and we may be nearing the irreducible minimum. Therefore, the dramatic reduction that we have seen over recent years may not continue. Our aim is that no patient is harmed by a preventable infection and this is a maximum number of cases, not a target.

Graph 10: Clostridium Difficile by Year



Data source: hospital Incident reporting system. This data is not governed by standard national definitions

The Trust reviewed all post 72 hours Clostridium Difficile (CDI) cases and carried out Post Infection Reviews (PIR). These were led by the Ward Manager responsible for the patient's care and were supported by clinical staff involved in the patient's journey. The Matron attended HCAI meetings to review all CDI cases with the co-ordinating commissioners for North Lancashire and South Cumbria and Lancashire County Council (LCC) Public Health Infection Prevention Team. This provided an additional opportunity to further discuss each case and conclude whether the cases were linked with lapses in care and, therefore, apportioned to UHMBFT. There has been a delay in the Cumbria HCAI meetings – hence currently 5 outstanding. This issue has been escalated within the acute Trust and the CCG, and it is hoped to be rectified imminently.

15 CDI cases, to date, were reviewed over the year resulting in 10 identified as having lapses in care. 5 cases are still awaiting this discussion. To comply with national reporting requirements, the total number of CDI cases assigned to UHMBFT remains as a raw actual number on the National Public Health England Data Capture System, i.e. the number of cases identified post 72 hours after a patient has been admitted. The reduced 'apportioned' number is the number used for contractual purposes against the UHMBFT annual target of 44. Therefore, whilst 20 CDI cases remain as the raw actual number only 10 of these have been apportioned to UHMBFT. This number may increase as the outstanding cases are discussed with the CCG.

A lapse in care would be indicated, by evidence, that policies and procedures consistent with national guidance and standards were not followed by the relevant provider. This would include evidence of:

- Transmission of CDI in hospital confirmed by ribotyping.
- Poor compliance in cleaning standards.
- Poor compliance with infection prevention precautions such as hand hygiene.
- Concerns identified with choice, duration, or documentation of antibiotic prescribing.

It must be noted that true causes of infection can rarely be identified. However, themes across UHMBFT mirror those nationally.

3.3.8 NHS Improvement (formerly Monitor) Governance Framework

NHS Improvement (NHSI) has introduced a new system of regulation described in its Single Oversight Framework which is available from the NHS Improvement web site https://improvement.nhs.uk/

Full details of NHS Improvement's regulatory ratings are provided in the Performance Section of the Annual Report.

The Care Quality Commission (CQC) carried out a re-inspection of the Trust in October 2016 with the report being published on 9 February 2017. The Trust's rating had improved to that of 'Good' overall, with an overall rating of Outstanding for caring with no areas rated as 'inadequate'.

The Report highlighted a number of areas where further work was needed to meet required standards, and these have begun to be addressed. The Trust's CQC Hospital Improvement Plan will include actions and outcomes against every area the CQC has reported that 'must' and 'should' improve, ensuring that they become embedded in day to day work.

The Trust submitted a comprehensive action plan to the CQC. This plan is regularly updated and displayed on the Trust's website, as has been done over the last year.

Following publication of the Chief Inspector of Hospitals Report on the CQC's re-inspection, the Trust is requested NHSI to review the requirements and content of the Enforcement Notice attached to its Licence. NHSI responded by removing the licence conditions in relation to Urgent Care, Maternity Services (Kirkup Report) and Quality.

3.4 Detailed Description of Performance on Quality in 2017/18 against Priorities in 2016/17 Quality Accounts

This section provides a detailed description regarding the quality initiatives (see Table 1) that have been progressed by the Trust based on performance in 2017/18 against the 2016/17 indicators for the following priorities:

- Priority 1: Patient Safety.
- Priority 2: Clinical Effectiveness.
- Priority 3: Patient Experience.

3.4.1 Priority 1: Patient Safety

Achieve at least 98% Harm Free Care 2017/18 TO 2018/19

We know that our services must not only be of high quality and effective, but that they must always be safe. We have a range of processes and procedures to ensure that safety remains a top priority.

Measures

- Achieve at least 98% Safety Thermometer Harm Free Care for new harms by year-end 2017/18.
- At least 99% of patients receiving Harm Free Care, consistent across every ward, as measured by the Department of Health monthly point prevalence 'Safety Thermometer Tool' within 5 years (by 2018/2019).
- This is in-line with the Trust target to ensure at least 99% of patients receive Harm Free Care within five years in line with the Trust's Quality Improvement Strategy and Plan (QIP) 2016-19.

Performance

- Safety Thermometer performance for April 2015 to March 2016 was 95.9% (March 2016 data for new harms) which was above the expected performance of 93.5%.
- Performance for April 2016 to March 2017 was 97.5% (March 2017 data for new harms) which was above the expected performance of 95%.
- Performance for April 2017 to March 2018 was 97.8% (January 2018 data for new harms) which was a little below the expected performance of 98%.

Embed the National Early Warning Score (NEWS) and monitor through audit tools

The National Early Warning Score (NEWS) was adopted within UHMBFT in August 2016 and is widely used across wards and departments. Accuracy of completion and adherence to the escalation pathway associated with NEWS is monitored through the Matron's audits, Quality Assurance Accreditation Scheme (QAAS), on rapid reviews conducted by resus in response to 2222 calls and at mortality reviews. NEWS2 has recently been nationally recommended as an updated version and we plan to change to NEWS2 in 2018.

Develop data systems to help to review a variation by site, specialty and clinician level which will be monitored through Trust dashboards.

The Trust's Informatics Team are working closely with the Medical Director to support the capture of structured clinical data which can be used to support clinical audit and the development of clinical outcomes performance measures. Pilot work has been undertaken with the Ophthalmology service who are maturing their integration with the Trust's Electronic Patient Record and are working with the Informatics team on the development of clinical analytics and dashboards. In addition, cross-organisation clinical groups are steering the development clinical dashboards to support pathway transformation, these include stroke, respiratory and urgent care.

Bring together, through the Patient Safety Unit, key partners to ensure that learning and remembrance underpin all events and awards throughout the year.

An outcome for the Listening into Action (LiA) Remembrance event last year was to hold an annual conference with a theme of "remembrance" relating to patient safety. The 2018 event coincided with the opening of the South Lakes Birth Centre with a number of initiatives chosen by families and the public, which will be installed over the next few weeks. This includes a remembrance garden and an installation designed by the local college, which will ensure that those who were harmed will never be forgotten.

2017/18 to 2018/19 96% improving documentation: improvement in e-nursing documentation quality outcomes.

Implementation of e-documentation for nurses was completed in 2016-17. The audit and governance capability built into this system supports the assurance of the quality of documentation from ward to board.
Since the implementation of e-nursing documentation, compliance of record keeping standards has greatly improved through the implementation of mandatory fields. This ensures that vital patient information is captured and an appropriate individualised plan of care is assessed, planned, implemented and evaluated. This is audited via the Quality Assurance Framework (QAF) which is designed to provide an evidence base to measure quality and effectiveness of care, and to identify what works well or where further improvements are required. Utilising the quality assurance methods, the QAF provides a structured process to demonstrate evidence of compliance with agreed standards of care. One of the standards audited in in relation to e-nursing documentation which is audited on a monthly basis. .

There is a dedicated Quality Assurance page live on intranet. http://uhmb/cs/QualityAssuranceFramework and the Quality Assurance Dashboard is live. A monthly blog is in place which shares news and achievements for the scheme and the link is http://www.freshthinking.uhmb.nhs.uk/2016/11/30/sally-young-quality-assurance-blog-6/

2017-18 to 2018-19 Mortality ratio to be 5-10% better than the national average.

HSMR: The Trust has achieved 77 (to Dec 2017) and therefore the Trust has achieved the target of 5-10% better than national average of 98.77.

SHMI: The Trust has achieved 86.85 and, therefore, the Trust has achieved the target of 5-10% better than national average of 90.4.

The Trust is keen to progress further in mortality and has established mortality reviews and mortality leads on the main hospital sites, weekly mortality reviews, Weekly Patient Safety Summit, weekly personal feedback and reflection, monthly divisional feedback and lessons learnt. It is envisaged that joint working with the Patient Safety Unit, the Governance team, sepsis leads, and VTE leads, together with clinicians and nurses, the Trust would continue to see 5-10% better mortality ratio in 2018-19.

2017/18 to 2018/19 Stroke mortality reduced to 75 or fewer deaths per annum as a result of admissions for stroke as a primary diagnosis.

In the period 2017/18, the Trust has seen a stroke mortality figure of 94 and, therefore, has not achieved the target of 75 deaths or fewer in 2017/18; however, we have improved performance from 2016/17 with a decrease of 33 deaths.

The Trust has ensured investment in a new stroke unit at RLI and a strong working partnership amongst the clinicians in FGH and RLI sites and leadership in this service. Stroke clinicians and diagnostic coding individually review all stroke deaths. The timeline of diagnosis, and action and improvement areas, are fed back. Over the last 2 years, our stroke data has improved significantly and we intend to improve further with more appointment of the support services.

3.4.2 Priority 2: Clinical Effectiveness

There are many schemes and initiatives that we can participate in that help us deliver high quality care. By meeting the exact and detailed standards of these schemes and initiatives, we must achieve a particular level of excellence; this then directly impacts on the quality of care and provides evidence for the Trust that we are doing all we can to provide clinical effectiveness of care.

2017/18 to 2018/19 Introduction of the remaining Care Bundle (Stroke) as 3 were introduced in 2016/17.

In May 2015, the CQC identified that the Trust should improve the management of people with a stroke in line with national guidance. Recent national audits indicated that although the Trust had made progress, the service still needed to make improvements to the care and treatment of people who had suffered a stroke and as a result the Trust was highlighted as a 'risk' for the Sentinel Stroke National Audit Programme (SSNAP) Programme. The Trust, therefore, committed to demonstrate improvements in the care and treatment of people who have suffered a stroke, enabling a visible improvement in the results highlighted by the SSNAP.

Previously, patients with known or suspected stroke could not always be cared for in the most appropriate place. Patients did not have the benefit of direct admission to a dedicated stroke unit and underwent multiple moves between wards.

A designated acute stroke unit was planned following the CQC recommendations. The unit became operational in September of 2017, and began taking thrombolysed patients in January 2018. This improved service allows all patients with suspected acute stroke to be admitted directly to a dedicated Acute Stroke Unit under the care of a stroke specialist multidisciplinary team. The unit is based on the emergency floor at the RLI and consists of a 6 bedded unit with an additional admission/assessment trolley, telemetry monitoring, overhead ceiling hoists and a therapy area with assessment kitchen.

In addition, there was a significant investment in staff to the British Association of Stroke Physicians (BASP) recommended staffing levels for acute stroke beds. This is 2.9 nurses per bed with a ratio of 80:20 trained to untrained. Allied health care staffing was also increased, to enable faster assessments and the provision of 45 minutes therapy, per day, in-line with national guidance.

The new care bundle (Stroke) pathway is evidence based, and focuses on safety, reduced morbidity and mortality, as well as ensuring that people have a better patient experience and the best possible chance of recovery from a stroke.

Patient Safety Unit (PSU) established and operational

The PSU was established in April 2016. It is led by an Assistant Chief Nurse (ACN), a Deputy Medical Director and support is provided by the governance team, I3 team (Informatics), and improvement teams as required.

Strong links are now well established with Lancaster University to add academic rigour to the work of the PSU. The results of the first piece of collaborative research between the Trust and Lancaster University linked psychological safety of staff when clinical incidents occur is due to be published later this year.

A second research proposal relating to the patient safety culture of the organisation from ward to board is being developed into a large study which may have national or international importance and an application for funding is underway.

This year, PSU work has concentrated on embedding the mortality, sepsis and VTE work, which began last year, with a number of safety related investigations undertaken relating to themes identified in the weekly patient safety summit. The coming year will see the PSU forge stronger links to patient safety activity of the integrated care system with an annual remembrance conference for sharing learning planned in the autumn.

Ward Accreditation scheme

- **Implementation rolled out 2017/18**

In order to support and promote consistent delivery of high standards of care within wards and departments, a ward level monitoring and accreditation system has been introduced that allows measurement and assessment of the wards and departments against a core framework of standards: the Quality Assurance & Assessment System (QAAS).

5% of Inpatient Wards at Exemplar Standard by 2017/18

There are over 70 areas across UHMBT that are eligible to be included in QAAS and to date, 50 areas inpatient wards and departments including 2 Emergency Departments, AHP services and 6 theatre / recovery areas are on the scheme. Since the launch of the scheme in September 2015, there are two areas who have now achieved exemplar status - RLI Radiology Day Care Unit and Morecambe Bay Cardiac Centre at WGH - with 7 more about to be accredited by June 2018.

Quality Assurance & Assessment System in progress in all Outpatient Areas

The main concentration of the Quality Assurance & Assessment System (QAAS) has been inpatient wards. Therefore, roll out of outpatient areas has not progressed as anticipated.

There are 5 Outpatients areas enrolled on the scheme, 4 of which are scoring green. The Trust will continue to roll out the QAAS for outpatient areas in 2018/19.

2017/18 to 2018/19 12 Standard Bulletins and 6 Themed Bulletins per annum

Lessons to be learnt are identified as part of the incidents, complaints, claims and risk investigation process. These are discussed at ward governance meetings, Learning to Improve Group and Serious Incidents Requiring Investigation (SIRI), then then cascaded to all staff.

- **12 Standard Bulletins**

There is a monthly 'Learning to Improve' meeting that identifies key lessons. The role of the 'Learning to Improve' group is to look at the whole process from sharing information to evaluating changes. Any key lessons identified are shared in 12 corporate 'Learning to Improve' bulletins. The bulletins are circulated throughout the organisation and shared with stakeholders through various committees in both electronic and print format; it is also tweeted, placed on noticeboards around the hospital sites and is available on the staff Trust intranet site.

- **6 Themed Bulletins**

As well as the monthly bulletins, 6 specialist themed bulletins are published on the areas identified by the group as needing a more concentrated message. At the beginning of the year, the group discuss and agree potential specialist topics and arrange for publication every two months. If a cluster of incidents from the same area or a pattern of errors become evident and need to be highlighted, or the trust experiences a Never Event, the topics may change to those identified.

When the specialist themed bulletins are produced, the group identifies ways to evaluate any impact, for example benchmarking incidents, complaints and comments from patient experience related to the concern and noting the contribution of other Trust initiatives.

The 6 themed bulletins for 2017/2018 were:

- Medication
- Pressure care
- Sepsis

- Acute Kidney Injury (AKI)
- Complaints
- Cannula care

Safety Incidents: Audit of lessons learned at 6-12 months following publication of themed bulletins to measure lessons being learned

- **Audit of Lessons Learned**

On a six monthly basis, discussions take place to evaluate the impact of the lessons on the highlighted areas of concern. This is done in a number of ways:

- Initial benchmarking record of the number of incidents, complaints, etc., where appropriate, to monitor quantitative changes.
- Identifying other initiatives within the organisation, such as Listening into Action (LiA), QAAS and audits that can help monitor qualitative impact.
- The divisional staff are asked to feedback any internal monitoring on particular incidents and these are discussed at the Learning to improve meeting and further action is agreed.

Over the past twelve months, through a range of initiatives implemented across the organisation, the following can be clearly demonstrated:

- Low grade pressure ulcer incidents have reduced.
- Reduction in the frequency of sharp injuries.
- Incidents including prescribing errors, including non-compliance of GMC & NMC numbers have decreased.

All the bulletins are used to share the success stories as well as the areas continuing to be of concern and a report is sent to the Quality Committee to every month.

CQUIN - Develop and maintain 95% delivery as a minimum for 2017/18

The key aim of the CQUIN framework for 2017/18 was to secure improvement in the quality of services and better outcomes for patients, whilst maintaining strong financial management. Schemes were established at national level to support national priorities. These schemes were augmented by local priorities set by the Clinical Commissioning Groups (CCGs). Detailed targets and timescales for each CQUIN scheme were included in the contract signed between the Trust and its commissioners.

Table 28: CQUIN Schemes for 2017/18

National CQUIN Scheme	Target
Staff Health and Wellbeing	Improvement of health and wellbeing of NHS staff
Building on the work undertaken in 2016/17 this scheme looked to improve upon the health and wellbeing of staff and linking in with the Trust's Flourish programme offered initiatives including:- Physical Activity – Work out at Work, Yoga sessions and Jogging pals. Mental Health – Mindfulness taster sessions, workshops on Using Resilience to Manage Stress and Change. Also continued to offer therapies such as counselling, CBT and hypnotherapy. Physiotherapy – Access to onsite physiotherapy which all staff members are able to self-refer to, work place assessments and discounted Slimming World vouchers. Following the success of the first Health and Wellbeing Conference held for staff in 2016 this took place again in 2017 with over 80 staff participating. The Trust have also received silver accreditation with the Better Health at Work scheme in 2017.	
Staff Health and Wellbeing	Healthy food for NHS staff, visitors and patients
This scheme aimed to maintain the changes already introduced during 2016/17 which were to: • Ban price promotions on sugary drinks and foods high in fat, sugar and salt (HFSS) • Ban advertisement in NHS premises of sugary drinks and foods with HFSS • Ban sugary drinks and foods with HFSS from checkouts These changes were maintained along with the following additional criteria:- • 70% of drinks lines stocked must be sugar free (less than 5 grams of sugar per 100ml) including energy and fruit juices (with an added sugar content of over 5 grams) and milk based drinks (with a sugar content of over 10 grams per 100ml) • 60% of confectionary and sweets sold do not exceed 250 kcal • At least 60% of pre-packed sandwiches and other savoury pre-packed meals (wraps, salads, pasta	

Table 28: CQUIN Schemes for 2017/18	
salads) The RVS have continued to support the Trust with this scheme; first 3 requirements have been implemented and are working towards the additional criteria. The Trust continues as part of the Flourish programme to promote the importance of healthy eating which includes ensuring that healthy options are available for all staff in the restaurants and cafes and vending machines for night workers.	
Staff Health and Wellbeing	Improving the uptake of flu vaccinations for front line staff within Providers
The requirement of this scheme was for the Trust to vaccinate 70% of frontline clinical staff by the 28th February 2018. A communications strategy was produced and implemented highlighting the importance of being vaccinated not only for individuals but for family, friends and patients. 88 members of staff completed peer vaccinator training across the Trust. The vaccination programme launched at the end of September 2017 with the target achieved by the beginning of December. The final data at the end of February shows 89.14% of frontline staff were vaccinated; the fourth highest performing Trust in the country.	
Reducing the impact of serious infection	Timely identification of sepsis in emergency departments and acute inpatient settings
This scheme required a minimum of 50 patient records per month to be reviewed for both Emergency Department admissions where screening should have taken place. The trajectory was set at 90% for each quarter with a variation agreed for quarter 1 only of 85%. Targets were achieved for quarters 1, 2, 3 and 4. 2 Sepsis/AKI Practice Educators were recruited. Five new screening tools have been developed and rolled out throughout the Trust; these now form part of the electronic patient record.	
Reducing the impact of serious infection	Timely treatment for sepsis in emergency departments and acute inpatient settings
This scheme requires the patients identified as having sepsis from the screening audit for both Emergency Departments and Inpatients to be reviewed to identify whether they received IV antibiotics within 1 hour of the diagnosis of sepsis. The trajectory was set at 90% for each quarter with a variation agreed for quarter 1 only of 85%. Targets were achieved for quarters 1, 2, 3 and 4. 2 Sepsis/AKI Practice Educators have been recruited. New screening tools have been developed and rolled out throughout the Trust and now form part of the electronic patient record.	
Reducing the impact of serious infection	Antibiotic Review
This scheme required an audit of a minimum of 30 patients to be undertaken on a quarterly basis of those identified as having sepsis that had a clinical antibiotic review between 24-72 hours and were still an inpatient at 72 hours. Trajectory targets were set as 25% for quarter 1, 50% for quarter 2, 75% for quarter 3 and 90% for quarter 4. The targets were achieved for quarters 1, 2, 3 and 4.	
Reducing the impact of serious infection	Reduction in antibiotic consumption per 1,000 admissions
Building on work undertaken during 2016/17 the requirements of this scheme was to reduce by 1%:- • Total antibiotic consumption per 1,000 admissions • Total consumption of carbapenem per 1,000 admissions • Total consumption of piperacillin-tazobactam per 1,000 admissions The reduction targets for carbapenem and piperacillin-tazobactam were achieved. The overall antibiotic consumption has decreased across the three quarters and has consistently remained under the national average.	
Improving service for people with mental health needs who present to A&E	20% sustainable reduction in the number of attendances to A&E for those within a selected cohort of frequent attenders who would benefit from mental health and psychosocial interventions
Cohorts of patients were identified at both RLI and FGH in conjunction with partner organisations (Cumbria Partnership and Lancashire Care) that would benefit from mental health and psychosocial interventions. All patients have a care plan and care co-ordinator in place. Regular meetings take place between organisations i.e. UHMB, CPFT/LCFT, NWAS, and Police; touch points with these services are monitored and updated on a quarterly basis. The 20% reduction target for the selected cohort was acheived.	
E-Referrals	• Publish all such services and make all first outpatient appointment slots available on NHS e-Referral Service (e-RS) by 31st March 2018 • Set a trajectory to reduce Appointment Slot Issues (ASI) to a level of 4%, or less, over Q2, Q3 and Q4

Table 28: CQUIN Schemes for 2017/18	
This scheme required all services to be published on e-RS with trajectories as Q2 80%, Q3 90% and Q4 100%. Targets for Q2, 3 and 4 were achieved. Trajectories were set and achieved at 9% for Q2 and Q3 following an agreed variation with Commissioner; the final position for ASI's was 13%.	
Offering Advice and Guidance	Set up and operate Advice and Guidance services for non-urgent GP referrals, allowing GPs to access consultant advice prior to referring patients to secondary care.
Prior to the start of this scheme and Advice and Guidance (A&G) system was in place and being rolled out across specialties. At the start of Q4 (January 2018), the requirement was to have A&G services operational for specialties that cover at least 35% of GP referrals and maintain it across the quarter. The position across Q4 was achieved with 23 specialties open to A&G, which were responsible for at least 69.89% of GP referrals. Response times are monitored on a monthly basis with 85.59% of responses given within 2 working days at the end of Q4.	
Proactive and Safe Discharge	Improve the proportion of patients admitted via non-elective routes discharged within 7 days of admission
This scheme required a 2.5% point increase from the baseline in the number of patients discharged to usual place of residence. Commissioners agreed to set the baseline as Q3 and Q4 of 2015/16 due to the significant amount of work that had taken place from 2016/17 onwards. Partnership working with other services continues to facilitate improved patient flow. The Trust has met the 2.5% increase in patients discharged to usual place of residence with a final position of 39.84% against a target of 39.30%	
NHS England CQUIN schemes	**Target**
Adult Intravenous Anticancer Therapy (SACT)	Standardisation of chemotherapy doses
Building on the work previously undertaken during 2016/17 this scheme required the Trust to agree at the local Drugs and Therapeutics Committee the principles of dose banding and dose adjustment required for the additional drugs included in the scheme. Baseline was 93% with trajectory targets were set as 90% for Q2, 92% for Q3, 95% for Q4. Q2, 3 and 4 were achieved.	
Medicines Optimisation	Support the procedural and cultural changes required to fully optimize the use of medicines commissioned by specialised services
This scheme comprised of 4 triggers:- • Trigger 1 – Faster adoption of prioritised best value medicines as they become available • Trigger 2 – Improving drug MDS data quality • Trigger 3 – Increase the use of cost effective dispensing routes for outpatient medicines • Trigger 4 – Improve data quality associated with outcomes databases (SACT and IVIg) Q1, Q2, Q3 and Q4 requirements were met.	
Strengthening Patient and Public Participation	Involve patients and the public to improve quality, access, coverage, uptake and the overall patient experience for Bowel and Breast screening
This scheme required an action plan to be developed around engagement activities with shared learning to be undertaken and agreed with Commissioners. To support this, an action plan was developed and implemented. Engagement work was undertaken in Breast Screening by the Screening Navigator to identify reasons why patients may not attend appointments in areas of low uptake. Bowel Screening took part in awareness sessions with Cumbria County Council and carried out an audit on how patients with learning disabilities are identified so the service can be tailored to their needs once completed anonymised data was shared with the LD Network Team. Q1, Q2, Q3 and Q4 were achieved.	

3.4.3 Priority 3: Patient Experience

Integrated stroke unit to be established and operational

A dedicated Stroke Unit has been established at the Royal Lancaster Infirmary and became operational in September 2017. The new care pathway is evidence based, and focuses on safety, reduced morbidity and mortality, and reduced length of stay in hospital. Accessibility to the Multi-Disciplinary Team (MDT) is expedited and intensity of therapy has increased.

Staff training on the unit has been fundamental to the delivery of best practice interventions, and has ensured that the team have the skills and knowledge to communicate effectively with patients and their families. The

higher staffing ratios ensure that the stroke team have regular contact with patients. The friends and family test indicates that patients are consistently receiving a better patient experience.

Complaints

The number of complaints received in 2017/2018 was 427, which is a 17.1% decrease on the 515 recorded last year, and 12.2% below the target level of 486 complaints for 2017/2018.

The number of PALS cases is 2502 a decrease of 165 (6.2%) and the number of Compliments has seen a decrease of 13% to 958.

Maintain complaint levels below a ratio of 1 Complaint per 1,000 patient attendances

UHMBT received 0.60 complaints per 1000 attendances, a decrease of 18% from last year's 0.73; therefore achieving the target.

100% of complaints acknowledged within 3 days

UHMBT maintained its 100% target to acknowledge receipt of a complaint or concern within 3 working days.

95% of complaints to be responded to within 35 days

UHMBT has achieved a 98.6% response rate to complaints responded to within 35 days; therefore achieving the target.

Table 29: Comparison of Complaints received from 2015-2018

Number of Complaints Received	2015/2016	2016/2017	2017/2018
Core Clinical Division	23	41	29
Corporate Services	6	8	3
Estates & Facilities	0	0	5
Medicine Division	183	191	167
Surgery & Critical Care Division	196	198	153
Women & Children's Division	74	77	70
Unspecified	1	0	0
Total	483	515	427

Lessons Learned – Complaints Closed in 2017/18

To ensure the organisation learns lessons from complaints, at the closure of each case, a lesson learned is captured on the Ulysses Safeguard System. Each division receives monthly reports detailing lessons learned resulting from complaints and these are discussed at their Governance meeting to ensure corrective action is taken, or new procedures are put into place. The Case Officers in the Patient Relations Department work closely with the Divisional Governance Leads to ensure all lessons raised through a complaint are actioned and closed within an appropriate timeframe.

Table 30 below summarises lesson learned and actions taken as a result of complaints closed in 2017/18.

Table 30: Summary of Lessons Learned from Complaints

Themes	Lessons Learned/Actions taken from Complaints
Admissions and Discharges	• All patients to be offered clothing if inadequately dressed for discharge • Staff to be extra vigilant when packing up/unpacking patient's belongings to ensure that items are inventoried.
Attitudinal Issues	Complaints about attitude are taken very seriously by the Trust and are not tolerated. Whilst it can be a difficult topic to approach, Clinical Directors, Clinical Leads and Matrons now ensure that all individuals receive constructive feedback on negative communication with patients and visitors.

Table 30: Summary of Lessons Learned from Complaints	
Themes	**Lessons Learned/Actions taken from Complaints**
Behaving professionally	Alongside attitudinal issues, unprofessional behaviour is not welcome or tolerated. Trust-wide, new Values and Behaviours have been created which introduced clearly defined behaviours that are acceptable and those that are not. Departmentally, formal departmental awareness sessions have been introduced to share with staff the number and reasons for complaints; in addition, these are used as an opportunity to reinforce the importance of behaving professionally.
Clinical Treatment issues	• To ensure staff are continuously up to date with hand hygiene and infection awareness • Earlier involvement of the palliative care team in complex patients who are nearing end of life • Further training and education regarding the location of POA information on Lorenzo has been provided to the Anaesthetists via clinical audit and a document circulated to all staff.
Administration errors	Administrations errors can cause problems for patients resulting in complaints begin received. The following are examples of changes made to enable good administration processes: • More robust tracking system in place for signing in and out of personal identifiable information being transported by courier • Ensure FY8 forms are included in maternity booking packs so all women that have Community Midwives books will have access to this information
Communication issues	The following are example of changes made in the way we communicate with our patients following receipt of communication complaints: • Ensure that all Community Midwives have a voicemail message on their work telephones with instructions for patients to contact Delivery Suite if the phones are not answered. • To keep patients informed and up to date with the clinical decision making process

Table 31 below summarises lesson learned and actions taken as a result of the Patient Advice and Liaison Service (PALS) cases closed in 2017/18.

Table 31: Summary of Lessons Learned from PALS	
Themes	**Lessons Learned / Action taken from PALS**
Clinical Treatment	Actions have been introduced in order to address concerns surrounding Clinical Treatment following informal concerns received. They include: • GP should have been contacted for clarification on incomplete x-ray form before patient was sent home without any treatment (x-ray) • Always post a copy of an IDS on the day if the patient has left before it has been written (when surgery cancelled)
Communication	Actions have been introduced in order to address concerns surrounding Community following informal concerns received. They include: • Change in practice for clinic letters with the time showing to be kept with the patient folder so that staff can monitor waiting time of the patients waiting to be seen and alert both reception team and patient to possible delays • As lift out of order at FGH, appointment letters in Clinical Investigations Unit to be amended advising/warning patients of this, to avoid patients having a long walk.

Table 32 below summarises lesson learned and actions taken as a result of the Parliamentary and Health Service Ombudsman (PHSO) reports in 2017/18.

Table 32: Summary of Lessons Learned from the PHSO reports	
Themes from PHSO Reports	**Lessons Learned / Action Taken from reports received from the PHSO**
Lack of information given regarding risk of surgery.	Changes in procedure ensure that the patient and doctor will re-sign the consent form prior to surgery.
Operation cancelled on two consecutive days.	Increase in the number of inpatient lists each week.
Job vacancy for head and neck radiologist leading to misdiagnosis.	Consultant radiologist appointed to the Trust.
No documentation of oral hygiene.	Lorenzo now has a section which includes mouth care.
The importance of record-keeping and communication to relatives following a fall.	Patient handling risk assessment forms must be updated on transfer between wards, if a patient's condition changes or otherwise, on a weekly basis. Ensure families are kept informed of a patient's condition if they are present when an incident occurs.
Failure to provide complainant with a meeting following an RCA report.	The Trust now has a Patient Family Support Officer to improve communication throughout the incident investigation process.
Complainant had an inadequate assessment by a doctor, whilst in a corridor in A&E.	Changes introduced to the triage process. Complaint discussed with both the doctor and nurse involved and they were asked to reflect on the incident. A&E staff have access to GP medical records.

6 public engagement events per annum

The 'Maternity Matters in Morecambe Bay' event in Kendal at the end of May saw members of the public speaking to UHMBT staff and partner health organisations about their experiences of local maternity services, and how they want to be involved in the future of the service.

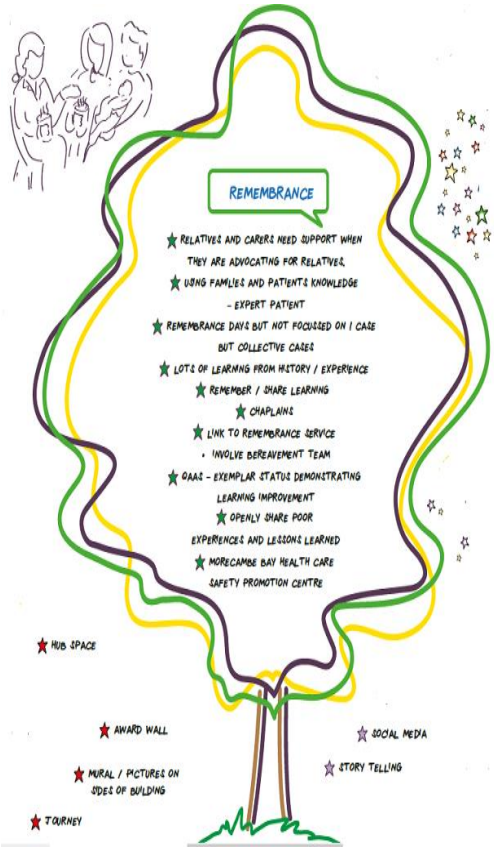
'Conversation cafes' where held where those that attended gave their honest and open views and opinions on their experiences and what they would like to see changed or done differently in the future.

Over the last two years, we have held public engagement events around our maternity services, which were excellent and gave us real examples of where we got things right for women and where we have not. Feedback like this is vital to allow us to continue to make changes that make a real difference to local people.
During 2017/18, we ran three community-based engagement events in Barrow in Furness, Kendal and Lancaster town centres to talk with the public about their experiences of our maternity, children and young people's services at Morecambe Bay. There are continue to be many opportunities for local people to get involved in our services and we want to hear from as many people as possible. We understand that people may want to get involved in diverse ways – some may wish to only receive information, whereas others may want to get involved personally, for example, sitting on staff interview panels, being involved in training, or proving feedback on their experiences. That is why we have been asking individuals how and when they want to be involved.

We are pleased that so many mums, dads, families and friends, took the time to come and talk to us and have their say. Not only did they let us know that we were on the right track with some of the work we are doing by telling us that it was important to them too, they also gave us some real food for thought on other areas where we can make our services even better for local women and families. Why not look at our video maternity matters in Morecambe Bay: https://youtu.be/Fgc9kRMMhSs

Members of the public and staff across the Morecambe Bay area have been asked to contribute their thoughts on healthcare. In association with Cumbria and Lancashire Healthwatch, we visited many community locations across Morecambe Bay.

During the past three years many new ways of working have been implemented, reducing the numbers of people attending hospital, providing more care closer to people's homes and integrating care across different organisations to make care less complicated. We want to hear the public's thoughts, so we utilised a 'Chatty Van'; however we understood that not everyone would be able to come to use so we also developed paper and on-line survey formats to gather people's thoughts about our Better Care Together Work.



Creating an organisation with a memory

The subject of remembrance is such an important one.

In September 2017, we invited Carl Macrae to the Trust to take part in a LiA workshop to help discussions on how we can use remembrance as a tool to improve patient safety and experience. Carl recently wrote that memory, and remembering the past is fundamental to patient safety and that the core objectives of safety improvement are to learn from the past in order to improve the future.

The community workshop generated lots of ideas and "themes" which have provided a great deal of food for thought. Since the workshop, a small team have been working with staff, citizens, patients and carers to develop core themes of remembrance. This work has been drawn up into a visual reference map and will become an integral part of our safety improvement strategy.

We have come so far in the last few years with the improvements we have made in patient safety and a number of other areas – but we do not want to forget the past.

One of the core objectives of safety improvement is to learn from the past in order to improve the future.

Integration of physical and mental health pathways

The following information covers the 4 areas of improvement in relation to the Integration of physical and mental health pathways which is detailed in the sections below:

- Quarter 4 of 2016/17 will see development:
- April 2017 7-day CAHMS support
- A mental health Matron working across The Orchard and the Emergency Department at the Royal Lancaster Infirmary.
- Baseline outcomes measured reported to ENACT

Quarter 4 of 2016/17 will see development in the integration of physical and mental health pathways

- Protocol being developed relating to an admission and discharge pathway for children and young people presenting at District General Hospital with mental health, emotional health and/or wellbeing needs – this will be piloted at UHMBFT and then rolled out across Lancashire.
- Shared protocol being reviewed and developed with Lancashire Care FT (LCFT), Blackpool Teaching Hospitals and North West Ambulance relating to the management of adults who need to attend the Emergency Department (ED) for an assessment of mental health needs.

April 2017 7-day Child and Adult Mental health Service (CAMHS) support

- We gained support from the STP Children's Transformation programme for funding to move forward in enhancing the environment for Children and young people with mental health needs to be assessed and cared for.
- During 2017/18, LCFT also developed their model of care for the CAMHS service and this meant that the service was available 6 days a week; this will further develop over 2018/19 with CPFT having a 7-day CAMHS service.
- Working with the Children and Young Persons Division to continue to develop a children and adolescence mental health service CAMHS liaison post.

A mental health Matron working across The Orchard and the Emergency Department at the Royal Lancaster Infirmary

- From April 2017, we successfully piloted with Lancashire Care Foundation Trust (LCFT) developing the Emergency Department (ED) mental health liaison team at RLI to a 24/7 service; this was then rolled out as a model of care moving forward.

Baseline outcomes measured reported to ENACT

Over 2016/17, the Trust worked closely with the local Mental Health Trusts (Cumbria Partnership NHS Foundation Trust and Lancashire Care NHS Foundation Trust) to enhance the care for people with mental health needs who need to be cared 7 days.

In December 2016, the Trust recruited an Assistant Chief Nurse (ACN) for corporate nursing. Part of their remit was to enhance care for people with mental health needs within the physical care environment. This role covers the entire age spectrum, and works cross-bay; the initial scoping work highlighted the complexity of the issue, the wide range of stakeholders involved and data that strongly suggests an increasing problem over a number of years.

The Trust has worked tirelessly over the year to enhance the care for people with mental health needs, and this work included:

- Ongoing work with the University of Cumbria relating to staff continued professional development and scoping the possibility of bespoke modules relating to mental health conditions to upskill physical health staff when faced with people with such needs.
- Continuation of the development of an evidence based Mental Health Algorithm assessment and resource pack. This assessment will improve how nursing staff identify if a person has mental health needs in conjunction with the physical health nursing assessment. This will enhance the nurse referral

and hand over to mental health teams and other agencies and promote use of SBAR tool (a communication tool that focuses on the situation, background, assessment and recommendation).

- Working with teams across the Trust to ensure the 2017/18 CQUIN Indicator 4 to improved services for people with mental health needs who present to the Emergency Department.
- The Trust is participating in the Better Care Together Mental Health Work stream, highlighting that Mental Health has not been as prominent within the Better Care Together (BCT) strategy as it should be; the development of the work stream acknowledges the need while also recognising that Better Care Together (BCT) projects need to embed mental health into delivery.
- The Trust has also participated in initiatives to support staff development in relation to mental health awareness. We developed films with staff highlighting their own mental health well-being; we have delivered two Mental Health first Aid Courses; we have worked with the Samaritans to develop self-help leaflets and Emotional Awareness courses for staff.
- The Trust has also developed care for people with Dementia and with support from the Royal Voluntary Service (RVS) a memory wall has been placed by the RVS café at the Royal Lancashire Infirmary, with another being planned for Furness General Hospital site to enhance the care environment.

As we move into 2018/19, we will further develop the environment in relation to caring for people with dementia.

Advice and Guidance for Nursing Homes - Working collaboratively with Care Homes

- **Agreement on early priorities that incorporate local need with high service pressure further collaboration and development of patient pathways to improve safety and experience. Measure to be developed to demonstrate the impact of the service.**

Work that is ongoing in relation to working collaboratively with care homes is as follows:

- We are using the proactive and safe discharge CQUIN 2017-2019 to build on relationships with care homes to enable us to work more collaboratively. This will help the Trust to measure the impact of the collaborative work undertaken on the service.
- We have allocated matron care home buddies to nursing homes.
- We have introduced weekly calls to support two homes that would be described as vulnerable in terms of their Care Quality Commission (CQC) status. We discuss every discharge that has occurred in the last 7 days (since last call) whether that is a new admission or a returning resident following a period of hospitalisation. Taken into consideration what the homes require in terms of discharge information Just in Case (JiC) drugs, appropriately completed Do Not Attempt Resuscitation (DNACPR) forms.
- Care home report- link to buddy role so the matrons can track their patients through the system ensuring their journey from admission to discharge is safe, timely and seamless looking at the plan for the future (after discharge).
- Appointed an Associate Nurse Practitioner (ANP) for care of the elderly who looks at patients returning to their home as soon as possible with a plan to manage their conditions in the community.
- Discharge to Assess (D2A) placements in local care homes, which enables us to build on relationships because both the hospital and care home staff will be working closely together to deliver the model.
- Further resource within discharge case management and allocation to specific areas to understand all patients in a particular area working closely with the patient, families and care homes to deliver a safe and timely plan.

Building relationships and improve participation by the people who use and care about our NHS services

- **Develop a strategy to involve service users in service planning and delivery**

Patients and the public are at the heart of everything we do, in line with the NHS Constitution. We believe that by listening to people who use and care about our services, we can understand their diverse health needs better, focus on and respond to what matters to them.

We have and will continue to work in partnership with patients and the public to improve patient safety, patient experience and health outcomes, and supporting people to live healthier lives. By prioritising the needs of those who experience the poorest health outcomes, we have more power to improve access to services, reduce health inequalities in our communities and make better use of our resources. During 2017/18, we have supported our staff to enable our people to develop a proactive and effective dialogue with patients and the public. We have also welcomed the support from other services, for example Healthwatch and the Maternity Services Liaison Committee (MSLC). The MSLC is a forum for maternity service users, providers and

commissioners of maternity services to come together to design services that meet the needs of local women, parents & families in the Morecambe Bay Area

Participation (sometimes referred to as engagement or involvement) has and continues to take place in a variety of ways. We now move forward to support our people to promote the patient voice and embed it across the accountable care system, from service design to programme management and strategy making. We recognise the links between staff engagement and public engagement, and value the contribution that staff members can make, not only as employees, but also as users of NHS services themselves.

It is important to us that we listen to our patients and citizens to make improvements to our services in response to their views. 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. The trust is in a much stronger position to reap the benefits of patient and public participation, following the implementation of the new patient and public involvement strategy launched in February 2018. A great deal of work has happened at locality and Integrated Care Community (ICC) level, with much strengthened connections, to embed our Better Care Together work.
To view a copy of the new patient and public involvement strategy please click on the below, https://www.uhmb.nhs.uk/files/5415/1869/8815/Patient_and_Public_Involvement_Strategy_2017-2020_FV2.pdf

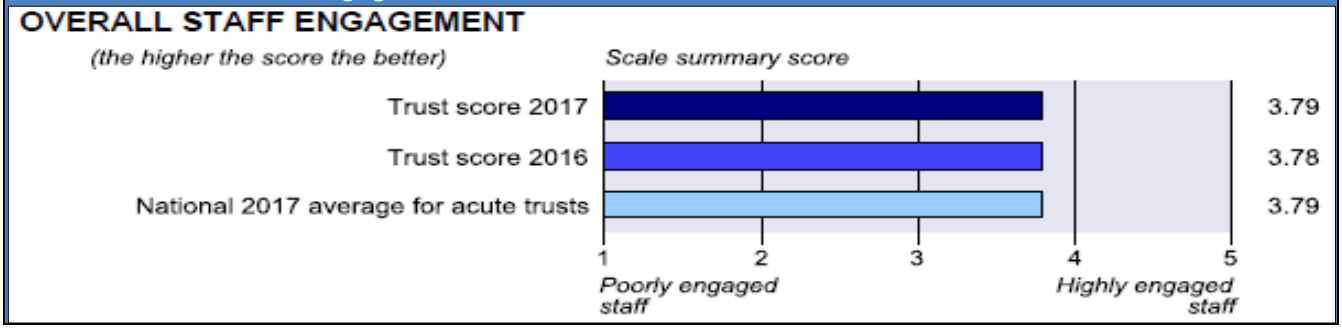
- **Monitor staff and user satisfaction via survey**

The Trust monitors staff and user satisfaction via the Annual National Staff Survey and the Annual National Patient Survey, respectively, which are covered in sections 3.3.5 and 3.3.6.

Improve on key result areas in the overall staff engagement figure from a baseline of 3.77 out of 5

The staff engagement figure for 2017 has levelled to that of the national average for acute Trusts increasing very slightly to 3.79. The Trust is focusing on delving deeply into the three core elements that contribute to the overall staff engagement figure- advocacy, involvement and motivation – to see the movement required to create the significant shift in the engagement levels among staff. This will be a strong focus for the Trust for 2018.

Table 33: Overall Staff Engagement



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

The statements supplied by the above stakeholders in relation to their comments on the information contained within the Quality Account can be found in Annex 1 of Part 4. Additional stakeholder feedback from Governors has also been incorporated into the Quality Account. The lead Clinical Commissioning Group has a legal obligation to review and comment on the Quality Account, while Local Healthwatch organisations have been offered the opportunity to comment on a voluntary basis. Following feedback, wherever possible, the Trust has attempted to address comments to improve the Quality Account whilst at the same time adhering to NHS Improvement's Foundation Trusts Annual Reporting Manual for the production of the Quality Account and additional reporting requirements set by NHS Improvement.

3.5 Quality Account Production

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

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

3.6 How to Provide Feedback on the Quality Account

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

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

3.7 Quality Account Availability

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

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

3.8 Our Website

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

Part 4: Appendices

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

1.1 Statement from Morecambe Bay Clinical Commissioning Group on the Quality Accounts – 14 May 2018

Morecambe Bay CCG (MBCCG) welcomes the opportunity to review and comment on the Quality Account for the University Hospitals Morecambe Bay NHS Foundation Trust (UHMBT).

MBCCG are committed to commissioning high quality services from UHMBT and take seriously their responsibility to ensure that patients' needs are met by the provision of safe high quality services and that the views and expectations of patients and the public are listened to and acted upon.

Through the Quality Assurance Meeting (QAM) the CCG have remained sighted on the Trust's priorities throughout the year for improving the quality of its services for its patients, and have continued to provide robust challenge and scrutiny at the QAM with the Trust.

The CCG would like to thank the Trust for sharing the 2017/18 Quality Accounts report and for the opportunity to comment upon it. We would like to acknowledge the openness and transparency in the work the Trust has achieved to date, in the delivery of the 2017/18 priorities and in the on-going delivery of the quality measures.

We would like to commend the hard work, commitment and resilience of UHMB staff, and the focus the Trust dedicate to improving its annual NHS Staff Survey and continued staff engagement. We welcome the transparency of reporting progress of the NHS Staff Survey and are supportive of the ongoing 2018/19 improvement trajectories. We also wish to acknowledge the activities the Trust have implemented to support staff health and wellbeing which we consider is a key driver of a Trust's engagement culture.

What do you like about the report?
The Trust has demonstrated some very positive quality achievements in year for the care it delivers to our population of Morecambe Bay CCG and we are pleased to see the future priorities for the coming year. The CCG looks forward to continued partnership working to address some of the challenges facing the Trust in 2018/19.

It is positive to see an emphasis on the learning achieved from Incidents, Health Care Associated Infections, Complaints and Patient Experience.

The CCG note the Trust for being open and transparent with its Serious Incident reporting and learning bulletins that it produces and for allowing the CCG's to attend its Serious Incidents Requiring Investigations (SIRI) Panel. The CCG are pleased to see a commitment to improved reporting and investigating of serious incidents and look forward to a greater focus on measuring the outcomes with evidence of improvement as well as the introduction of a Central Investigating Support Unit.

The CCG acknowledges the progress towards meeting the targets for Harm-Free Care and reducing avoidable mortality relating to stroke. Though the Trust has not met its locally set targets in all areas, the CCG are pleased to see these as a continued priority for 2018/19.

It is the efforts of the Trust staff that has contributed to the continued improvements stated within the Trust Quality Account and the CCG are immensely grateful to them for their continued commitment and dedication.

What do you dislike about the 2017/18 Quality Accounts?
It is disappointing that the Trust continues not to achieve the expected performance in some areas such as Emergency and Urgent Care and Referral to Treatment particularly given the activity being undertaken to correct this position. The CCG acknowledges that not all issues are within the direct influence of the Trusts

and therefore system wide approaches for improvement are required but the CCG ask that the Trust continue to focus on what is within the direct influence to support the continued drive to improve this position. The CCG recognise the approaches the Trust are taking to address the ongoing recruitment to nursing and medical vacancies including Nurse Apprenticeship.

It is disappointing that there appears to be a levelling off of the reduction in pressure ulcer harms across the Trust and although the CCG recognises some of the wider system challenges impacting this, the CCG would like to see a refresh review of improvements in this area of harm.

The CCG have noted the concern which staff are reporting upon within the staff survey alongside the slight increase in the numbers of staff reporting bullying and harassment which has put the Trust in the worst 20% for this key finding. The CCG note that this will continue to be an improvement focus in 18/19.

What suggestions do you have for additional content for 2017/18?
As stated in our response to the 16/17 and 17/18 Quality Accounts the CCG's would like to see the Trust publish its data on 12 hour Breaches of the A&E Target alongside the 4 Hour Targets, and include the learning that the trust has made and implemented in order to reduce the number of long A&E waits as a result of the 12 Hour breach review process already in place.

What other comments or suggestions for improvements would you like to propose?
The CCG would like to see a focus on discharge information provided to General Practitioners and Care homes, to ensure they receive the clinical information they require in order to maintain and develop the care required for their patients following discharge from hospital.

The CCG is looking forward to the outcomes of the Discharge to Assess Pilot.

The CCG looks forward to working with the Trust and other Bay Health and Care Partners to develop and agree a quality improvement plan for the Integrated Care Partnership for the population of Morecambe Bay.

What would you suggest are the Trust's priorities for quality improvements for 2018/2019?
We expect the Trust will continue to deliver its statutory quality requirements through the identification, monitoring and evaluation for continual improvement. The CCG would like to see an expanded plan of community engagement that compliments the wider Integrated Care Partnership plan and the wider Integrated Care System to maximize population outcomes, safety and experience.

The CCG welcomes the refresh of improvement trajectories following the transition of community health and care services from South Cumbria and North Lancashire.

The CCG would welcome a continued focus on Health Care Acquired Infections, Wound Care and Medicines Optimization to include pathway improvement that incorporates for example optimizing anticoagulation therapy across our populations in the prevention of Stroke.

Do you consider that the draft document contains accurate information in relation to NHS services provided by the Trust?

The CCG confirm to the best of their ability that the information provided in UHMBTs Quality Account is a fair reflection of the Trust's performance in relation to Quality for the year 2017/18.

Do you consider that any other information should be included relevant to the quality of NHS services provided by the Trust?
The CCG note the Trust's continued plans to improve services as they support the integration of community health and care services from South Cumbria and later in the year North Lancashire. The Trust is also a key partner in the rapid development of Integrated Care Communities (ICCs), which they acknowledge is the next step to enable the Trust to align services locally with the ICCs for improved patient outcomes and experience of our populations and staff who work across the Bay.

The Quality Account provides an open account of the achievements made in the past year and describes the priorities for 2018/19 and is an important contribution to public accountability in relation to quality. The CCG appreciates the amount of work involved in producing this report.

Name: Margaret Williams, Executive Chief Nurse
Role/Organisation/Group: Morecambe Bay CCG

1.2 Quality Accounts commentary from University Hospitals Morecambe Bay NHS Foundation Trust Governors - 11 April 2018

The Trust continually strives to improve quality and an integral part of this is to produce an annual Quality Account (report) which focusses on improvement priorities. Governors expressly said they wanted to be involved in the development of the Quality Account and following the implementation of the Council of Governors 'New Ways of Working' in March 2016 it was agreed the Council of Governors Quality and Patient Experience Group would continue to take this forward.

The Council of Governors Quality and Patient Experience Group met in May, July and October 2017, and in January and March 2018 to discuss the proposed performance indicators for external audit and the content of the Quality Account. Through this process of consultation Governors are developing a far greater understanding of the use of performance indicators to improve quality and have selected the local indicator '62 day cancer wait' for external audit testing. Governors have significantly contributed to the Quality Account for the benefit of the Trust.

1.3 Quality Accounts commentary from Healthwatch Cumbria – 16 May 2018

1. What do you like about the 2017/18 Quality Accounts?
Extremely well presented, very useful contents page, comprehensive glossary of Abbreviations and Terms making it a very readable and informative document for public communication.
We particularly liked the participation in a wide range of Clinical Audits and Clinical Research and thread of improvement and aspiration visible throughout the document. Also the forward momentum, improvement to the percentage of staff who would recommend the Trust and we would fully agree with the correlation between staff engagement and patient outcomes plus the Trust's responsiveness to the personal needs of patients. Overall it is an ambitious statement affirming commitment to continuous improvement and contribution to improvement in the local health-care economy.

2. What do you dislike about the 2017/18 Quality Accounts?
There are no elements that we dislike, however with reference to KF26 (percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months) we are surprised by this result

3. What suggestions do you have for additional content for 2017/18?
Following from the above regarding KF26, perhaps some additional detail is needed here to demonstrate how this anomaly is being addressed.

4. What other comments or suggestions for improvements would you like to propose?
We have no comments or suggestions for additional improvements

5. What would you suggest are the Trust's priorities for quality improvements for 2018/19?
We would suggest considering further collaborative work with Care Home and other partners e.g. NWAS and the use of digital technology, shared information and other means to explore ways to reduce emergency admissions and the demands on A & E.

6. Do you consider that the draft document contains accurate information in relation to NHS services provided by the Trust?
Yes. Based upon our information from members of the public, attendance at the public events and participation in the RAISE, QBR and PLACE activities we would consider the information to be accurate.

7. Do you consider that any other information should be included relevant to the quality of NHS services provided by the Trust?
We have no additional suggestions.

Name: Sue Stevenson
Role / Organisation / Group: Chief Operating Officer, Healthwatch Cumbria

1.4 Quality Accounts commentary from Healthwatch Lancashire – 8 May 2018

Healthwatch Lancashire has apologised for not responding to this year's Quality Accounts. The team has been involved in a transition process following a change of contract with Lancashire County Council to a new provider. This has impacted on their capacity at exactly the time that the Quality Accounts were due.

Healthwatch Lancashire has said that it will prioritise its review of the UHMBFT accounts next year and provide a comprehensive response.

1.5 Quality Accounts commentary from Cumbria Health Scrutiny Committee – 04 May 2018

The Cumbria Health Scrutiny Committee again welcomes the opportunity to comment on the Trust's draft Quality Account for 2017/18, and would like to acknowledge the good working relationship it has with the Trust.

The document is generally well laid out and reasonably straightforward to understand and enables Members to explore the Trust's performance over the year.

Members welcomed the outcome of the latest CQC inspection which rates the Trust as Good overall. They were also reassured that the standard of care provided by UHMBT was recognised as 'Outstanding'

Members felt that the draft document contained accurate information in relation to NHS services provided by the Trust, which reflected the experience of the Committee over the last 12 month including briefing provided to the Committee and meetings between the Lead Health Scrutiny Members and the Chair and Chief Executive of the Trust. Members would like to thank both Jackie Daniel and Pearse Butler for their commitment to work with the Committee and wish them all the best as they leave the Trust this year, the improvements they have driven are evident within this report.

The committee is pleased to note the continuation of ambitious target setting for service improvement over the coming year, and supports the trust in aiming for results that exceed the expected standards

The Committee understand the pressures faced by the Trust but would hope that further action can be taken to ensure it's Financial and operational targets can be met.

The Committee would always encourage the Trust to focus on patient and staff feedback as drivers for timely and continuous service improvement throughout.

Overall, we appreciate the co-operation received and look forward to continuing to work with the Trust during the coming year.

Name: Cllr Claire Driver
Role / Organisation / Group: Chair Cumbria Health Scrutiny Committee

1.6 Quality Accounts commentary from Lancashire Health Scrutiny Committee – 11 May 2018

I can confirm there is no comment from Health Scrutiny in relation to the Trust's Quality Account Report.

Name: Gary Halsall
Role / Organisation / Group: Senior Democratic Services Officer (Overview and Scrutiny)

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

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

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

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

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2017/18 and supporting guidance;
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period 1 April 2017 to 25 May 2018;
  - Papers relating to quality reported to the Board over the period 1 April 2017 to 25 May 2018;
  - Feedback from commissioners – Morecambe Bay Clinical Commissioning Group dated 14 May 2018
  - Feedback from Governors dated 8 January 2018; 23 January 2018; 11 April 2018.
  - Feedback from Healthwatch Lancashire dated 8 May 2018 and Healthwatch Cumbria organisations dated 16 May 2018;
  - Feedback from Cumbria Health Scrutiny Committee dated 04 May 2018 and Lancashire Health Scrutiny Committee dated11 May 2018.
  - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 16 April 2018;
  - The 2017 maternity survey, published 5 March 2018;
  - The 2016 national in-patient survey, published 31 May 2017;
  - The 2016 children & young people survey, published 28 November 2017;
  - The 2016 emergency department survey, published 17 October 2017;
  - The 2017 national staff survey, published 6 March 2018;
  - The 2017 local staff pulse surveys dated 21 May 2017, 25 July 2017 and 10 October 2017;
  - The Head of Internal Audit's annual opinion over the Trust's control environment dated 11 April 2018;
  - Care Quality Commission Inspection report dated 9 February 2017.
- The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- The performance information reported in the Quality Report is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- The Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the Board

Ian Johnson
Chairman

Date: 25 May 2018

Aaron Cummins
Chief Executive

Date: 25 May 2018

Annex 3: Glossary of Abbreviations And Glossary Of Terms

Table 34: Glossary of Abbreviations	
Abbreviation	**Meaning**
A & E	Accident and Emergency
ABR	Auditory Brainstem Response
ACN	Assistant Chief Nurse
AKI	Acute Kidney Injury
AMU	Acute Medical Unit
ANP	Advance Nurse Practitioner
ASI	Appointment Slot Issue
BAUS	British Association of Urological Surgeons
BASP	British Association of Stroke Physicians
BCT	Better Care Together
BTS	British Thoracic Society
CAMHS	Children and Adolescence Mental Health Service
CCG	Clinical Commissioning Group
CD	Compact Disc
CDI/CDT	Clostridium Difficile Infection/Toxin
CISU	Central Investigation Support Unit
CMP	Case Mix Programme
COPD	Chronic Obstructive Pulmonary Disease
CPFT	Cumbria Partnership Foundation Trust
CRM	Cardiac Rhythm Management
CTG	Cardiotography
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CYP	Children and Young People
DGAG	Divisional Governance Assurance Group
DNACPR	Do Not Attempt Cardiopulmonary Resuscitation
DoLS	Deprivation of Liberty Safeguards
D2A	Discharge to Assessment
E-coli	Escherichia coli (coliform bacterium)
ED	Emergency Department
ENACT	Executive Nurses Accountable Care Team
ENT	Ear, Nose and Throat
EPR	Electronic Patient Record
e-RS	e-Referral Service
FFFAP	Falls and Fragility Fractures Audit Programme
FFT	Friends and Family Test
FGH	Furness General Hospital
FIT (Testing)	Faecal Immunochemical Test
FNA	Fine Needle Aspiration
FNAC	Fine Needle Aspiration Cytology
GI	Gastrointestinal
GMC	General Medical Council
GP	General Practitioner
HANA	Head and Neck Cancer Audit
HCAI	Healthcare Associated Infection
HCC	Healthcare Communications
HFSS	High in Fat, Sugar and Salt
HPTP	Hospital Pharmacy Transformation Plan
HSMR	Hospital Standardised Mortality Ratio
HSCIC	Health and Social Care Information Centre
I3	Innovation, Information and Informatics
IBD	Inflammatory Bowel Disease
ICC	Integrated Care Communities
ICNARC	Intensive Care National Audit and Research Centre
IGT	Information Governance Toolkit

IQC	Internal Quality Control
iWGC	I Want Great Care
KF	Key Finding
LCC	Lancashire County Council
LCFT	Lancashire Care Foundation Trust
LeDeR	Learning Disabilities Mortality Review
LiA	Listening into Action
LPA	Lasting Power of Attorney
MBRRACE	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries
MCA	Mental Capacity Act
MDT	Multi-disciplinary Team
MIG	Medical Inter-operability Gateway
MINAP	Myocardial Ischaemia National Audit Project
MRSA	Methicillin-resistant Staphylococcus Aureus
MSLC	Maternity Services Liaison Committee
NABCOP	National Audit of Breast Cancer in Older Patients
NaDia	National Diabetes Inpatient Audit
NAOGC	National Oesophago-Gastric Cancer Audit
NBOCAP	National Bowel Cancer Audit
NCAA	National Cardiac Arrest Audit
NCASRI	National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs Following Major Injury
NELA	National Emergency Laparotomy Audit
NEWS	National Early Warning Score
NEWS2	National Early Warning Score (2nd version)
NHS	National Health Service
NHSI	National Health Service Improvement
NICE	National Institute for Health and Care Excellence
NICOR	National Institute for Cardiovascular Outcomes Research
NIHR	National Institute of Health Research
NJR	National Joint Registry
NLCA	National Lung Cancer Audit
NMC	Nursing and Midwifery Council
NMPA	National Maternal and Perinatal Audit
NNAP	National Neonatal Audit Programme
NPDA	National Paediatric Diabetes Audit
NPSA	National Patient Safety Agency
NRLS	National Reporting and Learning System
NWAS	North West Ambulance Service
NWNODN	North West Neonatal Operational Delivery Network
OSC	Overview and Scrutiny Committee
PALS	Patient Advice and Liaison Service
PANDA	Paediatric Autoimmune Neuropsychiatric Disorders Associated With Streptococcal Infections
PbR	Payment by Results
PCI	Percutaneous Coronary Interventions
PEF	Peak Expiratory Flow
PEG	Percutaneous endoscopic gastrostomy
PICANet	Paediatric Intensive Care Audit Network
PHSO	Parliamentary and Health Service Ombudsman
PIR	Post Infection Reviews
POMH	Prescribing Observatory for Mental Health
Pre-op	Pre-operative
PROMs	Patient Reported Outcome Measures
PSU	Patient Safety Unit
Q	Quarter
QAAS	Quality Assurance Accreditation Scheme
QAF	Quality Assessment Framework
QIP	Quality Improvement Strategy and Plan
RCA	Root Cause Analysis

RCEM	Royal College of Emergency Medicine
RCP	Royal College of Psychiatrists
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
RIG	Radiologically Inserted Gastrostomy
RLI	Royal Lancaster Infirmary
RN	Registered Nurse
RTT	Referral To Treatment
RVS	Royal Voluntary Service
SACT	Systemic Anti-Cancer Therapy
SBAR	Situation, Background, Assessment, Recommendation (Tool)
SCR	Summary Care Record
SHOT	Serious Hazards of Transfusion
SHMI	Summary Hospital Mortality Index
SIRI	Serious Incident Requiring Investigation
SSNAP	Sentinel Stroke National Audit Programme
StEIS	Strategic Executive Information System
STF	Sustainability and Transformation Fund
STP	Sustainability and Transformation Plan
STRATA	Electronic Referral System provided by Strata Health
TACO	Transfusion Associate Circulatory Overload
TARN	Trauma Audit and Research Network
TIA	Transient Ischemic Attack
UHMBFT	University Hospitals of Morecambe Bay Foundation Trust
VTE	Venous Thrombo-Embolism
WGH	Westmorland General Hospital

Table 35: Glossary of Terms

Abbreviation	Glossary of meaning
Breach	Failure to meet the standard/target
Cardiac Arrest	Cardiac arrest, (also known as cardiopulmonary arrest or circulatory arrest) is the cessation of normal circulation of the blood due to failure of the heart to contract effectively.
Clinical Commissioning Group	Responsible for most healthcare services available within a specific geographical area.
Clostridium Difficile	Clostridium Difficile (C. diff) is a bacterium that is present naturally in the gut of around two thirds of children and 3% of adults. C. diff does not cause any problems in healthy people. However, some antibiotics that are used to treat other health conditions can interfere with the balance of 'good' bacteria in the gut. When this happens, Clostridium Difficile bacteria can multiply and produce toxins (poisons), which cause illness such as diarrhoea and fever. At this point, a person is said to be 'infected' with C. diff.
Commissioning for Quality and Innovation	This is a system introduced in 2009 to make a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of care.
Deprivation of Liberty Safeguards (DoLS)	The Deprivation of Liberty Safeguards (DoLS) is part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. The safeguards should ensure that a care home, hospital or supported living arrangement only deprives someone of their liberty in a safe and correct way, and that this is only done when it is in the best interests of the person and there is no other way to look after them.
EQ-5D	A standardised instrument for measuring generic health status
Freedom to Speak Up Guardian	A staff member who acts as the independent advisor and Trust expert on matters relating to raising serious concerns, taking a highly visible role in promoting the processes through which these concerns can be raised (including trust and confidence in the processes themselves).
Harm	An unwanted outcome of care intended to treat a patient.
HOGAN	A standard scale to determine whether the death was avoidable
Hospital Standardised Mortality Ratio	The Hospital Standardised Mortality Ratio (HSMR) A system which compares expected mortality of patients to actual. It is an indicator of healthcare quality that measures whether the death rate at a hospital is higher or lower than you would expect. HSMR compares the expected rate of death in a hospital with the actual rate of death. Dr Foster looks at those patients with diagnoses that most commonly result in death for example, heart attacks,

Table 35: Glossary of Terms	
Abbreviation	**Glossary of meaning**
	strokes or broken hips. For each group of patients we can work out how often, on average, across the whole country, patients survive their stay in hospital, and how often they die.
i Want Great Care	iWantGreatCare is a company that Healthcare provider use to help patients leave meaningful feedback on their care, say thank you and help the next patient.
Kiss Goodbye To Sepsis	A national awareness day held on 14th February 2017 to raise awareness of Sepsis.
Methicillin Resistant Staphylococcus Aureus (MRSA)	It is a common skin bacterium that is resistant to some antibiotics. Media reports sometimes refer to MRSA as a superbug. An MRSA bacteraemia means the bacteria have infected the body through a break in the skin and multiplied, causing symptoms. Staphylococcus Aureus (SA) is a type of bacteria. Many people carry SA bacteria without developing an infection. This is known as being colonised by the bacteria rather than infected. About one in three people carry SA bacteria in their nose or on the surface of their skin.
Mental Capacity Act (MCA)	The Mental Capacity Act is designed to protect people who can't make decisions for themselves or lack the mental capacity to do so. This could be due to a mental health condition, a severe learning disability, a brain injury, a stroke or unconsciousness due to an anaesthetic or sudden accident
National Institute for Health and Care Excellence	This is an independent organisation that provides national guidance and standards on the promotion of good health and the prevention and treatment of ill health.
NCEPOD	A standard score to assess quality of care
NHS Outcomes Framework	The NHS Outcomes Framework is structured around five domains, which set out the high-level national outcomes that the NHS should be aiming to improve. They focus on: • Domain 1 Preventing people from dying prematurely • Domain 2 Enhancing quality caring of life for people with long-term conditions • Domain 3 Helping people to recover from episodes of ill health or following injury; • Domain 4 Ensuring that people have a positive experience of care; and • Domain 5 Treating and for people in a safe environment • Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance
Risk Adjusted Mortality Index	Risk Adjusted Mortality Index – is a measure of the outcomes of care for patients. Risk Adjusted Mortality compares us to what is expected from the types of cases we manage and compares us to other similar hospitals in the country.
Safety Thermometer	A point of care survey which is used to record the occurrence of four types of harm (pressure ulcers, falls, catheter associated urinary tract infection and venous thrombo-embolism).
SimMom	An advanced birthing simulator that provides manual and automatic delivery to best teach obstetric skills.
Summary Hospital Level Mortality Indicator (SHMI)	Summary Hospital Level Mortality Indicator is a system which compares expected mortality of patients to actual mortality (similar to HSMR) and measures whether mortality associated with hospitalisation was in line with expectations. Deaths within 30/7 discharged from hospital.
The Trust	University Hospitals Morecambe Bay HNS Foundation Trust - A Foundation Trust is part of the National Health Service in England and has to meet national targets and standards. NHS Foundation Trust status also gives us greater freedom from central Government control and new financial flexibility.
Venous Thrombo-Embolism	Venous Thrombo-Embolism (VTE) A blood clot forming within a vein. It is the collective term for deep vein thrombosis (DVT) and Pulmonary Embolism (PE). A DVT is a blood clot that forms in a deep vein, usually in the leg or the pelvis. Sometimes the clot breaks off and travels to the arteries of the lung where it will cause a pulmonary embolism (PE).We can avoid many VTEs by offering preventative treatment to patients at risk.
VTE Prophylaxis	Venous Thromboembolism (VTE) Prophylaxis is preventive treatment given to patients in order to protect them from developing a blood clot that forms in a deep vein.

Table 35: Glossary of Terms	
Abbreviation	**Glossary of meaning**
62 day Cancer waiting time standard	Number of patients receiving first definitive treatment for cancer within 62 days following an urgent GP referral as a percentage of the total number of patients receiving first definitive treatment for cancer following an urgent GP referral.
62 day cancer screening waiting time standard	Number of patients receiving first definitive treatment for cancer within 62 days referral from the screening programme as a percentage of the total number of patients receiving first definitive treatment for cancer following a referral from the screening programme.
MRSA Target	Number of patients identified with positive culture for MRSA bacteraemia
Clostridium. Difficile Target	Number of patients identified with positive culture for Clostridium Difficile
Monitor	Monitor was established in 2004 and authorises and regulates NHS Foundation Trusts. Monitor works to ensure that Foundation Trusts comply with the conditions they signed up to and that they are well led and financially robust.
Mortality Rate	Number of deaths http://www.ic.nhs.uk/statistics-and-data-collections/hospital-care/summary-hospital--level-mortality-indicator-shmi
Morbidity	Morbidity comes from the word morbid, which means “of or relating to disease”
NHS Improvement	NHS Improvement brings together Monitor, NHS Trust Development Authority, Patient Safety, the National Reporting and Learning System, the Advancing Change Team and the Intensive Support Teams. NHS Improvement will build on the best of what these organisations did, but with a change of emphasis. Its priority is to offer support to providers and local health systems to help them improve.
Patient Reported Outcome Scores	The patient reported outcome scores are for (i) groin hernia surgery,(ii) varicose vein surgery, (iii) hip replacement surgery, and (iv) knee replacement surgery http://www.ic.nhs.uk/statistics-and-data-collections/hospital-care/patient-reported-outcome-measures-proms
PICKER Institute	National Company that undertakes the National Inpatient Survey on behalf of the Trust.
Emergency readmissions to hospital within 28 days of discharge	http://www.ic.nhs.uk/pubs/hesemergency0910
Percentage of admitted patients risk-assessed for Venous Thrombo-Embolism	http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_131539
Rate of Clostridium Difficile	http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/ClostridiumDifficile/EpidemiologicalData/MandatorySurveillance/cdiffMandatoryReportingScheme/ The following information provides an overview on how the criteria for measuring this indicator has been calculated: • Patients must be in the criteria aged 2 years and above • Patients must have a positive culture laboratory test result for Clostridium Difficile which is recognised as a case • Positive specimen results on the same patient more than 28 days apart are reported as a separate episode • Positive results identified on the fourth day after admission or later of an admission to the Trust is defined as a case and the Trust is deemed responsible

Table 35: Glossary of Terms	
Abbreviation	**Glossary of meaning**
Maximum 62 days from urgent GP referral to first treatment for all cancers	The following information provides an overview on how the criteria for measuring this indicator has been calculated: • The indicator is expressed as a percentage of patients receiving their first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer; • An urgent GP referral is one which has a two week wait from the date that the referral is received to first being seen b y a consultation (see http://www.dh.gov.uk/prod-consum-dh/groups/dh-digitalassets/documents/digitalassset/dh-103431.pdf); • The indicator only includes GP referrals for suspected cancer (i.e. excludes consultant upgrades and screening referrals and where the priority type of the referral is National Code 3 – Two week wait); • The clock start date is defined as the date the referral is received by the Trust; and • The clock stop date is defined as the date of first definitive cancer treatment as defined in the NHS Dataset Change Notice. In summary this is the date of the first definitive cancer treatment given to a patient who is receiving care for a cancer condition or it is the date that cancer was discounted when the patient was first seen or it is the date that the patient made the decision to decline all treatment.
Rate of patient safety incidents and percentage resulting in severe harm or death	http://www.nrls.npsa.nhs.uk/resources/?entryid45=132789
Tertiary	Specialist hospital or service

Annex B – Statement of Directors' Responsibilities in Respect of the Quality Report

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

NHSI has issued guidance to NHS Foundation Trust Boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that NHS Foundation Trust Boards should put in place to support the data quality for the preparation of the Quality Report.

In preparing the Quality Report, Directors are required to take steps to satisfy themselves that:

The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2017/18 and supporting guidance;

- Board minutes and papers for the period 1 April 2017 to 25 May 2018;
- Papers relating to quality reported to the Board over the period 1 April 2017 to 25 May 2018;
- Feedback from commissioners – Morecambe Bay Clinical Commissioning Group dated 14 May 2018;
- Feedback from Governors dated 8 January 2018; 23 January 2018; 11 April 2018;
- Feedback from Healthwatch Lancashire dated 8 May 2018 and Healthwatch Cumbria organisations dated 16 May 2018;
- Feedback from Cumbria Health Scrutiny Committee dated 04 May 2018 and Lancashire Health Scrutiny Committee dated11 May 2018;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 16 April 2018;
- The 2017 maternity survey, published 5 March 2018;
- The 2016 national in-patient survey, published 31 May 2017;
- The 2016 children & young people survey, published 28 November 2017;
- The 2016 emergency department survey, published 17 October 2017;
- The 2017 national staff survey, published 6 March 2018;
- The 2017 local staff pulse surveys dated 21 May 2017, 25 July 2017 and 10 October 2017;
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 11 April 2018; and
- Care Quality Commission Inspection report dated 9 February 2017.

- The Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered;
- The performance information reported in the Quality Report is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- The Quality Report has been prepared in accordance with NHS Improvement's annual reporting guidance (which incorporates the Quality Accounts regulations) published at NHS Improvement as well as the standards to support data quality for the preparation of the Quality Report also available at NHS Improvement

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

By order of the Board.

Ian Johnson
Chairman

Date: 25 May 2018

Aaron Cummins
Chief Executive

Date: 25 May 2018

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Annex C – External Auditor's Limited Assurance Report on the Contents of the Quality Report

Independent Practitioner's Limited Assurance Report to the Council of Governors of University Hospitals of Morecambe Bay NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of University Hospitals of Morecambe Bay NHS Foundation Trust to perform an independent limited assurance engagement in respect of University Hospitals of Morecambe Bay NHS Foundation Trust's Quality Report for the year ended 31 March 2018 (the "Quality Report") and certain performance indicators contained therein against the criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and additional supporting guidance in the 'Detailed requirements for quality reports 2017/18' (the 'Criteria').

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to the limited assurance engagement consist of the national priority indicators as mandated by NHS Improvement:

- percentage of patients with a total time in Accident and Emergency (A&E) of four hours or less from arrival to admission, transfer or discharge (Royal Lancaster Infirmary and Furness General Hospital); and
- percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period.

We refer to these national priority indicators collectively as the 'Indicators'.

Respective responsibilities of the directors and Practitioner

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the Criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports 2017/18'; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance and the six dimensions of data quality set out in the ''Detailed requirements for external assurance for quality reports 2017/18'.

We read the Quality Report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes for the period 1 April 2017 to 25 May 2018;
- papers relating to quality reported to the Board over the period 1 April 2017 to 25 May 2018;
- feedback from commissioners dated 14 May 2018;
- feedback from governors dated 8 January 2018, 23 January 2018 and 11 April 2018;

- feedback from local Healthwatch organisations, Healthwatch Lancashire and Healthwatch Cumbria dated 8 May 2018 and 16 May 2018;
- feedback from Cumbria Health Scrutiny Committee and Lancashire Health Scrutiny Committee dated 4 May 2018 and 11 May 2018;
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, dated 16 April 2018;
- the 2017 maternity patient survey dated 5 March 2018;
- the 2016 in-patient survey dated 31 May 2017;
- the 2016 children and young people patient survey dated 28 November 2017;
- the 2016 emergency department patient survey dated 17 October 2017
- the 2017 national staff survey dated 6 March 2018;
- the local staff pulse surveys dated 21 May 2017, 25 July 2017 and 10 October 2017, and
- the Head of Internal Audit's annual opinion over the Trust's control environment dated 11 April 2018.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the "documents"). Our responsibilities do not extend to any other information.

The firm applies International Standard on Quality Control 1 (Revised) and accordingly maintains a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of University Hospitals of Morecambe Bay NHS Foundation Trust as a body, to assist the Council of Governors in reporting University Hospitals of Morecambe Bay NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2018, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body, and University Hospitals of Morecambe Bay NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- limited testing, on a selective basis, of the data used to calculate the indicators tested against supporting documentation;
- comparing the content requirements of the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable, measurement techniques that can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the Quality Report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance.

The scope of our limited assurance work has not included governance over quality or non-mandated indicators, which have been determined locally by University Hospitals of Morecambe Bay NHS Foundation Trust.

Our audit work on the financial statements of University Hospitals of Morecambe Bay NHS Foundation Trust is carried out in accordance with our statutory obligations. This engagement will not be treated as having any effect on our separate duties and responsibilities as University Hospitals of Morecambe Bay NHS Foundation Trust's external auditors. Our audit reports on the financial statements are made solely to University Hospitals of Morecambe Bay NHS Foundation Trust's members, as a body, in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. Our audit work is undertaken so that we might state to University Hospitals of Morecambe Bay NHS Foundation Trust's members those matters we are required to state to them in an auditor's report and for no other purpose. Our audits of University Hospitals of Morecambe Bay NHS Foundation Trust's financial statements are not planned or conducted to address or reflect matters in which anyone other than such members as a body may be interested for such purpose. In these circumstances, to the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than University Hospitals of Morecambe Bay NHS Foundation Trust and University Hospitals of Morecambe Bay NHS Foundation Trust's members as a body, for our audit work, for our audit reports, or for the opinions we have formed in respect of those audits.

Basis for qualified conclusion

The indicator reporting the percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period did not meet the six dimensions of data quality in the following respect:

- Accuracy - Our testing identified five errors in total in the twenty cases we tested, four errors in the clock start dates and one error in the clock end date. The errors resulted in clock start and end times being incorrectly recorded in line with the applicable guidance, with errors ranging from 3 to 89 days.

Qualified Conclusion

Based on the results of our procedures, with the exception of the matter reported in the Basis for qualified conclusion paragraph report above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- the Quality Report is not prepared in all material respects in line with the Criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports 2017/18'; and
- the indicators in the Quality Report identified as having been subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance.

Grant Thornton UK LLP

Grant Thornton UK LLP
Chartered Accountants
Glasgow

25 May 2018

Annex D – A Statement of the Chief Executive's Responsibilities as the Accounting Officer

Statement of the Chief Executive's Responsibilities as the Accounting Officer of University Hospitals of Morecambe Bay NHS Foundation Trust

The NHS Act 2006 states that the Chief Executive is the Accounting Officer of the NHS Foundation Trust. The relevant responsibilities of the Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require University Hospitals of Morecambe Bay NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of University Hospitals of Morecambe Bay NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Department of Health Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements;
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance; and
- prepare the financial statements on a going concern basis.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable him / her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.

Aaron Cummins
Chief Executive

Date: 25 May 2018

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Annex E – An Independent Auditor's Report to the Council of Governors

Independent auditor's report to the Council of Governors of University Hospitals of Morecambe Bay NHS Foundation Trust

Report on the Audit of the Financial Statements

Opinion

Our opinion on the financial statements is unmodified

We have audited the financial statements of University Hospitals of Morecambe Bay NHS Foundation Trust (the 'Trust') for the year ended 31 March 2018 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and notes to the accounts including a summary of accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and the NHS foundation trust annual reporting manual 2017/18.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2018 and of its expenditure and income for the year then ended; and
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the NHS foundation trust annual reporting manual 2017/2018; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Who we are reporting to

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Trust's Council of Governors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Council of Governors, as a body, for our audit work, for this report, or for the opinions we have formed.

Material uncertainty related to going concern

We draw attention to note 1.1 in the financial statements, which indicates that the Trust has incurred a deficit of £67.6 million during the year ended 31 March 2018 and has a further planned deficit of £69.4 million for 2018/19. The Trust has submitted a two year operational plan to NHS Improvement covering 2017/18 and 2018/19, which assumes that further support will be provided by the Department of Health and Social Care in the form of loans for required capital expenditure and revenue support. The second year of the two year plan has been refreshed and assumes revenue support to the level of the planned deficit. As stated in note 1.1, as at the date of our report, this support is not yet fully secured.

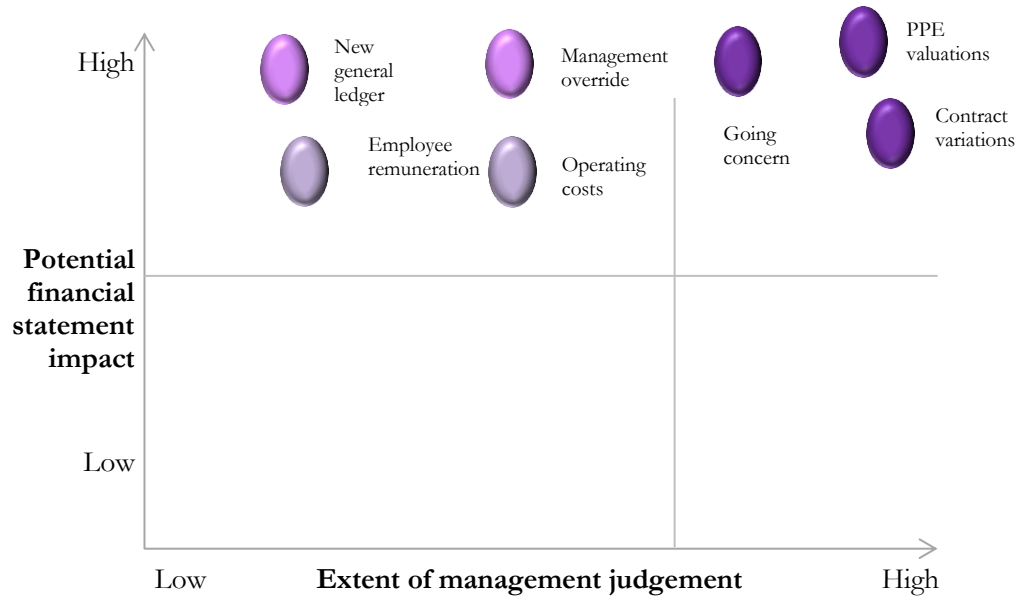
These events or conditions, along with the other matters explained in note 1.1, indicate that a material uncertainty exists that may cast significant doubt about the Trust's ability to continue as a going concern. Our opinion is not modified in respect of this matter.

Overview of our audit approach

- Overall materiality: £5,077,000 which represents 1.5% of the Trust's gross operating costs (consisting of operating expenses and finance expenses);
- Key audit matters were identified as:
  - Material uncertainty related to going concern;
  - Contract variations; and
  - Valuation of property, plant and equipment.
- We have tested the Trust's material income and expenditure streams and assets and liabilities covering 87% of the Trust's income, 77% of the Trust's expenditure, 77% of the Trust's assets and 88% of the Trust's liabilities.

Key audit matters

The graph below depicts the audit risks identified and their relative significance based on the extent of the financial statement impact and the extent of management judgement.



Key audit matters are those matters that, in our professional judgment, were of most significance in our audit of the financial statements of the current year and include the most significant assessed risks of material misstatement (whether or not due to fraud) that we identified. These matters included those that had the greatest effect on: the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters. In addition to the matter described in the *Material Uncertainty Related to Going Concern* section, we have determined the matters described below to be the key audit matters to be communicated in our report.

Key Audit Matter	How the matter was addressed in the audit
Risk 1 Contract variations Approximately 90% of the Trust's income is from patient care activities and contracts with NHS commissioners.	Our audit work included, but was not restricted to: • evaluating the Trust's accounting policy for recognition of income from patient care activities for appropriateness; • gaining an understanding of the Trust's system for accounting

Key Audit Matter	How the matter was addressed in the audit
These contracts include the rates for and the level of patient care activity to be undertaken by the Trust. Any patient care activities provided that are additional to those incorporated in these contracts (contract variations) are subject to verification and agreement by the commissioners. We therefore identified occurrence and accuracy of income from contract variations as a significant risk, which was one of the most significant assessed risks of material misstatement.	for income from patient care activities and evaluating the design of the associated controls; • agreeing all amounts recognised as income from the main NHS Commissioners in the financial statements to signed contracts and test any contract variations to invoices or supporting documentations; and • agreeing on a sample basis contract variations for the remaining NHS Commissioner contracts amounts recognised as income in the financial statements, to signed contracts, contract variations, invoices or supporting documentation. The Trust's accounting policy on revenue is shown in note 1.4 to the financial statements, and related disclosures are included in note 3. **Key observations** We obtained sufficient audit evidence to conclude that: • the Trust's accounting policy for income from patient activities is in accordance with the Department of Health and Social Care Group Accounting Manual 2017/18 and has been properly applied; and • income from patient care activities is not materially misstated.
Risk 2 Valuation of property, plant and equipment The Trust uses an external valuer to revalue its property, plant and equipment on an annual basis to ensure that carrying value is not materially different from fair value. This represents a significant estimate by management in the financial statements. We therefore identified the valuation of property, plant and equipment as a significant risk, which was one of the most significant assessed risks of material misstatement.	Our audit work included, but was not restricted to: • reviewing management's processes and assumptions for the calculation of the estimate, the instructions issued to the valuation expert and the scope of their work; • considering the competence, expertise and objectivity of any valuation expert used; • challenging the information and assumptions used by the valuer to assess completeness and consistency with our understanding; • assessing the overall reasonableness of the valuation movement; • testing, on a sample basis, any revaluations made during the year to ensure they are input correctly into the Trust's asset register and the financial statements; and • evaluating the assumptions made by management for those assets not revalued during the year and how management has satisfied themselves that these are not materially different to current value. The Trust's accounting policy on property, plant and equipment is shown in note 1.7 to the financial statements, and related disclosures are included in note 10. **Key observations** We obtained sufficient audit assurance to conclude that: • the basis of the valuation was appropriate and the assumptions and processes used by management in determining the estimates were reasonable; and • the valuation of property disclosed in the financial statements is reasonable.

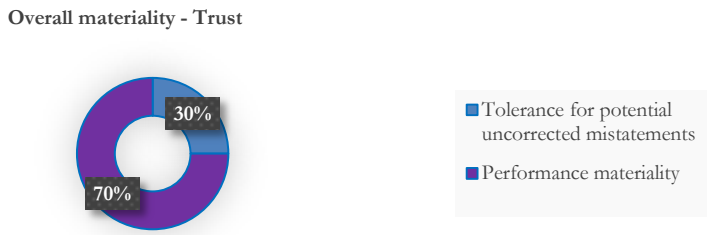
Our application of materiality

We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality in determining the nature, timing and extent of our audit work and in evaluating the results of that work.

Materiality was determined as follows:

Materiality Measure	Trust
Financial statements as a whole	£5,077,000 which is 1.5% of the Trust's gross operating costs. This benchmark is considered the most appropriate because we consider users of the financial statements to be most interested in how it has expended its revenue and other funding. Materiality for the current year is at the same percentage level of gross operating costs as we determined for the year ended 31 March 2017 as we did not identify any significant changes in the Trust or the environment in which it operates.
Performance materiality used to drive the extent of our testing	70% of financial statement materiality.
Specific materiality	Disclosures of senior manager remuneration in the Remuneration Report of £19,000 is based on 1.5% of the total executive and non-executive directors' remuneration. Disclosure of related party transactions £884,000 is based on 1.5% of total related party transactions expenditure.
Communication of misstatements to the Audit Committee	£253,000 and misstatements below that threshold that, in our view, warrant reporting on qualitative grounds.

The graph below illustrates how performance materiality interacts with our overall materiality and the tolerance for potential uncorrected misstatements.



An overview of the scope of our audit

Our audit approach was a risk-based approach founded on a thorough understanding of the Trust's business, its environment and risk profile. It included an evaluation of the Trust's internal controls including relevant IT systems and controls over key financial systems.

Our work involved obtaining evidence about the amounts and disclosures in the financial statements to give us reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. The scope of our audit included:

- undertaking an interim audit visit where we:
    - obtained an understanding of and evaluated the Trust's overall control environment relevant to the preparation of the financial statements, including its IT systems;
    - completed walk through tests of the Trust's controls operating in key financial systems where we consider that there is a risk of material misstatement to the financial statements; and
    - performed interim testing, on a sample basis, of operating expenditure and non-healthcare income.
- performing a year end audit of the Trust's financial statements, which focussed on gaining assurance around the Trust's material income streams and operating costs, testing the Trust's employee remuneration costs and the notes to the accounts to ensure that they were compliant with the Department of Health and Social Care's Group Accounting Manual for 2017/18.
- We tested, on a sample basis:
    - all of the Trust's material income streams, covering 87% of the Trust's income;
    - operating expenses, covering 77% of the Trust's expenditure;
    - 77% of the Trust's assets; and
    - 88% of the Trust's liabilities.

Other information

The Accounting Officer is responsible for the other information. The other information comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge of the Trust obtained in the course of our work including that gained through work in relation to the Trust's arrangements for securing value for money through economy, efficiency and effectiveness in the use of its resources or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

In this context, we also have nothing to report in regard to our responsibility to specifically address the following items in the other information and to report as uncorrected material misstatements of the other information where we conclude that those items meet the following conditions:

- Fair, balanced and understandable in accordance with provision C.1.1 of the NHS Foundation Trust Code of Governance – the statement given by the directors that they consider the Annual Report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy, is materially inconsistent with our knowledge of the Trust obtained in the audit; or
- Audit Committee reporting in accordance with provision C.3.9 of the NHS Foundation Trust Code of Governance – the section describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not meet the disclosure requirements set out in the NHS foundation trust annual reporting manual 2017/18. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Our opinion on other matters required by the Code of Audit Practice is unmodified

In our opinion:

- the parts of the Remuneration Report and the Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the NHS foundation trust annual reporting manual 2017/18 and the requirements of the National Health Service Act 2006; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust gained through our work in relation to the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources, the other information published together with the financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Under the Code of Audit Practice we are required to report to you if:

- we have reported a matter in the public interest under Schedule 10 (3) of the National Health Service Act 2006 in the course of, or at the conclusion of the audit; or
- we have referred a matter to the regulator under Schedule 10 (6) of the National Health Service Act 2006 because we had reason to believe that the Trust, or a director or officer of the Trust, was about to make, or had made, a decision which involved or would involve the incurring of expenditure that was unlawful, or was about to take, or had taken a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in respect of the above matters**.**

Responsibilities of the Accounting Officer and Those Charged with Governance for the financial statements

As explained more fully in the Statement of Accounting Officer's responsibilities, the Chief Executive, as Accounting Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions included in the NHS foundation trust annual reporting manual 2017/18, for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accounting Officer is responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Trust lacks funding for its continued existence or when policy decisions have been made that affect the services provided by the Trust.

The Audit Committee is Those Charged with Governance.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements – Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Qualified conclusion

On the basis of our work, having regard to the guidance issued by the Comptroller and Auditor General in November 2017, except for the effects of the matters described in the basis for qualified conclusion section of our report, we are satisfied that, in all significant respects, University Hospitals of Morecambe Bay NHS Foundation Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

Basis for qualified conclusion

Our review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources identified the following matters:

- The Trust delivered a deficit of £67.6 million in 2017/18, increasing the cumulative deficit of the Trust to £199.1 million. The Trust received £36.3 million of revenue support in 2017/18, from the Department of Health and Social Care. The Trust is projecting a deficit of £69.4 million for 2018/19, and is seeking further revenue support from the Department of Health and Social Care; and
- On 8 May 2018, NHS Improvement issued enforcement undertakings confirming the Trust needs to rectify the breach of conditions of its licence in relation to financial sustainability.

These matters identify weaknesses in the Trust's arrangements for setting a sustainable budget with sufficient capacity to absorb emerging cost pressures due to the current configuration of services. This issue is evidence of weaknesses in proper arrangements for sustainable resource deployment in planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.

Responsibilities of the Accounting Officer

The Accounting Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under paragraph 1 of Schedule 10 of the National Health Service Act 2006 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2017, as to whether in all significant respects, the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018, and to report by exception where we are not satisfied.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to be satisfied that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Report on other legal and regulatory requirements - Certificate

We certify that we have completed the audit of the financial statements of University Hospitals of Morecambe Bay NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Gareth Kelly

Gareth Kelly
Associate Director
for and on behalf of Grant Thornton UK LLP

110 Queen Street
Glasgow
G1 3BX

25 May 2018

Annex F – Annual Governance Statement 2017/18

Annual Governance Governance Statement 2017/18

University Hospitals of Morecambe Bay NHS Foundation Trust

1. Scope of Responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer Memorandum.*

2. The Purpose of the System of Internal Control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of University Hospitals of Morecambe Bay NHS Foundation Trust (the Trust), to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place for the Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

3. Capacity to Handle Risk

3.1 Leadership

As Accounting Officer, I have overall accountability and responsibility for ensuring that there are effective risk management and integrated governance systems in place within the Trust and for meeting all statutory requirements and adhering to guidance issued by NHS Improvement in respect of governance and risk management.

During 2017/18 the Trust's Risk Management Strategy has been reviewed and was approved by the Board of Directors on 31 January 2018. The Risk Management Strategy describes the roles and responsibilities of all employees within the Trust and sets out the requirement for an active lead from managers at all levels to ensure risk management is a fundamental part of the total approach to quality, safety, corporate and clinical governance, performance management and assurance. There is a clearly defined structure for the management and ownership of risk which through the Risk Register enables significant risks to be escalated to the Board via the Board Assurance Framework and Corporate Risk Register.

Through the Internal Audit Plan, the Audit Committee has continued to seek assurance on the effectiveness and compliance with the Risk Management Framework.

The Board of Directors has overall responsibility for setting the strategic direction of the Trust and managing the risks in delivering the strategy. All committees with risk management responsibilities have reporting lines to the Board.

A lead Executive Director has been identified for each strategic risk defined within the Board Assurance Framework; each risk is in relation to the Trust's strategic objectives. These 'high level' strategic risks within the Board Assurance Framework, supported by the Corporate Risk Register which contains 'high level' operational risks, are subject to ongoing review by the Board and its Committees on a quarterly basis.

The Director of Governance has overall responsibility for the implementation and compliance with the Risk Management Framework within the Trust in order that the Executive Directors are supported in providing strategic leadership for:

- Financial risks and the effective coordination of financial controls throughout the Trust;
- Clinical Quality and Safety Risks;
- Workforce and Staffing Risks;
- Medical Risks;
- Information Risks;
- Estate and Capital Risks;
- Governance Risks; and
- Divisional Risks.

All divisional triumvirate members have responsibility for the risk management activity in their Division, including:

- Providing leadership for risk management activities in their Division;
- Promoting and supporting the implementation of the Risk Management Strategy;
- Monitoring the risk mitigation activities within their Division to ensure that risks and remedial action plans are being appropriately managed, reviewed and updated in accordance with the Risk Management Strategy;
- Monitoring and, where appropriate, challenging the scoring of risks to ensure consistency with the Risk Matrix;
- Ensuring that Divisional risk management activity is discussed and reviewed at relevant divisional meetings (Divisional Governance and Assurance Group, Divisional Management Team, and Divisional Management Board);
- Ensuring that staff are given necessary information, instruction, training and supervision in relation to risk management activities;
- Ensuring staff are made aware of risks within their work environment and of their personal responsibilities for risk management;
- Presenting risk management reports to Trust Committees, where required;
- Management of the identified risks within their Division/Department, including the escalation of risks, where appropriate;
- To promote and embed an ‘open’ and ‘just’ culture; and
- Monitoring that all relevant risk assessments are undertaken, reviewed and documented appropriately.

Senior Managers and specialist advisors routinely attend each meeting to advise on special matters and provide assurance on operational risk management and divisional risk registers. Clinical Directors and Divisional General Managers are then able to provide assurance to the Board and its Committees on the Board Assurance Framework and Corporate Risk Register.

The Divisional Clinical Director is responsible for the Divisional Risk Register. The Divisional Risk Registers are reviewed at the Divisional Governance and Assurance Groups on at least a quarterly basis to ensure actions have been taken to mitigate the risks and to provide a formal minute. The Divisional Clinical Director is responsible for ensuring that any agreed local risks that are rated at 15 and above are included in the Divisional Risk Register Report that is submitted to the relevant Assurance Committee and addition to the Corporate Risk Register and/or Board Assurance Framework. Divisional Risk Registers are presented in a standard format providing a progress report on actions taken to mitigate risk by the Divisional Clinical Director to the relevant Assurance Committees according to the annual schedule.

Governors on behalf of members are able, through the governance framework and via the Council of Governors, to raise concerns and seek assurances from the Chairman and the Non-Executive Directors on issues affecting the Trust. Through their involvement in the strategic planning processes and the development of the Operational Plan and the Quality Account, Governors are able to ensure the Trust adequately addresses the risks that impact on the Trust.

3.2 Training

Through the Governance Division, training is provided to staff members who have direct responsibility for risk management within their area of work, as defined by the Trust Risk Management Strategy including the principles of risk management and escalation, when a risk is deemed to be tolerable and the frequency of review for the controls that mitigate risks and the operation and review of the Risk Register Module of the Safeguard System. Training is provided via e-Learning courses on the Trust's Training Management System (TMS) system, 'tailored' class room sessions for specific clinical or operational areas, one to one sessions for specific individuals and risk awareness training sessions for Directors and Senior Managers.

Through the local workplace induction checklist new employees are trained and notified of local risk arrangements including health and safety, incident reporting / escalation and risk assessments. In addition, the Trust's mandatory training programme reflects essential training needs and includes risk management processes such as health and safety, clinical risk management, fire safety, conflict resolution, resuscitation, moving and handling, safeguarding adults, safeguarding children, infection prevention, information governance and equality and diversity.

Facilitated by the Training and Development Team, the Trust has a Training Needs Analysis (TNA) in place which documents the mandatory training requirements for all staff within the financial year.

4. The Risk and Control Framework

4.1 Key Elements of the Risk Management Strategy

The Trust's Risk Management Strategy covers all aspects of risk and is subject to an annual review to ensure it remains appropriate and current. The Risk Management Strategy assigns responsibility for the ownership, identification and management of risks to all individuals at all levels in order to ensure that risks are managed appropriately at a local level together with a framework which allows risks to be escalated through the organisation. The process populates the Board Assurance Framework and Corporate Risk Register, Assurance Committee Risk Registers, Divisional Risk Registers and Specialty / Departmental Risk Registers to form a systematic record of risks including the control measures designed to mitigate and minimise identified risks. As part of the Risk Management Strategy the Board has adopted the following risk appetite statement to help guide staff with risk management activities:

The Trust recognises that it is operating in a competitive healthcare economy where patient safety, quality of service and organisational viability are vitally important.

The Trust also recognises that there is always a level of inherent risk in the provision of acute healthcare which must be accepted or tolerated, but which must also be actively and robustly monitored, controlled and scrutinised.

The Trust also recognises that it has finite resources in terms of staff, equipment and finances available to it in the delivery of healthcare services.

In response to these factors the Trust will seek to manage risks in accordance with the well-established ALARP principle - As Low As Reasonably Practicable, with priority being placed upon maintaining or improving Patient Safety ahead of any other aim or objective.

All identified Risks will be allocated a Risk Mitigation Strategy that ensures compliance with the ALARP Principle.

Risks can be identified from a variety of different sources through the operation of the Trust's business; these can be proactive processes (planning processes, general observations, and internal / external audits) or reactive processes (incidents, complaints, claims, inspections / assessments / accreditations / reviews and regulatory assessments). All identified risks are then assessed and are entered into the Trust Risk Register System, Ulysses Safeguard. The Trust's Risk Management Strategy is referenced to a series of related risk management documents, for example, reporting and management of incidents including serious incidents procedure, management procedure for the investigation and resolution of complaints and claims management procedure. The Risk Management Strategy is available to all staff via the Trust's Procedural Document Library, on the Trust's Intranet.

The Trust requires that all risks on the Risk Registers have an active, robust and time specific mitigation plan. The Board believes that the Trust must do all that is reasonable in the management of all risks and once it is satisfied that controls and assurances are in place and effective, the Board is prepared that a residual risk may be tolerated or accepted. The Board understands that some strategic risks associated with the business of the Trust carry a high level of inherent risk and provided that the condition of reasonableness has been met, the Trust is prepared to tolerate strategic risks at a high level. This approach forms a fundamental part of the Trust's thinking on risk, risk tolerance and corporate decision making. To aid the Trust in making decisions on risk, the Trust utilises the National Patient Safety Agency Risk Matrix, which the Board uses as the basis of identifying acceptable and unacceptable risk.

The Trust obtained an opinion of Significant Assurance from Internal Audit in the last audit of the Risk Management Strategy in January 2016 and in February 2017 the Trust Board Assurance Framework and Risk Registers received a positive assessment in the Trust's CQC Inspection Reports.

4.2 Key Elements of the Quality Governance Arrangements

Strategy

Patient safety, clinical effectiveness and patient experience, alongside improving efficiency, drive the Board's strategic framework, which identifies key elements in the quality of care it delivers to its patients and provides the basis for annual objective setting. The potential risks to patient safety, clinical effectiveness or patient experience are identified and escalated to the Board in accordance with the process outlined in section 4.1 above.

Capabilities and Culture

The Board of Directors is ensuring it has the necessary leadership, skills and knowledge to deliver on all aspects of the quality agenda. Board development activities are in place to support the Board in its leadership and strategic decision making. A formal review of Board effectiveness will be undertaken in 2018/19. All Board of Directors receive an annual appraisal and the Chair reports to the Nominations Committee and the Remuneration Committee on the composition of the Board.

The Board keeps under review its clinical leadership model which puts senior medical and nursing colleagues at the heart of decision-making and management of each Division within the Trust. During 2017/18, our culture continues to place patient care at the heart of everything we do in addition to being honest and open and striving for excellence.

During 2017/18, the Board continued to use the Listening into Action (LiA) scheme to provide staff the opportunity to make improvements that affect them and patients. When launched in 2014, the LIA was a fundamental shift in the way we worked and led. Since the initial launch, the scheme has gone from strength to strength as staff embraced the initiative. In May 2017 the Board of Directors approved the updated Organisational Development (OD) Strategy for the Trust, based on the national *Developing People Improving Care* framework. One of the key elements of the Trust's OD Strategy was the development of the Trust's Behavioural Standards Framework (BSF). The BSF was developed through the LiA initiative and launched in October 2015. When launched, the BSF sought to ensure that the Trust employ (and retain) people with the right values, attitudes and behaviours to deliver the high standards of care expected for every patient every time. Within this, behaviours were not 'something extra', but integral to everything that we do and will drive excellence in patient and employee experience. Building on from this, during 2017/18 we continued to raise awareness of the BSF, introduced specific employee training on the behavioural standards (e-learning module), introduced specific leadership development training on behaviours and impact of others (through e-learning and taught modules) and promoted Freedom to Speak Up, Respect Champions and the inclusion networks. These plans build on the ambition to deliver an organisation which operates wholly in accordance with core Trust values.

Processes and Structure

Accountability for patient safety, clinical effectiveness and patient experience and improved efficiency are set out in the Trust's Quality Improvement Strategy. The Board of Directors reviewed its Quality Improvement Priorities for 2017-19 on 25 January 2017. The Board of Directors has commenced work on a refreshed Strategy with new targets for 2018/19.

The Board of Directors hold ultimate accountability for ensuring the Trust's services are safe, effective and reflective of the needs of patients; to that end it is the responsibility of the Board to foster a culture of quality and patient safety within the organisation by driving and overseeing the implementation of this strategy and plan.

The Board of Directors monitors the work streams that underpin this strategy and plan by scrutinising the information contained in the Integrated Performance Report and the Quality, Workforce and Finance Dashboards which are produced regularly for the Board of Directors and its Assurance Committees.

Divisional Clinical Directors, Assistant Chief Nurses, Lead Allied Health Professionals and Divisional General Managers have responsibility for facilitating the implementation of this strategy and plan within their Care Groups. Furthermore, it is the responsibility of the divisional team to contribute to the delivery of the Trust's quality targets. This is managed through the development and delivery of divisional business plans which include specific requirements relating to quality, patient safety and risk.

All Trust managers and Trust staff have a responsibility for supporting the Trust in its implementation of this strategy and plan and to adopt the principles of quality to guide them in their day to day roles.

The Board of Directors commences every meeting with a patient story, reflecting on positive and negative experiences of patients using our services. The Assurance Committees of the Board receive Quality and Integrated Performance Reports to provide assurance on quality outcomes including compliance with Care Quality Commission (CQC) registration requirements and CQC Essential Quality and Safety Standards. This is achieved through the Divisional Governance and Assurance Groups, WESEE (**w**orkforce, **e**fficiency, **s**afety, **e**ffectiveness and **e**xperience) reporting and the Care Quality Assessment Tool report.

The Board actively seeks feedback from patients, members, governors, commissioners and other stakeholders in the pursuit of excellence as part of the continuous improvement cycle. All members of the Board of Directors routinely participate in patient safety walkabouts and leadership visits in clinical areas to engage with frontline teams, patients and visitors to evaluate the safety, clinical effectiveness and experience of care for patients.

Information reported to the Board, regarding performance against nationally mandated targets, is collated from the dataset submitted to the Department of Health. Likewise data to support compliance with locally commissioned services and targets is reported to the Board of Directors from the dataset provided to commissioners.

4.3 How Risks to Data Security are Being Managed

Data quality and data security risks are managed by the Informatics, Information and Innovation (I3) via the I3 Risk Management Forum and Information Governance / Data Quality Group and report to the Trust's Finance Committee with information generated through the risk management system. Any risks identified are added to the risk registers. In addition, independent assurance is provided by the Information Governance Toolkit self-assessment review process.

During 2017/18 the Informatics, Information and Innovation (I^3) Service has overseen:

- Continued development of a system to support secure information sharing for delivery of care,
- Continued development of assurance systems to monitor and assure the privacy of patient records accessed within the Trust,
- Continued roll-out of secure electronic record keeping in place of paper record systems, and
- IT system risk and criticality assessments.

During the financial year 2016/17, the Trust had 68 Personal Data Information Security related incidents reported all of which were severity rated from Level 0 – 2 (Level 0 – Near Miss, Level 1 – Not reportable and Level 2 – Reportable). All were thoroughly investigated and reported upon. Incidents classified as a severity rating Level 2 are reported as a Serious Untoward Incident and reported to Department of Health, Health & Social Care Information Centre, Monitor (now part of NHS Improvement) and the Information Commissioner. The tables below provide a summary of the incidents that were reported in 2017/18. In comparison there were 71 personal data information security related incidents recorded during 2016/17.

Table: Summary of personal data related incidents in 2017/18		
Breach Type	**Level 0 -1**	**Level 2**
Disclosure in error	41	0
Lost in transit	0	1*
Lost or stolen hardware	1	0
Lost or stolen paperwork	18	0
Non-secure disposal – paperwork	7	0

*Please note while the incident of data lost in transit was reported as a Level 2 this has subsequently downgraded due to the return of the lost items

The Trust achieved Information Governance Toolkit (IGT) internal assessment compliance score of 80% (Satisfactory) in 2017/08 comparable to a score of 80% (Satisfactory) in 2016/17. The IGT submission is subject to independent audit, the Trusts' auditors Mersey Internal Audit Agency (MIAA) have reviewed the evidence provided as part of the Version 14.1 submission and provided an overall Significant Assurance opinion in respect of our process of Self-Assessment.

4.4 Organisations Key Risks

The key organisational risks for the year were identified from the corporate strategic objectives for 2017/18, forming part of the Board Assurance Framework and included the following:

In-Year Risks 2017/18	Future Major and Significant Clinical Risks 2018/19
These are taken from the Board Assurance Framework, Corporate Risk Register, Better Care Together Strategy / 5 Year Strategic Plan, 2 Year Operational Plan, Integrated Performance Report and Quality Account	These are taken from the Board Assurance Framework, Corporate Risk Register, Better Care Together Strategy / 5 Year Strategic Plan, 2 Year Operational Plan, Integrated Performance Report and Quality Account
Key Strategic Risks **Finance Risk** Deliver the 2017/18 financial plan and continued development of the Sustainability and Transformation Plans to 2020/21. **Workforce Risk** Ensure the Trust has a motivated and engaged workforce, in sufficient numbers and appropriately trained, to deliver the Trust's vision, values and objectives to be a "great place to be cared for, great place to work". **Sustainable Operational Performance Risk** Ensuring the Trust achieves its trajectories on the NHS Constitution Access Standards for Urgent and Emergency Care, Elective Care and Cancer Care. **Key Corporate Risks** **Sustained Safe Staffing Levels** Inability to meet agreed safe staffing levels may lead to poor standards of care, increased complaints, demotivated and fatigued staff and loss of organisational reputation as well as the inability to	**Key Strategic Risks** **People Risk** Ensure the Trust has a motivated and engaged workforce, in sufficient numbers and appropriately trained, to deliver the Trust's vision, values and objectives to be a "great place to be cared for, great place to work". **Finance Risk** Deliver the 2018/19 financial plan and continued development of the Sustainability and Transformation Plans to 2020/21. **Urgent Care Performance Risk** Ensuring the Trust achieves its trajectories on the NHS Constitution Access Standards for Urgent and Emergency Care, Elective Care and Cancer Care. **Change and Transition Risk** Ensure the Trust leads the system change and retains delivery of safe services.

In-Year Risks 2017/18	Future Major and Significant Clinical Risks 2018/19
These are taken from the Board Assurance Framework, Corporate Risk Register, Better Care Together Strategy / 5 Year Strategic Plan, 2 Year Operational Plan, Integrated Performance Report and Quality Account	These are taken from the Board Assurance Framework, Corporate Risk Register, Better Care Together Strategy / 5 Year Strategic Plan, 2 Year Operational Plan, Integrated Performance Report and Quality Account
deliver the Trust's visions, values and objectives to be a "great place to be cared for, great place to work". **Patient Flow** Inability to maintain flow through the hospital may result in poor patient experience through delays in the emergency departments and delays in discharge and transfer of care, increased complaints, fatigued staff and poor compliance against the agreed trajectories for the NHS Constitution access standards, particularly in urgent and emergency care and elective care. **Provision and Access of Mental Health Services** Limited access to adult service provision resulting in patients with a mental health issue being treated in a sub-optimal place of care, whilst awaiting assessment which can result in poor patient and staff experience. There is limited access to Child and Adolescent Mental Health Services (CAMHS) resulting in treatment delivery of children and young people requiring all levels of CAMHS care in a sub-optimal place of care, usually the acute children's ward which can result in their condition deteriorating and also compromises the ability of staff to deliver care to other acutely unwell children.	**Key Corporate Risks** **Robust Sustainable Safe Staffing Levels** Inability to meet agreed safe staffing levels may lead to poor standards of care, increased complaints, demotivated and fatigued staff and loss of organisational reputation as well as the inability to deliver the Trust's visions, values and objectives to be a "great place to be cared for, great place to work". **Patient Flow** Inability to maintain flow through the hospital may result in poor patient experience through delays in the emergency departments and delays in discharge and transfer of care, increased complaints, fatigued staff and poor compliance against the agreed trajectories for the NHS Constitution access standards, particularly in urgent and emergency care and elective care. **Bullying and Harassment** Inability to provide workplaces free of bullying, harassment and discrimination will lead to a deterioration in employee experience and a subsequent increase in patient quality and safety harms. **Quality of Environment and fabric of our estate and its implications for patient safety and experience**. Inability to provide fit for purpose clinical areas will lead to deterioration in patient and employee experience and a subsequent increase in patient quality and safety harms.

The above risks have been risk assessed and validated by the Board of Directors as part of the Annual Planning Process for 2018/19. The Trust has identified mitigating actions to reduce the overall exposure arising from these risks.

Mitigating actions against the risks are set out in the Board Assurance Framework, Corporate Risk Register, Better Care Together Strategy / 5 Year Strategic Plan and 2 Year Operational Plan. Each risk remains under constant review and are assessed by reviewing progress with measurable targets, and auditing compliance with national and local standards / regulations. Mitigating actions and outcomes are monitored as a minimum on a quarterly basis by the reporting Committees identified in the Risk Management Strategy. Escalation and de-escalation of risks is dependent upon progress to achieve outcomes. Further information is given under Section 7

4.5 Effectiveness of Governance Structures

The Trust has reviewed its Corporate Objectives and Visions and Values which focus on quality. Underpinning these will be objectives and work programmes. Progress will be reported to the Board of Directors and its Assurance Committees.

The Corporate Quality and Governance Team works with Divisional Management Teams and Governance Leads to strengthen and embed the following areas within the Trust:-

- Risk Management;
- Incident Reporting and Investigation;
- Clinical Audit;
- NICE Guidance;
- Patient Reported Outcome Measures;
- Complaints and litigation;
- CQUIN;
- Divisional Governance Leads;
- Involving and engaging patients and the public; and
- Programme Management Office.

The Quality Improvement Strategy incorporates national requirements and locally identified measures. Quality goals have been selected to have the highest possible impact across the overall Trust. The majority of measures are specific, measurable and time-bound.

Each Division has a Divisional Governance Framework in place. Divisional performance meetings are held on a monthly basis and areas of concern are escalated to the Assurance Committees. At Divisional performance meetings, the Executive Directors hold Care Groups to account for their performance.

To test the effectiveness of its Governance structures and process that Trust employs Mersey Internal Audit Agency (MIAA) as its internal auditors. Set out below is the 2017/18 work programme delivered by Internal Audit:

REVIEW TITLE	ASSURANCE LEVEL High/Significant/Limited/No
Combined Financial Systems	Significant Assurance
Cost Improvement Programme	High Assurance
VTE – Follow Up	Significant Assurance
Discharge Planning – Follow Up	Significant Assurance
Information Governance Toolkit	Significant Assurance
Local Security Management Specialist (LSMS) Quality Assurance	High Assurance
Clinical Audit Effectiveness	Significant Assurance
5-Steps to Safer Surgery	Limited Assurance
Maintenance of Equipment	Limited Assurance
Payroll: High-Level Spend	Significant Assurance
Appraisals	Significant Assurance
Sickness Absence: Return to Work Interviews	Significant Assurance
NMC Registration	No Assurance
Complaints Management	Significant Assurance
Whistleblowing	Significant Assurance
Surgery and Critical Care Division – Patient Flow	Limited Assurance
Business Continuity Follow Up	Limited Assurance
Compliance with Standards	High Assurance

The Assurance Committees seek assurance from Executive Directors and Care Groups about risk and performance. Through the Integrated Performance Report and Finance, Quality and Workforce Dashboards, Non-Executive Directors are able to seek assurance and hold Directors to account for quality, risk and performance.

The Board also receives assurances through the Programme Management Office, external assessments, clinical audit, internal and external audit and clinical and non-clinical Committees, which report on a regular basis to the Assurance Committees. Regular leadership visits are undertaken by all Board members which enable the Board to meet with staff and patients and triangulate assurances received in formal meetings.

The Board of Directors receive submission of timely and accurate information to assess risks to compliance with the Trust's Licence by scrutinising the information contained in the Integrated Performance Report and the Finance, Quality and Workforce Dashboards.

Together with internal and external audit, the Director of Governance and the Company Secretary report to the Audit Committee on the effectiveness of governance systems and structures to ensure they remain fit for purpose. The Audit Committee is a sub-committee of the Board of Directors and provides independent assurance on aspects of governance, risk management and internal controls.

Using the NHS Improvement Quality Governance Framework the Trust has submitted a series of reports to the Audit Committee and the Quality Committee on the effectiveness of its governance structures and quality processes. The Annual Reporting Requirements for 2017/18 have been amended. References to the former quality governance framework were updated to refer to NHS Improvement's broader well-led framework, which effectively incorporates the quality governance framework. Assessments against this new framework have been undertaken and presented to the Audit Committee. The NHS Improvement Quality Governance Framework documentation, however, has been requested by the Care Quality Commission as part of the evidence portfolio for its inspection work and maybe requested again for the inspection scheduled to be held in 2018. 2017/18 has seen the continued use of inspections and visits to wards and clinical areas including CQC Mock Inspections by the Board, Governors and Clinical Leaders to improve quality and increase visibility of Executive and Non-Executive Directors.

The Trust had a Well Led Governance review in 2015 following which an action plan was approved and monitored by the Board of Directors. Using the 2015 review as a baseline, the Director of Governance will undertake an assessment against the latest Framework in 2018. The results will be submitted to the Audit Committee for their consideration.

During 2017/18, the Trust continued to meet its requirements to undertake a fit and proper person assessment of its directors and the duty of candour following the introduction of new procedures in 2016/17. This included the adoption of a revised Fit and Proper Persons Policy to confirm that the Trust has in place robust systems to ensure continuous assessment of the Fit and Proper Persons requirements.

The Trust continues its approach to lessons learned through the Learning to Improve Group. This Group has responsibility for seeking assurances on the effectiveness of systems for sharing lessons learned across the Trust. Learning from both good and bad practice is key to improving services to patients. Learning to Improve was launched in 2015. It brings together divisional safety and lessons-learned and considers these alongside organisational data from patient safety, audit, patient experience and legal services. This group produces the monthly Learning to Improve bulletin.

4.6 How Risk Management is Embedded in the Activity of the NHS Foundation Trust

The Trust has in place a Risk Management Strategy and Framework which ensures that risks are considered and managed as part of the activity of the Trust. Each Division has a Risk Register which is regularly reviewed and updated and operational risks are considered through the Divisional Governance Framework. Divisional Risk Registers in turn are used to develop the quarterly Corporate Risk Register report for the Board and quarterly Committee Risk Register report for its Assurance Committees.

The Assurance Committees also receive reports from clinical and non-clinical committees, on a regular basis which include details of how operational risks are being managed.

The Trust openly encourages staff to report incidents and near misses using the Trust's incident reporting system (Ulysses). The Trust encourages reporting within an open and fair culture, where reporting is congratulated and individuals are not blamed or penalised if they speak out. The Trust has adopted and supported Speak Out Safely.

Following the publication of the NHS Employers review into Raising Concerns in the Trust in March 2015, the organisation has continued to promote the culture of speaking up for our patients to improve and maintain the patient and staff experience. As one of the first Trusts in the country to appoint a Freedom to Speak up Guardian, we are seen as exemplar in our approach and we continue to closely follow the recommendations from Robert Francis' "Freedom to Speak up" report while now being supported by the National Guardian's office. The Trust's Freedom to Speak up Guardian is supported by a Non-Executive Director and the Trust's Medical Director.

An incident reporting system is in place and incidents are entered onto a database for analysis. All incidents that are submitted using the incident reporting system are evaluated with root cause analyses undertaken for instances of harm that are deemed to be serious under the Trust's reporting and management of incidents including serious incidents procedure . There is a weekly Patient Safety Summit meeting led by the Medical Director and / or Executive Chief Nurse that review the previous week's incidents and determine whether rapid reviews or other actions are required. All identified changes in practice required following a root cause analysis are overseen and implemented by the Serious Incidents Requiring Investigation Panel which is chaired by a Non-Executive Director.

The Patient Safety Unit promotes a positive safety culture in the organisation and works in partnership with Lancaster University to develop an evidence-based improvement programme in relation to patient safety with a focus on continuous improvement. The Unit is led by a Deputy Medical Director and supported by an Assistant Chief Nurse and a data analyst. The main objective is to improve safety and quality of care through evaluation against current standards with the subsequent development of quality enhancement systems. We will engage the entire clinical workforce and also our patients and stakeholders in the achievement of step-wise quality improvement trajectories. The Central Investigation Support Unit was established in 2017 to provide guidance and support for staff and the teams undertaking a serious patient safety incident investigation. The CISU team is a 'virtual team' that are continuing in their current posts and undertaking investigation cases on a rota basis to provide support to the lead investigator and the investigation team. A 'soft launch' began in October 2017 initially concentrating on serious incidents reportable to the Strategic Executive Information System (StEIS).

Impact Assessments and due diligence are used by the Trust in respect of business cases, programme management activities and cost improvement programme proposals. Significant proposals are signed off by the Medical Director and the Executive Chief Nurse. Impact Assessments are kept under review.

The Trust has a zero-tolerance approach to fraud. The Counter Fraud service is provided by Mersey Internal Audit Agency. This helps to embed and tackle fraud and potential fraud in several ways:

- developing an anti-fraud culture across the Trust's workforce;
- fraud proofing of all Trust policies and procedures;
- conducting fraud detection exercises into areas of risk;
- investigating any allegations of suspected fraud; and
- obtaining, where possible, appropriate sanctions and redress.

Since their inception within the Trust, all policies, procedures, guidelines, schemes, strategies have to have a completed Equality Impact Assessment (EIA) attached before being submitted to the relevant Committee for discussion and sign off. Likewise completion of an EIA is expected when there is a new service to be implemented, a change to a service or cessation of a service along with the relevant consultation and engagement with service users. Where an adverse impact is identified during the completion of the initial assessment, a full EIA is carried out. This involves consulting and engaging with people who represent protected characteristic groups and other groups if required to do so.

The Trust's Equality Objectives for 2015-2019 are:

1. To eliminate unlawful discrimination, harassment and victimisation;
2. To improve year on year the reported patient experience for protected groups;
3. To improve year on year the reported employee experience for protected groups; and
4. To reduce health inequalities for protected groups by improving access to all services.

In September 2016, the Trust Board approved a five year Inclusion and Diversity Strategy, which sets out the Trust's approach to becoming a truly inclusive service provider and employer. This includes a robust governance framework, and focusses on service user, employee engagement, the development of partnerships to make improvements and drive our inclusion improvement programme. As part of this work, and that of wider workforce wellbeing initiatives and

campaigns, the Trust now has a well-established infrastructure (Occupational Health and Flourish at Work) which is set to address inequalities. An Annual Report for Inclusion and Diversity was published in July 2017.

As well as 200 Personal Fair Diverse Champions, the Trust has five established staff networks for protected groups all with an executive sponsor: Lesbian, gay, bisexual and transgender (supported by Lancashire LGBT and Stonewall); Disability; Black and Minority Ethnic (supported by the British Association of Physicians of Indian Origin), Gender launched in March 2017 and Forces launched in May 2017. Included in our improvement work, the Trust has followed the Equality Delivery System (EDS 2) 'Steps for Implementation' as a guide to developing the Trust's systems and processes to be fit for purpose, to manage inclusion and diversity effectively and to meet the Trust's Public Sector Equality Duty.

The Trust was hugely privileged to have been selected as one of NHS Employers Equality and Diversity Partners for a second year running in 2016/17 and is now part of its Alumni programme. Plans for our Alumni responsibilities included hosting an event in November 2017.

The Workforce Race Equality Standard (WRES) became a mandatory requirement embedded within the NHS Contract in 2015 to ensure effective collection, analysis and use of workforce data to address the under-representation of BME staff across the NHS. It links to all four of the Trust's Equality Objectives. The WRES offered the Trust a fantastic platform to launch a new way of working with BME staff in the organisation, and meaningfully involve staff in understanding and exploring the data and developing a response in partnership. The Trust has published an Annual Report for WRES since 2015, communicating to staff and the public the current position and improvement plans. The Trust's well-established network of BME staff and the local branch of British Association of Physicians of Indian Origin have worked in partnership with Trust leadership to develop the action plan.

In December 2017 the Trust submitted an action plan to Time to Change outlining our plans to help end mental health stigma. In early January 2018 notification that the action plan had been fully endorsed, with no alterations, was received. This enables the implementation phase of our intentions to commence, which is described in more detail in the next section. The Time to Change pledge is broken down into 7 key principle areas which include ensuring this initiative was led by an Executive Director, accountability, raising awareness, ensuring our workforce policies reflect the required principles for ensuring an inclusive workplace, encouraging staff to share their personal experience of mental health, equipping line managers to have conversations about mental health and ensuring information is provided to staff about mental health.

4.7 Elements of the Assurance Framework

Through its Corporate Governance Statement (required under NHS Foundation Trust Condition 4(8) (b)) the Trust will demonstrate its on-going compliance with:

- Board leadership;
- Organisational management; and
- Quality governance.

Through its governance structures the Trust is able to assure itself on the Trust's Performance. The Trust Board receives submission of timely and accurate information in the Integrated Performance Report and the Finance, Quality and Workforce Dashboards, the Board Assurance Framework and the Corporate Risk Register which are produced regularly for the Board and its Assurance Committees.

The Board also receives assurances through the Programme Management Office, external assessments, inspections and visits, clinical audit and internal and external audit and clinical and non-clinical committees, which report on a regular basis to the Assurance Committees and the Audit Committee. The Trust is, therefore, satisfied that there is a high degree of rigour and Board oversight of risk and performance.

As a consequence of breaching its licence conditions the Trust had several action plans to ensure it became compliant. Through submission of timely and accurate information and its Action Plans the Board is able to assess risks to compliance with the Trust's Licence.

Therefore the Board is able to assure itself of the validity of its Corporate Governance Statement.

Through the Governance Division and the Governance Action plan the Board has laid the foundations to provide the framework to manage risks in these areas.

The Board Assurance Framework (BAF) has been embedded during 2017/18. The BAF:-

- Covers all of the Trust's main activities;
- Identifies the Trust's corporate objectives and targets the Trust is striving to achieve;
- Identifies the risks to the achievement of the objectives and targets;
- Identifies the system of internal control in place to manage the risks;
- Identifies and examines the review and assurance mechanisms, which relate to the effectiveness of the system of internal control; and
- Records the actions taken by the Board of Directors and Officers of the Trust to address control and assurance gaps.

In March 2018 the Trust was notified by Internal Audit that the organisation's Assurance Framework was structured to meet the NHS requirements, and was visibly used by the Board and clearly reflects the risks discussed by the Board.

Risk prioritisation and action planning is informed by the Trust's corporate objectives. The Board of Directors in preparation for the start of the new fiscal year identifies the key strategic risks to the organisation's objectives and ensures that mitigating measures are established and managed. The Trust uses its Risk Register to both manage the key strategic risks, receiving assurances that mitigating actions are effective and to enable the escalation of any new areas of risk that present in year. The risks managed on the Risk Register are derived from a number of internal and external sources including national requirements, national guidance, complaints, claims, incident reports and internal audit findings but are all contextualised against the Trust's strategic objectives. Strategic risks are owned at an executive level in the organisation (Board Directors) but the management of higher level value operational risks and their control measures and actions is undertaken at various levels in the Trust. Lead Executive Directors and Lead Managers are identified for each risk who assume responsibility for addressing any gaps in control or gaps in assurance by developing and managing the corresponding action plans.

The Board Assurance Framework (BAF) serves to assure the Board of Directors that the Trust is addressing its risks systematically. The action plan arising from each risk also serves as a work plan for the Trust through the Lead Managers to ensure mitigation against risks and closure of any gaps in control or assurance.

The 'elements' of the Board Assurance Framework are monitored and reviewed on a quarterly basis by the Executive Directors, Assurance Committees and the Board of Directors. The Board Assurance Framework is a live document and is used as a key component in the formulation of the Trust's annual reports.

The Trust's risk management and assurance processes are evaluated on an annual basis by the Audit Committee. The Audit Committee provides assurance that the Trust's internal controls are enabling it to achieve its objectives. Where there are gaps in assurance, these are highlighted to the Board of Directors who are responsible for overseeing the completion of action plans to address the gaps.

4.8 How Public Stakeholders are Involved in Managing Risks Which Impact on Them

The Trust involves both patients and public stakeholders in the governance agenda, strategic planning and risks facing the Trust.

This has been achieved through engagement with the Trust Membership and Governors, Local Clinical Commissioning Groups, Lancashire and Cumbria Overview and Scrutiny Committee, local Safeguarding Children's Boards and local Healthwatch Groups. The Trust is also represented at local Health and Well Being Boards.

If a risk that is affecting the Trust is also directly relevant to our Commissioners this can be recorded in the risk register. These risks are then included in reports to the Quality Assurance meeting that is held with Commissioners.

Through the Better Care Together (BCT) programme, the Trust has worked with the BCT engagement team and a variety of partners to remodel the local health economy to provide a sustainable integrated health care system. Part of

the programme has seen extensive consultation with the public, communities and voluntary and special interest groups have been able to participate in the programme.

The Trust has regular contact and performance meetings with its Commissioners. The Trust attends and provides regular reports to the Local Overview and Scrutiny Committees and works closely with Healthwatch.

Prior to the publication of the CQC re-inspection in October 2016, the CQC Improvement Plan was monitored through the Quality Surveillance Group (QSG) which was chaired by NHS England and included NHS Improvement, the CQC and Commissioner membership. Following publication of the CQC Quality Reports which identified an overall rating of "good", the CQC Hospital Improvement Plan was monitored during 2017/18 by the Board Assurance Committees and Board of Directors.

The Trust has worked closely with governors to help them fulfil their statutory roles. The governors continue to contribute to the Operational Plan and the Quality Account.

With support from NHS Providers and the Board of Directors, the Governors conducted a review of their effectiveness and introduced new working arrangements aimed at improving how they hold the Non-Executive Directors to account.

Governors have also participated in:-

- CQC mock inspections and other assessments and
- Several working groups and workshops

The Trust has a Patient and Public Involvement Strategy in place and this has been continuously implemented throughout 2017/18.

The Trust held a series of public events enable the members and public to meet with clinicians and leaders to learn about the Trust and the services it provides. This includes events such as Maternity and Young People Matters and the creation of three MacMillan Support Centres.

4.9 Disclosure of Registration Requirements

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

The Trust was subject to a CQC re-inspection in October 2016 and during this inspection no warning notices were issued or enforcement action needed. The final report was published in February 2017 and the overall rating for this Trust was "good" with "outstanding" for care.

On the basis of this improved outcome, in March 2017, NHS Improvement issued a compliance certificate in accordance with paragraph 12(1) of Schedule 11 to the Health and Social Care Act 2012 to certify that in respect of paragraph 1 (Quality of Care and Kirkup Report) of the Trust's Enforcement Undertakings accepted by NHS Improvement on 18 September 2015 and amended on 26 February 2016, the Trust has been fully compliant.

Following the publication of the CQC Quality Reports on 9 February 2017 the Trust has developed the CQC Hospital Improvement Plan which incorporates all the Trust Wide and Divisional Must and Should Do actions which were identified as areas for improvement within the CQC Quality Reports.

The CQC Hospital Improvement Plan includes key performance indicators which align to the CQC reporting domains, intended to address the areas of required improvement identified by the re-inspection.

The CQC Hospital Improvement Plan is divided into sections.

The Trust wide section details the Overall Actions the Trust 'Must' take to improve which are listed below:

- Urgent and Emergency Care: Monitor performance information to ensure 95% of patients are admitted, transferred or discharged within four hours of arrival in the emergency departments across the Trust;

- Urgent and Emergency Care: Ensure patients do not wait longer than the standard for assessment and treatment in the emergency departments across the Trust; and
- Services for Children and Young People: Ensure there are sufficient nursing staff to comply with British Association of Perinatal Medicine (BAPM) and Royal College of Nursing (RCN) guidance at Royal Lancaster Infirmary.

The Divisional sections detail the 'Should Do' Actions for each Division.

The CQC Hospital Improvement Plan will be monitored each month at the Assurance Committees; the Quality, Workforce and Finance Committees. A CQC Assurance Group was established in March 2017 which meets on a monthly basis. At the meeting the Care Groups will present their progress against actions and report on any areas where they have concerns regarding meeting the anticipated time frame for closure of the actions. A monthly report on the CQC Hospital Improvement Plan identifying any exceptions or areas of concern will be presented to the Executive Directors and Board of Directors.

The compliance team continually update the CQC Hospital Improvement Plan and as actions are progressed and closed the compliance team collate evidence from the Care Groups to support this.

The CQC published the final quality reports and ratings on their website which can be visited here.

4.10 Compliance with the NHS Pension Scheme Regulations

As an employer with staff entitled to membership of the two NHS Pension Schemes, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules and regulations and that member Pension Schemes records are accurately updated in accordance with the timescales detailed in the regulations.

4.11 Compliance with Equality, Diversity and Human Rights Legislation

Control measures are in place to ensure that all Trust's obligations under equality, diversity and human rights legislation are complied with. This is evidenced by the annual review and self-assessment carried out during the year, as the Trust is required to publish and monitor a variety of workforce metrics. This is also evidenced by demonstrating that all procedural documents incorporate an equality impact assessment prior to ratification by the relevant Committee.

4.12 Compliance with Climate Adaptation Requirements under the Climate Change Act 2008

The Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

5. Review of Economy, Efficiency and Effectiveness of the Use of Resources

The Trust has an annual plan which is approved by the Board of Directors and submitted to NHS Improvement. Performance against the plan is monitored by the Assurance Committees and the Board of Directors.

The monthly Integrated Performance Report is produced which contains performance indicators and NHS Improvement metrics for finance, performance, quality and workforce information.

The Trust's resources are managed within the Corporate Governance Framework, which includes Standing Financial Instructions. Financial governance arrangements are supported by internal and external audit who assess the economic, efficient and effective use of resources and provide assurance to the Audit Committee.

Divisional and corporate departments are responsible for the delivery of financial and other performance targets via a performance management framework incorporating service reviews with the executive team for key areas and compliance with the Trust's Financial Accountability Framework.

The Trust has in place a Programme Management Office and the Head of Programme Management Office and administrative support to scrutinise planning and delivery. In addition, the Trust is utilising external support to identify areas of improvement and develop / implement action plans to deliver the required efficiency.

Through the contracts and commissioning team, business cases are developed to ensure that rigour is applied to significant changes in operation or service provision. This includes impact assessments and due diligence tests

6. Annual Quality Report

The Trust's Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement (in exercise of the powers conferred by Monitor) has issued guidance to NHS Foundation Trust Boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the *NHS Foundation Trust Annual Reporting Manual.*

The Trust has built on the work undertaken to develop the Quality Report and has drawn on the various guidance published in-year in relation to the Quality Account. The consultation on the Quality Report was launched and included a number of presentations made to the Council of Governors and Stakeholders on Quality Reports. Through this engagement, the Trust has been able to ensure the areas chosen provide a balanced view of the organisation's priorities for 2017/18. In the preparation of the Quality Account, the Deputy Director Clinical Governance has led the development of the Quality Report, reporting to the Director of Governance. A formal review process was established, involving the submission of our initial draft Quality Report to our external stakeholders (Commissioners, Overview and Scrutiny Committees and Healthwatch). A working version of the Quality Report has formed the basis of the Trust's Quality Reporting for 2017/18 which has been overseen and formally reviewed through the Trust's governance arrangements; the Quality Committee and the Board of Directors. The Trust has delivered its 2017/18's quality priorities for improvement for clinical effectiveness, quality of the patient experience and patient safety. Work has been completed to develop new targets and priorities for 2018/19.

The Board of Directors can confirm that they have met the necessary requirements under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2012 to prepare its Quality Report for the financial year 2017/18. Steps have been put in place to assure the Board that the Quality Report presents a balanced view and that there are appropriate controls in place to ensure the accuracy of data. These steps cover the following areas as detailed below:

- **Governance and Leadership**

  The quality improvement system is led directly by the Board of Directors which also exercises its governance responsibilities through monitoring and reviewing the Trust's quality performance. The Quality Committee reporting directly to the Board leads the Trust's quality agenda and takes assurance on compliance with the Trust's Quality Indicators.

- **Policies**

  The Trust has in place a suite of policies which have quality at their heart, focusing on care that is safe, effective and reflective of the needs of patients and staff. The Quality Improvement Strategy sets out the framework in which quality improvements will be achieved within the Trust, with other key policies such as the Incident Policy and Complaints Policy.

- **Systems and Processes**

  The Board of Directors ensures that adequate systems and processes are maintained to measure and monitor the Trust's effectiveness, efficiency and economy as well as the quality of its healthcare delivery. The Board regularly reviews the performance of the Trust in these areas against regulatory requirements and approved plans and objectives.

- **People and Skills**

  The Trust actively encourages and supports employees to gain the skills and qualifications that will support their future employability and meet the needs of the organisation. The registered nurse apprentice degree programme was validated and received approval from the Nursing and Midwifery Council in January 2018. The students will commence the nursing degree programme in February 2018 with the University of Cumbria. This is an extremely welcome development and will provide opportunities for our staff to progress their nurse training whilst remaining a member of our workforce.

  During 2017/18, the Listening into Action (LiA) initiative, which was launched in 2014, continued to be embraced by staff. Since the initial launch, there had been 76 schemes and over 1100 staff had attended a Big Conversation event. Listening into Action had been evaluated by the Centre for Training and Development which had made a number of recommendations to progress the initiative further during 2018/19.

- **Data Use and Reporting**

  The Trust is provided with external assurance on a selection of the quality data identified within the Quality Report which was taken from national data submissions and national patient survey results, local inpatient survey results and information governance toolkit results. Local internal assurance is also provided via the analysis of data following local internally led audits in relation to nursing care indicators, analysis of data following incidents in relation to medication errors and slips, trips and falls incidents for patients and other patient harm. The quality and safety metrics are also reported monthly to the Board through the business monitoring report and the quality and safety report.

  The Trust has a data warehouse that has significant controls to ensure data gathering and reporting is validated by internal and external control systems.

  The Board of Directors at the Trust can confirm it has the appropriate mechanisms in place to prepare, approve and publish its Quality Report for 2017/18. The Board of Directors is satisfied that the Quality Report provides a balanced view and the appropriate controls are in place to ensure accuracy of data and a true reflection of overall quality within the organisation.

- **Assurances for Data Quality for elective waiting time data**

  There are a number of ways in which the Trust carries out checks to validate data quality for referral to treatment (RTT) elective waiting time reporting.

  Clinician's feedback on what RTT status each patient is at every time they are seen in clinic by completing an Electronic Outcome form. Our patient administration system Lorenzo aides completion of this by only offering logical sequences of RTT statuses to be picked, thus reducing human error mistakes.

  A Standard Operating Procedure (SOP) has been produced, which defines the validation and lists the criteria and point in the pathway that validation checks are made. It is called the "Validation of Lists of Patients Waiting for Treatment" and can be found on the Trust's Procedural Document Library. This SOP demonstrates that we validate patients at several points along their pathway and not just when they reach more than 18 week wait. Analysis of the patients that had been validated on our June 2017 national RTT return showed that 94 patients waiting 1 week had been validated; 97 patients waiting 5 weeks had been validated and 102 patients waiting 15 weeks had been validated. This is important because areas of national concern around late validation of waiting lists were highlighted in the Health Service Journal on 11 May 2017 by Rob Findlay[1]. He analysed Trust's RTT national returns and compared the patients still waiting with the subsequent time the clock stopped, to flag any services where there was a mismatch that may be attributed to "gaming" the waiting list by keeping patients waiting less than 18 weeks on the waiting list unnecessarily. He published his findings and concluded that the Trust was "Not Detected" at Trust and all Specialty levels, so does not have a late validation issue.

The Trust has a number of "safety net" indicators in a data quality dashboard that are reviewed on a daily basis to ensure that patients are progressed to the next stage of their treatment pathway and so that they are not lost. This helps to mitigate against human errors.

In March 2017 the Trust participated in the NHS Improvement (NHSI) Data Quality Self Assessment project, where a wide range of RTT reporting business rules and exclusions were documented and quantified. This produced a RAG rating around data quality risk. The outcome of this assessment was 29 low risks, 8 medium risks and 1 high risk. The high risk was for the percentage of follow-up outpatients who had passed their clinical review date. This is a key metric included in the Integrated Performance Report that goes to both Quality and Finance Committees, so is visible to the Board. The clinical Care Groups have action plans in place to reduce the number of follow-up patients waiting.

The Trust is currently working with the NHSI Intensive Support Team to review processes and governance around RTT. This has involved completion of a RTT Sustainability tool with key stakeholders within the clinical Care Groups, facilitated by the Intensive Support Team. This tool scored the Trust against a range of elements covering leadership and accountability, access policy and SOP's, training and expertise, pathway design, operational management, breach analysis, demand and capacity, reports and information and data quality. The outputs of this assessment have highlighted areas where the Trust could improve and this helped tailor the input given by the Intensive Support Team.

The Trust has specific Lorenzo RTT training modules which can be accessed by all staff, from Consultants to booking staff.

Each medical and surgical elective specialty now has an outcome crib sheet in outpatient rooms, to help clinicians select the appropriate RTT code outcome. These are bespoke to each specialty and tailored to include specific pathway scenarios.

RTT rules / guidance face to face training has been delivered to a wide range of staff, including medical secretaries, endoscopy staff, service managers / assistant service managers, validators and ward clerks. The NHSI Intensive Support Team developed a suite of national RTT e-learning training packages in late 2017 and 3 modules from this have been completed with both the Waiting List Offices at the Royal Lancaster Infirmary and Furness General Hospital in face to face group training.

A Trust RTT rules e-learning module was added to Training Management System and to date 652 staff have completed the training including consultants, doctors and nurses.

References:
[1]: Findlay, R. (2017) How Common is late validation of elective waiting lists. HSJ (10 May) [Online] Available from: https://www.hsj.co.uk/quality-and-performance/how-common-is-late-validation-of-elective-waiting-lists/7017824.article

7. Review of Effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Report attached to this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their Findings Reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and Assurance Committees and a plan to address weaknesses and ensure continuous improvement of the system is in place.

In describing the process that has been applied in maintaining and reviewing the effectiveness of the system of internal control I will detail below some examples of the work undertaken and the role of the Board of Directors, the Audit Committee, the Assurance Committees, clinical audit, internal audit and external audit in this process.

However I first must report that the Trust remains in breach of its NHS Improvement Licence conditions and has a single oversight framework segmentation of 3. This means the Trust is receiving mandated support for significant

concerns – there is actual / suspected breach of licence, and a Regional Support Group has agreed to seek formal undertakings from the provider or the Provider Regulation Committee has agreed to impose regulatory requirements.

In light of the positive CQC outcome, NHS Improvement confirmed in March 2017 that the Trust has complied with the enforcement undertakings in respect of Quality of Care and Kirkup Report. Only one enforcement undertaking is now attached to the Provider Licence by NHS Improvement. This relates to finance and sustainability. A revised enforcement notice in respect of financial sustainability was received in May 2018. Plans are in place to complete the required actions.

The Trust established the Morecambe Bay Investigation Committee to oversee and provide assurance of the Trust's response to the recommendations contained in the Morecambe Bay Investigation Report (the Kirkup Report). The Trust delivered its Kirkup Action Plan and this was subject to external assurance from Mersey Internal Audit Agency and was given significant assurance. The Morecambe Bay Investigation Committee concluded its work in the summer of 2016 with responsibility transferred to the Trust's Quality Committee. The Maternity Strategic Partnership between the Trust, Central Manchester University Hospitals NHS Foundation Trust and Lancashire Teaching Hospitals NHS Foundation Trust was established in the summer of 2015 following recommendations in the Kirkup Report. During the last two years the Trust has successfully ensured that the majority of obstetricians, midwives, paediatricians and anaesthetists go to our partner Trusts to observe good practice and bring back good ideas. It has become business as usual, and also the Trust has seen a two-way flow of ideas with some Trust developments being adopted at other trusts. The Trust has also seen reflections written by staff on Trust processes that have reassured the Trust that processes are as effective as those of partners. This is also reflected in the latest CQC inspection.

The final recommendation of the Kirkup Report was met with the completion of the new maternity unit at Furness General Hospital in December 2017. The unit became operational at the beginning of February 2018 and was officially opened on 14 February 2018 by Bill Kirkup, who led the investigation into the Trust's maternity services, and the local MP for Barrow, John Woodcock.

The Trust will continue to work with the Care Quality Commission and NHS Improvement to ensure that the quality and safety of services delivered to our patients continues to improve.

The Licence Condition in relation to finance and sustainability are being addressed through the Better Care Together programme. This is supplemented by annual Local Price Modification applications. During 2016/17, the Trust established a Sustainable Programme Board chaired by the Non-Executive Director (who is also the Chair of the Trust's Finance Committee). PwC were engaged to support the programme over a twelve month period. Their support to the programme was split in to two phases:

- **phase 1** focuses on developing the programme governance arrangements, developing financial grip and control, review of the PMO approach to CIP and how the PMO can support the programme going forward, and assessment of the trust's financial baseline position;

- **phase 2** will involve hands-on support to develop and deliver targeted projects within the programme, and conducting service reviews to identify future areas of focus for the programme.

In 2017/18 the Board did not agree a Control Total with its Regulators on the grounds that patient safety would be compromised. As a result the Trust was placed into the capped expenditure process. As a result penalties were imposed and access to certain NHSI funding denied.

The Trust does not wish to continue to rely upon revenue loans, local price modification support and national sustainability funding to meet its commitments and is in discussion with NHSE and NHSI to secure a sustainable funding package. The Trust has in place a long term plan to bring the organisation back into balance by addressing the structural deficit and implementing a Sustainability Programme. As part of its financial plans for the next five years the Trust is working with Morecambe Bay Clinical Commissioning Group, NHS Improvement and NHS England to secure the necessary resources to continue its operations and in the long term achieve financial sustainability.

The Board has taken assurance from assessments reported to the Quality Committee and the Audit Committee of how the Trust is meeting the requirements of the NHS Single Oversight Framework and Quality Governance Framework. The Trust is implementing many aspects of the framework and the Trust has received several reports and seen

measurable improvements in a range of indicators that suggest the improved governance arrangements are having an effect.

For example there remain a significant number of Internal Audit reports offering either high or significant assurance.

- Clostridium difficile (C diff) infection rates at their lowest in 20 years
- Levels of harm remain low as illustrated in the Quality Account
- The Trust exceeded its Cost Improvement Target for 2016/17 and 2017/18
- The average Friends and Family Score was 4.78 based on 61,346 reviews
- The Summary Hospital-level Mortality Indicator (SHMI)75% in September 2017

The assessment the Trust has undertaken against the NHS Improvement Quality Governance Framework has demonstrated that the Trust is making significant progress on embedding and cascading across all the Care Groups. The new governance systems and procedures and being able to evidence a significant change in the culture of the organisation at all levels. This triangulates with the findings of the Grant Thornton report and Internal Audit reports. Progress continues to be monitored by the Audit Committee on further actions to embed effective Governance systems at all levels within the Trust.

Additionally the Director of Internal Audit Opinion is that: **Substantial Assurance** can be given that that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.

The Internal Audit Reports show that the Trust has been successful in embedding good governance at many levels within the Trust. However the Trust remains vigilant and continues to strive for further improvements across all areas.

Performance indicators such as breaches of the Emergency Department 4 hour standard and the Referral to Treatment standard suggest that there is still some way to go and the new processes and procedures introduced need to be further strengthened.

The External Auditor has issued a qualified 'except for' opinion for 2017/18 in respect of financial sustainability as part of the Value for Money conclusion. The Auditor has a duty to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. This is a result of the Trust's in year deficit of £67.6 million and cumulative deficit of £199.1 million and the Trust's continued reliance upon revenue and capital loan funding.

The External Auditor has also issued a qualified 'except for' certificate following the limited assurance testing of the Referral to Treatment Times reported in our Quality Report. A management response has been prepared.

Although the Trust remains in breach of its Licence Conditions there have been no other significant failings identified in 2017/18.

In the light of the Internal and External audit work I am able to provide assurance that the system of internal control is well designed and is now effective and enables the Trust to isolate and respond to issues of concern. There are no significant internal control issues. The Trust is not complacent and recognises that whilst new systems have been introduced it will take time for them to become effective and will require on-going monitoring and evaluation.

The Trust continues to address those areas of risk identified by Regulators in addition to the strategic risk as set out in Section 4 above.

Fundamental to the future of the Trust is the development of an integrated care partnership in which local organisations take responsibility for the health and wellbeing of the whole population of Morecambe Bay through delivery of the Better Care Together strategy.

Through the Quality Report and the Quality Improvement strategy the Trust has identified its quality priorities and set out its plans to achieve them. Through participation in Open and Honest reporting, the Trust publishes staffing levels and key quality data including Harms Free Care for every ward on Ward Notice Boards and the Trust's internet for the public to access. The Trust is required by NHS Improvement to report data on our Patient Safety Incidents to the National Reporting and Learning Service (NRLS), earlier this year the NRLS commenced the monthly publication of a

national data set of the provisional patient safety incident data submitted by all NHS Trusts in England during the previous 12 months. As the Trusts NRLS data is now in the public domain, the Patient Safety Team now publish this information on the Trust's external website, as this would support our 'Open and Honest' culture around learning from Incidents and would also demonstrate our openness and transparency to our Patients and other stakeholders.

The Trust is responding to its workforce risk by delivering a workforce plan and organisational development strategy. Revisions to the recruitment processes have been implemented and an analysis of nursing staffing levels has been undertaken. The Workforce Committee has provided focus on this strategic risk.

8. Conclusion

My review of the effectiveness of the systems of internal control has taken account of the work of the Executive Management Team within the organisation, which has responsibility for the development and maintenance of the internal control framework within their discreet portfolios. In line with the guidance on the definition of the significant internal control issues, I have not identified any significant control issues.

Aaron Cummins
Chief Executive

Date: 25 May 2018

University Hospitals of Morecambe Bay NHS Foundation Trust

University Hospitals of Morecambe Bay NHS Foundation Trust

Annual Accounts

2017/2018

ANNUAL ACCOUNTS 2017/18

Foreword to the accounts

UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST

These accounts for the 12 months ended 31 March 2018, have been prepared by the University Hospitals of Morecambe Bay NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006.

Aaron Cummins
Chief Executive

Date : 25 May 2018

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2018

	NOTE	**2017/18 £000**	2016/17 £000
Revenue from continuing operations	3-4	**290,785**	324,297
Operating expenses	5	**(356,107)**	(338,476)
OPERATING SURPLUS/(DEFICIT)		**(65,322)**	(14,179)
Finance costs			
Interest received	8	**39**	28
Interest payable	8	**(2,345)**	(1,698)
Unwinding of discount on provisions	8	**(6)**	(30)
Public Dividend Capital dividends payable		**0**	(1,271)
Net finance costs		**(2,312)**	(2,971)
SURPLUS/(DEFICIT) FOR THE FINANCIAL YEAR		**(67,634)**	(17,150)
Other comprehensive income			
Revaluation gains/(losses) and impairment losses on property, plant and equipment			3,988
TOTAL COMPREHENSIVE INCOME AND EXPENSE FOR THE YEAR		**(67,634)**	(13,162)

The operating deficit for 2016/17 was after the receipt of income towards local price modifications agreed by NHS Improvement and NHS England. No such income has been received in 2017/18.

The notes on pages 227 to 266 form part of these accounts.

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2018

	NOTE	31 March 2018 £000	31 March 2017 £000
NON-CURRENT ASSETS			
Intangible assets	9	**478**	398
Property, plant and equipment	10	**152,735**	146,934
Trade and other receivables	13	**2,874**	2,646
Total non-current assets		**156,087**	149,978
CURRENT ASSETS			
Inventories	12	**3,263**	2,667
Trade and other receivables	13	**8,579**	17,602
Cash and cash equivalents	15	**4,410**	14,110
Total current assets		**16,252**	34,379
CURRENT LIABILITIES			
Trade and other payables	16	**(21,513)**	(15,852)
Borrowings	19	**(874)**	(116)
Provisions	20	**(743)**	(209)
Finance lease liabilities	17	**(71)**	(210)
Tax payable	16	**(5,020)**	(4,117)
Other liabilities	18	**(969)**	(1,931)
Total current liabilities		**(29,190)**	(22,435)
TOTAL ASSETS LESS CURRENT LIABILITIES		**143,149**	161,922
NON-CURRENT LIABILITIES			
Borrowings	19	**(158,347)**	(109,307)
Provisions	20	**(2,276)**	(2,421)
Finance lease liabilities	17	**0**	(71)
Total non-current liabilities		**(160,623)**	(111,799)
TOTAL ASSETS EMPLOYED		**(17,474)**	50,123
FINANCED BY TAXPAYERS' EQUITY			
Public Dividend Capital		**148,397**	148,360
Revaluation Reserve		**33,186**	33,186
Retained Earnings		**(199,057)**	(131,423)
TOTAL TAXPAYERS' EQUITY		**(17,474)**	50,123

The financial statements on pages 222 to 226 were approved by the Trust Board on 25 May 2018 and signed on its behalf by the Chief Executive. The notes on pages 227 to 266 form part of these accounts.

Signed:  (Chief Executive) Date: 25 May 2018

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

	2017/18 Public dividend capital (PDC)	Revaluation reserve	Retained earnings	Total
	£000	£000	£000	£000
TAXPAYERS' EQUITY AT 1 APRIL 2017	**148,360**	**33,186**	**(131,423)**	**50,123**
Changes in taxpayers' equity				
Retained deficit for the year	**0**	**0**	**(67,634)**	**(67,634)**
Public Dividend Capital received	**37**	**0**	**0**	**37**
TAXPAYERS' EQUITY AT 31 MARCH 2018	**148,397**	**33,186**	**(199,057)**	**(17,474)**

	2016/17 Public dividend capital (PDC)	Revaluation reserve	Retained earnings	Total
	£000	£000	£000	£000
TAXPAYERS' EQUITY AT 1 APRIL 2016	148,360	29,668	(114,743)	63,285
Changes in taxpayers' equity				
Retained deficit for the year	0	0	(17,150)	(17,150)
Impairment of property, plant and equipment	0	(1,192)	0	(1,192)
Revaluation gains on property, plant and equipment	0	5,180	0	5,180
Transfers between reserves in respect of asset disposals	0	(470)	470	0
TAXPAYERS' EQUITY AT 31 MARCH 2017	148,360	33,186	(131,423)	50,123

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2018

	NOTE	2017/18 £000	2016/17 £000
Cash flows from operating activities			
Operating surplus/(deficit)		**(65,322)**	(14,179)
Non-cash revenue and expenses			
Depreciation and amortisation		**12,456**	12,916
Impairments	8	**2,715**	949
Income recognised in respect of donated assets (non-cash)		**(29)**	0
(Increase)/decrease in inventories		**(596)**	(135)
(Increase)/decrease in trade and other receivables		**8,795**	(3,663)
Increase/(decrease) in trade and other payables		**6,674**	(3,731)
Increase/(decrease) in other liabilities		**(962)**	(40)
Increase/(decrease) in provisions	20	**383**	(47)
Net cash generated from operating activities		**(35,886)**	(7,930)
Cash flows from investing activities			
Interest received	8	**39**	28
Purchase of intangible assets	9	**0**	(52)
Purchase of property, plant and equipment		**(21,562)**	(21,043)
Sale of land and buildings		**0**	0
Net cash used in investing activities		**(21,523)**	(21,067)
Cash flows from financing activities			
Public Dividend Capital received		**37**	0
Loans received from the Department of Health & Social Care		**58,324**	58,530
Loans repaid to the Department of Health & Social Care		**(11,062)**	(14,145)
Other loans received		**2,536**	0
Interest paid		**(1,914)**	(1,575)
Public Dividend Capital dividends paid		**(2)**	(1,203)
Cash flows from/(used in) other financing activities		**(210)**	(55)
Net cash used in financing activities		**47,709**	41,552
Increase/(decrease) in cash and cash equivalents		**(9,700)**	12,555
Cash and cash equivalents at beginning of year		**14,110**	1,555
Cash and cash equivalents at 31 March	15	**4,410**	14,110

NOTES TO THE ACCOUNTS

1 Accounting Policies

NHS Improvement, in exercising the statutory functions conferred on Monitor, is responsible for issuing an accounts direction to NHS Foundation Trusts under the NHS Act 2006. NHS Improvement has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the Department of Health Group Accounting Manual (DH GAM) which shall be agreed with the Secretary of State. Consequently, the following financial statements have been prepared in accordance with the DH GAM 2017/18 issued by the Department of Health and Social Care. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual (FReM) to the extent that they are meaningful and appropriate to the NHS. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention and going concern

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets and inventories.

The Trust's accounts for 2017/18 have recorded a deficit of £67.6 million and the cumulative deficit position on retained earnings amounts to £199.1 million. The Statement of Financial Position shows negative net current assets and liabilities of £12.9 million. The Trust has submitted a two year operational plan to NHS Improvement covering 2017/18 and 2018/19 which assumes that further support will be provided by the Department of Health and Social Care in the form of loans for required capital expenditure and revenue support. The Trust has also submitted an application for Local Price Modifications for 2018/19 which has not yet been approved.

In line with national guidance the second year of the two year plan (2018/19) has been refreshed and assumes revenue support to support a planned deficit of £69.4m. At the date of approval of the accounts this support is not yet fully secured.

Significant work is ongoing with all statutory health and care partners in the Morecambe Bay area to create an integrated health and care system which is sustainable for the long term. The Bay Health and Care Partners represents 11 organisations and aims to co-ordinate ways of working and provide a platform for integration. The Trust is an integral part of this initiative. During 2018/19 some services for the Morecambe Bay area, which are currently undertaken by other providers, will be integrated into the Trust.

In accordance with IAS 1, management have made an assessment of the Trust's ability to continue as a going concern considering the significant challenges described above. Although these factors represent a material uncertainty that may cast significant doubt about the Trust's ability to continue as a going concern, the Directors, having made appropriate enquiries, still have a reasonable expectation that the Trust will have adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts and the financial statements do not include the adjustments that would result if the Trust was unable to continue as a going concern.

Notes to the Accounts - 1. Accounting Policies (continued)

1.2 Consolidation

Subsidiaries

Subsidiary entities are those over which the Trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full to the appropriate financial statement lines. The capital and reserves attributable to minority interests are included as a separate item in the Statement of Financial Position.

Where subsidiaries' accounting policies are not aligned with those of the Trust (including where they report under UK FRS 102) then amounts are adjusted during consolidation where the differences are material. Inter-entity balances, transactions and gains/losses are eliminated in full on consolidation.

Charitable funds

The Trust is Corporate Trustee for the Bay Hospitals Charity (formerly known as Morecambe Bay Hospitals Charity). The Charity's relationship with the Trust is that of a subsidiary because the Trust has the power to govern the financial and operating policies of the Charity so as to obtain benefits from its activities for itself, its patients or its staff.

With effect from 1 April 2013 all subsidiary NHS charities must be consolidated if material. Having considered the level of materiality applicable for the Trust, management have taken the decision not to consolidate the Charity on the grounds of immateriality.

Joint working arrangements

The Trust operates as a third partner in a GP Practice within its geographical boundary. This partnership is in the form of a collaborative working arrangement and does not meet the definition of a Joint Arrangement as defined in accounting standard IFRS 11. The Trust does not have control over the operation of the entity and has no rights to its assets.

The extent to which the Trust has contributed financially to this arrangement is shown in note 13.1 Receivables and note 23 Related party transactions. As this is not a Joint Arrangement no other accounting adjustments have been made.

1.3 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

Notes to the Accounts - 1. Accounting Policies (continued)

1.3.1 Critical judgements in applying accounting policies

Estimates and judgements have to be made in preparing the Trust's annual accounts. These are continually evaluated and updated as required, although actual results may differ from these estimates.

The Trust reviewed the application of accounting standard IAS 16 for non-current land and property assets during 2011/12. The valuation basis applied with effect from 31 March 2012 incorporates: alternative site methodology where the modern equivalent asset could be constructed in an alternative location; a reduced number of components over which asset values are assessed; and a review of useful economic lives. The Trust continues to apply this valuation basis.

In accordance with accounting standard IAS 27 the Trust has decided not to consolidate its charitable funds. This decision is based on the current value of funds held, which represent only 0.4% of the Trust's annual income. In addition, the majority of expenditure relating to the activities of the Charity is reflected in the Trust's accounts as operating income. This includes charitable donations for the purchase of non-current assets and contributions towards the revenue activities of the Trust. These items are included within charitable and other contributions to expenditure in note 4.1.

1.3.2 Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial period.

Asset valuations

Revaluations of land and building assets should be undertaken with sufficient regularity to ensure that asset values are reflected with reasonable accuracy in the accounts. The Trust revalues its assets at least every five years in accordance with accounting standards. In between full revaluations indices may be applied to asset values if it is deemed that a material change in value has occurred. If the change is assessed and found to be immaterial no adjustments are made.

The Trust last undertook a full revaluation of its land and building assets in line with accounting standards as at 1 March 2017. Further revaluations of the Trust's asset base may result in future material changes to the carrying value of non-current assets. Details of the basis of asset valuation and asset values can be found in note 10.

Notes to the Accounts - 1. Accounting Policies (continued)

Financial value of provisions for liabilities and charges

The Trust makes financial provision for obligations of uncertain timing or amount at the 31 March. These are based on estimates using as much relevant information as is available at the time the accounts are prepared. They are reviewed to confirm that the values included in the financial statements best reflect the current relevant information. Where this is not the case, the provision is amended. Details of provisions are shown in note 20.

Partially completed spells at the period end

Income relating to in-patient care spells that are part-completed at the end of the financial period have been apportioned between accounting periods based on average income per spell, the number of patients at the end of the reporting period and assuming that the treatment is 50% complete. The estimated income due may vary from one period end to another.

Actuarial assumptions for costs relating to the NHS pension scheme

The Trust reports, as operating expenditure, employer contributions to staff pensions. This employer contribution is based on an annual actuarial estimate of the required contribution to meet the scheme's liabilities. It is an expense that is subject to change.

1.4 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of revenue for the Trust is from commissioners for healthcare services. Revenue relating to patient care spells that are part-completed at the end of the financial period are apportioned across the financial periods.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met and is measured as the sums due under the sale contract.

The Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

1.5 Employee Benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees, except for leave earned but not yet taken, which is not accrued for at the year end, on the grounds of immateriality.

Notes to the Accounts - 1. Accounting Policies (continued)

Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. They are not designed to be run in a way that would enable the Trust to identify its share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the Trust of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

To ensure that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined by a full actuarial valuation, the Schemes are normally subject to a full actuarial valuation every four years and an accounting valuation every year. The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The annual accounting valuation of scheme liability as at 31 March 2018, is based on detailed membership data as at 31 March 2017 updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations and the HM Treasury discount rate have also been used. The latest assessment of the Scheme is contained in the Scheme actuary report which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Schemes relative to the employer cost cap. The Public Service Pensions Act 2013 allows for member benefits or contribution rates to be adjusted if the cost of the Schemes changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contiribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

Employers pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the Schemes except where the early retirement is due to ill health. The full amount of the liability for the additional costs is charged to expenditure at the time the Trust commits itself to the retirement, regardless of the method of payment.

Notes to the Accounts - 1. Accounting Policies (continued)

Alternative pension provision

With effect from 1 May 2013, employees who are not members of the NHS Pension Scheme have been automatically enrolled in an alternative pension scheme in accordance with Government guidance. The scheme offered by the Trust is the National Employment Saving Trust (NEST) scheme. Employees have an option to opt out of the scheme within one month of being automatically enrolled. The Trust contributed to the scheme at a rate of 1.5% of the employee's remuneration during 2017/18. With effect from 1 April 2018 the Trust will contribute at a rate of 2.4%.

The NEST scheme is also accounted for as a defined contribution scheme. The Trust is unable to identify its share of the assets and liabilities of the scheme and therefore shows only the contributions made to the scheme, which are included in operating expenses as and when they become due. This scheme is relevant to a minority of Trust employees.

1.6 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment or where items are held as inventories.

1.7 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow, or service potential will be supplied, to the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has a cost of at least £5,000; or
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

Measurement

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at valuation. An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IFRS 5.

Notes to the Accounts - 1. Accounting Policies (continued)

Land and buildings used for the Trust's services or for administrative purposes are stated in the Statement of Financial Position at their revalued amounts, being the value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Valuations are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. The Trust's land, buildings and dwellings assets have been valued on the basis of modern equivalent assets and where applicable an alternative site basis has been applied.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23. Assets are revalued and depreciation commences when they are brought into use.

Fixtures and equipment are carried at depreciated historic cost. In addition, the Trust undertakes an annual validation of equipment assets to re-assess the useful economic lives remaining and makes adjustments as and when appropriate.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification and it is probable that additional future economic benefits or service potential will flow to the Trust, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to operating expenses in the period in which it is incurred.

1.8 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the Trust; where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Notes to the Accounts - 1. Accounting Policies (continued)

Intangible assets acquired separately are initially recognised at cost. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use
- the intention to complete the intangible asset and use it
- the ability to sell or use the intangible asset
- how the intangible asset will generate probable future economic benefits or service potential
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it
- the ability to measure reliably the expenditure attributable to the intangible asset during its development.

Measurement

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IFRS 5.

1.9 Depreciation and amortisation

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

1.10 Revaluation gains and losses

An increase arising on revaluation is taken to the Revaluation Reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there.

Notes to the Accounts - 1. Accounting Policies (continued)

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the Revaluation Reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure.

Gains and losses recognised in the Revaluation Reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

1.11 Impairments

Impairment losses that arise from a clear consumption of economic benefit are charged to expenditure. A compensating transfer is made from the Revaluation Reserve to Retained Earnings of an amount equal to the lower of the impairment charged and the balance in the Revaluation Reserve attributable to the asset before the impairment.

An impairment arising from loss of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss are reversed. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is recognised in operating income to the extent of the decrease previously charged to expenditure and thereafter to the Revaluation Reserve. Where, at the time of the impairment, a transfer was made from the Revaluation Reserve to Retained Earnings, an amount is transferred back to the Revaluation Reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversal of other impairments are treated as revaluation gains.

1.12 Donated assets

Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are treated as for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the income.

The Trust has no non-current donated assets for which donors have imposed such conditions that would prevent the condition from being met in the future and therefore no income in relation to donated assets has been deferred.

1.13 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

Notes to the Accounts - 1. Accounting Policies (continued)

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the Revaluation Reserve is transferred to Retained Earnings.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.14 Leases

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property, plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost. The annual finance cost is calculated by applying the implicit interest rate to the outstanding liability and is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability is de-recognised when the liability is discharged, cancelled or expires.

Operating leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are deducted from the lease rentals and apportioned over the life of the lease.

Leases of land and buildings

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.15 Inventories

Inventories of consumables are valued at cost. Inventories of drugs and energy are valued at net realisable value using the weighted average cost formula. This is considered to be a reasonable approximation of fair value due to the high turnover of stocks.

Notes to the Accounts - 1. Accounting Policies (continued)

1.16 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

1.17 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where the effect of the time value of money is significant, i.e for early retirement and injury benefit provisions, the estimated risk-adjusted cash flows are discounted using HM Treasury's pension discount rate of 0.10% in real terms.

1.18 Clinical negligence costs

NHS Resolution (formerly NHS Litigation Authority) operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 20. These provisions are not recognised in the Trust's accounts.

1.19 Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they are incurred.

1.20 Contingencies

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

Where the time value of money is material, contingencies are disclosed at their present value.

Notes to the Accounts - 1. Accounting Policies (continued)

1.21 Financial instruments and financial liabilities

Financial assets

Financial assets are recognised when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are initially recognised at fair value.

Financial assets are classified into the following categories: financial assets at fair value through profit and loss; held to maturity investments; available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

The Trust holds financial assets in the form of cash and cash equivalents and non-current and current receivables, which are classified as loans and receivables.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method. Fair value is determined by reference to quoted market prices where possible. In the case of cash fair value is the same as book value.

Loans from the Department of Health and Social Care are not held for trading and are measured at historic cost with any unpaid interest accrued separately.

Impairment of financial assets

At the end of the reporting period, the Trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

The carrying amount of individual debts is written down directly where it is certain that the debt cannot be recovered. Where there is a level of uncertainty as to the recoverability of individual debts, an appropriate provision is made.

Notes to the Accounts - 1. Accounting Policies (continued)

1.22 Financial liabilities

Financial liabilities are recognised on the Statement of Financial Position when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

After initial recognition, all financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

The Trust holds financial liabilities in the form of trade and other payables which are included within current liabilties. Borrowings and finance lease liabilities are also held. These are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabiltities.

1.23 Value Added Tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of non-current assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.24 Foreign exchange

The functional and presentational currencies of the Trust are sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. Any resulting exchange gains and losses are taken to the Statement of Comprehensive Income.

1.25 Corporation Tax

Under s519A Income and Corporation Taxes Act 1988 the Trust is regarded as a Health Service body and is therefore exempt from taxation on its income and capital gains. Section 148 of the Finance Act 2004 provided HM Treasury with powers to disapply this exemption. Accordingly the Trust is potentially within the scope of corporation tax in respect of activities which are not related to or ancillary to the provision of healthcare and where annual profits exceed £50,000. Any tax liability will be accounted for in the relevant tax year.

1.26 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in note 24 to the accounts.

1.27 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilties at the time of the establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

Notes to the Accounts - 1. Accounting Policies (continued)

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health and Social Care as Public Dividend Capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of assets less the value of liabilities, except for, donated assets, average daily cash balances with the Government Banking Service and any PDC dividend receivable or payable. For 2016/17 the value of revenue accrued from the Sustainability and Transformation Fund in the form of an incentive payment and bonus, was also excluded from the dividend calculation.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the pre-audit version of the annual accounts. The dividend is therefore not revised should any adjustment to net assets occur as a result of the audit of the annual accounts. As at 31 March 2018 the Trust has negative average relevant net assets and this results in no PDC dividends being payable for the year 2017/18.

1.28 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the Health Service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS Foundation Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

1.29 Accounting standards that have been issued but have not yet been adopted

The DH GAM does not require the following Standards and Interpretations to be applied in 2017/18 as these standards are still subject to HM Treasury FReM adoption. IFRS 9, IFRS 15 and IFRIC 22 are to be implemented in 2018/19 and the date for implementation of IFRS 16 and IFRS 17 is still subject to HM Treasury consideration. IFRIC 23 is not applicable until 2019/20.

- IFRS 9 Financial Instruments
- IFRS 15 Revenue from Contracts with Customers
- IFRS 16 Leases
- IFRS 17 Insurance Contracts
- IFRIC 22 Foreign Currency Transactions and Advance Consideration
- IFRIC 23 Uncertainty over Income Tax Treatments

There will be some impact on the Trust arising from the implementation in 2018/19 of IFRS 9 and IFRS 15, however this is not likely to have a material effect on the accounts. The implementation of IFRIC 22 is unlikely to have any impact on the Trust.

1.30 Accounting standards issued that have been adopted early

No accounting standards in issue have been adopted early.

2. Operating segments

The Foundation Trust is engaged mainly in healthcare activity and the majority of revenue is received from Clinical Commissioning Groups who are the main purchasers of the Trust's services. The majority of expenses incurred are payroll expenditure on staff involved in the delivery or support of healthcare activities together with the related supplies and overheads.

The Board of Directors is considered to be the Chief Operating Decision Maker and they receive reports on the Trust's financial position with supplementary information relating to income and divisional expenses. Decisions are based on the overall financial position.

The single segment of 'Healthcare' has therefore been identified as consistent with the core principle of IFRS 8 which is to enable users of the financial statements to evaluate the nature and financial effects of business activities and economic environments. In addition, as the whole of the Trust's activites relate to the provision of healthcare and operate in the same economic environment, the aggregation criteria set out in IFRS 8, paragraph 12, are met.

3. Revenue from patient care activities

3.1 Revenue from patient care activities by type of activity

	2017/18	2016/17
	£000	£000
Elective income	**42,052**	49,232
Non elective income	**76,076**	89,458
Outpatient income	**48,023**	54,449
A & E income	**12,522**	13,157
Other NHS clinical income	**82,740**	79,839
Private patient income	**152**	147
Other clinical income	**1,174**	876
	262,739	287,158

NHS clinical income for 2016/17 included the application of Local Price Modifications agreed by NHS Improvement and NHS England. This resulted in increases to the tariffs applied to income and the income received is shown within the relevant income type. No such modification to prices was applied in 2017/18.

Private patient income includes income for the treatment of overseas patients where no reciprocal or bi-lateral agreement exists for their treatment.

Other clinical income includes income from injury cost recovery, prescription charges and non English healthcare commissioners.

3.2 Revenue from patient care activities by source

	2017/18	2016/17
	£000	£000
Public Health England	**215**	215
NHS England and CCGs	**260,995**	285,720
NHS Foundation Tusts	**129**	123
NHS Trusts	**74**	77
Non-NHS: Private patients	**14**	24
Non-NHS: Overseas patients (non-reciprocal)	**138**	123
NHS Injury Cost Recovery Scheme	**909**	676
Other non-NHS income	**265**	200
	262,739	287,158

Injury cost recovery income is subject to a provision for impairment of receivables of 22.84% to reflect expected rates of collection.

3.3 Overseas visitors income

	2017/18	2016/17
	£000	£000
Income recognised during the year	**138**	123
Cash payments received in year	**85**	90
Amounts written off in-year	**25**	9

The above note relates to treatment of overseas visitors charged directly by the Trust in accordance with Guidance on implementing the overseas charging regulations 2015 issued by the Department of Health and Social Care.

3.4 Revenue from commissioner requested services

	2017/18 £000	2016/17 £000
Income from commissioner requested services	**261,413**	286,136
Income from all other patient care activities	**1,326**	1,023
	262,739	287,159

The Trust is required to provide for the purposes of the health service in England, the commissioner requested services listed in Schedule 2 of the Foundation Trust's Terms of Authorisation.

3.5 Private patient income

Foundation Trusts are obliged to make sure that the income received from providing goods and services for the health service in England (their principal purpose) is greater than income from other sources including the provision of private healthcare. The Trust has been compliant with this requirement during 2017/18 and 2016/17.

4. Other operating revenue

4.1 Operating revenue

	2017/18 £000	2016/17 £000
Research and development	**809**	967
Education and training	**10,548**	9,934
Charitable and other contributions to expenditure	**633**	702
Non-patient care services to other bodies	**8,583**	8,322
Sustainability and Transformation Fund income	**0**	10,921
Rental revenue from operating leases	**1,624**	1,612
Other revenue	**5,849**	4,681
	28,046	37,139

Charitable and other contributions to expenditure includes income received in the form of donations for the purchase of non-current assets. During the year £215,000 was received from the Bay Hospitals Charity for this purpose. The sum of £315,000 was received from this Charity in 2016/17.

Access to a Sustainability and Transformation Fund was made available to NHS providers with effect from 2016/17, linked to the achievement of financial controls and performance targets. Income from this fund generated during 2016/17 amounted to the sum of £10,921,000 including an additional incentive payment and bonus of £1,656,000.

For 2017/18 the Trust was unable to agree to the control total set by NHS Improvement. For this reason no Sustainability and Transformation funding has been available in the year.

4.1 Operating revenue (continued)

	2017/18 £000	2016/17 £000
Other revenue includes the following items		
Car parking charges	**1,105**	1,077
Catering	**1,280**	1,229
Clinical excellence awards	**261**	214
Improved Better Care Fund	**1,471**	0
Rent from staff accommodation	**477**	472
Other miscellaneous items	**1,255**	1,689
	5,849	4,681

During the year 2017/18 the Trust has received funding from the Improved Better Care Fund which is made up of CCG funding and local government grants.

4.2 Operating revenue from operating leases

The Trust leases various areas within its sites to other organisations. The majority of leases are to other NHS bodies who provide healthcare services to the same general population and these are for up to 5 years.

For 2017/18 operating lease income includes the sum of £1,592,000 relating to service level agreements with other Foundation Trusts and £32,000 for property leased by NHS Blood and Transplant.

Some areas currently leased to Cumbria Partnership NHS Foundation Trust will no longer be leased with effect from 1 April 2018 as the services will be integrated within the Trust. Lease payments receivable in future years reflect this change.

During 2016/17 operating lease income received from other Foundation Trusts amounted to £1,578,000 and £34,000 was received from NHS Blood and Transplant.

Rental revenue	2017/18 £000	2016/17 £000
Rents recognised as revenue	**1,624**	1,612
Contingent rents	**0**	0
Total rental revenue	**1,624**	1,612
Total future minimum lease payments receivable		
Not later than one year	**1,097**	1,612
Between one and five years	**4,389**	6,448
After five years	**0**	0
Total	**5,486**	8,060

5. Operating expenses

5.1 Operating expenses	2017/18 £000	2016/17 £000
Purchase of healthcare from non NHS bodies	**5,083**	5,314
Chair and Non Executive directors costs	**130**	132
Employee benefits including Executive directors	**235,260**	225,993
Drugs costs	**28,771**	27,622
Supplies and services - clinical (excluding drugs)	**28,571**	27,702
Supplies and services - general	**5,068**	4,987
Establishment	**2,903**	2,589
Business travel	**1,529**	1,286
Transport	**759**	818
Premises - business rates payable to Local Authorities	**1,647**	1,560
Premises - other	**9,602**	8,769
Operating lease rentals	**1,791**	1,679
Depreciation and amortisation	**12,456**	12,916
Impairments of property, plant and equipment	**2,715**	949
Increase/(decrease) in provisions for impairment of receivables	**322**	(465)
Change in the discount rate on provisions	**33**	272
Audit fees - statutory audit	**53**	55
Other auditors remuneration - audit related assurance	**7**	11
Internal audit and counter fraud services	**143**	144
Redundancy costs	**27**	0
Early retirement costs	**(38)**	308
Clinical negligence premium	**13,477**	10,447
Legal fees	**500**	386
Insurance premiums	**317**	310
Consultancy services	**416**	893
Education and training	**1,439**	907
Other	**3,126**	2,892
	356,107	338,476

Employee benefits shown above now include the cost of staff and Executive Directors. Directors costs were previously shown on a separate line and comparative information has been amended for this change.

Negative expenditure showing against early retirement costs in 2017/18 is as a result of the reversal of provisions unused during the year. As a consequence of the reversals a credit has been made to the expenditure heading used when the provision was originally created.

5.2 Operating lease expenses

Leases paid during 2017/18 include £491,000 (2016/17 £514,000) in respect of leased vehicles which are usually contracted for a period of 3 years and towards which employees pay a contribution for any personal use element.

A lease commenced in November 2012 for temporary ward buildings at the Royal Lancaster Infirmary. This was due to expire in November 2017.

In November 2015 an additional lease was established for further similar facilities at the site and this is due to expire in March 2021.

The original lease was re-negotiated in March 2016 to expire at the same time as the additional lease. Both leases therefore now extend until March 2021. The sum of £1,295,000 has been recognised as expenditure in 2017/18 in respect of these leases (2016/17 £1,154,000).

Other leases include a lease for endoscopy equipment which extends to November 2019. No leases extend beyond 5 years.

Payments recognised as an expense	**2017/18**	2016/17
	£000	£000
Minimum lease payments	**1,791**	1,679
Contingent rents	**0**	0
	1,791	1,679

Total future minimum lease payments payable		
Not later than one year	**2,081**	1,844
Between one and five years	**2,879**	4,100
Total	**4,960**	5,944

6. Employee costs and numbers

6.1 Employee costs

	2017/18		
	Permanently Employed	**Other**	**Total**
	£000	**£000**	**£000**
Salaries and wages	**173,529**	**7,168**	**180,697**
Social Security Costs	**15,710**	**679**	**16,389**
Apprenticeship levy	**816**	**128**	**944**
Employer contributions to NHS Pension scheme	**19,951**	**863**	**20,814**
Termination benefits	**27**	**0**	**27**
Agency staff	**0**	**16,985**	**16,985**
Employee benefits expense	**210,033**	**25,823**	**235,856**

	2016/17		
	Permanently Employed	Other	Total
	£000	£000	£000
Salaries and wages	163,813	6,685	170,498
Social Security Costs	14,584	625	15,209
Employer contributions to NHS Pension scheme	18,729	803	19,532
Other pension costs	308	0	308
Agency staff	0	21,584	21,584
Employee benefits expense	197,434	29,697	227,131

Of the total employee benefits shown above £569,000 has been charged to capital and the balance of £235,287,000 has been charged to revenue (2016/17 £830,000 was charged to capital and £226,301,000 was charged to revenue). Staff costs are capitalised in relation to work undertaken on capital projects.

Expenditure incurred on agency staff comprises 7.2% (2016/17 9.5%) of total staff costs. Agency staff continue to be utilised to cover recruitment gaps in specific specialities and to provide sufficient staff to patient ratios in respect of nursing and midwifery. The Trust continues to progress with recruitment, with the aim of reducing reliance on agency staff.

Costs of £130,000 relating to the chair and non executive directors are excluded from this note (2016/17 £132,000).

Other pension costs include expenses for early retirements and injury benefits which are recharged to the Trust by the NHS Business Services Authority - Pensions Division.

6.2 Directors' remuneration and other benefits

During the year key management received remuneration and benefits in kind as summarised below. Key management is defined as the Executive and Non Executive Directors of the Trust. Further details of their remuneration can be found in the Remuneration Report within the Trust's Annual Report.

	2017/18	2016/17
	£000	£000
Remuneration including employers national insurance contributions	**1,383**	1,347
Employers contribution to Executive Directors' pensions	**70**	75
Benefits in kind - leased vehicles	**21**	19

At 1 April 2017 there were a total of 5 Directors to whom benefits were accruing under a defined benefit scheme. At 31 March 2018 there are 4 Directors accruing these benefits.

6.3 Retirements due to ill health

During 2017/18 there were 4 early retirements from the Trust agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £293,000 (2016/17 there were 7 retirements with an additional liability of £461,000). The cost of ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

7. Better Payment Practice Code

7.1 Better Payment Practice Code - measure of compliance	**2017/18**		2016/17	
	Number	**£000**	Number	£000
Total Non-NHS trade invoices paid in the financial period	**74,754**	**182,752**	93,780	179,226
Total Non NHS trade invoices paid within target	**43,007**	**139,560**	84,673	164,991
Percentage of Non-NHS trade invoices paid within target	**58%**	**76%**	90%	92%
Total NHS trade invoices paid in the financial period	**2,200**	**28,960**	2,771	64,738
Total NHS trade invoices paid within target	**1,077**	**26,038**	2,093	62,483
Percentage of NHS trade invoices paid within target	**49%**	**90%**	76%	97%

The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

7.2 The Late Payment of Commercial Debts (Interest) Act 1998

There were no amounts included within finance costs arising from claims made for late payment of debts under the above legislation.

8. Finance costs

8.1 Finance income

	2017/18 £000	2016/17 £000
Interest on bank accounts	**39**	28
Total	**39**	28

All surplus cash balances are retained within the Government Banking Service which pays minimal interest.

8.2 Finance expenses

	2017/18 £000	2016/17 £000
Interest payable on loans from the Department of Health & Social Care	**(2,345)**	(1,698)
Unwinding of discount on provisions	**(6)**	(30)
Total	**(2,351)**	(1,728)

8.3 Impairment of assets

	2017/18 £000	2016/17 £000
Impairments charged to operating expenditure as a result of changes in market price	**(2,715)**	(949)
Total impairments charged to operating expenditure	**(2,715)**	(949)
Impairments charged to the revaluation reserve	**0**	(1,192)
Total	**(2,715)**	(2,141)

The impairment recognised during 2017/18 relates to the revaluation of the Trust's South Lakes Birthing Centre at Furness General Hospital. This asset was brought into use during February 2018. Details of the impairment can be found in note 10.

Impairments recognised during 2016/17 relate to the revaluation of land and property assets at 1 March 2017. Details of the revaluations made are included in note 10.

9. Intangible assets

	2017/18 Computer software - purchased	2016/17 Computer software - purchased
	£000	£000
Gross cost at beginning of period	**2,295**	2,186
Additions purchased	**0**	52
Reclassifications	**265**	199
Disposals/derecognition	**0**	(142)
Gross cost at 31 March	**2,560**	2,295
Amortisation at beginning of period	**1,897**	1,920
Charged during the period	**185**	119
Disposals/derecognition	**0**	(142)
Amortisation at 31 March	**2,082**	1,897
Net book value		
Purchased	**475**	395
Donated	**3**	3
Total at 31 March	**478**	398

All intangible assets held are software licences that have been purchased by the Trust. These are held at amortised cost and the economic lives are adjusted to reflect fair value in use.

All intangible assets have finite useful lives and are amortised on a straight-line basis. Lives range from 1 to 6 years. The Trust holds no Revaluation Reserve balances for intangible assets.

10. Property, plant and equipment

2017/18:	Land	Buildings excluding dwellings	Dwellings	Assets under construct and poa	Plant and machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2017	11,003	104,720	1,842	5,225	42,399	16,766	3,322	185,277
Additions purchased	0	8,114	3	10,136	2,531	24	0	20,808
Additions donations of assets (non-cash)	0	0	0	0	29	0	0	29
Additions grants/donations	0	88	0	0	127	0	0	215
Impairments charged to operating expenses	0	(2,715)	0	0	0	0	0	(2,715)
Reclassifications	0	12,342	0	(14,589)	0	1,982	0	(265)
Disposals/derecognition	0	0	0	0	(785)	0	0	(785)
At 31 March 2018	11,003	122,549	1,845	772	44,301	18,772	3,322	202,564
Depreciation at 1 April 2017	0	586	12	0	24,898	11,240	1,607	38,343
Charged during the period	0	7,409	148	0	3,087	1,384	243	12,271
Disposals/derecognition	0	0	0	0	(785)	0	0	(785)
Depreciation at 31 March 2018	0	7,995	160	0	27,200	12,624	1,850	49,829
Net book value								
Purchased	11,003	112,043	1,685	772	15,570	6,148	1,366	148,587
Donated	0	2,511	0	0	1,531	0	106	4,148
Total at 31 March 2018	11,003	114,554	1,685	772	17,101	6,148	1,472	152,735
Asset financing								
Owned	11,003	114,554	1,685	772	17,101	6,148	1,472	152,735
Finance Leased	0	0	0	0	0	0	0	0
Total at 31 March 2018	11,003	114,554	1,685	772	17,101	6,148	1,472	152,735

10. Property, plant and equipment

2016/17:	Land	Buildings excluding dwellings	Dwellings	Assets under construct and poa	Plant and machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2016	10,669	106,497	2,081	2,766	41,982	15,141	3,271	**182,407**
Additions purchased	0	8,364	92	7,179	3,680	30	26	**19,371**
Additions grants/donations	0	55	0	0	260	0	0	**315**
Impairments charged to operating expenses	0	(949)	0	0	0	0	0	**(949)**
Impairments charged to the revaluation reserve	0	(1,192)	0	0	0	0	0	**(1,192)**
Reclassifications	0	2,083	0	(4,720)	0	1,805	633	**(199)**
Revaluations	334	(10,138)	(331)	0	0	0	0	**(10,135)**
Disposals/derecognition	0	0	0	0	(3,523)	(210)	(608)	**(4,341)**
At 31 March 2017	**11,003**	**104,720**	**1,842**	**5,225**	**42,399**	**16,766**	**3,322**	**185,277**
Depreciation at 1 April 2016	0	7,428	162	0	25,654	9,933	2,025	**45,202**
Charged during the period	0	8,144	179	0	2,767	1,517	190	**12,797**
Revaluations	0	(14,986)	(329)	0	0	0	0	**(15,315)**
Disposals/derecognition	0	0	0	0	(3,523)	(210)	(608)	**(4,341)**
Depreciation at 31 March 2017	**0**	**586**	**12**	**0**	**24,898**	**11,240**	**1,607**	**38,343**
Net book value								
Purchased	11,003	101,558	1,830	5,225	15,802	5,526	1,592	**142,536**
Donated	0	2,576	0	0	1,699	0	123	**4,398**
Total at 31 March 2017	**11,003**	**104,134**	**1,830**	**5,225**	**17,501**	**5,526**	**1,715**	**146,934**
Asset financing								
Owned	11,003	104,134	1,830	5,225	17,501	5,526	1,715	**146,934**
Finance Leased	0	0	0	0	0	0	0	**0**
Total at 31 March 2017	**11,003**	**104,134**	**1,830**	**5,225**	**17,501**	**5,526**	**1,715**	**146,934**

10. Property, plant and equipment (continued)

No overall revaluation of land, buildings or dwellings was undertaken during 2017/18 as the underlying indices upon which the valuation is based had not moved so significantly that they would have resulted in a material movement in the value of the Trust's land or property assets. Valuation was undertaken in accordance with accounting policies on one specific new asset which was brought into use during the year. The South Lakes Birthing Centre was built at a total cost of £12,452,000. The valuation applied by the valuer was £9,737,000 resulting in an impariment of £2,715,000 which was charged in full to expenditure.

The last full revaluation of the Trust's land, buildings and dwellings was undertaken as at 1 March 2017 by professional valuers GVA Grimley Limited. The revaluation undertaken resulted in a total of £5,180,000 upwards revaluations and £2,141,000 of impairments in respect of land and property assets. The net effect of these changes amounted to an increase in asset values of £3,039,000. Of the impairments incurred, £949,000 was charged to operating expenses and the balance of £1,192,000 was charged to the Revaluation Reserve.

The valuer valued the assets in accordance with the terms of the Royal Institution of Chartered Surveyors' Valuation Standards 2 of the RICS Valuation Standards - Global and UK 7th Edition, in so far as these terms are consistent with the requirements of HM Treasury, the National Health Service and the Independent Regulator of Foundation Trusts. The majority of the Trust's land, buildings and dwellings are classified as specialised operational assets and are valued on a depreciated replacement cost basis based on the the current cost of replacing an asset with its modern equivalent asset less deductions for physical deterioration and obsolescence. Where properties are not considered to be specialised, market values for existing use have been applied.

Where appropriate, land and property assets can be valued based on an alternative location where relocation could be considered to be a factor in determining fair value. Of asset values at 31 March 2018, 35% of assets have been valued based on the modern equivalent asset valuation in their current location and for 62% of assets, alternative site valuations have been used. The remaining 3% of assets have been valued at market value in existing use.

Where individual parts of an asset are significant enough to be assigned separate depreciation profiles, these elements are treated as separate components of the asset. The Trust's assets are valued based on 4 individual components in accordance with accounting standard IAS 16 which allows for similar components to be grouped. The individual components are; frame; finishes and fittings; service engineering; and external works. Each component is assigned a maximum expected economic life which is adjusted for condition and deterioration as appropriate to the individual component.

Asset lives for non-current assets are as follows:	**Minimum Life Years**	**Maximum Life Years**
Buildings (excluding dwellings)	**2**	**80**
Dwellings	**5**	**34**
Plant and machinery	**1**	**19**
Information technology	**1**	**9**
Furniture and fittings	**1**	**23**

10. Property, plant and equipment (continued)

For all non-property assets, a validation exercise is undertaken during the year. In 2017/18 no revisions were made to asset lives as a result of this exercise. No revisions were made during 2016/17.

Assets bought with donated funds during the year totalled £215,000. All of this sum was received from the Bay Hospitals Charity for the purchase of assets. During 2016/17 the Bay Hospitals Charity donated funds for the purchase of assets totalling £315,000.

One additional asset was donated to the Trust in 2017/18 from the charity Medequip 4 Kids which was valued at £29,000. This was a donation of equipment for the South Lakes Birthing Centre and this has been accounted for as a non-cash donation in the Trust's accounts.

During 2017/18 assets amounting to £37,000 were purchased with capital Public Dividend Capital received from the Improving Places of Safety Scheme awarded by the Department of Health and Social Care. No Public Dividend Capital was received for the purchase of capital assets during 2016/17.

There were no sales of equipment during the year 2017/18 or during 2016/17.

11. Capital commitments

At 31 March 2018 contracted capital commitments amounted to £1,238,000 for the following items:

£168,000 for the completion of works to the Physiotherapy Suite at Royal Lancaster Infirmary. This is due to complete in June 2018.
£1,070,000 for the purchase and installation of a new Gamma Camera with CT scanning technology at Furness General Hospital. This is due to be completed in August 2018.

Capital commitments which were outstanding at 31 March 2017 amounted to a total of £9,023,000. These included the building of a new Maternity Unit at Furness General Hospital for which commitments totalled £7,540,000; the purchase and installation of cardiac equipment at Westmorland General Hospital of £722,000; £707,000 for electrical compliance works and£27,000 for security works across all sites; and £27,000 for asbestos removal works at Furness General Hospital. All of these schemes were completed during 2017/18.

The above schemes have been funded from a mixture of internal resources generated by the Trust and loans received from the Department of Health and Social Care. Details of capital loans are included in note 19.

12. Inventories

12.1 Inventories	31 March 2018 £000	31 March 2017 £000
Drugs	**934**	993
Consumables	**2,218**	1,543
Energy	**111**	131
Total	**3,263**	2,667

12.2 Inventories recognised in expenses	31 March 2018 £000	31 March 2017 £000
Inventories recognised as an expense in the period	**25,900**	24,206
Write-down of inventories (including losses)	**64**	39
Total	**25,964**	24,245

13. Trade and other receivables

13.1 Trade and other receivables

	31 March 2018 £000	31 March 2017 £000
Current		
NHS receivables	**5,338**	14,772
Provision for the impairment of receivables	**(1,271)**	(971)
Prepayments	**1,189**	943
Accrued income	**231**	275
Other receivables	**3,092**	2,583
Total	**8,579**	17,602
Non-current		
Other receivables	**2,874**	2,646
Total	**2,874**	2,646

The great majority of trade is with Clinical Commissioning Groups, as commissioners for NHS patient care services. As Clinical Commissioning Groups are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

Items shown as non-current receivables include amounts due in future years from the Injury Costs Recovery scheme of £2,839,000 and working capital cash provided to the Waterloo GP Practice in Millom of £35,000. Non-current receivables in 2016/17 included £2,540,000 and£35,000 for these items plus sums due from employees in relation to salary sacrificed for the purchase of computer equipment of £71,000.

13.2 Provision for impairment of receivables	31 March 2018 £000	31 March 2017 £000
Balance at beginning of year	**(971)**	(1,507)
Amount written off during the year	**22**	71
(Increase)/decrease in receivables impaired	**(322)**	465
Balance at 31 March	**(1,271)**	(971)

Receivables impaired include £813,000 relating to anticipated unrecoverable items from the Injury Costs Recovery Scheme, £402,000 in relation to receivables with other NHS organisations and £56,000 of other general provisions (31 March 2017 £778,000, £115,000 and £78,000 respectively).

13.3 Ageing of financial assets	31 March 2018 £000	31 March 2017 £000
Impaired financial assets		
By three to six months	**0**	0
By more than six months	**458**	193
Total	**458**	193
Financial assets past their due date but not impaired		
By up to one month	**1,045**	1,367
By one to two months	**475**	900
By two to three months	**194**	103
By three to six months	**500**	290
By more than six months	**731**	121
Total	**2,945**	2,781

This note shows the ageing of impaired and past due financial assets. It excludes receivables which do not meet the definition of a financial instrument under IFRS 39. Receivables from the Injury Costs Recovery Scheme are not classified as financial assets and are therefore excluded from this note.

Receivables past their due date include £306,000 (31 March 2017 £208,000) of managed debts which are being settled by instalments. These relate to overpayments of salary and cycle scheme salary sacrifice arrangements.

14. Non-current assets held for sale

There were no assets classified for sale or sold during 2017/18 or 2016/17.

15. Cash and cash equivalents	31 March 2018 £000	31 March 2017 £000
Balance at beginning of year	**14,110**	1,555
Net change in year	**(9,700)**	12,555
Balance at end of year	**4,410**	14,110
Made up of		
Cash with the Government Banking Service (GBS)	**4,393**	14,087
Commercial banks and cash in hand	**17**	23
Cash and cash equivalents as in statement of financial position	**4,410**	14,110
Bank overdraft	**0**	0
Cash and cash equivalents as in statement of cash flows	**4,410**	14,110

The cash balance shown at 31 March 2017 was significantly above the Trust's forecast cash balance. This was due to a material payment received from NHS England towards the end of March. This sum was utilised during 2017/18 in the normal course of business.

16. Trade and other payables	Current 31 March 2018 £000	Current 31 March 2017 £000
NHS payables	**2,949**	821
PDC dividend payable	**0**	2
Amounts due to other related parties	**2,909**	2,704
Trade payables - capital	**945**	1,484
Other trade payables	**4,296**	1,842
Tax payable	**5,020**	4,117
Accruals	**7,996**	6,062
Other payables	**2,418**	2,937
Total	**26,533**	19,969

All trade and other payables are due within 12 months and are classified as current payables. There are no non-current payables at 31 March 2018.

Amounts due to other related parties comprise oustanding pension contributions due to be paid to the NHS Business Services Authority - Pensions Division.

There are no payables due at 31 March 2018 in respect of pensions for payments due for future years under the arrangements to buy out the liability for early retirement over 5 years.

17. Finance lease liabilities	31 March 2018 £000	31 March 2017 £000
Current		
Computer salary sacrifice scheme	**71**	210
Total	**71**	210
Non-current		
Computer salary sacrifice scheme	**0**	71
Total	**0**	71

The Trust entered into finance leases in previous years to finance the purchase of personal computers offered to employees as a salary sacrifice scheme. The total amount of the combined liability at 31 March 2018 is £71,000 and this relates to two ongoing finance leases. The employees have elected to sacrifice salary equivalent to the cost of the computer equipment and the amounts due from employees will meet the full cost of the finance leases. Outstanding employee contributions are shown within current receivables at note 13.1. No further schemes have been offered to employees during 2017/18.

18. Other liabilities	31 March 2018 £000	31 March 2017 £000
Current		
Deferred income	**969**	1,931
Total	**969**	1,931

19. Borrowings

Loan funding from the Department of Health and Social Care to support the deficit position of the Trust has been accessed since March 2015. Loans have also been agreed to enable the Trust to undertake capital works to reduce backlog maintenance and fund specific projects which could not be afforded from internal resources.

A capital loan was agreed with the Department of Health and Social Care in March 2016 for a total value of £13,600,000. The loan has an interest rate of 1.85% and the principal is repayable in equal instalments over a period of 22 years. This loan was fully drawn down during 2016/17 and 2017/18 with the final amount utilised in January 2018. The first repayment of principal was paid in November 2017 and subsequent instalments are due at six monthly intervals.

A second capital loan was agreed with the Department of Health and Social Care in January 2018 for a total value of £10,100,000. This loan has an interest rate of 2.52% and the principal is repayable in equal instalments over a period of 24 years. Up to 31 March 2018 the sum of£2,700,000 has been drawn against this loan and the first installment of principal is due to be paid in August 2019. Subsequent installments are due at six monthly intervals.

During 2017/18 the Trust also received a capital loan from Salix Finance Ltd which provides interest-free Government funding to the public sector to improve energy efficiency. The value of this loan is £2,535,789 and this was all drawn down by 31 March 2018. This loan is free of interest charges and principal is repayable in equal installments over 5 years. The first installment of principal is due to be paid in October 2018 with subsequent installments due at six monthly intervals.

19. Borrowings (continued)

The Trust has a further 14 outstanding loans from the Department of Health and Social Care agreed by the Secretary of State for Health as at 31 March 2018. All these loans support the revenue position of the Trust. The values for all loans are shown in the table below.

Outstanding Loan Value	**31 March 2018**	31 March 2017
	£000	£000
Current		
Capital loan DHSC (1.85%)	**620**	116
Capital loan (Salix)	**254**	0
Total	**874**	116
Non-current		
Capital loan DHSC (1.85%)	**12,714**	4,984
Capital loan DHSC (2.52%)	**2,700**	0
Capital loan (Salix)	**2,282**	0
Revenue loan (repayable March 2020)	**21,000**	21,000
Revenue loan (repayable September 2020)	**39,100**	39,100
Revenue loan (repayable January 2020)	**25,168**	27,168
Revenue loan (repaid April 2017)	**0**	3,372
Revenue loan (repaid April 2017)	**0**	5,424
Revenue loan (repayable February 2020)	**8,259**	8,259
Revenue loan (repayable May 2020)	**2,865**	0
Revenue loan (repayable June 2020)	**6,002**	0
Revenue loan (repayable July 2020)	**5,414**	0
Revenue loan (repayable September 2020)	**4,961**	0
Revenue loan (repayable October 2020)	**4,653**	0
Revenue loan (repayable November 2020)	**4,546**	0
Revenue loan (repayable December 2020)	**4,760**	0
Revenue loan (repayable January 2021)	**4,841**	0
Revenue loan (repayable February 2021)	**2,380**	0
Revenue loan (repayable March 2021)	**6,702**	0
Total	**158,347**	109,307

Prior to 2016/17 the Trust had access to a Working Capital Facility provided by the Department of Health and Social Care. In January 2017 access to Working Capital facilities was withdrawn and all balances at that time were converted into loans.

All access to funding which supports deficit positions for NHS organisations is now in the form of an Interim Revenue Support Facility which is accessed on a monthly basis based on resource requirements. No loan faciities can be accessed in advance of need.

Interest due on revenue loans issued to the Trust up to 31 March 2017 is at a fixed rate of 1.5%. All revenue loans issued since 1 April 2018 are subject to an interest rate of 3.5%. This higher rate has been applied due to the inability of the Trust to agree to the control total set by NHS Improvement. The principal on each loan is due to be paid on the date shown above.

20. Provisions

	31 March 2018		31 March 2017	
	Current	**Non-current**	Current	Non-current
	£000	**£000**	£000	£000
Early retirements	**31**	**265**	34	302
Injury benefits	**118**	**2,011**	118	2,119
Employer and public liability	**58**	**0**	57	0
Equal Pay provisions	**536**	**0**	0	0
Total	**743**	**2,276**	209	2,421

	2017/18			
	Pensions	**Legal Claims**	**Other**	**Total**
	£000	**£000**	**£000**	**£000**
At beginning of period	**2,573**	**57**	**0**	**2,630**
Arising during the period	**42**	**55**	**536**	**633**
Used during the period	**(149)**	**(36)**	**0**	**(185)**
Reversed unused	**(80)**	**(18)**	**0**	**(98)**
Change in the discount rate	**33**	**0**	**0**	**33**
Unwinding of discount	**6**	**0**	**0**	**6**
At 31 March	**2,425**	**58**	**536**	**3,019**
Expected timing of cash flows:				
Within 12 months	**149**	**58**	**536**	**743**
Between 1 and 5 years	**595**	**0**	**0**	**595**
Over 5 years	**1,681**	**0**	**0**	**1,681**
	2,425	**58**	**536**	**3,019**

	2016/17			
	Pensions	Legal Claims	Other	Total
	£000	£000	£000	£000
At beginning of period	2,194	78	375	2,647
Arising during the period	324	70	0	394
Used during the period	(231)	(60)	0	(291)
Reversed unused	(16)	(31)	(375)	(422)
Change in the discount rate	272	0	0	272
Unwinding of discount	30	0	0	30
At 31 March	2,573	57	0	2,630
Expected timing of cash flows:				
Within 12 months	152	57	0	209
Between 1 and 5 years	605	0	0	605
Over 5 years	1,816	0	0	1,816
	2,573	57	0	2,630

20. Provisions (continued)

Pensions provisions include the cost of early retirements and permanent injury compensation settlements. None of these provisions relate to former directors. Legal claims provisions relate to employer and public liability claims.

At 31 March 2018 the Trust has provided for the anticipated cost of Equal Value Claims made by employees. Approval from HM Treasury is required before these claims can be settled.

At 31 March 2016 the Trust had provided for expenditure anticipated in respect of the implementation of a Clinical Stategy in conjunction with healthcare commissioners. During 2016/17 funding of this strategy was reviewed and the costs were met from within existing Trust resources and other external resources. The provision was therefore removed.

Where appropriate the Trust has obtained independent advice and provisions are based on that advice. As far as can be ascertained, it is anticipated that these amounts are likely to become payable in the future.

The Trust is a member of the Clinical Negligence Scheme for Trusts (CNST) which is independently operated by NHS Resolution (formerly the NHS Litigation Authority) and is a risk pooling scheme. NHS Resolution accounts for provisions relating to the Trust's claims in its financial statements. At 31 March 2018 these provisions totalled £177,145,000 (31 March 2017 £132,159,000).

21. Contingent liabilities

Equal Value claims from employees which were previously disclosed as contingent liabilities have now been provided for and are shown in note 20 above.

22. Financial Instruments

22.1 Financial risk management

Financial Reporting Standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks the Trust faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with clinical commissioners and the way those clinical commissioners are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the Financial Reporting Standards mainly apply.

22.1 Financial risk management (continued)

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's Standing Financial Instructions and policies agreed by the Trust Board. No current investment activity is undertaken as average daily balances held in the Government Banking Service are excluded from the calculation of PDC dividend payable. As dividend is charged at 3.5% of net assets and interest rates are currently below this level, the Trust would not benefit from investing surplus cash balances. All Trust treasury activity is subject to review by the Trust's internal auditors.

22.2 Exposure to risk

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust is permitted to borrow to fund capital expenditure, subject to affordability as confirmed by NHS Improvement. The relevant interest rate is determined at the point of the first draw on the loan and does not vary for subsequent drawings. As at 31 March 2018, the Trust has entered into two loan arrangements with fixed interest rates of 1.85% and 2.52%. The Trust therefore has a low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2018 are in receivables from customers, as disclosed in the Trade and other receivables note 13.

Liquidity risk

The Trust's operating costs are incurred under contracts with clinical commissioners, which are financed from resources voted annually by Parliament and the Trust has funded its capital expenditure from funds generated from internal resources and loan finance. However, the Trust has a deficit of expenditure against its projected income and is therefore exposed to liquidity risks. Plans are being developed with the Regulator and Commissioners to mitigate this risk.

Investment risk

The Trust does not currently invest cash which is not immediately required to fund operating expenses on a short term basis. The Trust is therefore not exposed to significant risk from investment activity.

22.3 Financial assets	2017/18		2016/17	
	Loans and receivables	**Total**	Loans and receivables	Total
	£000	**£000**	£000	£000
Cash at bank and in hand	**4,410**	**4,410**	14,110	14,110
Trade and other receivables	**6,887**	**6,887**	15,965	15,965
Total at 31 March	**11,297**	**11,297**	30,075	30,075

22.4 Financial liabilities	Other	Total	Other	Total
	£000	**£000**	£000	£000
Borrowings	**159,221**	**159,221**	109,423	109,423
Obligations under finance leases	**71**	**71**	281	281
Trade and other payables	**18,373**	**18,373**	13,154	13,154
Total at 31 March	**177,665**	**177,665**	122,858	122,858

22.5 Maturity of financial assets and liabilities

The financial assets shown above include the sum of £35,000 (31 March 2017 £106,000) due after more than one year. This relates to monies due from the Waterloo GP Practice (Millom). The balance of £11,262,000 (31 March 2017 £29,969,000) is due within one year.

Of the financial liabilities shown above, the sum of £158,347,000 (31 March 2017 £109,378,000) in respect of borrowings is due after more than one year and the balance of £19,318,000 (31 March 2017£13,480,000) is due for payment within one year. Details of borrowings are included in note 19.

22.6 Fair value of Financial Instruments

The fair values of financial assets and liabilities held by the Trust are estimated to be equal to book value. Amounts held in cash are repayable on demand at the carrying value. The majority of trade receivables and payables are current assets and liabilities and are not subject to material changes due to the effects of time on the future cash flows. The value of loans received from the Department of Health and Social Care are non amortising and therefore fair value is equal to book value.

23. Related party transactions

During the year ending 31 March 2018 and the prior year (2016/17) none of the Board Members, key management or members of the Council of Governors (or parties related to them) has undertaken any material transactions with the University Hospitals of Morecambe Bay NHS Foundation Trust. Details of Directors' remuneration and other benefits are set out in the Remuneration Report in the Annual Report.

A small number of key members of staff have connections with other organisations which also have transactions with the Trust. Material transactions with these organisations are listed at the top of the following tables. The assessment of materiality is made in relation to the value of transactions with each organisation based on their overall turnover.

During 2016/17 the Trust established a collaborative working arrangement with the Waterloo GP Practice in Millom and contributed a sum of working capital to the Practice. This sum will be repaid from any future surplus generated by the Practice and is therefore shown as a receivable in the tables below.

The Trust receives revenue and capital contributions from the Bay Hospitals Charity where the Trust Board members are Trustees of the Charity. The Charity is required by the Charities Commission to prepare a separate Annual Report and Accounts. The figures in the tables below relate to the income received from the Charity to support the provision of healthcare by the Trust.

The Department of Health and Social Care is regarded as a related party. The University Hospitals of Morecambe Bay NHS Foundation Trust has a significant number of material transactions with the Department and with other entities for which the Department is regarded as the parent Department.

	2017/18			
	Income	Expenditure	Receivable	Payable
	£000	£000	£000	£000
Morecambe Bay Radiology LLP	-	14	-	-
Waterloo GP Practice (Millom)	-	-	35	-
Bay Hospitals Charity	513	-	44	-
Department of Health & Social Care	164	4	96	-
Public Health England	215	40	2	8
NHS Foundation Trusts	7,692	3,081	2,014	1,046
NHS England and CCGs	263,044	14	2,163	1,447
Health Education England	10,937	10	65	124
NHS Resolution (was NHSLA)	-	13,687	-	-
NHS Pension Scheme	-	20,814	-	2,909
NHS Property Services	-	247	-	85
NHS Shared Business Services	-	309	-	96
NHS Trusts	923	815	351	225
HM Revenue and Customs	-	18,412	622	5,020
Cumbria County Council	149	-	85	-
Lancashire County Council	167	-	116	-
Welsh, Scottish & Irish Health Bodies	191	-	25	-
National Blood	96	1,266	2	14
Other NHS & Government Organisations	8	257	13	0
Total	284,099	58,970	5,633	10,974

23. Related party transactions (continued)

	2016/17			
	Income £000	Expenditure £000	Receivable £000	Payable £000
Morecambe Bay Radiology LLP	-	234	-	-
Waterloo GP Practice (Millom)	-	-	35	-
Bay Hospitals Charity	633	-	24	-
Department of Health	240	-	20	2
Public Health England	267	49	9	6
NHS Foundation Trusts	7,807	2,827	1,464	494
NHS England and CCGs	297,856	36	12,895	821
Health Education England	10,166	15	74	13
NHS Litigation Authority	-	10,662	-	1
NHS Pension Scheme	-	19,532	5	2,704
NHS Property Services	2	314	5	103
NHS Shared Business Services	-	294	-	-
NHS Trusts	744	769	287	61
HM Revenue and Customs	-	15,209	592	4,117
Cumbria County Council	145	-	11	30
Lancashire County Council	154	-	20	-
Welsh, Scottish & Irish Health Bodies	160	-	8	-
National Blood	91	1,169	13	4
Other NHS organisations	20	188	0	0
Total	318,285	51,298	15,462	8,356

24. Third party assets

The Trust held £4,000 cash and cash equivalents at 31 March 2018 which relates to monies held by the Trust on behalf of patients (31 March 2017 £3,000). This has been excluded from the cash and cash equivalents figure reported in the accounts.

25. Losses and special payments

	2017/18		2016/17	
	Number	**Value £000**	Number	Value £000
Losses				
Cash losses	**0**	**0**	30	25
Fruitless payments	**0**	**0**	0	0
Bad debts and claims abandoned	**1**	**25**	70	24
Stores losses	**1**	**64**	1	39
Total losses	**2**	**89**	101	88
Special payments				
Ex gratia payments	**53**	**73**	68	70
Extra statutory and regulatory	**2**	**3**	4	147
Total special payments	**55**	**76**	72	217
Total losses and special payments	**57**	**165**	173	305

25. Losses and special payments (continued)

There have been no individual losses or special payment cases which have exceeded £300,000 in either 2017/18 or 2016/17.

Stores losses identified are aggregated in accordance with the net loss identified at each type of store and treated as one case. Those shown above relate to drugs stocks written off during the year. Bad debts and claims abandoned relate to the number of individual debtors.

The above losses and special payments are reported on an accruals basis and do not include any provisions for future losses.

26. Private Finance Initiative (PFI) transactions

The Trust has no PFI arrangements at 31 March 2018.

27. Audit fees

During 2017/18 the Trust's audit contract was undertaken by Grant Thornton UK LLP who were re-appointed as the Trust's auditors with effect from 2017/18. Auditors remuneration amounted to £60,000 during the year. Of this sum £53,000 relates to the statutory audit function and £7,000 relates to the audit of the Quality Accounts, which is classified as other auditors remuneration - audit related assurance.

During 2016/17, remuneration amounting to £66,000 was paid to Grant Thornton UK LLP. Of this sum £55,000 related to the statutory audit function and £11,000 to the cost of auditing the Trust's Quality Accounts. All audit fees are inclusive of VAT at 20%.

Grant Thornton UK LLP is also engaged to provide external audit for the Bay Hospitals Charity. Fees of £2,000 will be paid by the Charity in relation to this service for 2017/18 (2016/17 £2,000). This service is limited to an independent review in accordance with the income threshold specifed for charities above which a full audit is required.

28. Limitation on auditor's liability

The limitation on the auditor's liability is specified as £2 million.

In practice the liability will be assessed depending on the nature of the issue. Grant Thornton UK LLP's liability for any damages or losses incurred by the Trust will be limited to the proportion of the total damage which may be attributed to Grant Thornton UK LLP after taking into account any contributory negligence of the Trust and any other third party found to be liable to contribute to the damage incurred.

29. Events after the reporting period

The Trust is working with statutory health and care partner organisations in the development of an integrated health and care system for the Morecambe Bay area which is sustainable for the long term. During 2018/19 some services undertaken by other providers will be integrated into the Trust. This includes services from Cumbria Partnership NHS Foundation Trust worth approximately £23 million which transferred with effect from 1 April 2018. Further negotiations are ongoing in relation to other transfers but these are not agreed or quantified at this stage. All transfers will be reflected in the accounts for 2018/19 and there is no impact on the position at 31 March 2018.

Annex H – Preparation of the Annual Reports and Accounts

The Annual Reports and Accounts are prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2017/18.

The Annual Reporting Manual requires that the Directors explain in the Annual Report their responsibility for preparing the Annual Report and Accounts, and state that they consider the Annual Report and Accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS Foundation Trust's performance, business model and strategy.

The co-ordination and review of the Trust–wide input into the Annual Report and Accounts is a sizeable exercise performed within an exacting time frame which runs alongside the formal audit process undertaken by the external auditors.

Arriving at a position where initially the Audit Committee, and then the Board are satisfied with the overall fairness, balance and clarity of the documents is underpinned by the following:-

- comprehensive guidance issued to contributors at strategic and operational level;
- verification process dealing with factual content of the report;
- comprehensive reviews undertaken at different levels in the Trust that aim to ensure constituency and overall balance; and
- comprehensive review by senior leadership team.

Therefore, each of the Directors considers that the Annual Report and Accounts taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and other stakeholders to assess the NHS Foundation Trust's performance, business model and strategy.

Further copies of the Annual Report and Accounts for the period 1 April 2017 to 31 March 2018 can be obtained by writing to:

Company Secretary
University Hospitals of Morecambe Bay NHS Foundation Trust
Trust Headquarters
Westmorland General Hospital
Burton Road
Kendal
LA9 7RG

Alternatively the document is accessible on the Trust's website here.

If you would like to make comments on our Annual Report or would like further information, please write to:

Chief Executive
University Hospitals of Morecambe Bay NHS Foundation Trust
Trust Headquarters
Westmorland General Hospital
Burton Road
Kendal
LA9 7RG

The Constitution of the Trust

The Constitution of the Trust is accessible on the Trust's website here.

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Annex I – Compliance with the NHS Improvement Code of Corporate Governance

The creation of Foundation Trusts has led to the requirement for a framework for corporate governance, applicable across the Foundation Trust Network. NHSI has produced the NHS Foundation Trust Code of Governance.

This code consists of a set of Principles and Provisions to ensure that Boards operate to the highest levels of corporate governance.

The Board of Directors has taken actions to comply with the Code, and where appropriate established governance policies that support the delivery of corporate governance.

Further information is contained throughout the Constitution of the Trust and this Annual Report.

Foundation Trusts are required to report against this Code each year in their Annual Report on the basis of either compliance with the Code provisions or an explanation where there is non-compliance.

The Board of Directors considers that, throughout the 2017/18 reporting year, the Trust has applied the principles and met the provisions and the requirements of the Code of Governance with no exception.

Set out below are the elements of the Code that the Foundation Trust is required to report against but do not form part of this Annual Report.

The disclosures set out in the NHS Foundation Trust Code of Governance		
NHS Foundation Trust Code of Governance Requirement and Reference		**Commentary**
n/a	If, during the financial year, the Governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. This is required by paragraph 26(2)(aa) of schedule 7 to the NHS Act 2006, as amended by section 151 (8) of the Health and Social Care Act 2012. * Power to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the foundation trust's or directors' performance). ** As inserted by section 151 (6) of the Health and Social Care Act 2012)	The Governors have not exercised this power during 2017/18.

NHS Foundation Trust Code of Governance Requirement and Reference		Commentary
Provision B.5.6	Governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	Public Governors regularly attend the Hospitals and events at the Trust. They have been invited to Better Care Together Engagement events. Staff Governors and Appointed Governors are able to use formal structures to canvass opinions. Through these mechanisms Governors have been able to canvass opinions and provide feedback at Council of Governors when the Forward Plans and the Quality Account are being discussed. Governors regularly meet with Non-Executive Directors and attend the Board Assurance Committees. The Chair meets regularly with the Head Governor.
C.3.5	If the council of governors does not accept the audit committee's recommendation on the appointment, reappointment or removal of an external auditor, the board of directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the council of governors has taken a different position.	No such recommendation has been made in 2017/18
D.1.3	Where an NHS foundation trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.	No such arrangements exist
A.1.6	The board should report on its approach to clinical governance.	This forms part of the Quality Account
A.1.7	The chief executive as the accounting officer should follow the procedure set out by NHSI for advising the board and the council and for recording and submitting objections to decisions.	This forms part of the Constitution
A.1.8	The board should establish the constitution and standards of conduct for the NHS foundation trust and its staff in accordance with NHS values and accepted standards of behaviour in public life	The Constitution is formed on this basis
A.1.9	The board should operate a code of conduct that builds on the values of the NHS foundation trust and reflect high standards of probity and responsibility.	The Trust's Behavioural Standards Framework reflects the values of the NHS Constitution.
A.1.10	The NHS foundation trust should arrange appropriate insurance to cover the risk of legal action against its directors.	Insurance has been put in place

NHS Foundation Trust Code of Governance Requirement and Reference		Commentary
A.3.1	The chairperson should, on appointment by the council, meet the independence criteria set out in B.1.1. A chief executive should not go on to be the chairperson of the same NHS foundation trust.	The Chair meets the criteria. The Chief Executive is not the Chairman of the Trust
A.4.1	In consultation with the council, the board should appoint one of the independent non-executive directors to be the senior independent director.	Denis Lidstone is the Senior Independent Director
A.4.3	Where directors have concerns that cannot be resolved about the running of the NHS foundation trust or a proposed action, they should ensure that their concerns are recorded in the board minutes.	The Constitution makes provision for this
A.5.4	The roles and responsibilities of the council of governors should be set out in a written document.	These are set out in the Constitution
A.5.5	The chairperson is responsible for leadership of both the board and the council but the governors also have a responsibility to make the arrangements work and should take the lead in inviting the chief executive to their meetings and inviting attendance by other executives and non-executives, as appropriate.	The Chair of the Board is also the Chair of the Council of Governors
A.5.6	The council should establish a policy for engagement with the board of directors for those circumstances when they have concerns.	The Constitution makes provision for this
A.5.7	The council should ensure its interaction and relationship with the board of directors is appropriate and effective.	Within the cycle of meetings arrangements exist for joint Board of Directors' and Council of Governors' meetings
A.5.8	The council should only exercise its power to remove the chairperson or any non-executive directors after exhausting all means of engagement with the board.	The Constitution makes provision for this
A.5.9	The council should receive and consider other appropriate information required to enable it to discharge its duties.	The Trust is compliant with this requirement
B.1.2	At least half the board, excluding the chairperson, should comprise non-executive directors determined by the board to be independent.	The Trust is compliant with this requirement
B.1.3	No individual should hold, at the same time, positions of director and governor of any NHS foundation trust.	The Trust is compliant with this requirement
B.2.4	The chairperson or an independent non-executive director should chair the nominations committee(s).	The Trust is compliant with this requirement
B.2.5	The governors should agree with the nominations committee a clear process for the nomination of a new chairperson and non-executive directors.	The Trust is compliant with this requirement
B.2.6	Where an NHS foundation trust has two nominations committees, the nominations committee responsible for the appointment of non-executive directors should consist of a majority of governors.	The Trust is compliant with this requirement

NHS Foundation Trust Code of Governance Requirement and Reference		Commentary
B.2.7	When considering the appointment of non-executive directors, the council should take into account the views of the board and the nominations committee on the qualifications, skills and experience required for each position.	The Trust is compliant with this requirement
B.2.9	An independent external adviser should not be a member of or have a vote on the nominations committee(s).	The Trust is compliant with this requirement
B.3.3	The board should not agree to a full-time executive director taking on more than one non-executive directorship of an NHS foundation trust or another organisation of comparable size and complexity.	The Trust is compliant with this requirement
B.5.1	The board and the council governors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make.	The Trust is compliant with this requirement
B.5.2	The board and in particular non-executive directors, may reasonably wish to challenge assurances received from the executive management. They need not seek to appoint a relevant adviser for each and every subject area that comes before the board, although they should, wherever possible, ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis.	The Trust is compliant with this requirement
B.5.3	The board should ensure that directors, especially non-executive directors, have access to the independent professional advice, at the NHS foundation trust's expense, where they judge it necessary to discharge their responsibilities as directors.	The Trust is compliant with this requirement
B.5.4	Committees should be provided with sufficient resources to undertake their duties.	The Trust is compliant with this requirement
B.6.3	The senior independent director should lead the performance evaluation of the chairperson.	The Trust is compliant with this requirement
B.6.6	There should be a clear policy and a fair process, agreed and adopted by the council, for the removal from the council of any governor who consistently and unjustifiability fails to attend the meetings of the council or has an actual or potential conflict of interest which prevents the proper exercise of their duties.	Provisions are contained in the Constitution
B.8.1	The remuneration committee should not agree to an executive member of the board leaving the employment of an NHS foundation trust, except in accordance with the terms of their contract of employment, including but not limited to service of their full notice period and/or material reductions in their time commitment to the role, without the board first having completed and approved a full risk assessment.	The Trust is compliant with this requirement

NHS Foundation Trust Code of Governance Requirement and Reference		Commentary
C.3.3	The council should take the lead in agreeing with the audit committee the criteria for appointing, re-appointing and removing external auditors.	The Trust is compliant with this requirement. An Audit Appointments Committee exists for this purpose
C.3.7	When the council ends an external auditor's appointment in disputed circumstances, the chairperson should write to NHSI informing it of the reasons behind the decision.	The Trust is compliant with this requirement
C.3.8	The audit committee should review arrangements that allow staff of the NHS foundation trust and other individuals where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters.	The Trust is compliant with this requirement
D.1.1	Any performance-related elements of the remuneration of executive directors should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels.	The Trust is compliant with this requirement. This falls within the Terms of Reference of the Board's Remuneration Committee
D.1.2	Levels of remuneration for the chairperson and other non-executive directors should reflect the time commitment and responsibilities of their roles.	The Trust is compliant with this requirement. This is reviewed by the Governors' Nominations Committee
D.1.4	The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination.	The Trust is compliant with this requirement. This falls within the Terms of Reference of the Board's Remuneration Committee
D.2.2	The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments.	The Trust is compliant with this requirement. This falls within the Terms of Reference of the Board's Remuneration Committee
D.2.3	The council should consult external professional advisers to market-test the remuneration levels of the chairperson and other non-executives at least once every three years and when they intend to make a material change to the remuneration of a non-executive.	The Trust is compliant with this requirement. This is reviewed by the Governors' Nominations Committee
E.1.3	The chairperson should ensure that the views of governors and members are communicated to the board as a whole.	The Trust is compliant with this requirement. At the invitation of the Chair the Head Governor attends public and private meetings of the Board. The Board meets with the Council of Governors on a regular basis.
E.2.1	The board should be clear as to the specific third party bodies in relation to which the NHS foundation trust has a duty to co-operate.	The Trust is compliant with this requirement

NHS Foundation Trust Code of Governance Requirement and Reference		Commentary
E.2.2	The board should ensure that effective mechanisms are in place to co-operate with relevant third party bodies and that collaborative and productive relationships are maintained with relevant stakeholders at appropriate levels of seniority in each.	The Trust is compliant with this requirement

Annex J – Notice of the Trust's Annual Members' and Public Meeting 2018

The Annual Members' and Public Meeting of the University Hospitals of Morecambe Bay NHS Foundation Trust will be held at 10.30am on Tuesday 18 September 2018.

Further information can be obtained by writing to:

Paul Jones
Company Secretary
University Hospitals of Morecambe Bay NHS Foundation Trust
Trust Headquarters
Westmorland General Hospital
Burton Road
Kendal
LA9 7RG

Alternatively further information can be obtained from our website www.uhmb.nhs.uk

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