University Hospitals of Morecambe Bay NHS Foundation Trust

Annual Report and Accounts 2018-19

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Chairman's and Chief Executive's Welcome

Our first year

We are both honoured and privileged to have been appointed to our roles as the Chairman and the Chief Executive of the Trust. 2018/19 is the first year that we have been in our respective roles at the Trust and what a year it has been! A year of incredible contrasts.

This first year coincided with the NHS's 70th birthday and the celebrations, and indeed, the respect and love people showed for our NHS across Morecambe Bay and the country really inspired us and proved – if we ever had a doubt – that our services are held in the highest regard locally.

It has been a year in which we have seen the Trust grow – with the addition of more than 800 community staff from both south Cumbria and north Lancashire, who joined our hospital colleagues, reinforcing our vision of joined up services across Morecambe Bay. It has been a year which has seen £19 million invested in transforming our facilities – and providing some truly world-class new areas for our colleagues to work in. And it has been a year when we finalised our refreshed Trust strategy – which was approved in January 2019 and which we are now beginning to share and communicate.

We are naturally disappointed, however, that following a series of inspections carried out in 2018; the Care Quality Commission has rated the Trust as "Requires Improvement" after having been previously rated as "Good" under the previous inspection regime in 2016. That said we welcome the report and, in particular, the view of the CQC that colleagues across the Bay continue to provide caring and effective services to our patients despite significant pressures.

In this Annual Report we will reflect on the past year – and we have grouped our activities on our Trust values – or the five "P"s of performance, progress, people, partnerships and patients – which are the themes used within our strategy.

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 continues to be 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, and 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 to achieve sustainability 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 and develop our services so they are sustainable now and into the future. For 2019/20 the Trust has agreed its Control Target with NHS Improvement and NHS England. If the Trust meets its financial plan for 2019/20 the Trust will receive sustainability recovery funding that will improve the overall financial position. To achieve the plan the Trust will look at cost improvements and how it can improve its productivity and efficiency using model hospital data.

Despite the pressures we have been facing, our staff have worked exceptionally hard to make savings in their services. Our approach has been one of establishing ourselves as a Great Place to Work and a Great Place to be Cared For, and we will continue to use that as the yardstick that our performance can be measured by.

Some of the areas outlined in the following pages show that 2018/19 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 admirably, 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, is that 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 you all.

2019/20 will be a year when we really begin to see us re-energising our shared vision of Bay Health and Care Partners working together.

Progress

Our work under the progress banner has seen us make a number of strides – particularly in the digital world. We were really pleased to be given a platform on the national stage at the end of 2018 to travel to London to present some of our digital advances to the Academy of Fab NHS Stuff https://fabnhsstuff.net.

We were able to showcase some of the technology which allows us to examine trends in referrals, provide real time data to our clinicians, and also save time and wastage on our wards by utilising technology for meal ordering, saving paper and ensuring that patients get the meal they want.

We've also made progress in establishing our Integrated Care Communities across Morecambe Bay. There are nine of these – grouped around GP Practices looking at care locally for our residents and establishing links within these communities to make care smooth for the people who live in that area.

As well as those:

- Our Advice and Guidance service has seen nearly 10,000 'conversations' take place between GPs and hospital specialists; with 71% of cases resulting in having their treatment changed by their GP;
- Our integrated musculoskeletal (iMSK) programme has hosted 3,692 appointments since they started at specialist clinics in Grange-over-Sands, Millom, Kendal and Barrow, in addition to pre-existing clinics in Morecambe, Heysham and Lancaster;
- Since September 2016, an impressive 9,300 appointments have been delivered by optometrists in the community instead of in the hospital, covering a variety of conditions and services. This has not only reduced travel and associated costs for patients and has meant they have been seen quicker; it has also freed up hospital appointments for people with more complex conditions that can only be managed in a hospital – meaning staff can intervene earlier to address any worsening of conditions; and
- The 'Patient Initiated Follow-Up Service' (PIFU) has seen 1,534 patients under different specialities receive a phone number if their condition worsens, rather than having regular follow-up appointments. This means they get access to specialist advice when they need it, rather than waiting for a regular appointment, releasing clinical teams to see new and more complex patients in a timely manner.

We also held new sessions for stakeholders and the public in February to reconfirm our commitment to Better Care Together – and begin the next stage of our journey.

And it would be remiss of us not to mention that our technology was cited by the national Chief Medical Officer as an example of how technology can support patient care and was something other Trusts should aspire to.

People

People are the lifeblood of our services – we touch so many lives each year with the services we operate – and whatever service is it, whatever developments we make – there is a person at the end of it – making the improvements and receiving the benefits.

Our NHS Staff Survey results were also published in March and a number of areas of staff experience at the Trust continue to improve year on year, according to the results.

Feedback from staff showed big improvements in a number of areas, when compared to the previous year's results, including:

- Staff feeling satisfied with the extent the organisation values their work;
- Staff with a disability feeling the organisation made reasonable adjustments to enable them to carry out their work;
- Staff feeling satisfied with recognition for good work; and
- Staff feeling communication between senior management and staff is effective.

Of the 10 themed areas of the survey, the Trust scored above average in 7 including:

- Employee health and wellbeing;
- Immediate Managers;
- Morale;
- Quality of Appraisals;
- Safety Culture; and
- Staff Engagement.

The one theme below average relates to colleagues experiencing bullying and harassment at work. We have an ambition to eradicate bullying and harassment across our organisation, with a Chief Executive led Working Party, including colleagues represented from our Governors, staff side organisations, staff inclusion networks and Care Groups working jointly together to address this priority area for action.

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

Our staff's mental health is as important as their physical health and we continued to invest in Headspace – a gymnasium for your mind. The Headspace application has helped to encourage 250 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.

We also launched our Flourish mile – a mile-long route around each of our hospitals for staff to walk or run and exercise.

This culminated in December when we were awarded Gold from the Better Health at Work Awards. Its testament to the hard work which has gone into promoting staff health that the judges said that our Trust had: "demonstrated their commitment to both the award and health and wellbeing in general by embracing the 'asks' and consistently working to a very high standard."

During the year our Listening into Action (LiA) and Improvement programme has trained 56 Quality, Service and Improvement Redesign (QSIR) Practitioners from across the Trust Bay Health and Care Partners. QSIR is an improvement approach developed by NHS Improvement and delivered over 5 days. Each Practitioner will have training in Improvement tools and techniques to take back to their Care Groups.

A total of 26 groups of staff have also been involved in the LiA improvement programme and some of the highlights include:

- Achieving 100% accuracy in nutritional information given to women during pregnancy;
- Improving knowledge, awareness and clinical interventions for time critical emergency procedures in theatre ensuring life threatening emergency situations that are rare but probable are managed as well as everyday occurrences; and
- Ensuring that all patients with dysphagia following a stroke on the Huggett Suite and ward 23 at the Royal Lancaster Infirmary receive the correct consistency diet and fluids.

In November 2018, we were also named as the seventh most inclusive employer in the UK in the Inclusive Top 50 UK Employers List – which was both a great honour and an achievement – and an improvement of one place since the previous list. 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 continue to be of vital importance to the Trust Board and our staff. This year, we have backed this up with the continuation of our 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.

To protect our staff and patients, we promoted the national flu vaccination and ended the year having protected 84% of our frontline staff (and 82% of all staff) – one of the highest levels achieved in the country and reached the national target earlier than ever before. 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, corporate teams 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:

Won over 17 awards including:

- The Overall Winner Award Personnel today and one for Employee Engagement;
- Ranked 7th in the Inclusive Top 50 Employers;
- Cavell Stars Awards for various staff in the Trust;
- HPMA North West Awards for the cultural transformation at Morecambe Bay;
- Academy of Fab Stuff - The Hartly Larkin Award for the Acute Surgical Unit, Royal Lancaster Infirmary;
- Allocate Awards 2018 - Impacting clinical and performance targets; and
- Health Business Awards for Estates and Facilities Porter Allocation System.

Shortlisted for over 15 awards in 23 categories including:

- Burdett Trust;
- HPMA Awards;
- 2 Health Service Journal value awards;
- Public Sector Paperless Awards 2018;
- RCNi Nurse Awards;
- Employers Network for Equality and Inclusion;
- 2 Personnel Today;
- 2 Nursing Times Awards;
- 3 nominations NHS70 Parliamentary Awards;
- 3 RCM Awards;
- 2 Health Business Awards; and
- 2 Academy of Fab Stuff.

We also saw a rise in the number of awards the Trust applied for – and we either won or were shortlisted for around two thirds of those – a fantastic achievement.

And in the 70th birthday celebrations we held barbecues and tea parties for our staff to ensure as many as possible were able to join in the celebrations.

It is fair to say that it is the people that make our Trust what it is – and we are immensely proud of all our teams across the Bay.

Partnership

As we have mentioned, engagement with people and partners has been a feature of the work of the Trust for some time now.

Last year we continued to work as one of the Bay Health and Care Partners (BHACP) to continue our efforts to ensure our public see one service – which flows seamlessly.

As we have already mentioned – as part of our efforts we saw over 800 staff working predominantly in community services in north Lancashire and south Cumbria join the Trust.

Our aim is to create a service which supports people to be cared for at home as long as they can be safely, and only get them to visit hospital when they absolutely have to, and the move to creating one service across Morecambe Bay is a step in that direction.

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

- Our innovative Advice and Guidance scheme means GPs have had almost 10,000 'electronic' conversations about patients with hospital specialists, resulting in more than 71% having their care plans changed;
- Thousands of 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; and
- We have honed our Integrated Care Communities (ICCs) into nine across our area which continue to grow from strength to strength. For example 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.

Patients

As we have already outlined - during the year, we have seen hundreds of thousands of people come through our doors from across Morecambe Bay and beyond. People came to us either as an emergency – to our Emergency Departments or to our Urgent Treatment Centre at Westmorland General Hospital, they may have been booked in directly, we may have seen them at a first outpatient appointment, for a review outpatient appointment, or they may have been admitted for an operation or procedure.

Over the course of the year we know that our dedicated staff touch so very many lives across Morecambe Bay, and we continue to strive to provide the very best care we can to each of them.

The safety of our patients, and the quality of the service they receive, continues to be our prime motivation, and as we have outlined elsewhere, we need to ensure that our finances are sound so we can continue to invest in the quality and safe care for the years and decades to come.

The Long Term Plan for the NHS, published in January, gives us some stability and a direction of travel that is not very different from our own aspirations. We will continue to talk to you as we develop our plans, and pursue our goal of providing an NHS and care service local people continue to be proud of.

We have begun to create an assembly of local people to help give a patient voice on any issues we wrestle with – and help inform decisions on the future developments we undertake – meaning the patient truly has a voice over Morecambe Bay.

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

It would be remiss of us not to mention our fabulous volunteers – without whom so many patients would receive a much poorer service. They are included when we say our staff are true heroes of healthcare across the Bay.

Ian Johnson
Chairman

Date: 24 May 2019

Aaron Cummins
Chief Executive

Date: 24 May 2019

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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 attendances increased by more than 6% and more than 15% 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 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 the achievements in 2018/19.

Quality Improvement Metric	Progress in 2017/18	Achieved in 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

The Board of Directors approved the refreshed Quality Improvement Strategy for 2019-22 at its meeting in March 2019. The table below sets out the priorities of our Quality Improvement Strategy for 2019-22:

Quality Improvement Metric	Target for 2019/20
Mortality	• To maintain mortality scores consistently in the 'statistically as expected' range, or better, for the HSMR ratio with an average score 5-10% better than the national average; • To maintain scores consistently in the 'statistically as expected' range, or better, for the SHMI index with an average score 5-10% better than the national average; and • To reduce the HSMR for stroke by 10% based on 2018-19 baseline.
Proportion of patients receiving harm-free care	98%
Coverage of mortality reviews	100%

Further details can be found in the Trust's Quality Improvement Strategy:

https://www.uhmb.nhs.uk/about-us/key-publications

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. On 1 October 2018 adult community services in North Lancashire transferred 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, Urgent Care Treatment Centre and a wide range of outpatient services. It is also home to 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.

In February 2017 the CQC assessed the Trust as good overall and outstanding for care.

A CQC Unannounced Core Service Inspection of the Trust took place mid November 2018. This was followed by a Use of Resources Assessment late November 2018. This was led by NHS Improvement and consisted of a day of interviews with members of the Board and senior operational teams. There was an announced CQC 'Well-led' inspection in December 2018. The final CQC Quality Report was published in May 2019 and rated the Trust as Requires Improvement overall. The overall rating for Royal Lancaster Infirmary also fell to Requires Improvement, whilst Furness General Hospital and Westmorland General Hospital remained rated as Good overall.

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. The Board of Directors approved the Bay Health and Care Partners' five year financial recovery plan at their meeting in October 2018, which will address the enforcement notice. The plan would continue to be refreshed in light of the NHS 10 year plan, winter, 2019/20 planning guidelines and the Trust's overall system 2018/19 financial out-turn.

The Board of Directors is not complacent and there are still significant challenges facing not only the Trust but the wider health economy. Through Lancashire and South Cumbria Integrated Care System 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

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.

Healthier Lancashire & South Cumbria

At a regional level we are part of the Lancashire and South Cumbria Integrated Care System (ICS). This is known as Healthier Lancashire and South Cumbria https://www.healthierlsc.co.uk/

Healthier Lancashire and South Cumbria is a partnership of organisations working together to improve services and help the 1.7 million people in Lancashire and South Cumbria live longer, healthier lives.

The Lancashire and South Cumbria ICS 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 the Lancashire and South Cumbria ICS and 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.

Our vision for Lancashire and South Cumbria is that communities will be healthy and local people will have the best start in life, so they can live and age well.

At the heart of this are the following ambitions:

- We will have healthy communities;
- We will have high quality and efficient services; and
- We will have a health and care service that works for everyone, including our staff.

The following illustration shows the added value of the ICS:

The priorities for the ICS are as follows:

- Maximise the benefits of our work in neighbourhoods;
- Deliver an integrated health and social care workforce for the future with the capacity and capability; to provide sustainable care and support to our local communities;
- Strengthen the resilience and mental health of people and communities;
- Establish a group model for all hospital services in Lancashire and South Cumbria;
- Reinvigorate strategic partnerships across the public sector;
- Establish a public sector enterprise and innovation alliance with our ICS partners, including academic partners and Local Enterprise Partnerships to deliver inward investment and support job creation;
- Bring the entire health and social care system back into financial balance; and
- Consolidate commissioning so that our arrangements for planning and prioritising our resources improve our population's health and the outcomes of health and social care.

The following infographic illustrates that the intent of the ICS to:

- Support our communities and our staff;
- Strengthen partnerships/relationships to improve care and promote innovation; and
- Plan to improve our population's health and our use of resources.

The next steps are to agree a strategic document which will be developed as part of the ICS response to the NHS Long Term Plan (published in January 2019).

Bay Health and Care Partners

Bay Health & Care Partners delivering | bettercare together

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 accessed via http://www.bettercaretogether.co.uk

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 which can be accessed via https://www.england.nhs.uk/publication/next-steps-on-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. As a system leader within Bay Health and Care Partners, we remain committed to delivering the "Better Care Together Strategy" (2014). This vision for the future is built on well-articulated aims, strong clinical and care professional leadership and new governance arrangements to support the emerging Integrated Care Partnership (ICP) with a commitment to stronger, faster delivery of better patient outcomes, addressing inequalities, financial sustainability, and delivering the NHS Constitutional standards.

Journey so Far

2012	Better Care Together (BCT) review of health services across Morecambe Bay began.

2014	BCT Strategy: a clinically-led view of delivery of safe services setting out integration of services across primary, community, mental health, social and secondary care via Integrated Care Communities (ICCs). Co-production of care with patients and communities focussing on self-management, care planning and health improvement. Smaller and safer hospitals providing core essential services.
	NHS Five Year Forward View published. BCT one of 50 Vanguard sites. Vanguard status awarded for 3 years achieved. This enabled development of a new care model.
	May 2014: 12 ICC's across South Cumbria and North Lancashire formed with health and social Care professionals, GP's voluntary sector and the community working as one team in each ICC to improve health and well-being of local population including the growing elderly population with increasingly complex health needs.

2016	February 2016: Trust released from Special Measures.
	April 2016: Accountable Care System (ACS) Memorandum of Understanding signed: 11 Bay partners (Bay Health and Care Partners) supported a framework to describe the system changes necessary including both provision and commissioning to develop an ACS.
	June 2016: Bay Health and Care Partners (BHACP) launched to support integration of services across the Bay: Shadow governance arrangements commenced based on the BCT model to support a programme of integrating services, governance framework and leadership, building a "common platform".

2017	January 2017: BHACP affirm development of ACS based on agreed principles: • Introducing critical milestones and stepped changes to ensure progress is made at scale across BHACP; • Defining partnership, governance and accountability arrangements to allow delivery of system-wide changes; • Reviewing leadership roles and responsibilities of the BHACP model, acknowledging the need to address sustainability; and • Greater emphasis on the impact BHACP has on integrated services and front-line delivery, ensuring development of ICCs.
	February 2017: Trust rated "outstanding" for caring and "good overall".
	April 2017: Single Bay Commissioner formed.
	August 2017: Creation of pathway and structures: Create defined portfolio of community services across the Bay to support integration of adult, physical health community services.

2018	April 2018: Integration of South Lakes Community Services. Garstang ICC transferred to Fylde and Wyre Clinical Commissioning Group on 1 April 2018. 11 ICCs operating within Morecambe Bay
	Established Programme Management Office for BHACP programme and work streams: BHACP agreed priorities for 2018/19.
	September 2018: Diabetes services from South Cumbria integrate with diabetes service at the Trust.
	October 2018: Integration of North Lancashire Community Service. Children's community services from North Lancashire integrate with children's services at the Trust.

The table on the previous page clearly articulates the progress which has been made since 2014 in the delivery of the BCT Strategy. 2018/19 has seen a number of changes in system leadership and the development and implementation of new ICP leadership and governance arrangements; these build on a strong foundation of managing significant change from the establishment of Morecambe Bay Clinical Commissioning Group to the successful transfer of community services into the Integrated Care Communities (ICCs) hosted by the Trust. Creating a new way of working continues to be central to this strategy through investing in our people, clinical leadership, ICCs infrastructure, cultural and organisational development and programme support.

Through the clinical and care professional leaders there is continued focus to place significant emphasis on improving efficiency and productivity through care pathway redesign. At a time of nationally recorded increased activity trends in hospital admissions and emergency department attendances, the national New Care Models Team review of all the Vanguard sites highlighted that Morecambe Bay was:

- Best performing Vanguard site for emergency admissions trends, with a 7% reduction since 2015/16 baseline;
- Second best performing site for non-elective bed days at around 4% reduction in real terms since 2015/16; and
- One of the few areas to focus on children services: the system wide pathway change work has seen a reduction in bed days associated with children inpatient admissions, reduced inpatient admissions and the need for hospital outpatient follow ups.

Whilst some notable progress has been made in 2018/19, the envisaged pace and scale of Bay Health and Care Partners' (BHACP) ambition has yet to be fully realised. Long term delivery of the vision for a care system delivering better health, better care and sustainability (including workforce, finance and performance) will require addressing three significant challenges:

- Delivering productivity and efficiency gains significantly above national benchmarks;
- Transforming and creating a new care system; and
- Significant structural and organisational reform.

As a partner in the Lancashire and South Cumbria Integrated Care System (ICS), the BHACP ICP will work closely with the ICS to maximise the efficiencies from standardised commissioning policies and application of new clinical pathways. Delivering on Right Care, Getting it Right First Time and the model hospital programme will be key short term priorities delivering significant cost efficiencies.

Transforming and creating a new care system has been at the heart of the Better Care Together Strategy. The next phase of the programme will focus on stabilising and transforming primary care and integration with our ICCs. As the ICCs mature, the pathway redesign work will compliment and accelerate the overall efficiency aims and enable the cost savings to be released at a system level. The ambition to transform out-patient services will be one of the clearest measures of our success as will creating an environment that nurtures and attracts the best staff and a care system that gains the recognition and respect of our peers.

The Better Care Together Strategy established a set of "stakes in the ground" with respect to service configurations which BHACP intend to revisit and challenge further opportunities for estates rationalisation, particularly in administrative areas. There is a commitment to working with the ICS to address fragile services and progress the reconfiguration of pathology services.

The BCT Strategy is now 5 years old and the intention is to review the strategy as our strategic approach has evolved over time and the original strategy has been broadened to place more emphasis on key elements such as integration and population health. BHACP teams want to continue to engage and involve patients and our local communities in developing and delivering our strategy and ensure it addresses the health and care challenges as they see them. A BCT strategy workshop was held in February 2019 to commence a new programme of work to refresh our strategy in line with the local and national context. The recent NHS Long Term Plan (2018) sets out the agenda for the NHS over the next 10 years. It is right that the ICP reflect on this and ensure it is integral to our local strategy and to understand what this means for the local Bay-wide strategy.

Integration of Community Services

The Trust, as a key partner within the BHACP partnership, has been instrumental in taking forward the integration of services within Morecambe Bay, by facilitating the transfer of community services – which is a key enabler to move the BCT Strategy direction for integration forward to deliver sustainable health and care services in the future.

The BCT Strategy (2014) envisaged a closer integration of health and care services currently provided by a range of providers and partners (BHACP) to Bay area residents. This integration of Community services supports the new care model which is delivered through Integrated Care Communities (ICCs) and which are expected to deliver a number of benefits, leading to improved health outcomes and more sustainable local services:

- improved patient pathways;
- population health segmentation;
- increased system multidisciplinary team working;
- better care coordination and navigation across the system;
- improved sharing of clinical information; and
- reduced per capita cost.

A wider and more comprehensive development of an integrated care programme will enable the Morecambe Bay community to support improvement in the clinical and operational performance, with the levers in place to influence demand and recruitment challenges in the right way that ensures delivery of truly mobilised communities as a partnership. Ultimately this will support our ability to address the longer-term financial sustainability challenges of the health economy.

Adult community services from South Cumbria and North Lancashire were successfully transferred from Cumbria Partnership NHS Foundation Trust and Blackpool Teaching Hospitals Foundation Trust to the organisational leadership of community services within the Bay Area as a key enabler of our system's approach to address the challenges we collectively face in Morecambe Bay. This recognises that community services work in a multi team/agency role collaborating with all care partner organisations including that of the voluntary sector which will offer a critical facilitative role for Integrated Care Communities and acute colleagues enabling care in a range of settings across the whole pathway.

Our Future Business Plans – look forward for 2019/20

The Trust's annual plan for 2019/20 was approved by the Board of Directors in March 2019. This is the first annual plan submission as an Integrated Care Provider. We have a well-established Integrated Care Partnership with Bay Health Care Partners; with a robust governance structure to support health and care system partners to think and act beyond traditional organisational boundaries in order to provide seamless care to individuals within a system-wide financial framework. Our plan includes the steps we are taking with partners to establish an outstanding integrated care system – a system which better predicts plans and delivers care to individuals in a way which ensures the future sustainability of services. We want to shift incentives and behaviours to focus on population health and in doing so, rebalance capacity in the health and care system from acute to non-acute settings.

We have recently refreshed our Trust Strategy. Further details can be found on the Trust's Strategy: https://www.uhmb.nhs.uk/about-us/our-strategy

The refreshed Trust Strategy has reaffirmed our core values; the annual plan is aligned with this Strategy:

Our Patients

Our patients will be treated with compassion, dignity and respect; patient experience is our most important measure of achievement.

Our People

Our colleagues (employees and volunteers) are the ones who make the difference; colleagues understand and share our values and this is reflected in everything they do.

Making Progress

Our progress will be improved through innovation, education, research and technology to meet the challenges of the future.

In Partnership

Our partnerships make us stronger; by investing in them, we will deliver the best possible care to our communities.

Improving Performance

Our performance drives our organisation. Providing consistently safe, high quality patient-centred care is how we define ourselves and our success.

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:

Patients – Quality Improvement

- Delivering effective reliable care – reducing unwarranted variation;
- Reducing harm;
- Simplify governance and assurance functions – external governance review;
- Making improvements to Care Quality Commission standards;
- Development of clinical leaders;
- Implementation of care bundles;
- Development of a Patient Experience Strategy; and
- Development of a Research and Innovation Strategy.

People and Organisational Development

- Development of a Colleague Experience Strategy;
- Implementation of a real-time colleague feedback tool;
- Payroll transition;
- Implementation of Talent Management approach;
- Recruitment and retention plans;
- Improving colleague health and well-being; and
- Creating positive work culture.

Performance – Financial Delivery

- Achievement of Control Total;
- Reduce unwarranted variation and reduce cost;
- Develop service line reporting;
- Submit capital bids to support improving current infrastructure and estate; and

- Budget accountability and financial governance.

Performance – Operational Delivery

- Improvement in delivery of NHS constitutional standards;
- Improvement in patient flow in particular at the Royal Lancaster Infirmary site;
- Development of a Clinical Service Strategy;
- Transformation of outpatients; and
- Implementation of an acute frailty service for at least 70 hours a week and same day emergency care services seven days a week, 12 hours a day.

Partnership

- Maintain current relationship with Morecambe Bay Clinical Commissioning Group to execute operational plan delivery;
- Maintaining key role in Bay Health and Care Partners – system leadership and transformation
- Ensure close working with the Integrated Care System to ensure:
  - Engaged in fragile service review;
  - Alignment / support in financial delivery; and
  - To influence the Integrated Care System transformation
- Continue to develop key partnership with Lancaster University;
- Recognise emerging partnership with primary care / GP providers; and
- Internally ensure engagement with governors and members.

Further details can be found in the Trust's Annual Plan www.uhmb.nhs.uk/about-us/key-publications

To deliver the priorities in the Annual Plan, the Trust has developed a robust risk management framework. The Risk Management Strategy nurtures the balance between risk taking, risk management and rewards in line with the Trust's risk appetite statement. Further information on the management of risk is given in the Annual Governance Statement. The Board of Directors has also taken an assessment of the strategic risks to the delivery of the annual plan and these are listed below:

Strategic Risks 2019/20

Failure to achieve the financial plan	
Description	If the Trust does not deliver the 2019/20 Trust financial plan and Control Total (which includes year 1 of the 5 year financial recovery plan), we will not receive the provider sustainability fund and financial recovery fund support worth £21.5 million. Access to other support and capital may be restricted potentially compromising safety, quality, and sustainability of the organisation leading to poor patient and staff experience and a negative impact on the position of the Trust.
Mitigation	• Sustainability Programme and Cost Improvement Plans are in place with support from the Programme Management Office; • Scrutiny from Finance and Performance, and Cost Control Board; • Quality and Equality Impact Assessments; • Bay Health and Care Partners' Leadership team and Partnership Board; • Integrated Care Group Business Plan with focus on activity, capacity, workforce and financials managed through executive led monthly performance meetings; • Integrated Care System wide integrated performance and financial planning and strategy development; • Agreed to Control Total for 2019/20 and as part of Integrated Care System (ICS) Control Total; and • Work has commenced on establishing the nine cross cutting programmes aimed to improve the quality of care delivered to our patients and to maximise the efficiency opportunities identified within the trust. These are outpatient flow programme; theatres and endoscopy programme; diagnostics programme; medicines and prescribing programme; effective use of our people programme; ward standardisation; service sustainability; space utilisation and procurement.

Strategic People and Organisational Development	
Description	If the Trust does not have a sufficiently motivated and engaged workforce, in sufficient numbers, appropriately trained and working in a positive work culture, this could lead to an inability to deliver safe, sustainable care and the aspiration to be a great place to be cared for, a great place to work.
Mitigation	• Colleague Experience Strategy and Plan; • Organisational Development Strategy and Plan; • Towards Inclusion Strategy and Plan; • Workforce Plan (sustainable workforce across Bay Health and Care Partners' footprint); • Recruitment and Retention Plan; • Core Skills and Essential Skills Frameworks; • Quality and Service Improvement approach; • Behavioural Standards Framework; • Colleague Health and Wellbeing Plan (Flourish); and • Oversight and challenge from the Workforce Assurance Committee.
Failure to achieve operational performance trajectories towards the NHS Constitutional Access Standards	
Description	A challenging operating environment is impacting on the Trust's ability to achieve operational performance trajectories towards the NHS Constitutional Access Standards. This could lead to compromising quality of care provided and patient safety, which could impact adversely on health outcomes for patients and their experience; and intervention from regulators.
Mitigation	Implementation of improvement schemes and methodologies to improve patient flow through urgent and emergency care pathways and elective care pathways. This will include oversight of delivery of a consolidated urgent care improvement plan through the A&E Delivery Board and Finance and Performance Assurance Committee and oversight of delivery of an elective care improvement plan through the Elective Care Board and the Finance and Performance Assurance Committee.
Inadequate capital funding to enable priority schemes including maintenance of the physical condition of the Trust's estate, infrastructure and medical equipment	
Description	If the Trust does not gain access to the required level of capital funding, the Trust will not be able to address the inherent defects in the Trust's infrastructure including the deterioration in the fabric of the Trusts ageing estate, nor the estates developments required to improve clinical adjacencies and efficiencies, nor ensure availability of the required medical equipment to meet service demand aged beyond its planned life. This will lead to an adverse effect on service continuity, productivity and patient and staff experience.
Mitigation	• Improved capital planning process to identify priorities consistent with service, finance, workforce and estate planning; • Development of a long term estates strategy that is consistent with the Integrated Care Partnership and Integrated Care System estates strategy; • Continued representation to NHS England, NHS Improvement and the Integrated Care System to secure the required capital funding; and • Scrutiny from Finance and Performance, and Capital Plan Group.
Building and Maintaining Strong Partnerships	
Description	If the Integrated Care Partnership and the Integrated Care System do not operate effectively in a collaborative, joined-up way, the Trust may not be able to deliver the overall system triple aim of better care, better health, delivered sustainably.
Mitigation	• Bay Health and Care Partners' (BHACP) Delivery Plan; • BHACP Strategic Financial Recovery Plan; • BHACP Leadership Team Development; • BHACP Assurance and Governance Framework; • BHACP representation on ICS decision-making bodies; • Trust and Primary Care Interface Programme; and • Scrutiny and challenge from BHACP Partnership Board.

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 Trust has adequate resources to continue in operational existence for the foreseeable future.

The Trust is forecasting a planned deficit for 2019/20 before impairments of £38.6 million which is after a cost improvement programme of £22 million and access to Provider Sustainability funding and Financial Recovery funding amounting to £21.5 million. However, the overall Financial Plan includes a cash flow forecast for the coming twelve months which 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 2019/20 which represents a significant percentage of total budgeted income. The financial plan for 2019/20 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 and also relies on additional capital from the Department of Health and Social Care.

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

Aaron Cummins
Chief Executive

Date: 24 May 2019

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
- Social Value

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.

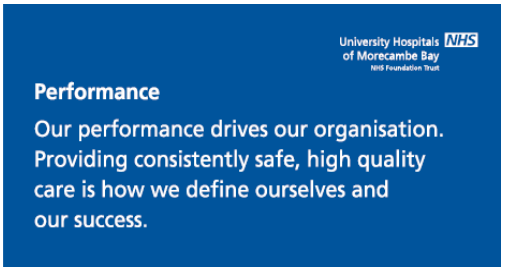
Data quality and data security risks are managed by the Informatics, Information and Innovation (I^3) Steering Group and Risk Management Forum with information generated through the risk management system. A Data Quality Group has been established to set; steer and performance manage the implementation 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.



2018/19 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 improved profile and improved performance of cancer services, the impact of both theatre and major diagnostic equipment failure, increased trauma and the transfer of community services from Cumbria Partnership NHS Foundation Trust and the Blackpool Teaching Hospitals NHS Foundation Trust.

The Trust did not achieve Cancer 62 Day Standard in Quarters 1 to 4 2018/19. The Cancer 31 Day standard was met for all four quarters for drug treatment and for Quarters 2 to 4 for surgery. Cancer 14 Day Standard was achieved in Quarters 3 and 4. In Quarter 4, all cancer standards were met except Cancer 62 Day from urgent GP referral and from a screening programme. 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 2018/19.

The Diagnostic 6 week standard, where less than 1% of patients should wait greater than 6 weeks for a diagnostic test, was achieved in February 2019 only. The key cause of delay has been the multiple breakdown of MRI, CT and DEXA scanners which poses a delay to patient care and a risk to the achievement of the standard into 2019/20, unless the scanners are replaced.

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.

Tables 3 to 8 give the detailed assessment of performance against the healthcare standards including national and locally agreed targets.

Table 1: Performance against Quality Standards and Indicators - Quarterly Key Performance Indicators

	2016/17				2017/18				2018/19			
Standard	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
A&E: maximum waiting time of four hours from arrival to admission/ transfer/ discharge	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet
All cancers: 31-day wait for second or subsequent treatment - surgery	Met	Met	Met	Met	Met	Met	Met	Met	Failed to Meet	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	Failed to Meet	Met	Failed to Meet	Failed to Meet	Met	Met	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet
All cancers: 62-day wait for first treatment from NHS Cancer Screening Service referral	Met	Met	Met	Met	Failed to Meet	Met	Met	Failed to Meet	Failed to Meet	Failed to Meet	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	Met	Met	Met	Met	Met	Met	Met	Met	Failed to Meet	Failed to Meet	Met	Met
Data Source: Unify Data												

Table 2: 2018/19 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	85.09%	85.65%	85.09%	84.00%	82.07%	82.28%	82.43%	83.42%	83.02%	82.57%	**82.85%**	**82.67%**
Diagnostic waits over 6 weeks	2.35%	1.79%	6.18%	6.21%	6.82%	1.82%	1.08%	2.64%	2.14%	1.84%	**0.87%**	**1.21%**
Urgent Operations cancelled for the second or subsequent time	0	0	0	0	0	0	0	0	0	0	0	0
Ambulance Handover Time	19	17.2	18	18.1	17.7	18.5	18.9	19.6	21	26.2	23	21.9
Data Source: Unify Data												

Other Quality Indicators

Referral to Treatment (RTT) Data

The Provider Sustainability Framework for RTT was met in April and May 2018; however, the national standard of 92% has not been achieved in 2017/18. Eight out of 10 specialties within the Care Groups of Medicine and Women's and Children's are sustainably exceeding the national standard of 92%; thus, supporting the overall Trust position. However, all surgical specialties are consistently underperforming against the national standard: anaesthetics, ophthalmology, ear, nose and throat, oral surgery, general surgery, trauma and orthopaedics and urology. 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 impacted throughout 2018/19 due to:

- The ongoing impact of elective cancellations due to the continuing winter pressures into Quarter 1, with patients requiring emergency care taking priority over elective routine cases. For example in April 2018, the urgent care pressures into reduced RTT achievement by 0.31%;
- Unavailability of theatres; theatre breakdown throughout Quarters 1 to 4 has substantially reduce elective capacity and impacted upon the RTT standard; and
- The unprecedented level of orthopaedic trauma in Quarter 1 resulted in the reduction of elective orthopaedic activity.

Examples of Key actions to improve RTT performance within the Care Group of Surgery and Critical Care include:

- A mobile Vanguard theatre at Westmorland General Hospital from November 2018 for 24 weeks to replace Theatre 2 whilst remedial works to the air handling unit are undertaken. The project has been fully managed to ensure that this theatre is utilised to its maximum capacity. Without the Vanguard theatre, the reduction of 299 elective surgical cases was forecast. With the theatre an additional 201 cases will take place;
- A review of the theatre timetable and programme of increasing efficiency using national benchmarking data ('Model Hospital' and 'Getting It Right First Time'). This includes the use of

treatment rooms for more minor cases, freeing up main theatres for additional more major cases;

- Pathway development including a pilot for self-management for patients on a pain management pathway, which will optimise patient experience and outcome, reduce demand for unnecessary follow-up and procedures; and
- Additional activity sessions across multiple specialties in order to treat patients in a timely manner.

In 2017/18, a new, waiting list size standard was introduced. 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. The standard was met in March 2019. 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. The Trust is committed to ensuring that no patient waits greater than 52 weeks. In 2018/19 61 patients have waited greater than 52 weeks for first treatment against a maximum trajectory of 156.

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

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 (STF) trajectory and the national standard of 92%.

Table 3: Month on Month RTT Performance for 2017/18

RTT Performance	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Average for 17/18
RTT Incomplete Standard 92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%
STF Trajectory %	88.60 %	89.10 %	89.70 %	90.00 %	90.20 %	91.80 %	91.70 %	92.00 %	92.00 %	92.00 %	92.00 %	92.00 %	90.93 %
<18 weeks against National Standard	89.39 %	89.49 %	89.19 %	88.72 %	88.29 %	87.60 %	87.96 %	87.50 %	86.08 %	85.53 %	85.40 %	84.75 %	87.49 %
<18 weeks against STF Trajectory	89.39 %	89.49 %	89.19 %	88.72 %	88.29 %	87.60 %	87.96 %	87.50 %	86.08 %	85.53 %	85.40 %	84.75 %	87.49 %

Data Source: Unify Data

Table 4: Month on Month RTT Performance for 2018/19													
RTT Performance	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Average for 18/19
RTT Incomplete Standard 92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%
STF Trajectory %	84.67 %	84.82 %	86.12 %	86.52 %	85.78 %	85.17 %	85.51 %	85.97 %	84.48 %	85.39 %	85.12 %	86.45 %	85.50 %
<18 weeks against National Standard	85.09 %	85.65 %	85.09 %	84.00 %	82.07 %	82.28 %	82.43 %	83.42 %	83.02 %	82.57 %	82.85 %	82.67 %	83.56 %
<18 weeks against STF Trajectory	85.09 %	85.65 %	85.09 %	84.00 %	82.07 %	82.28 %	82.43 %	83.42 %	83.02 %	82.57 %	82.85 %	82.67 %	83.56 %
Data Source: Unify Data													

Accident and Emergency Department 4 hour standard for 2017/2018 and 2018/19

As shown in Table 5 below and 7 overleaf, the Trust did not achieve the 4 hour Accident and Emergency standard in 2017/18 or 2018/19.

Table 5: Trust wide Accident and Emergency Department 4 hour standard for 2017/18												
A&E Performance	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
A&E standard 95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
STF Trajectory	80.01 %	85.01 %	87.01 %	90.00 %	90.01 %	90.00 %	90.00 %	90.01 %	88.00 %	85.00 %	85.00 %	85.00 %
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 %
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 2017/18													
A&E Performance	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Average for 17/18
A&E Standard 95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
RLI	84.05 %	83.04 %	87.70 %	80.76 %	83.10 %	87.35 %	87.19 %	81.36 %	79.79 %	75.06 %	75.63 %	69.07 %	81.18 %
FGH	81.03 %	82.75 %	84.83 %	83.49 %	87.23 %	87.75 %	90.64 %	93.13 %	83.73 %	76.26 %	83.98 %	77.13 %	84.33 %
Average RLI and FGH (Type 1)	82.54 %	82.90 %	86.27 %	82.13 %	85.17 %	87.55 %	88.92 %	87.25 %	81.76 %	75.66 %	79.81 %	73.10 %	82.75 %
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 7 below, the Trust has failed to meet the 95% 4 hour Accident and Emergency Standard in 2017/18, but met the Provider Sustainability Fund trajectory from April to June in both 2017 and 2018, and also in October 2018.

Table 7: Trust wide Accident and Emergency Department 4 hour standard for 2018/19												
A&E Performance	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
A&E standard 95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
PSF Trajectory	80.01 %	85.01 %	87.01 %	90.00 %	90.01 %	90.00 %	90.00 %	90.01 %	88.00 %	85.00 %	85.00 %	85.00 %
Trust 95% performance	85.26 %	90.64 %	90.03 %	87.21 %	86.94 %	85.88 %	84.86 %	86.08 %	82.42 %	78.48 %	79.81 %	81.05 %
>4 hours	85.26 %	90.64 %	90.03 %	87.21 %	86.94 %	85.88 %	84.86 %	86.08 %	82.42 %	78.48 %	79.81 %	81.05 %
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 2018/19													
A&E Performance	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Average for 18/19
A&E Standard 95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
RLI	80.56 %	87.44 %	86.01 %	83.92 %	81.46 %	77.50 %	79.22 %	82.13 %	72.00 %	68.12 %	71.71 %	71.87 %	80.56 %
FGH	83.17 %	91.85 %	90.79 %	84.76 %	88.76 %	89.39 %	89.01 %	87.48 %	92.33 %	84.66 %	81.74 %	85.99 %	83.17 %
Average RLI and FGH (Type 1)	81.87 %	89.65 %	88.40 %	84.34 %	85.11 %	83.45 %	84.12 %	84.81 %	82.17 %	76.39 %	76.72 %	78.93 %	84.03 %
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:

- Staffing levels on wards resulting in beds closed;
- Ability to recruit registered nurses and maximise beds;
- Patients who are not in the optimal place but remains in an acute hospital bed;
- High numbers of patients requiring an in-patient mental health bed attending ED;
- 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%, this has continued in 2018/19. A number of actions have been implemented throughout the year to improve patient flow, including:

- The introduction of Discharge to Assess where patients are transferred from the acute hospital at the point where they no longer require acute hospital care through one of three pathways: either at home and may require further care and/or therapy (pathway 1 - Home First); in a community intermediate care bed with rehabilitation (pathway 2); or in a care home to enable a period of recovery and completion of longer term care assessments (pathway 3). With these pathways, health and/or social care assessments are completed outside of the acute hospital environment. The expected outcomes from this work include shorter lengths of stay, improved overall patient experience through patients having their care needs assessed in a more appropriate setting and reduced use of beds; and
- Other targeted actions, included in the comprehensive plan include the development of a Control Room to manage patient flow, a series of actions within the A&E departments including the safety checklist, second triage scheme at FGH and capacity and demand analysis in relation to staffing shifts.

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.

The Trust has seen a significant and sustained reduction in the number of falls resulting in patient harm during the past few years. The baseline rate for inpatient falls resulting in any harm outcome for 2016/17 was 156 and for 2017/18 it was 93. During 2018/19, the number is 77.

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 2018/19 cases of *Clostridium difficile* infection has been set at 43 cases. Between April 2018 and March 2019, there have been 28 cases of hospital onset *Clostridium difficile* infection; significantly lower than our nationally set annual trajectory. 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 2018/19 have recorded a deficit of £69.5 million (adjusted to £69.3 million after permissible technical accounting adjustments). This is after delivering a cost improvement programme of £14.6 million and accounting for impairments of £7.1 million.

For 2019/20 the Trust is forecasting a planned deficit before impairments of £38.6 million which is after a cost improvement programme of £22 million. The Trust has agreed a Control Total with NHS Improvement which will, providing the required targets are met, allow the Trust access to receipt of monies from the Provider Sustainability Fund and the Financial Recovery Fund amounting to £21.5 million. After delivery of the cost improvement programme and receipt of these additional funds the Trust aims to achieve a deficit of no more than £38.6 million by the end of 2019/20. However, the overall financial plan includes a cash flow forecast for the coming twelve months which 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 2019/20 which represents a significant percentage of total budgeted income. The financial plan for 2019/20 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 and also relies on additional capital from the Department of Health and Social Care to address urgent estate issues. Significant time and resources have also been invested across the Morecambe Bay area to achieve digitisation of our patient records and other technological advances which contribute to providing high quality care at any point of contact with the services provided, both within and outside of the hospital setting.

The Trust has total revenue loans outstanding of £210.1 million at 31 March 2019. This includes loans of £54.4 million which are recognised as due for repayment in 2019/20 and discussions are ongoing with the regulators concerning extension of the loan terms. Although this has not yet been agreed it is anticipated that the sums will not require to be repaid during 2019/20. 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 report on our financial performance is given in our Accounts for the Period 1 April 2018 to 31 March 2019 at Annex G.

The Trust delivered within its 2018/19 plan of £69.4 million deficit, reporting a deficit of £69.3m. This would not have been possible without rigorous and ongoing review of income and expenditure, activity, capacity and workforce predictions. The Trust has a completely outdated and failing estate which resulted in unpredictable closures and diagnostic equipment failure, the financial consequences of which (income and cost: revenue and capital, cash) have had to be dealt with in year. This we have done diligently and still managed to hit the year-end target. These failures contributed to an in year overspend, but the Trust mitigated the impact of this through strategic and operational financial stewardship. Our Board, Assurance Committees, Cost Control Board and monthly meetings with the Director of Finance and Chief Operating Officer demonstrate how we have both managed our immediate challenges and maintained a focus on the future.

The Trust played an integral part in the development of the Bay-wide Sustainability and Financial Recovery Plan which clearly illustrates the detailed, integrated approach we have for financial planning. This immensely complex and detailed plan is driven by activity, capacity, workforce and illustrates the action being taken to reduce our deficit by over 50% over five years, whilst also meeting the demands of an ageing workforce and local demographic changes.

The Trust has significant estates challenges, linked to ageing estate and lack of available funding over a number of years which result in major operational, reputational and financial challenges. Despite outlining our case for investment and the real, adverse effect our estate has on continuity, productivity, patient experience and money, we have none the less maintained operational performance. The Trust will continue to prioritise its capital resources to ensure high levels of patient care. In 2019/20 The Trust will be submitting an Emergency Capital Bid to NHS Improvement and NHS England.

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.

2018/19 was the final year of our six year I^3 strategy and efforts have been split delivering against its eight themes, noted below, and collaborating with digital leader colleagues across Lancashire and South Cumbria on a new single I^3 strategy for Bay Health and Care Partners, built around five major themes:

- Empower the Person;
- Support the Frontline;
- Integrating Services;
- Manage the System more effectively; and
- Create the Future.

Delivering a unified Informatics, Information and Innovation Department

A single unified department has been established for a number of years. This year we expanded the team with additional analysts and application support staff to meet the needs of the circa 800 community services staff who joined the Trust.

Developing a single Electronic Patient Record (EPR) for the Trust

The EPR Optimisation Programme completed in the summer and the I^3 governance model was recast with a shift from a 'push' of functionality to one of 'pull', with the direction of priorities for future EPR development work set by the divisional care groups. Consequently projects in 2018/19 have included electronic prescribing for the emergency departments, intensive care units and electronic requesting of diagnostic tests in outpatients which is on schedule to complete early next year. To support maternity's digital journey, we developed this year an app for pregnant ladies to view their maternity record. The app was successfully piloted and a wider implementation is underway.

Business Intelligence

The Business Intelligence team continue to develop operational, quality and safety dashboards to Care Group and corporate team specifications and are collaborating with the performance team on a standard set of performance metrics intended to be integrated into day to day performance management. In December 2018 the hospital launched a digital command centre with the aim to support patient flow into and out of the hospital. The project which has received international recognition is an important step towards 'real time' bed management reducing the time patients wait to be admitted and discharged from hospital.

A new I^3 Governance Structure

A new I^3 governance model was established with a new Digital Strategy Board to replace and combine the responsibilities of the Electronic Patient Record Delivery Board and Electronic Patient Record Clinical Design Authority, for the purposes of consulting, steering and governing the information management and technology agenda, with particular focus in the following three areas;

- Ensuring the EPR system is fully functioning and safe for all users (in and out of hospital);
- Determining and delivering the agreed priorities for integrated health and social care technologies, particularly the hospital and GP interface; and
- Determining and delivering the agreed priorities for self-care, including patient navigations and home monitoring.

The group represents the executives, senior clinicians and managers from the Trust with direct input from Morecambe Bay and Primary Care.

eHospital

The I^3 team welcome, from every member of staff in the Trust, new ideas for digital innovations and solutions which might deliver business and clinical efficiencies. During 2018/19 we completed the implementation of an electronic meal ordering system, which has improved the patient and nurse experience on our wards, whilst reducing waste in the kitchens and saving thousands of pounds. The system was built on an idea which originated from a nurse colleague in Lancaster.

Developing a Projects Portfolio

The I^3 Business Support Unit (BSU) provides PRINCE2 based project management support to a range of projects managed through a project portfolio. Highlights and key risks of the project portfolio are reported through to the Trust Digital Strategy Board and Finance Committee. This year the I^3 BSU also began tracking some projects for Morecambe Bay Clinical Commissioning Group.

Interoperability

Interoperability, or in lay terms, the connecting of systems across the hospital and wider geographies to share digital content is a growth area as the volume of electronic content that is produced increases as does the potential audiences that can consume this content. This year, the team integrated into the Electronic Patient Record a patient level view of clinical documentation produced by the other care provider organisations in Lancashire.

Infrastructure

The IT team have made significant progress this year upgrading computers to the latest Windows 10 operating system and are on schedule to upgrade all 5507 computers before Windows 7 becomes unsupported in 2020.

Additional mobile equipment, including bespoke drug trolleys with integrated laptops, was deployed to every inpatient area as part of the electronic prescribing and medicines management project.

The number of users connected to the Hospital Electronic Patient Record peaks mid-week around 1350 and never drops below 100 around the clock, 7 days a week. To match availability with demand the Service Desk, who provide a single point of contact 'front door' to the I^3 service moved to a 24 hour, 7 days a week footprint earlier this year. In December 2018, the Service Desk also launched a self-service portal, improving access to the service and simultaneously freeing up the traditional telephone support service for high priority issues.

Approximately 800 community services colleagues joined the Trust this year from Cumbria Partnership NHS Foundation Trust and Blackpool Teaching Hospitals NHS Foundation Trust. All new staff were migrated successfully to the standard informatics platform provided by I^3 to Bay Health and Care Partners, allowing new staff to share an online address book, calendars, documents and systems.

Cyber Security

The I^3 Technical team have worked as an early adopter to implement the NHS Digital Advanced Threat Protection (ATP) tools. ATP monitors the Microsoft Windows operating system running on all Trust computers to identify any abnormalities or suspicious behaviour. The I^3 team can then take action to contain the issue and isolate the computer if necessary.

The I^3 team continue to monitor, assess, prioritise and address vulnerabilities, which are identified by the NHS Computer Emergency Response Team (CareCERT).

The I^3 server team have developed an assurance dashboard that shows the status of Microsoft Windows vulnerability software fixes.

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 strategies and plans that will help achieve sustainable healthcare and provide a framework for waste minimisation, the impacts of transport, energy and resource use, use of water, and environmental emissions.

We have made significant progress in becoming more environmentally-friendly by dramatically increasing recycling and energy savings across our local hospitals.

In 2018, the Trust diverted a total of 727 tonnes of general waste from landfill to Refuse Derived Fuel (RDF), a fuel produced from various types of wastes such as non-recyclable plastics.

By sending waste to RDF the Trust has saved over 412,313Kgs of carbon emissions and generated enough energy to power 132 homes in the UK all year.

Other environmental contributions from the Trust in 2018 included:

- 157.84 tonnes of card and paper recycled – the equivalent of saving 2,683 trees and 3.95M litres of water;
- 3.55 tonnes of glass recycled – preventing 81 litres of oil being used;
- 2.14 tonnes of cans recycled – the equivalent of 6,420 passenger miles in carbon emissions;
- 40 tonnes of plastic recycled - the equivalent of 3,333,333 carrier bags;
- 1,458858 kilowatt hours (kWh) saved by sending materials for recycling and recovery – enough to power 312 households for a year; and
- 892 tonnes of waste diverted from landfill – saving 2,675 cubic metres of land.

The following table details environmental performance in key areas.

Waste produced	**2014-15**		**2015-16**		**2016-17**		**2017-18**		**2018-19**	
	Tonne	*£000s*	*Tonne*	*£000s*	*Tonne*	*£000s*	*Tonne*	*£000s*	*Tonne*	*£000s*
Clinical	481	172	315	157	613	201	638	258	931	315
Landfill	349	51	566	90	427	92	86	16	260	36
Recycled	433	49	375	39	641	138	896	165	836	129
Total	1,352	378	1,580	425	1,692	431	1,620	439	2027	480
Use of utilities										
Gas, water, electricity	-	4,103	-	3,844	-	3,652	-		-	

Our use of energy is managed within a long term downward cost path. The best improvement will arise from a major energy-saving investment programme which is nearing full implementation. It will reduce annual energy costs by over £1 million after scheme completion, and reduce carbon usage by 3,800 tonnes a year. This will be achieved from the operation of two gas-fed combined heat and power units to manufacture electricity and recover generated heat, complemented by a £2.4 million investment in LED lights across all sites.

Day to day responsibility for implementing most aspects of the Sustainability Strategy and the future Sustainability Plan 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.

We are on a long term improving trend for the recycling of waste generated by the Trust, despite fluctuations in the total volume of waste produced. We are particularly pleased with progress on non-hazardous healthcare waste, improved segregation and better training for Trust staff.

Other highlights from 2018/19 include:

- The Trust built on its progress from 2017/18 and is continuing to work towards being even more eco-friendly;
- New LED lighting has already been installed in corridors, waiting areas and wards across all three hospital sites. As well as generally improving the lighting, LED lights provide lower running costs and a reduced carbon footprint; and
- Introduction of reusable coffee cups to help reduce the amount of disposable coffee cups across the sites.

We intend, during 2019/20, to develop and adopt a *Sustainability Management Plan*, which will for the first time bring together the separate threads of our sustainability actions and measure them against recognised Department of Health and Social Care criteria. It will embrace the indirect impacts that we influence through procurement and our choice of contractors and suppliers. We shall start to use and input data to the Sustainability Reporting Portal. We have also developed a Sustainable Travel Plan for use at our principal hospital in Lancaster, which will start to operate once planning permission is received from Lancaster City Council for some car park improvements. The Trust will contribute finance to support a doubling of the capacity and frequency of a park and ride bus service from the principal M6 junctions to the hospital, with the intent of changing journey-to-work patterns from the present heavy reliance on private car use. The Travel Plan will be monitored by Lancashire County Council.

Clinical Waste

The Trust is a member of the Northern Consortium from a waste management perspective; collaboratively we have engaged the services of an approved waste contractor, Healthcare Environmental Services (HES) who have been removing clinical wastes from all hospital sites.

In September 2018, we were informed that the Environment Agency (EA) had conducted a number of inspections of HES over a 12 month period and as a result of this EA had given notice to the company that action had to be taken in September and October 2018.

We were instructed by NHS England and NHS Improvement to start contingency planning to ensure continuity of services in the event of a disruption and were advised that an emergency contract would be brought into place to cover the services provided by HES, should disruption occur. A contract was awarded to Mitie Waste Management Services to remove clinical wastes from the Trust's sites in light of the ongoing EA investigation of HES.

Brexit

The Trust undertook local EU Exit readiness planning, local risk assessments and planned for wider potential impacts. There were seven areas of activity in the health and care system that the Department of Health and Social Care (DHSC) asked the Trust to focus on in the event as part of its 'no deal' exit contingency planning:

- Supply of medicines and vaccines;
- Supply of medical devices and clinical consumables;
- Supply of non-clinical consumables, goods and services;
- Workforce;
- Reciprocal healthcare;
- Research and clinical trials; and
- Data sharing, processing and access.

In preparation for a 'no deal' exit, the DHSC, with the support of NHS England and Improvement and Public Health England, set up a national Operational Response Centre. This lead on responding to any disruption to the delivery of health and care services in England caused or affected by EU Exit.

In line with national advice local planning started in October / November 2018. Workforce, pharmacy and procurement started to develop plans as directed by the Department of Health and Social Care that focused on the four critical local areas, in which there has been local planning within:

- Supply of medicines and vaccines;
- Supply of medical devices and clinical consumables;
- Supply of non-clinical consumables, goods and services; and
- Workforce.

The Trust prepared plans that considered and planned for risks that may have arisen due to a 'no-deal' Brexit. Additionally, the Trust is reviewing its business continuity planning, taking into account the national planning.

Notwithstanding the further extension of the Article 50 period we are monitoring the situation and are ready to stand up our no deal plans again if required.

Social Value

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.

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. Local people are being encouraged to take responsibility for their own health and well-being and we support people to have the right information about their health conditions. As a consequence life expectancy and the quality of life is expected to improve.

For example, the library service has developed an innovative and unique relationship with Cumbria and Lancashire library services. The library service team are working with local authority librarians to improve their knowledge and skills in identifying quality patient information resources. Events take place where the public contact our staff and we provide focussed support on their particular areas of concern such as diabetes and arthritis. In conjunction with Cumbria public libraries, our service has purchased 10 e-readers to enable inpatients to borrow public library books and magazines to improve their experience and thereby reducing the risk of infections.

The Trust is an important local employer and always looks for ways to develop its role and to work with the local community to develop pathways into employment for disadvantaged groups. We offer a range of schemes such as work experience, traineeships, voluntary worker schemes, apprenticeships and

work with the long-term unemployed. We continue to provide a comprehensive apprenticeship scheme and are committed to maintaining this.

Through our volunteer work we offer a variety of opportunities for different sectors of our community and very practical and essential support for the most vulnerable members of our community. An example of this is the Meals on Wheels service which we run. This has become a lifeline to some of Barrow's elderly and most isolated people with its volunteers delivering not only hearty meals three times a day but also providing company and support.

In 2018/19 we funded the Royal Voluntary Service to deliver 362 chair based exercises classes both in the community and in hospital, a total of 3257 patients / citizens have attended these classes – the sessions focus on tasks which help people maintain their independence in the home. These sessions also create a social environment.

In 2018/19 the North West volunteer Blood Bikes travelled approximately 42,000 miles delivering items for the Trust.

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

During 2019/20 the Trust will be looking at further opportunities to develop its stakeholder relationships and create further social value. In 2019 Lancaster University will be opening the Health Innovation Campus. Working on this with our campus partners is a key priority for the future. Amongst other things we will be supporting small to medium enterprises with the research and development of new innovative technologies and products in the health sector. By inspiring and organising collaboration, we aim to ensure patients reap the benefits of the world class research, clinical services and partnerships by developing health innovation in the Bay area.

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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 three 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 Bay Health and Care Partners.

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 People 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.

During 2018/19 one Non-Executive Director was reappointed for a further 12 months having served two terms of office. As he is Chair of the Finance Committee and the Trust's Senior Independent Director, a one year extension to his term of office was agreed by the Council of Governors in order to retain his skills and knowledge of the Trust. This also ensured a degree of continuity during a period of change in Board membership with both the Chief Executive and Chair leaving the Trust at the end of 2017/18. A new Chief Executive, formerly the Trust's Director of Finance and Deputy Chief Executive was appointed and commenced post on 1 April 2018. A new Chair was appointed and commenced post on 1 April 2018. An Interim Director of Finance was appointed between April 2018 and June 2018. He was appointed as Director of Finance with effect from 5 June 2018. The Executive Chief Nurse took on the role of Deputy Chief Executive with effect from May 2018. In December 2018, the Director of Governance announced her retirement and left the Trust in March 2019. In January 2019, the Board of Directors agreed that the Director of Governance portfolio would be aligned to the Deputy Chief Executive to provide executive oversight from 1 April 2019 supported by the Company Secretary, a newly appointed Director of Governance and two Directors of Nursing.

The Terms of Office of two Non-Executive Directors expired in 2018 and two Non-Executive Directors will see their term of office expire in 2019. The Chairman will review the knowledge and experience of new candidates with the Governors to ensure the future needs of the Trust are met during 2019/20.

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

Name	Post	Appointment Date	Term of Office	End Date
Mr Ian Johnson	Chairman	1 April 2018	3 years	31 March 2021
Mr Denis Lidstone	Non-Executive-Director	25 June 2012	4 years (+2 year extension) (+1 year extension	24 June 2019
Professor Neil Johnson	Non-Executive-Director	1 July 2016	3 years	30 June 2019
Mrs Helen Bingley	Non-Executive Director	1 September 2017	3 years	31 August 2020
Ms Elizabeth Sedgley	Non-Executive Director	4 September 2017	3 years	3 September 2020
Mr M Jassi (known as Bruce Jassi)	Non-Executive-Director	24 February 2015	3 years (+3 year extension)	23 February 2021
Mr Adrian Leather	Non-Executive Director	1 May 2018	3 years	30 April 2021
Ms Jill Stannard	Non-Executive Director	1 September 2018	3 years	31 August 2021
Ms Helen Denton	Non-Executive Director	25 June 2012	3 years (+ 3 year extension)	24 June 2018

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	9	60%
BME	2	13.33%	Female	6	40%
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.

At the start of 2018/19, the Board's Assurance Committees produced Annual Reports and reviewed their effectiveness. The new Chairman and Chief Executive have kept under review effectiveness of the Board and its structures. In 2018 Deloitte LLP were commissioned to undertake a Board Development Programme; the purpose of which was to help the Board enhance its capacity and skills to lead a complex health organisation in the current context of the NHS.

In 2019 Deloitte LLP were commissioned to undertake a governance review to focus on processes for managing risk, issues and performance, roles, responsibilities and systems for accountability and effective use of information.

Board Activity

There have been nine formal Board of Directors' meetings in 2018/19.

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

At each meeting of the Board of Directors a standing agenda item requires all Executive and Non-Executive Directors to make known any interest in relation to the agenda, and any changes to their declared interests. During 2018/19, to improve the process for declaring and publishing the Conflicts of Interest and to ensure the Trust complied with the 'Managing Conflicts of Interest in the NHS' guidance, which came into force on 1 June 2017, the Trust deployed a digital solution called MES Declare and published an up-to-date register of interests for decision-making staff, as required by the guidance.

The following interests have been declared. Ian Johnson has declared he is Chair of the Lancaster University Health Innovation Campus Board, a member of the Lancaster University Council and, Director of Pension Fund Trustee for Wood Pensions Trustee Ltd. Sue Smith has declared she is a Director of Transform Healthcare Cambodia (registered charity) and a Non-Executive Director for St. John's Hospice. Helen Bingley has declared that she is Treasurer and Trustee for Mind in Furness, Chair and Director of Aaban (a private health care provider), involved in the development of two business cases for Birmingham and Solihull Mental Health NHS Foundation Trust and involved in a Consultant Job Planning Project and Medical Staffing Review for Barts Health. Bruce Jassi has declared he is a Non-Executive Director with Jigsaw Homes Group and has shareholding with Barratt Dev, BAT, BT, Centrica, INTU, KCOM, L&G, Lloyds, Nat Grid, Pendragaon, RDS B, SSE, Std Life Aberdeen, Vodafone, Berkeley, Talk Talk. Neil Johnson has declared that he is employed by Lancaster University, a member of the Lancaster University Council and Chair of the Expert Reference Group for the General Medical Council. Adrian Leather has declared that he is CEO of Active Lancashire. Jill Stannard has declared that she is a non-remunerated Board Director for the University of Cumbria. Liz Sedgley has declared she is a self-employed accountant.

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

Ian Johnson (Chairman)
Appointed – 1 April 2018

Ian Johnson joined the Trust in April 2018. Mr Johnson has wide commercial, management and board level experience both in the UK and Internationally. His most recent role was Chairman of Blackpool Teaching Hospitals NHS Foundation Trust.

A qualified solicitor, Ian has more than 30 years' experience in the legal profession and has worked at a number or prestigious international law firms at FTSE 100 companies.

Ian is also a Member of Council at Lancaster University, Chair of the University's Health and Development Board, Vice Chair of NHS Providers North West Network and sits as a magistrate in Lancashire.

Elizabeth Sedgley (Non-Executive Director and Vice Chair)
Appointed – 4 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 UK 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 patient 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.

Helen Bingley OBE DL (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 and a Queen's Awards Assessor.

Helen was awarded an OBE in the New Year's Honours List 2019 for her voluntary service in the UK and abroad.

In January 2019 Helen was appointed as Deputy Lieutenant for Lancashire. Helen will support the Lord-Lieutenant and assist him in carrying out his role as the Queen's representative.

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

Professor Neil Johnson 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.

Adrian Leather (Non-Executive Director)
Appointed – 1 May 2018

Adrian joined the Trust in May 2018, while also working as the Chief Executive of Active Lancashire.

Adrian has developed Active Lancashire to become an innovative and transformational change organisation; developing ground breaking partnerships and programmes which contribute to health and economic outcomes using sport and active lifestyles as the tool of choice.

His recent activities include work to promote and test digital health technologies and the development of a £7 million European funding bid focused on the economic benefits of getting deprived communities active.

Adrian is committed to ensuring that charities and voluntary sector organisations have the opportunity to step up and work creatively with public services to deliver better outcomes to communities.

Denis Lidstone (Non-Executive Director and Senior Independent Director)
Re-appointed – 25 June 2018

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.

Jill Stannard (Non-Executive Director)
Appointed – 1 September 2018

After graduating from Southampton University, Jill worked for the voluntary sector with homeless people before qualifying as a social worker in 1982.

Jill worked for Hampshire Social Services for 20 years, taking a secondment to America in 1993 to study mental health services. After returning she became Area Director of the New Forest responsible for Children and Adult Social Services and then Assistant Director for Disability Services across Hampshire.

In 2005 Jill moved to Cumbria to become Director of Adult Social Care and in 2009 Chief Executive of Cumbria County Council. Jill led the recovery from the Cumbria floods in 2009 and the rebuilding of infrastructure over the following three years.

Jill retired from the council in 2013 and from 2014 she served for four years as Chair of the Quality Committee and Senior Independent for Cumbria Partnership NHS Foundation Trust. She is currently a Director of Cumbria University chairing the Employment Policy Committee.

Helen Denton (Non-Executive Director)
Term of Office Ended on 24 June 2018

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.

Aaron Cummins (Chief Executive)
Appointed – 1 April 2018

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

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, Aaron was appointed as the Trust's next Chief Executive and commenced post on 1 April 2018.

Sue Smith OBE (Executive Chief Nurse and Deputy Chief Executive)
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.

Sue was awarded an OBE in the New Year's Honours List 2019 for services to the NHS and patient safety.

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

Foluke is the 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 the 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.

In December 2018, Mary announced her retirement and left the Trust in March 2019.

Keith Griffiths (Director of Finance)
Appointed – 1 April 2018

Keith Griffiths joined the Trust in April 2018 having previously worked as Director of Sustainability for East Lancashire Hospitals NHS Trust.

Keith has worked as a Director of Finance in specialist and acute NHS providers for over 20 years across the north of England, and in his previous role provided support to the Chief Executive and Chairman to ensure the long term sustainability of the organisation.

Keith has significant experience of working across complex political health systems and has ensured Trusts deliver financial surpluses.

He also has experience of working towards transformation programmes and ensuring their sustainability financially, clinically and in terms of the workforce.

David Walker (Medical Director)
Appointed – 1 January 2015

David is the 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. He is also the chair of the UK National Screening Committee.

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

David is the Director of People 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: Adrian Leather was appointed as a Non-Executive Director, to replace Jacqueline Telfer who left the Trust on 31 March 2018, 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. Jill Stannard was appointed as a Non-Executive Director, to replace Helen Denton whose term of office ended on 24 June 2018, and commenced post on 1 September 2018.

Board Attendance 2018/19

MEMBERS	25/04/2018	25/05/2018	30/05/2018	25/07/2018	26/09/2018	31/10/2018	28/11/2018	30/01/2019	27/03/2019
Ian Johnson, Chair									
Aaron Cummins, Chief Executive									
Foluke Ajayi, Chief Operating Officer									
Mary Aubrey, Director of Governance									
Helen Bingley, Non-Executive Director									
Helen Denton, Non-Executive Director (Term of Office ended 24/06/02018)									
Keith Griffiths, Director of Finance									
Bruce Jassi, Non-Executive Director									
Neil Johnson, Non-Executive Director									
Adrian Leather, Non-Executive Director (from 1 May 2018)									
Denis Lidstone, Non-Executive Director									
Elizabeth Sedgley, Non-Executive Director									
Sue Smith, Executive Chief Nurse									
Jill Stannard, Non-Executive Director (from 1 September 2018)									
David Walker, Medical Director									
David Wilkinson, Director of People 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.

In 2017/18 the Annual Reporting Requirements were 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. Using this framework the Trust undertook a self-assessment as part of the Care Quality Commission inspections in November and December 2018.

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 undertook a Board Development Programme in 2018, which will continue in 2019, to ensure capability and capacity is maintained. The Bay Health and Care Partners Senior leadership team reviewed its Leadership, Governance and Assurance Framework in 2018.
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 was clearly articulated in its Operational Plan and five year Financial Recovery Plan. These were refreshed and approved by the Board of Directors in 2018/19 This also incorporated the Better Care Together strategy, which focuses on restructuring of the Trust's healthcare for the local population with a significant shift in emphasis on to community care.
3. Is there a culture of high quality, sustainable care?	Having delivered on the targets in the Quality Improvement Strategy 2016/19, the Board of Directors approved its Quality Improvement priorities for 2019-2022. The refreshed strategy sets out ambitious plans over the next three years to deliver sustained, significant and continuous improvements to the quality and safety of the care provided to patients.
4. Are there clear responsibilities, roles and systems of accountability to support good governance and management?	The Board of Directors approved a Governance and Assurance Strategy for 2018/21 which was updated and approved by the Board of Directors in 2018/19.
5. Are there clear and effective processes for managing risks, issues and performance?	The Board of Directors approved a 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 Care Group 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 Programme 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 2019-2022 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 Care Group 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 the performance section of the Trust's website which can be accessed via https://www.uhmb.nhs.uk/about-us.

The Trust is required by NHS Improvement to report data on our Patient Safety Incidents to the National Reporting and Learning Service (NRLS). In 2018 NRLS commenced the monthly publication of a national data set of 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 the Trust should be self-publishing this data on the Trust's external website, as this would support the 'Open and Honest' culture around learning from incidents and would also demonstrate openness and transparency to patients and other stakeholders.

The Trust's patient safety incident data can be found via the performance section of the Trust's website https://www.uhmb.nhs.uk/about-us/data-patient-safety-incidents.

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.

In July 2015 we were one of the first Trusts in the country to appoint a Freedom to Speak Up Guardian, and seen as exemplar in our approach. The Trust continues to follow the recommendations from Robert Francis' 'Freedom to Speak Up' report, while now being supported by the National Guardian's Office guidelines which have been taken to the Board of Directors. The Trust commissioned NHS Employers to review the Trust's raising and handling concerns process (published in August 2015), and the Trust has continued to promote the culture of speaking up to improve our patients' safety and quality of care and staff well-being.

The National Guardian's Office oversees the work done by all Freedom to Speak Up Guardians, publishing data and survey results on the National Guardian's section of the Care Quality Commission's

website. The Trust's Freedom to Speak Up Guardian submits the anonymised data of concerns raised on a quarterly basis and these statistics are available alongside all other Trusts' data.

The Trust is recognised for its work on Raising Concerns and the 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 practice, and the rate of concerns being raised has increased. With the arrival of community colleagues the Board of Directors recognised the need for increasing the ring-fenced time for the role so that the Guardian has the time to support all who work in the Trust to speak up.

Raising concerns for patient safety and staff well-being is underpinned by the Trust's Behaviour Standards Framework, created through the Listening into Action programme in 2015. 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. Recently there has been increasing national recognition of the direct impact of behaviours on patient care and the Freedom to Speak up Guardian is on the Joint Working Party to address bullying and harassment issues.

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 2500 concerns/enquiries per year across the three sites. 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 430 formal complaints in 2018/19.

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 has 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 Case 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 a mandatory part of the complaints process with the dedicated Case 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.

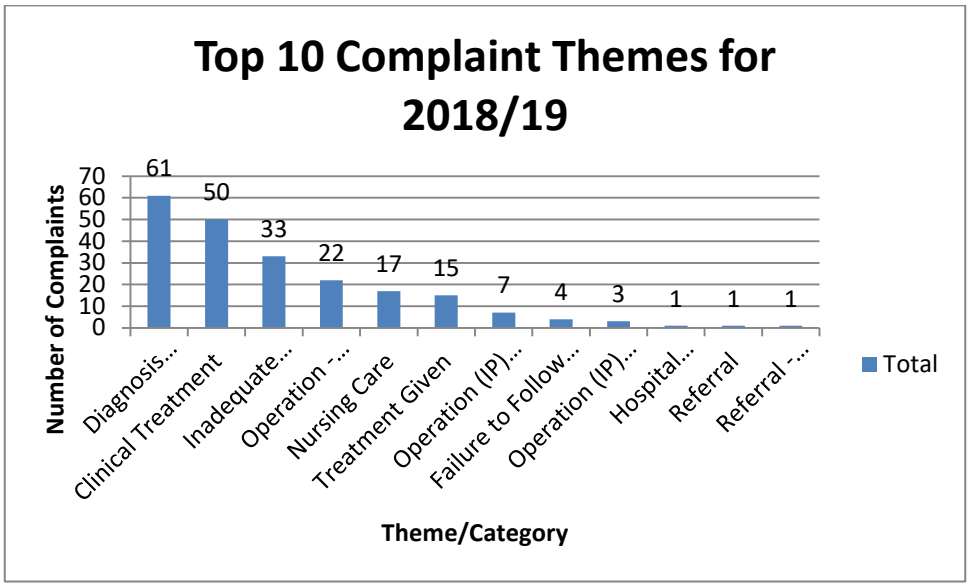
The number of complaints received in 2018/19 was 430 and the number of PALS cases was 2668.

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	425
2018/19	2668	430

For 2018/19, 13 cases have been accepted for review by the PHSO. Of these 13, 2 cases were not upheld, 3 cases were partly upheld and 1 case was upheld.

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
2018/19	13	2	3	1	10 plus 1 referred back by PHSO for further investigation

Themes of Complaint



Patient Experience and Patient-Led Work

We have developed a Patient Experience Strategy to keep pace with the changes in the NHS and to meet the needs of our population. Advancement in technology and medicine have changed not only the way we deliver healthcare, but also the expectations of patients and their families. To ensure the needs of patients are articulated, the role of health and care professionals is to listen to what our patients and our population say is important to them.

There are four key strategic themes in the Patient Experience Strategy that are emerging from the feedback we have received so far from patients, their families and their staff. These are:

Improving Access	Co-design	Care Environment	Behaviours and Customer Experience Culture
Appointments	Listening events	Accommodation	Welcome
Car parking	Service improvement	Temperature	Communication and checking understanding
Signage	Care pathways and guidelines	Food	Kindness and respect
Clear information	Changes to the physical environment	Décor and furnishings	Patients on senior clinical interview panels
	Care planning		Feedback

Patients, their families and staff have helped us to redesign the way we work to reduce duplication; they have helped us to write guidelines and we also have patients sitting on some of our interview panels. Listening to patients has influenced a number of improvements over the last few years and in response; we have seen patient experience improve and complaints reduce.

Our aim of the strategy is to improve the way we deliver meaningful patient engagement to enhance patient experience.

Friends and Family Test

The NHS friends and family test (FFT) is an important opportunity for patients to provide feedback on the care and treatment they have received. It was created to help service providers like the Trust and commissioners understand whether patients were happy with the services they received, or whether they felt improvements were required.

FFT is a national government initiative and, as such, 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 provide additional comments (if they wish to do so) to help us understand what worked and what didn't in respect of their hospital experience.




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 FFT 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	2018/19
Number of Reviews	37,005	55,423	61,346	66,875	88,067
% Likely to Recommend	91.59%	93.65%	93.91%	94.24%	94.29%
% Unlikely to Recommend	3.21%	2.24%	2.37%	2.41%	2.66%

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. FFT comments can be compared with information gathered from other feedback mechanisms used across the Trust such as Patient Advice and Liaison Service (PALS) referrals, formal complaints, letters of appreciation, and incident reporting and so on.

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 the Trust. 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.

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 useful (both positive and negative) and important lessons can often be learnt from both positive feedback and negative feedback.

National Patient Experience Surveys

All national patient satisfaction survey requirements are up to date. The Trust is supported by Picker Institute to undertake this mandatory requirement. The most recent publication was the 2018 Maternity Survey.

300 women were invited to undertake the survey of which 296 were eligible at the end of the survey. A total of 101 women completed the survey (34%). The results were very pleasing in that there were no dips in performance either historically or when comparing to other Trusts who chose to use Picker to undertake this survey on their behalf. In fact there were areas that scored significantly higher.

Summary results are as follows:

		Historical comparison*	Comparison with average*
98%	C19+. Treated with respect and dignity		
99%	C20+. Had confidence and trust in staff		
97%	C18+. Involved enough in decisions about their care		

*Chart shows the number of questions that are better, worse, or show no significant difference

It is always essential to continue to deliver excellent patient experience overall, there are always areas of particular focus that we want to ensure we improve upon. The next tables illustrate both the top and the lowest scoring results to key questions. Examining results by question allow us to really examine aspects of care, their value to our patients and how we performed through their experience.

	Top 5 scores (compared to average)
61%	F1+. Given a choice about where to have check-ups
86%	F16+. Received suppport or advice about feeding their baby during evenings, nights or weekends
86%	C14. Not left alone when worried
90%	C15+. Felt concerns were taken seriously
79%	D2+. Felt length of stay in hospital was about right

	Bottom 5 scores (compared to average)
66%	D8+. Found partner was able to stay with them as long as they wanted
89%	C10+. Had skin to skin contact with baby shortly after birth
80%	B17+. Provided with relevant information about feeding their baby
75%	F19+. Told who to contact if they needed advice about any emotional changes
85%	F18+. Given enough information about any emotional changes

	Most improved from last survey
87%	E3+. Felt midwives gave consistent advice
86%	C14. Not left alone when worried
61%	F1+. Given a choice about where to have check-ups
90%	C15+. Felt concerns were taken seriously
93%	E4+. Felt midwives gave active support and encouragement about feeding their baby

	Least improved from last survey
85%	F18+. Given enough information about any emotional changes
78%	F7. Saw the midwife as much as they wanted
54%	D3. Discharged without delay
79%	F8+. Felt midwives aware of medical history
37%	B7+. Given a choice about where to have check-ups

The Care Quality Commission is examining the future strategic direction of the NHS Patient Survey Programme. To date the programme has been an entirely paper based methodology, but there is scope to move towards digital data collection too. If this was to occur, the robust patient information database and patient experience software system enjoyed by the Trust would lend itself to this data collection method. The potential advantages would be reflected in cost savings (reduction in postal costs) and speed and flexibility of survey delivery.

Local Survey Work

As well as the high-level surveys being undertaken, many other engagement activities do take place in the form of focus groups and public engagement events.

Key local surveys can be undertaken using the Envoy software. The outcomes of these surveys can then be sent to the relevant Care Group for review and areas for improvement can be identified and addressed. There are a number of local services using the system for their patient experience survey work including breast screening, pharmacy and core clinical.

The patient experience team support a number of local initiatives. A recent example of this related to the Discharge to Access work. The patient experience team designed and carried out a telephone survey for patients who had experienced the "Home First" method of discharge. A report was then compiled and presented to the department for inclusion in their presentation to the project board.

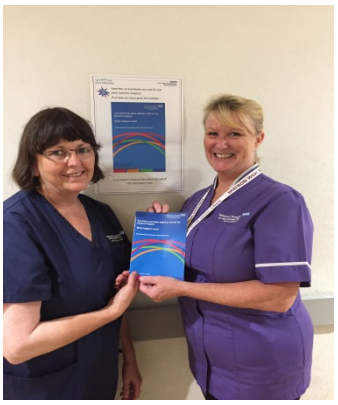
Improvement Initiatives

The "What Matters to You" and "Always" work continues.

The Always Event® framework is based on patient led improvement. To be clear, projects which are co-designed and created from listening to patients and carers talk about their experiences of using our services and what they want. Any changes are then inspired by patients for patients.

During this year a patient booklet has been developed to provide information for surgical patients who are listed for surgery. The need for this type of information booklet was expressed by patients and the project was undertaken using the Always® methodology. This booklet has now been published and introduced at Royal Lancaster Infirmary Outpatient Department for a trial and evaluation, with a view to rolling our Trust wide in due course.

Pictured here is Matron Sue Howard presenting the first issue of the Booklet to Outpatient Sister Pat Bell.



Always Listening Trees are being used as a way of gathering views from patients, carers and staff.

Patient diaries continue to be used to measure patient experiences and the Experience Based Design model (EBD) which is used to support the co-design of services is well established across the Trust.

The Patient Experience Focus Group sessions are scheduled every 3 months. These sessions have largely focussed on examining complaint response letters to patients ensuring that the language and tone used is appropriate and the contents of the letter addresses the issues raised, as well as explanations being clear and understandable.

Presentations relating to patient experience and the Morecambe Bay approach have been delivered at local development days. Feedback has been really positive.

Finally the patient experience team welcomed community colleagues to the Trust and embraced patient experiences from further afield.

Patient-Led Assessments of the Care Environment (PLACE)

Between February 2018 and May 2018, the Trust participated in the established Patient-Led Assessment of the Care Environment (PLACE) inspections; all assessments were concluded by 4 June 2018.

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 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, 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, ensuring that any ward or department that treats patients with dementia is designed to be less alienating, safe and secure; 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. Although the scores across all 3 sites were still high, they had decreased slightly in comparison to the previous year.

Ward Food

The food and hydration scores are very pleasing, with comments such as 'as good as any restaurant' provided during the assessment.

Organisational Food

This is a sub section of the main food domain and is an area for development. All sites scored higher than last year.

- 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

All three sites scored lower than the previous year. 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. Work is required on this domain as the results had decreased in comparison to last year's assessment. However, there is clear evidence that our hospitals are thinking about the environment for people with dementia when planning ward and department refurbishments. The assessment was undertaken across all assessed hospital wards, including the communal areas, Emergency Departments, Outpatient Departments and clinics.

Disability

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.

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, if not improved.

Following a review of the PLACE Assessment by NHS Improvement, the 2019 Assessment is expected to launch in September.

For more information and to view our scores please access via:

www.uhmb.nhs.uk/about-us/place-assessments

Volunteers

Over four years ago 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 360 volunteers working in over 30 different areas across the Trust in roles such as meet and greets, reception information desk, patient support, gardening, hospital radio, Macmillan information, chair based exercises, charity, breast feeding support, onward arts and crafts, chaplaincy and Pets As Therapy activities. We have a further 110 partner volunteers who support our organisation externally in areas such as Blood Bikers, Hospital Equipment shops and gardening clubs.

In December 2018 a 24-year-old Morecambe volunteer has been named Young Volunteer of the Year at the inaugural Helpforce Champion Awards for health volunteers, in London

Louise Munro won the award for her contribution to staff and patients and the value she brings to the Trust.

Louise said she "wanted to give something back to the NHS and use her own patient experience to help improve other patient's experiences in hospitals."

Volunteers bring a wealth of experience, time, and commitment to our hospital and community 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 and community health care settings. 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 continue to review our detailed plans to grow and develop volunteering. In 2018 we started working with Helpforce, in a partnership arrangement with NHS England. Helpforce has funded a local project to help further transform volunteering in and around our hospital settings focusing on developing mobility, nutrition and hydration volunteers. Helpforce continues to help us to develop high-impact volunteer innovations that will be refined and shared to help other Trusts in the UK adopt effective volunteer services.

https://www.helpforce.community/our-work/volunteer-innovators-programme/

The Royal Voluntary Service celebrated its 80th birthday in 2018. Barry Rigg, Head of Inclusion and Diversity (Service) at the Trust said "our RVS volunteers play an essential role in the way we provide care. Our hospital and community RVS volunteers make a unique contribution to patients, carers, and staff."

ROYAL VOLUNTARY SERVICE
Together for older people

Some of our Key Volunteers' Celebrations

PETS AS THERAPY
visiting volunteer

Pets As Therapy is a national charity founded in 1983 by Lesley Scott-Ordish. Volunteers with their behaviourally assessed animals from the charity regularly visit our hospitals to help enhance health and wellbeing within our ward areas. John, along with his delightful Pets As Therapy dog, Otis, regularly visits patients on the children's ward at Furness General Hospital.

Lorraine Foster, Hospital Play Specialist at the Trust said “they are a professional, compassionate and dedicated duo and have made an outstanding contribution to the wellbeing of our patients, we are so grateful for John and Otis coming to visit us. It really does help the children and the staff; it boosts morale for us all. Seeing Otis come onto the ward just lifts everyone and puts a smile on everybody’s face. It’s wonderful that we have the opportunity to provide this kind of therapy for the children and their families.”

Macmillan launches its brand new information and support service supported by volunteers to provide vital assistance to anyone affected by cancer in Lancaster, Morecambe and South Cumbria. The Macmillan Information and Support Centre will be run by an Information and Support Centre Manager, alongside a team of trained volunteers.

Volunteers signpost anyone with a cancer diagnosis, or who is concerned about cancer, including family, friends and carers, as well as clinicians and health care professionals, to other local support services and provide a facility to help people to live with and beyond cancer

Hospital Radio

Volunteers provided entertainment from two hospital radio stations, Radio Lonsdale at Furness General Hospital and the Bay Trust Radio for Westmorland General Hospital and Royal Lancaster Infirmary. Hospital radio volunteers help social interaction 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 continually increase awareness of health and wellbeing by delivering information and advice in an appropriate and sensitive way.

Patient and Public Involvement

In February 2018 we launched our new Patient and Public Involvement Strategy. 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:

https://www.uhmb.nhs.uk/files/5415/1869/8815/Patient_and_Public_Involvement_Strategy_2017-2020_FV2.pdf

Our vision continues to be our commitment to promote participation and engagement with patients, carers, public and communities through a relationship based on trust, transparency and shared decision making. We continue to work hard to ensure that citizens understand how they are able to contribute and influence and how they are influencing our approach and decision making. We are proud of work undertaken within the last 12 months around addressing health inequalities and making improvements using feedback from a variety of sources and stakeholders including partners in the voluntary and statutory sectors, individuals and groups of specific patient populations.

Our Care Groups are now starting to lead their own citizen involvement activities; this is helping to ensure engagement arrangements allow the right people to hear and understand the views of our

diverse local population and those residents who represent the characteristics protected by the Equalities Act 2010.

We recognise that it is important to have a clear understanding of who our stakeholders are. Each stakeholder or stakeholder group will have differing characteristics, roles, needs, expectations and interests and these will vary per the issue under consideration.

Careful stakeholder analysis and the development of a tailored “stakeholder map” contributes to the success of our engagement projects.

Our engagement activities continue to offer the widest opportunity for the involvement, attention has been given to involving groups who may be seldom heard.

On 10 October 2018 we asked local people to talk with us about why breast surgery services matter, we called this Breast Care Matters in Morecambe Bay. The aim of the event, which took place during Breast Cancer Awareness Month was to listen to women and men and use their feedback to shape future breast surgery services at the Trust for the better. This event gives local people who currently use the Trust’s breast surgery services or those who support the services the chance to meet the team involved and give their honest feedback on their experiences.

We have now created three Macmillan Information and Support Centres are situated near the main entrances of Furness General Hospital, Westmorland General Hospital and Royal Lancaster Infirmary. These hubs are run by staff and volunteers who offer practical and emotional support to anyone affected by cancer.

Our Maternity and Young People Matters community conversion continue we find these events so valuable, 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.

On 1 May 2018 our public grading event was attended by our equality and inclusion business partner from the Midlands Clinical Commissioning Group; supportive and developmental feedback was given to the Trust with regards to a suggested methodology for clearly identifying sources of evidence linked to the relevant protected groups. Based on this feedback we have developed a simple mapping matrix to support this development activity.

Throughout our EDS2 month (May 2018) we asked citizens, patients, service users, public, governors, volunteers, and staff to review our evidence. The results can be viewed by following the link below:

https://www.uhmb.nhs.uk/about-us/inclusion-and-diversity-matter-uhmb/annual-reporting

Our patient and public participation matters model continues to deliver and inform how we deliver our services, detailed below is a list of some of our events undertaken within the last 12 months:

- Westmorland Community Show;
- Health Screening Awareness;
- What Matter to You events;
- Always Events;
- Critical Care Services – Patient Involvement Matters;
- Kendal Community Health Day;
- Lancaster Health and Heritage Matters event;
- Foundation Trust Annual Members' meeting;
- NHS 70 celebrations;
- Step in to Health community engagement;
- Beyond Boundaries Inclusion Conference;
- Children and Young People Mental Health Event;
- Living Well Beyond Cancer;
- Volunteer Matters;
- Health Screening Matters; and
- Organ Donation Matters.

Aaron Cummins
Chief Executive

Date: 24 May 2019

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 2018/19 financial year was as follows:

Membership of the Remuneration Committee 2018/19	
Ian Johnson	Chair (Chair of the Committee)
Helen Bingley	Non-Executive Director
Helen Denton (term of office ended 24 June 2018)	Non-Executive Director
Bruce Jassi	Non-Executive Director
Neil Johnson	Non-Executive Director
Adrian Leather (from 1 May 2018)	Non-Executive Director
Denis Lidstone	Non-Executive Director
Liz Sedgley	Non-Executive Director
Jill Stannard (from 1 September 2018)	Non-Executive Director

The Chief Executive, who is not a member of the Remuneration Committee and has no voting rights, may attend to advise the Committee for the purpose of approval of Directors' and other staff members' terms and conditions of service. The Chief Executive will not attend for discussions about his own remuneration and terms of service.

Committee Attendance 2018/19

Members	11/04/2018	11/07/2018	10/10/2018	09/01/2019	27/02/2019
Ian Johnson, Chair					
Helen Bingley, Non-Executive Director					
Helen Denton, Non-Executive Director (term of office ended 24 June 2018)					
Bruce Jassi, Non-Executive Director					
Neil Johnson, Non-Executive Director					
Adrian Leather, Non-Executive Director (from 1 May 2018)					
Denis Lidstone, Non-Executive Director					
Liz Sedgley, Non-Executive Director					
Jill Stannard, Non-Executive Director (from 1 September 2018)					

Attended	Apologies	Deputy	Not commenced in post

Annual Statement on Remuneration from the Chair of the Remuneration Committee

During the course of 2018/19, the Committee:

- Reviewed Executive Directors' salaries;
- Reviewed levels of remuneration across the highest earning staff;
- Received a report on quarterly settlement agreements;
- Received reports on equal pay;
- Received reports on the recruitment process of the Director of Finance;
- Ratified the appointment of the Director of Finance; and
- Reviewed the Committee's Terms of Reference and Schedule of Business.

The Committee has oversight responsibility for Settlement Agreements and during 2018/19 has sought to assure itself that its arrangements were compliant with current guidance. The Trust has not entered into any exit agreements containing a non-disclosure agreement. Any Settlement Agreements the Trust has concluded have a confidentiality clause about the agreement but this clause does not in any way stop the individual from raising concerns about patient or staff safety. During 2019/20, the Committee will review the Trust's Settlement Agreements to further assure itself that all Trust Settlement Agreements continued to be compliant with current guidance.

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 (£142,500), 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.

Keith Griffiths was appointed as the Trust's new Director of Finance 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. In light of the General Data Protection Regulation, we sought Board members' consent to publish their remuneration details within this report. All Board members have consented.

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 and 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 People and Organisational Development	110-115	4,100	12.5-15	125-130

Pension related benefits represents 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.

Executive Directors' Remuneration 2018/19 Subject to Audit Review	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**
Mr A Cummins – Chief Executive	215-220	0	n/a	215-220
Mr D Walker – Medical Director	230-235	0	n/a	230-235
Ms S Smith – Executive Chief Nurse and Deputy Chief Executive	155-160	8,700	80-82.5	245-250
Mr K Griffiths – Director of Finance (from 5 June 2018)	150-155	0	55-57.5	205-210
Ms M Aubrey – Director of Governance (to 10 March 2019)	95-100	5,600	n/a	100-105
Ms F Ajayi – Chief Operating Officer	135-140	7,700	115-117.5	260-265
Mr D Wilkinson – Director of People and Organisational Development	115-120	7,000	80-82.5	205-210

Aaron Cummins, Director of Finance and Deputy Chief Executive was appointed as Chief Executive with effect from 1 April 2018. Keith Griffiths was appointed as Interim Director of Finance between April 2018 and June 2018. He was appointed as Director of Finance with effect from 5 June 2018. His remuneration includes an element paid to his previous NHS organisation for the period of his interim role. Sue Smith took on the role of Deputy Chief Executive with effect from May 2018. Mary Aubrey retired from the Trust with effect from 10 March 2019.

Pension related benefits represents 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 2019 and deducting the equivalent value from the amount due at 31 March 2018. 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 2018/19 the Director was not a member of the NHS Pension Scheme or has retired in year.

Pension Benefits Values Subject to Audit Review	Real increase in pension at pension age	Real increase in lump sum at pension age	Total accrued pension at pension age at 31 March 2019	Total accrued lump sum at pension age at 31 March 2019	Cash Equivalent Transfer Value at 31 March 2019	Cash Equivalent Transfer Value at 31 March 2018	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 – Chief Executive	0	0	20-25	60-65	294	294	0
Mr D Walker – Medical Director	0	0	70-75	210-215	1,392	1,392	0
Ms S Smith – Executive Chief Nurse & Deputy Chief Executive	2.5-5	7.5-10	55-60	165-170	1,295	1,084	156
Mr K Griffiths – Director of Finance	0-2.5	0-2.5	60-65	175-180	1,359	1,175	105
Ms M Aubrey – Director of Governance	0	100-102.5	35-40	235-240	889	889	0
Ms E Ajayi – Chief Operating Officer	5-7.5	2.5-5	50-55	70-75	737	564	136
Mr D Wilkinson – Director of People and Organisational Development	2.5-5	2.5-5	40-45	95-100	785	630	120

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 www.nhsbsa.nhs.uk/nhs-pensions. No payments are made to any other pension scheme on behalf of Executive Directors.

The pension benefits values table 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 Executives. Where the Executive Director in post at 31 March 2019 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 2017/18 and 2018/19	**2018/19**	**2017/18**
	Salary Bands of £5000	**Salary Bands of £5000**
Name and Title	**£000**	**£000**
Mr I Johnson – Chair (from 1 April 2018)	40-45	n/a
Mr J P Butler – Chair (to 31 March 2018)	n/a	40-45
Mr M Jassi – Non-Executive Director	10-15	10-15
Prof N Johnson – Non-Executive Director	10-15	10-15
Mr D Lidstone – Non-Executive Director	10-15	10-15
Ms H Bingley – Non-Executive Director	10-15	5-10
Ms E Sedgley – Non-Executive Director	10-15	5-10
Mr A Leather – Non-Executive Director	10-15	n/a
Ms J Stannard – Non-Executive Director	5-10	n/a
Ms H Denton – Non-Executive Director (to 24 June 2018)	0-5	10-15
Ms J Telfer – Non-Executive Director (to 31 March 2018)	n/a	10-15
Mr P Armer – Non-Executive Director (to 31 August 2017)	n/a	5-10
Ms M Weeks – Non-Executive Director (to 24 June 2017)	n/a	0-5

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

Director Expenses 2018/19

Name and Title	2018/19
Non-Executive Directors	**(£)**
Mr I Johnson – Chair	3,343.83
Ms H Bingley – Non-Executive Director	1,402.39
Mr M Jassi – Non-Executive Director	3,483.16
Mr Neil Johnson – Non-Executive Director	227.05
Mr A Leather – Non-Executive Director	234.80
Mr D Lidstone – Non-Executive Director	1,535.94
Mrs E Sedgley – Non-Executive Director	2,749.21
Ms J Stannard – Non-Executive Director	1,500.10
Executive Directors	**(£)**
Mr A Cummins – Chief Executive	4,208.20
Mrs F Ajayi – Chief Operating Officer	3,013.41
Ms M Aubrey – Director of Governance	834.31
Mr K Griffiths – Director of Finance	3,727.59
Ms S Smith – Executive Chief Nurse and Deputy Chief Executive	1,707.94
Mr D Wilkinson – Director of People and Organisational Development	3,239.00
Mr D Walker – Medical Director	3,429.24
Total Sum of Expenses	**34,636.17**

Director Expenses 2018/19

Total number of Directors in office	Number of Directors receiving expenses	Total Sum of Expenses
15	15	£34,636.17

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 2018/19 was £212,500. This was 7.5 times the median remuneration of the workforce, which was £28,400. In 2017/18 the mid point was £207,500 which was 7.9 times the median remuneration of £26,400.

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 11 employees received remuneration in excess of the highest paid director. A total of 9 employees received higher remuneration during 2017/18.

Remuneration ranged from £16,000 to £257,000 for 2018/19. The range of remuneration for 2017/18 was between £15,000 and £291,000.

Aaron Cummins
Chief Executive

Date: 24 May 2019

Staff Report – Creating a Great Place to Work

The people and organisational development (OD) service plays an essential role in helping to achieve the strategic priorities of the 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*.

The function has evolved considerably over the last 12 months and has seen a number of changes to improve the service it delivers. Specific examples of the service's achievements over the last 12 months include the continued development of the Behavioural Standards Framework and the evolving work to eradicate bullying and harassment across the Trust supporting the aspiration to have a positive working culture and making the Trust *a Great Place to Work*. Further examples include the improvement and Listening into Action approach, developing the improvement capabilities of frontline colleagues. In addition, a review of learning and development has been undertaken so that it focuses on system leadership, compassionate and inclusive leadership, improvement capability for all and Talent Management. Finally, the development of digital strategy and the Ask Sami service providing a proactive supportive service which puts colleagues at the centre of all we do.

There has been significant progress with the approach to recruitment, including collaboration with JustR (a social media partner) for bespoke recruitment campaigns, the on-going development of the Bay Health and Care Partners' (BHACP) recruitment portal #Betterwithyou and leading a Global Health Recruitment Pilot. The innovative approaches to recruitment have resulted in significant volumes of applicants and appointments, resulting in a vacancy rate of 8.0% registered nurses; 10.1% midwives; 11.5% consultants and residual vacancy rates of 2.7% registered nurses; 6.7% midwives; 11.5% consultants (as at 22 March 2019).

The Trust has been at the forefront of nurse apprenticeship development and in 2018/19 made effective use of the apprenticeship levy with the creation of a portfolio of modern apprenticeships across a variety of functions. The Learning and OD team have also launched a new development programme for aspirant and existing clinical leads, which will continue across the next financial year. Transforming the Bay Together, a system wide leadership development programme, also successfully concluded in year.

There has been a significant amount of progress across inclusion and diversity, with the Trust now regarded as a leader in the field of inclusion and diversity. Most notably the Trust has been ranked the 7th most inclusive employer in the UK in the Top 50 Inclusive Employer awards (top NHS Trust).

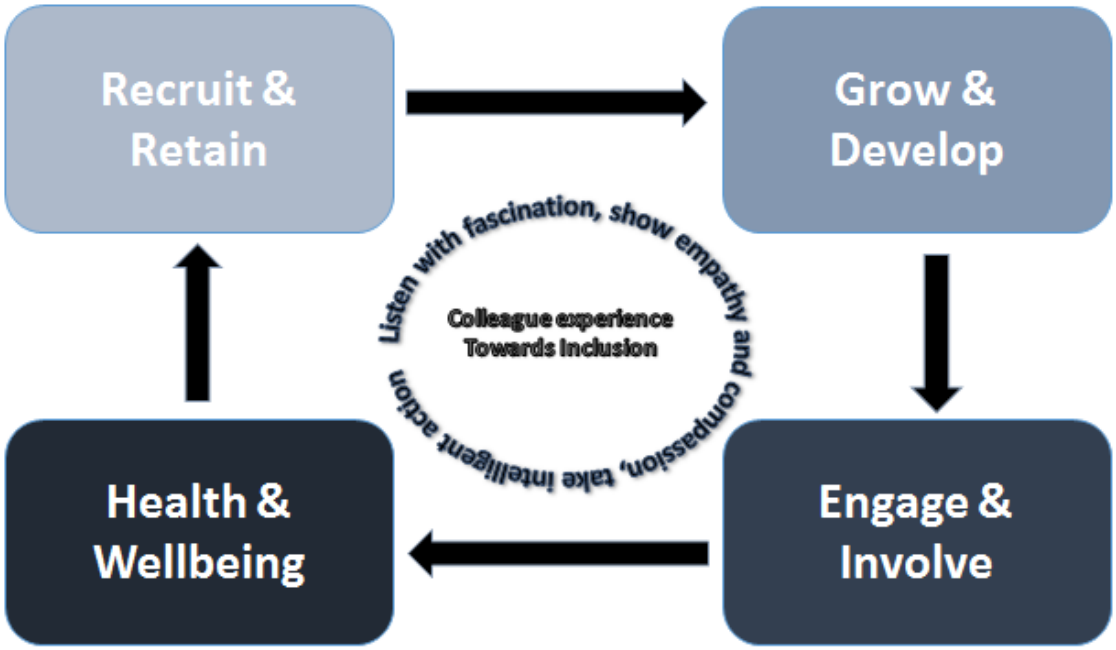
Partnership working with Staff Side, Inclusion Networks, Improvement Champions, Respect Champions and Personal Fair Diverse Network has enabled effective leadership at all levels. It is through this that the people and OD team have achieved so much, and the continuation of working in partnership with staff is key to the effective implementation of the people and OD 2019/20 business plan.

The progress across the Division has resulted in the Trust being recognised for its innovative approaches, such as the Health Business Award for Healthcare Recruitment 2018, and the Personnel Today Awards for Employee Engagement and Overall Winner Personnel Today 2018.

People & OD Strategy

The Trust is committed to creating a performance-driven culture focused on safety and quality, underpinned by compassionate, strong and effective leadership; empowerment, involvement and continuous improvement. The people and OD Model is based on a Cycle of Excellence that leads to individualised people-centric support for colleagues that truly makes the Trust *a great place to work* and through an engaged and motivated workforce creates a *great place to be cared for*.

People & OD Model – Cycle of Excellence



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

The People and Organisational Development (OD) priorities fall into the following strategic focus areas:

Recruit & Retain

- We will attract, hire and 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 colleagues 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 and 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 has continued to be at extraordinary levels in 2018 and the workforce team has responded to this with support in all aspects of recruitment for managers at the Trust, but also in the wider health economy. Whilst the Trust has been successful over the past 12 months, particularly in nurse recruitment with 201.1 wte recruited in year, closing the gap remains a challenge. Careers engagement is a core element of the long-term strategic approach to recruitment – recruiting local people and growing our own through apprenticeships.

The Trust has recruited at unprecedented levels in 2018/19. These are demonstrated in the vacancy rates and recruitment levels but the work has been much more than that. The approach has taken account of both recruitment and retention, it has also sought to support innovative methods to support healthcare colleagues back to clinical work with "return to practice" schemes and built on the apprenticeship model to grow our own workforce. At the start of 2018/19 the Trust reviewed its recruitment strategy, in particular the Nurse Recruitment Strategy. The Trust set an ambitious nursing recruitment target of 236 in year, against which 210.1 wte have been recruited and will commence by the end of April 2019. This target 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; however in 2018/19 the Trust has welcomed 43 international nurses to the Trust.

Actions are in place to address the nursing gap, which includes a continued focus on international recruitment through Jane Lewis and Health Education England's Global Learners programme, a renewed focus in the promotion of the Trust's return to practice opportunities, and further emphasis on the nursing cohort recruitment days. Recognising the Trust's geographic challenges and the national shortages impacting on nurse recruitment, this level of recruitment is cause for celebration, in particular the Trust has seen our highest number of international nurses and student nurses start in 2018/19 with the residual vacancy figures for registered nurses reducing in year from 8.7% to 2.7%.

Specific medical recruitment campaigns have been commissioned in 2018/19. Appointments have been made to a number of long standing consultant vacancies in gastroenterology and rheumatology. Equally the departments of anaesthetics have reviewed its recruitment and skill mix and consultant posts were converted to Trust associate specialist posts and applicants have been appointed 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, with on-boarding of 4 Global Fellow Radiologists.

Recognising the national challenge and shortage of nurses, the Trust has continued to strengthen and develop the Nurse Degree Programme with 54 colleagues taking part in nursing apprenticeships in 2018/19. The Trust's approach to apprenticeships as a whole has continued positively in 2018/19 with a total of 140 colleagues taking part in various apprenticeships, including nursing, business administration / HR, management and leadership, pharmacy, healthcare science, estates and facilities and finance / IT. This includes the first cohort of trainee nurse associate apprentices who commenced in December 2018.

2018/19 saw the Trust refresh its approach to recruitment to have a much greater emphasis on social media. Working with a specialised recruitment partner, JustR, the Trust significantly increased the Trust's social media presence, allowing the Trust to reach an audience hitherto untapped. It is estimated that JustR reached over 200,000 and engaged directly with over 7,000 individuals across various staff groups. This is a presence previously unavailable to the Trust and one that has had a significant impact on recruitment. Analysis of the activity with JustR has shown that for the period February 2018 – November 2018 they supported the Trust to attract 89 individual applications, leading to 63 interviews and 38 offers of employment.

Through Health Education England the Trust continues to support the Global Health Exchange programme, the ethos of which is 'Earn, Learn, Return' and has made employment offers to 22 Global Learner nurses.

Career engagement is a core element of the long-term strategic approach to recruitment – recruiting local people and growing our own. 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 majority of the careers and engagement team's projects and events across 2017 and 2018 have been targeted at students in secondary school education. However, 2018 saw the development of a number of employability programmes which aimed to support unemployed adults and young people in local FE colleges; these programmes have increased the percentage of events in which attendees have been adults or college students.

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 2018/19 contingent staffing has remained a key element of the Trust's 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 by effectively utilising and deploying resources to meet the NHS Improvement (NHSI) agency spend ceiling.

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. Four key work streams identified for 2018/19 have supported the Care Groups to develop plans to meet the challenging spend reduction target:

- Nurse staff utilisation and deployment;
- Procurement;
- Medical staff utilisation and deployment; and
- Recruitment.

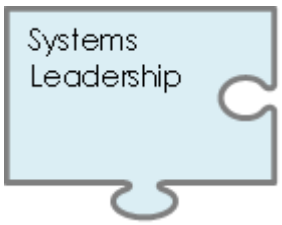
Working closely with the finance and procurement teams the following successes have been achieved:

In the three years the Agency Use Programme had been running the interventions put in place have reduced agency spend by just short of £10 million, which is a 40% reduction in overall spend. Further innovative work across workforce, finance and procurement is being undertaken to support the Care Groups to understand the current pay spend in order to maximise productivity and savings opportunities for 2019/20, which will support the ongoing delivery of the NHSI required reductions.

Grow & Develop

The Trust's Organisational Development (OD) Strategy: Shaping the Future; Developing People; Improving Care was approved by the Board in May 2017 and set out a framework to build leadership and improvement capabilities:

- systems leadership for colleagues 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 colleagues and service users' knowledge and experience to improve service quality and efficiency;
- inclusive and compassionate leadership, so that all colleagues 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.



System Leadership – Transforming the Bay Together

The organisational development work stream focused on enabling the growth of a clinical community across the Morecambe Bay area to significantly advance closer working of primary and secondary care successfully concluded with Transforming the Bay Together, a system wide leadership development programme.

Improvement & Engagement

In 2018 the Trust adopted the NHS Quality Service Improvement Redesign (QSIR) approach in order to train to a more advanced level and embed deeper improvement capability within Care Groups. QSIR includes a wide breadth of service improvement skills providing participants with the skills and ability to design and implement more efficient patient-centred services. QSIR and Listening into Action (LiA) now form the Trust's improvement strategy.

Great Leaders – Great Care

The Trust recognises the value of investing in leadership to develop a culture where colleagues 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 and colleague experience 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, Stepping Up, the Aspiring Chief Executives Programme, the Directors Programme, Pushing the Boundaries – Aspirant Talent. In addition, the Trust has launched a new development programme for aspirant and existing clinical leads which will continue across the next financial year.

2018 saw the completion of a third Senior Leadership Development Programme cohort delivered in partnership with Lancaster University Management School (LUMS). That programme was replaced in-year with a three level leadership apprenticeship programme, accredited by Lancaster University, including a Level 7 MSc level modern apprenticeship.

Talent Management

The Trust's Organisational Development (OD) plan 'Developing People – Improving Care' (approved in 2017) placed a clear focus on the need to develop 'compassionate and inclusive leadership' at all levels of the organisation. The strategy was written in response to the national NHS document of the same name, launched in late 2016. The latter highlighted the importance of talent management and succession as a key element of ensuring colleague engagement and organisational performance.

2018 has seen the Trust develop its approach to Talent Management proposals to further support and reinforce the Trust's 2017 'Developing People – Improving Care' OD Strategy and suggest a Talent Management approach aligned to national NHS guidance and schemes.

The planned approach aims to ensure that the Trust has an abundance of clearly identified, talented individuals in place across the organisation, at all levels. These high performing individuals should exemplify Trust values and behaviours and provide leadership that positively influences colleague experience and outstanding care.

The Trust has now set out its approach to Talent Management across three levels:

a. Succession Planning (senior colleagues at sub-board level);
b. Managing individuals with highest potential to progress to sub board level; and
c. Inclusive, fair and consistent talent conversations and development for all colleagues, including the identification of talent.

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

Apprenticeships offer a longer-term solution for the workforce of the future for the Trust and partners in Bay Health and Care Partners (BHACP), developing a more sustainable pipeline and investment in local communities. Gaps in key workforce groups, such as nurses, midwives, pharmacy, estates and facilities and business administration / HR / IT can all be supported through the development of apprenticeship pathways.

The Trust's apprenticeship programme has strengthened considerably over 2018/19 with 140 colleagues taking part in various apprenticeships, a working example of *Growing Our Own to Provide Great Care*. Building on the innovative and ground breaking approach to apprenticeships, where the Trust was one of the first in the country to launch the nurse degree apprenticeship, the Trust has in December 2018 commenced its first cohort of trainee nurse associate apprenticeships within the Community Care Group, developing new and innovative roles.

The Trust also continues to maximise the use of apprenticeships for leadership and management opportunities, with 45 colleagues undertaking apprentices in leadership to support the development of a *Great Place to Work*.

Learning and Development

The approach to coaching training has been strengthened through the training of two coaching supervisors and ongoing coaching skills courses. Alongside this three trainers have been trained to deliver health coaching courses as part of an Integrated Care System initiative.

The Trust's corporate induction process continues to be developed and meets with a very appreciative audience. In total 913 people have participated in the new corporate induction. This includes a welcome from the Chief Executive and focuses on values and beliefs via our Behavioural Standards Framework.

Improving Systems and Governance

A key focus for the Learning and Organisation Development through 2018 has continued to be the on-going development of Educational Governance and improving the Trust systems to support this. The Education Governance Group is now fully established, as a sub-committee of the Workforce Assurance Committee, with cross divisional representation working in partnership to review the efficiency and effectiveness of the nine core skill training elements identifying potential opportunities to stream line and improve the delivery.

Engage & Involve

Behavioural Standards Framework

The Behavioural Standards Framework (BSF), developed by staff, for staff, describes how the vision and values were to be embedded within everyone's role through their behaviours and actions. 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 colleagues and everyone who works for the Trust plays a part in achieving this.

The BSF sets out the behaviours and attitudes expected of all colleagues (and those it does not expect) 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.

During 2018/19 a 12 month programme has focused on the BSF Behaviours, with sponsorship each month by a different leadership trio. Information boards have been displayed across the Trust as a visual and daily reminder of the BSF. An e-learning training module for all colleagues raises awareness of the BSF and reinforces the BSF for individuals by requiring each employee to set a personal ambition based on the BSF which is then linked to their next appraisal discussion

Further developments to develop and further embed the BSF during 2018/19 have included:

- Continuing to raise awareness of the Behavioral Standards Framework at all stages of the employee lifecycle;
- Introduction of Inclusive Behaviors face to face training; and

- Development and promotion of Freedom to Speak Up, Respect Champions and the Inclusion Networks.

A key area of challenge for the Trust is the ambition to deliver a bullying and harassment free organisation. The Trust held a Creating Positive Cultures Conference in November 2018, at which colleagues heard from expert speakers in the field of bullying, harassment and incivility. During the day, colleagues shared their own experiences of bullying, harassment and incivility and got involved in developing ideas for creating a truly *great place to work* for everyone at the Trust.

The Trust wide Bullying and Harassment Joint Working Party has been refreshed, with new membership ensuring Care Group, professional groups and inclusion networks are represented. Chief Executive led, this group has reviewed feedback from colleagues about their lived experience, considered best practice and expert recommendations and agreed on the priority areas of focus for 2019/20.

Inclusion

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

- To eliminate unlawful discrimination, harassment and victimisation;
- 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.

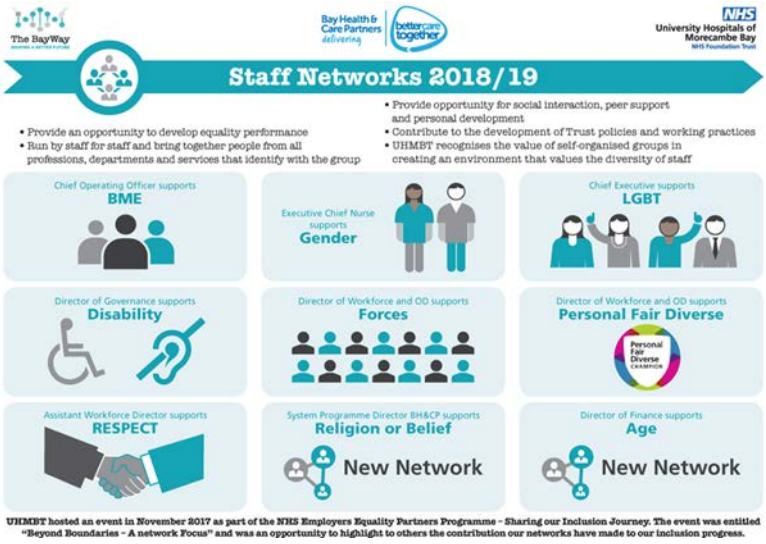
The Trust's five year Inclusion and Diversity Strategy was approved at Trust Board in September 2016 and subsequent annual updates (with supporting action plans) approved in July 2017 and July 2018.

Tremendous progress has been made across each of the four key areas of the strategy. This progress has been recognised nationally – the Trust is now regarded as a leader in the field of inclusion and diversity. 2018/19 accolades include:

- 7th most inclusive employer in the UK in the Top 50 Inclusive Employer awards (top NHS Trust);
- Awarded the Armed Forces Covenant Silver Award;
- Disability Confident Employer (with involvement in the development of the national Workforce Race Equality Standard);
- Silver ENEI TIDE Benchmarking;
- Winner of two Personnel Today awards: Employee Engagement and Overall Organisation; and
- HPMA North West awards 'We Improve the Culture' Winner.

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. There are

now ten networks, each with an executive sponsor. The most recently established network is specifically designed to support EU colleagues through the challenges and changes of Brexit.



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 Stonewall Equality Index, the second 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.

Inclusive Behaviours

Skills development is a key element of the Trust's Towards Inclusion Strategy. In partnership with CETAD at Lancaster University, the Trust has developed a half day Inclusive Behaviours workshop which enables colleagues to:

- Understand the relevance inclusion to themselves;
- Identify inclusive and non-inclusive behaviour (including case studies developed from the lived experience of Trust colleagues);
- Understand how bias and assumptions affect behaviour;
- Understand how to support, challenge and escalate behaviour when experienced or witnessed; and
- Commit to promoting inclusive behaviours.

The Trust has set a challenging target of all colleagues taking part in the Inclusive Behaviours workshop by the end of 2022. Two workshops per week are being delivered most weeks of the year to enable all colleagues to take part over the next five years.

Examples of commitments people are making during the workshops include being "more proactive in giving feedback", "challenging inappropriate behaviours", "being more aware of own biases/assumptions/judgements" and "taking time to consider other people's perspectives".

Feedback from colleagues who have attended the workshop has been wholly positive and colleagues' self-evaluation scores indicating participants understanding of inclusion, personal biases / assumptions and relevance to them in their role consistently increases by end of each workshop.

As well as threading inclusive behaviours and leadership themes throughout internal leadership development programmes, a new Inclusive Leadership module is in development for launch in 2019/20.

Inclusive Top 50

In late 2018 the Trust was named as the seventh most inclusive employer in the UK (the highest ranking NHS employer in the country) 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

A strategic objective of the Trust's 'Developing People Improving Care' strategy was to develop Trust wide improvement capacity and capability. Listening into Action (LiA), introduced at the Trust in September 2014, is an improvement and engagement approach that trains colleagues to foundation level. In 2018 the Trust adopted the NHS Quality Service Improvement Redesign (QSIR) approach in order to train to a more advanced level and embed deeper improvement capability within Care Groups. QSIR includes a wide breadth of service improvement skills providing participants with the skills and ability to design and implement more efficient patient-centred services

Together LiA and QSIR form the Trust's and Bay Health and Care Partners' overall improvement strategy:

UHMBT's and Bay Health and Care Partner's overall improvement strategy

There have been 3 waves of Listening into Action (LiA) and Improvement in the 2018/19. These are for all colleagues to access and as a result there have been 26 new LiA schemes in these waves and 140 in total since the start of the programme. In addition, a number of listening events (part of the LiA process) have taken place across the year to support the development of the Colleague Experience Strategy, seeking colleagues views on eradicating bullying and harassment, and environmental opportunities allowing colleagues to contribute to developing the organisation's continuous improvement towards being *A great place to be cared*; *A great place to work*.

The QSIR training programme started in June 2018 in order to build improvement capacity and capability. Currently there are six colleagues qualified as Teaching Associates for QSIR who have delivered 3 cohorts of training. A further 5 colleagues are completing the Teaching Associate programme. By the end of March 2019, 90 colleagues from Bay Health and Care Partners will qualify as QSIR Practitioners and the health community will be on track to achieve 150 colleagues trained by November 2019. All practitioners will work on an improvement project related to their role.

Staff Engagement

Staff engagement is at the heart of the Trust's approach to colleague experience and creating a Great Place to be Cared For; Great Place to Work. Key mechanisms for engagement Trust wide include:

- 10 staff inclusion networks (gender, BME, disability, LGBT, religion and belief, age, Forces, Respect Champions, Personal Fair Diverse Champions, European Union colleagues);
- Bullying and Harassment Joint Working Party (a coalition of partners from across the Trust, led by the Chief Executive);

- Feedback and partnership working with Staff Side colleagues;
- National Staff Survey & Staff Friends and Family test;
- Listening into Action / QSIR Improvement approach; and
- Fresh eyes (new starter) and leaver interviews.

NHS Staff Survey

The NHS staff survey is conducted annually. From 2018 onwards, the results from questions are grouped to give scores in ten indicators. The indicator scores are based on a score out of 10 for certain questions with the indicator score being the average of those.

For the third 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 and 2017. The response rate to the 2018 survey among Trust staff was 39% (2017: 40%). Scores for each indicator together with that of the survey benchmarking group (acute and community providers) are presented below.

	2018/19		2017/18		2016/17	
	Trust	Benchmarking Group	Trust	Benchmarking Group	Trust	Benchmarking Group
Equality, diversity and inclusion	9.2	Best: 9.5 Average: 9.2 Worst: 8.3	9.2	Best: 9.5 Average: 9.2 Worst: 8.3	9.3	Best: 9.6 Average: 9.3 Worst: 8.3
Health and wellbeing	6.2	Best: 6.4 Average: 5.9 Worst: 5.5	6.3	Best: 6.4 Average: 6.0 Worst: 5.6	6.2	Best: 6.6 Average: 6.1 Worst: 5.6
Immediate managers	6.9	Best: 7.3 Average: 6.8 Worst: 6.5	6.7	Best: 7.4 Average: 6.8 Worst: 6.4	6.6	Best: 7.3 Average: 6.8 Worst: 6.4
Morale	6.4	Best: 6.5 Average: 6.2 Worst: 5.7	Themed results not published			
Quality of appraisals	5.6	Best: 6.2 Average: 5.4 Worst: 4.5	5.4	Best: 6.3 Average: 5.3 Worst: 4.8	5.2	Best: 6.3 Average: 5.4 Worst: 4.6
Quality of care	7.6	Best: 7.9 Average: 7.4 Worst: 7.1	7.5	Best: 7.9 Average: 7.5 Worst: 7.1	7.6	Best: 8.0 Average: 7.5 Worst: 7.2
Safe environment – bullying and harassment	7.9	Best: 8.6 Average: 8.1 Worst: 7.4	7.9	Best: 8.5 Average: 8.1 Worst: 7.5	8.0	Best: 8.6 Average: 8.2 Worst: 7.5
Safe environment – violence	9.5	Best: 9.7 Average: 9.5 Worst: 9.3	9.4	Best: 9.7 Average: 9.5 Worst: 9.3	9.4	Best: 9.7 Average: 9.5 Worst: 9.2
Safety culture	6.8	Best: 7.1 Average: 6.7 Worst: 6.3	6.8	Best: 7.2 Average: 6.7 Worst: 6.2	6.7	Best: 7.2 Average: 6.7 Worst: 6.2
Staff engagement	7.1	Best: 7.4 Average: 7.0 Worst: 6.6	7.0	Best: 7.5 Average: 7.0 Worst: 6.5	6.9	Best: 7.6 Average: 7.0 Worst: 6.4

Staff experience at the Trust continues to improve year on year, according to the results of the 2018 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 satisfied with the extent the organisation values their work;

- Staff with a disability feeling the organisation made reasonable adjustments to enable them to carry out their work;
- Staff feeling satisfied with their level of pay;
- Staff feeling satisfied with recognition for good work; and
- Staff feeling communication between senior management and staff is effective.

Of the 10 themed areas of the survey, the Trust scored above average in 7 of the areas, with 2 average and just one area below average. Areas the Trust is above average nationally include:

- Employee health and wellbeing;
- Immediate Managers;
- Morale;
- Quality of Appraisals;
- Quality of Care;
- Safety Culture; and
- Staff Engagement.

Future Priorities and Targets

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 Trust has achieved its target for improvement in employee engagement score and achievement of 60% of themed areas above average for the benchmarking group. Performance is monitored annually through the Trust's Quality Accounts, with the Board and Workforce Assurance Committee overseeing and monitoring progress against priority actions.

The journey is not complete and there are a number of areas that need further consideration and focussed attention throughout 2019/20 within individual Care Groups. On a wider Trust basis work will continue with a number of initiatives already underway to support those areas of colleague experience which require the most urgent attention, including collaborative working to address bullying, harassment and abuse by creating positive working environments led by the Trust's Chief Executive.

Trade Union Facility Time

Partnership working with Staff Side 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 effective implementation of our Colleague Experience Strategy. The Staff Side Officers are Alasdair Boyle (Staff Side Chair); Andy Robson (Staff Side Secretary); Theresa Knowles (Staff Side Vice-Chair) and Alan Minchom (Joint Local Negotiating Committee Chair).

There are 22 Trade Union representatives at the Trust. The percentage of time spent on facility time is as follows: 8 representatives spent 1% and 14 spent up to 50% of their time on trade union activities. This amounted to 5991 hours, which equates to 42.39% of paid facility time spent on paid trade union activities.

Health & Wellbeing: Occupational Health & Wellbeing

The occupational health and wellbeing team support colleagues across the Trust to remain well for example Flourish campaign and wellbeing campaigns and provide support for attendance, in particular stress and musculoskeletal cases.

The Trust has an Attendance Management at Work Policy that focuses on supporting individual colleagues who are absent from work, with the emphasis on individualising their support to enable their return to work. It is recognised that the highest reasons for absence are:

- Stress/Anxiety/depression; and
- Musculoskeletal.

The occupational health and well-being team have expanded the service in both physiotherapy and talking therapies to respond to the need for support in these areas. In addition the Trust #Flourish campaign promotes pro-active personal health management with support across four key interlinked and supporting health areas (Move more, Healthy Heart, Mindfulness and Nourish). The #Flourish campaign aims to both educate and support colleagues in the benefits of maintaining a healthy lifestyle with a view to influencing the wider community to respond to the Public Health messages and agenda. The occupational health and 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 musculoskeletal (MSK) conditions, therapist that specialise in person centred counselling / hypnotherapy, cognitive behaviours therapy. The service is offered to the Trust to support colleagues across all 3 sites.

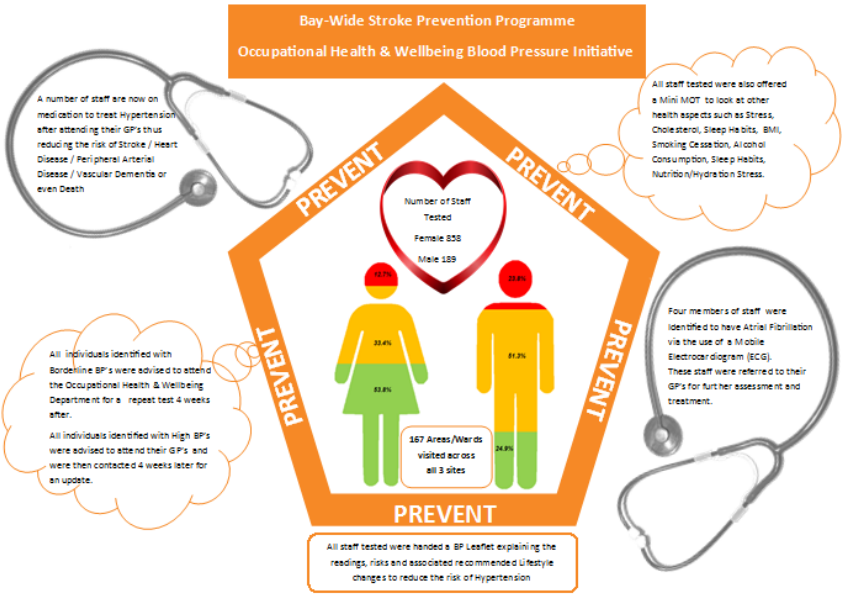
The services offered range from pre-employment screening and assessment of fitness to work following illness or injury, healthy lifestyle checks to supportive therapeutic interventions and physiotherapy. This enables to the Trust to respond to, and support, colleagues with health and wellbeing concerns and assists in reducing the current absence rates. Key areas of focus for the occupational health and wellbeing service are the two main drivers of absence, namely musculoskeletal and stress related absences in addition to supporting colleagues with other absences and providing preventative interventions (for example menopause courses, blood pressure initiatives, Man-Sheds men's health courses).

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 2019. It is very positive to note that the SEQOHS assessors provided the occupational health service with excellent feedback, in particular complementing the continuous improvements being made year-on-year.

The Trust has for the 5th 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 84% of front line 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 and wellbeing service has continued to be a key element and driver of the #Flourish Campaign in 2018/19. The Trust achieved the Better Health at Work Gold accreditation in late 2018. The occupational health and wellbeing service have run a number of supportive preventative health campaigns such a weight reduction, female and male health awareness courses, stress and resilience and back awareness. In addition, the Bay-Wide Stroke Prevention Campaign significantly improved the health and wellbeing of colleagues identifying 384 colleagues with borderline blood pressure and 154 with high blood pressure.



The occupational health and wellbeing service will have a key role in the re-design of the #Flourish Strategy as part of the Colleague Experience strategy development in 2019/20. The focus for 2019/20 will be the re-launch of the #Flourish Campaign, which will allow for a number of supportive interventions and educational promotions that will support a variety of Public Health interventions, for example healthy heart, mental health, benefits of regular exercise and healthy eating habits which contribute to a reduction in diabetes etc. This will also include a focus on gender specific preventative wellbeing campaigns that will support both education and increasing awareness of a variety of health conditional that affect either men or women.

Attendance Management

The Trust continues to implement a supportive, proactive and people-centric approach to managing attendance, shifting the focus away from merely tackling sickness absence to delivering individualised support for colleagues to aid their return to work by providing a range of supportive interventions that will assist their early return to work, or help colleagues to remain in work. It is positive to note that the Trust's approach has led to improving levels of attendance, although performance is slightly below the key performance indicator target of 95.7%, at 95.4%, the Trust has seen improving levels of attendance through the year.

The Trust provides monthly updates to the Board outlining work within the Care Group teams, focusing on increasing attendance and a number of interventions, including the identification of remain "hot spots" of high absence across a number of Care Group and specific interventions across workforce and occupational health and wellbeing have been put in place to support these areas.

In addition, the Trust has made investments into preventative measures and campaigns to develop staff resilience, providing colleagues with advice, guidance and tips on how they can stay healthy and well over the winter period; and includes a focus on mental health, flu vaccination and physical wellbeing.

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%
2017/18	95.2%
2018/19	95.3%

Staff sickness absence (HSCIC data) and Average working days lost				
Staff sickness absence (HSCIC data)	**2018**	**2017**	**2016**	**2015**
	Number	**Number**	**Number**	**Number**
Total days lost	54,261	49,577	50,954	47,534
Total staff years	5,195	4,703	4,559	4,439
Average working days lost	10.4	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.

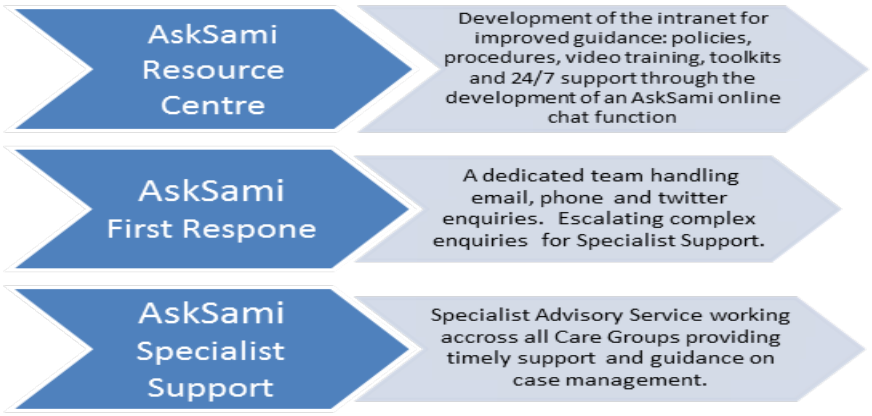
Sickness absence data is published by the Health & Social Care Information Centre (HSCIC) based on monthly extracts from the Trust's ESR payroll system.

There has been a focused drive to improve the health of colleagues through the #Flourish Campaign and the health and wellbeing service 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). SAMI has been very well received by managers across the Trust and has received positive feedback. This advisory service supports colleagues 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 colleagues across the Trust's 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 a people centred service that gave value to the organisation.

In September 2018 Specialist Advisory Support was integrated into Ask Sami. The Business Partner role remain aligned to the Care Groups and offer organisation development and people support to Care Groups, delivery of the People Strategy and change management.



A number of helpful management resources and tools have been developed by the SAMI team as well as improving the intranet site. Work continues with the I^3 department to support the delivery of the People and Organisational Development (OD) Digital Strategy including the development of a People Dashboard and Chat Bot. There is further modernisation work to undertake, particularly of the intranet and a people and OD App, to make it a modern fully interactive support service, however the activity undertaken over the past year is providing an excellent foundation for onward development.

In order to provide accessible, up-to-the-minute training data for care groups and managers, the learning and OD team have developed and launched the QlikSense Training Application. The app is mobile enabled and has supported improvement in core-skills compliance in Care Groups.

Average number of Colleagues Employed

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	2018/19		
	Permanently Employed	Other	Total
	Number	Number	Number
Medical and dental	533	59	592
Administration and estates	1,231	33	1,264
Healthcare assistants and other support staff	1,193	178	1,371
Nursing, midwifery and health visiting staff	1,686	126	1,812
Scientific, therapeutic and technical staff	570	32	602
Healthcare science staff	210	2	212
Total	5,423	430	5,853

Of the above there were 19 staff (Whole Time Equivalent) engaged on capital projects during 2018/19 (14 WTE staff engaged on capital projects during 2017/18).

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 304 bank staff and 126 agency staff (2017/18, 263 and 133 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 2019, for more than £220 per day and that last for longer than six months:	
No. of existing engagements as at 31 March 2019	0
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	0
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 2018 and 31 March 2019, 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 2018 and 31 March 2019	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	0
No. for whom assurance has been requested	0
Of Which…	
No. for whom assurance has been received	0
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 2018 and 31 March 2019	
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.	16

Exit Packages

Exit packages	2018/19		2017/18	
	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	0	0	1	27
Exit package cost band £50,001 to £100,000	0	0	0	0
	0	0	1	27
Contractual redundancy	0	0	0	0
National MARS	0	0	0	0
	0	0	1	27
There were no termination benefits paid to employees or Directors during 2018/19. During 2017/18 the Trust agreed a departure with 1 employee. This departure was paid in line with contractual notice requirements, no additional payments were made. There were no termination benefits paid to Directors in 2017/18.				

Consultancy Expenditure

Consultancy Services Expenditure	Value
Electronic Patient Record System	£9,000
Leadership	£9,000
Total	£18,000

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 for it 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 2018/19 financial year was as follows:

Membership of the Audit Committee	
Helen Bingley	Non-Executive Director
Helen Denton (term of office ended 24 June 2018)	Non-Executive Director
Bruce Jassi	Non-Executive Director
Neil Johnson	Non-Executive Director
Adrian Leather (from 1 May 2018)	Non-Executive Director
Denis Lidstone	Non-Executive Director
Liz Sedgley	Non-Executive Director (Chair)
Jill Stannard (from 1 September 2018)	Non-Executive Director

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

- Deputy Chief Executive
- Director of Finance;
- Director of Governance;
- Head of Financial Services;
- Internal Audit representatives;
- Local Anti-Fraud Specialist;
- External Audit representatives;
- Deputy Director of Finance
- Head of Financial Services;
- Company Secretary and;
- Trust Board Administrator.

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 Chief Operating Officer and Director of People and OD.

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 2017/18

Through the NHS Foundation Trust Annual Reporting Manual 2017/18, NHS Improvement advised that the submission deadline for the production of NHS Foundation Trust Annual Accounts and Report for 2017/18 was 29 May 2018. As the Board of Directors' meeting was scheduled to take place on 30 May 2018, the Audit Committee and an extraordinary Board of Directors' meeting took place on 24 May 2018 to allow the accounts and annual report to be presented and approved before the submission deadline of 29 May 2018. The Board of Directors considered the Annual Report and Accounts including the Quality Report and was satisfied with the content and formally recommended the Board of Directors adopted them.

Internal Control and 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;
- receiving and considering reports derived from the Annual Plan.

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;
- receiving the Head of Internal Audit's annual opinion on the Trust's system of internal control.

Set out below is the 2018/19 work programme delivered by Internal Audit:

Review Title	Assurance Level High/Substantial/Moderate/Limited/No
Risk Management	Substantial
Immediate Discharge Summaries	Substantial
GMC Registration	Substantial
Data Protection and Security Toolkit (IGT)	Substantial
Business Continuity and Disaster Recovery (IM&T)	Substantial
Nurse Staffing Levels	Moderate
Hand Hygiene	Moderate
Financial Systems / Financial Integrity	Moderate
e-Rostering	Moderate
Integrated Community Services	Limited
Fit and Proper Persons	Limited

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 which came into force from 1 June 2017. These included.

- Actions taken by the Trust to implement the new policy;
- Approval of Conflicts of Interest Policy for the Trust;
- Feedback from audits undertaken by Mersey Internal Audit Agency (MIAA) including a review from the Anti-Fraud Specialist;
- Progress made against the recommendations made by MIAA;
- Implementation of a digital solution called MES Declare to improve the processes for managing and recording of Conflicts of Interest.

The Trust's Managing Conflicts of Interest Policy was updated to reflect the findings and recommendations made by MIAA. The Policy remained consistent with the national requirements.

To improve the process for declaring and publishing Conflicts of Interest, the Trust deployed a digital solution called MES Declare in February 2019. Key features of the system included:

- Full integration with Electronic Staff Records;
- Staff declarations were captured and published seamlessly on the Trust's website;
- Quick and easy to access on a PC, tablet or smartphone;
- Reporting is aligned with NHS England guidance;
- Data can be segmented and analysed for greater transparency and reporting;
- Breach investigations facility; and
- Portal providing a complete view of staff declarations, management of local decision making groups and a KPI dashboard.

All staff are required to declare interests as they arise (and in any event within 28 days). The different categories of interests needing to be declared included:

- Gifts;
- Hospitality;
- Outside Employment;
- Patents;
- Loyalty Interests;

- Sponsored Events;
- Sponsored Research;
- Sponsored Posts;
- Donations;
- Clinical Private Practice; and
- Shareholding and other Ownership Issues.

MIAA found that there was no training for staff around Conflicts of Interest. National training had been developed for Clinical Commissioning Groups and the Company Secretary contacted NHS England (NHSE) to obtain support in developing a similar e-learning package for Foundation Trusts. NHSE have agreed to establish a working group with the NHS Providers Company Secretaries Network to develop a staff training package. The Company Secretary of the Trust will be a member of this group.

Working with Other Committees

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

Committee Effectiveness and Looking Ahead to 2019/20

As the development of Bay Health and Care Partners progresses during 2019/20, the Audit Committee will play a significant role in supporting the governance arrangements of partnership working.

Looking ahead into 2019/20, the Committee will continue to carry out its duties to provide the necessary assurance to the Board of Directors.

The Committee's Terms of Reference were reviewed in March 2019 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 2018/19 reporting year, the Trust has applied the principles and met the provisions and the requirements of the NHS Foundation Trust Code of Governance with no exceptions. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance code issued in 2012.

Full details can be found at Annexe I

NHS Improvement's (NHSI) Single Oversight Framework

Performance against NHSI Single Oversight Framework

The NHSI Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

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

Based on information from these themes, providers are segmented from 1 to 4 where "4" reflects providers receiving the most support and "1" reflects providers with maximum autonomy. A Foundation Trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

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

Segment	Description
1	Providers with maximum autonomy: no actual support needs identified across the five themes. Lowest level of oversight; segmentation decisions taken quarterly in the absence of any significant deterioration in performance.
2	Providers offered targeted support: support needed in one or more of the five themes, but not in breach of licence and / or NHS Improvement considers formal action is not needed. Targeted support as agreed with the provider to address issues identified and help move the provider to Segment 1.
3	Providers receiving mandated support: significant support needs and is in actual or suspected breach of the licence, but is not in special measures. Mandated support as determined by NHS Improvement to address specific issues and help move the provider to segment 2 or 1.
4	Providers in special measures: the provider is in actual or suspected breach of its licence with very serious/complex issues. Mandated support as determined by NHS Improvement to minimise the time the provider is in special measures.

The Trust has a single oversight framework segmentation of 3 which means the Trust is receiving mandated support for significant areas identified. Further information regarding this can be found in the Trust's Annual Governance Statement. This segmentation information is the Trust's position as at 31 March 2019. Current segmentation information for NHS Trusts and Foundation Trusts is published on the NHS Improvement website which can be accessed via https://improvement.nhs.uk/resources/single-oversight-framework-segmentation.

Care Quality Commission Hospital Inspection

A CQC Unannounced Core Service Inspection of the Trust took place mid November 2018. This was followed by a Use of Resources Assessment late November 2018. This was led by NHS Improvement and consisted of a day of interviews with members of the Board and senior operational teams. There was an announced CQC 'Well-led' inspection in December 2018.

When the CQC published its Quality Report, the CQC also published a Use of Resources (UoR) assessment undertaken by NHS Improvement (NHSI) that rated the Trust as inadequate for the use of resources. The combined rating for the Trust, taking into account CQC's inspection for the quality of services and NHSI's assessment of Use of Resources, is Requires Improvement. The overall rating for Royal Lancaster Infirmary also fell to Requires Improvement, whilst Furness General Hospital and Westmorland General Hospital remained rated as Good overall.

The full reports from our latest inspection can be viewed on the CQC's website at https://www.cqc.org.uk

Following the inspection, the CQC issued requirement notices regarding compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Report included also highlighted a number of other areas where further work was needed to meet required standards, and these have begun to be addressed.

Details of the Trust's Improvement Plan can be found on the Trust's website https://www.uhmb.nhs.uk/about-us/key-publications

NHS Improvement Provider Licence

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. The notice required the Trust to take all reasonable steps to deliver its services on a financially sustainable basis and set out a number of key actions; one of which required the Trust to present to NHS Improvement a summary of a Board of Directors approved Sustainability Plan. The Board of Directors approved the Bay Health and Care Partners' five year financial recovery plan at their meeting in October 2018, which will address the enforcement notice. The plan was co-produced by the Trust and Morecambe Bay Clinical Commissioning Group. It took into account the geography, health inequalities, ageing demographic, GP and hospital and community workforce constraints and the poor and ageing estate. The plan set out the actions Bay Health and Care Partners intended to make to transform patient pathways, reduce variation, digitally connect patients, primary care and second care and reshape workforce. The plan would continue to be refreshed in light of the NHS 10 year plan, winter, 2019/20 planning guidelines and the Trust's overall system 2018/19 financial out-turn.

Other Statements and Notes

External Auditors

During 2018/19 the Trust's audit contract was undertaken by Grant Thornton UK LLP.

The planned audit fees are £44,000 in respect of the Annual Accounts and £6,000 for the audit of the Quality Report.

Grant Thornton UK LLP is also engaged to provide external audit for Bay Hospitals Charity. Fees of £1,500 will be paid by the Charity in relation to this service for 2018/19.

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 Counter Fraud Authority (CFA) has set out the framework within the NHS plans to minimise losses through fraud. The Trust is required to comply with the requirements set out in the NHS CFA's Standards for Providers. 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 365,000 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 an Urgent Care Treatment Centre 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 Annexe D.

Annual Governance Statement

The Annual Governance Statement is given in Annexe 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, partner organisations and the public 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 32 Governors as follows:-

Elected Governors Constituency / Class to be elected	Number of Governors to be elected
Public Constituency	
Area 1 – Barrow and West Cumbria	5
Area 2 – Lancashire and North West of England and North Yorkshire	7
Area 3 – South Lakeland and North Cumbria	5
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
Class 6 – Community Services	1
Total Elected Governors	**24**
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
Mental Health Organisation (to be agreed)	1
Total Appointed/Partner Governors	**8**

Total Membership Of Council of Governors
Appointed/Partner Governors – 4 (currently four vacancies)
Staff Governors (elected) – 5 (currently two vacancies)
Public Governors (elected) – 16 (currently one vacancy)
Total membership of Council of Governors – 25 (currently seven vacancies)

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

Name	Constituency/Organisation	Date of Appointment and Term of Office
Public Governors		
Deborah Brownson	Barrow & West Cumbria	1 October 2018 for 3 Years
Leslie Hall	Barrow & West Cumbria	1 October 2016 for 3 Years
Lynne Slavin	Barrow & West Cumbria	1 October 2018 for 3 Years
Peter Taylor	Barrow & West Cumbria	23 February 2019 for 3 years
John Thorne	Barrow & West Cumbria	1 February 2019 for 3 years
Lorraine Crossley Close	Lancashire & North Yorkshire	26 March 2018 for 3 Years
Janet Hamid	Lancashire & North Yorkshire	26 March 2018 for 2 Years 7 months (second term extended until 31 March 2018)
Colin Hartley	Lancashire & North Yorkshire	26 March 2018 for 2 Years 7 months (first term extended until 31 March 2018)
Arthur Jones	Lancashire & North Yorkshire	1 October 2016 for 3 Years
John Pearson	Lancashire & North Yorkshire	1 October 2016 for 3 Years
Val Richards	Lancashire & North Yorkshire	1 October 2016 for 3 Years
Jim Wood	Lancashire & North Yorkshire	1 October 2016 for 3 Years
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	26 March 2018 for 2 Years 7 months (first term extended until 31 March 2018)
Annette Miller	South Lakeland & North Cumbria	1 October 2018 for 3 years
David Wilton	South Lakeland & North Cumbria	12 April 2016 for 3 years
Staff Governors		
Sam Hubbard	Allied Health Practitioners	1 February 2019 for 3 years
Ben Hignett	Management & Admin	26 March 2018 for 2 Years 7 months (first term extended until 31 March 2018)
Karnad Krishnaprasad	Medical Practitioner	26 March 2018 for 2 Years 7 months (first term extended until 31 March 2018)
Sally Sagar	Registered Nurses, Midwives & Operating Department Practitioners	1 February 2019 for 3 years
David Barrett	Registered Nurses, Midwives & Operating Department Practitioners	1 February 2019 for 3 years
Appointed/Partner Governors		
Cllr Anne Burns	Cumbria County Council	1 June 2016 for 3 Years
Alison Dixey	Cancer Care	1 October 2018 for 3 years
Cllr Shaun Turner	Lancashire County Council	12 July 2018 for 3 years
Sarah Wroe	Lancaster University	26 April 2018 for 3 years

Resignations/ Removals

Public Governors: John Thorne, Public Governor

Appointed/Partner Governors: Hugh Tomlinson, Age UK

Staff Governors: Chris Norman, Registered Nurses, Midwives and Operating Department Practitioners
Peter Taylor, Registered Nurses, Midwives and Operating Department Practitioners

At the request of the Council of Governors those governors who had not attended regular meetings during 2017/18 were removed.

Meetings of the Council of Governors

Meetings of the Council of Governors took place on the following dates in 2018/19:-

11 April 2018
14 June 2018
14 August 2018
1 November 2018
15 January 2019
20 March 2019

Attendance at Council of Governors Meetings

Governor Attendance	
Governors	**Number of Meetings (6)**
Alison Dixey	5
Annette Miller	6
Arthur Jones	6
Ben Hignett	5
Chris Norman (end date June 2018)	0
Cllr Anne Burns	0
Cllr Shaun Turner	4
Colin Hartley	3
Colin Ranshaw	6
Dave Waddington (end date 30 September 2018)	1
David Barrett (start date 1 February 2019)	0
David Stamp	5
David Wilton	5
Deborah Brownson (start date 1 October 2018)	2
George Butler	5
Glyn Davies (end date 30 September 2018)	2
Hugh Tomlinson (end date June 2018)	0
Janet Hamid	4
Jim Wood	6
John Pearson	6
Karnad Krishnaprasad	4
Leslie Hall	4
Lorraine Crossley-Close	5
Lynne Slavin (start date 1 October 2018)	3
Peter Taylor, Public Governor	5
Peter Taylor, Staff Governor (end date June 2018)	0
Roger Titcombe (end date 30 September 2018)	3
Sally Sagar (start date 1 February 2019)	1
Sam Hubbard (start date 1 February 2019)	1
Sarah Wroe (start date 26 April 2018)	3
Shahnaz Ashgar (end date 30 September 2018)	3
Steve Cvijanovic (end date 30 September 2018)	0
Val Richards	6

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
2017/18	28	15	£12,212.14
2018/19	25	16	£11,439.25

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 three joint meetings with the Board of Directors, and 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 2018/19, the Council of Governors and its Sub Groups and Committees received and considered reports on a number of issues including:-

- The Operational Plan;
- Annual Report and Accounts;
- Quality Account and External Audit Report on the Quality Accounts;
- Budget and Financial Information;
- Performance Information;
- Communications and Membership reports;
- Membership Strategy;
- Trust Constitution;
- Serious Untoward Incidents Update;
- Patient Relations Update (PALS, Compliments and Complaints);
- Bay Health and Care Partners;
- Staff Survey; and
- Recruitment.

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

- Annual Members' Meeting 2018;
- Trust Board as observers;
- Corporate Quality Reviews;
- Quality Assurance Accreditation Scheme Reviews;
- PLACE Audits;
- Constituency meetings;
- 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;
- Estates and Facilities Committee; and
- Patient Safety meeting

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 at www.uhmb.mydeclarations.co.uk or via 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 can do so by contacting the Company Secretary or via email at governors@mbht.nhs.uk

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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 seven Governors:

Ian Johnson (Chair of the Committee),
Denis Lidstone (Senior Independent Director),
George Butler Public Governor,
Les Hall, Public Governor,
Janet Hamid Public Governor,
Arthur Jones, Public Governor,
Colin Ranshaw, Head Governor,
Val Richards, Public Governor,
David Wilton, Public Governor.

Meetings of the Nominations Committee:-

There have been several meetings of the Nominations Committee during 2018/19.

The Committee undertook the review of the process for appointment of two Non-Executive Directors and the 12 month extension of one Non-Executive Directors term of office.

Chairman and Non-Executive Director Appraisals

In 2016/17 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.

As the Chair commenced in post in April 2018 it was agreed that the Chair and Non-Executive Director appraisals would be postponed for a period of 6-12 months to enable more meaningful feedback from colleagues. Individual development plans and objectives were set and mid-term reviews were held.

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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 20 March 2019 and by the Board of Directors on 29 March 2019.

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 years. 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;
- Use of the Trust's Twitter and Facebook social network sites to engage and inform members and the wider public of developments and events at the Trust; and
- A Trust 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 to retain our existing members.

- Introduction of an electronic newsletter;
- All members were invited to the Public Governor Meetings throughout the year and to the Annual Members' meeting in September 2018; 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 Dying Matters.

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 voicemail 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 2019 was as follows:-

Age	Public	Staff	Total
0-16	1	0	1
17-21	19	204	223
22+	4,064	7,707	11,771
Not stated	1,425	0	1,425
Total	5,509	6,741	13,420

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

Gender	Public	Staff	Total
Unspecified	70	3,797	3,867
Male	2.053	723	2,776
Female	3,386	3,391	7,174

Ethnicity	Public	Staff	Total
White - English, Welsh, Scottish, Northern Irish, British	3,924	3,687	7,611
White - Irish	19	9	28
White - Gypsy or Irish Traveller	0	0	0
White - Other	34	84	118
Mixed - White and Black Caribbean	0	3	3
Mixed - White and Black African	9	5	14
Mixed - White and Asian	12	21	33
Mixed - Other Mixed	16	9	25
Asian or Asian British - Indian	17	59	76
Asian or Asian British - Pakistani	7	14	21
Asian or Asian British - Bangladeshi	0	2	2
Asian or Asian British - Chinese	12	5	17
Asian or Asian British - Other Asian	14	14	28
Black or Black British - African	6	6	12
Black or Black British - Caribbean	0	1	1
Black or Black British - Other Black	1	3	4
Other Ethnic Group - Arab	0	0	0
Other Ethnic Group - Any Other Ethnic Group	12	16	28
Not stated	1,426	3,973	5,399

Acorn Socio-Economic Category	Public	Staff	Total
Lavish Lifestyles [A]	21	33	54
Executive Wealth [B]	675	836	1,511
Mature Money [C]	1,052	1,235	2,287
City Sophisticates [D]	16	17	33
Career Climbers [E]	74	202	276
Countryside Communities [F]	646	689	1,335
Successful Suburbs [G]	343	645	988
Steady Neighbourhoods [H]	440	843	1,283
Comfortable Seniors [I]	417	397	814
Starting Out [J]	137	387	524
Student Life [K]	49	118	167
Modest Means [L]	551	960	1,511
Striving Families [M]	259	435	694
Poorer Pensioners [N]	208	176	384
Young Hardship [O]	310	581	891
Struggling Estates [P]	75	125	200
Difficult Circumstances [Q]	99	116	215
Not Private Households [R]	70	103	173
Not available [NA]	67	13	80

Office for National Statistics NHSI Classifications	Public	Staff	Total
AB	1,513	2,118	3,631
C1	1,584	2,350	3,934
C2	1,179	1,729	2,908
DE	1,159	1,691	2,850

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

I am pleased to present to you our Quality Account for 2018/19, which is an annual review of the quality of NHS healthcare services provided by University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBT) during 2018/19. It also outlines the key priorities for improvement to be undertaken in 2019/20. 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 2018/19 Quality Account; the priorities for improving the quality of services in 2019/20 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 2018/19. 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 2018/19. It includes an overview of the quality improvements and achievements we have made in 2018/19 and sets out our priorities for quality improvement for 2019/20.

2018/19 has been a challenging year as increasing demand 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 117 of this document. Over the last 12 months, both Hospital Standardised Mortality Ratio (HSMR) and Standardised Hospital Mortality Indicator (SHMI) have shown 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 Trust responded to 99% of complaints within our target of 35 working days in 2018/19 with the average complaint response time being 34.85 days.

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 corporate monthly *Learning to Improve* bulletins, bi-monthly special editions, and each Care Group produces their own focused bulletin. In addition, the group now creates 'Safety Pins' which are A4 posters for focused learning. The Care Quality Commission (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.

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 2019-22 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.

2019/20 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 patients, citizens and staff, regulators, commissioners, healthcare providers and other organisations to influence future models of care delivery and deliver further improvement to quality during 2019/20.

The areas we have chosen as our quality improvement priorities for 2019/20 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: 24 May 2019

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

2.1 Priorities for improvement

Quality Achievements in our 2018/19 priorities as set out in the 2017/18 Quality Account

In this section, the Trust's performance in 2018/19 is reviewed and compared to the priorities that were published in the Trust's Quality Account in 2017/18.

This section tells you about the quality initiatives we progressed during 2018/19 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 comparative, benchmarked data over previous years. This will assist you to understand our progress over time and is a means of demonstrating performance compared to other similar Trusts. 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 2018/19 comparators may differ than the Quality Accounts 2017/18 dated 25 May 2018 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 2017/18 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 2018/19						
Key	Target Achieved / On Plan	Close to Target	Behind Plan	2016/17	2017/18	2018/19
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		93.61% Mar 17 93.37% 2016/17 Average	97.8% April 2017 to March 2018 (January data for new harms)	98% achieved

Table 1: Performance Against Trust Priorities 2018/19						
Key	Target Achieved / On Plan	Close to Target	Behind Plan	2016/17	2017/18	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 (93) of data reported through NRLS rates of all harms by bed day broken down by harm category and ward		Not reported in Quality Accounts 2016/17	Not reported in Quality Accounts 2017/18	77 (to Feb 2019) (Hospital only)
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		Not reported in Quality Accounts 2016/17	NEWS1 embedded and audited	NEWS1 embedded and audited. 93% achieved
		Reduction in StEIS reportable incidents that identify a failure in clinical escalation taken from 2016/17 baseline		Not reported in Quality Accounts 2016/17	Not reported in Quality Accounts 2017/18	Did not achieve
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		100%	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		97 (As at Feb 2017)	77 (to Dec 2017)	87 (to Dec 2018)
		Mortality ratio 5 -10 % better than National Average		2-5 better than National Average	5-10% better than National Average: 98.77	5-10% better than National Average: 97
		SHMI within expected statistical range		123 (As at Dec 2016)	86.85	89 (to Aug 2018)
		2-5 better than National Average		2-5 better than National Average	5-10% better than National Average 90.4	5-10% better than National Average 93
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		115	93	66
Priority 2: Clinical Effectiveness						
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		Not reported in Quality Accounts 2016/17	Not reported in Quality Accounts 2017/18	29% reduction NHSE data
				Accreditation Scheme now	Accreditation	Accreditation

Table 1: Performance Against Trust Priorities 2018/19						
Key	Target Achieved / On Plan	Close to Target	Behind Plan	2016/17	2017/18	2018/19
Ward Accreditation scheme Ward Accreditation scheme cont.		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		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	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	Scheme now active in 49 Inpatient Depts. /Wards (one area now closed) and 5 Outpatient Depts. 16 wards at 'Green' Standard. 17 at 'Amber' Standard 1 at ' Red' Standard 11 total clinical areas have achieved exemplar standard With 3 deferred
		50% of inpatient wards/Dept. at Exemplar standard by 2017/18 to 2018/19		Not reported in Quality Accounts 2016/17	4% (2 of 50) wards achieved	18% (9 of 49) Inpatient wards / departments
		15% of Outpatients areas to achieve exemplar status by 2017/18 to 2018/19		Not reported in Quality Accounts 2016/17	5 Outpatient areas implemented	40% (2 of 5) Outpatient areas Achieved implemented
Sharing Lessons Learned from Patient Safety Incidents		12 Standard Bulletins		12 Standard Bulletins	12 Standard Bulletins	12 Standard Bulletins
		6 Themed Bulletins per annum		7 Bulletins	6 Bulletins	6 Bulletins
		Safe incidents: Audit of Lessons Learned		Audit of Lessons Learned completed	Audit of Lessons Learned completed	Audit of Lessons Learned completed
Commissioning for Quality and Innovation (CQUIN)		Develop and maintain 95% delivery as a minimum		92%	98%	99%
Priority 3: Patient Experience						
Improvement Outcome 3 – Care that provides a positive experience for patients						
Improvement in Patient Flow and Experience						
The Trust is described as provider of choice		Inpatient areas to maintain Healthcare Communications (HCC) (previously IWGC)		Achieved 100% (HCC)	Achieved 100% (HCC)	Achieved 100% HCC

Table 1: Performance Against Trust Priorities 2018/19						
Key	Target Achieved / On Plan	Close to Target	Behind Plan	2016/17	2017/18	2018/19
for Consultants under 'I Want Great Care'		Healthcare Communications embedded in to Consultant experience feedback in 5 specialities by 2018/19		95% of Consultants registered on IWGC. 23% of Consultants Active on IWGC. Used in Ophthalmology Reviews.	Achieved IWGC introduced in to Consultant experience feedback in at least one speciality	System now in place in 5 specialities for FFT reviews to be available by Consultant and date field as an alternative to Location searches
Reduce Formal Complaints and improve complaints response timescales		Maintain complaint levels below a ratio of 1 Complaint per 1,000 patient attendance (Equivalent to 0.1%)		0.73 complaints per 1,000 patient attendance	0.52 complaints per 1,000 patient attendance	0.6 complaints per 1,000 patient attendance
		100% of complaints acknowledged within 3 days		100%	100%	100%
		95% of complaints to be responded to within 35 days		97.7%	98.6%	99%
Increase the scope and depth of public engagement		6 public engagement events 2017/18 to 2018/19		13 Events held	15 Events held	19 Events held
Integration of Physical and mental health pathways		7 day Child and Adult Mental health Service (CAMHS) support for Cumbria and Lancashire North		Not reported in Quality Accounts 2016/17	6 day service achieved	Under review by CCG
		A Mental Health Matron working across The Orchard and the Emergency Department at the Royal Lancaster Infirmary		Not reported in Quality Accounts 2016/17	Achieved	Achieved
		Baseline outcomes measured reported to ENACT		Not reported in Quality Accounts 2016/17	Complete	Complete
Delivery of the SAFER Care Bundle which is fundamental to optimising flow and requires clinical leadership		**S** – **Senior Review** **A – All patients** will have an Expected Discharge Date and Clinical Criteria for Discharge **F – Flow of patients** will commence at the earliest opportunity **E – Early discharge** **R – Review**		Not reported in Quality Accounts 2016/17	Not reported in Quality Accounts 2017/18	SAFER is being implemented across both FGH & RLI
Reduce avoidable referrals into hospital through increased uptake in advice and		10% reduction in avoidable referrals: this relates to absolute number of admissions avoided through advice and		Not reported in Quality Accounts 2016/17	Not reported in Quality Accounts 2017/18	Did Not achieve

Table 1: Performance Against Trust Priorities 2018/19						
Key	Target Achieved / On Plan	Close to Target	Behind Plan	2016/17	2017/18	2018/19
guidance to GPs		guidance in 2018/19 compared to 2017/18				
Work with local GP's and community nursing staff to reduce the number of patients who die in hospital against their wishes: Work with local nursing homes 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. 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		Not reported in Quality Accounts 2016/17	Not reported in Quality Accounts 2017/18	In progress
Improve Staff Experience ***Please note change in national staff survey benchmarking. As a transitional year previous key findings scores have been reported.***						
Increase voice for staff in how their organisation can be improved		Achievement of 60% on key result areas in the better than average/best 20% 2017/18 to 2018/19		Not reported in Quality Accounts 2016/17	56%	70%
		Staff ability to contribute to improvements at work (65%)		69%	69%	72%
		Staff recommendation of the Trust as a place to work or receive treatment (3.39 out of 5)		3.73 out of 5	3.79 out of 5	3.85 out of 5 (transitional report) 6.8 out of 10
		Staff motivation at work (3.76 out of 5)		3.90 out of 5	3.90 out of 5	3.97 out of 5 (transitional report) New report: move to 3 motivation themes I look forward to going to work: 6.7 out of 10 I am enthusiastic about my job: 7.7 out of 10 Time passes quickly when I am working: 7.9 out of 10
		Overall Staff Engagement		3.78	3.79	3.85 out of 5

Table 1: Performance Against Trust Priorities 2018/19						
Key	Target Achieved / On Plan	Close to Target	Behind Plan	2016/17	2017/18	2018/19
		Figure		out of 5	out of 5	(transitional report) 7.1 out of 10

2.1.2 Selected Priorities for Quality Improvement in 2019/20

This section tells you about how we prioritised our quality improvements for 2019/20. 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 2019/20

On 19 February 2019, the Trust published a timetable for the process of developing the Quality Account for 2019/20, including consultation with stakeholders, our Governors and importantly, by talking to staff, patients and carers.

A draft Annual Quality Account was produced in March 2019 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 2019-22.

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 2019/20

The Trust is currently refreshing its three-year Quality Improvement Strategy for 2019-22. The Quality Improvement Strategy describes 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 and Quality Strategy.

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; and
- 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 2019-22 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 2019-22 was endorsed by the Board of Directors on 27 March 2019. 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 Goals for 2018/19 have been taken from the Quality Improvement Strategy 2016-19, and an additional four Key Quality Improvement Priorities for 2019/20 were agreed through consultation with staff and stakeholders to be included in the Quality Accounts and agreed by the Quality Committee on 18 March 2019 and subsequently on 15 April 2019 and these are detailed in *Key Priority* in Table 2 in bold italics.

Table 2: Priorities for Quality Improvement for 2019/20 detailed in Quality Improvement Strategy and Plan 2019-2022

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	98% of patients receiving harm free care
	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 2018/19 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	***Monitor National Early Warning Score (NEWS2) through audit tools to achieve 90% standard***
		Reduction in StEIS reportable incidents that identify ***failure to rescue*** taken from 2016/17 baseline
Improving Documentation	Delivery of E-Nursing Documentation across all In-Patient Wards	***Monitor the quality of E-nursing documentation on all inpatient wards through audit tool***
Reducing Avoidable & Premature Mortality	Reducing the Summary Hospital-level Mortality Indicator for HSMR & Summary Hospital-level Mortality Indicator (SHMI)	2018-19 to 2019-20 Mortality ratio to be 5-10% better than the national average 2018-19 to 2019-20 SHMI index 5-10% better than national average
		Reduce HSMR for stroke ***by 10% based on 18/19 baseline***
		75% coverage of mortality reviews by March 2020
Improvement Outcome 2 – Care that is clinically effective		
Deliver Effective and Reliable Care	Reduce E-coli infection rates for Hospital Acquired E-Coli BSI	***2019/20 - No greater than 32 cases based on a 10% reduction per annum from the baseline (calendar year ending December 2016 of 47 cases)***
	Quality Assurance Assessment System: Quality Accreditation Scheme	50% of Clinical Departments at Exemplar Standard by 2019/20
	Commissioning for Quality and Innovation (CQUIN)	Develop and Maintain 95% delivery as a minimum for 2019/20
	Consistent application of best evidence	***Implementation of national guidance assured through Trust's clinical audit programme***
	GIRFT, Right Care & Model Hospital ***Analytical Review & Implementation of Recommendations***	***Part i: PMO to support a programme to reduce variation using benchmark data by service and specialty Part ii: Aim to remove unwarranted variation; improve care & outcome: identify 3 areas of variation to focus on & improve by Q4***
Improvement Outcome 3 – Care that provides a positive experience for patients		

Table 2: Priorities for Quality Improvement for 2019/20 detailed in Quality Improvement Strategy and Plan 2019-2022		
Quality Goal	**Key Priority**	**Measurable Outcome**
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 care groups	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 ***aligned to the Trust's Patient Experience Strategy and NHS Plan***
	Delivery of the SAFER Care Bundle which is fundamental to optimising flow and requires clinical leadership.	*Continue the improvement work to implement the SAFER bundle consistently in all areas.* *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.*
	Work with local GP's and community nursing staff to reduce the number of patients who die in hospital against their wishes	• ***Expansion of care home team across bay which will link with GP practices and facilitate wider care planning.*** • ***Continue work with Hospice teams who are supporting care homes with End of life care education facilitating end of life care in their preferred place for end of life care.*** • ***Continue to support the regulated care sector enable resilience in relation to workforce challenges and competency of staff in collaboration with the CCG team***
	Work with local nursing homes to reduce the number of patients who die in hospital against their wishes	
	Patient Experience Strategy	***Development of a Patient experience strategy with citizens, patients and staff***
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 themed result areas above average in 2019-20 *N.B. National staff survey reporting changed in 2019.*
	Colleague Experience Strategy	***Development of a Colleague experience strategy with staff***

2.1.5 Commissioning for Quality and Innovation (CQUIN) Schemes in 2019/20

Working closely with our Commissioners, we have developed a comprehensive CQUIN programme for 2019/20 focusing on delivering key quality outcomes for patients, rather than process outcomes. The delivery of schemes will be via teams from across our Clinical Care Groups supported by colleagues in I[3], Transformation and Programme Management Office and Strategy and Business Development so that improvements are fully embedded in a sustainable way.

There are currently 9 CQUIN Schemes proposed for 2019/20. These are across a number of commissioning organisations including Morecambe Bay Clinical Commissioning Group (CCG) and Specialist Commissioning.

Table 3 below lists the selected CQUIN schemes for 2019/20 that will be reported on in the Quality Account 2020/21.

Table 3: CQUIN Schemes for 2019/20	
National CQUIN Scheme	**Target**
Prevention of Ill Health **Antimicrobial Resistance – Lower Urinary Tract Infections in Older People & Antibiotic Prophylaxis in Colorectal Surgery** (Acute)	• Achieving 90% of antibiotic prescriptions for lower UTI in older people meeting NICE guidance for lower UTI (NG109) and PHE Diagnosis of UTI guidance in terms of diagnosis and treatment. • Achieving 90% of antibiotic surgical prophylaxis prescriptions for elective colorectal surgery being a single dose and prescribed in accordance to local antibiotic guidelines.
Prevention of Ill Health **Flu vaccinations** (Acute/ Community)	• Achieving an 80% uptake of flu vaccinations by frontline clinical staff between 1 September 2019 and February 28th 2020.
Prevention of Ill Health **Alcohol and Tobacco Screening and Brief** (Acute/ Community)	• Achieving 80% of inpatients admitted to an inpatient ward for at least one night who are screened for both smoking and alcohol use. • Achieving 90% of identified smokers given brief advice. • Achieving 90% of patients identified as drinking above low risk levels, given brief advice or offered a specialist referral.
Patient Safety **Three high impact actions to prevent hospitals falls** (Acute/ Community)	• Achieving 80% of older inpatients receiving key falls prevention actions. - Lying and standing blood pressure to be recorded - No hypnotics or anxiolytics to be given during stay OR rationale documented - Mobility assessment and walking aid to be provided if required.
Best Practice Pathways **Same Day Emergency Care** (Acute)	• Achieving 75% of patients with confirmed pulmonary embolus being managed in a same day setting where clinically appropriate. • Achieving 75% of patients with confirmed atrial fibrillation being managed in a same day setting where clinically appropriate. • Patients with or confirmed Community Acquired

Table 3: CQUIN Schemes for 2019/20	
	Pneumonia should be managed in a same day setting where clinically appropriate
Regional CQUIN Scheme	**Target**
None identified	
Local CQUIN Schemes	**Target**
None identified	
NHS England CQUIN schemes	**Target**
Medicines Optimisation and Stewardship (Acute)	1. Improving efficiency in the IV chemotherapy pathway from pharmacy to patient 3. Supporting national treatment criteria through accurate completion of prior approval proformas (Blueteq) 4. Faster adoption of prioritised best value medicines and treatment 5. Anti-Fungal Stewardship - Reduce inappropriate use of anti-fungal agents and prevent the development of resistance to antifungals.
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 2019/20 is to achieve a 95% delivery as a minimum.

2.1.6 Rationale for the Selection of Priorities to be removed in 2019/20

This section includes a list of areas that the Board of Directors have chosen to remove from the quality improvement priorities for 2019/20. 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:

- Reduce avoidable referrals into hospital through increased uptake in advice and guidance to GPs ;
- 15% of outpatient 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;
- Audit of lessons learned at 6-12 months following publication of themed bulletins to measure lessons being learned;
- 7-day CAMHS support for Cumbria and Lancashire North; and
- Healthcare Communications embedded in to Consultant experience feedback in 5 specialities.

2.1.7 How we will Monitor, Measure and Report on-going progress to achieve our priorities for quality improvement 2019/20

When identifying the quality improvement priorities for 2019/20 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 Care Group 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; and
- 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 2019/20 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 Care Group Risk Register process.

The Trust will also report on-going progress regarding implementation of the quality improvements for 2019/20 to our staff, patients and the public via our performance section of our website which can be accessed at the following link: http://www.UHMBT.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.UHMBT.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 2018/19 the University Hospitals of Morecambe Bay NHS Foundation Trust provided and/or subcontracted 39 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 39 of these relevant Health Services.

The income generated by the relevant Health Services reviewed in 2018/19 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 2018/19.

2.2.2 Participation in Clinical Audits and National Confidential Enquiries

During 2018/19, 40 national clinical audits and 3 national confidential enquiries covered relevant Health Services that University Hospitals of Morecambe Bay NHS Foundation Trust provides.

During 2018/19, University Hospitals of Morecambe Bay NHS Foundation Trust participated in 89.7% 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 2018/19 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 2018/19

Number	Title of National Clinical Audit	Column A Participate	Column B Cases Submitted	Column C Cases submitted (% of cases required)
1	Adult Community Acquired Pneumonia	Yes	None submitted yet ongoing until May	Planned 100%
2	National Cardiac Audit Programme (NCAP)	Yes	MINAP – 219 FGH 203 RLI CRM 386 NICOR - 397	100%
3	Case Mix Programme (CMP)	Yes	943	100%
4	Falls and Fragility Fractures Audit Programme (FFFAP)* NHFD	Yes	FGH107 RLI218	100% 100%
5	Feverish Children (Care in Emergency Departments)	Yes	FGH 25 RLI 112	100% 100%
6	Inflammatory Bowel Disease Programme/ IBD Registry	Yes	FGH 145 RLI 164	100%
7	Major Trauma Audit	Yes	297	94%
8	National Asthma and COPD Audit Programme	Yes	FGH 26 RLI 30	100% 46%
9	National Audit of Care at the End of Life (NACEL)	Yes	Trust 80 - Report published May 2019	100%
10	National Audit of Dementia	Yes	FGH 61 RLI 78	100%
11	National Gastro-intestinal Cancer Programme	Yes as diagnosing Trust only	NBOCAP – 201 NOGCA - 147	92% >90%
12	National Cardiac Arrest Audit (NCAA)	Yes	FGH 49 RLI 49	100% 100%
13	National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)	Yes	91	Not known
14	National Comparative Audit of Blood Transfusion Programme	Yes	0 eligible	N/A
15	National Diabetes Audit – Adults	Yes	FGH 0 RLI 2	100% 100%
16	National Emergency Laparotomy Audit (NELA)	Yes	187	100%
17	National Joint Registry	Yes	1326	100%
18	National Lung Cancer Audit (NLCA)	Yes	Awaiting figures	
19	National Maternity and Perinatal	Yes	2907	Not known

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 2018/19				
Number	**Title of National Clinical Audit**	**Column A Participate**	**Column B Cases Submitted**	**Column C Cases submitted (% of cases required)**
	Audit (NMPA)			
20	National Neonatal Audit Programme (NNAP)	Yes	319	97.9%
21	National Opthalmology Audit	Eligible but not submitting	None	None
22	National Paediatric Diabetes Audit (NPDA)	Yes	None yet Submission not due until May	Planned 100%
23	National Prostate Cancer Audit	Yes	271	100%
24	Non-Invasive Ventilation – Adults	Yes	Ongoing until June	-
25	Reducing the Impact of Serious Infections (Antimicrobial Resistance and Sepsis)	Yes	50 cases per month	100%
26	Sentinel Stroke National Audit Programme (SSNAP)	Yes	555	80-89%
27	Seven Day Hospital Services	Yes	160	100%
28	UK Cystic Fibrosis Registry	Yes	14	100%
29	Vital Signs in Adults (Care in Emergency Departments)	Yes	FGH 101 RLI 178	100% 100%
30	BAUS Urology Audit - Cystectomy	Not eligible	N/A	N/A
31	BAUS Urology Audit – Female Stress Urinary Incontinence (SUI)	No	Procedure on hold by NHS England so no procedures carried out	N/A
32	BAUS Urology Audit – Nephrectomy	Not eligible	N/A	N/A
33	BAUS Urology Audit – (PCNL) Percutaneous Nephrolithotomy	Not eligible	N/A	N/A
34	BAUS Urology Audit – Radical Prostatectomy	Not eligible	N/A	N/A
35	Child Health Clinical Outcome Review Programme (NCEPOD) • Long term ventilation	Yes	Ongoing	
36	Elective Surgery (National PROMs Programme)	Yes	1460	100%
37	Learning Disability Mortality Review Programme (LeDeR)	Yes	N/A	N/A
38	Mandatory Surveillance of Bloodstream Infections and Clostridium difficile Infection	Yes	111	100%
39	Maternal, Newborn and Infant Clinical Outcome Review Programme	No, decommissioned	N/A	N/A
40	Mental Health Clinical Outcome Review Programme	Not eligible	N/A	N/A
41	National Audit of Anxiety and Depression	Not eligible	N/A	N/A
42	National Audit of Breast Cancer in Older People	No, eligible but not participating	None submitted	None submitted
43	National Audit of Intermediate Care	Not eligible	N/A	N/A
44	National Audit of Pulmonary Hypertension	Not eligible	N/A	N/A
45	National Audit of Seizures and Epilepsies in Children and Young	Yes	FGH 6 RLI 0	Unknown

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 2018/19				
Number	**Title of National Clinical Audit**	**Column A Participate**	**Column B Cases Submitted**	**Column C Cases submitted (% of cases required)**
	People – Epilepsy12			
46	National Bariatric Surgery Register (NBSR)	Not eligible	N/A	N/A
47	National Clinical Audit of Psychosis	Not eligible	N/A	N/A
48	National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs Following Major Injury (NCASRI)	Not eligible	N/A	N/A
49	National Mortality Case Record Review Programme	No	Not participating	Not participating
50	National Vascular Registry	Not eligible	N/A	N/A
51	Neurosurgical National Audit Programme	Not eligible	N/A	N/A
52	Paediatric Intensive Care (PICANet)	Not eligible	N/A	N/A
53	Prescribing Observatory for Mental Health (POMH-UK)	Not eligible	N/A	N/A
54	Serious Hazards of Transfusion (SHOT):UK National Haemovigilance	Yes	17	100%
55	Surgical Site Infection Surveillance Service	Yes	3	
56	VTE Risk in Lower Limb Immobilisation (Care in Emergency Departments)	No, decommissioned, not enough cases	N/A	N/A
57	National Audit of Cardiac Rehabilitation	Not eligible	N/A	N/A
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 2018/19.				
Number	**Title of National Confidential Enquiries**	**Column A Participate In**	**Column B Cases submitted**	**Column C Cases submitted (% of cases required)**
1	Pulmonary Embolism	Yes	10	91%
2	Long Term Ventilation	Yes	2 but ongoing	ongoing
3	Acute Bowel Obstruction	Yes	10	100%
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 2018/19, 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.UHMBT.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.		
Number.	**Title of National Clinical Audit reports received in 2018/19**	**Details of actions taken or being taken to improve the quality of local services and the outcomes of care.**
1	National Emergency	Pathway to be designed to improve care for patients undergoing an

Table 6: Details of actions taken or being taken to improve the quality of local services and the outcomes of care.		
Number.	**Title of National Clinical Audit reports received in 2018/19**	**Details of actions taken or being taken to improve the quality of local services and the outcomes of care.**
	Laparotomy Audit (NELA)	emergency laparotomy
2	Sentinel Stroke National Audit Programme (SSNAP)	Developed an electronic stroke pathway to allow the data needed for SSNAP to be identified and captured.
3	RCM Procedural Sedation	Refurbish and streamline the complete Sedation checklist to a single page as this previously consisted of 4 sheets of paper
4	National Pregnancy in Diabetes Audit	To work with primary care with the aim to improve folic acid 5mg pre-conception
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 414 local clinical audits were reviewed by the provider in 2018/19 and University Hospitals of Morecambe Bay NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided: a sample of improvements made to the quality of healthcare provided as a result of audit findings from audits undertaken during 2018/19 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 2018/19 at www.UHMBT.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 2018/19	**Details of actions taken to improve the quality of local services and the outcomes of care**
Audit and Re-audit of 'Time to see Consultant'	• Raise awareness of importance that new patients are seen by consultants. • Change daily ward round culture and the way patients are divided to be seen by middle grade/consultant. • Highlight new patients on ward round diary or computer list
MyAssurance for Controlled Drugs Audit	Alert to be issued to remind staff about controlled drugs balance checks
Caesarean section audit	New form developed within Lorenzo should improve documentation
Adult Bronchoscopy	Updated patient leaflet and sedation guide
Safe and Secure Storage of Medicines	Undertake a risk assessment of all non-standard Controlled Drug cupboard by the end of September 2018
Turn-around Times for Prostate Core Biopsies	Appointment of a sub-specialist uro-pathologist consultant to report the uro-pathology cases
Audit of Waiting Times in Symptomatic Breast Clinic	Review clinic template and alter as appropriate to reduce impact on flow for new patients in the clinic Utilise PACS (image reporting system) function for quicker report verification
Audit of PCC Use	Update PCC Policy to include instructions for laboratory staff to write patient INR and weight on transfusion request forms
Bedside Audit of Blood Transfusion	Identify staff and discuss the importance of taking observations at the correct times during transfusion episodes to monitor for transfusion reactions.
Prescription of Blood Components and Medical Notes: Round 3	Liaise with education centre to agree slots on FY1 and FY2 training Liaise with clinical skills team, practice educators to provide training slots

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 2018/19	**Details of actions taken to improve the quality of local services and the outcomes of care**
Section 11 & Contracts for 2018-2019	Recruit a Safeguarding Educator to place the current external agencies currently delivering training.
18/19 HTM03 - Ventilation Systems Management RLI	Capital Bid for ventilation plant
Cannula Care	• Audit information to be shared with clinical skills team. Team to update staff during cannulation training sessions on an ongoing basis. • Attend Ward Manager meetings for surgery & medicine at FGH and RLI to report findings of audit • Update new FY1 doctors during shadowing period • VIP score to be updated and disseminated to ward areas following approval at procedural documents group.
COSHH and Door Security – CQC	• Posters to be developed for ward/clinical areas to display core information per COSHH product used. This is to ensure staff who have limited access to their PC's can still find useful COSHH information for the products they use.
Chest Drain Care Plan (QIP FGH)	• Written consent should be taken for all chest drain insertions • Address common complications of procedure-related pain and drain fall out rate with emphasis on optimum insertion and fixation techniques within formal training programmes • Aim for all drains for fluid to be placed with real-time ultrasound guidance, avoiding the remote X marks the spot technique • Care plan should be completed for all ICT insertions • Repeat CXR should be performed within 2 hours. • Put in place a live Intercostal Drain Care Plan on Lorenzo
Audit of current practice of management of anaemia in elderly admitted to ward 22	Educate juniors to measure B12/folate in all cases of macrocytic anaemia and advise them to measure B12/folate in all cases of normocytic anaemia to offer higher standards or medical management.
Oxygen Prescription FGH	• Teaching/Encouraging Doctors about the importance of prescribing oxygen on Lorenzo. • Teaching Nursing Staffs about appropriate delivery device use and the importance of keeping the patients in the target saturation (mandatory E-Learning) Updating E-Learning about prescribing oxygen on Lorenzo. • Putting the reminder poster in the clerking areas (AMU and ED) for prescribing Oxygen and how to prescribe on Lorenzo at the time of admission. Default oxygen prescription on Lorenzo to be dealt with before proceeding with patient's medication prescription. • Re-Audit in a month time after implementations.
Data source: Annual Clinical Audit Report 2018/19	

2.2.3 Participation in Clinical Research in 2018/19

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

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

The number of patients receiving relevant health services provided or sub-contracted by the Trust in 2018/19 that were recruited during that period to participate in research approved by a research ethics committee was 978 (to 15 March 2019).

Currently, there are 140 open research studies, a doubling in activity compared to 2017/18. All of these are adopted on to the National Institute for Health Research (NIHR) Clinical Research Network portfolio. These studies are high quality trials that benefit from the infrastructure and support of the Clinical Research Network (CRN) in England. We are currently hosting 32 actively recruiting clinical trials involving medicinal products, with eight further studies in the planning stage, which demonstrate the Trust's enthusiasm to improve and offer the latest medical treatments.

The Trust has a strong team of 14 dedicated research nurses working generically on a variety of research studies and 5.6 clinical trials support staff. The Trust has strong research activity in cancer, anaesthetics, respiratory, gastrointestinal, cardiovascular, dermatology, surgery, musculoskeletal and paediatrics, and we actively encourage more departments to get involved. There are currently 35 clinical staff acting as the Trust lead investigator on approved research studies, across multiple specialties.

The Trust research nurses work closely with the clinicians to identify suitable research studies that fit with the patient population and also to identify eligible patients to participate. It is envisaged that the continued dedication and flexibility of the Research Nurses, together with the enthusiasm and support of the clinicians will further raise the profile of Research and Development in 2019/20.

2018/19 has seen a number of achievements for the Research Department:

- The Research Department successfully held its first external research conference at the Town Hall in May 2018 and has plans to hold its next conference in May 2019;
- One of our occupational therapists, working in stroke, has been successful in obtaining an NIHR pre doctoral award;
- Four of clinical staff have been awarded NIHR Collaborations for Leadership in Applied Health Research and Care (CLAHRC) Internships;
- We have been awarded an NIHR Health Service and Delivery award, led by an anaesthetist; and
- We have our first two active collaborations with local small medtech companies, and Lancaster University, to evaluate the products in a real life setting.

The Trust continues to participate in research studies that are feasible in terms of the services we offer and our patient population and we aspire to raise the profile of research further still in 2019/20.

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

The Commissioning for Quality and Innovation (CQUIN) payment framework aims to support the cultural shift towards making quality the organising principle of NHS services. 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 2018/19 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. Further details of the agreed goals for 2018/19 and for the following 12 month period 2019/20 are available electronically via our performance section of our website which can be accessed via the following link: http://www.UHMBT.nhs.uk/about-us/key-publications/.

For 2018/19, the baseline value of the CQUIN was £6.6m. 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 2018/19, conditional upon achieving quality improvement and innovation goals, is £6.6m; however, it is estimated that the Trust will achieve a monetary total value of £6.5m (currently projected value) for the associated payment in 2018/19 (compared to 2017/18, the Trust achieved a monetary total value of £5.5m). 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 2018/19 are detailed in Table 23; in addition, further details of the 9 agreed CQUIN schemes 2019/20 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 2018/19.

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 2018/19.

University Hospitals of Morecambe Bay NHS Foundation Trust intends to take the appropriate action to address the conclusions or requirements reported by the CQC. This will be actioned through a CQC improvement plan monitored by the board.

Special Reviews

University Hospitals of Morecambe Bay NHS Foundation Trust has participated in special reviews by the Care Quality Commission in 2018/19.

Overview

In February 2017, the CQC assessed the Trust as good overall and outstanding for care.

A CQC Unannounced Core Service Inspection of the Trust took place mid November 2018. This was followed by a Use of Resources Assessment late November 2018. This was led by NHS Improvement and consisted of a day of interviews with members of the Board and senior operational teams. There was an announced CQC 'Well-led' inspection in December 2018. The final CQC Quality Report was published in May 2019 and rated the Trust as requires improvement overall. The overall rating for Royal Lancaster Infirmary also fell to Requires Improvement, whilst Furness General Hospital and Westmorland General Hospital remained rated as Good overall.

Care Quality Commission Hospital Inspection

A CQC Unannounced Core Service Inspection of the Trust took place mid November 2018. This was followed by a Use of Resources Assessment late November 2018. This was led by NHS Improvement and consisted of a day of interviews with members of the Board and senior operational teams. There was an announced CQC 'Well-led' inspection in December 2018.

When the CQC published its Quality Report, the CQC also published a Use of Resources (UoR) assessment undertaken by NHS Improvement (NHSI) that rated the Trust as inadequate for the use of resources. The combined rating for the Trust, taking into account CQC's inspection for the quality of services and NHSI's assessment of Use of Resources, is Requires Improvement. The overall rating for Royal Lancaster Infirmary also fell to Requires Improvement, whilst Furness General Hospital and Westmorland General Hospital remained rated as Good overall.

The full reports from our latest inspection can be accessed via the following link:
https://www.cqc.org.uk/provider/RTX

Following the inspection, the CQC issued requirement notices regarding compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Report included also highlighted a number of other areas where further work was needed to meet required standards, and these have begun to be addressed.

Details of the Trust's CQC Improvement Plan can be can be accessed via the following link:
https://www.uhmb.nhs.uk/about-us/c-q-c/

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:

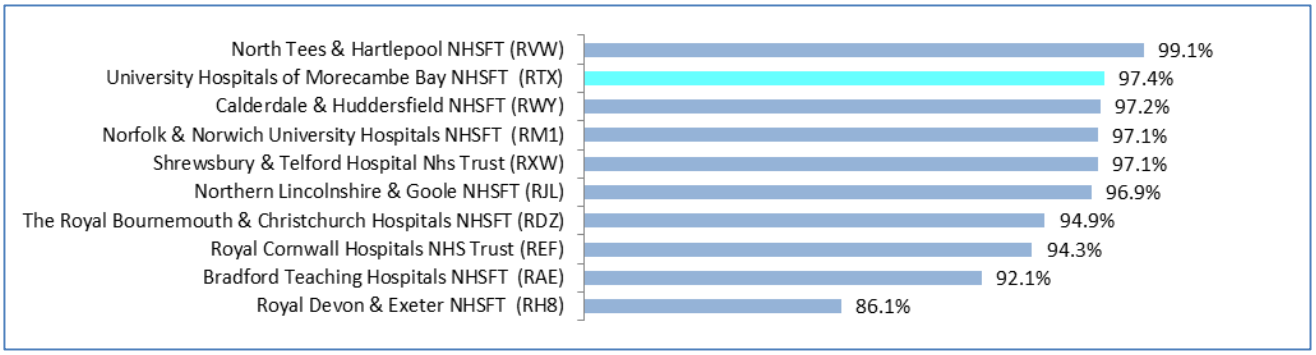
- The delivery of patient care within the e-Hospital environment;
- The delivery of the Trust's core business objectives;
- The delivery of the Trust's Business Intelligence framework, including on-demand real-time reporting and analytics;
- The development of a Clinical Information Culture including 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; and
- Accountability and transparency.

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

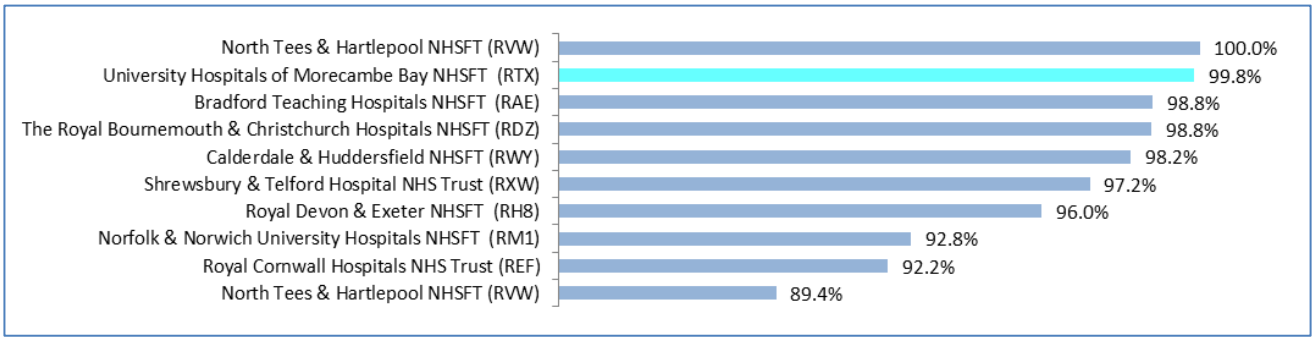
- Legal (Data Protection Act 1998);
- Contractual (Contracts of employment); and
- Ethical (Professional codes of practice).

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 2018/19 against its peer group:

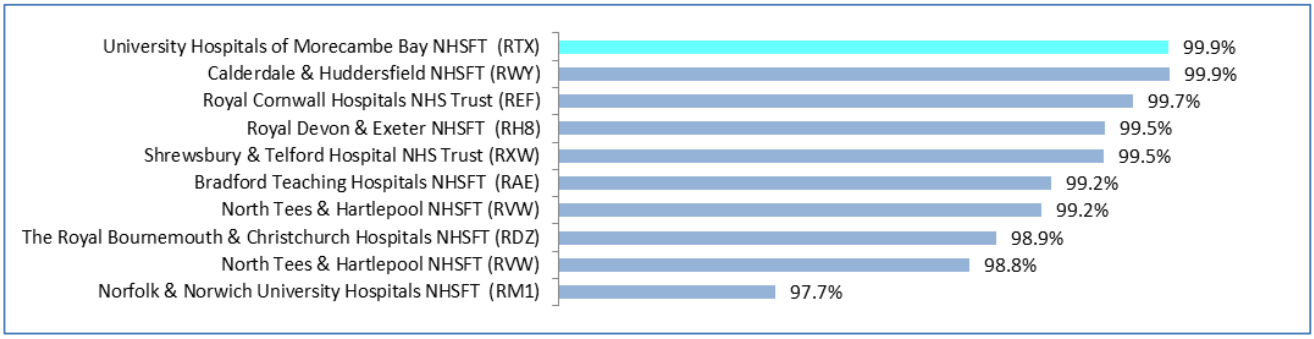
Accident & Emergency Data Quality:



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 2018/19 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 2018):

which included the patient's valid NHS Number was:

- 100% for Admitted Patient Care;
- 100% for Outpatient Care; and
- 100% 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 2018/19

University Hospitals of Morecambe Bay NHS Foundation Trust Information Governance Assessment (Data Security and Protection Toolkit) overall score for 2018/19 was "Standards Met".

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 1 April 2018 – 31 March 2019 by the Audit Commission. It is expected that the Trust will undertake a PbR Audit during 2019/20; however, this has not yet been confirmed by the Regulator, Monitor.

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

- Focused data quality improvement directed through the Information Governance and Data Quality Group;
- Implementation of a Trust-wide data quality monitoring framework;
- Ward-based focused data quality improvement initiative; and
- Focus on continued clinical system data quality to support patient care and real-time analytics.

2.2.7 Learning from Deaths

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 Royal Lancaster Infirmary and Furness General Hospital sites. The monthly mortality reviews are also discussed in each Care Group 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.UHMBT.nhs.uk/about-us/data-patient-safety-incidents/.

Any patient safety concern which is logged in the Trust's governance system of moderate or high risk category, all near misses and harms get discussed in the Weekly Patient Safety Summit and a Root Cause Analysis (RCA) or Rapid Review is conducted. Appropriate cases are discussed at the Serious Incidents Requiring Investigation (SIRI) panel. The Deputy Medical Director produces quarterly reports for the Quality committee.

This provides the Trust with assurance in the following:

- Oversight of the mortality review process, ensuring that site based mortality reviews are undertaken by the Care Groups;
- Assurance that the majority of deaths are reviewed in all specialities regardless of site and all reviews include data in relation to HSMR and SIMI;
- That the mortality report sets out the learning and provides a triangulation of the data linking in the areas of governance and coding and feeds back to the clinicians in the Care Groups on the learning points; and
- That the learning points are discussed in the Care Group governance meetings via their mortality report.

Review findings are fed back via a quarterly mortality report to the Trust's Quality Committee.
The lead clinician for the site based mortality reviews guarantees that a weekly multi-disciplinary team mortality case review for all adult deaths is undertaken to ensure that:

- The data collection on the electronic dashboard is accurate and uses the process of HOGAN and NCEPOD scoring;
- Deaths deemed as avoidable are highlighted and Lessons Learned are disseminated in the Care Groups;
- From a patient's and family experience point of view, bereavement staff continue to support families through the difficult time, and for this they have had very good feedback; and
- The majority of the cases where care quality could have been better are discussed in mortality reviews and also in care group meetings. The near misses or any potential harm is discussed through the Weekly Patient Safety Summit and SIRI panel, as appropriate.

Over the last 6 months, both HSMR and SHMI have shown some variations; however, the improvement sustained. From a morbidity point of view, we monitor other indicators of Methicillin-resistant Staphylococcus aureus (MRSA), Clostridium difficile toxin (CDT) and falls. The Trust Venous thromboembolism (VTE) lead and a sepsis lead are undertaking regular audits on those areas to ensure the quality and standard of care are improved.

During the period 1 April 2018 to 31 March 2019, 1103 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:

- 253 in the first quarter;
- 241 in the second quarter;
- 289 in the third quarter; and
- 321 in the fourth quarter.

By 31 March 2019, 504 case record reviews and 857 investigations have been carried out in relation to 1103 of the deaths included in the item above.

In 332 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:

- 257 (Averaged) in the first quarter;
- 257 (Averaged) in the second quarter;
- 257 (Averaged) in the third quarter; and
- 257 (Averaged) in the fourth quarter.

*4 representing 0.36% 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:

- 1 representing 0.09% for the first quarter;
- 1 representing 0.09% for the second quarter;
- 1 representing 0.09% for the third quarter; and
- 1 representing 0.09% for the fourth quarter.

*Based on those assessed with a HOGAN score of 3 or above.

We have introduced electronic documentation of mortality reviews and also full Electronic Patient Records (EPR); this has made information readily available and reduced the chances of delay in treatment. We have completed sepsis training for the junior doctors through the teaching and training days. VTE assessment has been introduced in the patient EPR confirming all clinicians go through the VTE assessment.

We have used the Mortality Review Process and a standard pathway and process through which the site based mortality leads conduct mortality reviews. This is documented in the new electronic dashboard in a standard template along with NCEPOD and HOGAN scores.

There is a site based mortality report submitted to care group 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, an 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 is circulated to the Care Group teams and Care Group Governance Assurance Groups (CGGAG) for lessons learnt. Depending on the themes, we also do themed reviews (for example: include falls, missed fractures, radiology reporting, 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.

34 case record reviews and 11 investigations completed after 31 March 2018 which related to deaths which took place before the start of the reporting period.

2 representing 0.17% 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.

9 representing 0.76% of the patient deaths during 2017/18 are judged to be more likely than not to have been due to problems in the care provided to the patient.

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

The weekly Patient Safety Summit has highlighted examples of good practice which includes:

- good documentation;
- appropriate palliative care referral;
- good communication with patients and family;
- early involvement of senior clinicians;
- early involvement of ITU;
- early involvement of multi-disciplinary team;
- appropriate instigation of DNACPR;
- daily ward round reviews;
- early recognition of futility discussion with families;
- quick appropriate treatment in AMU;
- clear and caring discussion with the families regarding their wishes on place of death;
- prompt communication when patient has failed to respond to standard care;
- some good summaries in the death certificates;
- early management of perceived deterioration and communication to families with preferred place of care to die and arranging fast end of life support in chosen place by the patient; and
- good interface used between GP notes which is now available through electronic communication, and
- Community DNACPR communication within the hospital.

Documented areas of learning points include lack of mention of co-morbidities in some death certificates; use of GMC numbers by the doctors in documents could be better; in some cases not documenting where the chosen place of care is; to improve documentation on communication to patients; delayed referral in two cases to other clinical team which contributed to delayed care; unable to access electronic records due to lack of training and computer problems; and long stay in hospital because of poor number of community beds. The lessons learned also include better compliance of sepsis pathways, communication between teams, quality of handover, appropriate VTE prophylaxis, proactive DNACPR decision and prompt communication between care groups. The Trust has taken steps in each case to share the learning, teaching and training of junior doctors and staff so that such incidents in future could be avoided. The data monitoring through the weekly Patient Safety Summit and mortality dashboard continues.

We continue our journey to reflect on our current system and performance, change where needed in a responsive way and monitor our progress through mortality meetings and the weekly Patient Safety Summit.

2.3 Reporting Against Core Quality Indicators

Set out in Table 8 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 8 with:

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

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

Table 8: 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 16 to Dec 16	1.03 Band 2	1.00	1.19	0.69	32.9%	30.1%	56%	7.3%
Apr 16 to Mar 17	1.05 Band 2	1.00	1.21	0.71	32.7%	30.7%	56.9%	11.1%
Jul 16 to Jun 17	1.05 Band 2	1.00	1.23	0.72	33.8%	31.0%	58.59%	11.2%
Oct 16 to Sep 17	1.02 Band 2	1.00	1.25	0.73	35.6%	31.4%	59.8%	11.5%
Jan 17 to Dec 17	1.00 Band 2	1.00	1.22	0.72	37.3%	32.2%	60.3%	11.7%
Apr 17 t0 Mar 18	0.99 Band 2	1.00	1.23	0.70	39.8%	32.5%	59.0%	12.6%
Jul 17 to Jun 18	0.98 Band 2	1.00	1.23	0.70	41.6%	33.1%	58.7%	13.4%
Oct 17- Sep 18	1.00 Band 2	1.00	1.27	0.69	41.4%	33.6%	59.5%	14.3%

Data includes the most recent publication on the NHS Digital, published in November 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 there was a slight increase in SHMI for the period Oct 17 to Sep 2018. This is attributable mostly to 2 deaths.

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

- See section 2.2.7.

**HSMR data can be found on page 168.*

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
2015/16	186	54.8%	50.9%
2016/17	100	53.0%	51.3%
2017/18	80	40.0%	39.1%
2018/19	2018/19 Data will not be available until November 2019		

Varicose Veins – Percentage of patients with improvement in EQ-5D health scores			
Year	Eligible Episodes	Trust	National Average
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			
2018/19			

Hip Replacement – Percentage of patients with improvement in EQ-5D health scores			
Year	Eligible Episodes	Trust	National Average
2015/16	277	90.6%	89.7%
2016/17	262	86.3%	89.1%
2017/18	272	88.2%	90.0%
2018/19	2018/19 Data will not be available until November 2019		

Knee Replacement – Percentage of patients with improvement in EQ-5D health scores			
Year	Eligible Episodes	Trust	National Average
2015/16	318	78.6%	81.6%
2016/17	318	80.6%	81.5%
2017/18	347	79.7%	81.1%
2018/19	2018/19 Data will not be available until November 2019		

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

Pre-op

- There were a total of 1976 procedures
- Of which there were 1443 questionnaires completed
- In 16/17 the response rate was 67.8% with an improvement to 73.0% in 17/18

Post-op

- UHMBT performed 0.9% better than the national average for groin hernias
- UHMBT performed 1.8% worse than the national average for hip replacements
- UHMBT performed 0.4% worse than the national average for knee replacements

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:

- Continuation to improve information on knee replacement surgery which will enables more informed and appropriate choices.
- Work is ongoing to encourage attendance at the Trust's Hip & Knee School pre-operatively to assist patients with their expectation of surgery, post-surgery and recovery.
- Pathways are being streamlined across the Trust's three sites.

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		
2018/19	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%
2016-Aug	679	77	11.34%
2016-Sep	712	78	10.96%
2016-Oct	754	99	13.13%
2016-Nov	900	122	13.56%
2016-Dec	833	108	12.97%
2017-Jan	713	104	14.59%
2017-Feb	624	82	13.14%
2017-Mar	819	107	13.06%
2017/18	**8,288**	**1159**	**13.98%**
2017-Apr	704	95	13.49%
2017-May	727	107	14.72%
2017-Jun	690	92	13.33%
2017-Jul	731	89	12.18%
2017-Aug	655	89	13.59%
2017-Sep	784	110	14.03%
2017-Oct	783	91	11.62%
2017-Nov	897	138	15.38%

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	2,662	312	11.72%
2016-Sep	2,647	291	10.99%
2016-Oct	2,583	300	11.61%
2016-Nov	2,583	284	10.99%
2016-Dec	2,610	316	12.11%
2017-Jan	2,490	272	10.92%
2017-Feb	2,271	238	10.48%
2017-Mar	2,651	324	12.22%
2017/18	**28,452**	**3332**	**11.71%**
2017-Apr	2,470	282	11.42%
2017-May	2,653	300	11.31%
2017-Jun	2,663	300	11.31%
2017-Jul	2,587	307	11.53%
2017-Aug	2,621	324	12.36%
2017-Sep	2,636	302	11.46%
2017-Oct	2,730	315	11.54%
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
2018/19 (Dec)	**8,815**	**1,141**	**12.94%**	**2018/19 (Dec)**	**33,303**	**4,120**	**12.37%**
2018 -Apr	697	92	13.20%	2018 -Apr	2,708	304	11.23%
2018-May	715	89	12.45%	2018-May	3,045	399	13.10%
2018-Jun	626	54	8.63%	2018-Jun	2,775	346	12.47%
2018-Jul	649	67	10.32%	2018-Jul	2,776	344	12.39%
2018-Aug	619	83	13.41%	2018-Aug	2,755	352	12.78%
2018-Sep	763	132	17.30%	2018-Sep	2,605	309	11.86%
2018-Oct	821	129	15.71%	2018-Oct	2,887	343	11.88%
2018-Nov	938	135	14.39%	2018-Nov	2,808	345	12.29%
2018-Dec	782	85	10.87%	2018-Dec	2,699	362	13.41%
2019-Jan	765	100	13.07%	2019-Jan	2,854	379	13.28%
2019-Feb	668	91	13.62%	2019-Feb	2,547	319	12.52%
2019-Mar**	772	84	10.88%	2019-Mar**	2,844	318	11.18%

*Data source: UHMBT Electronic Patient Record - Lorenzo Data shown: Apr 17- Mar 2019 (**March data not yet complete as under 28 days since month end)*

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

- The data for both 0-15 and 16+ patients includes readmissions that were for any reason regardless of the original admission reason.
- However, readmission attendance in 2018/19 was higher than the previous year; we continue to see high number of elderly patients with multiple comorbidities and high acuity.
- The figures provided report on all admissions under 15 years of age to UHMBT. It is difficult to give an accurate narrative as they consist of all three sites where young people may attend the emergency department (ED), assessment or inpatient wards.

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:

- Our Care of the Elderly (COTE) team is working during attendance to try and return the older patient home preventing admissions; however this can impact on readmissions. We also are starting to see patients in ambulatory care [alluding to National Guidance that 30% of medical admissions should be seen in the ACU facility]; this could mean numerous attendances for patients. An earlier discharge with attendance at ACU is a normal pathway. The medical care group also care for patients with chronic conditions which inevitably will result in re-admission due the nature of illness, i.e. respiratory and cardiac diagnoses.
- In 2015, as part of a CQUIN programme, we were asked to reduce the length of stay on the children's units at both FGH and RLI. One measure taken was to remove the ability for patients to leave the units on overnight leave; this was where they would leave the hospital overnight and return the following day without being classed as a discharge on the Lorenzo system. The change meant that patients had to be discharged when they left hospital that night and readmitted the following day to re-commence their treatment. An example of this could be where a young person had a fractured forearm and it was decided that it was best for them to go home overnight and return fasted for surgery in the morning, this increased the re-admission rate.

  These figures also do not reflect the fact that the patient could attend an inpatient unit one week and then attend ED the following week with an unrelated illness.

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	69.6	68.6	85.0	60.5
2018/19	2018/19 information is not currently available and will be published by NHS Digital in August 2019.			

Source NHS Digital Outcomes Framework 4.2

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

- 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%
2018/19	72%	70%	90%	49%
Please note: Latest update was 26/02/2019 for 2018/19 survey.				

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	93.1%	95.11%	100%	66.44%
2018/19 Q2	91.9%	95.69%	100%	68.67%
Please note: Figures for 2018/19 are complete to the end of September 2018- these will be updated as March 2019 data becomes available in September 2019.				

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

- Data has been collected as census data from the electronic patient records but unfortunately does not include any patients who have been assessed using the (old) paper risk assessment forms. 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 (all reported cases)				
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	44.8	38.3	157.5	0
2018/19	2018/19 information will be published by Public Health England in July 2019			

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

Rate per 100,000 bed days of cases of Clostridium Difficile Infection (HO Cases)				
Year	**Trust**	**England Average**	**England Highest**	**England Lowest**
2015/16	15.5	15	67.1	0
2016/17	12.8	13	82.6	0
2017/18	9.4	14	91	0
2018/19	2018/19 information will be published by Public Health England in July 2019			

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 and hospital onset healthcare associated cases are now below the national average per 100,000 bed days.

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

- Ensured that all staff are trained annually in hand hygiene.
- Maintained surveillance meetings every month with the CCG to support the monitoring of cases and thorough review of all cases.
- 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 post infection review meetings are undertaken for all Clostridium Difficile cases identified as hospital onset healthcare associated within the trust. For 2019/20 onwards all community onset healthcare associated cases identified in UHMBT will also be investigated and a post infection review completed.

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	49.37	N/A	124	24.19	0.1	0.3	1.5	0
Apr 2018 to Sep 2018	The figures for Apr 2018 to Sep 2018 will be published in September 2019.							
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 an increase in the number of incidents reported, this being expected following the integration of community services

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 incident training plan has been reviewed with a diversified programme and varied methods of delivery available.
- Fresh Eyes Review has been developed to improve scrutiny of Serious Incidents Requiring Investigation.

- Weekly senior manager review of all incidents causing moderate or greater harm has been maintained
- The Learning to Improve group has moved into monitoring the implementation of lessons from incidents using learning journeys for each care group plus one for cross care group incidents such as pressure care, documentation, communication, blood transfusion and cannula care. This means that the group monitors the lessons following circulation in the bulletins. In addition the group has now started to initiate deeper dives into themes where improvement is limited
- Development of multi -level investigations within Ulysses risk management system
- Enhanced Duty of candour monitoring process
- Patient and Family Support Officer in place to provide enhanced support for Patients /relatives /carers through the serious incident process

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.UHMBT.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 2018/19:

3.1 An Overview of the Quality of Care Based on Performance in 2018/19 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 2018/19 report. Additional information regarding the rationale for the priority selection is detailed in 2.1.4.

Section 2.1.6 included a list of priorities that have been chosen to be removed by the Board of Directors from the quality improvements priorities for 2019/20. 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:

- Reduce avoidable referrals into hospital through increased uptake in advice and guidance to GPs ;
- 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;
- Audit of lessons learned at 6-12 months following publication of themed bulletins to measure lessons being learned;
- 7-day CAMHS support for Cumbria and Lancashire North; and
- Healthcare Communications embedded in to Consultant experience feedback in 5 specialities.

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 2018/19 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 2018/19. 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 2018/19 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 9 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

2018/19 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 improved profile and improved performance of cancer services; the impact of both theatre and major diagnostic equipment failure; increased trauma; and the transfer of community services from Cumbria Partnership NHS Foundation Trust and Blackpool Teaching Hospitals NHS Foundation Trust.

The Trust did not achieve Cancer 62 Day Standard in Quarters 1 to 4 2018/19. The Cancer 31 Day standard was met for all four quarters for drug treatment and for Q2-Q4 for surgery. Cancer 14 Day Standard was achieved in Quarter 3 and Quarter 4. In Quarter 4, all cancer standards were met except Cancer 62 Day from urgent GP referral and from a screening programme. 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 2018/19.

The Diagnostic 6 week standard, where less than 1% of patients should wait greater than 6 weeks for a diagnostic test, was achieved in February 2019. The key cause of delay has been the multiple breakdown of MRI, CT and DEXA scanners which poses a delay to patient care and a risk to the achievement of the standard into 2019/20, unless the scanners are replaced.

Table 9 and 10 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 9: Performance against Quality Standards and Indicators- Quarterly Key Performance Indicators

	2016/17				2017/18				2018/19			
Standard	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
A&E: maximum waiting time of four hours from arrival to admission/ transfer/ discharge	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet
All cancers: 31-day wait for second or subsequent treatment - surgery	Met	Met	Met	Met	Met	Met	Met	Met	Failed to Meet	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	Failed to Meet	Met	Failed to Meet	Failed to Meet	Met	Met	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet
All cancers: 62-day wait for first treatment from NHS Cancer Screening Service referral	Met	Met	Met	Met	Failed to Meet	Met	Met	Failed to Meet	Failed to Meet	Failed to Meet	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	Met	Met	Met	Met	Met	Met	Met	Met	Failed to Meet	Failed to Meet	Met	Met

Data Source: Unify Data

Table 10: 2018/19 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	85.09%	85.65%	85.09%	84.00%	82.07%	82.28%	82.43%	83.42%	83.02%	82.57%	82.85%	82.67%
Diagnostic waits over 6 weeks	2.35%	1.79%	6.18%	6.21%	6.82%	1.82%	1.08%	2.64%	2.14%	1.84%	0.87%	1.21%
Urgent Operations cancelled for the second or subsequent time	0	0	0	0	0	0	0	0	0	0	0	0
Ambulance Handover Time	19	17.2	18	18.1	17.7	18.5	18.9	19.6	21	26.2	23	21.9

Data Source: Unify Data

3.2.2 Other Quality Indicators

Referral to Treatment (RTT) Data

The Provider Sustainability Framework for RTT was met in April and May 2018; however, the national standard of 92% has not been achieved in 2018/19. Eight out of 10 specialties within the Care Groups of Medicine and Women and Children's are sustainably exceeding the national standard of 92%; thus, supporting the overall Trust position. However, all surgical specialties are consistently underperforming against the national standard: anaesthetics, ophthalmology, ear, nose and throat, oral surgery, general surgery, trauma and orthopaedics and urology. 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 impacted throughout 2018/19 due to:

- The ongoing impact of elective cancellations due to the continuing winter pressures into Quarter 1, with patients requiring emergency care taking priority over elective routine cases. For example in April 2018, the urgent care pressures into reduced RTT achievement by 0.31%;
- Unavailability of theatres - theatre breakdown throughout Quarters1 to 3 has substantially reduced elective capacity and impacted upon the RTT standard; and
- The unprecedented level of orthopaedic trauma in Quarter 1 resulted in the reduction of elective orthopaedic activity.

Examples of Key actions to improve RTT performance within the Care group of Surgery and Critical Care include:

- A mobile Vanguard Theatre at Westmorland General Hospital from November 2018 for 24 weeks to replace Theatre 2 whilst remedial works to the air handling unit are undertaken. The project has been fully managed to ensure that this theatre is utilised to its maximum capacity. Without the Vanguard theatre, the reduction of 299 elective surgical cases was forecast. With the theatre an additional 201 cases will take place;
- A review of the theatre timetable and programme of increasing efficiency using national benchmarking data ('Model Hospital' and 'Getting It Right First Time'). This includes the use of treatment rooms for more minor cases, freeing up main theatres for additional more major cases;
- Pathway development including a pilot for self-management for patients on a pain management pathway, which will optimise patient experience and outcome, and reduce demand for unnecessary follow-up and procedures; and
- Additional activity sessions across multiple specialties in order to treat patients in a timely manner.

In 2017/18, a new, waiting list size standard was introduced. 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. The standard was met in March 2019. 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. The Trust is committed to ensuring that no patient waits greater than 52 weeks. In 2018/19, 61 patients have waited greater than 52 weeks for first treatment against a maximum trajectory of 156.

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

Table 11a details month on month RTT performance for 2017/18. Table 11b details month on month RTT performance for 2018/19 against the Sustainability and Transformation Fund trajectory and the national standard of 92%.

Table 11a: Month on Month RTT Performance for 2017/18

RTT Performance	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Average for 17/18
RTT Incomplete Standard 92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%
PSF Trajectory %	88.60 %	89.10 %	89.70 %	90.00 %	90.20 %	91.80 %	91.70 %	92.00 %	92.00 %	92.00 %	92.00 %	92.00 %	90.93 %
<18 weeks against National Standard	89.39 %	89.49 %	89.19 %	88.72 %	88.29 %	87.60 %	87.96 %	87.50 %	86.08 %	85.53 %	85.40 %	84.75 %	87.49 %
<18 weeks against STF Trajectory	89.39 %	89.49 %	89.19 %	88.72 %	88.29 %	87.60 %	87.96 %	87.50 %	86.08 %	85.53 %	85.40 %	84.75 %	87.49 %

Data Source: Unify Data

Table 11b: Month on Month RTT Performance for 2018/19

RTT Performance	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Average for 18/19
RTT Incomplete Standard 92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%
STF Trajectory %	84.67%	84.82 %	86.12 %	86.52 %	85.78 %	85.17 %	85.51 %	85.97 %	84.48 %	85.39 %	85.12 %	86.45 %	85.50 %
<18 weeks against National Standard	85.09%	85.65 %	85.09 %	84.00 %	82.07 %	82.28 %	82.43 %	83.42 %	83.02 %	82.57 %	82.85 %	82.67 %	83.56 %
<18 weeks against STF Trajectory	85.09%	85.65 %	85.09 %	84.00 %	82.07 %	82.28 %	82.43 %	83.42 %	83.02 %	82.57 %	82.85 %	82.67 %	83.56 %

Data Source: Unify Data

Accident and Emergency Department 4 hour standard for 2017/18 and 2018/19

As shown in Table 12a and 12b below, the Trust has failed to meet the 95% 4 hour Accident and Emergency Standard in 2017/18, but met the Provider Sustainability Fund (PSF) Improvement trajectory in October 2017.

Table 12a: Trust wide Accident and Emergency Department 4 hour standard for 2017-18

A&E Performance	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
A&E standard 95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
PSF Trajectory	80.01 %	85.01 %	87.01 %	90.00 %	90.01 %	90.00 %	90.00 %	90.01 %	88.00 %	85.00 %	85.00 %	85.00 %
Trust 95% performanc e	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 %
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 12b: RLI and FGH Accident and Emergency Department 4 hour standard for 2017/18

A&E Performan ce	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Averag e for 17/18
A&E Standard 95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
RLI	84.05 %	83.04 %	87.70 %	80.76 %	83.10 %	87.35 %	87.19 %	81.36 %	79.79 %	75.06 %	75.63 %	69.07 %	81.18 %
FGH	81.03 %	82.75 %	84.83 %	83.49 %	87.23 %	87.75 %	90.64 %	93.13 %	83.73 %	76.26 %	83.98 %	77.13 %	84.33 %
Average RLI and FGH (Type 1)	82.54 %	82.90 %	86.27 %	82.13 %	85.17 %	87.55 %	88.92 %	87.25 %	81.76 %	75.66 %	79.81 %	73.10 %	82.75 %
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 13a below and 13b overleaf, in 2018/19, the 4 hour standard has not been achieved but the PSF trajectory was achieved in April, May and June, therefore achieving in Quarter 1.

Table 13a: Trust wide Accident and Emergency Department 4 hour standard for 2018-19

A&E Performanc e	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
A&E standard 95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
PSF Trajectory	80.01 %	85.01 %	87.01 %	90.00 %	90.01 %	90.00 %	90.00 %	90.01 %	88.00 %	85.00 %	85.00%	85.00%
Trust 95% performance	85.26 %	90.64 %	90.03 %	87.21 %	86.94 %	85.88 %	84.86 %	86.08 %	82.42 %	78.48 %	79.81%	81.05%
PSF actual	85.26 %	90.64 %	90.03 %	87.21 %	86.94 %	85.88 %	84.86 %	86.08 %	82.42 %	78.48 %	79.81 %	81.05%
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 13b: Site & Trust Wide Accident and Emergency Department 4 hour standard for 2018-19													
A&E Performance	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Average for 18/19
A&E Standard 95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
RLI	80.56 %	87.44 %	86.01 %	83.92 %	81.46 %	77.50 %	79.22 %	82.13 %	72.00 %	68.12 %	71.71 %	71.87 %	80.56 %
FGH	83.17 %	91.85 %	90.79 %	84.76 %	88.76 %	89.39 %	89.01 %	87.48 %	92.33 %	84.66 %	81.74 %	85.99 %	83.17 %
Average RLI and FGH (Type 1)	81.87 %	89.65 %	88.40 %	84.34 %	85.11 %	83.45 %	84.12 %	84.81 %	82.17 %	76.39 %	76.72 %	78.93 %	84.03 %
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 95% Urgent Care standard:

- Staffing levels on wards resulting in beds closed;
- Ability to recruit registered nurses and maximise beds;
- Patients who are not in the optimal place but remain in an acute hospital bed;
- High numbers of patients requiring an in-patient mental health bed attending ED;
- 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%; this has continued in 2018/19. A number of actions have been implemented throughout the year to improve patient flow, including:

- The introduction of Discharge to Assess where patients are transferred from the acute hospital at the point where they no longer require acute hospital care through one of three pathways:
  - either at home and may require further care and/or therapy (pathway 1 - Home First);
  - in a community intermediate care bed with rehabilitation (pathway 2); or
  - in a care home to enable a period of recovery and completion of longer term care assessments (pathway 3);

  With these pathways, health and/or social care assessments are completed outside of the acute hospital environment. The expected outcomes from this work include shorter lengths of stay, improved overall patient experience through patients having their care needs assessed in a more appropriate setting and reduced use of beds; and
- Other targeted actions, included in the comprehensive plan include the development of a Control Room to manage patient flow, a series of actions within the A&E departments including the safety checklist, second triage scheme at FGH and capacity and demand analysis in relation to staffing shifts.

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 14: Inpatient readmissions within 28 days									
Care Group	Number of Monitor Readmissions < 28 Days			Percentage (%) of Monitor Readmission Rate < 28 Days			Number of Spells		
	2016/17	2017/18	2018/19	2016/17	2017/18	2018/19	2016/17	2017/18	2018/19
Acute Medicine Elective Medicine	2345	2244	2467	13.57%	13.05%	13.72%	17285	17192	17,978
Women's and Children's	1183	1436	1,277	12.29%	13.92%	12.51%	10656	10318	10,210
Core Clinical Services	1	1	2	10.00%	14.29%	12.50%	10	7	16
Surgery	1131	1272	1515	8.97%	9.95%	10.89%	12613	12782	13,914
TRUST TOTAL	**4787**	**4953**	**5,261**	**11.80%**	**12.29%**	**12.49%**	**37091**	**40299**	**42,118**
Data Source: UHMBT Data Warehouse Readmissions Model (please note Monitor readmission rate calculation applies exclusion criteria). The definition for this indicator is in relation to emergency re-admissions within 28 days of discharge from hospital. Period 01/04/2018 – 31/03/2019)									

Cancer 62 day Waiting Time Standard for first treatment

The Trust did not achieve Cancer 62 Day Standard in Quarters 1 to 4 2018/19. The Cancer 31 Day standard was met for quarters 1 to 4 and Cancer 14 Day Standard in Quarter 3 & 4. In Quarter 4 six of the eight Cancer standards were met.

Table 15a: Performance against Cancer 62 day waiting time standard for first treatment- Quarterly Key Performance Indicators													
	2016/17				2017/18				2018/19				
Standard	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	2018/19
All cancers: 62-day wait for first treatment from urgent GP referral for suspected cancer	Met	Failed to Meet	Met	Failed to Meet	Failed to Meet	Met	Met	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet	Failed to Meet
All cancers: 62-day wait for first treatment from NHS Cancer Screening Service referral	Met	Met	Met	Met	Failed to Meet	Met	Met	Failed to Meet	Failed to Meet	Failed to Meet	Met	Failed to Meet	Failed to Meet
Data Source: Unify Data													

Table 15b: Performance against Cancer 62 day waiting time standard for first treatment- Quarterly Key Performance Indicators													
A&E Performance 2018/19	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	
62 day standard 85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	2018/19
All cancers: 62-day wait for first treatment from urgent GP referral for suspected cancer	86%	74.1%	72.3%	78.8%	80.6%	80.4%	76.6%	79.2%	86.5%	81.9%	65.9%	74.7%	78.17%
All cancers: 62-day wait for first treatment from NHS Cancer Screening Service referral	85.7%	73.7%	62.5%	73.5%	87%	89.3%	91.4%	84.0%	97.1%	84.4%	94.4%	86.4%	83.66%
Data Source: Unify Data													

Key national expectations for 2019/20 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; and
- Progress towards the 2020 diagnosis by Day 28 standard.

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; and
- Service pressures such Clinical Nurse Specialist and Medical vacancies.

Actions in 2019/20 include:

- Contribution to the design, and implementation, of the Cancer Alliance wide pathways for lung, Upper and Lower Gastrointestinal (GI) and Prostate;
- Enhanced learning through breach analysis;
- Identification of pathway improvements to achieve the 28 day and 62 day standards and improve the patient experience;
- Improvement trajectories to be agreed by tumour group;
- Programme of continuous capacity and demand for cancer 2 week wait slots to assist capacity planning; and
- Delivery of the new Cancer Board to drive forward improvements in cancer services.

Seven Day Hospital Services

Providers of acute services are asked to include a statement regarding progress in implementing the priority clinical standards for seven day hospital services. This progress is assessed as guided by the Seven Day Hospital Services Board Assurance Framework published by NHS Improvement. Further information can be found at https://improvement.nhs.uk/resources/seven-day-services/

The Trust is committed to achieving the standards by March 2020. Whilst progress has been made over the last year, the Trust is currently only delivering against STANDARD 5, Access to Diagnostic Tests. The Care Groups have all undertaken an assessment of their current compliance; actions to move them to compliance are being assessed and feature within each of their business plans.

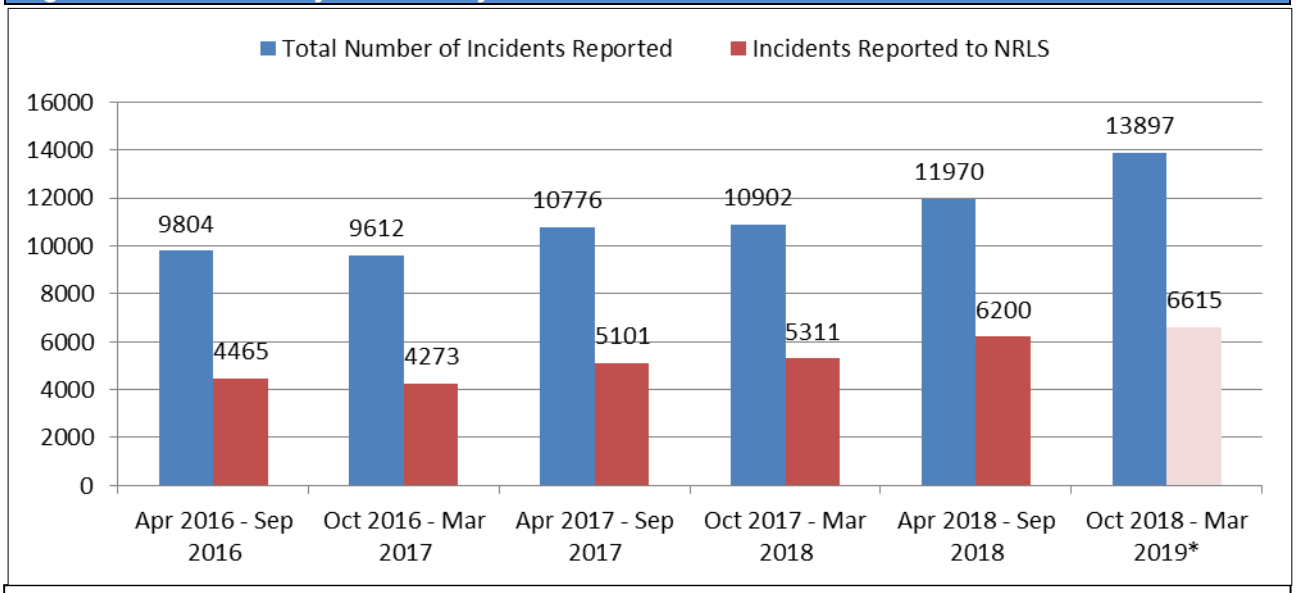
3.3 Other Additional Information in Relation to the Quality of NHS Services

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 13,897 patient safety incidents in 2018/19. 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/. Figure 1 below shows the total number of incidents reported and the number reported to the NRLS.

Figure 1 – Patient Safety Incidents by Year



Data source: NPSA and Trust Incident Management System. This data is governed by standard national definitions

**Oct 2018 – Mar 2019 - NRLS data not yet published.*

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 Care Group and organisational newsletters. The following example topics were included in bulletins in 2018/19:

The investigation process routinely identifies lessons to be learned and these are then discussed at ward governance meetings and cascaded to relevant staff. The monthly 'Learning to Improve' meeting discusses and shares appropriate lessons in the corporate bulletins. The following example topics were included in bulletins in 2018/19:

- Pressure Care;
- Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) communication;
- Cannula care (VIPs Scores);
- Fluid balance charts;
- Falls;
- Blood transfusion; and
- Situation Background Assessment Recommendation (SBAR) communication.

Table 16 below shows the number of patient safety incidents reported in UHMBT each month for the year. This table excludes non-patient safety incident (I.e. Health, Safety and Security and Safeguarding) to give an overview from a patient safety perspective. This data will differ to the data published by the NRLS as we are only required to report incidents directly involving patients. 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 8).

Table 16. Patient Safety Incidents by Year 2018 / 2019													
	2018									2019			Total
Row Labels	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
1 No Injuries	880	907	898	881	894	849	1115	1215	1065	1184	889	931	11708
2 Low	282	325	366	322	308	346	497	584	550	570	590	575	5315
3 Moderate	25	26	22	18	31	46	30	30	52	35	36	61	412
4 Severe	1	2	3	4	2		1	4		2			19
5 Death				2	1	2	1	1	1	2	2	2	14
6 Near Miss	54	48	51	60	50	49	52	67	60	38	45	46	620
Blank	4											6	10
Total	**1246**	**1308**	**1340**	**1287**	**1286**	**1292**	**1696**	**1901**	**1728**	**1831**	**1562**	**1621**	**18098**

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 17 below shows the number of external incidents that have been reported between 2013/14 and 2018/19.

2018/19 shows a notable decrease in the number of external Tissue Viability incidents reported. This is an expected decrease due to the Integrated Community Care Group joining us in April 2018.

Table 17. External Incidents Reported						
Incident Group	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Tissue Viability – Outside our Care	1121	1378	1339	1539	1448	1062
Safeguarding - (Children)	956	1362	2316	4023	4650	4221
Other Incidents	81	385	486	377	295	353
Safeguarding - (Adults)	169	289	550	983	668	676
Data source: Trust Incident Management System. This data is not governed by standard national definitions 2018/2019						

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 Duty of Candour and the evidence is monitored by 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. A live compliance report has now been developed and a new monitoring process has been put in place.

3.3.4 Sign up to Safety – now referred to as Reduction in Harms

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 aimed 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 UHMBT response to improving safety for patients, the Trust committed to take part in a 3 year *Sign up to Safety* campaign. This ran parallel to *Our Quality Improvement Plan 2016 - 2019.* From 2019/20 this will be undertaken under Reduction in Harms.

The following information details the scope of the campaign in UHMBT, which focused on four change programmes. Please note that the reduction of incidence of pressure ulcers, falls, and reduction of deaths with a primary diagnosis of stroke are reported elsewhere in this document.

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 18: Progress with Medication Safety within UHMBT 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
2018-19	1925	387	20	372,841
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
2018-19	5.163	1.038	0.054	372,841
% Change 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
2014-2018/19	+40.29%	+56.79%	-10.00%	+5.94%

There has been a 50% increase in the reporting of medication incidents in 2018/19 which makes direct year on year comparison more difficult, the increase seems to be a result of:

- Increased awareness and reporting in pharmacy – the continued development of the Pharmacy Governance team has been led by the UHMBT Medication Safety Officer. There has been additional pharmacy workforce recruitment particularly to the FGH site as the reporting of medication incidents continues to grow. The Pharmacy Governance team have continued to promote medication incident reporting and the work to improve the feedback to reporters following a medication incident report. This is seen as a continued positive culture change towards reporting medication incidents and effective action plans following incidents;
- The result of a thematic review into patient experience of oncology and day-case patients receiving medication. This has led to increased awareness and reporting of problem areas to try to identify ways to improve processes;

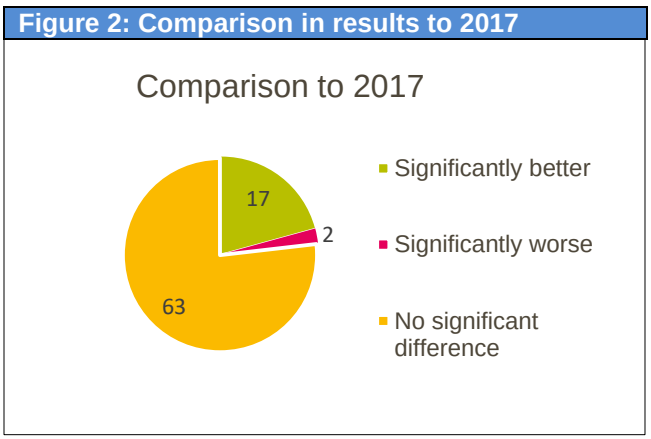
- The Community Care Group (from CPFT and BTH) joined UHMBT during 2018. This has had an inevitable effect of additional numbers of medication incidents;
- The successful introduction of the Lorenzo Electronic Prescribing and Medicines Administration system (EPMA) during 2018 also had an impact on medication incident reporting as the system was embedded into normal practice. There was an increase in reported prescribing incidents during this period which was expected based on feedback from other Trusts implementing an electronic prescribing system. In addition, EPMA allows for easier detection and reporting of prescribing and administration errors on an ongoing basis. A consultant led EPMA steering group is in place to address this specific group of medication incidents and feed into the I^3 team who lead on updating processes through the Lorenzo developers; and
- The UHMBT Medication Safety Group has continued to improve the profile of medication safety issues and encouraging reporting and feedback of process changes. This year has seen the addition of representatives from the Community Care Group, a patient representative and a non-medical prescriber. The reports received by Medication Safety Group, from each Care Group, continue to be refined to ensure useful information can be extracted and exceptions highlighted. Each Care Group has a responsibility to highlight areas of concern and implement clear action plans for improvement and associated monitoring. At the request of group members Medication Safety group has moved from a two monthly to a monthly meeting to maintain the momentum of actions identified and follow up in a timelier manner. The UHMBT Learning to improve Medication Special is a result of themes from medication incidents along with regular contributions to the UHMBT Learning to Improve (L2I) monthly bulletin. Continually raising the profile of medication issues is thought to have an impact on medication incident reporting.

3.3.5 Improvement in 2018 staff survey

Staff experience at the Trust continues to improve year on year, according to the results of the 2018 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 satisfied with the extent the organisation values their work;
- Staff with a disability feeling the organisation made reasonable adjustments to enable them to carry out their work;
- Staff feeling satisfied with their level of pay;
- Staff feeling satisfied with recognition for good work; and
- Staff feeling communication between senior management and staff is effective.

Figure 2: Comparison in results to 2017



National benchmarking data enables comparison with other Acute and Community Provider organisations. Of the 10 themed areas of the survey, the Trust scored above average in 7 of the areas, with 2 average and just one area below average. Areas the Trust is above average nationally include:

- Employee health and wellbeing;
- Immediate Managers;
- Morale;
- Quality of Appraisals;
- Safety Culture; and

- Staff Engagement.

The area below average - a continued area of focus for the Trust - relates to the level of staff reporting having experienced harassment, bullying or abuse. Action to address this corporate risk is now being led by the Chief Executive.

The overall staff engagement score has increased significantly, following the trend over recent years. 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.

3.3.6 Freedom to Speak Up

Freedom to Speak Up (FTSU) is an integral part of a safety focused organisation culture, with clear and effective systems and processes for dealing with concerns that are raised; it is about effective training and development of leaders at all levels so that the quality and safety of our patients can be maintained and improved through creating a supportive staff culture.

Although concerns have been raised from nearly all areas within the Trust, including staff, locums, governors, ex-employees and volunteers; for the purpose of the following information, all those speaking up are referred to as “staff”.

Following the recommendations of Robert Francis’ FTSU review, published in February 2015, UHMBT launched its FTSU campaign and recruited to the post of the FTSU Guardian in July 2015, following a fair recruitment process.

The National Guardian’s Office (NGO) now takes a more prominent role in overseeing the work of the FTSU Guardians throughout the country and collates and publishes the FTSU data from all the FTSU Guardians.

Freedom to Speak Up Guardian Role

Following the guidelines of the FTSU report, the FTSU Guardian role is independent of management and able to hold the Board to account. UHMBT’s FTSU Guardian is supported by the Trust Board to create an open culture which is based on listening, learning and not blaming.

The FTSU Guardian has now been in post more than three years and was pro-active in the FTSU Guardian role for nearly a year before the National Guardian’s office became functional. With the support of Trust leadership and monthly meetings with the Medical Director as designated Board member lead, and a lead Non-Executive Director for FTSU, the FTSU Guardian continues to raise awareness about the role, promoting the raising concerns culture.

The National Guardian’s Office has published FTSU guidance for Trust Boards, and this supports the role of FTSU as part of the Well Led domain which is pivotal for Care Quality Commission inspections.

The FTSU Guardian undertakes the following:

1. Promotes Raising Concerns as ‘business as usual’ at UHMBT through education and pro-actively meeting with staff; and
2. Is a point of contact for all staff who wish to raise concerns that have not been resolved through the usual line management routes.

Raising Concerns at the Trust

After extensive consultation with staff side and other staff groups UHMBT had its “Freedom to Speak up – Raising concerns” policy ratified in December 2016. This sits under the National Policy. The policy includes a staged process, where informal steps are included and provides clear routes for raising issues and concerns; ensuring that staff are aware of their entitlements to be supported, informed and protected, including remaining anonymous should they wish to and if not legally obliged to be named. These developments sought to respond to feedback from staff who had invoked the policy, their experiences, and to amend its limitations ensuring staff feel protected and supported from reporting a concern to the final outcome.

The Public Interest Disclosure Act 1998 (PIDA) protects employees under the law by ensuring that employers will not victimise any employee who raises a concern internally or to a prescribed regulator or prescribed person. The UHMBT has consistently complied with the PIDA requirements.

In accordance with the Trust's values, culture, staff engagement and equality and diversity, the policy currently embraces the requirements of PIDA but is not limited to this, as it is actively encouraging staff to participate within a culture where raising concerns is routine and takes place as part of everyday practice making speaking up business as usual.

Staff can contact the FTSU Guardian by telephone, direct approach, through the Freedom to Speak up App, by email, and by letter. The FTSU App is easy to use and can be installed on any iPhone or Android phone and has increased the number of anonymous concerns that have been raised. All concerns are recorded on the FTSU anonymised tracker and escalated as appropriate.

The staff member is kept updated with feedback from the FTSU Guardian and when the concern is closed the FTSU Guardian requests feedback from each staff member who has raised the concern.

Three months after a concern is resolved the FTSU Guardian contacts the staff member to make sure no detriment has been incurred.

The Trust promotes awareness of being able to speak up through posters, a dedicated leaflet, the Trust's Weekly News magazine, and it is constantly reviewing the ways in which staff can speak up.

Concerns raised at the Trust through FTSU from 31 March 2018 to 1 April 2019

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

Table 19. Concerns raised at UHMBT through FTSU from 31/03/2018 – 01/04/2019

Quarter	Total	Anon	Patient Safety	Unacceptable Behaviours	Suffered Detriment
1	23	0	2	6	0
2	33	3	13	18	1
3	35	7	7	23	1
4	36	0	8	23	0

These are the concerns brought through FTSU and so are formally recorded, as within the stages of the Raising Concerns policy, there is the opportunity for individuals to raise matters informally initially. This informal process has been promoted with the Trust's open culture; however, in terms of capturing data the Trust is unable to report the number of concerns that are raised and resolved informally, at source, via line management or another route such as through staff side, workforce and organisational development (Human Resources).

Work continues to develop the open and transparent culture that is necessary to encourage staff to raise matters, and for speaking up for patient safety and staff well-being to be routine. The resulting number of formal cases suggests that staff feel comfortable to raise matters and that informal resolution is achieved in most cases. It is important to remain focused on feedback from individuals who have raised concerns and relevant stakeholders within the process to ensure the current policy captures the spirit of the Trust's values and that staff feel that they can raise concerns or issues without fear of victimisation, blame or reprisal. The FTSU Guardian has had concerns raised from all staff groups including volunteers and governors.

3.3.7 National Inpatient Survey

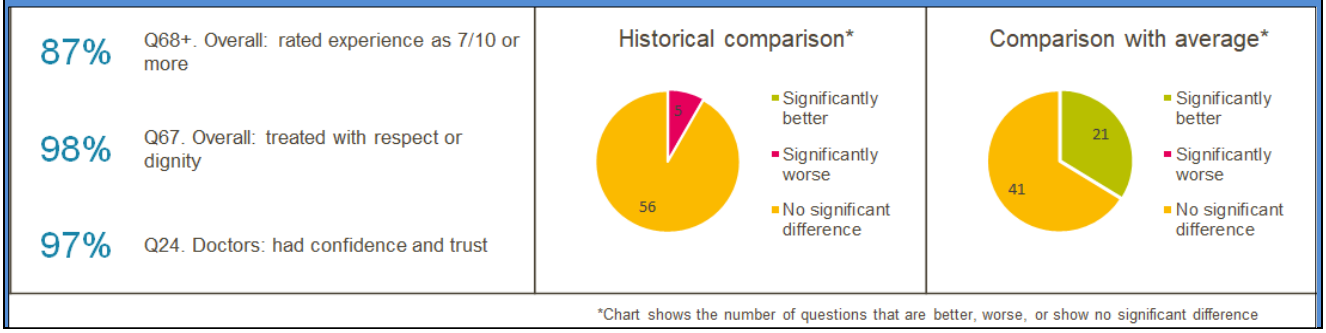
All Acute NHS Trusts are required by the Care Quality Commission (CQC) to undertake an annual inpatient survey. The Picker Institute was commissioned by 77 trusts to undertake the 2018 Inpatient Survey. The National Inpatient Survey is due to be published in May/June 2019. A total of 2500 patients from UHMBT were invited to complete the postal survey.

The numbers of invitations were deliberately boosted at the request of the Trust, the aim being to attract more feedback from which to analyse results (2500 compared to the sample size of 1232 patients who were invited to complete the survey in 2017). Of this year's sample, 2404 patients were eligible for the survey, of which 1098 returned a completed questionnaire, giving a response

rate of 46%. The average response rate for the 77 'Picker' trusts was 43%.

A total of 62 questions from the survey can be positively scored. Of these, 61 can be compared historically between the 2017 and 2018 surveys. The results include every question answered by the required minimum of 30 respondents. Figure 3 below shows the overall comparisons, both historical and the comparison with average results from the trusts using Picker for this 2018 Inpatient survey round.

Figure 3: Overall comparisons, both historical and the comparison with average results from the trusts using Picker for this 2018 Inpatient survey round.



- Question 68 Overall experience rating as 7/10 or more is similar to that of 2017 (which was just 2% higher at 89%);
- Question 67 The overall score relating to dignity and respect has increased from 87% to 98% this year;
- Question 24 Doctors: Had confidence and trust. This score has increased from 86% to 97%;
- Compared to the other organisations who commissioned Picker for the 2018 Adult Inpatient Survey, the results for 21 of the questions asked were scored “significantly better”; and
- There was “no significant difference” in scores for 56 of the questions when comparing UHMBT results with the previous year. However, there were 5 areas where scores dipped and these areas will need close focus.

Table 20 indicates highest and lowest scores (compared to average) and most improved and least improved elements from the last survey (historical).

Table 20: Overall comparisons, both historical and the comparison with average results from the trusts using Picker for this 2018 Inpatient survey round.

	Top 5 scores (compared to average)
87%	Q30. Nurses: knew which nurse was in charge of care
67%	Q29. Nurses: always or nearly always enough on duty
68%	Q14. Hospital: not bothered by noise at night from other patients
85%	Q64+. Discharge: staff discussed need for additional equipment or home adaptation
89%	Q38+. Care: enough emotional support from hospital staff

	Bottom 5 scores (compared to average)
68%	Q6. Planned admission: was admitted as soon as necessary
10%	Q52. Discharge: delayed by no longer than 1 hour
83%	Q59+. Discharge: given clear written/printed information about medicines
56%	Q58+. Discharge: told side-effects of medications
63%	Q60+. Discharge: told of danger signals to look for

	Most improved from last survey
89%	Q38+. Care: enough emotional support from hospital staff
84%	Q65+. Discharge: staff discussed need for further health or social care services
79%	Q3. A&E Department: right amount of information about treatment or condition
89%	Q46. Procedure: told how to expect to feel after operation or procedure
82%	Q54+. Discharge: got enough support from health or social care professionals

	Least improved from last survey
19%	Q71. Overall: received information explaining how to complain
10%	Q52. Discharge: delayed by no longer than 1 hour
14%	Q70. Overall: asked to give views on quality of care
79%	Q18+. Hospital: able to take own medication when needed to
85%	Q61+. Discharge: family or home situation considered

The results of the survey need to be communicated and priorities for service improvement identified and agreed across the organisation. Clearly elements of discharge will need to have a high focus of attention.

The broad stages of work required 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; and
- Raise awareness about the patient surveys – publish results and action plans.

It is necessary to maintain high standards that have been recorded for this survey round particularly when comparing results against other organisations who commission Picker for this survey round. There were some dips in performance when comparing the 2017 historical results for this Trust. These will need addressing. It should be taken into account that the survey sample was deliberately boosted this year, and the number of respondents more than doubled when compared to the 2017 survey.

Overall, 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. UHMBT will continue to work hard to ensure that patient experience targets are met and that standards are high across the Trust.

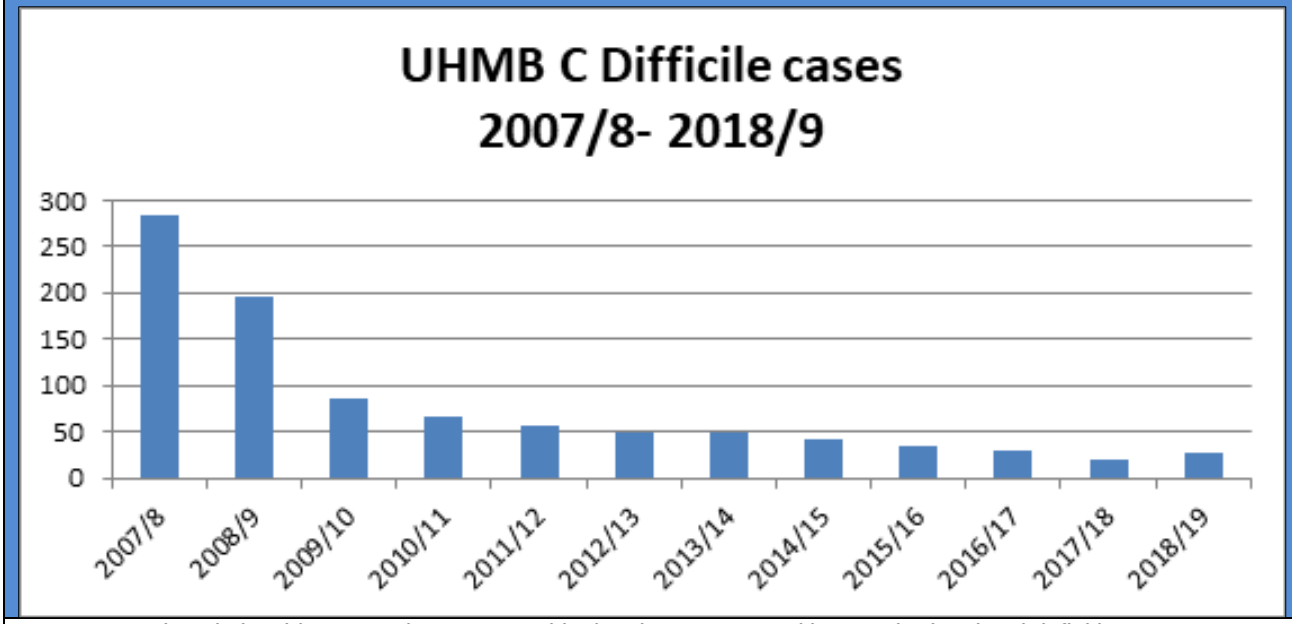
3.3.8 Hospital Acquired Infections

UHMBT continue to commit to the reduction in Health Care Acquired Infection (HCAI) by reducing the avoidable cases of *Clostridium difficile* (*Cdifficile*) infection in line with the annual trajectory given to us by NHS England.

The annual trajectory in 2018/19 for hospital-onset cases of Clostridium difficile infection was set at 43 cases. Our aim is that no patient is harmed by a preventable infection and this is the maximum number of cases expected for our population, not a target.

- Between April 2018 and March 2019, there have been 28 cases of hospital onset Clostridium difficile infection; significantly lower than our nationally set annual trajectory;
- 9 of these cases have been identified as having “no lapses in care”; and
- 2 additional Clostridium difficile infection cases have been attributed to a ward previously supported by CPFT and, therefore, did not form part of the original UHMBT footprint when the trajectory of cases was set.

Figure 4: Clostridium Difficile by Year



Data source: hospital Incident reporting system. This data is not governed by standard national definitions

The Trust reviewed all hospital acquired Cdifficile cases completing 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 Trust Infection Prevention Matron attended the CCG Cdifficile review group to review all CDI cases with the CCG. 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 UHMBT.

To comply with national reporting requirements, the total number of Cdifficile cases assigned to UHMBT remains as a raw actual number on the National Public Health England Data Capture System, i.e. the number of cases identified on admission day plus two. The reduced ‘apportioned’ number is the number used for

contractual purposes against the UHMBT annual trajectory of 43. Therefore, whilst 28 CDI cases remain as the raw actual number only 19 of these have been identified as having lapses in care.

There have been 2 additional Cdifficile cases noted from wards which transferred to UHMBT during the 2018/19 season. These wards have been supported from an infection prevention point of view by an SLA from CPFT and these cases were not factored into the trust annual trajectory. Therefore, they have not been included in the figures detailed above any PIR process and CCG review has been completed by the CPFT IP team.

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; and
- 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 UHMBT mirror those nationally.

3.3.9 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/

The Trust is rated as Segment 3. 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'.

When the CQC published its Quality Report, the CQC also published a Use of Resources (UoR) assessment undertaken by NHS Improvement (NHSI) that rated the Trust as inadequate for the use of resources. The combined rating for the Trust, taking into account CQC's inspection for the quality of services and NHSI's assessment of Use of Resources, is Requires Improvement. The overall rating for Royal Lancaster Infirmary also fell to Requires Improvement, whilst Furness General Hospital and Westmorland General Hospital remained rated as Good overall.

3.4 Detailed Description of Performance on Quality in 2018/19 against Priorities in 2017/18 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 2018/19 against the 2017/18 indicators for the following priorities:

- Priority 1: Patient Safety;
- Priority 2: Clinical Effectiveness; and
- Priority 3: Patient Experience.

3.4.1 Priority 1: Patient Safety

Reducing Harm

Achieve 98% Harm Free Care (HFC) for ward areas 2017/18 to 2018/19.

The Trust monitors the number of incidents reported which result in patient harm. The number of incidents reported has increased since the integration with community services in April 2018 and again in October 2018, but the Trust actively encourages reporting as a way of seeking to learn and improve.

For inpatient areas, the bed day rate and number of incidents reported is used to calculate the harm rate for inpatients. This data includes a wider range of harms than those which used to be monitored to give a more rounded picture of the safety of the patient experience. 2018/19 is a part year at the time of writing.

Table 21: Harms

Year	Harms	Bed Days	HCF rate
2014/2015	1416	234047	99.39%
2015/2016	869	234359	99.63%
2016/2017	863	231809	99.63%
2017/2018	817	220386	99.63%
2018/2019	875	208066	99.58%

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.

The baseline rate for inpatient falls resulting in any harm outcome for 2016/17 was 156 and for 2017/18 it was 93. To date (February), during 2018/19, the number is 77. Rates for inpatients falls resulting in all harm categories are reported each month, following validation by the Associate Director of Nursing, to the Quality Committee. The reports provide the department, bed days and harms levels for each ward.

Embed the revised (2018) National Early Warning Score (NEWS2) and monitor through audit tools to achieve 95% standard.

NEWS/NEWS2 was developed to improve the detection and response to clinical deterioration in patients with acute illness – these patients could be in any care setting, especially given the move to accountable care organisations and more care being provided outside of secondary care. For this reason when UHMBT moved to NEWS2 (from NEWS), it was introduced across our acute in hospital areas, community hospitals and also our community teams - so that we are all speaking a common language.

A common language is the fundamental pillar of human communication; therefore, teams involved in patients' care, using the same tools and language, means that concerns regarding patient observations/deterioration are better communicated with a reduced chance of failure or breakdown in communication.

In October 2018, UHMBT moved to NEWS2 from NEWS as advised by NHS England and the national work underway. The move to NEWS 2 took place on 8th October – with our community nursing teams in Barrow in Furness (district nurses) being the first team to implement it. During its implementation, the Resuscitation and Acute Care Practice Educators 'floor-walked' to trouble shoot any problems and help staff with familiarisation of the new chart.

The NEWS2 has an updated front page which incorporates new scoring for acute onset of confusion, and also an updated Spo2 scale. The advice and guidance on the reverse of the chart, which includes recommendations regarding when to contact GPs/refer to hospitals, remains unchanged from that used previously with NEWS.

There was wide consultation with staff working in the 3 key areas when the chart was developed, and this has meant that its implementation has been well accepted. The planned introduction was shared with teams in advance, meaning that areas were prepared and knew what to expect.

Training on NEWS2 is provided both via e learning and face to face training on annual training days. The e-learning platform has proved problematic for some staff, and this is a national e learning platform so the problems were escalated to the host sites.

NEWS2 is in place and is audited in the same way as NEWS (through GURU reports). Current figures for the 6 months since its introduction are: Medicine Care Group 93.87% and Surgery 92.95% which are below the Key Performance Indicator KPI of 95%. Wards of poor performance are identified and assistance offered. What is noted is that often it is the plotting completion of the charts that leads to low compliance of the KPIs , rather than the correct totalling or adherence to the escalation pathway.

Compliance with NEWS2 is not only audited as part of the GURU reports, but also is reviewed when the Resuscitation Team undertake rapid reviews of 2222 calls. Any problems noted with the NEWS2 completion or action are identified at the Weekly Patient Safety Summit and the relevant ward/care group ensures actions are in place to rectify.

Reduction in StEIS reportable incidents that identify a failure in clinical escalation (failure to rescue) taken from 2016/17 baseline.

This improvement priority relates to resuscitation. Table 22 below shows the number of resuscitation incidents that were StEIS reported from 1 April 2016 – 31 March 2019. The numbers of resuscitation incidents have increased year on year.

Table 22: Number of resuscitation incidents that were StEIS reported in 2016 - 2019

	2016 - 2017	2017 - 2018	2018 - 2019
StEIS reported resuscitation incidents	0	2	5

The Resuscitation Team historically only reviewed actual cardiac arrest calls up until 18 months to 2 years ago. The Resuscitation Team now review all 2222 calls whether it be a peri-arrest or cardiac arrest, and all these are discussed weekly at the Patient Safety Summit.

In the last 12 months, the Resuscitation Team have included a review of the NEWS/NEWS2 score of the patient prior to the incident, which does highlight any delays in escalation or recognition of a deteriorating patient. Prior to 12 months ago this was not a standard part of the reviews.

Whilst there is an increase in the number of incidents reported to StEIS, there is also an increase in the number of resus incidents reported generally, as all 2222 calls should have a corresponding incident report. In addition, the reporting of Sepsis incidents commenced in October 2018 and these are to note any missed screening opportunities or delays in the administration of antibiotics (these have a separate cause group to resus).

Staff also feel more confident in reporting or identifying when practice could be improved which is an obvious a positive step in the reporting culture; subsequently, an increase in incidents reported is inevitable.

Improving Documentation

E-nursing documentation implemented on all inpatient wards

E-nursing documentation is now implemented on all inpatient wards. Compliance will be monitored through the Quality Assurance Framework.

Reducing Avoidable Mortality (See also 2.2.7 Learning from Deaths)

Maintain scores consistently in the ‘statistically as expected’ range, or better, for both the HSMR and SHMI measures:

- HSMR of 98 or less;
- Mortality ratio 5 -10 % better than National Average;
- SHMI within expected statistical range; and
- 2-5 better than National Average.

HSMR is a ratio of observed hospital deaths with expected number of hospital deaths for diagnosis groups which contribute to deaths in England, this data is sourced from Healthcare Evaluation Data (HED) produced on this model and rebased on a monthly basis.

The Summary Hospital level Mortality Indicator (SHMI) is a nationally agreed mortality indicator which reports mortality across the NHS in England and uses a standard methodology. The ratio of the observed deaths in the Trust during this period by the expected number of deaths up to 30 days post discharge has been measured. The national average SHMI is 100 and looking at our data we are reassured that we are within the mean of the comparative peer hospitals. SHMI account and national comparison:

Figure 5. SHMI Trust comparison

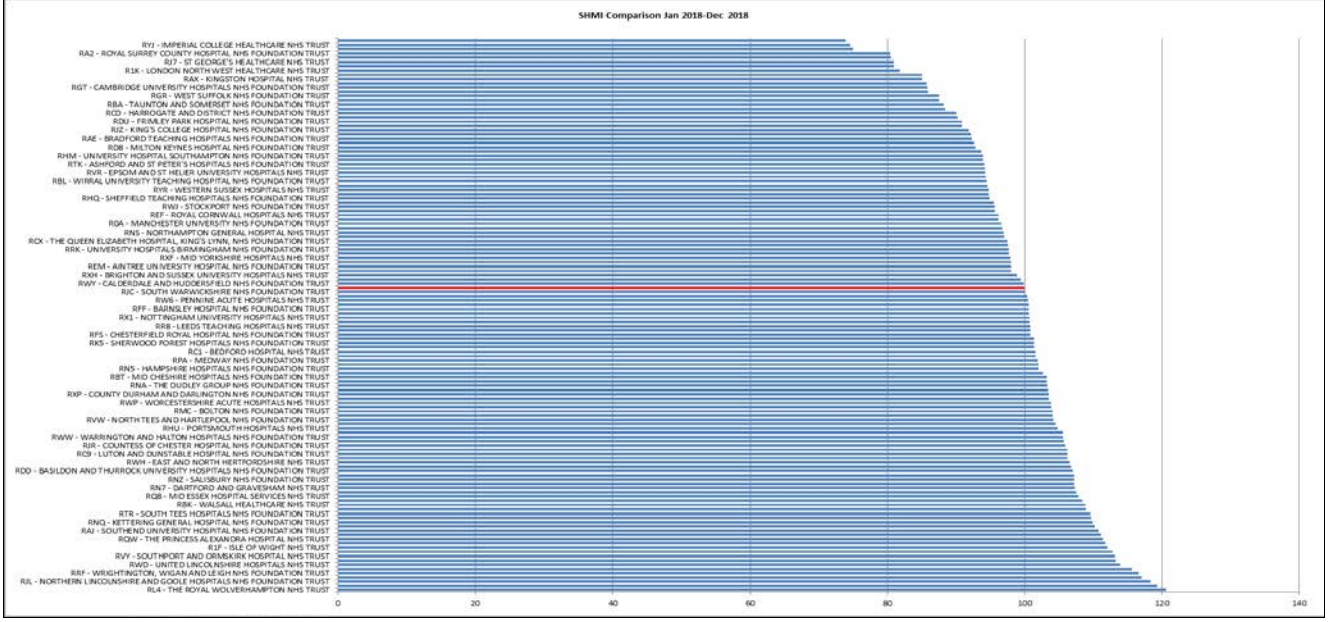
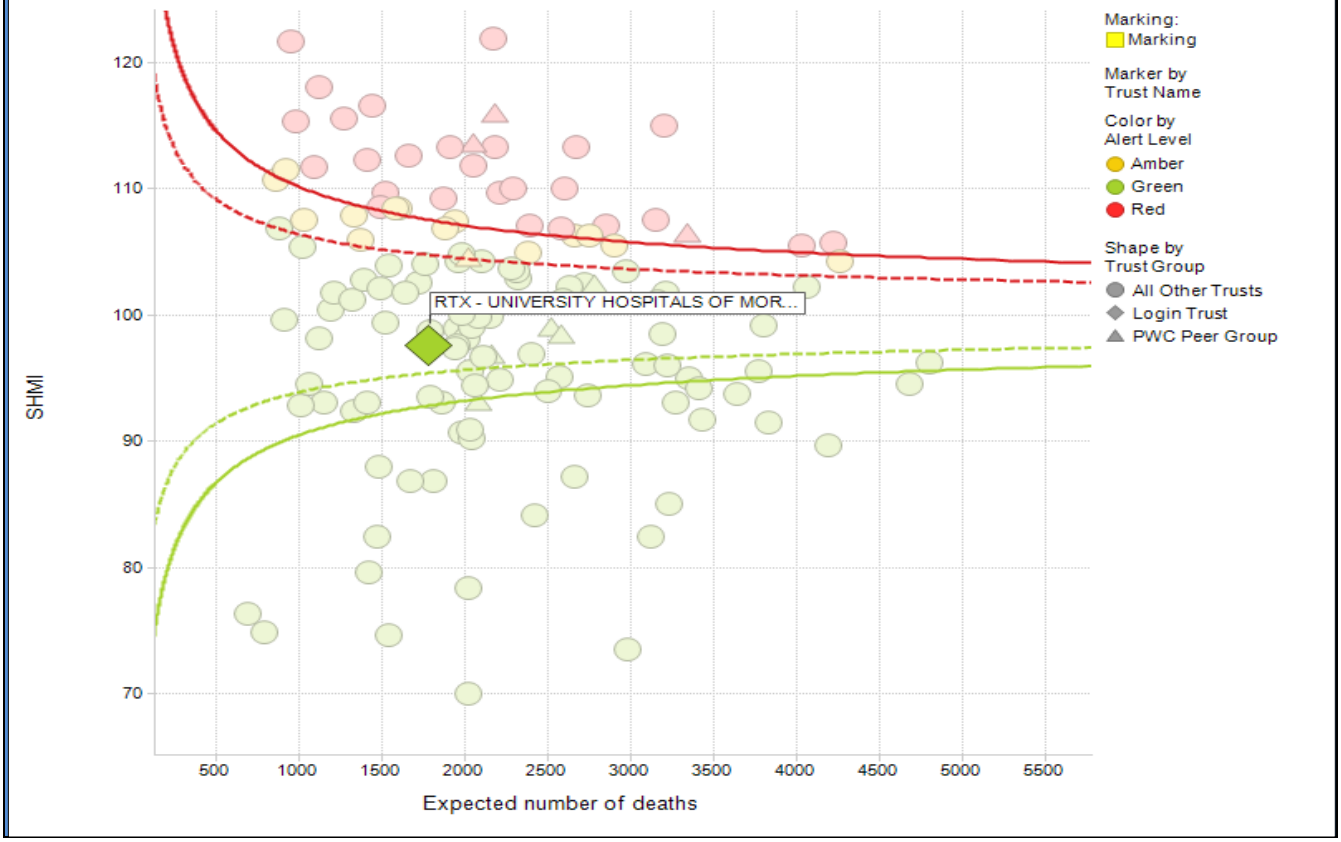


Figure 6 . UHMBTSHMI Position for Expected Number of Deaths

Please note that funnel plot is only valid when SHMI score is 100 for all the organisations (shown below) as a whole. It can be verified through highlighting all data items and checking grand total in Tab 3 breakdown table.



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

The Trust has seen a stroke mortality figure of 66 for the year and has achieved the target of 75 deaths or fewer in 2018/19; we have improved performance from 2017/18 with a decrease of 27 deaths.

Strong working partnership amongst the clinicians at the Royal Lancaster Infirmary and Furness General Hospital and leadership in this service have been fundamental to these improvements. 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 3 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

Deliver Effective and Reliable Care

25% reduction in hospital E-coli infections against baseline data from 2016/17 by the end of 2018/19 Gram-negative bloodstream infections (BSIs)

From April 2017, there is an NHS ambition to halve the numbers of healthcare associated Gram-negative BSIs by 2021.

Clinical Commissioning Groups (CCGs) are leading on achieving the Quality Premium (from April 2017, for two years), aiming to reduce all *E. coli* BSIs by 10% in Year 1 as an initial target.

Defining healthcare associated Gram-negative BSIs

A healthcare associated Gram-negative BSI will be a laboratory-confirmed positive blood culture for a Gram-negative pathogen in patients who had received healthcare in either the community or hospital in the previous 28 days.

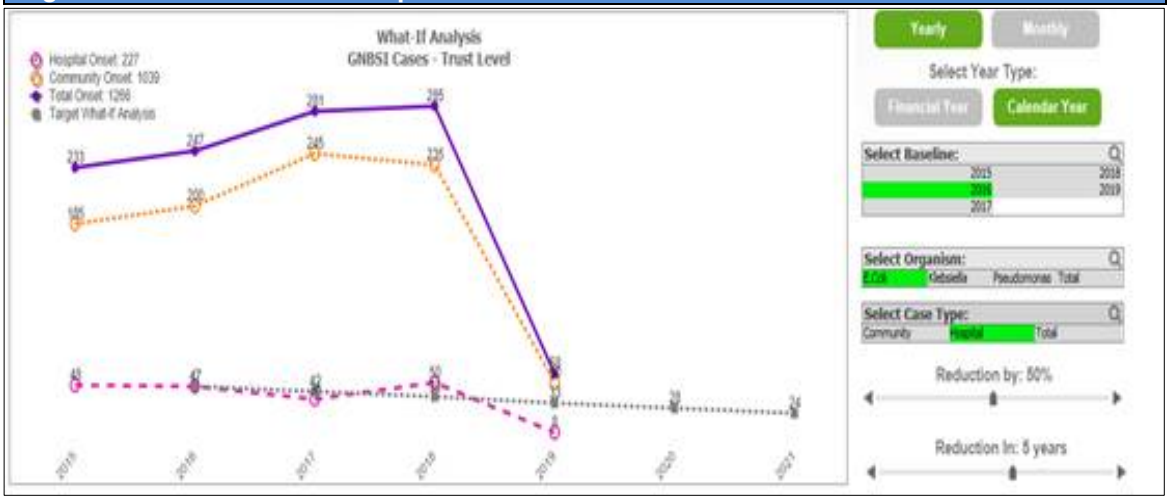
Gram-negative BSIs occurring following hospitalisation (at least 48 hours after admission) are healthcare associated. The classification of the community onset cases is much more difficult. Some information is included in the mandatory enhanced surveillance system but it is not clear how these cases are classified.

It should be noted that nationally the target for 10% reduction in ecoli BSI and wider ambition to reduce gram negative blood stream infections by 50% by 2021 has been challenging. Furthermore the latest UK Antimicrobial Resistance (AMR) publication for 2019-24 quotes that the UK would, *"Continue work to halve healthcare associated Gram-negative BSIs, adopting a systematic approach to preventing infections and delivering a 25% reduction by 2021-2022 with the full 50% by 2023-2024."*

This is a significant change to the initial ambition and may have been in response to the challenges faced in achieving the initial 10% reduction by many Trusts.

Figure 7: Total gram negative blood stream infection cases by financial year.

Figure 8: Number of Ecoli hospital onset healthcare associated cases



Ward Accreditation Scheme

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). In addition, since the acquisition of some community services in 2018, the scheme is also being rolled out to these areas.

50% of inpatient wards at Exemplar standard by 2017/18 to 2018/19

18% of inpatient wards (9 of 49) have achieved exemplar standard:

- Westmorland General Hospital:
  - Morecambe Bay Cardiac Centre
  - Day Surgery Unit (DSU)
  - Ward 6 / 7
  - Helme Chase Maternity Unit
- Furness General Hospital:
  - Emergency Department
  - Complex and Coronary Care Unit (CCCU)
  - Ward 9
- Royal Lancaster Infirmary:
  - Acute Frailty Unit (AFU)
  - Radiology Day Care Unit.

We have, therefore, not achieved the target of 50%.

15% of Outpatients areas to achieve exemplar status by 2017/18 to 2018/19

The Ward Accreditation Scheme is now active in all 5 Outpatient Departments and 40% (2 of 5) of the Outpatient areas have achieved exemplar status:

- Queen Victoria Hospital:
  - Joint Therapies
- Westmorland General Hospital:
  - Joint Therapies

We have, therefore, far exceeded the 15% target.

Sharing Lessons Learned from Patient Safety Incidents:

12 Standard Bulletins / 6 Themed Bulletins per annum

During 2018/19, the 'Learning to Improve' (L2I) group published twelve monthly bulletins, six themed bulletins and fifteen safety pins. All were circulated throughout the organisation, shared with stakeholders through various committees in both electronic and print format.

The monthly corporate bulletin during this period covered twenty-four main topics relating to incidents highlighted through the learning to improve process and the relevant department or care group provides updates until the evidence suggests that they have embedded the learning.

The Library and Knowledge Service published the six specialist themed issues on the areas identified by the group as needing a more concentrated message, namely:

- Medication;
- Claims;
- Health & Safety;
- Communication;
- Documentation; and
- Patient Relations.

These are part of the ongoing focus for improvement highlighted in the recent Learning to Improve report for the Quality Committee, along with blood transfusion and sharps. The benchmarking for these during 2017/18 focused upon incident figures, but going forward they will be part of the learning journey process and the new quality improvement generators currently being developed.

In addition to the monthly bulletins, L2I continues to use the successful "Safety Pins" posters to highlight key messages. Subjects this year are:

- Falls
- Patient medication
- Zimmer frames
- Fault reporting
- Storage boxes
- Gentamicin
- Pressure Care
- Manual Handling
- Chair Castors
- Drugs packaging issues
- Fridge Temperatures
- Lanyards

Safe incidents: Audit of Lessons Learned

The Learning to Improve Group has moved into monitoring the implementation of lessons from incidents using learning journeys for each care group plus one for cross care group incidents such as pressure care, documentation, communication, blood transfusion and cannula care. This means that the group monitors the lessons following circulation in the bulletins. In addition the group has now started to initiate deeper dives into themes where improvement is limited and where appropriate care groups introduce audits (via the Trust's clinical audit process) to monitor and ensure sustainability of improvements.

Commissioning for Quality and Innovation (CQUIN):

Develop and maintain 95% delivery as a minimum

The key aim of the CQUIN framework for 2018/19 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 23: CQUIN Schemes for 2018/19	
National CQUIN Scheme	**Target**
Staff Health and Wellbeing	Improvement of health and wellbeing of NHS staff
Building on the work undertaken in 2016/17 and 2017/18 this scheme aims to improve the Health and Wellbeing of staff with initiatives covering physical activity, mental health and physiotherapy. It links with the	

Table 23: CQUIN Schemes for 2018/19	
Trust's Flourish programme offering a variety of initiatives including:- Work out at Work, Yoga and Tai Chi sessions, the Flourish mile, Mindfulness taster sessions and workshops on Using Resilience to Manage Stress and Change. Staff also have access to therapies such as counselling, CBT and hypnotherapy, physiotherapy, work place assessments, discounted Slimming World vouchers and mini health MOT's. There is an annual Health and Wellbeing Conference for staff and in 2018 the Trust achieved Gold accreditation in conjunction with the Better Health at Work scheme.	
Staff Health and Wellbeing	Healthy food for NHS staff, visitors and patients
This scheme aimed to maintain the changes introduced during 2016/17 and 2017/18 and in 2018/19 achieved the following:- • No price promotions on sugary drinks and foods high in fat, sugar and salt (HFSS) • No advertisement in NHS premises of sugary drinks and foods with HFSS • No sugary drinks and foods with HFSS available at checkouts • All outlets are signed up to the national SSB reduction scheme and total litres of SSBs sold are 10% or less of all litres of drinks sold in 2018/19 • 80% of confectionary and sweets sold do not exceed 250 kcal • At least 75% of pre-packed sandwiches and other savoury pre-packed meals (wraps, salads, pasta salads) are under 400 cals. The Royal Voluntary Service continues to support the Trust with this scheme to ensure all requirements are embedded. As part of the Flourish programme the Trust promotes the importance of healthy eating which includes ensuring that healthy options are available for all staff in the restaurants, cafes and vending machines for night workers. The Catering Department have also worked with local schools to promote the importance of a healthy diet.	
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 75% of frontline clinical staff by the 28th February 2019. A communications strategy was produced and implemented highlighting the importance of being vaccinated not only for individuals but for family, friends and patients. A needle phobia campaign was completed to help dispel fears and anxiety and encouraged vaccination. The vaccination programme launched at the end of September 2018 with the target achieved in November ahead of schedule. The final data at the end of February shows 84% of frontline staff were vaccinated.	
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 and Inpatient admissions to identify patients who met the criteria for screening and were screened. From January 2019 the requirements changed to patients who met the National Early Warning Score 2 (NEWS 2) criteria and were screened for sepsis using the appropriate tool. The trajectory was set at 90% for each quarter and achieved across the year.	
Reducing the impact of serious infection	Timely treatment for sepsis in emergency departments and acute inpatient settings
This scheme required 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. Targets were achieved for quarters 1, 2 and 4 and narrowly missed in quarter 3 standing at 89.1%. To ensure continual improvement in patient care all patients identified as not receiving timely antibiotics have a clinical incident raised and are investigated with all actions required implemented.	
Reducing the impact of serious infection	Antibiotic Review
This scheme requires a minimum of 30 patients with sepsis per quarter to be reviewed to identify the percentage of patients who have had an appropriate review of their prescription carried out, which meets all the following criteria: - 1. Have an appropriate clinical review carried out by a competent clinician within 72 hours; 2. Have a documented outcome of review recorded from a list of 7 options; 3. Where appropriate an IV to oral switch decision was made. If the decision was for the patient to remain on IV antibiotics, a documented rationale for not switching is clearly documented. The targets were exceeded each quarter with performance at 96% in Q4.	
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 were to:- • Maintain the total antibiotic consumption per 1,000 admissions from 2017/18 • Reduce the total consumption of carbapenem per 1,000 admissions by 2% • Implement an action plan for the use of antibiotics within the Access group of the AWaRe category The consumption target for antibiotic consumption was exceeded slightly but the trust focused on the appropriate use of antibiotics across the year. The reduction target for carbapenem consumption was met	

Table 23: CQUIN Schemes for 2018/19	
and the agreed action plan has been implemented to ensure appropriate use of the drugs within the access group.	
Improving service for people with mental health needs who present to A&E	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
This scheme required the Trust to sustain the reduction achieved in year 1 of attendances to A&E for those within the selected cohort of frequent attenders who would benefit from mental health and psychosocial interventions and to identify a new cohort frequent attenders to A&E during 2017/18 who would benefit from mental health and psychosocial interventions and achieve a 20% reduction in their attendances. The reduction in attendances for cohort 1 achieved a further 81% reduction on the year 1 achievement and cohort 2 achieved a 51% reduction in the number of attendances.	
Preventing Ill Health (Acute)	Through Risky Behaviours – Alcohol & Tobacco
This scheme required the following the following criteria to be achieved:- • 90% of unique adult patients screened for smoking status and results are recorded • 90% of unique patients who smoke given very brief advice • 30% of unique patients who smoke referred to stop smoking services and offered stop smoking medication • 50% of unique adult patients screened for drinking levels and results recorded • 80% of unique patients who drink alcohol above low-risk levels given brief advice or offered specialist referral if potentially alcohol dependent Patient admission forms held in Lorenzo, the electronic patient record system, were updated to gather the relevant data and reports were developed to monitor compliance. Training implemented for staff to support delivery and an incremental approach to the targets was agreed with commissioners. The targets agreed were achieved in quarters 1, 2 and 3. There was partial achievement in Q4, with two out of five areas meeting national targets and the remaining areas showing significant improvements.	
Preventing Ill Health (Community)	Through Risky Behaviours – Alcohol & Tobacco
This scheme required the following the following criteria to be achieved:- • 90% of unique adult patients screened for smoking status and results are recorded • 90% of unique patients who smoke given very brief advice • 30% of unique patients who smoke referred to stop smoking services and offered stop smoking medication • 50% of unique adult patients screened for drinking levels and results recorded • 80% of unique patients who drink alcohol above low-risk levels given brief advice or offered specialist referral if potentially alcohol dependent New templates were developed and implemented in EMIS, the electronic patient record, to streamline the process. Training implemented for staff to support delivery and an incremental approach to the targets was agreed with commissioners. The targets agreed were achieved in quarters 1, 2 and 3. There was partial achievement in Q4, with three out of five areas meeting national targets.	
Offering Advice and Guidance	Provide access to Advice and Guidance services for non-urgent GP referrals.
The scheme required 75% of GP referrals to be made to elective outpatient specialties which provide access to Advice and Guidance services for non-urgent GP referrals. This allows GPs to access consultant advice prior to referring patients to secondary care. 80% of responses to be given within 2 working days Prior to the start of this scheme an Advice and Guidance (A&G) system was in place and being rolled out across specialties. The targets were met throughout the year and at the end of Q4 90% of specialties were open to Advice & Guidance and 88% of responses were given within 2 working days.	
Personalised Care and Support Planning (South Cumbria)	Embed personalised care and support planning for people with long-term conditions
This scheme required the following to be achieved:- • >75% of the identified cohort have evidence of care and support planning conversations recorded; • >50% of the identified cohort demonstrates an improvement in their patient activation assessment (PAM) Baseline data previously captured for this scheme with year 1 completed prior to the transfer to UHMBT as part of the Community Services Transfer Programme. Report developed to identify all patients going forwards with a PAM level of 1 or 2 and collate number of conversations/training/education undertaken to evidence actions taken to increase the PAM level. Quarter 4 requirements were achieved with 93.33% of the identified cohort having evidence of care and support planning conversations taking place and recorded; and 71.43% of the cohort increasing their PAM level.	
Personalised Care and Support Planning (North	Embed personalised care and support planning for

Table 23: CQUIN Schemes for 2018/19	
Lancs)	people with long-term conditions
This scheme required the following to be achieved:- • >75% of the identified cohort have evidence of care and support planning conversations recorded; • >50% of the identified cohort demonstrates an improvement in their patient activation assessment (PAM) Baseline data previously captured for this scheme with year 1 completed prior to the transfer to UHMBT as part of the Community Services Transfer Programme. Report developed to identify all patients going forwards with a PAM level of 1 or 2 and collate number of conversations/training/education undertaken to evidence actions taken to increase the PAM level. Quarter 4 requirements were achieved with evidence of care and support planning conversations taking place and recorded; and 71.43% of the cohort increasing their PAM level.	
Improving the Assessment of wounds (South Cumbria)	Increase the number of full wound assessments for wounds which have failed to heal after 4 weeks
This scheme required a clinical audit to be undertaken on a minimum of 50 case notes in both quarter 2 and quarter 4 of completed wound assessments with targets set as 60% compliance in Q2 and 80% in Q4. Baseline data stands at 54% (data collected in Year 1). Targets were exceeded in both quarters with 76% in Q2 and 82% in Q4. This was due to the implementation of a template on EMIS and training for staff.	
Improving the Assessment of wounds (North Lancs)	Increase the number of full wound assessments for wounds which have failed to heal after 4 weeks
This scheme transferred to UHMBT on the 1st October 2018 as part of the Community Services Programme. There were no requirements for the Trust with this scheme until the end of quarter 4 when the following was to be achieved: - Clinical audit to be undertaken on a minimum of 100 case notes of wound assessments with the target set at 80% compliance. The Q2 audit gave a baseline position of 16% and work was undertaken including introduction of a new template and staff training and the final position in Q4 was 83% against a target of 80%.	
NHS England CQUIN schemes	**Target**
Adult Intravenous Anticancer Therapy (SACT)	Standardisation of chemotherapy doses
Building on the work previously undertaken during 2016/17 and 2017/18 this scheme required the Trust to report achievement: - 1: % of doses standardised per drug as agreed following submission of the baseline data and 2: Trust agreement and adoption of standard product descriptions (where these are available) for individual chemotherapy drugs whether procured externally of prepared within the provider. Targets set as 90% for Q2, 92% for Q3, 95% for Q4 for dose banding with quarters 1, 2 and 3 achieved. For the adoption of standard product descriptions a target of 75%. All targets have been met.	
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 – N/A for 2017/18 • Trigger 3 – Increase the use of cost effective dispensing routes for outpatient medicines • Trigger 4 – Not applicable for 2017/18 • Trigger 5 – Reporting of all NHS England excluded drugs dispensed data through the Trust pharmacy systems All requirements have been met for each quarter of this this scheme.	

3.4.3 Priority 3: Patient Experience

Improvement in Patient Experience

The Trust is described as provider of choice for Consultants under 'I Want Great Care':

Inpatient areas to maintain Healthcare Communications (HCC) (previously IWGC)

Envoy system supported by Healthcare Communications (HCC) is used across the Trust. All Friends and Family (FFT) reviews are captured and access using this system.

Healthcare Communications embedded in to consultant experience feedback in 5 specialities by 2018/19

Healthcare Communications was embedded into consultant experience feedback in 5 specialities during 2018/19 so that reviews could be accessed by consultant (pulling together reviews relating to individual

consultants, as opposed to simply accessing reviews by clinic/ward/department and date field. It is now possible for FFT reviews to be specifically accessed by consultants across all areas. This feature is now about to be rolled out across the Trust.

Complaints

Reduce Formal Complaints and improve complaints response timescales

The number of complaints received in 2018/19 was 430, which is a 1% increase on the 425 recorded last year, and 18% below the defined upper limit of 528 complaints for 2018/19.

The number of Patient Advice and Liaison Service (PALS) cases is 2668, an increase of 158 (5%) and the number of Compliments has seen an increase of 15% to 1665.

Maintain complaint levels below a ratio of 1 Complaint per 1,000 patient attendances (Equivalent to 0.1%)

UHMBT received 0.6 complaints per 1000 attendances, an increase of 11% from last year's 0.54; but still within the range.

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 or an agreed date

UHMBT has achieved a 99% response rate to complaints responded to within 35 days; therefore achieving the target.

Table 24: Comparison of Complaints received from 2015-2019

Number of Complaints Received	2016/2017	2017/2018	2018/19
Community Health	0	0	11
Core Clinical Care Group	41	29	31
Corporate Services	8	3	12
Estates & Facilities	0	5	0
Medicine Care Group	191	166	169
Surgery & Critical Care Group	198	153	145
Women & Children's Care Group	77	69	62
Unspecified	0	0	11
Total	515	425	430

Lessons Learned – Complaints Closed in 2018/19

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 Care Group 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 Governance Business Partners to ensure all lessons raised through a complaint are actioned and closed within an appropriate timeframe.

Table 25 below summarises lesson learned and actions taken as a result of complaints closed in 2018/19.

Table 25: Summary of Lessons Learned from Complaints

Themes	Lessons Learned/Actions taken from Complaints
Waiting Time for Results	The radiology department are working on an electronic system to advise clinicians when results are available, which will enable them to acknowledge receipt of the results electronically.

Table 25: Summary of Lessons Learned from Complaints	
Themes	**Lessons Learned/Actions taken from Complaints**
Patient's Personal Property	Staff to be more proactive when missing teeth are lost in contacting the maxillofacial department in order for a new set to be established. The protocol for missing teeth is now placed in a high visibility area in order for staff to familiarise themselves with it.
Community/Info to Patients	We have learnt that it is important to check that all surgeons are formally and fully made aware of any changes. An email has been sent to the clinicians notifying them that the cut off, (last listing date), for Toric lens on the NHS was 18/01//2018.
Waiting Time Outpatient Appointment	In Ophthalmology we are continuously seeking to improve are capacity issues to meet our demand. We are actively adding additional clinics where possible to ensure our long waiting patients are seen in clinic and improve indicative review date).

Table 26 below summarises lesson learned and actions taken as a result of the Patient Advice and Liaison Service (PALS) cases closed in 2018/19.

Table 26: Summary of Lessons Learned from PALS	
Themes	**Lessons Learned / Action taken from PALS**
Premises Unclean	Car Park & Security Team have carried out a general litter tidy up in the area. It has been re-iterated to the people who move the bins about them being taken out and returned to their normal resting place on collection days. The Team will try and be vigilant and monitor the situation going forward. A letter is being sent to all family flats to remind of correct use of recycling bins
Communication/Info to Patient	The department need to develop a Standard Operating Procedure (SOP) for 'Mailing letters to patients' and include independent validation of patient list from Lorenzo in the SOP to prevent further recurrence of this happening in the future.
Unable to Contact	As a team we have decided to deflect the phones from the front reception every morning to the booking team and hopefully this will be more efficiently managed, to rerecord the message for the answer phone to ensure clear identification details and contact telephone number is left as this is sometimes not always clear and opening times of the department.
Customer Care - Other	Paediatric text reminders changed to say 'your child' instead of 'your' appointment
Transfer Arrangements	Communication between midwives and women needs to be more effective with clear explanations of why women have to be diverted to other units. To share themes of complaint at May staff meeting.
Discharge Arrangements	Anonymised case discussed at local audit meeting to highlight the confusion for patients and relatives for building up oral intake in surgical patients, after major intestinal surgery.
Administrative Procedures	To try to reduce this risk in the future next time they place an order for request forms to be printed they will redesign the form so that the fasting tick box is in the same area as the test tick boxes. Most of our other Trust wards and departments (and also GPs) use electronic test requesting systems which eliminates the risk of this error occurring entirely, unfortunately the Outpatients Department have not yet managed to migrate to electronic requesting but hope to do so in the near future.
Communication/Info to Patient	Communication to be incorporated into Customer Service training, which is currently being taken by all members of staff within the department.

Table 27 below summarises lesson learned and actions taken as a result of the Parliamentary and Health Service Ombudsman (PHSO) reports in 2018/19.

Table 27: Summary of Lessons Learned from the PHSO reports	
Themes from PHSO Reports	**Lessons Learned / Action Taken from reports received from the PHSO**
Diagnosis Problems	There is a need to follow up on abnormal findings from elective surgical procedures. Appreciate that retention of information given immediately post operatively is poor, so there is a need to consider future follow up clinic appointments for further discussion of operative findings at a future date to improve retention. The PHSO accepted that the Trust had already acknowledged failings and the lessons learnt were from the actual complaint to the Trust.
Treatment Given	To support patients who are given a terminal diagnosis. There was a delay in ensuring that staff were engaged in a timely manner regarding end of life care.

Public Engagement

Increase the scope and depth of public engagement: 6 public engagement events 2017/18 to 2018/19

In February 2018, we launched our new Patient and Public Involvement Strategy. 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: https://www.UHMBT.nhs.uk/files/5415/1869/8815/Patient_and_Public_Involvement_Strategy_2017-2020_FV2.pdf

Our vision continues to be our commitment to promote participation and engagement with patients, carers, the public, and communities through a relationship based on trust, transparency and shared decision making. We continue to work hard to ensure that citizens understand how they are able to contribute and influence and how they are influencing our approach and decision making. We are proud of work undertaken within the last 12 months around addressing health inequalities and making improvements using feedback from a variety of sources and stakeholders, including partners in the voluntary and statutory sectors, individuals, groups of specific patient populations.

Our Care Groups are now starting to lead their own citizen involvement activities; this is helping to ensure engagement arrangements allow the right people to hear and understand the views of our diverse local population and those residents who represent the characteristics protected by the Equalities Act 2010.

We recognise that it is important to have a clear understanding of who our stakeholders are. Each stakeholder or stakeholder group will have differing characteristics, roles, needs, expectations and interests and these will vary per the issue under consideration. Careful stakeholder analysis and the development of a tailored "stakeholder map" contributes to the success of our engagement projects.

Our engagement activities continue to offer the widest opportunity for the involvement; attention has been given to involving groups who may be seldom heard.

On 10 October 2018, we asked local people to talk with us about why breast surgery services matter: we called this *Breast Care Matters in Morecambe Bay*. The aim of the event, which took place during Breast Cancer Awareness Month, was to listen to women and men and use their feedback to shape future breast surgery services at the Trust for the better. This event gave local people who currently use the Trust's breast surgery services or those who support the services the chance to meet the team involved and give their honest feedback on their experiences.

We have now created 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); these hubs are run by staff and volunteers who offer practical and emotional support to anyone affected by cancer.

Our Maternity and Young People Matters community conversations continue; we find these events so valuable, 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 in allowing us to really listen to their ideas and suggestions on what we can do to make things even better for local communities.

On 1 May 2018, our public grading event was attended by our Equality and Inclusion Business Partner from the Midlands CCG; supportive and developmental feedback was given to the Trust with regards to a suggested methodology for clearly identifying sources of evidence linked to the relevant protected groups. Based on this feedback we have developed a simple mapping matrix to support this development activity.

Throughout our EDS2 month (May 2018), we asked citizens, patients, service users, public, governors, volunteers, and staff to review our evidence. The results can be viewed by following the link below https://www.UHMBT.nhs.uk/about-us/inclusion-and-diversity-matter-UHMBT/annual-reporting.

The Trust's patient and public participation matters model continues to deliver and inform how we deliver our services; detailed below is a list of some of our events undertaken within the last 12 months:

- Westmorland County Show;
- Health Screening Awareness;
- What Matter to You events;
- Always Events;
- Critical Care Services – Patient Involvement Matters;
- Kendal Community Health Day;
- Lancaster Health and Heritage Matters event;
- Foundation Trust Annual members meeting;
- NHS 70 celebrations;
- Step in to Health community engagement;
- Beyond Boundaries Inclusion Conference;
- Children and Young People Mental Health Event;
- Living Well Beyond Cancer;

- Volunteer Matters;
- Health Screening Matters; and
- Organ Donation Matters.

The Trust is in the process of developing a Patient Experience Strategy. The aim of this strategy is to ensure that all patients, their families, carers and visitors have a positive experience in our care, ensuring their physical and emotional needs and expectations are met or exceeded.

Integration of Physical and mental health pathways:

7 day Child and Adult Mental health Service (CAMHS) support for Cumbria and Lancashire North

The key work that has been undertaken includes:

- 7 day Child and Adult Mental health Service (CAMHS) support for Cumbria and Lancashire North. This project has now finished and there are plans to commission the out- of-hours service differently, after having undertaken taken a full review of the times and frequency of attendance. However, there is no formal agreement in place yet as to exact offer;
- The 9-5pm Monday to Friday arrangement will remain the same on both sites at present;
- The CAMHS pathway is working well at Furness General Hospital and has made some improvements at the Royal Lancaster Infirmary (RLI); there are plans to continue to improve the focus on the pathway by using the LIA methodology;
- The refurbishment of the orthopaedic outpatient area adjacent to Emergency Department (ED) at RLI which will provide a more suitable environment for the management and assessment of our mental health patients. This is underway and expected to be completed in May 2019; this area will be staffed by Registered Mental Health Nurses (RMN) provided by Lancashire Care Foundation Trust (LCFT) and be PLAN standard compliant;
- Working collaboratively with LCFT, third sector, and experts by experience, we held a listening event on 7 March 2019 to help in the redesign of the current service and support development of pathways and the standard operating procedures for the new bays in ED RLI. These provide a more suitable environment to ensure patient safety and that assessments can take place to a way which ensures their privacy and dignity;
- A review is being undertaken of care and treatment plans and how the information can be shared within ED for both UHMBT and LCFT with a view to enabling a shared care protocol;
- The pilot of Richmond Fellowship and The Well working within the Emergency Department at RLI and early reports indicate. This is having a positive impact on providing individualised support for our patient and reducing some re attendance. It has also reduced inappropriate referrals to crisis team;
- Although there has been a small reduction in 12 hour breaches for patients waiting for mental health beds, we continue to still perform below the National average;
- The Well will provide a 7 day service both within RLI and also in the community to support service users to attend appointments, engage with services/provide meaningful groups etc;
- More GPs taking part in Section 12 of the Mental Capacity Act (MCA) training in Cumbria which reduces the amount of time patients have to wait for an assessment under the MCA;
- There are mental health training dates arranged for staff with Expert by Experience input with plans for further dates this year;
- There are plans in place to commence Learning Disability (LD)/RMN clinical supervision working with LCFT and looking at future plans for a buddy system working across the organisations to enhance skills for both mental health staff and general nurses from April 2019;
- The first LD listening event took place on 20 March 2019 at Forum 28, Barrow. The next listening event is for Autism on 22 May 2019 at Moor Lane Mills;
- The Autism Development Group met and there is now a plan for developing this further
- Our LD/Autism matron has presented a case study at the LeDeR and STOMP North West conference in Preston, attendees were very impressed with our commitment to ensure we improve services for LD and autism patients and were very complimentary about the reasonable adjustments we make to enhance care;
- We have been working with LCFT to ensure that our mental health patient information is shared to enable patient safety, reduction in duplication of information, and a streamlined patient

assessment; this is still evolving, but supports the patients' management and experience within the Emergency department; and

- Working with our Lancashire partners across the health economy of Lancashire, we have been involved in the development of updating the 12 hour breach Standard Operating Procedure to provide a timeline for escalating and reporting 12 hour breaches alongside the responsibilities and actions of each organisation involved in that patients journey, which provide clarity in shared care and the expected quality standards.

Delivery of the SAFER Care Bundle which is fundamental to optimising flow and requires clinical leadership

SAFER is being implemented across both FGH and RLI. There is a weekly SAFER meeting where members of the nursing team, along with therapies, pharmacy & I3 meet to discuss progress / issues / actions. UHMBT have been part of a SAFER collaborative with 3 other Trusts, supported by the Emergency Care Intensive Support Team (ECIST), to aid learning from others in relation to implementing SAFER. There are plans for a national collaborative, supported by ECIST later this year.

S – Senior Review. All patients will have a senior review before midday by a clinician able to make management and discharge decisions

All patients should have a senior review; however, this is dependent on medical cover on the wards as some clinicians are covering multiple wards. This is monitored on an ongoing basis, reviewed at the weekly SAFER meeting and periodic matron / peer reviews completed.

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

The improvement team are working to support the progress in Expected Discharge Date (EDD) and a 'ready to go' date. We have recently been involved in an NHSi collaborative with Criteria Led Discharge & this is due to be rolled out across all areas over the next 12months.

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

The discharge profile across RLI is discussed at the weekly SAFER meetings, in relation to discharge before midday. We have tested the process / metrics for reviewing this and it will now be rolled out to the FGH site. Work is ongoing between the AMU/base wards to establish flow from the AMUs earlier in the day; however, this is dependent on the early discharges from downstream wards.

E – Early discharge. 33% of patients will be discharged from base inpatient wards before midday

As above.

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

Length of stay reviews led by the discharge team are undertaken weekly on each site to review all patients – this is currently for patients over 14 days.

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

The Advice & Guidance system (A&G) is a web-based system which provides a conversational link - a type of "chat room" - between a GP and a Consultant via a secure link. GP's can request advice and/or guidance, from Consultants, on patient issues and discuss symptoms, conditions, treatments and concerns. The Advice and Guidance service was first introduced in 2013 initially to support GPs and patients in deciding the appropriateness of referral to Outpatient clinics.

The use of Advice and Guidance service by GP's has steadily increased and the year to 31 March 2019 saw the number of consultant / GP conversations reach the 10,000 mark for the first time. Table 28 below shows the increase in the number of conversation since 2016 rise from 5332 to 10,425. This has seen a steady

increase as more specialities have been added to the service during this time and increased up-take of the service by GP's.

Despite the increase in A&G conversations taking place in both 2017/18 and 2018/19, the number of intended patient admissions by GP's, and the intended and did admit conversations remain consistent and, therefore, this suggests that the service is used predominantly by GP's for advice and guidance in relation to forming a decision to admit as opposed to prior decision to admit already being made. This highlights the success of the service to not only provide support to GP's but also to avoid unnecessary referrals and admissions to hospital.

Table 28 also shows the comparison in percentages in 2017/18 performance with 2018/19. Despite there not being a 10% reduction in avoidable referrals in 2018/19 compared with the previous year, the percentage of avoided referrals is consistently high and the wide-spread use of the service to inform a decision demonstrates that the qualitative benefits to the patient have been achieved.

Table 28: Advice and Guidance Conversations and Admissions Avoided

Fiscal Year	Total A&G Conversations	Conversations where the GP intended to Admit Patient Prior to A&G Discussion	Conversations where the GP intended to Admit and Did Admit	Admissions Avoided	% of Referrals Avoided
2016/17	5332	79	14	65	82%
2017/18	8013	101	18	83	82%
2018/19	10425	103	16	87	84%

Work with local GP's, community nursing staff and local nursing homes 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

Two care home nurses have been appointed in South Lakes. They have supported care homes to complete comprehensive care plan assessments with residents from the care homes. One aim of the comprehensive care plans is to ensure that the individual's preferences for care, longer term care and end of life care can be recorded. Unnecessary admission to hospital is one aim of the care planning. Early data indicates a reduction in emergency admission for the two ICC's that the nurses are working in.

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

A dedicated care home project has been established with the two hospices in the Bay. In this initial phase the teams are supporting a number of care homes with bespoke education programmes to improve end of life care. The aim is to ensure staff are confident in caring for people at end of life. Whilst it is not yet possible to provide any outcome data in relation to this, the engagement with the care homes has been positive.

Improvement in Staff Experience

Increase voice for staff in how their organisation can be improved

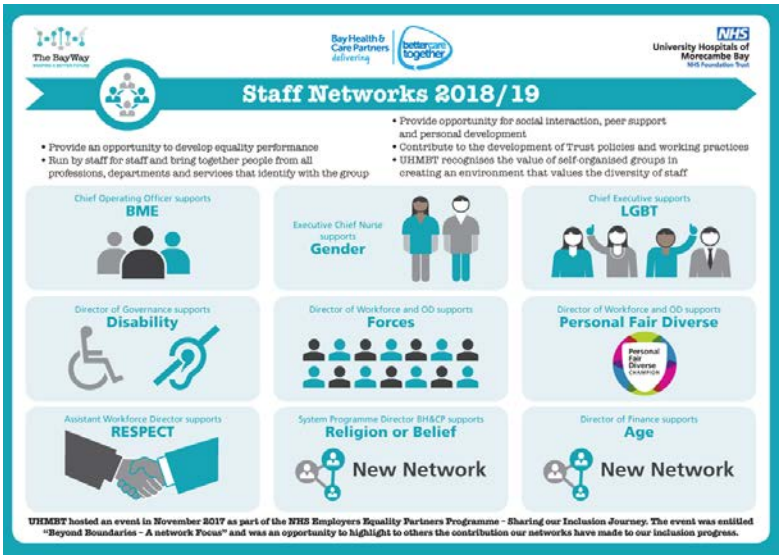
The Colleague Experience Strategy, like the Behavioural Standards Framework (BSF), will be developed in partnership with our colleagues, by our colleagues for our colleagues. It will set out what the Trust's culture will be to ensure the best colleague experience which will deliver improved patient experience and will underpin the delivery of our performance and quality aspirations. This will be achieved by building on the standards already set out by our colleagues within the BSF of the expected behaviours and attitudes, taking further colleague feedback about what they want their experience at work to be, what matters most and how they want to be at work.

The intention is that, like the BSF, the Colleague Experience Strategy will become part of the collective fabric of the Trust creating a shared culture of joy and

kindness that makes the Trust a truly *Great Place to Work*. It will become part of everyone's daily approach and their work; it will be part of what we do every day – with high visibility across the Trust.

The Colleague Experience Strategy will be incorporated throughout the employee lifecycle, from values based recruitment and induction, and through annual cycles of performance and development review/appraisal. The approach to colleague experience will be fundamental to setting out how colleagues will work together, valuing each other's contribution whilst recognising and appreciating each other's differences. It will set out our aspiration to making UHMBT a Great Place to work that is not only joyful but kind and based on team support.

A central core of UHMBT's approach to colleague experience and employee engagement is understanding that the views of colleagues is key to developing the Trust into a *Great Place to be Cared For*; *Great Place to Work* and is important data, not only to inform priority areas of action, but also to assess progress in relation to organisational strategies. This is supported by the approach to engagement with colleagues across the Trust to learn from lived experiences to create a *Great Place to Work* for <u>every</u> individual. The Trust has 9 staff inclusion networks, each with an executive sponsor, which supports giving all staff a voice as part of the work to become 'effortlessly inclusive'.



In addition to the National Staff Survey, options to develop methods of feedback and a 'temperature testing' programme to engage with colleagues will be reviewed and rolled out through 2019-21. The development of this approach will be undertaken through Colleague Experience Strategy engagement.

3.5 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.

3.6 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.

3.7 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

3.8 Quality Account Availability

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

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

3.9 Our Website

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

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 – 15 May 2019

Quality Accounts 2018/19 – Stakeholder Feedback: Morecambe Bay Clinical Commissioning Group

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 Assuring Quality Group (AQG) 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 AQG with the Trust.

The CCG would like to thank the Trust for sharing the 2018/19 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 2018/19 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 2019/20 improvement trajectories. We also wish to acknowledge the activities the Trust have implemented to support staff health and wellbeing included within its Flourish campaign.

The CGG recognise that 2018/19 was an extremely busy and challenging year for the Trust but are pleased to see the Trust engaging and moving toward a system wide approach.

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 2019/20.

It is positive to see an emphasis on improved quality outcomes, service user and staff experience. The trust has rolled out staff training specific to Quality Service Improvement and Redesign Tools (QSIR) which it has applied to a range of service improvement projects such as implementing a Discharge to Assess model aiming to support people to leave hospital as soon as they well enough to do so.

The CCG note the Trust for being open and transparent with its Serious Incident reporting and for allowing the CCG's to attend its Serious Incidents Requiring Investigations (SIRI) Panel as well as its Quality Committee and ENACT meetings. The CCG are pleased to see a commitment to improved reporting and investigating of serious incidents and the oversight of improvement actions arising from incidents. The CCG is pleased to see the continued production of the Learning to Improve bulletins highlighting a range of topics including Pressure Care, Fluid balance charts and falls.

The CCG acknowledges the Trusts progress towards improving its learning and responses to complaints. 2018/19 and continued support to the Patient Relations Team in achieving a more efficient and timely turnaround of complaints alongside staff training and display of posters.

The CCG recognises the collaboration undertaken between University Hospitals of Morecambe Bay NHS Foundation Trust and both Cumbria Partnership NHS Foundation Trust and Blackpool Teaching Hospitals in safely integrating hospital and community services across Morecambe Bay in 2018/19.

We recognise the approaches the Trust are taking to address the ongoing recruitment to nursing and medical vacancies including Nurse Apprenticeship and the success in recruitment from oversees.

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 would you suggest are the Trust's priorities for quality improvements for 2019/2020?

We expect the Trust will continue to deliver its statutory quality requirements through the identification, monitoring and evaluation for continual improvement. The CCG will continue to build a transparent, open relationship with the Trust, with working interactions that incorporate supportive challenge, scrutiny and collaboration.

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 2018/19.

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. The Trust is also a key partner in the rapid development of Integrated Care Partnership (ICP), which they acknowledge is the next step to enable the Trust to align services locally with the Integrated Care Communities 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 2019/20 and is an important contribution to public accountability in relation to quality. The CCG appreciates the amount of work involved in producing this report.

Margaret Williams
Chief Executive Nurse
Morecambe Bay CCG

1.2 Quality Accounts commentary from University Hospitals Morecambe Bay NHS Foundation Trust Governors – 20 March 2019

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 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 2018, and in January and February 2019 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

Summary Hospital-level Mortality Indicator (SHMI) 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 – 10 May 2019

Quality Accounts 2018/19 – Stakeholder Feedback: Healthwatch Cumbria

What do you like about the 2018/19 Quality Accounts?

Healthwatch Cumbria is pleased to be able to submit the following considered response to University Hospitals of Morecambe Bay NHS Foundation Trust Quality Accounts Report for 2018/19.

A very commendable document, clearly presented data combined with succinct but sufficiently detailed narrative makes it easy to understand all sections. The overall tenor of the report expresses ambition and a number of challenging targets supported by description of the actions that will be taken to achieve successful outcomes, we really liked the setting of 'challenging' rather than 'comfortable' targets.

Specific items we liked would include:

The weekly Patient Safety Summit: we are very pleased to note that it has been nationally recognised as an exemplar patient safety initiative.

The continuing implementation of the Ward Accreditation scheme.

The clear format of the presentation of data and relevant benchmarking against other Trusts providing similar services when applicable.

The supplementary explanation to the Quality Standards and Indicators.

The appointment of nurses supporting care homes to ensure the individual's preferences for care are recorded.

We were particularly pleased to see the evidence at 3.3.6 Freedom to Speak Up with accompanying data for the 12 month period ahead of legislation, as requested by NHS Improvement.

What do you dislike about the 2018/19 Quality Accounts?

There are no elements that we dislike.

What suggestions do you have for additional content for 2018/19?

We have no comments or suggestions for additional content.

What other comments or suggestions for improvements would you like to propose?

We have no comments or suggestions for additional improvements.

What would you suggest are the Trust's priorities for quality improvements for 2019/20?

We note that the Trust has taken the views of patients, public, staff and governors from a number of sources including the Corporate Quality Reviews, actions we fully support and hence would agree with the priorities as described. Healthwatch Cumbria would like to find ways of supporting this in practice.

Do you consider that the draft document contains accurate information in relation to NHS services provided by the Trust?

Intelligence received by Healthwatch Cumbria supports the facts as described within the report.

Do you consider that any other information should be included relevant to the quality of NHS services provided by the Trust?

We have no comments or suggestions for additional information.

Please indicate below your name and which role, organisation or group you represent.

Sue Stevenson
Chief Operating Officer
Healthwatch Cumbria

1.4 Quality Accounts commentary from Healthwatch Lancashire – 10 May 2019

Quality Accounts 2018/19 – Stakeholder Feedback: Healthwatch Lancashire

What do you like about the 2018/19 Quality Accounts?

Healthwatch Lancashire is pleased to be able to submit the following considered response to University Hospitals of Morecambe Bay NHS Foundation Trust Quality Accounts Report for 2018-19.

Very easy to read and understand, the data clear and well presented.

The character of the report expresses ambition and a number of challenging targets supported by description of the actions that will be taken to achieve successful outcomes, we really liked the setting of 'challenging' rather than 'comfortable' targets.

Specific items we liked would include:

The weekly Patient Safety Summit: we are very pleased to note that it has been nationally recognised as an exemplar patient safety initiative.

The clear format of the presentation of data and relevant benchmarking against other Trusts providing similar services when applicable.

The continuing implementation of the Ward Accreditation scheme.

The supplementary explanation to the Quality Standards and Indicators.

The appointment of nurses supporting care homes to ensure the individual's preferences for care are recorded.

We were particularly pleased to see the evidence at 3.3.6 Freedom to Speak Up with accompanying data for the 12 month period ahead of legislation, as requested by NHS Improvement.

What do you dislike about the 2018/19 Quality Accounts?

There are no elements that we dislike.

What suggestions do you have for additional content for 2018/19?

We have no comments or suggestions for additional content.

What other comments or suggestions for improvements would you like to propose?

We have no comments or suggestions for additional improvements.

What would you suggest are the Trust's priorities for quality improvements for 2019/20?

We note that the Trust has taken the views of patients, public, staff and governors from a number of sources including the Corporate Quality Reviews, actions we fully support and hence would agree with the priorities as described. Healthwatch Lancashire would like to find ways of supporting this in practice.

Do you consider that the draft document contains accurate information in relation to NHS services provided by the Trust?

Intelligence received by Healthwatch Lancashire supports the facts as described within the report.

Do you consider that any other information should be included relevant to the quality of NHS services provided by the Trust?

We have no comments or suggestions for additional information.

Please indicate below your name and which role, organisation or group you represent.

Sue Stevenson
Chief Operating Officer
Healthwatch Lancashire

1.5 Quality Accounts commentary from Cumbria Health Scrutiny Committee – 9 May 2019

The Cumbria Health Scrutiny Committee again welcomes the opportunity to comment on the Trust's draft Quality Account for 2018/19, 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 Trust's aim to be one of the safest organisations within the NHS.

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 months including briefings provided to the Committee and meetings between the Lead Health Scrutiny Members and the Chair and Chief Executive of the Trust.

The committee is pleased to note how the views of patients, relatives, carers and the wider public have been taken into account, for the selection of priorities for quality improvement in 2019/20.

Overall, we appreciate the co-operation received and look forward to continuing to work with the Trust during the coming year.

Cllr Claire Driver
Chair
Cumbria Health Scrutiny Committee

1.6 Quality Accounts commentary from Lancashire Health Scrutiny Committee – 12 April 2019

This year the Lancashire County Council Health Scrutiny Committee will be providing a comprehensive joint response to two of the eight Quality Accounts we receive. Although we are unable to comment on this year's University Hospitals of Morecambe Bay Quality Account, we are keen to engage and maintain an ongoing dialogue throughout 2019/20.

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 2018/19 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 2018 to 29 May 2019;
  - Papers relating to quality reported to the Board over the period 1 April 2018 to 29 May 2019;
  - Feedback from commissioners – Morecambe Bay Clinical Commissioning Group dated 15 May 2019
  - Feedback from Governors dated 7 January 2019, 15 January 2019, 20 March 2019;
  - Feedback from Healthwatch Lancashire dated 10 May 2019 and Healthwatch Cumbria organisations dated 10 May 2019;
  - Feedback from Cumbria Health Scrutiny Committee dated 9 May 2019 and Lancashire Health Scrutiny Committee dated 12 April 2019;
  - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 dated 15 April 2019;
  - The 2017 National In-Patient Adult survey published 13 June 2018;
  - The 2017 Local UHMBT Adult In-patient survey final report received 7 February 2018;
  - The 2017 National Cancer Patient Experience survey published 28 September 2018;
  - The 2018 National Maternity Survey published 29 January 2019
  - The 2018 Local UHMBT Maternity Survey received 29 September 2018
  - The 2018 National Staff Survey published 28 February 2019;
  - The Head of Internal Audit's annual opinion over the Trust's control environment dated 10 April 2019; and
  - Care Quality Commission Inspection report dated 16 May 2019.
- 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: 24 May 2019

Aaron Cummins
Chief Executive

Date: 24 May 2019

Annex 3: Glossary of Abbreviations And Glossary Of Terms

Table 29: Glossary of Abbreviations	
Abbreviation	**Meaning**
A & E	Accident and Emergency
A & G	Advice and Guidance Service
AMR	Antimicrobial Resistance
AMU	Acute Medical Unit
ANP	Advance Nurse Practitioner
BAUS	British Association of Urological Surgeons
BCT	Better Care Together
BSF	Behavioural Framework Standard
BSI	Bloodstream Infections
CAMHS	Children and Adolescence Mental Health Service
CBT	Cognitive Behavioural Therapy
CCCU	Complex and Coronary Care Unit
CCG	Clinical Commissioning Group
CDI/CDT	Clostridium Difficile Infection/Toxin
CGGAG	Care Group Governance Assurance Group
CLAHRC	Collaborations for Leadership in Applied Health Research & Care
CMP	Case Mix Programme
COPD	Chronic Obstructive Pulmonary Disease
COSHH	Control of Substances Hazardous to Health
COTE	Care Of The Elderly Team
CPFT	Cumbria Partnership Foundation Trust
CRM	Cardiac Rhythm Management
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CT Scan	Computerized Tomography Scan
DEXA	Dual-energy X-ray absorptiometry Scan
DNACPR	Do Not Attempt Cardiopulmonary Resuscitation
ECIST	Emergency Care Intensive Support Team
E-coli	Escherichia coli (coliform bacterium)
ED	Emergency Department
EDD	Expected Discharge Date
EDS2	Equality Diversity System
EMIS	EMIS Health, formerly known as Egton Medical Information Systems
EPMA	Electronic Prescribing and Medicines Administration system
EPR	Electronic Patient Record
e-RS	e-Referral Service
FFT	Friends and Family Test
FGH	Furness General Hospital
FIT (Testing)	Faecal Immunochemical Test
FTSU	Freedom to Speak Up
GI	Gastrointestinal
GIRFT	Getting It Right First Time
GP	General Practitioner
HCAI	Healthcare Acquired Infection
HCC	Healthcare Communications
HFC	Harm Free Care
HFSS	High in Fat, Sugar and Salt
HO	Healthwatch Organisations
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
IV	Intravenous
INR	International Normalised Ratio

IP	Infection Prevention
iWGC	I Want Great Care
L2I	Learning to Improve
LCFT	Lancashire Care Foundation Trust
LeDeR	Learning Disabilities Mortality Review
LiA	Listening into Action
MINAP	Myocardial Ischaemia National Audit Project
MRSA	Methicillin-resistant Staphylococcus Aureus
NACEL	National Audit of Care at End of Life
NBOCAP	National Bowel Cancer Audit
NBSR	National Bariatric Surgery Register
NCAA	National Cardiac Arrest Audit
NCAREIA	National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis
NELA	National Emergency Laparotomy Audit
NEWS	National Early Warning Score
NEWS2	National Early Warning Score (2nd version)
NGO	National Guardians Office
NHFD	National Hip Fracture Database
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
NLCA	National Lung Cancer Audit
NMC	Nursing and Midwifery Council
NMPA	National Maternal and Perinatal Audit
NNAP	National Neonatal Audit Programme
NOGCA	National Oesophago-Gastric Cancer Audit
NPDA	National Paediatric Diabetes Audit
NRES	National Research Ethics Service
NRLS	National Reporting and Learning System
OSC	Overview and Scrutiny Committee
PALS	Patient Advice and Liaison Service
PAM	Patient Activation Assessment
PbR	Payment by Results
PCNL	Percutaneous nephrolithotomy
PICANet	Paediatric Intensive Care Audit Network
PHSO	Parliamentary and Health Service Ombudsman
PIDA	Public Interest Disclosure Act (1998)
PIR	Post Infection Reviews
POMH	Prescribing Observatory for Mental Health
Pre-op	Pre-operative
PROMs	Patient Reported Outcome Measures
PSF	Provider Sustainability Fund
Q	Quarter
QAAS	Quality Assurance Accreditation Scheme
QIP	Quality Improvement Strategy and Plan
RCA	Root Cause Analysis
RIG	Radiologically Inserted Gastrostomy
RLI	Royal Lancaster Infirmary
RMN	Registered Mental Nurse
RN	Registered Nurse
RTT	Referral To Treatment
SACT	Systemic Anti-Cancer Therapy
SBAR	Situation, Background, Assessment, Recommendation (Tool)
SHOT	Serious Hazards of Transfusion
SHMI	Summary Hospital Mortality Index
SIRI	Serious Incident Requiring Investigation
SOP	Standard Operating Procedure
Spo2	Peripheral Capillary Oxygen Saturation
SSB	Sugar-Sweetened Beverages (Scheme)

SSNAP	Sentinel Stroke National Audit Programme
StEIS	Strategic Executive Information System
STOMP	Stopping over medication of people with a learning disability, autism or both
SUI	Stress Urinary Incontinence
UHMBT	University Hospitals of Morecambe Bay Foundation Trust
UTI	Urinary Tract Infection
VIP	Visual Infusion Phlebitis
VTE	Venous Thrombo-Embolism
WGH	Westmorland General Hospital

Table 30: Glossary of Terms	
Abbreviation	**Glossary of meaning**
AWaRe category	Access, Watch and Reserve Antibiotics in the WHO Essential Medicines List
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.
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, 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.
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.
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

Table 30: Glossary of Terms	
Abbreviation	**Glossary of meaning**
	• 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
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.
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
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	http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_131539

Table 30: Glossary of Terms	
Abbreviation	**Glossary of meaning**
Thrombo-Embolism	
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
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.

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 2018/19 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 2018 to 29 May 2019;
  - Papers relating to quality reported to the Board over the period 1 April 2018 to 29 May 2019;
  - Feedback from commissioners – Morecambe Bay Clinical Commissioning Group dated 15 May 2019;
  - Feedback from Governors dated 7 January 2019, 15 January 2019, 20 March 2019;
  - Feedback from Healthwatch Lancashire dated 10 May 2019 and Healthwatch Cumbria organisations dated 10 May 2019;
  - Feedback from Cumbria Health Scrutiny Committee dated 9 May 2019 and Lancashire Health Scrutiny Committee dated 12 April 2019;
  - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 dated 15 April 2019;
  - The 2017 National In-Patient Adult survey published 13 June 2018;
  - The 2017 Local Trust Adult In-patient survey final report received 7 February 2018;
  - The 2017 National Cancer Patient Experience survey published 28 September 2018;
  - The 2018 National Maternity Survey published 29 January 2019;
  - The 2018 Local Trust Maternity Survey received 29 September 2018;
  - The 2018 National Staff Survey published 28 February 2019;
  - The Head of Internal Audit's annual opinion over the Trust's control environment dated 10 April 2019; and
  - Care Quality Commission Inspection report dated 16 May 2019.
- 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: 24 May 2019

Aaron Cummins
Chief Executive

Date: 24 May 2019

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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 2019 (the "Quality Report") and certain performance indicators contained therein against the criteria set out in the 'NHS foundation trust annual reporting manual 2018/19' and additional supporting guidance in the 'Detailed requirements for quality reports 2018/19' (the 'Criteria').

Scope and subject matter

The indicators for the year ended 31 March 2019 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);
- maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.
- 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 2018/19' 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 2018/19' 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 2018/19'; 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 2018/19' and supporting guidance and the six dimensions of data quality set out in the ''Detailed requirements for external assurance for quality reports 2018/19'.

We read the Quality Report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual 2018/19' 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 2018 to 24 May 2019;
- papers relating to quality reported to the Board over the period 1 April 2018 to 24 May 2019;
- feedback from commissioners dated 15 May 2019;
- feedback from local Healthwatch organisations, Healthwatch Lancashire and Healthwatch Cumbria, both dated 10 May 2019;
- feedback from Cumbria Health Scrutiny Committee and Lancashire Health Scrutiny Committee dated 9 May 2019 and 12 April 2019 respectively;
- feedback from the Council of Governors dated 07 January 2019, 15 January 2019 and 20 March 2019;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and National Health Service Complaints (England) Regulations 2009, dated 15/04/2019;
- the national cancer patient experience survey dated 28 September 2018;
- the national maternity survey dated 29 January 2019;
- the national adult inpatient survey dated 13 June 2018;
- the local adult inpatient survey dated 07 February 2018;
- the local maternity survey dated 29 September 2019;

- the 2018 national staff survey dated 28 February 2019;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated 10 April 2019; and
- the Care Quality Commission's inspection report dated 16 May 2019.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these 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 2019, 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 2018/19' and supporting guidance to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is narrower 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 2018/19' 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 and is subject to separate terms and conditions. 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.

Conclusion

Based on the results of our procedures, as described in this report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- 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 2018/19' 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 2018/19'; and
- the indicators in the 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 2018/19' and supporting guidance.

Grant Thornton UK LLP

Grant Thornton UK LLP
Chartered Accountants
Glasgow

24 May 2019

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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 and Social Care 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 and Social Care 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;
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS Foundation Trust's performance, business model and strategy; 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: 24 May 2019

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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 2019 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 significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the Accounts Directions issued under the National Service Act 2006, the NHS foundation trust annual reporting manual 2018/19 and the Department of Health and Social Care group accounting manual 2018/19.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2019 and of its expenditure and revenue for the year then ended;
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care group accounting manual 2018-19; 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.

Material uncertainty related to going concern

We draw attention to note 1.1 in the financial statements, which indicates that the Trust's accounts for 2018/19 record an adjusted deficit of £69.3 million, and a cumulative deficit on retained earnings of £275.1 million. The Trust has a planned deficit for 2019/20 of £38.6 million and has submitted an operational plan to NHS Improvement which assumes that further support will be provided by the Department of Health and Social Care in the form of loans for required revenue support for this planned deficit.

As stated in note 1.1, the Trust is due to repay loan principal of £54.4 million on Department of Health and Social Care loans between January and March 2020. It is anticipated that the repayment terms of these loans will be extended and that these payments will not be required during 2019/20. This has not yet been confirmed with the Department of Health and Social Care.

These events or conditions, along with the other matters as set out 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

Financial statements audit

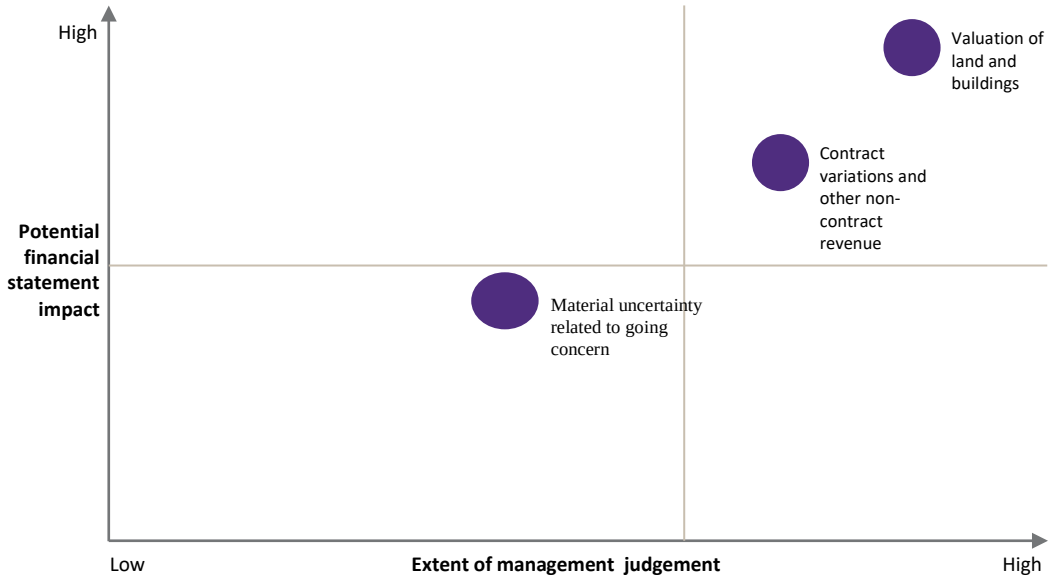
- Overall materiality: £6,134,000 which represents 1.5% of the Trust's gross operating expenses;
- Key audit matters were identified as:
  - Material uncertainty related to going concern
  - Occurrence and accuracy of revenue from patient care contract variations and other non-contract revenue
  - Valuation of land and buildings.
- We have tested the Trust's material revenue and expenditure streams and assets and liabilities on a sample basis, covering 100% of the Trust's revenue, 100% of the Trust's expenditure, 98% of the Trust's assets and 98% of the Trust's liabilities.

Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

- We identified two significant risks in respect of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources regarding financial outturn and sustainability and reconfiguration of services (see Report on other legal and regulatory requirements section).

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 – Occurrence and accuracy of revenue from patient care contract variations and other non-contract revenue Approximately 90% of the Trust's revenue is from patient care activities and contracts with NHS commissioners. 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. The Trust also receives other operating revenue which is predominantly in respect of, non-patient care services and other contract income. We have not identified a significant risk of material misstatement in relation to education, training and research and development revenue as it is principally derived from contracts agreed in advance at a fixed price. We therefore identified occurrence and accuracy of revenue from contract variations and other non-contract revenue 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: • evaluating the Trust's accounting policy for recognition of revenue from patient care activities and other non-contract revenue for appropriateness and compliance with the Department of Health and Social Care (DHSC) Group Accounting Manual 2018/19; • updating our understanding of the Trust's system for accounting for revenue from patient care activities and other operating revenue and evaluating the design of the associated controls; • investigated unmatched revenue over the NAO £0.3 million threshold; • agreed on a sample basis, contract variations to signed contract variations, invoices, cash receipts or other supporting documentation; and • agreed, on a sample basis, other operating revenue to invoices and cash receipts or other supporting evidence. The Trust's accounting policy on revenue recognition 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 revenue recognition is in accordance with the DHSC group accounting manual 2018/19 and has been properly applied; and • revenue from patient care contract variations and other non-contract revenue is not materially misstated.
Risk 2 - Valuation of land and buildings The valuation of land and buildings of £125.7 million represents a significant balance on the Trust's Statement of Financial Position. The Trust uses an external valuer to revalue its land and buildings on an annual basis to ensure that carrying value is not materially different from current value. This represents a significant estimate by management in the financial statements. The valuation of land and buildings is based on key accounting estimates which are sensitive to changes in assumptions and market conditions. We therefore identified the valuation land and buildings 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: • evaluating management's processes and assumptions for the calculation of the estimate, the instructions issued to the valuation expert and the scope of their work; • evaluating the competence, capabilities and objectivity of any valuation expert used; • testing the completeness and accuracy of the information provided to the valuer; • 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; and • 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. 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

Key Audit Matter	How the matter was addressed in the audit
	that: • the basis of the valuation was appropriate, and the assumptions and processes used by management in determining the accounting estimates were reasonable; and • the valuation of land and buildings disclosed in the financial statements is reasonable.

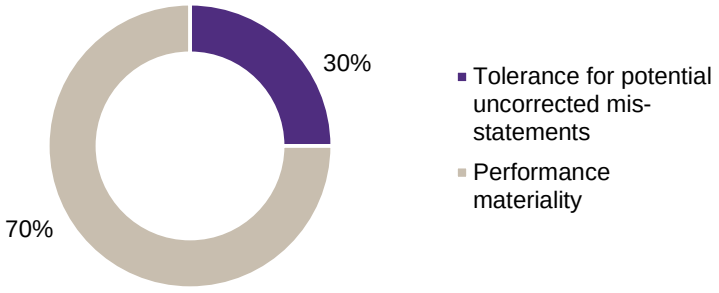
Our application of materiality

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	£6,134,000 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 the Trust 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 2018 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.
Communication of misstatements to the Audit Committee	£300,000 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.

Overall materiality – Trust



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 environment including relevant IT systems and controls over key financial systems.

We tested, on a sample basis:

- all of the Trust's material revenue streams, covering 100% of the Trust's revenue;
- operating expenses, covering 100% of the Trust's expenditure;
- 98% of the Trust's assets; and
- 98% 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 obtained in the audit 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 the 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 2018/19 or is misleading or inconsistent with the information of which we are aware from our audit. 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 2018/19 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 issue a report 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 refer a matter to the regulator under Schedule 10 (6) of the National Health Service Act 2006 because we have reason to believe that the Trust, or a director or officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of expenditure that was unlawful, or is about to take, or has begun to take 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 the Chief Executive's responsibilities as the accounting officer, 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 2018/19, 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 Accounting Officer has been informed by the relevant national body of the intention to dissolve the Trust without the transfer of the Trust's services to another public sector entity.

The Audit Committee is Those Charged with Governance. Those charged with governance are responsible for overseeing the Trust's financial reporting process.

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

Adverse conclusion

On the basis of our work, having regard to the guidance issued by the Comptroller and Auditor General in November 2017, because of the significance of the matters described in the basis for adverse conclusion section of our report, we are not 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 2019.

Basis for adverse conclusion

In considering the Trust's arrangements for securing efficiency, economy and effectiveness in its use of resources, we identified the following matters:

- During 2018/19 the Trust reported a significant deficit for the year of £76.0 million, with an adjusted deficit position excluding impairments of £69.3 million. This has increased the cumulative deficit position of the Trust to £275.1 million at 31 March 2019. The deficit has been funded by revenue borrowing from the Department of Health and Social Care, increasing the level of revenue borrowing to £210.1 million at 31 March 2019.

- The Trust achieved a Cost Improvement Programme (CIP) for 2018/19 of £14.6 million against a £14.0 million target. The level of non-recurrent savings was £8.6 million against a plan of £3.6 million, which now places further pressure on the budget for 2019/20 and beyond.
- The Trust has agreed a control total with NHS Improvement for 2019/20 of a £60.1 million deficit. This plan includes planned CIP delivery of £22.0 million. Whilst some £9.3 million of savings plans have been identified by the Trust as at 31 March 2019, there remains a savings gap of £12.7 million yet to be fully identified. This level of unidentified savings represents a significant risk that the 2019/20 control total is not achievable.
- As a condition of the enforcement undertaking on the Trust's licence issued by NHS Improvement in May 2018, the Trust was required to submit a sustainability and financial recovery plan to NHS Improvement covering the period to 2023/24. This plan projects a deficit position in each of the five years up to 2023/24. In total, these in-year deficits cumulate to a further £299 million before any financial support.
- The Care Quality Commission (CQC) published the Trust's Use of Resources report on the 16 May 2019, which is based on an assessment undertaken by NHS Improvement. The Trust was rated as 'Inadequate' for using its resources productively, as a result of the deteriorating deficit position and it now being the largest percentage of turnover deficit in England, the Trust's reliance on external loans and the Trust's poor underlying productivity.

The above matters highlight pervasive 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 and levels of demand on 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.

Significant risks

Under the Code of Audit Practice, we are required to report on how our work addressed the significant risks we identified in forming our conclusion on the adequacy of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. Significant risks are those risks that in our view had the potential to cause us to reach an inappropriate conclusion on the audited body's arrangements. The table below sets out the significant risks we have identified. These significant risks were addressed in the context of our conclusion on the Trust's arrangements as a whole, and in forming our conclusion thereon, and we do not provide a separate opinion on these risks.

Significant risks forming part of our adverse conclusion	**How the matter was addressed in the audit**
Risk 1 – Financial Outturn and sustainability The Trust faces significant financial challenges in the short and medium term, which will require robust 'informed decision making' to create financial plans to achieve 'sustainable resource deployment'. The Trust has a history of reporting a deficit outturn position, the cumulative impact of which was £199.4 million at 31 March 2018. The Trust was forecasting a further deficit of £69.4 million in 2018/19, which required further revenue borrowing from the Department of Health and Social Care. The Trust had a Cost Improvement Programme (CIP) target of £14 million for 2018/19, which included a 26% target of non-recurrent savings. High levels of non-recurrent savings put greater pressure on future operational budgets.	Our audit work included, but was not restricted to: • monitoring of financial outturn, and CIP performance against plans in 2018/19; • challenging senior members of the finance team on financial outturn and sustainability plans; • assessment of the 2019/20 Operational Plan, including CIP targets, and medium-term financial recovery plans to understand financial projections to address the in-year and cumulative deficit position; and • assessment of the impact of reconfiguration of services and working with partners on financial performance in the Bay Health and Care Partners Sustainability and Financial Recovery Plan. **Key findings** We have qualified our conclusion in respect of this risk, as set out in the basis of adverse conclusion section of the report.

Significant risks not forming part of our adverse conclusion	How the matter was addressed in the audit
Risk 2 – Reconfiguration of services – Better Care Together The Trust is 'working with partners' more closely than ever in order to help address the operational and financial challenges it faces. The Trust is a key partner in the Vanguard status 'Better Care Together' integrated care partnership, and the wider integrated care system (ICS) being formulated in North Lancashire and South Cumbria. The reconfiguration of services being driven by the partnership working is creating tangible changes, such as the transfer of community services into the Trust during 2018/19. The Trust's operational and financial plans have strong links to partnership working and therefore the failure to work with partners effectively represents a significant risk to the Trust achieving its strategic and operational priorities.	Our audit work included, but was not restricted to: • inquiries with senior management responsible for managing key partnerships, reconfiguration of services and the transfer of community services; • assessing the oversight and governance structures the Trust has in place to ensure partnership working is successfully managed; • challenging the processes, controls and governance procedures in place to ensure the successful transfer of Community services to the Trust; and • assessing key Trust plans and strategies to understand the impact of partnership working on these, and how this is being managed by the Trust. **Key findings** The Trust has proper arrangements to work with other parties to deliver strategic and operational priorities. The Trust is taking an active role in the reconfigurations of services in North Lancashire and South Cumbria, but the challenge remains on making these services financially sustainable in the short to medium term.

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 2019, 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.

Use of our report

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.

Gareth Kelly

Gareth Kelly, Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor

Glasgow
24 May 2019

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Annex F – Annual Governance Statement 2018/19

Annual Governance Statement 2018/19

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 2019 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 2018/19 the Trust's Risk Management Strategy has been reviewed and was approved by the Board of Directors on 31 January 2018 and will be reviewed again in May 2019. 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 Trust was awarded significant 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 Deputy Chief Executive 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
- Care Group Risks.

All Care Group triumvirate members have responsibility for the risk management activity in their Care Group, including:

- Providing leadership for risk management activities in their Care Group;
- Promoting and supporting the implementation of the Risk Management Strategy;
- Monitoring the risk mitigation activities within their Care Group 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 Care Group risk management activity is discussed and reviewed at relevant Care Group meetings (Care Group Governance and Assurance Group, Care Group Management Team and Care Group 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 Care Group/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 Care Group risk registers. Clinical Directors and Associate Directors of Operations for each Care Group are then able to provide assurance to the Board and its Committees on the Board Assurance Framework and Corporate Risk Register.

The Care Group Clinical Director is responsible for the Care Group Risk Register. The Care Group Risk Registers are reviewed at the Care Group 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 Care Group Clinical Director is responsible for ensuring that any agreed local risks that are rated at 15 and above are included in the Care Group Risk Register Report that is submitted to the relevant Assurance Committee and addition to the Corporate Risk Register. Care Group Risk Registers are presented in a standard format providing a progress report on actions taken to mitigate risk by the Care Group 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 UHMB Strategy, Annual 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, incident reporting, 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 will be reviewed in May 2019 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, Care Group 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's 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.

In January 2019, the Trust obtained an opinion of Substantial Assurance from Internal Audit in the last audit of the Trust's risk management arrangements to ensure that the risks are identified, managed, reported on and escalated through the appropriate governance structures

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 was undertaken in 2018/19 with the support of Deloitte and will continue in 2019/20. 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 Care Group within the Trust. During 2018/19 a review of the clinical leadership structure took place with appointments of Deputy Medical Directors, Care Group Clinical Directors, the Chief Clinical Information and the Lead Clinician roles completed. The appointments were linked to a two year leadership development programme which would continue for the next 18 months. The Trust's culture continues to place patient care at the heart of everything the Trust does in addition to being honest and open and striving for excellence.

During 2018/19, 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 the Trust 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 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 the Trust does and will drive excellence in patient and employee experience. Building on from this, during 2018/19 the Trust 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. The BSF was refreshed in October 2017. The relaunch focused on a 12 month programme on BSF behaviours. 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 for staff to access via the Trust's Training Management System in April 2018.

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 2019-2022 on 27 March 2019 and approved the refreshed Quality Improvement Strategy. The new strategy was developed with input from staff, patients, carers, strategic partners and other key stakeholders. The strategy sets out ambitious plans over the next three years to deliver sustained, significant and continuous improvements to the quality and safety of the care provided to patients.

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.

Care Group Clinical Directors, Assistant Chief Nurses, Lead Allied Health Professionals and Associate Directors of Operations have responsibility for facilitating the implementation of this strategy and plan within their Care Groups. Furthermore, it is the responsibility of the Care Group team to contribute to the delivery of the Trust's quality targets. This is managed through the development and delivery of Care Group 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 the Trust's 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 Care Group Governance and Assurance Groups, WESEE (workforce, efficiency, safety, effectiveness and experience) 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 (I^3) via the I^3 Risk Management Forum and Information Governance and Data Quality Group reporting 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 Data Security and Protection Toolkit self-assessment review process.

During 2018/19 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 2018/19, the Trust had 138 Personal Data related incidents reported, all were thoroughly investigated and reported upon. In comparison there were 68 personal data information security related incidents recorded during 2017/18.

The tables below provide a summary of the incidents that were reported in 2018/19. Up to 25 May 2018 incidents were classified as Level 0-2 with Level 2 being reported to externally to the Department of Health and Social Care, NHS Digital, NHS Improvement and the Information Commissioner. After 25 May 2018 incidents are classified as 'No impact has occurred', 'An impact is unlikely', 'Reported to the ICO' and 'Reportable to the ICO and DHSC notified' with 'Reported to ICO' and 'Reportable to ICO and DHSC notified' being reported externally to the Information Commissioner and Department of Health and Social Care'. The change was a result of the Data Protection Act 2018 / General Data Protection Regulations and Networks and Information Systems (the NIS Directive).

Summary of personal data related incidents up to 25 May 2018		
Breach Type	**Level 0 -1**	**Level 2**
Disclosure in error	7	
Lost or stolen paperwork	3	
Non-secure disposal - paperwork	1	1

Summary of personal data related incidents after 25 May 2018					
Breach Type		**No Impact**	**An impact is unlikely**	**Reported to ICO**	**Reportable to ICO and DHSC Notified**
Confidentiality	Unauthorised or accidental disclosure	45	26		
	Unauthorised or accidental access	12		1	
Availability	Unauthorised or accidental loss	28	7		
	Unauthorised or accidental destruction	7			
Integrity	Unauthorised or accidental alteration				

The Trust achieved Data Security and Protection Toolkit (DSPT) internal assessment compliance score of "Standards Met". The DSPT submission is subject to independent audit, the Trust's internal auditors Mersey Internal Audit Agency (MIAA) have reviewed the evidence provided as part of the DSPT compliance and provided an overall Substantial 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 2018/19, forming part of the Board Assurance Framework and included the following:

In-Year Risks 2018/19	Future Major and Significant Clinical Risks 2019/20
These are taken from the Board Assurance Framework, Corporate Risk Register, Bay Health and Care Partners' Financial Recovery Plan, Operational Plan, Integrated Performance Report and Quality Account	These are taken from the Board Assurance Framework, Corporate Risk Register, Bay Health and Care Partners' Financial Recovery Plan, Operational Plan, Integrated Performance Report and Quality Account
Key Strategic Risks: **Finance Risk** Deliver the 2018/19 financial plan and continued	**Key Strategic Risks:** **Failure to achieve the financial plan** If the Trust does not deliver the 2019/20 Trust financial

In-Year Risks 2018/19	Future Major and Significant Clinical Risks 2019/20
These are taken from the Board Assurance Framework, Corporate Risk Register, Bay Health and Care Partners' Financial Recovery Plan, Operational Plan, Integrated Performance Report and Quality Account	These are taken from the Board Assurance Framework, Corporate Risk Register, Bay Health and Care Partners' Financial Recovery Plan, Operational Plan, Integrated Performance Report and Quality Account
development of the Sustainability and Transformation Plans to 2020/21. **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". **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. **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 the Trust's Estate** 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.	plan and control total (which includes year 1 of the 5 year financial recovery plan), we will not receive PSF and FRF support worth £21.5 million. Access to other support and capital may be restricted potentially compromising safety, quality, and sustainability of the organisation leading to poor patient and staff experience and a negative impact on the position of the Trust. **Strategic People and Organisational Development** If the Trust does not have a sufficiently motivated and engaged workforce, in sufficient numbers, appropriately trained and working in a positive work culture, this could lead to an inability to deliver safe, sustainable care and the aspiration to be a great place to be cared for, a great place to work **Failure to achieve operational performance trajectories towards the NHS Constitutional Access Standards** A challenging operating environment is impacting on the Trust's ability to achieve operational performance trajectories towards the NHS Constitutional Access Standards. This could lead to compromising quality of care provided and patient safety, which could impact adversely on health outcomes for patients and their experience; and intervention from regulators. **Inadequate capital funding to enable priority schemes including maintenance of the physical condition of the Trust's estate, infrastructure and medical equipment** If the Trust does not gain access to the required level of capital funding, the Trust will not be able to address the inherent defects in the Trust's infrastructure including the deterioration in the fabric of the Trust's ageing estate, nor the estates developments required to improve clinical adjacencies and efficiencies, nor ensure availability of the required medical equipment to meet service demand aged beyond its planned life. This will lead to an adverse effect on service continuity, productivity and patient and staff experience **Building and Maintaining Strong Partnerships** If the Integrated Care Partnership and the Integrated Care System do not operate effectively in a collaborative, joined-up way, the Trust may not be able to deliver the overall system triple aim of better care, better health, delivered sustainably

The risks on the previous page have been risk assessed and validated by the Board of Directors as part of the Annual Planning Process for 2019/20. 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, Bay Health and Care Partners' Financial Recovery Plan and the Annual 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 Care Group 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;
- Safety Alerts;
- Care Group 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 Care Group has a Care Group Governance Framework in place. Care Group performance meetings are held on a monthly basis and areas of concern are escalated to the Assurance Committees. At Care Group 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. Each year the Trust agrees priority areas for MIAA to audit. Set out below is the 2018/19 work programme delivered by Internal Audit and the outcomes of the Audit Work:

Review Title	Assurance Level High/Substantial/Moderate/Limited/No
Risk Management	Substantial
Immediate Discharge Summaries	Substantial
GMC Registration	Substantial
Data Protection and Security Toolkit (IGT)	Substantial
Business Continuity and Disaster Recovery (IM&T)	Substantial
Nurse Staffing Levels	Moderate
Hand Hygiene	Moderate
Financial Systems / Financial Integrity	Moderate
e-Rostering	Moderate
Integrated Community Services	Limited
Fit and Proper Persons	Limited

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.

In 2017/18 the Annual Reporting Requirements were 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. Using this framework the Trust undertook a self-assessment as part of the Care Quality Commission inspections in November and December 2018. 2018/19 has seen the continued use of inspections and visits to wards and clinical areas including corporate quality reviews by the Board, Governors and Clinical Leaders to improve quality and increase visibility of Executive and Non-Executive Directors.

During 2017/18 the Trust revised its 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. Building on from this a review of the fit and proper person assessment was undertaken by the Trust's internal auditors, Mersey Internal Audit Agency (MIAA), as part of the internal audit plan for 2018/19. The overall objective of the review was to ensure that individuals who hold Executive and Non-Executive Director level roles within the Trust were fit and proper persons to lead the organisation in charge of the provision of direct patient care. Following their assessment, the Trust obtained an opinion of Limited Assurance from MIAA. Although a robust control design framework was found to be in place to administer and meet the obligations of the fit and proper persons requirements, MIAA recommended a number of actions to comply with the requirements of the fit and proper persons assessment. These included a review of the Trust's pre-employment checks to assess a director's fitness on appointment and record keeping.

The Trust continues its approach to lessons learned through the Learning to Improve Steering Group, established in 2015. The Group reports to the Quality Committee and reviews its Terms of Reference on an annual basis; these are available on the Trust's procedural document library. 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. It brings together Care Group 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 Care Group has a Risk Register which is regularly reviewed and updated and operational risks are considered through the Care Group Governance Framework. Care Group Risk Registers in turn are used to develop the quarterly Corporate Risk Register report for the Board of Directors' meeting 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 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, the Trust is seen as exemplar in its approach and the Trust 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. The national Freedom to Speak Up office surveyed the Freedom to Speak up Guardians in the summer of 2018 and the results of this review were published in October 2018. The review set out 12 recommendations for improvements and the Trust met all of the recommendations which included fair and open recruitment of the Guardian; ring-fenced time; gathering feedback; supporting the guardian to attend national and regional Freedom to Speak up events and training; supporting the Guardian to link up with minority networks and giving the Guardian direct access to Board members and regular monthly meetings with the lead Non-Executive Director and 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 Patient Safety Unit was established to provide a resource for investigating and acting on potential patient safety concerns for example through issues arising from the patient safety summit or routine clinical data. The Patient Safety Unit links clinical patient safety activity with academic research through its partnership with Lancaster University. At the core of this vision is the fostering of a culture in which research and innovation are embedded in routine clinical practice and the creation of an environment in which research findings lead to sustained improvements in the quality of patient care. The Trust will engage the entire clinical workforce and also 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) - NHS England's web-based serious incident management system, through which providers record incidents. The Unit reviewed its standard operating procedure in January 2019.

Quality 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 are:

- To eliminate unlawful discrimination, harassment and victimisation;
- 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.

In September 2016, the Board of Directors approved a five year Inclusion and Diversity Strategy developed in partnership with the Trust's inclusion networks. The Strategy 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 the Trust's 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 2018. Year 2 of the five year strategy saw a continued commitment to delivering on the effortlessly inclusive ambitions. The annual report provided a detailed update on the actions, activities and events.

As well as 179 Personal Fair Diverse Champions, the Trust has established 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 and forces. Included in the Trust's 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 be selected as one of NHS Employers Equality and Diversity Partners for a second year running in 2016/17 and in 2018/19 was termed an Alumni partner. This enables the Trust to share good and bad experiences with other organisations.

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 Time to Change outlining its 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. Through February 2018 the Trust ran a series of pledge roadshows supporting the Time to Talk element of the Time to Change campaign, and secured over 130 pledges from staff. In the months following, members of the inclusion infrastructure have followed up on the pledges, to find out firstly if the pledge was followed through, and secondly what difference it made to the individuals. The Time to Change action plan enables the implementation phase of the Trust's intentions to commence. 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 the Trust's 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 Board of Directors receive 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.

The Board, therefore, is able to assure itself of the validity of its Corporate Governance Statement.

Through the Governance Division and the governance action plan, the Board of Directors has laid the foundations to provide the framework to manage risks in these areas.

The Board Assurance Framework (BAF) has been embedded during 2018/19. The BAF:

- Covers all of the Trust's main activities;
- Identifies the Trust's corporate objectives and targets the Trust in 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. In March 2019 the Trust obtained from Internal Audit an opinion that confirmed that 'the organisation's Assurance Framework is structured to meet the NHS requirements, is 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 of 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, Morecambe Bay Clinical Commissioning Group, 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 its 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 Bay Health and Care Partners, the Trust has worked with it partners to remodel the local health economy to provide a sustainable integrated health care system. Part of this programme has seen extensive consultation with the public, communities and voluntary and special interest groups have been able to participate in the programme. Building on from this, work has begun and will continue in 2019/20 to develop the next phase of the Better Care Together strategy.

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.

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 2018/19.

During 2018/19, the Trust held a series of talks for members on a number of different subjects. These included the appropriate use of the Emergency Department, stroke services, and to co-incide with the 70th birthday of the NHS, a series of talks across the area on the history of the NHS in Morecambe Bay, particularly focussed around the story of an oral surgeon who also happened to be the dentist in Colditz prison camp.

4.9 How the Trust Complies with the Developing Workforce Safeguards Recommendations

The People and Organisational Development (OD) Strategy focusses on creating the right conditions for colleagues to flourish developing a highly engaged workforce that is productive and focused on achieving excellence every time.

The aspiration is to become a 'Great Place to be Cared For; Great Place to Work'. A culture of continuous improvement and care that is safe, clinically effective and provides a positive experience for colleagues, patients and their families are core to the values of the people and OD team.

Workforce numbers, colleague capability, employee engagement and the Trust's commitment to eradicating bullying and harassment are amongst the Trust's top strategic risks. The people and OD team has a leading role in supporting the Care Croups and operational teams to put the right conditions in place to mitigate against these risks and ensure that the Trust is a great place to be cared for and a great place to work.

Central to the People and OD Strategy is the development of the Colleague Experience Strategy, which will support the achievement of a great place to work. Alongside this, the following people and OD strategic areas will respond to the Trust's capacity risks:

- Recruit and Retain;
- Grow and Develop;
- Engage and Involve; and
- Health and Wellbeing.

4.10 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.

A CQC Unannounced Core Service Inspection of the Trust took place mid November 2018. This was followed by a Use of Resources Assessment late November 2018. This was led by NHS Improvement (NHSI) and consisted of a day of interviews with members of the Board and senior operational teams. There was an announced CQC 'Well-led' inspection in December 2018. The final CQC Quality Report was published in May 2019. Although the publication date is after 31 March 2019 it is a material matter that has arisen after year end that needs to be reported in this statement.

The Care Quality Commission (CQC) has rated the services provided by the Trust as Requires Improvement overall. Previously it was rated Good. The Trust was rated as Requires Improvement for being safe, responsive and well-led and Good for being effective and caring. A team of CQC inspectors assessed three core services: urgent and emergency care, surgery and medicine. They also looked specifically at management and leadership to answer the key question: Is the trust well-led? While the overall rating for Royal Lancaster Infirmary has fallen to Requires Improvement, Furness General Hospital and Westmorland General Hospital remain rated as Good overall.

CQC also published the Trust's Use of Resources (UoR) report, which is based on an assessment undertaken by NHS Improvement. The Trust was rated as Inadequate for using its resources productively. The combined rating for the Trust, taking into account CQC's inspection for the quality of services and NHSI's assessment of Use of Resources, is Requires Improvement.

Following the publication of the CQC Quality Reports the Trust began to develop a new CQC Hospital Improvement Plan which incorporated all the Trust Wide and Care Group Must and Should Do actions which were identified as areas for improvement within the CQC Quality Reports. The Improvement Plan is to be presented to the CQC by 12 June 2019.

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 CQC published the final quality reports and ratings on their website which can be visited at www.cqc.org.uk.

4.11 Publication of Trust Register of Interests

The Trust publishes an up-to-date register of interests for decision-making staff in accordance with the 'Managing Conflicts of Interest in the NHS' requirements.

4.12 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.

4.13 Compliance with Equality, Diversity and Human Rights Legislation

Control measures are in place to ensure that all the 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.

4.14 Compliance with Climate Adaptation Requirements under the Climate Change Act 2008

The Trust has undertaken risk assessments and has plans in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaption 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.

Care Group 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 on 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 Trust's priorities for 2018/19. In the preparation of the Quality Account, the Deputy Governance Hub Manager has led the development of the Quality Report, reporting to the Director of Governance. A formal review process was established, involving the submission of the Trust's initial draft Quality Report to the Trust's 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 2018/19 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 2018/19'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 2019/20.

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 2018/19. 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 first cohort of 27 register nurse apprentices commenced the nursing degree programme in February 2018 with the University of Cumbria. The Trust is the first Trust in the country to have registered nurse apprentices and this is a key part of the Trust's strategy to "grow-our-own" workforce. The ambition is to extend this programme across Bay Health and Care Partners in the next year.

  In 2018 the approach to improvement at the Trust was reviewed and strengthened. Alongside Listening into Action (LiA), in May 2018 the Trust introduced the Quality Service Improvement and Redesign (QSiR) programme and together they form the Trust's overall strategy for developing improvement capability and capacity. LiA continues to enable and empower staff to develop their own improvement initiatives. Since inception the Trust has had 140 schemes taken through by staff at all levels. QSIR delivers a more in depth improvement science training that enables participants to become local champions and experts in improvement knowledge and practice allowing the Trust to develop an organisational capacity and capability to support our transformational agenda. The aim is to train 150 practitioners by October 2019 and currently the Trust is on track to meet this trajectory. 2019/20 will see the widening of access to include Bay Health and Care Partners.

- **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 of Directors 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 2018/19. 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:

  Clinicians' 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) was published last year and is still being used. It defines 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 January 2019 national RTT return showed that 1,420 patients waiting between 0 and 12 weeks had been validated and 852 patients waiting between 12 and 18 weeks had been validated. This is important because it demonstrates that not only patients waiting over 18 weeks are routinely validated. 5,536 patients out of the total 19,750 patients waiting had been validated.

  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 the last year the Trust worked with the NHS Improvement Intensive Support Team to review processes and governance around RTT and has now been signed off as all work-streams complete. This 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.

  The surgical RTT navigator team are feeding back weekly to individual services on where RTT outcome errors have been made, so that users can learn from their mistakes and get codes right first time.

  A Survey Monkey survey was completed by 81 clinicians, giving feedback on what they found difficult when recording RTT outcome codes and what training would be useful. As a result of this a RTT data quality report was taken to the Trust's data quality meeting in January and it was agreed that RTT data quality would form one of the key themes for focus in a new Data Quality Strategy that is due to be approved in April 2019. This would facilitate managing RTT data quality improvement as a project in 2019/20.

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 management letter and other 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.

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. The notice required the Trust to take all reasonable steps to deliver its services on a financially sustainable basis and set out a number of key actions; one of which required the Trust to present to NHS Improvement a summary of a Board of Directors approved Sustainability Plan. The Board of Directors approved the Bay Health and Care Partners' five year financial recovery plan at their meeting in October 2018, which will address the enforcement notice. The plan was co-produced by the Trust and Morecambe Bay Clinical Commissioning Group. It took into account the geography, health inequalities, ageing demographic, GP and hospital and community workforce constraints and the poor and ageing estate. The plan set out the actions Bay Health and Care Partners intended to make to transform patient pathways, reduce variation, digitally connect patients, primary care and secondary care and reshape workforce. The plan would continue to be refreshed in light of the NHS 10 year plan, winter, 2019/20 planning guidelines and the Trust's overall system 2018/19 financial out-turn.

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 patients continues to improve.

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 NHS England and NHS Improvement to secure a sustainable funding package. The Trust is committed to bringing the organisation back into balance by addressing the structural deficit. The 'Sustainability and Financial Recovery' Plan indicates an annual deficit over the life of the plan, and does not address the cumulative deficit. As part of its financial plans for the next five years the Trust is working with its partners to secure the necessary resources to continue its operations and in the long term achieve financial sustainability.

For 2019/20 the Board has resolved to agree a Control Total with NHS Improvement on the grounds that the Trust could achieve the financial targets without compromising patient safety. As a result, the Trust will secure access to provider sustainability funding and an additional financial recovery fund which will provide the Trust a significant opportunity to address the financial deficit.

Through the Assurance Framework, the Board demonstrates how it 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:

- A significant number of internal audit reports offering either significant or moderate assurance;

- Levels of harm remain low as illustrated in the Quality Account;
- The Trust achieved its Cost Improvement Target and financial plan for 2018/19;
- Continued improvements in the outcomes of the staff survey; and
- The Summary Hospital-level Mortality Indicator (SHMI) remains top quartile.

The Quality Improvement Strategy for 2019-22 sets out the priorities and ambitions for quality improvement, refines our approach to quality improvement and describes the processes to ensure quality improvement is effective.

Additionally the Head of Internal Audit Opinion is that Moderate Assurance can be given that there is an adequate system of internal control, however, in some areas weaknesses in design and/or inconsistent application of controls puts the achievement of some of the organisation's objectives at risk.

The internal audit reports show that the Trust has been successful in embedding good governance at many levels within the Trust with the number of reports receiving substantial assurance far greater than the number with limited assurance. 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 an 'adverse qualified' opinion for 2018/19 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 adjusted in year deficit of £69.3 million and cumulative deficit of £275.1 million and the Trust's continued reliance upon revenue and capital loan funding.

Although the Trust remains in breach of its Licence Conditions there have been no other significant failings identified in 2018/19.

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 ongoing monitoring and evaluation.

The Trust continues to address those areas of risk identified by its Regulators in addition to the strategic risk as set out in section 4.

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 Bay Health and Care Partners. Work has begun on developing the next phase 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 patient safety incidents to the National Reporting and Learning Service (NRLS), in 2017/18 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 now publish this information on the Trust's external website, as this would support the open and honest culture around learning from incidents and would also demonstrate openness and transparency to 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

In reviewing the Trust's system of internal control I am satisfied that the Trust has systems in place that support the achievement of the Trust's policies, aims and objectives whilst safeguarding the public funds and assets. I am pleased that the Trust's internal auditors have provided the Trust with positive assurance in respect of the Trust's overall level of internal control.

The scale of the annual and cumulative deficit and the material uncertainty regarding financial sustainability, however, warrant a disclosure as a significant control issue for the Trust. In reaching this conclusion, I have taken into account:

- The external audit Value for Money conclusion relating to financial sustainability;
- The NHS Improvement findings in the Use of Resources assessment;
- The financial outturn and revenue support levels the Trust requires; and
- An agreed refinancing for the borrowing due for repayment in 2019/20 is not in place.

The Trust has in place mitigations and recovery plans within these areas which I have identified within the Annual Governance Statement.

Aaron Cummins
Chief Executive

Date: 24 May 2019

University Hospitals of Morecambe Bay NHS Foundation Trust

Annual Accounts

2018/19

ANNUAL ACCOUNTS 2018/19

Foreword to the accounts

UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST

These accounts for the 12 months ended 31 March 2019, 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 : 24 May 2019

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2019

	NOTE	**2018/19 £000**	2017/18 £000
Revenue from continuing operations	3-4	**336,247**	290,785
Operating expenses	5	**(408,919)**	(356,107)
OPERATING SURPLUS/(DEFICIT)		**(72,672)**	(65,322)
Finance costs			
Interest received	8	**108**	39
Interest payable	8	**(4,121)**	(2,345)
Unwinding of discount on provisions	8	**(2)**	(6)
Net finance costs		**(4,015)**	(2,312)
Gains from transfers by absorption	25	**643**	0
SURPLUS/(DEFICIT) FOR THE FINANCIAL YEAR		**(76,044)**	(67,634)
Other comprehensive income			
Revaluation gains/(losses) and impairment losses on property, plant and equipment	10	6,585	
TOTAL COMPREHENSIVE INCOME AND EXPENSE FOR THE YEAR		**(69,459)**	(67,634)
Adjusted financial performance (control total basis):			
Surplus/(deficit) for the period		**(76,044)**	(67,634)
Remove impact of impairments charged to I&E		**7,145**	2,715
Remove (gains)/losses on transfers by absorption		**(643)**	0
Remove I&E impact of capital grants and donations		**220**	222
Adjusted financial performance surplus/(deficit)		**(69,322)**	(64,697)

Adjusted financial performance shows the figures used by NHS Improvement to assess the Trust's performance for the year against the annual plan. The Trust's plan for 2018/19 was a deficit of £69.4 million.

The notes on pages 239 to 283 form part of these accounts.

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2019

	NOTE	31 March 2019 £000	31 March 2018 £000
NON-CURRENT ASSETS			
Intangible assets	9	**751**	478
Property, plant and equipment	10	**159,840**	152,735
Trade and other receivables	13	**2,898**	2,874
Total non-current assets		**163,489**	156,087
CURRENT ASSETS			
Inventories	12	**3,740**	3,263
Trade and other receivables	13	**15,083**	8,579
Cash and cash equivalents	15	**2,380**	4,410
Total current assets		**21,203**	16,252
CURRENT LIABILITIES			
Trade and other payables	16	**(24,722)**	(21,513)
Borrowings	19	**(56,944)**	(874)
Provisions	20	**(256)**	(743)
Finance lease liabilities	17	**0**	(71)
Tax payable	16	**(5,938)**	(5,020)
Other liabilities	18	**(584)**	(969)
Total current liabilities		**(88,444)**	(29,190)
TOTAL ASSETS LESS CURRENT LIABILITIES		**96,248**	143,149
NON-CURRENT LIABILITIES			
Borrowings	19	**(179,174)**	(158,347)
Provisions	20	**(2,167)**	(2,276)
Total non-current liabilities		**(181,341)**	(160,623)
TOTAL ASSETS EMPLOYED		**(85,093)**	(17,474)
FINANCED BY TAXPAYERS' EQUITY			
Public Dividend Capital		**150,237**	148,397
Revaluation Reserve		**39,803**	33,186
Retained Earnings		**(275,133)**	(199,057)
TOTAL TAXPAYERS' EQUITY		**(85,093)**	(17,474)

The financial statements on pages 235 to 238 were approved by the Trust Board on 24 May 2019 and signed on its behalf by the Chief Executive. The notes on pages 239 to 283 form part of these accounts.

Signed: …… (Chief Executive) Date: 24 May 2019

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

	2018/19			
	Public dividend capital (PDC)	**Revaluation reserve**	**Retained earnings**	**Total**
	£000	**£000**	**£000**	**£000**
TAXPAYERS' EQUITY AT 1 APRIL 2018	**148,397**	**33,186**	**(199,057)**	**(17,474)**
Changes in taxpayers' equity				
Retained deficit for the year	**0**	**0**	**(76,044)**	**(76,044)**
Transfers by absorption, transfers between reserves	**0**	**32**	**(32)**	**0**
Impairment of property, plant and equipment	**0**	**(2,542)**	**0**	**(2,542)**
Revaluation gains on property, plant and equipment	**0**	**9,127**	**0**	**9,127**
Public Dividend Capital received	**1,840**	**0**	**0**	**1,840**
TAXPAYERS' EQUITY AT 31 MARCH 2019	**150,237**	**39,803**	**(275,133)**	**(85,093)**

	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)

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2019

	NOTE	2018/19 £000	2017/18 £000
Cash flows from operating activities			
Operating surplus/(deficit)		**(72,672)**	(65,322)
Non-cash revenue and expenses			
Depreciation and amortisation		**14,092**	12,456
Impairments	8	**7,145**	2,715
Income recognised in respect of donated assets (non-cash)		**0**	(29)
(Increase)/decrease in inventories		**(470)**	(596)
(Increase)/decrease in trade and other receivables		**(6,528)**	8,795
Increase/(decrease) in trade and other payables		**4,837**	6,674
Increase/(decrease) in other liabilities		**(385)**	(962)
Increase/(decrease) in provisions	20	**(598)**	383
Net cash generated from operating activities		**(54,579)**	(35,886)
Cash flows from investing activities			
Interest received	8	**108**	39
Purchase of intangible assets	9	**(414)**	0
Purchase of property, plant and equipment		**(21,104)**	(21,562)
Net cash used in investing activities		**(21,410)**	(21,523)
Cash flows from financing activities			
Public Dividend Capital received		**1,840**	37
Loans received from the Department of Health & Social Care		**76,800**	58,324
Loans repaid to the Department of Health & Social Care		**(620)**	(11,062)
Other loans received		**0**	2,536
Other loans repaid		**(254)**	0
Interest paid		**(3,737)**	(1,914)
Public Dividend Capital dividends paid		**0**	(2)
Cash flows from/(used in) other financing activities		**(70)**	(210)
Net cash used in financing activities		**73,959**	47,709
Increase/(decrease) in cash and cash equivalents		**(2,030)**	(9,700)
Cash and cash equivalents at beginning of year		**4,410**	14,110
Cash and cash equivalents at 31 March	15	**2,380**	4,410

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 and Social Care Group Accounting Manual (GAM) which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2018/19 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards (IFRS) to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy judged to be most appropriate to the Trust's particular circumstances for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These 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, inventories and certain financial assets and financial liabilities.

The Trust's accounts for 2018/19 have recorded an adjusted deficit of £69.3 million and the cumulative deficit position on retained earnings amounts to £275.1 million. The Statement of Financial Position shows negative net current assets and liabilities of £67.2 million. The Trust was unable to agree the control total set by NHS Improvement for 2018/19 and for this reason had no entitlement to Provider Sustainability funding during the year. An operational plan has been submitted to NHS Improvement for 2019/20 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.

In line with national guidance the annual plan (2019/20) has been submitted and assumes revenue support to support a planned deficit of £38.6m. The Trust has agreed with NHS Improvement a control total for 2019/20 which reflects this plan.

The Trust is due to repay loan principal of £54.4m to the Department of Health and Social Care between January and March 2020. It is anticipated that the repayment terms of these loans will be extended and that these payments will not be required during 2019/20. This has not yet been confirmed with the Department of Health and Social Care.

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 6 organisations across health and social care and aims to co-ordinate ways of working across the system to provide a platform for integration. The Trust is an integral part of this initiative. During 2018/19 some community services, undertaken by other providers for the Morecambe Bay area, were integrated into the Trust.

Notes to the Accounts - 1. Accounting Policies (continued)

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.

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. 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.

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.

Notes to the Accounts - 1. Accounting Policies (continued)

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.

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 has reviewed the application of accounting standard IAS 16 for non-current land and property assets. The valuation basis applied incorporates: alternative site methodology where the modern equivalent asset could be constructed in an alternative location; a 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.

Notes to the Accounts - 1. Accounting Policies (continued)

The Trust undertook a full revaluation of its land and building assets in line with accounting standards as at 31 March 2019. 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.

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 from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics. As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3(b) of the Standard. The Standard has been applied retrospectively but the cumulative effects have been recognised at the date of initial application, 1 April 2018. Comparative information has not been amended.

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by the transfer of promised goods/services to the customer and is measured at the amount of transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in the year. Where entitlement to consideration for those goods or services is unconditional, a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Notes to the Accounts - 1. Accounting Policies (continued)

1.4.1 Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs that care. The customer is the commissioner but customer benefits are realised as services are provided to the patient. Even where contracts could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. Where a patient care spell is incomplete at the year end, the Trust accrues income relating to the activity delivered in that year.

Revenue is recognised to the extent that collection of consideration is probable. Where contract challenges from commissioners are expected to be upheld, the Trust reflects this in the transaction price and derecognises the relevant portion of income. Where the Trust is aware of a penalty based on contractual performance, the Trust reflects this by reducing revenue in line with the value of the penalty.

The Trust does not receive income where a patient is readmitted within 30 days of discharge from a previous planned stay. This is considered an additional performance obligation to be satisfied under the original transaction price.

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioners but they affect how care is provided to patients. The CQUIN payments are not considered distinct performance obligations in their own right, instead they form part of the transaction price for performance obligations under the main contract.

The majority of contracts held by the Trust with commissioners are agreed at the year end and revenue is recognised in line with the agreed full and final settlements. This results in material certainty in respect of consideration due under revenue from NHS contracts.

1.4.2 NHS injury cost recovery scheme

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, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the relevant NHS2 form and confirmed there are no discrepancies with the treatment provided. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts. This allowance is in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

1.4.3 Revenue grants and other contributions to expenditure

Government grants are grants from government bodies other than income from commissioners or Trusts for the provision of services. Where a grant is used to fund expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

Notes to the Accounts - 1. Accounting Policies (continued)

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

1.4.4 Other income

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.

1.5 Expenditure on 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.

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. Both are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State for Health 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 annual valuation of scheme liability is undertaken by the Government Actuary's Department as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2019, is based on valuation data as at 31 March 2018 updated to 31 March 2019 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 Schemes is contained in the Scheme actuary report which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

Notes to the Accounts - 1. Accounting Policies (continued)

The purpose of the full actuarial valuation is to assess the level of liability in respect of benefits due under the Schemes, taking account of recent demographic experience and to recommend contribution rates payable by employees and employers. The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Schemes relative to the employer cost cap set following the 2012 valuation. This 'employer cost cap' allows for member benefits or contribution rates to be adjusted if the cost of the Schemes changes by more than 2% of pay. Following a judgement by the Court of Appeal in December 2018 the Government announced a pause to that part of the valuation pending conclusion of the continuing legal process.

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.

Alternative pension provision

Employees who are not members of the NHS Pension Scheme are 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 2% of the employee's remuneration during 2018/19. With effect from 1 April 2019 the Trust will contribute at a rate of 3%.

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.

Notes to the Accounts - 1. Accounting Policies (continued)

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.

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.

Notes to the Accounts - 1. Accounting Policies (continued)

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.

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.

Notes to the Accounts - 1. Accounting Policies (continued)

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.

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.

Notes to the Accounts - 1. Accounting Policies (continued)

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 De-recognition

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.

Following reclassification, held for sale assets are measured at the lower of their existing carrying amount and fair value less costs to sell. Depreciation ceases to be charged. Fair value is open market value including alternative uses. Assets are de-recognised when all material sale contract conditions have been met.

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.

Notes to the Accounts - 1. Accounting Policies (continued)

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.

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 0.29% in real terms.

1.18 Clinical negligence costs

NHS Resolution 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.

Notes to the Accounts - 1. Accounting Policies (continued)

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.

1.21 Financial instruments

1.21.1 Financial assets

Financial assets are recognised when the Trust becomes party to the contractual provisions of a financial instrument and as a result has a legal right to receive cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument. This includes the sale of non-financial items such as goods or services which are recognised when performance occurs i.e. when delivery of the goods or services is made. Items classified as a tax by the Office of National Statistics are not classified as financial instruments.

Financial assets are initially recognised at fair value and are de-recognised when the contractual rights to receive cash flows have expired or when the Trust has transferred substantially all the risks and rewards of ownership.

The Trust holds financial assets in the form of cash and cash equivalents and non-current and current receivables, which are all classified as subsequently measured at amortised cost.

Financial assets at amortised cost

Financial assets at amortised cost are those held with the objective of collecting contractual cash flows and include cash and contract receivables. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset to the gross carrying amount.

Interest revenue is calculated by applying the effective interest rate to the gross carrying amount of the financial asset and recognised in the Statement of Comprehensive Income as financing income.

Notes to the Accounts - 1. Accounting Policies (continued)

1.21.2 Impairment of financial assets

For all financial assets measured at amortised cost the Trust recognises an allowance for expected credit losses. The Trust adopts the simplified approach to impairment for contract receivables, measuring expected losses as at an amount equal to lifetime expected losses.

Receivables are assessed based on the likely probability of the cash due from the financial asset being realised. No impairment losses are recognised in respect of NHS receivables in accordance with the guidance specified in the GAM. Differences in the value of income received or expected to be received from NHS contracts are offset directly against the value of revenue recognised in the Trust's accounts.

For impaired financial assets, expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows. Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

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.

Financial liabilities at amortised cost

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. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

The Trust holds financial liabilities in the form of trade and other payables which are included within current liabilities and borrowings. Borrowings held 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 liabilities.

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.

Notes to the Accounts - 1. Accounting Policies (continued)

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 liabilities 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.

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.

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 2019 the Trust has negative average relevant net assets and this results in no PDC dividends being payable for the year 2018/19.

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.

Notes to the Accounts - 1. Accounting Policies (continued)

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 Transfers of functions from other NHS bodies

For functions that have been transferred to the Trust from another NHS body, the assets and liabilities transferred are recognised in the accounts as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net gain corresponding to the transfer is recognised within income but not within operating activities.

For property, plant and equipment assets and intangible assets, the cost and accumulated depreciation from the transferring entity's accounts are preserved on recognition in the Trust's accounts. Where the transferring body recognised Revaluation Reserve balances attributable to the assets, the Trust makes a transfer from its Income and Expenditure Reserve to its Revaluation Reserve to maintain transparency within public sector accounts.

During 2018/19 the Trust transferred in functions from other NHS bodies with effect from 1 April 2018 and 1 October 2018. The net gains as a result of these transfers are shown as transfers by absorption on the Statement of Comprehensive Income and the Revaluation Reserve balance has been adjusted in line with the value held by the transferring bodies. Details of transfers by absorption can be found in note 25.

1.30 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 2018/19 as these standards are still subject to HM Treasury FReM adoption. IFRS 14 is not EU-endorsed and is not applicable to DHSC bodies. Implementation of IFRS 16 has been deferred until 2020/21 for the public sector and IFRS 17 is not applicable until 2021/22. IFRIC 23 is applicable from 2019/20.

- IFRS 14 Regulatory Deferral Accounts
- IFRS 16 Leases
- IFRS 17 Insurance Contracts
- IFRIC 23 Uncertainty over Income Tax Treatments

The implementation of IFRIC 23 is unlikely to have a significant impact on the Trust.

1.31 Accounting standards issued that have been adopted early

No accounting standards in issue have been adopted early.

Notes to the Accounts - 1. Accounting Policies (continued)

1.32 Information on reserves

Revaluation reserve

Increases in asset values arising from revaluations are recognised in the Revaluation Reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the Revaluation Reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or reduction in service potential.

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the Trust.

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 Care Group 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 activities 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

	2018/19	2017/18
	£000	£000
Elective income	**42,445**	42,052
Non elective income	**80,476**	76,076
Outpatient income	**49,551**	48,023
A & E income	**13,971**	12,522
Community services income	**29,945**	0
Other NHS clinical income	**86,632**	82,740
Private patient income	**170**	152
AfC Pay award central funding	**3,993**	0
Other clinical income	**903**	1,174
	308,086	262,739

As a result of transfers of functions from other NHS bodies, the Trust now receives income for the provision of Community Services from commissioners.

Private patient income includes income for the treatment of overseas patients where no reciprocal or bi-lateral agreement exists for their treatment.

During 2018/19 the Trust received national funding from the Department of Health and Social Care for the additional costs incurred as a result of the pay award made to staff on Agenda for Change employment contracts. Due to the late agreement of the pay award these costs were not included in the tariffs used for performance of contracts with healthcare commissioners and were funded centrally.

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

	2018/19	2017/18
	£000	£000
Public Health England	**214**	215
NHS England and CCGs	**302,646**	260,995
NHS Foundation Trusts	**121**	129
NHS Trusts	**39**	74
Department of Health & Social Care	**3,993**	0
Non-NHS: Private patients	**31**	14
Non-NHS: Overseas patients (non-reciprocal)	**139**	138
NHS Injury Cost Recovery Scheme	**624**	909
Other non-NHS income	**279**	265
	308,086	262,739

Injury cost recovery income is subject to a provision for impairment of receivables of 21.89% to reflect expected rates of collection.

3.3 Overseas visitors income

	2018/19 £000	2017/18 £000
Income recognised during the year	**139**	138
Cash payments received in year	**87**	85
Amounts written off in-year	**17**	25

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

	2018/19 £000	2017/18 £000
Income from commissioner requested services	**307,013**	261,413
Income from all other patient care activities	**1,073**	1,326
	308,086	262,739

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 2018/19 and 2017/18.

4. Other operating revenue

4.1 Operating revenue

	2018/19 £000	2017/18 £000
Operating revenue recognised in accordance with IFRS 15		
Research and development	**791**	809
Education and training	**10,893**	10,548
Non-patient care services to other bodies	**7,559**	8,583
Provider Sustainability Fund income	**0**	0
Other revenue	**7,301**	5,849
Operating revenue recognised in accordance with other standards		
Rental revenue from operating leases	**903**	1,624
Charitable and other contributions to expenditure	**714**	633
	28,161	28,046

Charitable and other contributions to expenditure includes income received in the form of donations for the purchase of non-current assets. During the year £276,000 was received from the Bay Hospitals Charity for this purpose. The sum of £215,000 was received from this Charity in 2017/18.

4.1 Operating revenue (continued)

Access to Provider Sustainability funding was made available to NHS providers with effect from 2016/17, linked to the achievement of financial controls and performance targets. The Trust was unable to agree the control total set by NHS Improvement for 2017/18 and 2018/19. For this reason the Trust is not entitled to any Provider Sustainability Fund income.

	2018/19	2017/18
	£000	£000
Other revenue includes the following items		
Car parking charges	**1,141**	1,105
Catering	**1,267**	1,280
Clinical excellence awards	**264**	261
Improved Better Care Fund	**1,998**	1,471
Rent from staff accommodation	**507**	477
Other miscellaneous items	**2,124**	1,255
	7,301	5,849

During the year 2018/19 and 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 2018/19 operating lease income includes the sum of £872,000 relating to service level agreements with other Foundation Trusts (2017/18 £1,592,000) and £31,000 (2017/18£32,000) for property leased by NHS Blood and Transplant.

Some service functions occupying areas previously leased to Cumbria Partnership NHS Foundation Trust were integrated within the Trust with effect from 1 April 2018 and the leases ceased.

	2018/19	2017/18
Rental revenue	**£000**	£000
Rents recognised as revenue	**903**	1,624
Contingent rents	**0**	0
Total rental revenue	**903**	1,624
Total future minimum lease payments receivable		
Not later than one year	**903**	1,097
Between one and five years	**3,611**	4,389
After five years	**0**	0
Total	**4,514**	5,486

5. Operating expenses

5.1 Operating expenses

	2018/19 £000	2017/18 £000
Purchase of healthcare from non NHS bodies	**4,603**	5,083
Chair and Non Executive directors costs	**129**	130
Employee benefits including Executive directors	**273,969**	235,260
Drugs costs	**29,286**	28,771
Supplies and services - clinical (excluding drugs)	**30,284**	28,571
Supplies and services - general	**5,888**	5,068
Establishment	**5,387**	2,903
Business travel	**2,020**	1,529
Transport	**915**	759
Premises - business rates payable to Local Authorities	**1,922**	1,647
Premises - other	**11,495**	9,602
Operating lease rentals	**1,810**	1,791
Depreciation and amortisation	**14,092**	12,456
Impairments of property, plant and equipment	**7,145**	2,715
Increase/(decrease) in provisions for impairment of receivables	**(170)**	322
Change in the discount rate on provisions	**(42)**	33
Audit fees - statutory audit	**53**	53
Other auditors remuneration - audit related assurance	**7**	7
Internal audit and counter fraud services	**143**	143
Redundancy costs	**0**	27
Early retirement costs	**78**	(38)
Clinical negligence premium	**13,975**	13,477
Legal fees	**519**	500
Insurance premiums	**352**	317
Consultancy services	**18**	416
Education and training	**1,565**	1,439
Other	**3,476**	3,126
	408,919	356,107

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 2018/19 include £510,000 (2017/18 £491,000) 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.

5.2 Operating lease expenses (continued)

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 2018/19 in respect of these leases (2017/18 £1,295,000).

Other leases include a lease for endoscopy equipment which extends to November 2019. No leases extend beyond 5 years.

	2018/19	2017/18
	£000	£000
Payments recognised as an expense		
Minimum lease payments	**1,810**	1,791
Contingent rents	**0**	0
	1,810	1,791
Total future minimum lease payments payable		
Not later than one year	**2,035**	2,081
Between one and five years	**1,656**	2,879
Total	**3,691**	4,960

6. Employee costs and numbers

6.1 Employee benefits

	2018/19	2017/18
	Total	Total
	£000	£000
Salaries and wages	**205,170**	173,529
Social Security Costs	**20,384**	17,468
Apprenticeship levy	**961**	944
Employer contributions to NHS Pension scheme	**24,718**	20,814
Termination benefits	**0**	27
Temporary staff (including agency)	**23,794**	23,074
Employee benefits expense	**275,027**	235,856

In line with the GAM this employee benefits note is now shown in a single column for all categories of staff and comparative information has been amended to reflect this change.

Of the total employee benefits shown above £1,058,000 has been charged to capital and the balance of £273,969,000 has been charged to revenue (2017/18 £569,000 was charged to capital and £235,287,000 was charged to revenue). Staff costs are capitalised in relation to work undertaken on capital projects.

6.1 Employee benefits (continued)

Expenditure incurred on agency staff in 2018/19 totalled £15,063,000 (2017/18 £16,985,000) and comprises 5.5% (2017/18 7.2%) 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 and expenditure remains within the agency ceiling set by NHS Improvement for 2018/19.

Costs of £129,000 relating to the chair and non executive directors are excluded from this note (2017/18 £130,000).

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.

	2018/19	2017/18
	£000	£000
Remuneration including employers national insurance contributions	**1,378**	1,383
Employers contribution to Executive Directors' pensions	**91**	70
Benefits in kind - leased vehicles	**29**	21

At 1 April 2018 there were a total of 4 Directors to whom benefits were accruing under a defined benefit scheme. At 31 March 2019 there are 4 Directors accruing these benefits.

6.3 Retirements due to ill health

During 2018/19 there were 6 early retirements from the Trust agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £168,000 (2017/18 there were 4 retirements with an additional liability of £293,000). 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	2018/19 Number	2018/19 £000	2017/18 Number	2017/18 £000
Total Non-NHS trade invoices paid in the financial period	**81,844**	**195,116**	74,754	182,752
Total Non NHS trade invoices paid within target	**64,719**	**166,024**	43,007	139,560
Percentage of Non-NHS trade invoices paid within target	**79%**	**85%**	58%	76%
Total NHS trade invoices paid in the financial period	**2,662**	**30,543**	2,200	28,960
Total NHS trade invoices paid within target	**1,516**	**26,334**	1,077	26,038
Percentage of NHS trade invoices paid within target	**57%**	**86%**	49%	90%

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	2018/19 £000	2017/18 £000
Interest on bank accounts	**108**	39
Total	**108**	39

All surplus cash balances are retained within the Government Banking Service which pays minimal interest.

8.2 Finance expenses	2018/19 £000	2017/18 £000
Interest payable on loans from the Department of Health & Social Care	**(4,121)**	(2,345)
Unwinding of discount on provisions	**(2)**	(6)
Total	**(4,123)**	(2,351)

8.3 Impairment of assets	**2018/19**	2017/18
	£000	£000
Impairments charged to operating expenditure as a result of changes in market price	**(7,145)**	(2,715)
Total impairments charged to operating expenditure	**(7,145)**	(2,715)
Impairments charged to the revaluation reserve	**(2,542)**	0
Total	**(9,687)**	(2,715)

Impairments recognised during 2018/19 relate to the revaluation of land and property assets at 31 March 2019. Impairments recognised during 2017/18 relate to the revaluation of the South Lakes Birthing Centre when it was brought into use in February 2018.

Details of all revaluations made are included in note 10.

9. Intangible assets	**2018/19 Computer software - purchased**	2017/18 Computer software - purchased
	£000	£000
Gross cost at beginning of period	**2,560**	2,295
Additions purchased	**0**	0
Reclassifications	**414**	265
Disposals/derecognition	**0**	0
Gross cost at 31 March	**2,974**	2,560
Amortisation at beginning of period	**2,082**	1,897
Charged during the period	**141**	185
Disposals/derecognition	**0**	0
Amortisation at 31 March	**2,223**	2,082
Net book value		
Purchased	**749**	475
Donated	**2**	3
Total at 31 March	**751**	478

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 7 years. The Trust holds no Revaluation Reserve balances for intangible assets.

10. Property, plant and equipment

2018/19:	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 2018	11,003	122,549	1,845	772	44,301	18,772	3,322	202,564
Transfers by absorption	60	383	0	0	65	128	0	636
Additions purchased	0	8,503	25	8,555	3,682	34	319	21,118
Additions grants/donations	0	55	0	0	221	0	0	276
Impairments charged to operating expenses	0	(9,708)	0	0	0	0	0	(9,708)
Impairments charged to the revaluation reserve	0	(6,804)	0	0	0	0	0	(6,804)
Reclassifications	0	618	0	(6,276)	2,144	2,955	145	(414)
Revaluations	0	(931)	9	0	0	0	0	(922)
Disposals/derecognition	0	0	0	0	(1,806)	0	0	(1,806)
At 31 March 2019	11,063	114,665	1,879	3,051	48,607	21,889	3,786	204,940
Depreciation at 1 April 2018	0	7,995	160	0	27,200	12,624	1,850	49,829
Charged during the period	0	8,595	151	0	3,253	1,725	227	13,951
Impairments charged to operating expenses	0	(2,563)	0	0	0	0	0	(2,563)
Impairments charged to the revaluation reserve	0	(4,262)	0	0	0	0	0	(4,262)
Reclassifications	0	(16)	0	0	0	0	16	0
Revaluations	0	(9,738)	(311)	0	0	0	0	(10,049)
Disposals/derecognition	0	0	0	0	(1,806)	0	0	(1,806)
Depreciation at 31 March 2019	0	11	0	0	28,647	14,349	2,093	45,100
Net book value								
Purchased	11,063	112,169	1,879	3,051	18,521	7,540	1,473	155,696
Donated	0	2,485	0	0	1,439	0	220	4,144
Total at 31 March 2019	11,063	114,654	1,879	3,051	19,960	7,540	1,693	159,840
Asset financing								
Owned	11,063	114,654	1,879	3,051	19,960	7,540	1,693	159,840
Finance Leased	0	0	0	0	0	0	0	0
Total at 31 March 2019	11,063	114,654	1,879	3,051	19,960	7,540	1,693	159,840

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 (continued)

During 2018/19 a full revaluation of the Trust's land, buildings and dwellings was undertaken as at 31 March 2019 by professional valuers GVA Grimley Limited. The revaluation undertaken resulted in a total of £9,127,000 upwards revaluations and £9,687,000 of impairments in respect of land and property assets. The net effect of these changes amounted to a reduction in asset values of £560,000. Of the impairments incurred,£7,145,000 was charged to operating expenses and the balance of £2,542,000 was charged to the Revaluation Reserve.

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 impairment of £2,715,000 which was charged in full to expenditure. Impairment of building assets on first use writes off the peripheral costs of building such as design and planning fees.

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 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 2019, 37% of assets have been valued based on the modern equivalent asset valuation in their current location and for 60% 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.

10. Property, plant and equipment (continued)

Asset lives for non-current assets are as follows:	Minimum Life Years	Maximum Life Years
Buildings (excluding dwellings)	**3**	**79**
Dwellings	**5**	**32**
Plant and machinery	**1**	**18**
Information technology	**1**	**9**
Furniture and fittings	**1**	**22**

For all non-property assets, a validation exercise is undertaken during the year. In 2018/19 no revisions were made to asset lives as a result of this exercise. No revisions were made during 2017/18.

Assets bought with donated funds during the year totalled £276,000. All of this sum was received from the Bay Hospitals Charity for the purchase of assets. During 2017/18 the Bay Hospitals Charity donated funds for the purchase of assets totalling £215,000.

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 was accounted for as a non-cash donation in the Trust's accounts.

During 2018/19 assets amounting to £1,840,000 were purchased with Public Dividend Capital received from the Department of Health and Social Care. This included the sum of £936,000 for improvements to emergency care facilities and £687,000 for improvements to information technology. Both projects were awarded from Urgent and Emergency Care capital with the focus on improving patient flows through the healthcare system within Morecambe Bay. The sum of £205,000 was awarded for enhancements to public Wi-Fi and a further £12,000 to upgrade the pharmacy medicines information system.

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.

There were no sales of equipment during the year 2018/19 or during 2017/18.

11. Capital commitments

At 31 March 2019 contracted capital commitments amounted to £1,886,000 for the following items:

£228,000 for the refurbishment of a theatre at Westmorland General Hospital due to be completed in May 2019.

£126,000 for the creation of clean drug preparation areas on two adjacent wards at the Royal Lancaster Infirmary. This work will be finished in May 2019.

£126,000 for the creation of a safe Mental Health Facility in the Emergency Department at the Royal Lancaster Infirmary. This is due to complete in June 2019.

£636,000 for expansion of the Resuscitation Suite at Furness General Hospital with completion due in July 2019.

11. Capital commitments (continued)

Further commitments relating to Trust wide projects include £127,000 for electrical infrastructure works due to be finished in May 2019, £476,000 for replacement of BMS systems and £167,000 for fire stopping works, both of which are due to be completed by March 2020.

Capital commitments which were outstanding at 31 March 2018 amounted to a total of £1,238,000. These included £168,000 to complete a Physiotherapy Suite at Royal Lancaster Infirmary and £1,070,000 for a new Gamma Camera facility at Furness General Hospital. Both of these schemes were completed during 2018/19.

The capital programme in 2018/19 was 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 2019**	31 March 2018
	£000	£000
Drugs	**1,203**	934
Consumables	**2,355**	2,218
Energy	**182**	111
Total	**3,740**	3,263

12.2 Inventories recognised in expenses	**31 March 2019**	31 March 2018
	£000	£000
Inventories recognised as an expense in the period	**27,819**	25,900
Write-down of inventories (including losses)	**98**	64
Total	**27,917**	25,964

13. Trade and other receivables

13.1 Trade and other receivables

	31 March 2019	31 March 2018
	£000	£000
Current		
Contract receivables	**14,600**	0
NHS receivables	**0**	5,338
Provision for the impairment of receivables	**(1,074)**	(1,271)
Prepayments	**900**	1,189
Accrued income	**0**	231
Other receivables	**657**	3,092
Total	**15,083**	8,579
Non-current		
Contract receivables	**2,898**	2,874
Total	**2,898**	2,874

Following the application of IFRS 15 from 1 April 2018 the Trust's entitlement to consideration for work performed under contracts with customers is shown separately as contract receivables. This replaces the previous analysis into NHS/other receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis has not been restated under IFRS 15.

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 £2,863,000 and working capital cash provided to the Waterloo GP Practice in Millom of £35,000. Non-current receivables in 2017/18 included £2,839,000 and£35,000 for these items.

13.2 Allowances for credit losses 2018/19

	Contract receivables £000
Allowances as at 1 April 2018	**(1,271)**
New allowances arising	**(28)**
Changes in existing allowances	**42**
Reversals of allowances	**156**
Utilisation of allowances (write offs)	**27**
Allowances as at 31 March 2019	**(1,074)**

Allowances for credit losses include £771,000 relating to anticipated unrecoverable items from the Injury Costs Recovery Scheme and £303,000 of other general impairment provisions. There are no credit losses relating to contracts with NHS customers in accordance with the adoption of IFRS 9 and IFRS 15.

13.3 Allowances for credit losses 2017/18

	All receivables £000
Allowances as at 1 April 2017	(971)
Increase in receivables impaired	(335)
Amount written off during the year	22
Unused amounts reversed	13
Allowances as at 31 March 2018	(1,271)

IFRS 9 and IFRS 15 are adopted without restatement therefore this analysis is prepared in line with the requirements of IFRS 7 prior to IFRS 9 adoption. As a result this differs in format to the current period disclosure.

Receivables impaired at 31 March 2018 included £813,000 relating to the Injury Costs Recovery Scheme, £402,000 relating to other NHS organisations and £56,000 of general provisions.

14. Non-current assets held for sale

There were no assets classified for sale or sold during 2018/19 or 2017/18.

15. Cash and cash equivalents	31 March 2019 £000	31 March 2018 £000
Balance at beginning of year	**4,410**	14,110
Net change in year	**(2,030)**	(9,700)
Balance at end of year	**2,380**	4,410
Made up of		
Cash with the Government Banking Service (GBS)	**2,357**	4,393
Commercial banks and cash in hand	**23**	17
Cash and cash equivalents as in statement of financial position	**2,380**	4,410
Bank overdraft	**0**	0
Cash and cash equivalents as in statement of cash flows	**2,380**	4,410

The cash balance shown at 1 April 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 2019 £000	Current 31 March 2018 £000
NHS payables	**2,380**	2,949
Other trade payables	**4,947**	4,296
Capital payables	**821**	945
Accruals	**9,149**	7,410
Amounts due to other related parties	**3,505**	2,909
Tax payable	**5,938**	5,020
Accrued interest on loans	**0**	586
Other payables	**3,920**	2,418
Total	**30,660**	26,533

Following the adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Accrued interest is now included in the carrying value of the loans shown in note 19. IFRS 9 is applied without restatement therefore comparatives have not been restated. The value of interest payable accrued at 31 March 2018 is shown above.

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 2019.

Amounts due to other related parties comprise outstanding pension contributions due to be paid to the NHS Business Services Authority - Pensions Division.

There are no payables due at 31 March 2019 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

The Trust has no finance lease liabilities at 31 March 2019.

As at 31 March 2018 the value of outstanding finance lease liabilities was £71,000. This related to finance leases offered to employees as a salary sacrifice scheme to finance the purchase of personal computer equipment. Two leases were outstanding and employee contributions were shown within current receivables at note 13.1. These salary sacrifice schemes have now been completed and the finance leases have been paid in full during 2018/19.

18. Other liabilities	31 March 2019 £000	31 March 2018 £000
Current		
Deferred income	**584**	969
Total	**584**	969

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. This loan was fully drawn down during 2017/18 and 2018/19 with the final amount drawn in March 2019. The first repayment of principle is due to be paid in August 2019 with subsequent instalments 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 instalments over 5 years. The first instalment of principal was paid in October 2018 and subsequent instalments are due at six monthly intervals.

19. Borrowings (continued)

The Trust has a further 20 outstanding loans from the Department of Health and Social Care agreed by the Secretary of State for Health as at 31 March 2019. All these loans were issued to support the revenue position of the Trust. The values for all loans are shown in the table below.

19.1 Outstanding loan values	**31 March 2019**	31 March 2018
	£000	£000
Current		
Capital loan DHSC (1.85%)	**705**	620
Capital loan DHSC (2.52%)	**443**	0
Capital loan (Salix)	**507**	254
Revenue loan (repayable January 2020)	**25,242**	0
Revenue loan (repayable February 2020)	**8,273**	0
Revenue loan (repayable March 2020)	**21,011**	0
Interest payable on revenue loans below	**763**	0
Total	**56,944**	874
Non-current		
Capital loan DHSC (1.85%)	**12,095**	12,714
Capital loan DHSC (2.52%)	**9,680**	2,700
Capital loan (Salix)	**1,775**	2,282
Revenue loan (repayable March 2020)	**0**	21,000
Revenue loan (repayable September 2020)	**39,100**	39,100
Revenue loan (repayable January 2020)	**0**	25,168
Revenue loan (repayable February 2020)	**0**	8,259
Revenue loan (repayable May 2020)	**2,865**	2,865
Revenue loan (repayable June 2020)	**6,002**	6,002
Revenue loan (repayable July 2020)	**5,414**	5,414
Revenue loan (repayable September 2020)	**4,961**	4,961
Revenue loan (repayable October 2020)	**4,653**	4,653
Revenue loan (repayable November 2020)	**4,546**	4,546
Revenue loan (repayable December 2020)	**4,760**	4,760
Revenue loan (repayable January 2021)	**4,841**	4,841
Revenue loan (repayable February 2021)	**2,380**	2,380
Revenue loan (repayable March 2021)	**6,702**	6,702
Revenue loan (repayable April 2021)	**5,000**	0
Revenue loan (repayable May 2021)	**4,500**	0
Revenue loan (repayable June 2021)	**6,000**	0
Revenue loan (repayable July 2021)	**5,000**	0
Revenue loan (repayable February 2022)	**19,500**	0
Revenue loan (repayable March 2022)	**29,400**	0
Total	**179,174**	158,347

19.1 Outstanding loan values (continued)

All access to funding which supports deficit positions for NHS organisations is issued in the form of an Interim Revenue Support Facility which is accessed on a monthly basis based on resource requirements. No loan facilities 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.

Following the implementation of IFRS 9 with effect from 1 April 2018, loan values are shown at amortised cost, including the value of interest payable accrued at the year end. Comparative information has not been amended.

Individual loans classified as current borrowings include the value of principal and interest due at 31 March 2019. For loans classified as non-current borrowings, interest is shown as an aggregate amount in the analysis.

19.2 Reconciliation of liabilities arising from financing activities

	2018/19			
	DHSC Loans	Other Loans	Finance Leases	Total
	£000	£000	£000	£000
Carrying value at 1 April 2018	**156,685**	**2,536**	**71**	**159,292**
Impact of applying IFRS 9 at 1 April 2018	**586**	**0**	**0**	**586**
Cash movements:				
Financing cash flows - principal	**76,180**	**(254)**	**0**	**75,926**
Financing cash flows - interest	**(3,737)**	**0**	**0**	**(3,737)**
Non-cash movements:				
Interest charge arising in year	**4,121**	**0**	**0**	**4,121**
Other changes	**1**	**0**	**(71)**	**(70)**
Carrying value at 31 March 2019	**233,836**	**2,282**	**0**	**236,118**

20. Provisions

	2018/19				
	Pensions	**Injury benefits**	**Legal Claims**	**Equal Pay**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**
At beginning of period	**296**	**2,129**	**58**	**536**	**3,019**
Arising during the period	**21**	**108**	**78**	**64**	**271**
Used during the period	**(24)**	**(121)**	**(16)**	**(592)**	**(753)**
Reversed unused	**(53)**	**0**	**(21)**	**0**	**(74)**
Change in the discount rate	**(2)**	**(40)**	**0**	**0**	**(42)**
Unwinding of discount	**0**	**2**	**0**	**0**	**2**
At 31 March	**238**	**2,078**	**99**	**8**	**2,423**
Expected timing of cash flows:					
Within 12 months	**31**	**118**	**99**	**8**	**256**
Between 1 and 5 years	**125**	**470**	**0**	**0**	**595**
Over 5 years	**82**	**1,490**	**0**	**0**	**1,572**
	238	**2,078**	**99**	**8**	**2,423**

	2017/18				
	Pensions	Injury benefits	Legal Claims	Equal Pay	Total
	£000	£000	£000	£000	£000
At beginning of period	336	2,237	57	0	2,630
Arising during the period	10	32	55	536	633
Used during the period	(31)	(118)	(36)	0	(185)
Reversed unused	(22)	(58)	(18)	0	(98)
Change in the discount rate	2	31	0	0	33
Unwinding of discount	1	5	0	0	6
At 31 March	296	2,129	58	536	3,019
Expected timing of cash flows:					
Within 12 months	31	118	58	536	743
Between 1 and 5 years	125	470	0	0	595
Over 5 years	140	1,541	0	0	1,681
	296	2,129	58	536	3,019

With effect from 2018/19 the analysis of provisions has been revised to separately identify provisions for injury benefit liabilities. Previously these were shown within pensions. Pensions now represents the cost of early retirement pensions only. Comparative information has been amended for this disclosure.

None of the provisions held relate to former directors. Legal claims provisions relate to employer and public liability claims.

20. Provisions (continued)

At 31 March 2018 the Trust provided for the anticipated cost of Equal Value Claims made by employees. Approval from HM Treasury was granted in June 2018 to settle the outstanding claims and payments were agreed and made to the claimants in February and March 2019. These claims have been recorded in the losses register and details are included in note 26.

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 and is a risk pooling scheme. NHS Resolution accounts for provisions relating to the Trust's claims in its financial statements. At 31 March 2019 these provisions totalled£156,898,000 (31 March 2018 £177,145,000).

21. Contingent liabilities

The Trust has no contingent liabilities as at 31 March 2019. Equal Value claims from employees which were previously disclosed have now been settled as per 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.

The Trust’s treasury management operations are carried out by the finance department, within parameters defined formally within the Trust’s Standing Financial Instructions, policies agreed by the Trust Board and guidance issued by NHS Improvement. The Trust is required to retain an appropriate level of working capital at all times in accordance with the borrowing regime guidance issued by the Department of Health and Social Care. 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 2019, 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 2019 are in contract receivables, 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 continue to be 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 Carrying value of financial assets

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. Comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analysis.

	Held at amortised cost	**Total**
Carrying value of financial assets as at 31 March 2019 under IFRS 9	**£000**	**£000**
Trade and other receivables	**16,449**	**16,449**
Cash and cash equivalents	**2,380**	**2,380**
Total at 31 March 2019	**18,829**	**18,829**

	Loans and receivables	Total
Carrying value of financial assets as at 31 March 2018 under IAS 39	£000	£000
Trade and other receivables	6,887	6,887
Cash and cash equivalents	4,410	4,410
Total at 31 March 2018	11,297	11,297

22.4 Carrying value of financial liabilities

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. Comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analysis.

	Held at amortised cost	**Total**
Carrying value of financial liabilities as at 31 March 2019 under IFRS 9	**£000**	**£000**
Loans from the Department of Health & Social Care	**233,836**	**233,836**
Other borrowings	**2,282**	**2,282**
Trade and other payables	**21,300**	**21,300**
Total at 31 March 2019	**257,418**	**257,418**

	Other financial liabilities	Total
Carrying value of financial liabilities as at 31 March 2018 under IAS 39	£000	£000
Loans from the Department of Health & Social Care	156,685	156,685
Other borrowings	2,536	2,536
Obligations under finance leases	71	71
Trade and other payables	18,373	18,373
Total at 31 March 2018	177,665	177,665

22.5 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 amortised using the interest rate applicable to the loan.

22.6 Maturity of financial liabilities

	31 March 2019 £000	31 March 2018 £000
In one year or less	**78,244**	19,318
In more than one year but not more than two years	**87,771**	55,666
In more than two years but not more than five years	**73,788**	89,941
In more than five years	**17,615**	12,740
Total financial liabilities	**257,418**	177,665

23. Related party transactions

During the year ending 31 March 2019 and the prior year (2017/18) 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 where applicable. The assessment of materiality is made in relation to the value of transactions with each organisation based on their overall turnover.

The Trust established a collaborative working arrangement with the Waterloo GP Practice in Millom and contributed a sum of working capital to the Practice during 2016/17. 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.

	2018/19			
	Income £000	Expenditure £000	Receivable £000	Payable £000
Waterloo GP Practice (Millom)	-	-	35	-
Bay Hospitals Charity	557	-	25	-
Department of Health & Social Care	4,201	-	-	-
Public Health England	214	45	-	11
NHS Foundation Trusts	6,041	4,722	2,190	1,420
NHS England and CCGs	305,956	-	9,556	240
Health Education England	10,741	17	178	16
NHS Resolution	4	14,236	-	-
NHS Pension Scheme	-	24,718	-	3,505
NHS Property Services	-	228	-	291
NHS Shared Business Services	-	451	-	135
NHS Trusts	1,104	1,045	403	357
HM Revenue and Customs	-	21,345	632	5,938
Cumbria County Council	116	-	24	-
Greater Manchester Combined Authority	43	-	52	-
Lancashire County Council	102	-	154	-
Welsh, Scottish & Irish Health Bodies	202	-	42	-
National Blood	100	1,259	4	27
Other NHS & Government Organisations	5	236	-	18
Total	329,386	68,302	13,295	11,958

23. Related party transactions (continued)

	2017/18			
	Income £000	Expenditure £000	Receivable £000	Payable £000
Morecambe Bay Radiology LLP	-	14	-	-
Waterloo GP Practice (Millom)	-	-	35	-
Bay Hospitals Charity	513	-	44	-
Department of Health	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	-	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

24. Third party assets

The Trust held £4,000 cash and cash equivalents at 31 March 2019 which relates to monies held by the Trust on behalf of patients (31 March 2018 £4,000). This has been excluded from the cash and cash equivalents figure reported in the accounts.

25. Transfers by absorption

	CPFT £000	BTHFT £000	Total £000
Property plant and equipment			
Land	**60**	**0**	**60**
Buildings excluding dwellings	**383**	**0**	**383**
Plant & machinery	**51**	**14**	**65**
Information technology	**91**	**37**	**128**
Net book value of PPE transferred	**585**	**51**	**636**
Inventories			
Consumables	**0**	**7**	**7**
Total inventories transferred	**0**	**7**	**7**
Net gain on absorption transfers	**585**	**58**	**643**

25. Transfers by absorption (continued)

The Trust received transfers of functions from Cumbria Partnership NHS Foundation Trust on 1 April 2018 and Blackpool Teaching Hospitals NHS Foundation Trust on 1 October 2018. These related to the transfer of Community Services and resulted in the assets transferred by absorption as disclosed in this note. The transfer value is shown on the Statement of Comprehensive Income.

A Revaluation Reserve balance of £32,000 was transferred from Cumbria Partnership NHS Foundation Trust in respect of land transferred as part of the transfer by absorption. This is shown as included in the Trust's Revaluation Reserve with a corresponding entry to the Income and Expenditure Reserve on the Statement of Changes in Taxpayer's Equity.

The values of the functions transferred which are included within operating activities for the year 2018/19 amount to additional income of £29.9m shown within income from activities in note 3.1 and an equivalent amount of expenditure shown within operating expenses in note 5.1. Approximately 70% of expenditure relates to staffing costs. The full year effect of these functions during 2019/20 will amount to around £36m.

26. Losses and special payments

	2018/19		2017/18	
	Number	**Value £000**	Number	Value £000
Losses				
Cash losses	**25**	**5**	0	0
Fruitless payments	**0**	**0**	0	0
Bad debts and claims abandoned	**53**	**22**	1	25
Stores losses	**1**	**98**	1	64
Total losses	**79**	**125**	2	89
Special payments				
Compensation under court order	**1**	**104**	0	0
Ex gratia payments	**49**	**28**	53	73
Other employment related payments	**69**	**592**	0	0
Extra statutory and regulatory	**3**	**0**	2	3
Total special payments	**122**	**724**	55	76
Total losses and special payments	**201**	**849**	57	165

There have been no individual losses or special payment cases which have exceeded £300,000 in either 2018/19 or 2017/18.

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.

Special payments were made during 2018/19 relating to one employment tribunal case and in respect of the settlement of outstanding Equal Value Claims. HM Treasury approval was granted to the Trust in June 2018 based on a percentage offer of settlement and little or no prospect of defending the claims further. A total of 69 employees and former employees received payments. The employment tribunal case is shown as compensation under court order and the equal value settlements are shown as other employment related payments.

The above losses and special payments are reported on an accruals basis and do not include any provisions for future losses.

27. Private Finance Initiative (PFI) transactions

The Trust has no PFI arrangements at 31 March 2019.

28. Initial application of standards IFRS 9 and IFRS 15

28.1 Initial application of IFRS 9

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities , a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £586,000 and trade payables correspondingly reduced.

The GAM expands the definition of a contract in the context of financial instruments to include legislation and regulations, except where this gives rise to a tax. Implementation of this adaptation on 1 April 2018 has led to the classification of receivables relating to the Injury Cost Recovery Scheme as a financial asset measured at amortised cost. The carrying value of these receivables at 1 April 2018 was £2,746,000.

Other than these impacts described above, the implementation of IFRS 9 has not had a material impact on the Trust.

28.2 Initial application of IFRS 15

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of the initial application recognised as an adjustment to the Income and Expenditure Reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

The implementation of IFRS 15 has had no impact for the Trust other than changes in the disclosures and classifications already referred to in the notes to the accounts.

29. Audit fees

During 2018/19 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 2017/18, remuneration amounting to £60,000 was paid to Grant Thornton UK LLP. Of this sum £53,000 related to the statutory audit function and £7,000 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 2018/19 (2017/18 £2,000). This service is limited to an independent review in accordance with the income threshold specified for charities above which a full audit is required.

30. 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.

31. 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. This may result in further transfers of services from other NHS organisations in the future.

The Trust is due to repay substantial loan balances to the Department of Health and Social Care between January and March 2020. It is anticipated that the loans subject to repayment will be reviewed and the loan terms will be extended but this has not yet been confirmed.

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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 2018/19.

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.

The Annual Report has been prepared on the same group basis as the accounts for 2018/19.

Further copies of the Annual Report and Accounts for the period 1 April 2018 to 31 March 2019 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:

https://www.uhmb.nhs.uk/about-us/key-publications.

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:

https://www.uhmb.nhs.uk/about-us/key-publications

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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 2018/19 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 2018/19.

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 2018/19.
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 2019

The Annual Members' and Public Meeting of the University Hospitals of Morecambe Bay NHS Foundation Trust will be held on Tuesday 17 September 2019.

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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