PUBLIC TRUST BOARD OF DIRECTORS' MEETING

Wednesday 28 September 2022 in the Board Room, Westmorland General Hospital, Burton Road, Kendal LA9 7RG

Please note the meeting will also take place via Microsoft Teams.

Commencing at 9.30am

Reference Document Pack			
Item		**Lead**	**Paper**
Matters for Consideration			
113	Patient Story *An account from a patient on their experience of recovering from a stroke.*	Chief Nursing Officer	Attached
Patients			
117 i	Recovery Support Programme – UHMB Improvement Plan 1. *Appendix 1: Letter dated 12.09.2022 from Sir Andrew Morris, Vice Chair of NHS England, following the July 2022 national RSP review meeting* 2. *Appendix 2: RSP Metric Report*	Deputy Chief Executive / Intensive Support Director	Attached
118 i	Care Quality Commission (CQC) and Royal College of Surgeons (RCS) Improvement Plan	Director of Governance	Attached
119	Maternity Update Appendices	Chief Nursing Officer / Director of Midwifery	Attached
Performance			
120 ii	Assurance Committee Minutes	Chairs of the Assurance Committees	Attached
121 ii	Emergency Preparedness, Resilience and Response (EPRR): Annual Assurance Return 1. *Applicable Core Standards Summary* 2. *EPRR Core Standards Action Plan* 3. *Statement of Compliance*	Chief Operating Officer	Attached
People			
122	Positive Difference Annual Report 2021/22	Interim Chief	Attached

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

i	*1. Annual Report; and* *2. Colleague story to be presented to the Board of Directors.*	People Officer	
125	Trust-wide Risk Register	Director of Governance	Attached

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

THIS PAGE IS INTENTIONALLY BLANK

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

University Hospitals of Morecambe Bay NHS Foundation Trust

Patient Story

Hello,

My name is David, and this is my story.

I had a stroke on my 70th birthday party.

I only had 6 visits in the 4 months that I spent in hospital.

My wife was allowed to send food in but not allowed to visit, which was hard due to Covid.

It was tough receiving difficult news from the Doctors alone.

I had a few visits from the Speech and Language team once home, but I would have liked more to work on my speech and pronunciation.

Background

I had a stroke on my 70th birthday party. I was having a garden party serving guests drinks when Boom, I managed to make to the bench, and I said, “I think I am having a stroke”.

My head dropped and my right arm and leg was dead.

An ambulance came within 20 minutes, and I was taken to Furness General Hospital.

The rest was a bit of a blur.

In Hospital

I had a dense right-sided weakness. My speech was terrible, and it was quite shocking. I was aware that the words I wanted to say were not coming out, and people could not understand what I was trying to say.

The physiotherapists had to work on my sitting balance as I could not sit up, they worked, and I had to be hoisted in and out of bed, but I don't remember any of that.

I remember the later stages when I was trying to walk between the parallel bars, it gave me a sense of achievement, but it was very hard work.

I was peg fed, but I also don't remember that.

I remember trying the food, and the food wasn't bad.

My wife was allowed to send food in but not allowed to visit, which was hard due to Covid.

I only had 6 visits in the 4 months that I spent in hospital.

It was tough receiving difficult news from the Doctors alone.

I was told I would recover a bit, but I would not make a full recovery. This made me feel quite depressed, and it was difficult news for my wife and me.

Discharged home

It was amazing to be finally discharged home after 4 long months.

I was discharged home with 2x carers 4x per day. I used a re-turn to transfer from bed to chair etc., and 2x carers to get in and out of bed and to help with personal care.

I received input from the Integrated Community Stroke Team (ICST) every working weekday with a combination of physiotherapy and occupational therapy.

Physio worked on strengthening exercises and had arranged an orthosis for my knee to enable walking practice at home. I worked hard each day, working on standing up from a chair and walking with the knee brace and quad stick.

The Occupational Therapists helped me work on my bed transfers and getting in and out of the shower. They ordered the equipment I needed, such as a ripple mattress.

I had a few visits from the Speech and Language team once home, but I would have liked more to work on my speech and pronunciation.

Now at 6 months post discharge

I have reduced my carers to 1x carer 1x a day, can independently get in and out of bed, and have moved back into my bed 3 days ago. I am now mobilising around my home independently with a quad stick and can go to the toilet alone.

I eat all my food at the dining table, and I can make my cup of coffee and unload the cutlery from the dishwasher. I have also started walking short distances outdoors with a quad stick and the assistance of 1.

I can independently get in and out of a car and have been out to socialise at my favourite restaurant and have recently been signed off by my neuro consultant, and I am now under the care of my GP.

The ICST service has been excellent, everyone has been:

- kind,
- friendly
- very helpful, and I feel I have made very good / quick progress – thank you.

Colleague refection

We have nominated David for the patient rehab legend. For his amazing determination, hard work and remarkable progress. David has been a pleasure to work with every single session. It has been awe-inspiring to be part of David's journey.

He has made us laugh and impressed and shocked us with his ability to work through even the most challenging days.

"Everyone has their own story. Everyone has their own moments of happiness, of suffering, of loneliness, of love, that have shaped them into who they are today.

Everyone has their own story, and everyone deserves someone who is willing to listen to it"

If you would like to share your story please contact the Patient Experience team
Patientexperience@mbht.nhs.uk

To: **Mike Thomas**, Chair of University Hospital of Morecambe Bay NHS Foundation Trust

Aaron Cummins, Chief Executive Officer of University Hospital of Morecambe Bay NHS Foundation Trust

Sir Andrew Morris
Vice Chair, NHS England

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

12 September 2022

Dear Mike and Aaron,

Recovery Support Programme (RSP) Review meeting: University Hospital of Morecambe Bay NHS Foundation Trust

Thank you for attending the second RSP Review meeting for University Hospital of Morecambe Bay NHS Foundation Trust held on Thursday, 14 July 2022. The national NHSE executives and I were grateful for your presentation regarding your progress and for the positive and helpful discussions on stress testing the improvement plan and risks to progress.

In summary, we recognised the progress and tangible steps that have been made since the entry review meeting held in December 2021. There are good improvement plans in place and the focus now must be on continuing to pick up the pace on delivery, with continued support from the Integrated Care Board. We agreed to meet again in the new year, to review the progress you have made and assess whether the trust remains on track to exit RSP in April 2023.

I have also attached to this letter, a copy of the meeting note, see Annex A. Please do not hesitate to let me know if you have any questions or if anything needs further clarification.

Best Wishes,

Andw Morris

Sir Andrew Morris
Vice Chair, NHS England

Copy:

Professor Sir Stephen Powis, National Medical Director, NHSE
Sir David Sloman, Chief Operating Officer, NHSE
Dame Ruth May, Chief Nursing Officer, NHSE
Julian Kelly, Chief Financial Officer, NHSE
Peter Ridley, Deputy Chief Finance Officer – Operational Finance, NHSE
Simon Currie, Director of Financial Planning & Delivery, NHSE
Duncan Burton, Deputy Chief Nursing Officer, NHSE
Richard Barker, Regional Director, North West, NHSE
Michael Gregory, Interim Regional Medical Director, NHSE
Jackie Hanson, Regional Chief Nurse, NHSE
Stephen Downs, Director of Operational Finance, NHSE
Nicola Allen, Regional Intensive Support Director, NHSE
Caroline Kurzeja, Acting National Director of Intensive Support, NHSE
Caroline Griffiths, Improvement Director, NHSE
Chris Adcock, Deputy CEO, SRP for RSP, Director of Finance, UHMBT
Scott MCLean, Chief Operating Officer, UHMBT
Bridget Lees, Executive Chief Nurse, UHMBT
Dr Sarah Hauxwell, Clinical Director for RSP, UHMBT
Sarah Rees, Non-Executive, UHMBT
David Flory, Designate Chair of Lancashire and South Cumbria ICB
Kevin Lavery, Chief Executive Designate of Lancashire and South Cumbria ICB
Sarah O'Brien, Designate ICB Chief Nurse, Lancashire and South Cumbria ICB
David Levy, Chief Medical Officer, Lancashire and South Cumbria ICB
Kevin McGee, Chief Executive Officer of Lancashire Teaching Hospitals

We are UHMBT

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

University Hospitals of Morecambe Bay NHS Foundation Trust

UHMBT Recovery Support Programme - Metric Summary

Improving Together

August 2022

Summary 1: Jul-2022 (or latest available position)

University Hospitals of Morecambe Bay NHS Foundation Trust

Fundamentals of Care

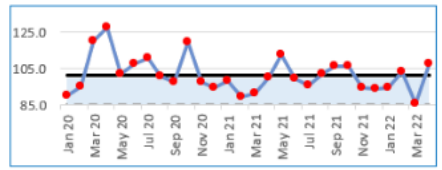
Metric	Plan	Actual	Variation	Assurance
All Inpatient Falls Per 1000 Bed Days	N/A	7.2		
Inpatient Falls (with Moderate & Above Harm) per 1000 Bed Days	N/A	0.1		
Inpatient Category 2, 3 & 4 Pressure Ulcers (Developed) Per 1000 Bed Days	N/A	1.6		
Number Of Inpatient Category 3 & 4 Pressure Ulcers (Developed)	N/A	1		
Infection Prevention - MSSA Cases Per 1000 Bed Days	N/A	0.1		
Infection Prevention - MRSA (HOHA) Cases Per 1000 Bed Days	N/A	0.0		
Infection Prevention - CDiff (HOHA) Cases Per 1000 Bed Days	N/A	0.4		
Infection Prevention - GNBSI (HOHA) Cases Per 1000 Bed Days	N/A	0.1		
Percent of Patients who have a MUST Assessment within 24 Hours of Admission	N/A	82.97%		
Percent of Subsequent MUST Assessments Completed within 7 days of the Previous MUST Assessment	N/A	58.79%		
Nutrition & Hydration: Dietetics Referrals Compliance	N/A	39.04%		
Medication Incidents Per 1000 Bed Days	N/A	5.7		

Risk Management

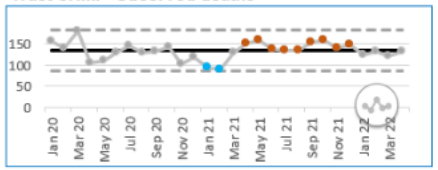
Metric	Plan	Actual	Variation	Assurance
Extreme Risks Remaining Extreme For 12 Or More Months	N/A	20		
Risks Remaining At The Same Risk Score For 12 Or More Months	N/A	102		
Volume of Risks with a Score of 20 or 25 and a Severity of '5-Catastrophic'	N/A	3		
Volume of Risks with a Score of 5, 10 or 15 and a Severity of '5-Catastrophic'	N/A	15		
Volume Of Tolerated Risks	N/A	59		
Compliance to Risk Management Training	N/A	96.06%		
Volume Of New Risks By Month	N/A	30		
Volume Of Closed Risks By Month	N/A	11		
Risk Reviews Completed On Time	N/A	91.27%		
Risks Beyond Target Completion Date	N/A	24.23%		
Risk Actions Beyond Target Completion Date	N/A	18.18%		

Summary Hospital-level Mortality Indicator

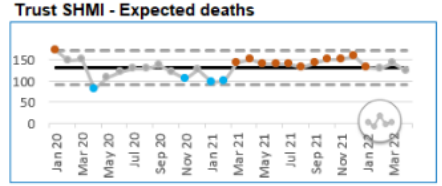
Latest month	Apr 22
SHMI	107.74
Observed deaths	132
Expected deaths	123



Trust SHMI - Observed deaths



Trust SHMI - Expected deaths



Mortality

Metric	Plan	Actual	Variation	Assurance
Mortality Review with a HOGAN (preventability of death) Score of Possibly or Probably Preventable	N/A	9.38%		
Mortality Review with a HOGAN (preventability of death) Score of Strong Evidence For or Definitely Preventable	N/A	0.00%		
Mortality Review with a NCEPOD (quality of care) Rating of Room For Improvement	N/A	28.13%		
Mortality Review with a NCEPOD (quality of care) Rating of Less than Satisfactory	N/A	3.13%		
Hospital Deaths Scrutinised By Medical Examiner	100.00%	96.24%		
Hospital Deaths Receiving a Mortality Review	N/A	12.78%		

Summary 2: Jul-2022 (or latest available position)

University Hospitals of Morecambe Bay NHS Foundation Trust

Stroke and Section 31

Metric	Plan	Actual	Variation	Assurance
Median Arrival Time to Scan (mins) - by month	60	39		
CT Scan Within 1hr	70.00%	69.23%		
CT Scan Within 12hrs	100.00%	98.08%		
Admitted to Stroke Unit within 4hrs	100.00%	61.22%		
Thrombolysed within 1hr	100.00%	66.67%		
Swallow Screened within 4hrs	100.00%	78.43%		
Assessed by Stroke Consultant within 24h	100.00%	86.54%		
Assessed by Specialist Nurse within 24hr	100.00%	96.15%		
Occupational Therapy Assessment within 72h	100.00%	95.24%		
Physiotherapy Assessment within 72h	100.00%	97.62%		
Speech & Language Therapist Assessment within 72hrs	100.00%	94.12%		

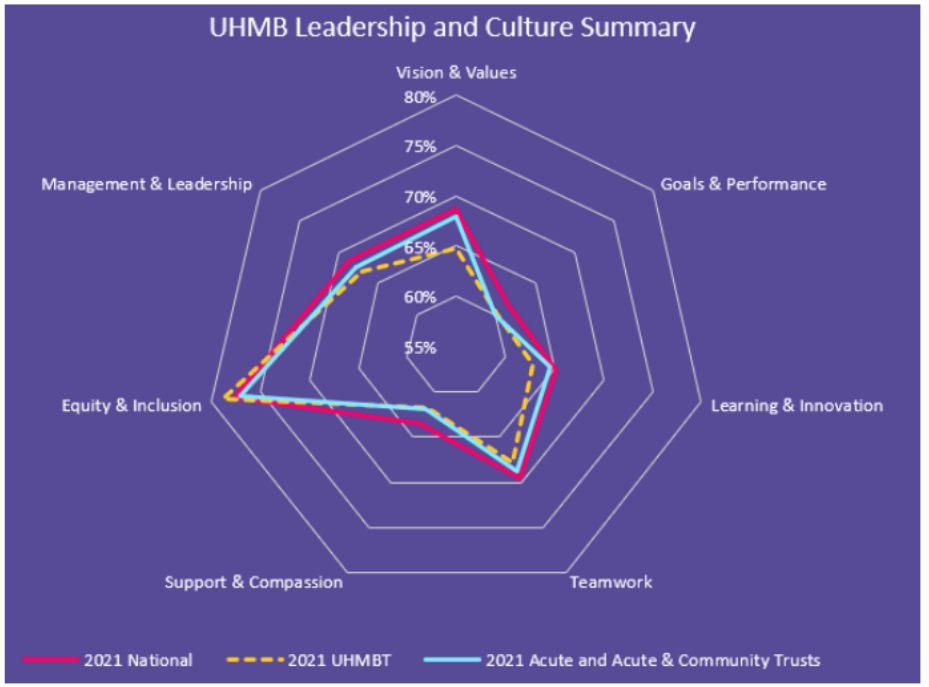
Safety Investigations

Metric	Plan	Actual	Variation	Assurance
Serious Incident Investigations Approved At First Panel	N/A	100.00%		
Open & Overdue Incidents	N/A	1759		
Duty Of Candour Completed In Time	N/A	83.95%		
Investigations Where Author(s) Have Received RCA Training	N/A	66.67%		

Clinical Service Reviews

Metric	Plan	Actual	Variation	Assurance
Wards/Areas Achieving Silver Standard Or Greater	N/A	100.00%	NO SPC	
Wards/Areas Achieving Gold Standard	N/A	66.67%	NO SPC	

Leadership and Culture



Safe Staffing

Metric	Plan	Actual	Variation	Assurance
Registered Nurse Fill Rate	85.00%	92.56%		
Clinical Support Worker Fill Rate	85.00%	84.51%		

Summary 3: Jul-2022 (or latest available position)

University Hospitals of Morecambe Bay NHS Foundation Trust

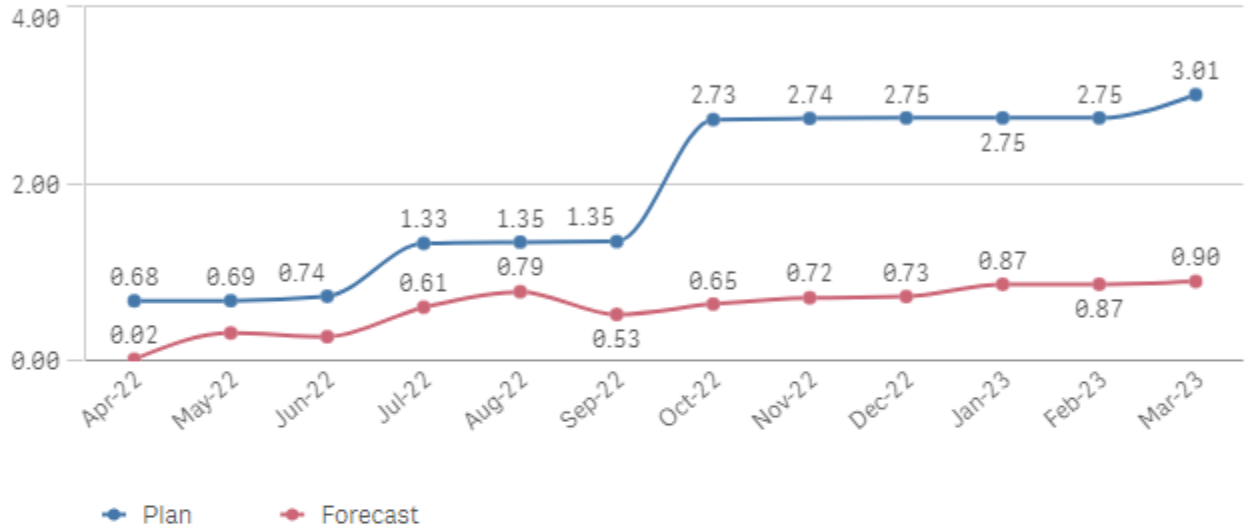
Urgent & Emergency Care

Metric	Plan	Actual	Variation	Assurance
ED 4 hrs (%)	95.00%	70.93%		
2 Hour Urgent Community Response	70.0%	92.9%		
Ambulance Average Turnaround Time (mins)	N/A	38.2		
Patients Spending over 12 hours in A&E	2.00%	4.94%		
Patients Spending over 12 hours in ED: Mental Health Reasons	N/A	35		
Patients Spending over 12 hours in ED: Physical Health Reasons	N/A	526		
Non Elective Average Length of Stay	N/A	4.8		
SDEC - % 0 Day LOS	40.00%	42.56%		
NMC2R - % of G&A Bed	16.00%	20.25%		
NMC2R - 21 Day LOS Mean Value Monthly	N/A	137.5		

Summary 4: Jul-2022 (or latest available position)

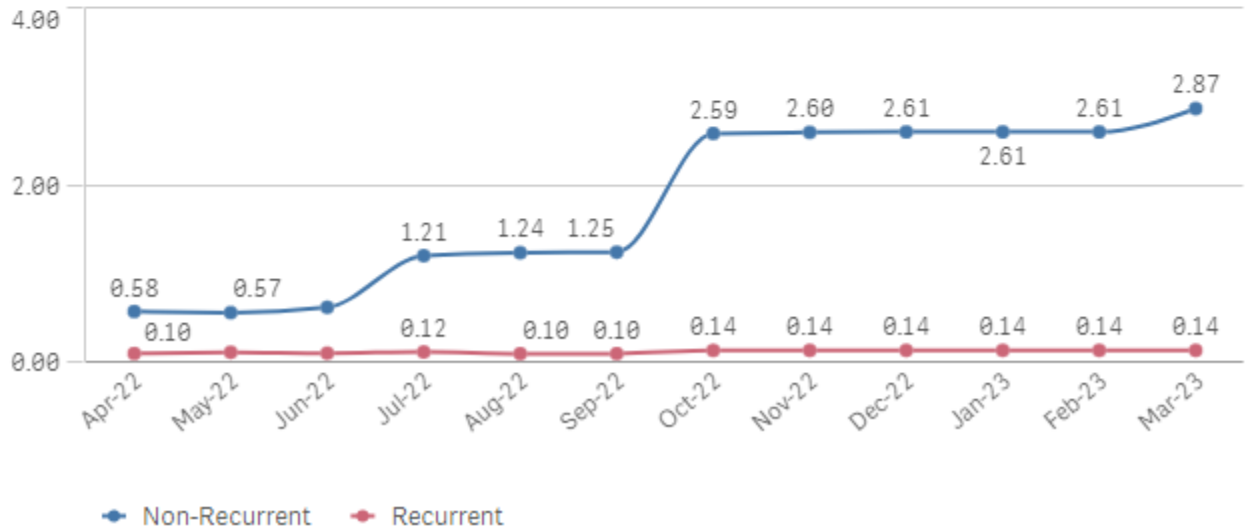
University Hospitals of Morecambe Bay NHS Foundation Trust

Plan vs Forecast (£ million)

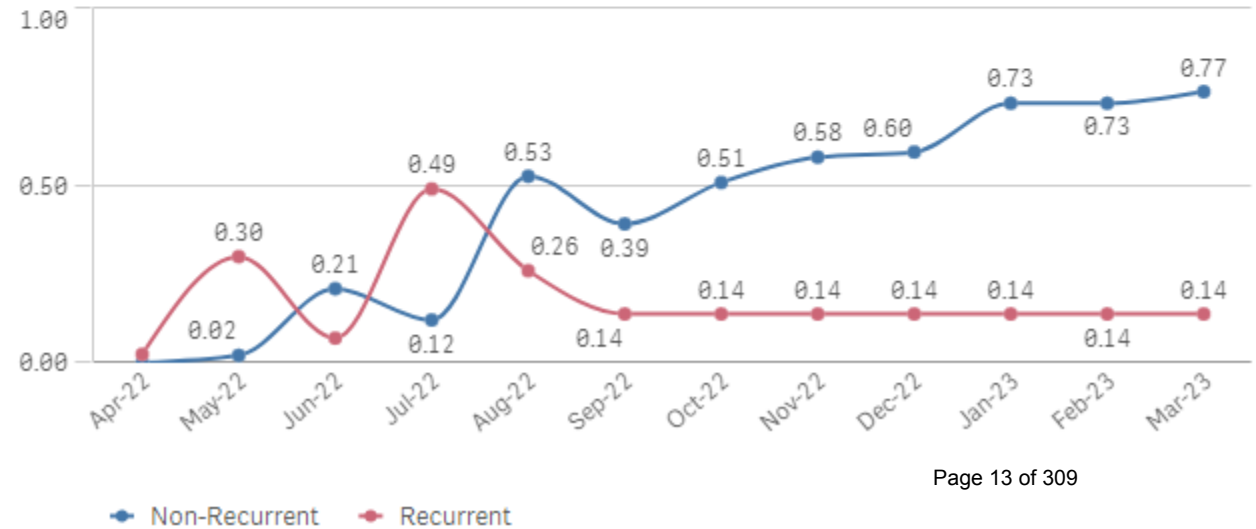


Description	Value
Target 2022/23	£ 23.00 million
Plan 2022/23	£ 23.03 million
Forecast 2022/23	£ 7.30 million
Variance 2022/23	£ 15.73 million
Value of Pipeline Schemes 2022/23 - Profiled	£ 0.06 million
Pipeline Minimum 2022/23	£ 3.20 million
Pipeline Maximum 2022/23	£ 1.11 million
Plan on a Page Required (Phase 1 schemes)	38
Plan on a Page Completed (Phase 1 schemes)	7
Quality Impact Assessment Required (Phase 1 schemes)	38
Quality Impact Assessment Completed (Phase 1 schemes)	7

Plan - Recurrent vs Non-Recurrent (£ million)



Forecast - Recurrent vs Non-Recurrent (£ million)



Summary 5: Jul-2022 (or latest available position)

NHS
University Hospitals of Morecambe Bay
NHS Foundation Trust

5.2 Financial Control Environment

NHSi Grip and Control Checklist was last completed in July 2022, the outputs and recommendations from this review are to be agreed. The next NHSi Grip and Control Checklist is to to be completed in January 2023.

Summary of Output from July 2022's NHSi Grip and Control Checklist

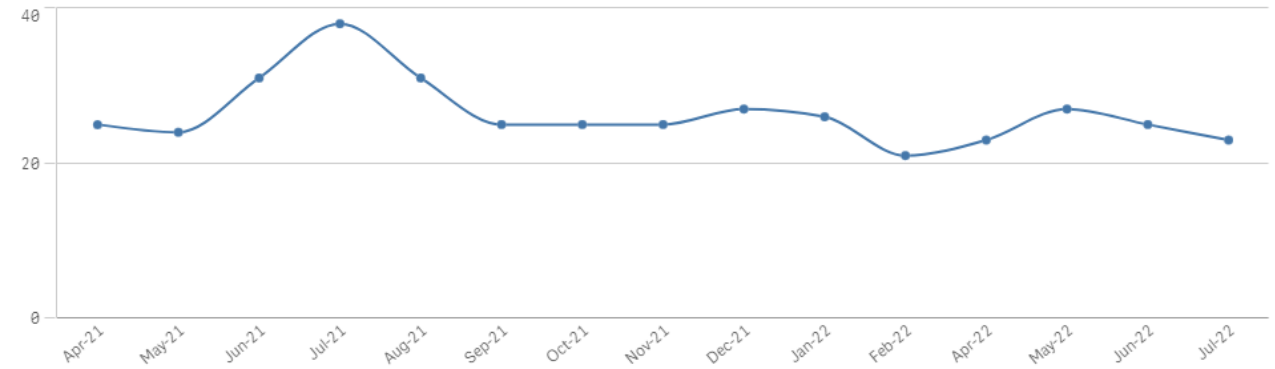
N.B. this table is included for information purposes. It is not intended as an indication of improvement

Summary	Total no of Actions	Excluded at this Review	GREEN	AMBER	RED	Identified for Detailed Review
1)Rapid actions	45	5	13	27	0	0
2)Gov & Comms	26	0	11	15	0	0
3) Pay	51	0	4	40	7	0
4) Nonpay	18	2	12	4	0	0
5) Procurement	34	0	31	3	0	0
6)Inventory	13	0	10	3	0	0
7)N/R actions	20	3	17	0	0	0
8)Cash	30	1	26	3	0	0
Total	**237**	**11**	**124**	**95**	**7**	**0**

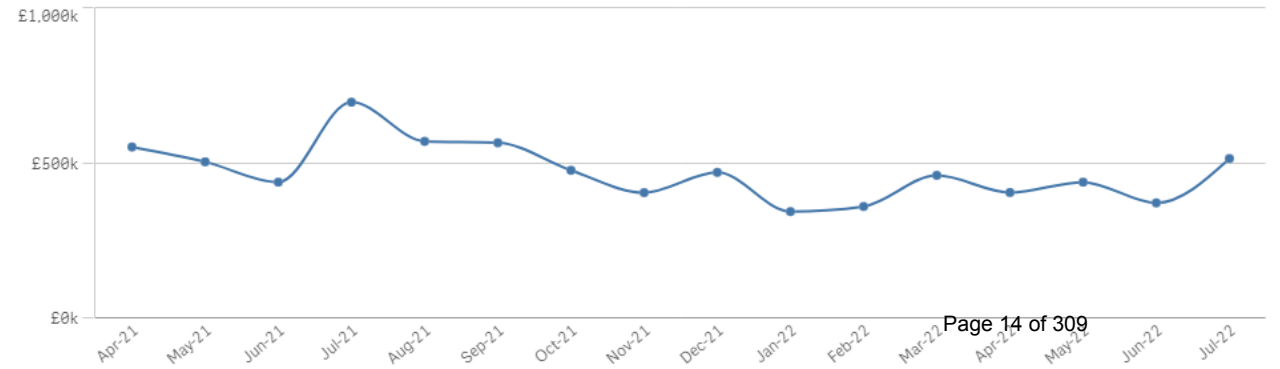
Business Cases

MiscMetric	Month			
	Apr-22	May-22	Jun-22	Jul-22
Cases under development - Financial year total as of 1st of Month	64	65	59	69
Capital cases - Financial year total as of 1st of Month	0	41	39	46
Cases in approval process - Financial year total as of 1st of Month	26	28	37	43
Cases in monitoring - Financial year total as of 1st of Month	31	33	29	30
Cases for logging (approved in care group)	1	1	0	0
No. of prior approvals approved to business case	4	3	7	3
Business cases to be submitted (PAF approved) - Financial year total as of 1st of Month	26	30	30	40
Grand Total Approved Business Cases - Financial year total as of 1st of Month	2	2	0	2
Business Cases Approved by IPG - Financial year total as of 1st of Month	2	2	0	2
Business Cases Approved by TMG - Financial year total as of 1st of Month	1	0	1	0
Business Cases Approved by FC - Financial year total as of 1st of Month	1	0	0	0
Business Cases Approved by Trust Board - Financial year total as of 1st of Month	0	0	0	0
No. cases monitored - Financial year total as of 1st of Month	1	7	7	0
Number people trained via TMS training - Financial year total as of 1st of Month	1	0	0	7
Feedback on TMS training is good or excellent - Financial year total as of 1st of Month	1	1	1	1

Number of High Cost Agency Doctors



Cost of High Cost Agency Doctors



We are UHMBT

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

NHS
University Hospitals of Morecambe Bay
NHS Foundation Trust

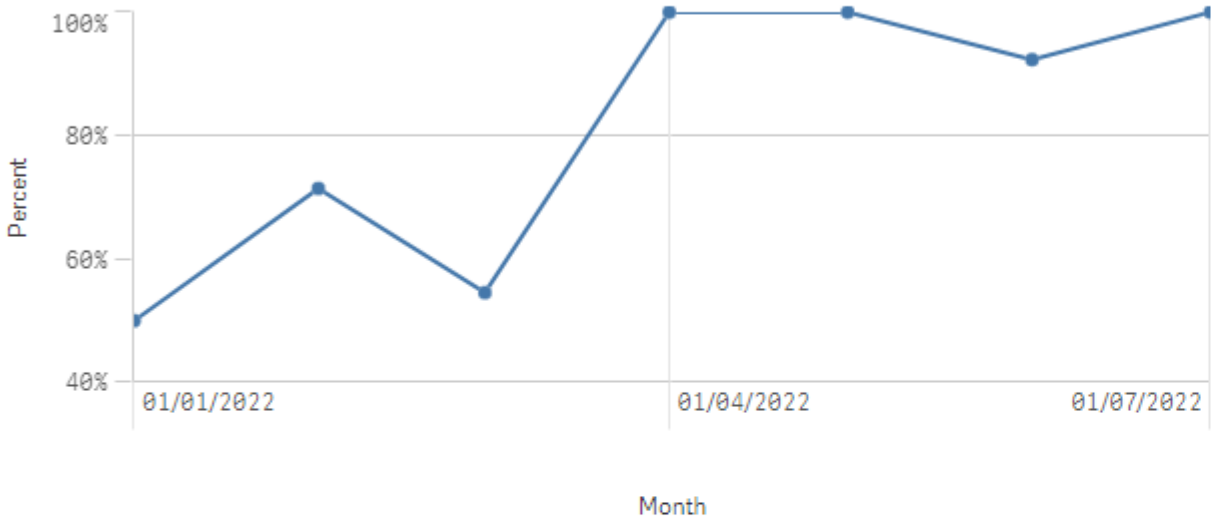
UHMBT Recovery Support Programme - Data Pack

Improving Together

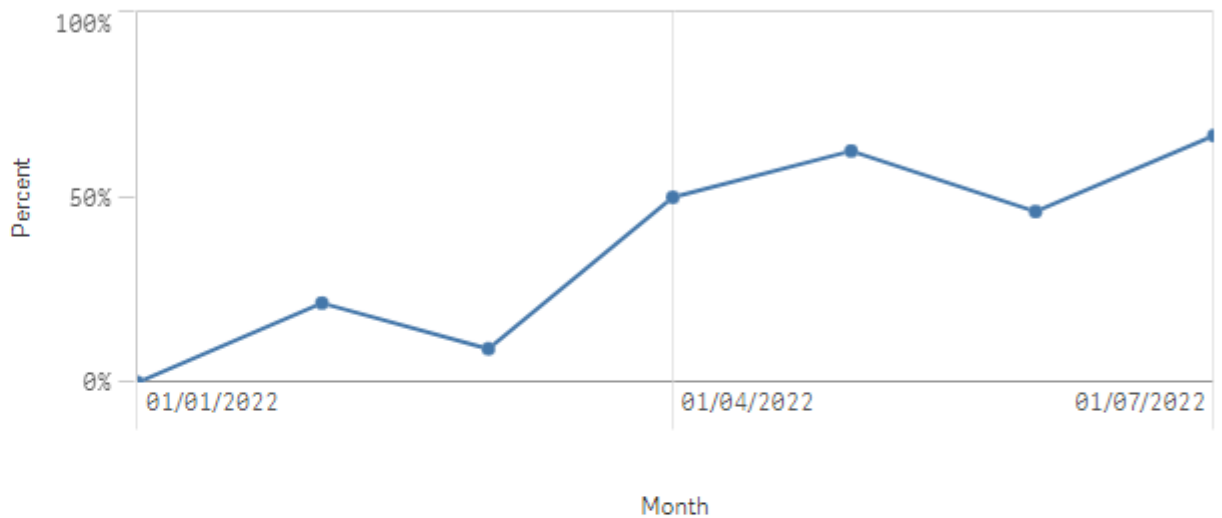
Clinical Service Reviews & Ward Manager Skills

University Hospitals of Morecambe Bay NHS Foundation Trust

Wards/Areas Achieving Silver Standard Or Greater



Wards/Areas Achieving Gold Standard



Please note the above results are based on small volumes, and are therefore not statistically significant. Please see data table

Reviews Conducted

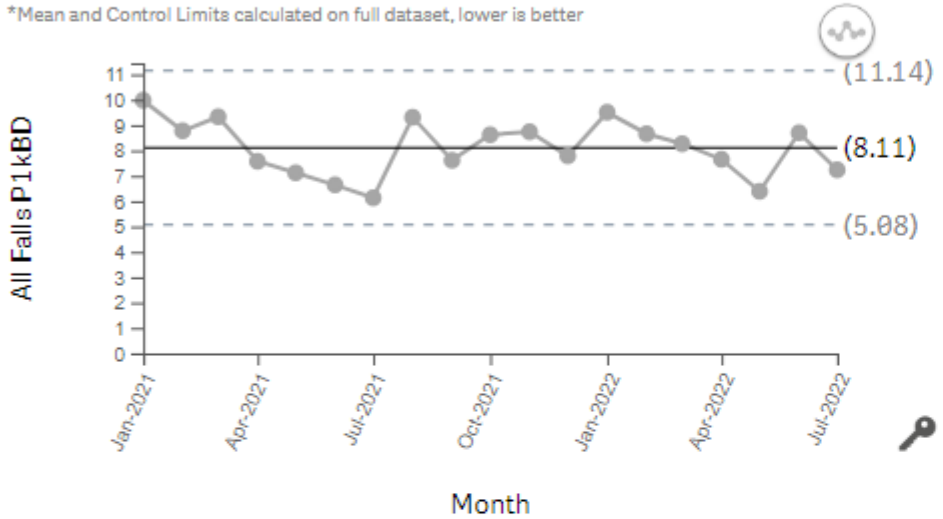
Month	Reviews Conducted
Totals	**67**
Jan-2022	2
Feb-2022	14
Mar-2022	22
Apr-2022	2
May-2022	8
Jun-2022	13
Jul-2022	6

Fundamentals of Care - 1

University Hospitals of Morecambe Bay NHS Foundation Trust

All Inpatient Falls Per 1,000 Bed Days

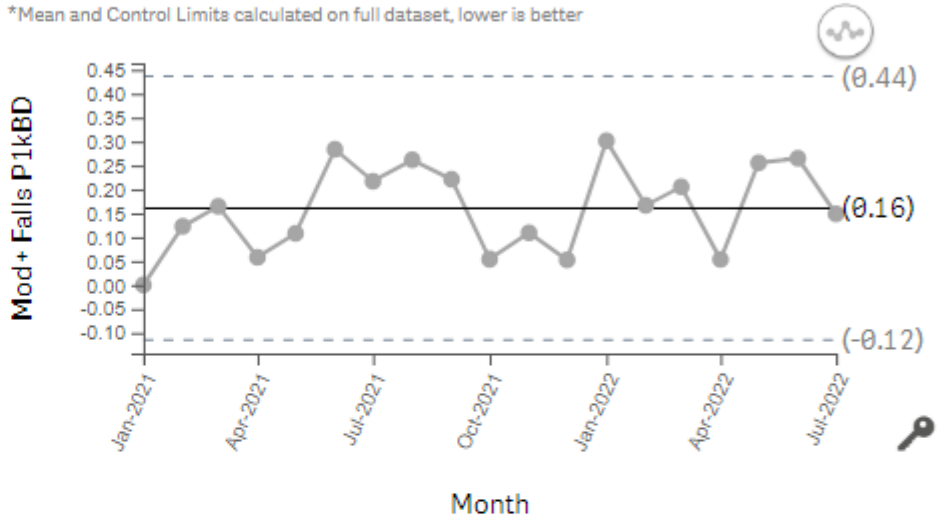
*Mean and Control Limits calculated on full dataset, lower is better



Latest
7.2
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Inpatient Falls (with Moderate & Above Harm) per 1000 Bed Days

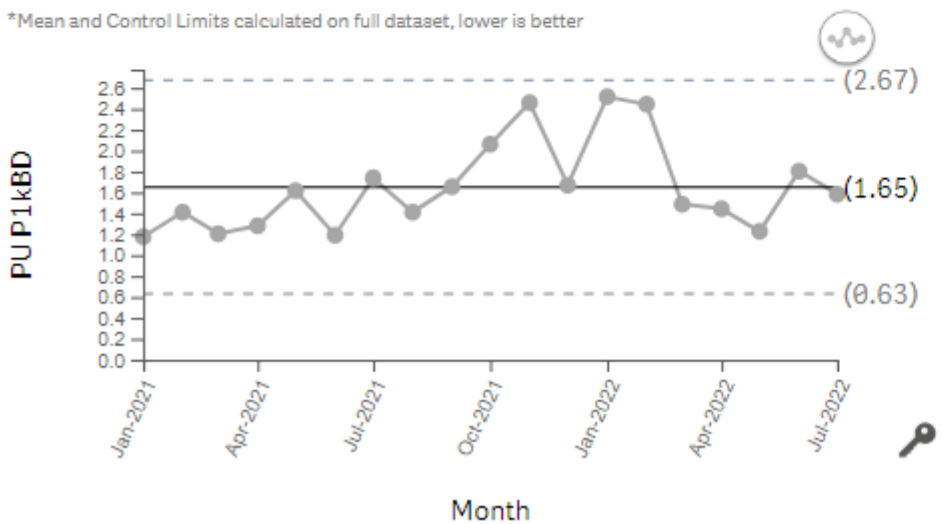
*Mean and Control Limits calculated on full dataset, lower is better



Latest
0.15
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

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

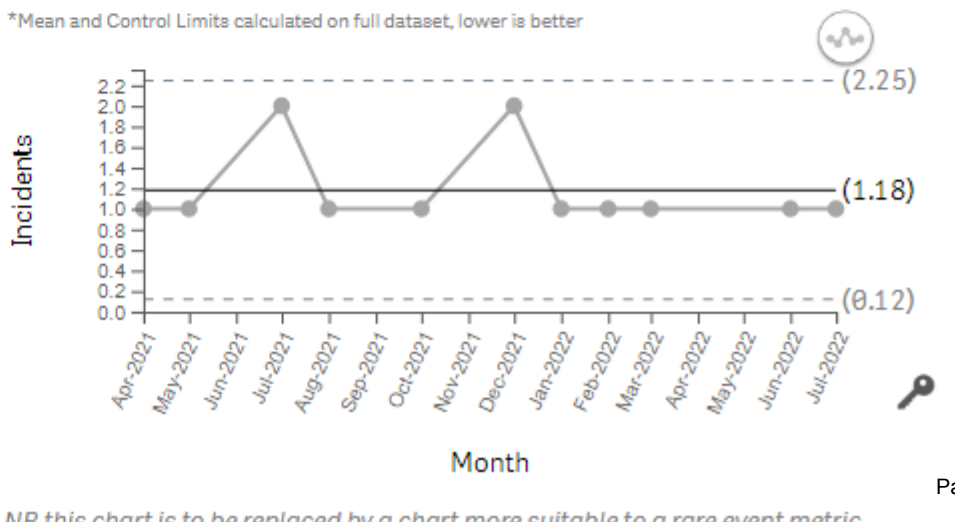
*Mean and Control Limits calculated on full dataset, lower is better



Latest
1.6
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Number of Inpatient Category 3 & 4 Pressure Ulcers (Developed)

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



Latest
1.000
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

NB this chart is to be replaced by a chart more suitable to a rare event metric

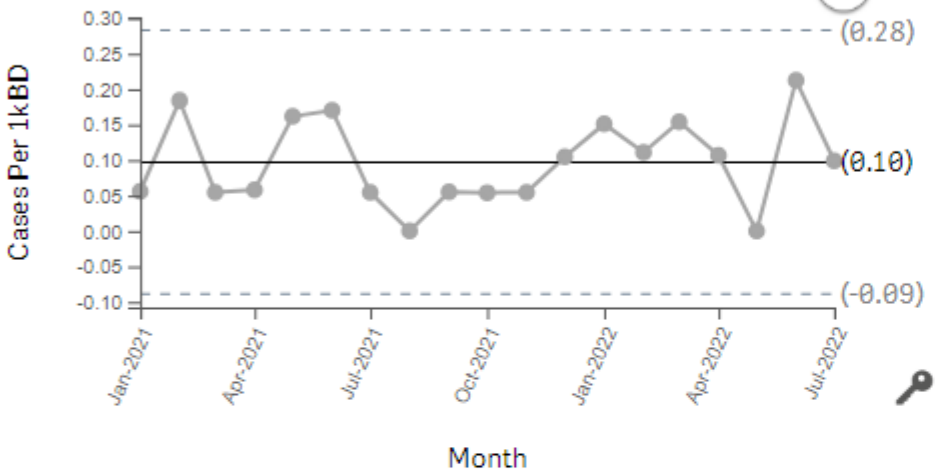
Fundamentals of Care - 2

**HOHA = Hospital-Onset Healthcare Associated*

University Hospitals of Morecambe Bay NHS Foundation Trust

Infection Prevention - MSSA (HOHA*) Cases Per 1000 Bed Days

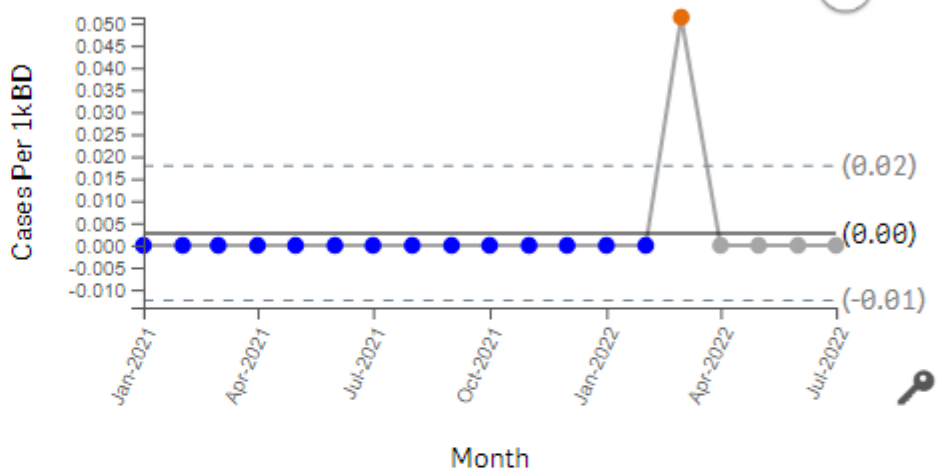
*Mean and Control Limits calculated on full dataset, lower is better



Latest
0.1
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Infection Prevention - MRSA (HOHA*) Cases Per 1000 Bed Days

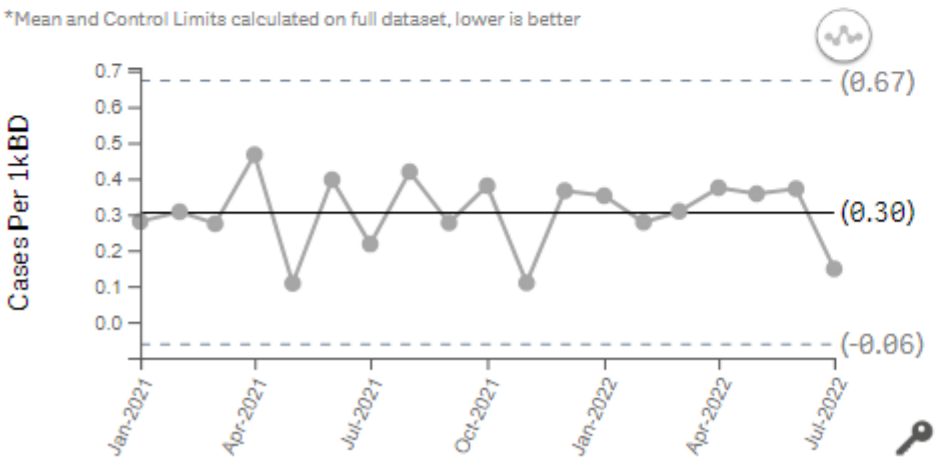
*Mean and Control Limits calculated on full dataset, lower is better



Latest
0.0
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Infection Prevention - GNBSI (HOHA*) Cases Per 1000 Bed Days

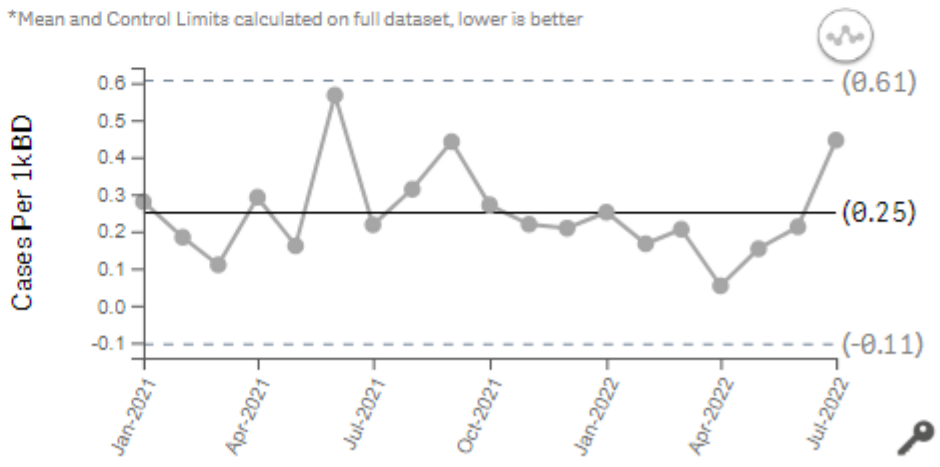
*Mean and Control Limits calculated on full dataset, lower is better



Latest
0.1
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Infection Prevention - CDiff (HOHA*) Cases Per 1000 Bed Days

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



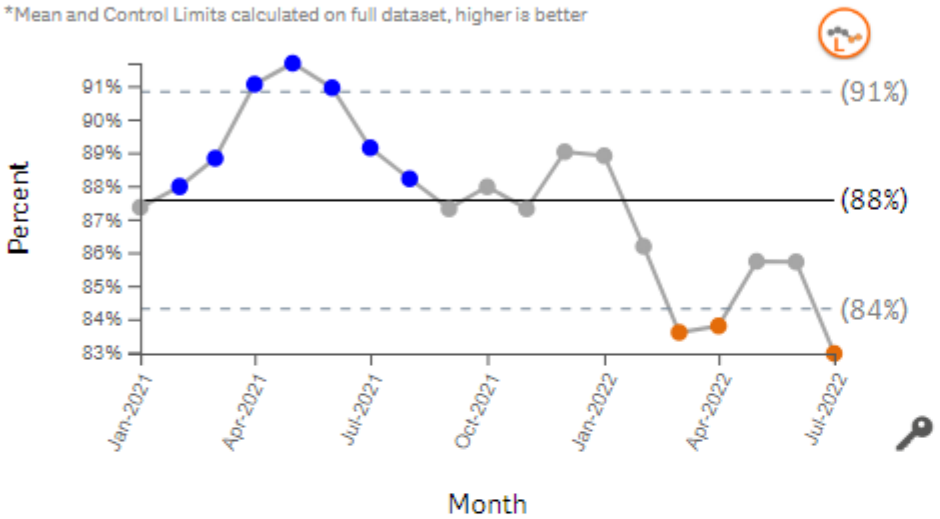
Latest
0.4
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Fundamentals of Care - 3

NHS
University Hospitals of Morecambe Bay
NHS Foundation Trust

Nutrition & Hydration: Patients who have a MUST Assessment in 24hrs of Being A...

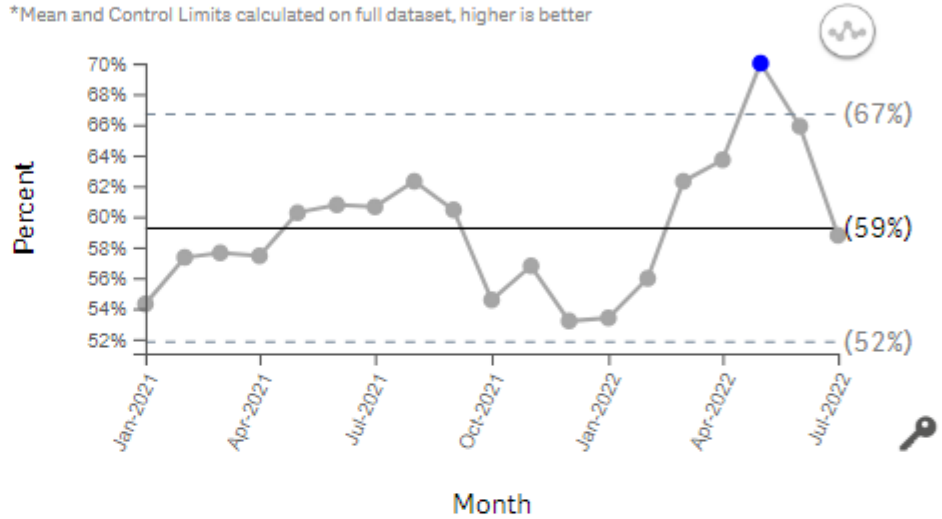
*Mean and Control Limits calculated on full dataset, higher is better



Latest
83.0%
Variance Type
Special cause variation - cause for concern (indicator where low is a concern)
Target
N/A
Target Achievement
N/A

Nutrition & Hydration: MUST Assessments Completed in 7 Days of the Previous M...

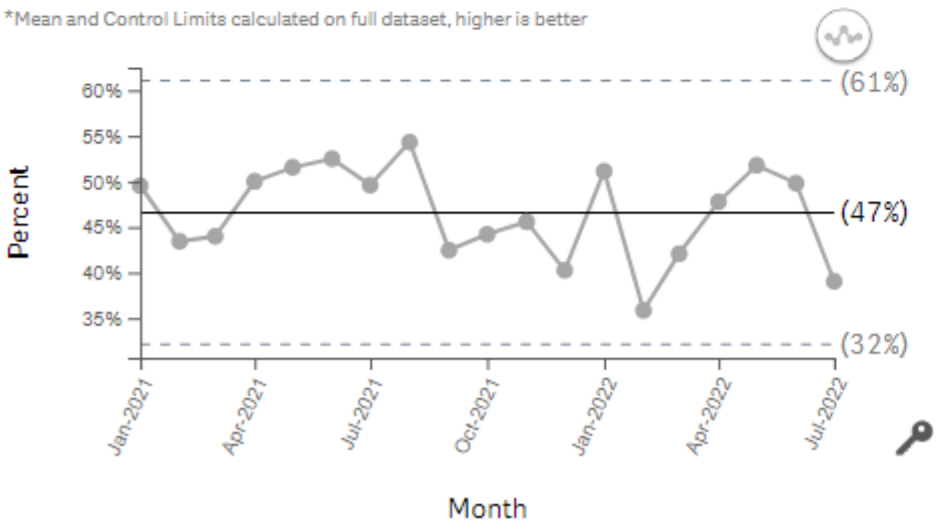
*Mean and Control Limits calculated on full dataset, higher is better



Latest
58.8%
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Nutrition & Hydration: Dietetics Referrals Compliance

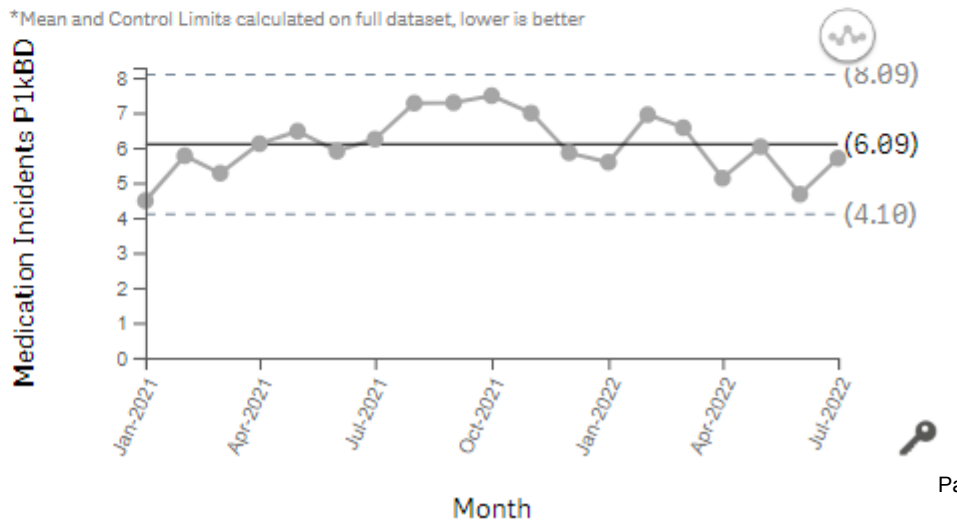
*Mean and Control Limits calculated on full dataset, higher is better



Latest
39%
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Medication Incidents Per 1,000 Bed Days

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



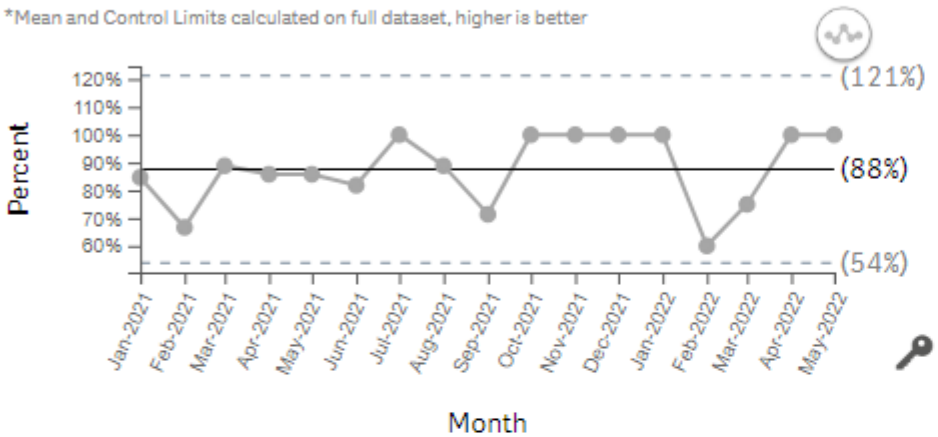
Latest
5.7
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Safety Investigations

University Hospitals of Morecambe Bay NHS Foundation Trust

Serious Incident Investigations Approved at First Panel

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

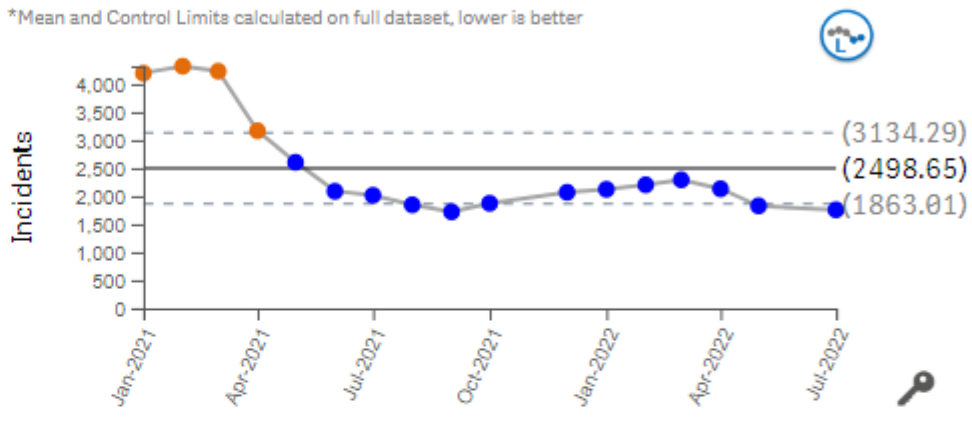


Latest
100%
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

*by month reported on StEIS & only includes where Final Report has been submiited. This is the reason for the time lag

Open & Overdue Incidents

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

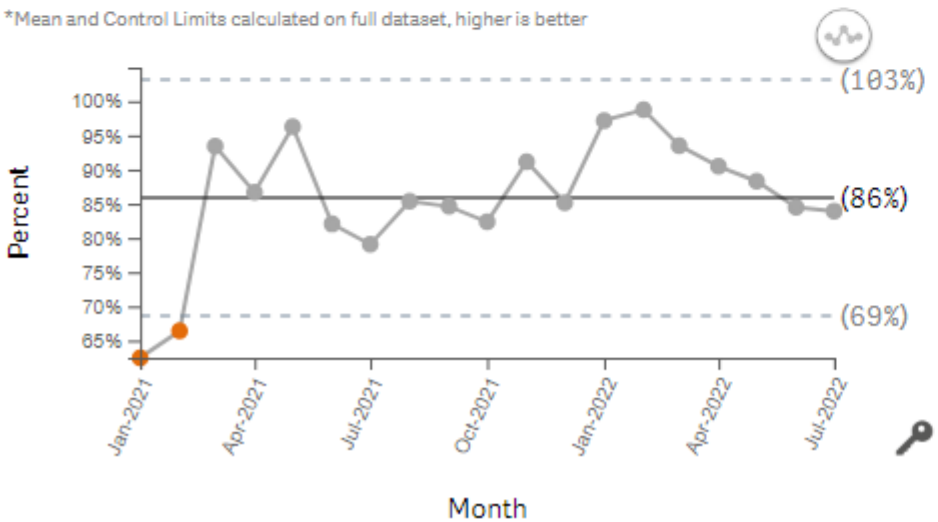


Latest
1,759
Variance Type
Special cause variation - improvement (indicator where low is good)
Target
N/A
Target Achievement
N/A

N.B. Due to a data capture issue Data for June 2022 is missing

Duty of Candour Completed Within Target

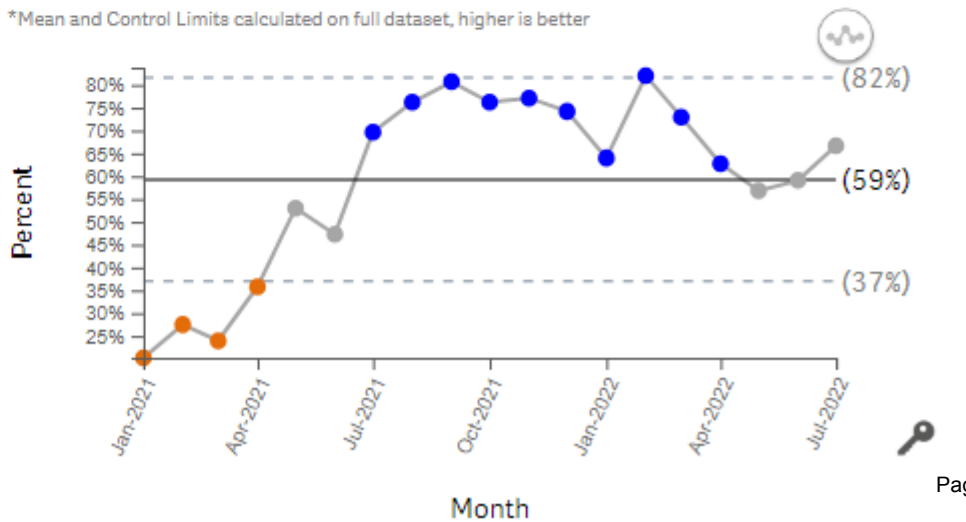
*Mean and Control Limits calculated on full dataset, higher is better



Latest
84%
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Investigations Where Author(s) Have Received RCA Training

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



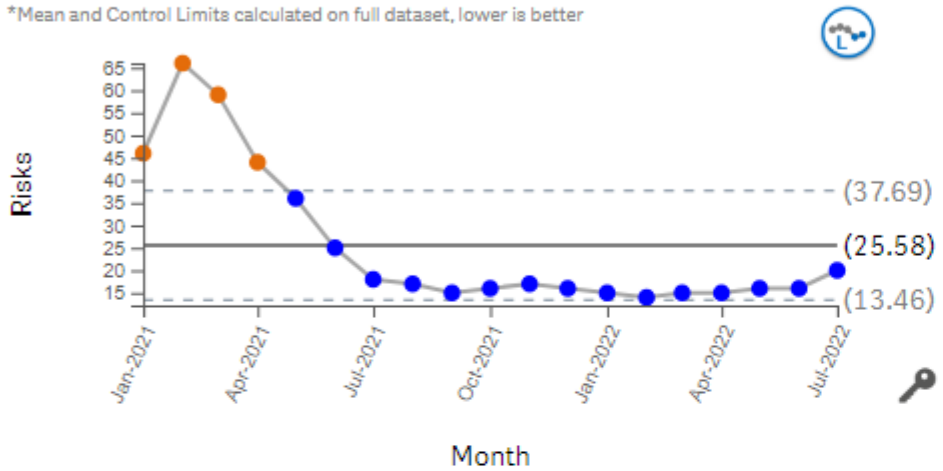
Latest
66.7%
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Risk - 1

University Hospitals of Morecambe Bay NHS Foundation Trust

Extreme Risks Remaining Extreme For 12 Or More Months

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

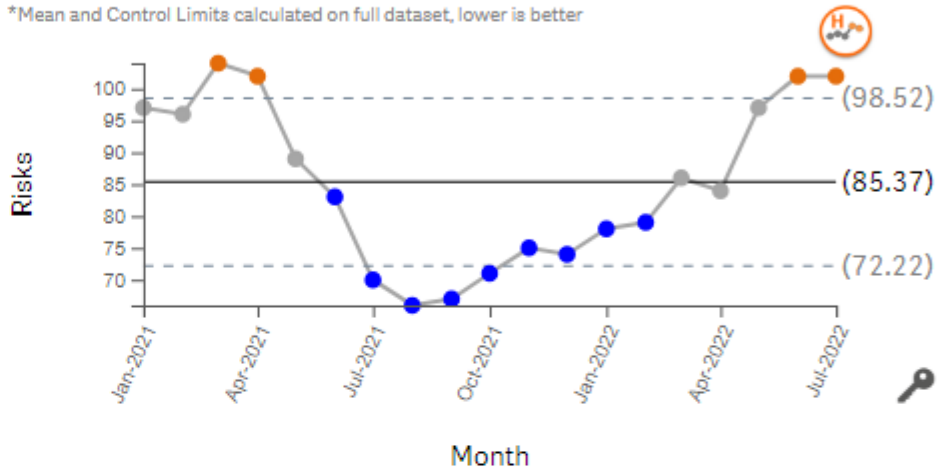


Latest
20
Variance Type
Special cause variation - improvement (indicator where low is good)
Target
N/A
Target Achievement
N/A

*Some risks are not wholly owned by the trust so will be beyond the ability of the trust to influence the score

Risks Remaining At The Same Risk Score For 12 Or More Months

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

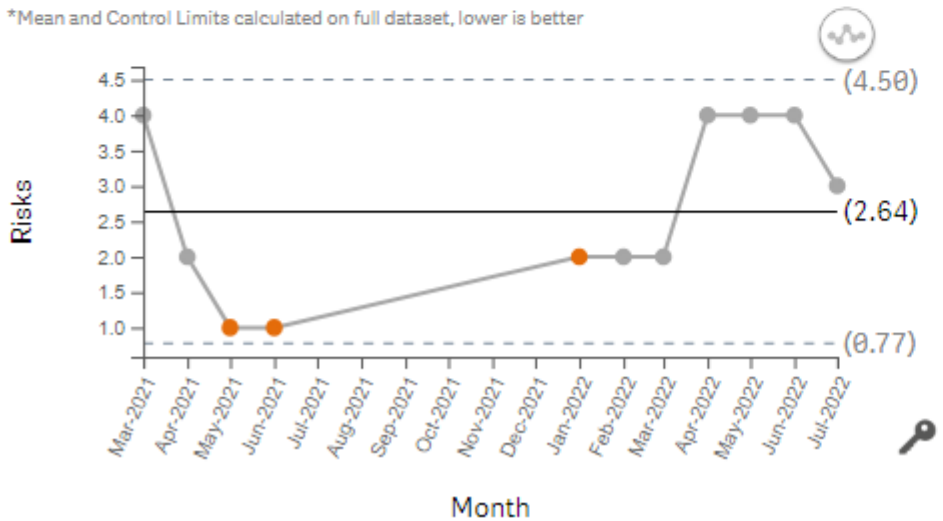


Latest
102
Variance Type
Special cause variation - cause for concern (indicator where high is a concern)
Target
N/A
Target Achievement
N/A

*Some risks are not wholly owned by the trust so will be beyond the ability of the trust to influence the score

Volume of Risks with a Score of 20 or 25 and a Severity of '5-Catastrophic'

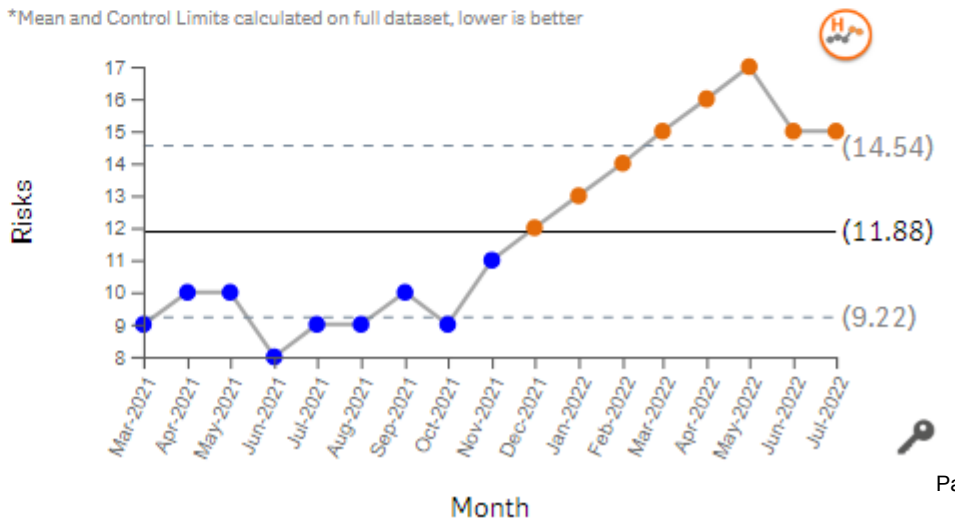
*Mean and Control Limits calculated on full dataset, lower is better



Latest
3
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Volume of Risks with a Score of 5, 10 or 15 and a Severity of '5-Catastrophic'

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



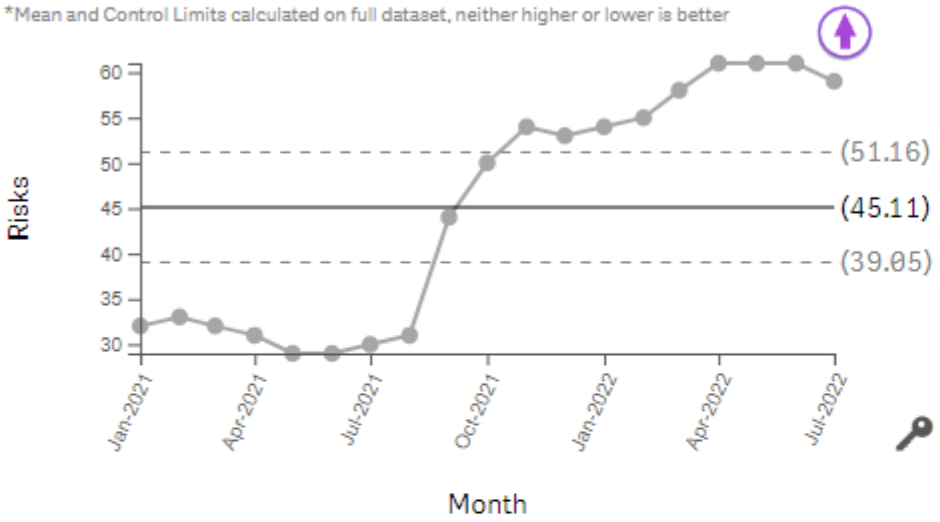
Latest
15
Variance Type
Special cause variation - cause for concern (indicator where high is a concern)
Target
N/A
Target Achievement
N/A

Risk - 2

University Hospitals of Morecambe Bay NHS Foundation Trust

Volume Of Tolerated Risks

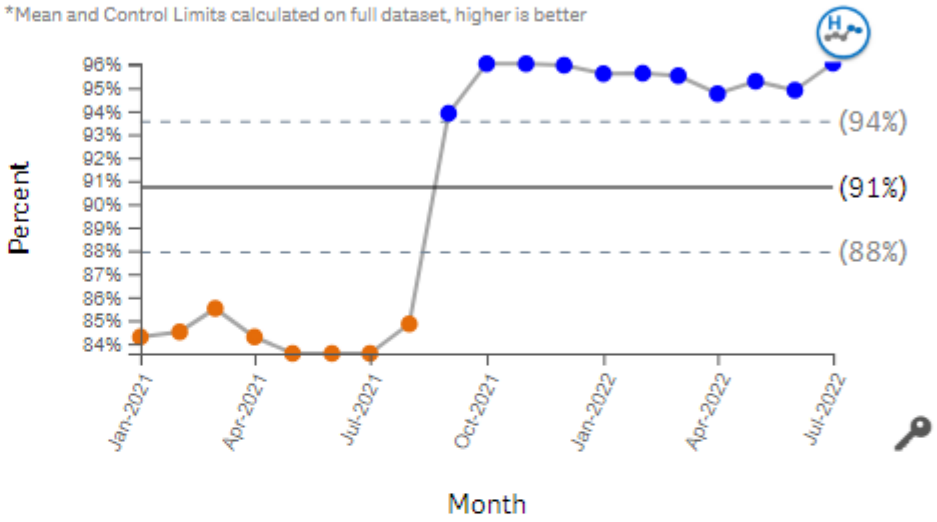
*Mean and Control Limits calculated on full dataset, neither higher or lower is better



Latest
59
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Compliance to Risk Management Training

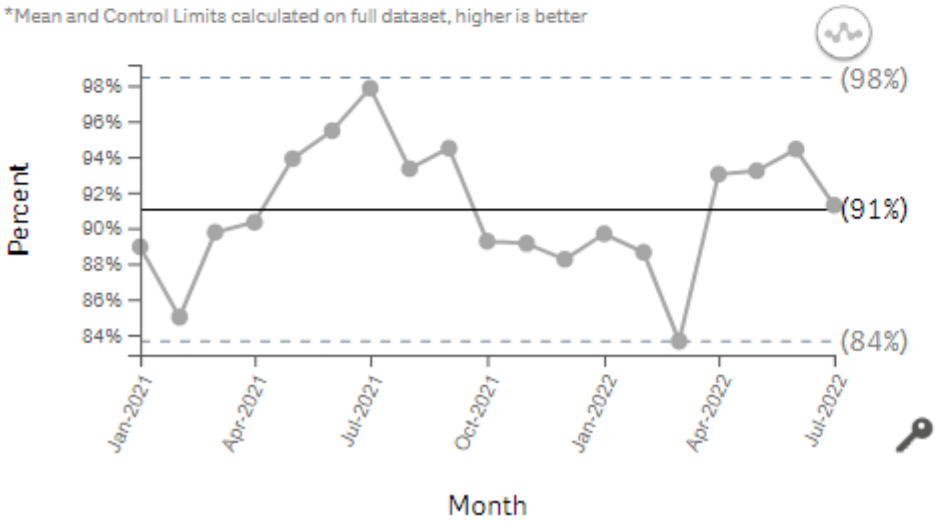
*Mean and Control Limits calculated on full dataset, higher is better



Latest
96.1%
Variance Type
Special cause variation - improvement (indicator where high is good)
Target
N/A
Target Achievement
N/A

Risk Reviews Completed On Time

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



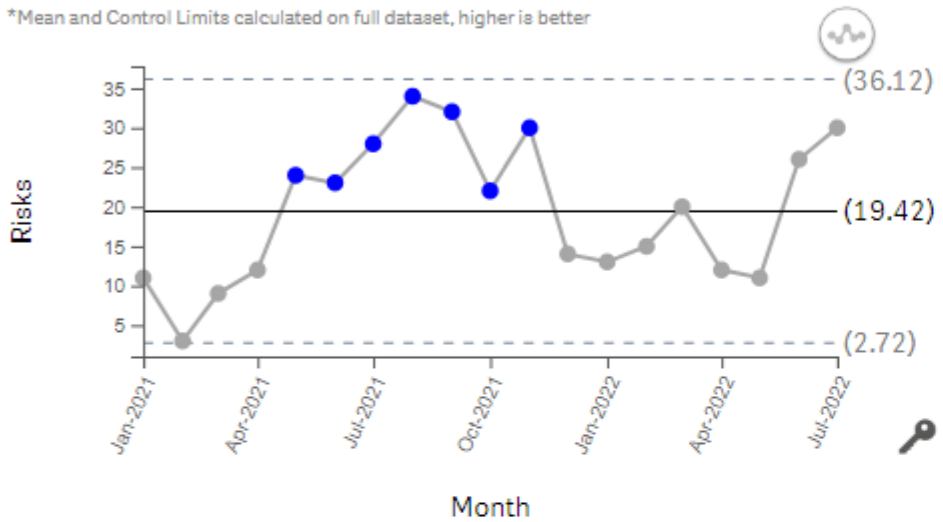
Latest
91.3%
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Risk - 3

University Hospitals of Morecambe Bay NHS Foundation Trust

Volume Of New Risks By Month

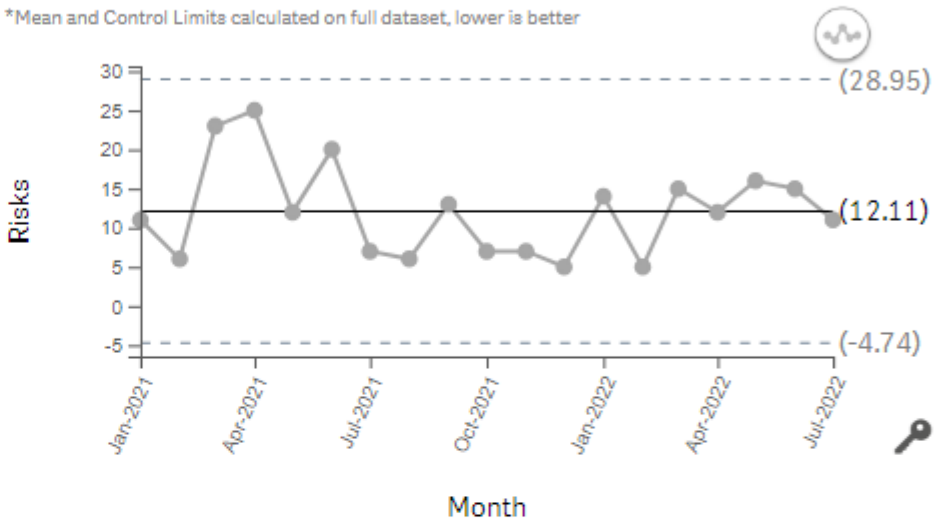
*Mean and Control Limits calculated on full dataset, higher is better



Latest
30
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Volume Of Closed Risks By Month

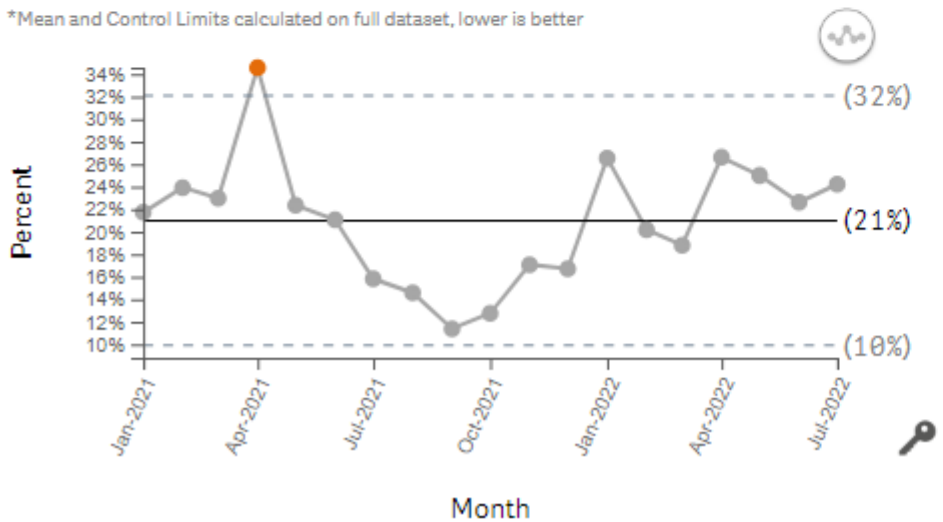
*Mean and Control Limits calculated on full dataset, lower is better



Latest
11
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Risks Beyond Target Completion Date

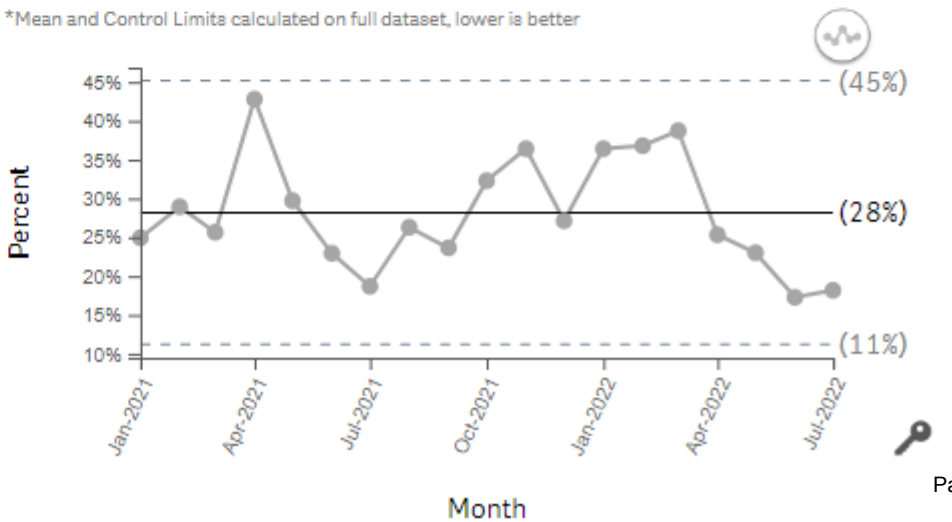
*Mean and Control Limits calculated on full dataset, lower is better



Latest
24.2%
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Risk Actions Beyond Target Completion Date

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



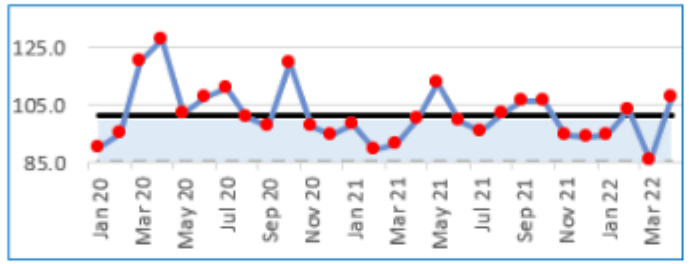
Latest
18.2%
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Mortality - 1

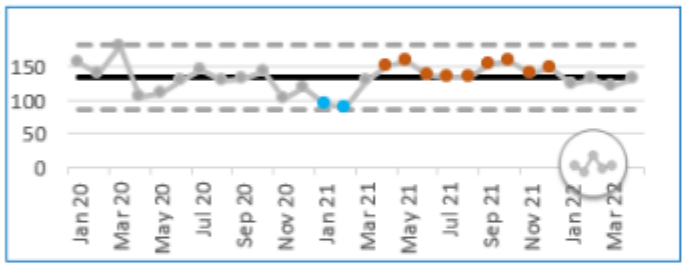
University Hospitals of Morecambe Bay NHS Foundation Trust

Summary Hospital-level Mortality Indicator

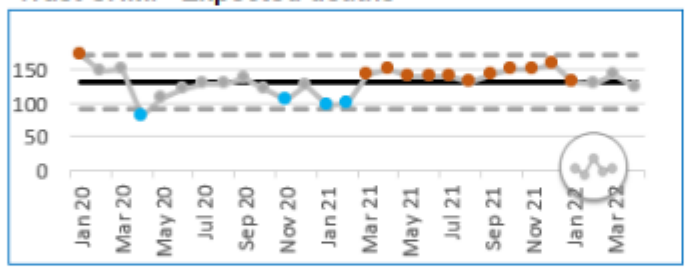
Latest month	Apr 22
SHMI	107.74
Observed deaths	132
Expected deaths	123



Trust SHMI - Observed deaths

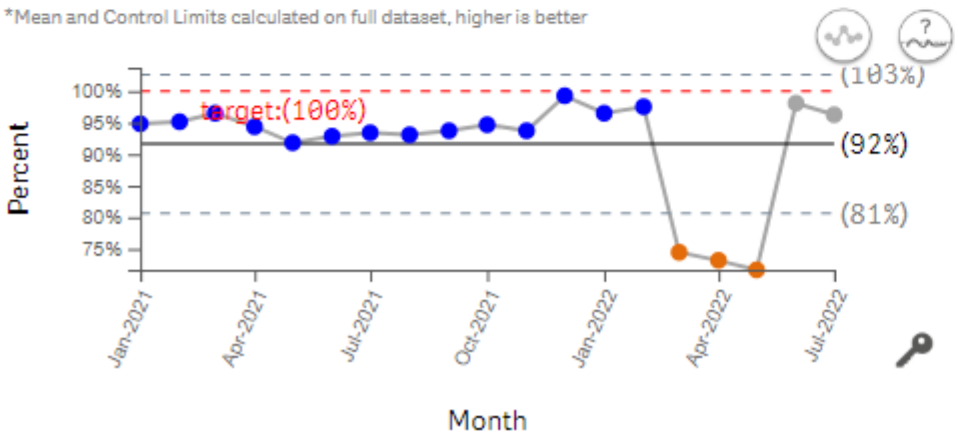


Trust SHMI - Expected deaths



Hospital Deaths Scrutinised by Medical Examiner

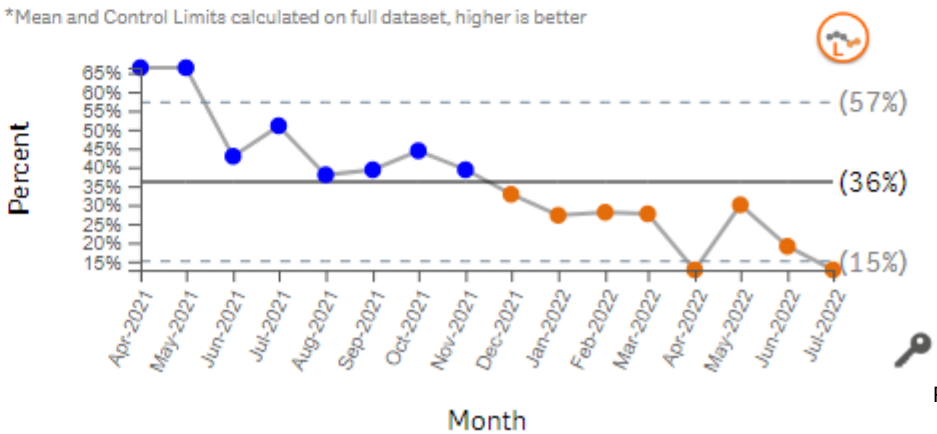
*Mean and Control Limits calculated on full dataset, higher is better



Latest
96%
Variance Type
Common cause variation
Target
100%
Target Achievement
The system may achieve or fail the target subject to

Hospital Deaths Receiving a Mortality Review

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



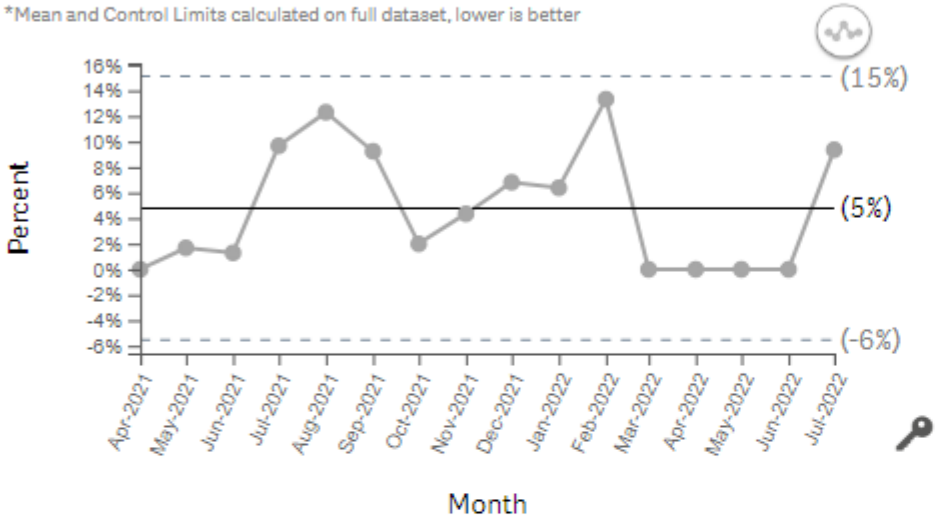
Latest
13%
Variance Type
Special cause variation - cause for concern (indicator where low is a concern)
Target
N/A
Target Achievement

Mortality - 2

University Hospitals of Morecambe Bay NHS Foundation Trust

Mortality Review: HOGAN (preventability of death) - Possibly or Probably Preventa...

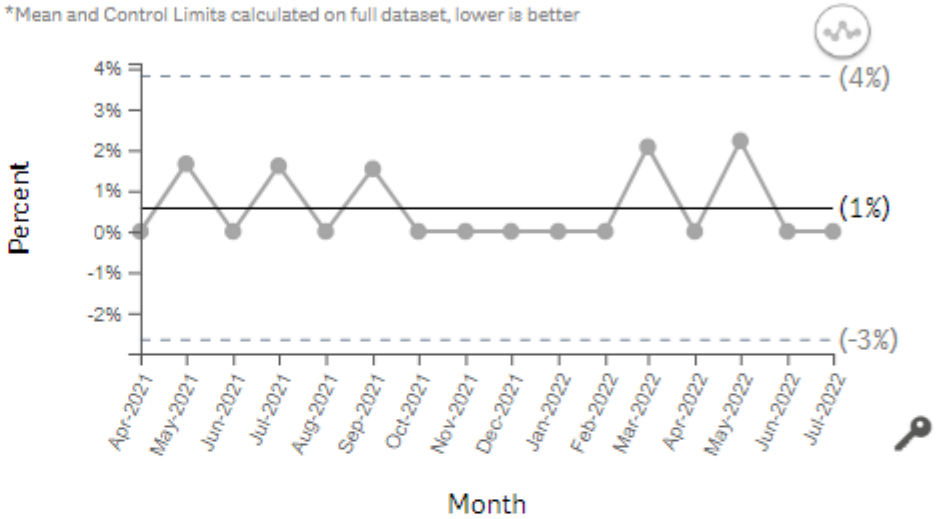
*Mean and Control Limits calculated on full dataset, lower is better



Latest
9%
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Mortality Review: HOGAN (preventability of death) - Strong Evidence For or Defini...

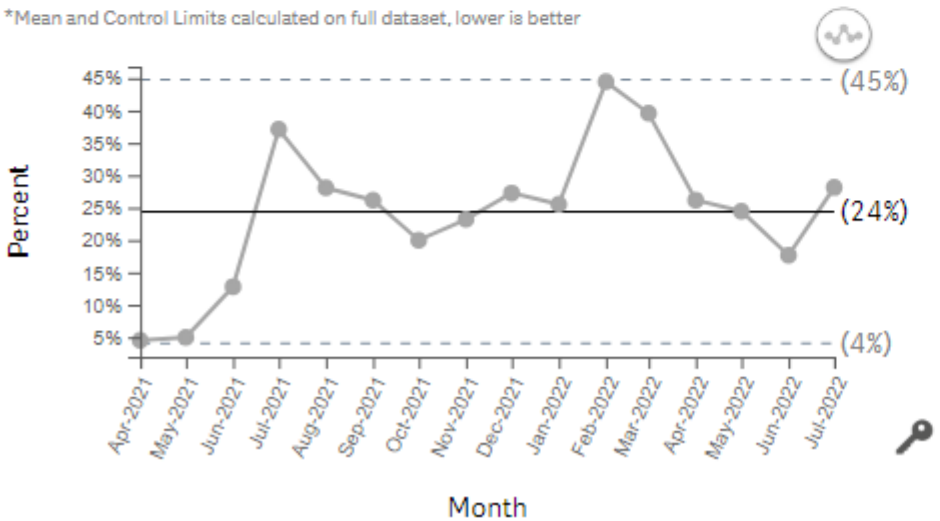
*Mean and Control Limits calculated on full dataset, lower is better



Latest
0%
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Mortality Review: NECPOD (quality of care) - Room For Improvement

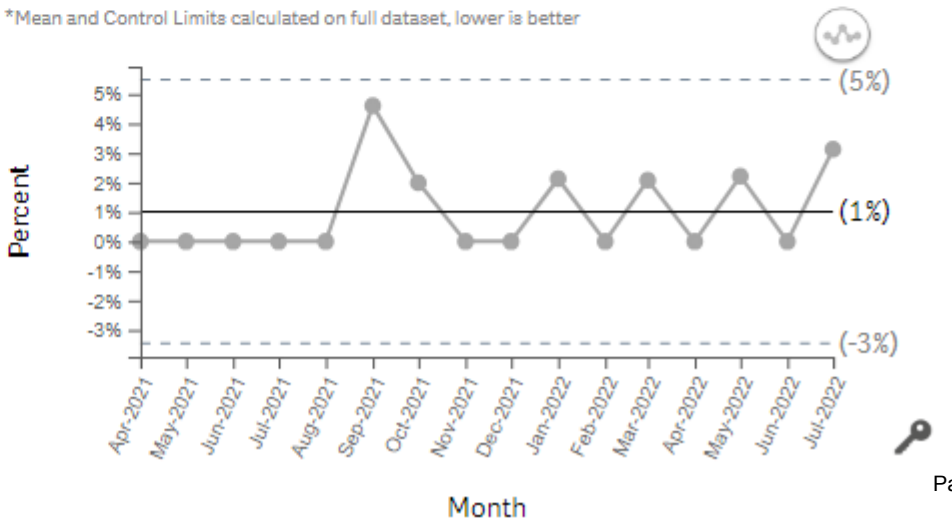
*Mean and Control Limits calculated on full dataset, lower is better



Latest
28%
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Mortality Review: NECPOD (quality of care) - Less than Satisfactory

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



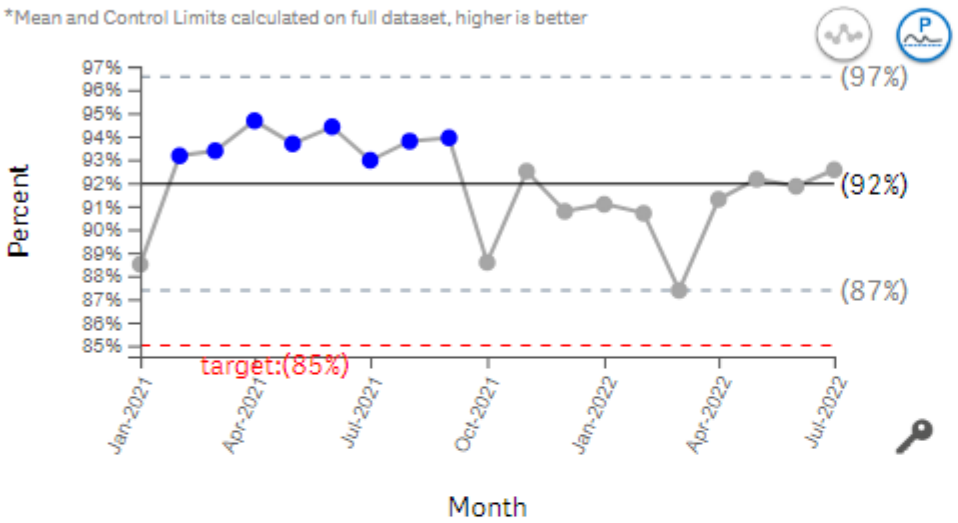
Latest
3%
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Safer Staffing

University Hospitals of Morecambe Bay NHS Foundation Trust

Registered Nurse Fill Rate

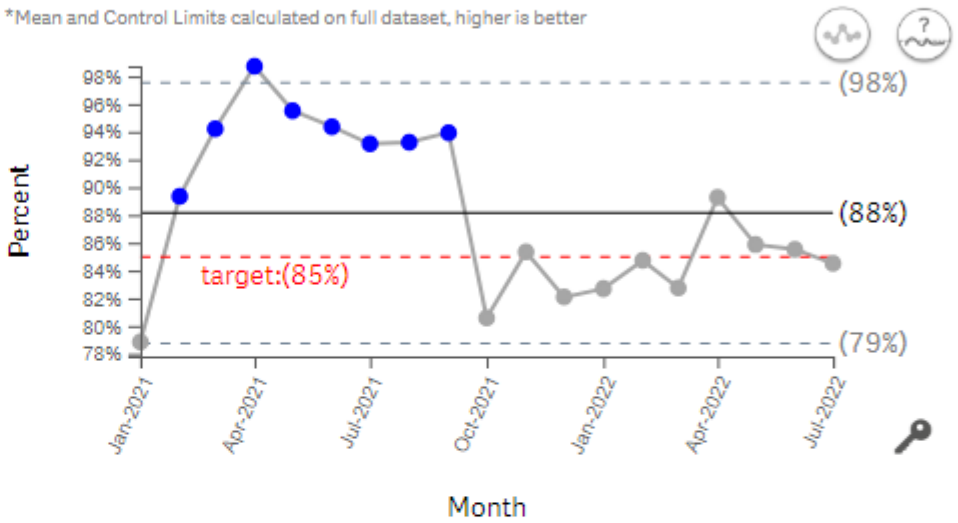
*Mean and Control Limits calculated on full dataset, higher is better



Latest
92.6%
Variance Type
Common cause variation
Target
85%
Target Achievement
The system is expected to consistently pass the target

Clinical Support Worker Fill Rate

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



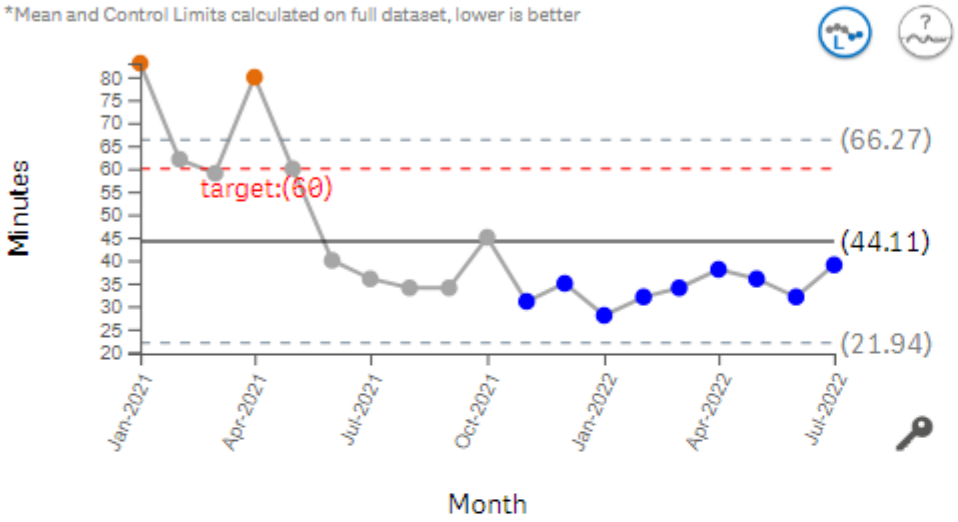
Latest
84.5%
Variance Type
Common cause variation
Target
85%
Target Achievement
The system may achieve or fail the target subject to random variation

Stroke - 1

University Hospitals of Morecambe Bay NHS Foundation Trust

Median Arrival Time to Scan (mins)

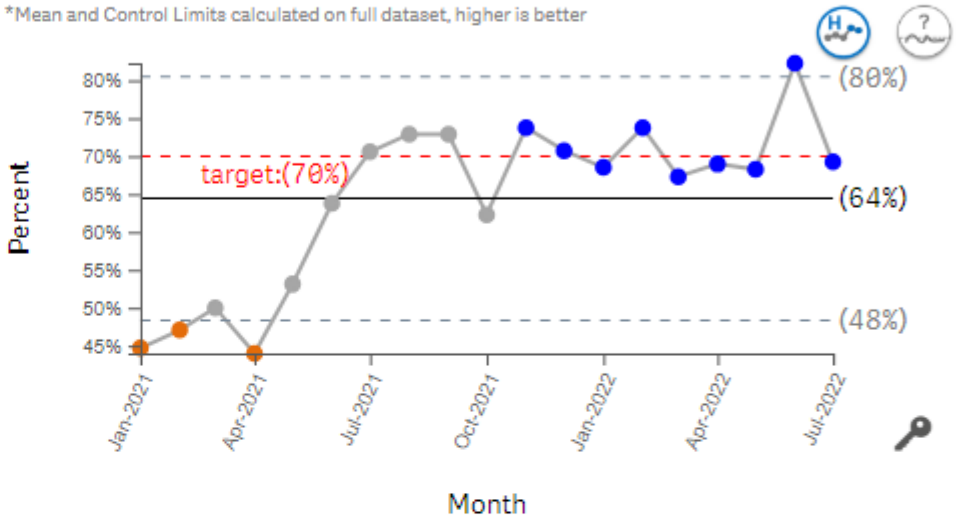
*Mean and Control Limits calculated on full dataset, lower is better



Latest
39
Variance Type
Special cause variation - improvement (indicator where low is good)
Target
60
Target Achievement
The system may achieve or fail the target subject to

CT Scan Within 1hr

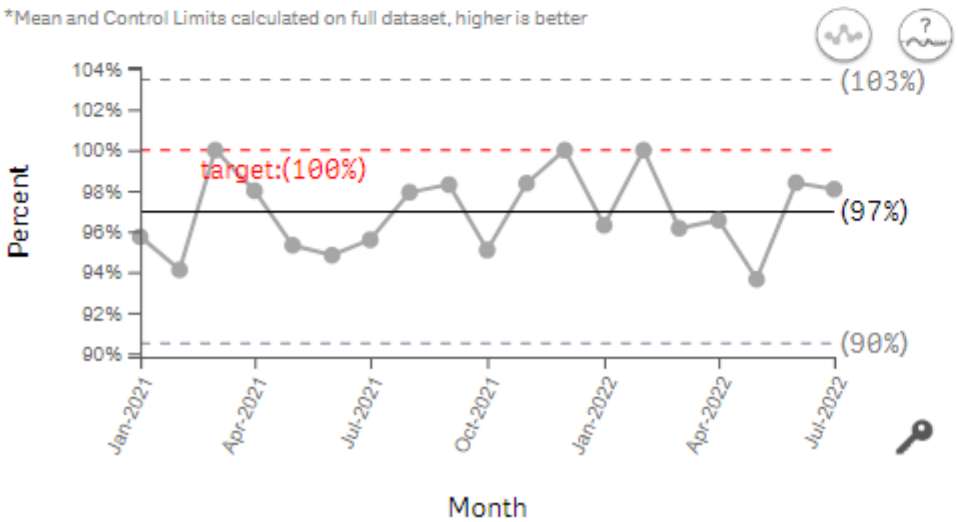
*Mean and Control Limits calculated on full dataset, higher is better



Latest
69.2%
Variance Type
Special cause variation - improvement (indicator where high is good)
Target
70%
Target Achievement
The system may achieve or fail the target subject to

CT Scan Within 12hrs

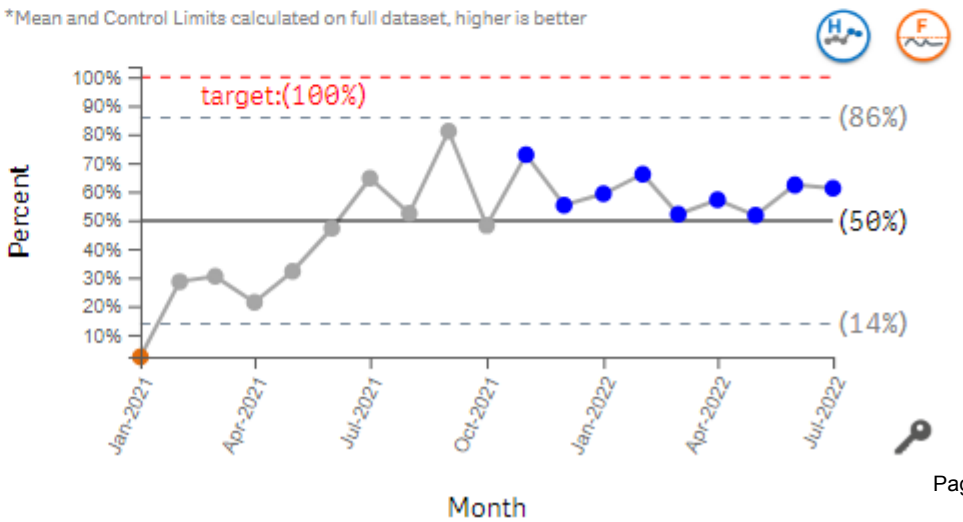
*Mean and Control Limits calculated on full dataset, higher is better



Latest
98.1%
Variance Type
Common cause variation
Target
100%
Target Achievement
The system may achieve or fail the target subject to random variation

Admitted to Stroke Unit within 4hrs

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



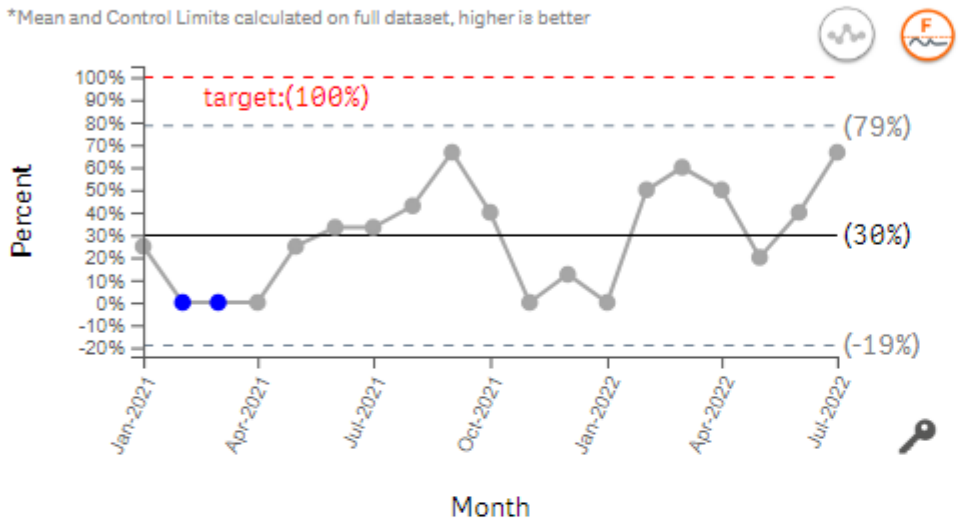
Latest
61.2%
Variance Type
Special cause variation - improvement (indicator where high is good)
Target
100%
Target Achievement
The system is expected to consistently fail the

Stroke - 2

University Hospitals of Morecambe Bay NHS Foundation Trust

Thrombolysed within 1hr

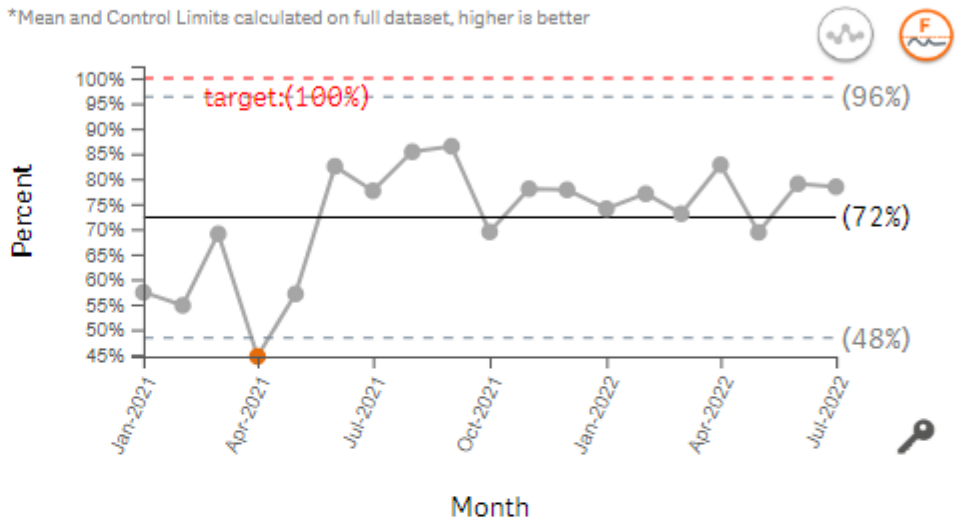
*Mean and Control Limits calculated on full dataset, higher is better



Latest
66.7%
Variance Type
Common cause variation
Target
100%
Target Achievement
The system is expected to consistently fail the target

Swallow Screened within 4hrs

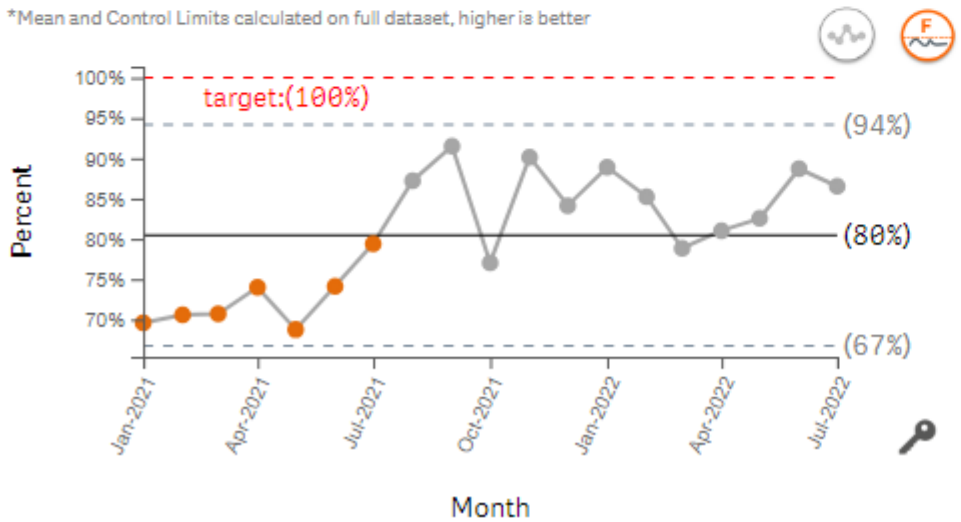
*Mean and Control Limits calculated on full dataset, higher is better



Latest
78.4%
Variance Type
Common cause variation
Target
100%
Target Achievement
The system is expected to consistently fail the target

Assessed by Stroke Consultant within 24h

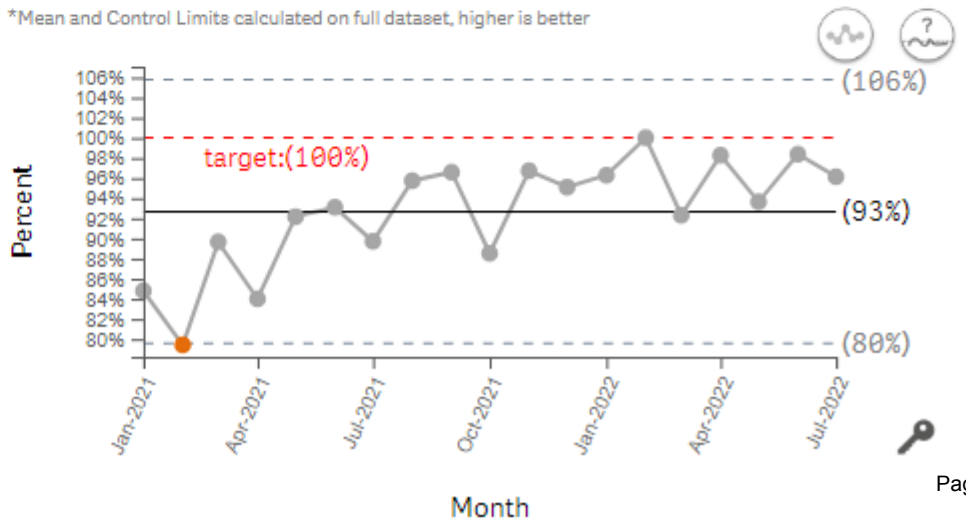
*Mean and Control Limits calculated on full dataset, higher is better



Latest
86.5%
Variance Type
Common cause variation
Target
100%
Target Achievement
The system is expected to consistently fail the target

Assessed by Specialist Nurse within 24hr

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



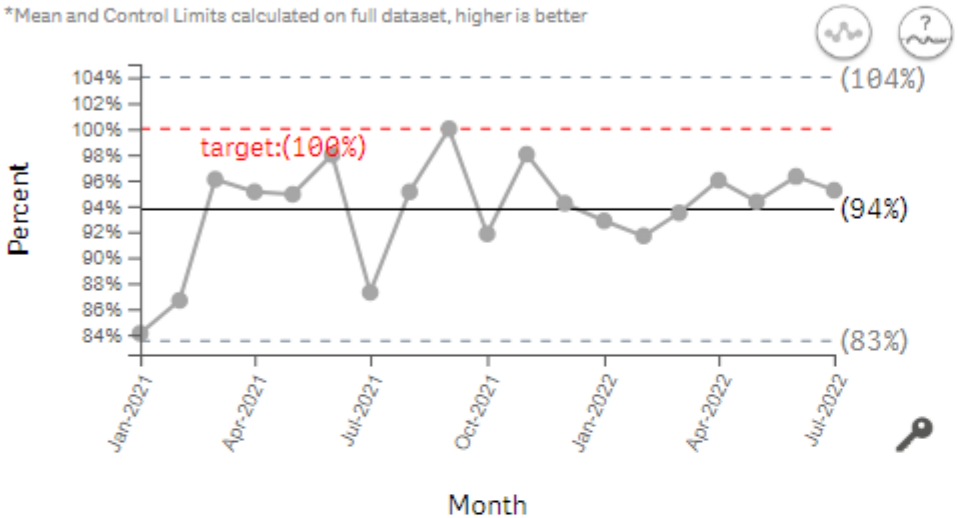
Latest
96.2%
Variance Type
Common cause variation
Target
100%
Target Achievement
The system may achieve or fail the target subject to random variation

Stroke - 3

University Hospitals of Morecambe Bay NHS Foundation Trust

Occupational Therapy Assessment within 72h

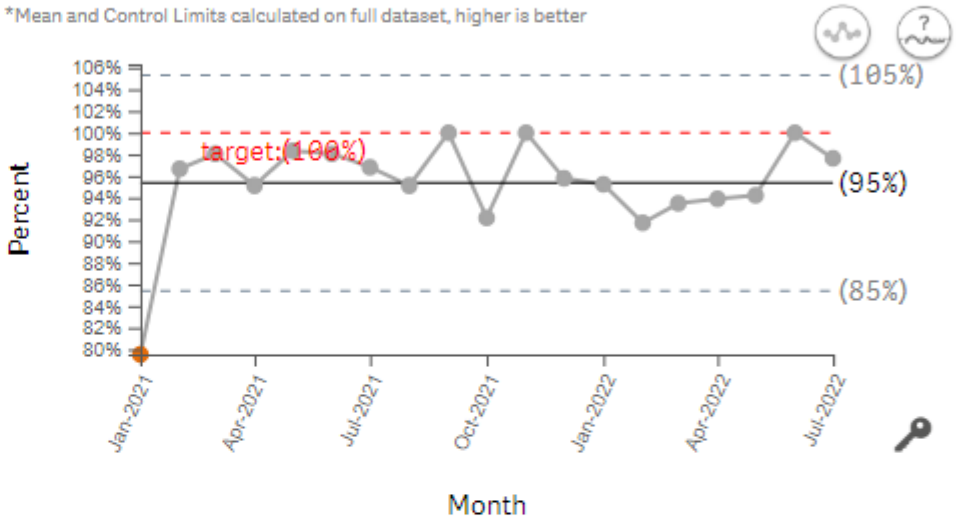
*Mean and Control Limits calculated on full dataset, higher is better



Latest
95.2%
Variance Type
Common cause variation
Target
100%
Target Achievement
The system may achieve or fail the target subject to random variation

Physiotherapy Assessment within 72h

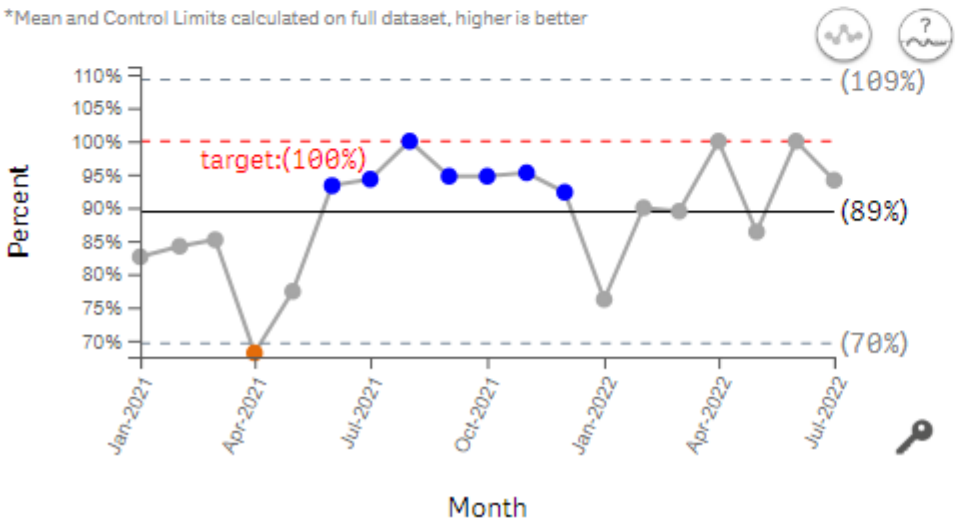
*Mean and Control Limits calculated on full dataset, higher is better



Latest
97.6%
Variance Type
Common cause variation
Target
100%
Target Achievement
The system may achieve or fail the target subject to random variation

Speech & Language Therapist Assessment within 72hrs

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



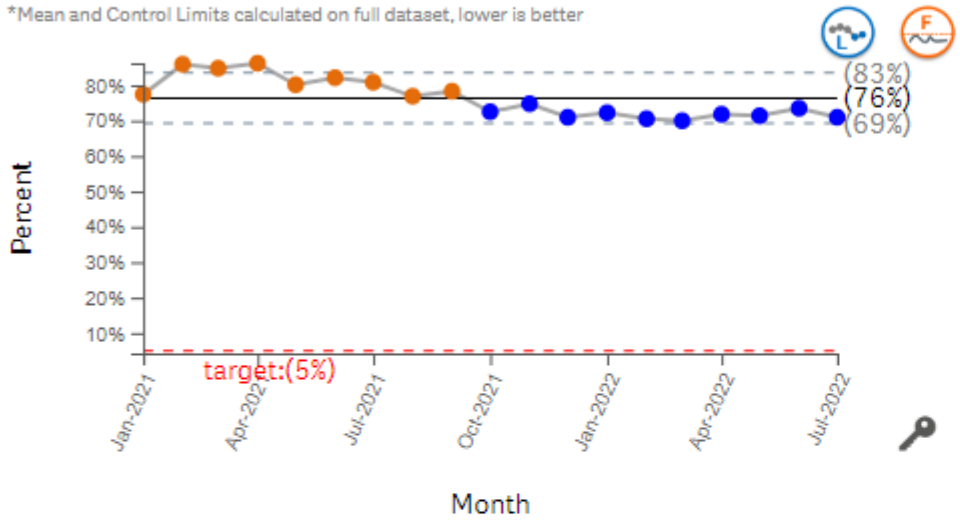
Latest
94.1%
Variance Type
Common cause variation
Target
100%
Target Achievement
The system may achieve or fail the target subject to random variation

Urgent & Emergency Care - 1

University Hospitals of Morecambe Bay NHS Foundation Trust

ED 4 hrs (%)

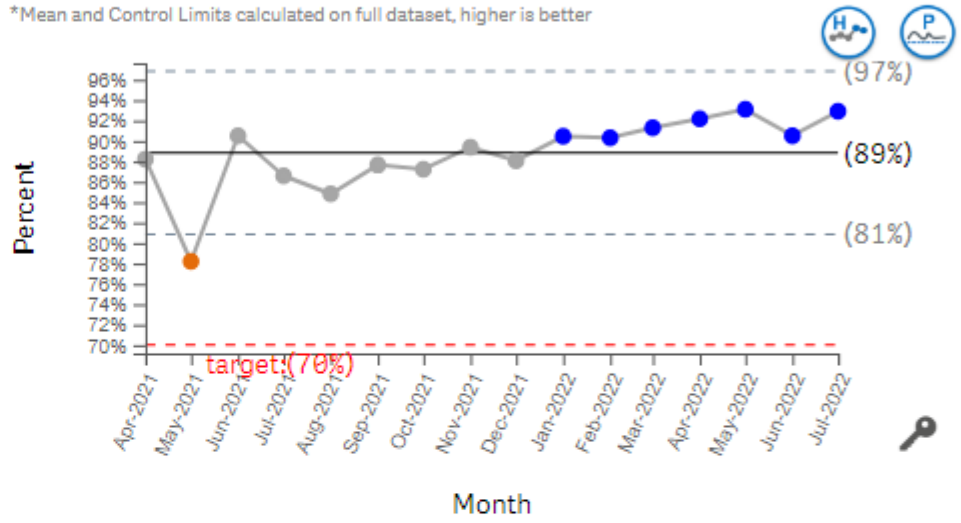
*Mean and Control Limits calculated on full dataset, lower is better



Latest
70.9%
Variance Type
Special cause variation - improvement (indicator where low is good)
Target
5%
Target Achievement
The system is expected to consistently fail the

2 hour Urgent Community Response

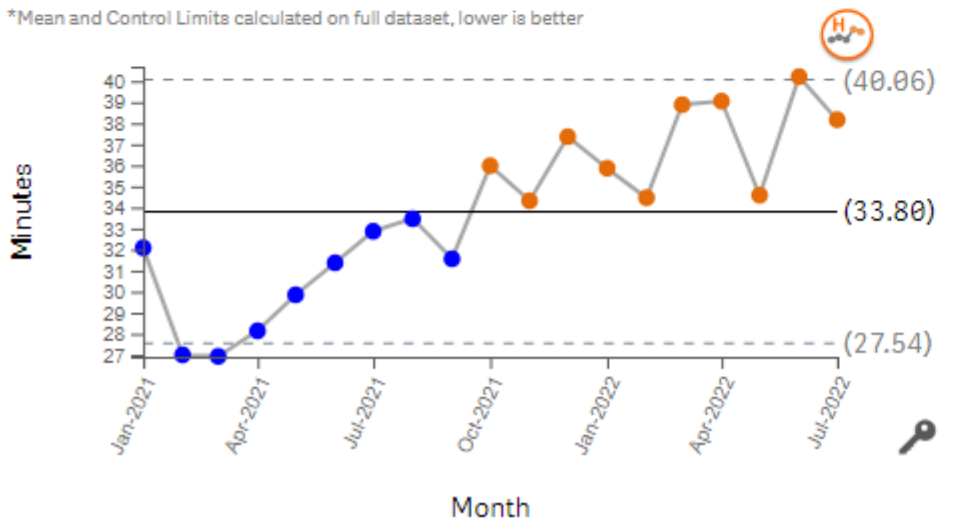
*Mean and Control Limits calculated on full dataset, higher is better



Latest
92.9%
Variance Type
Special cause variation - improvement (indicator where high is good)
Target
70%
Target Achievement
The system is expected to consistently pass the

Ambulance Average Turnaround Time (mins)

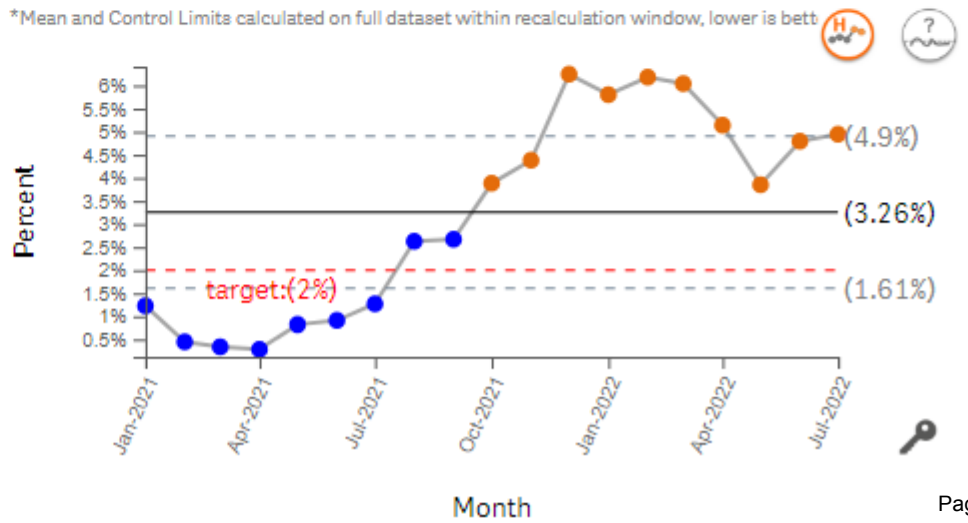
*Mean and Control Limits calculated on full dataset, lower is better



Latest
38.2
Variance Type
Special cause variation - cause for concern (indicator where high is a concern)
Target
N/A
Target Achievement
N/A

Patients Spending over 12 hours in A&E

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



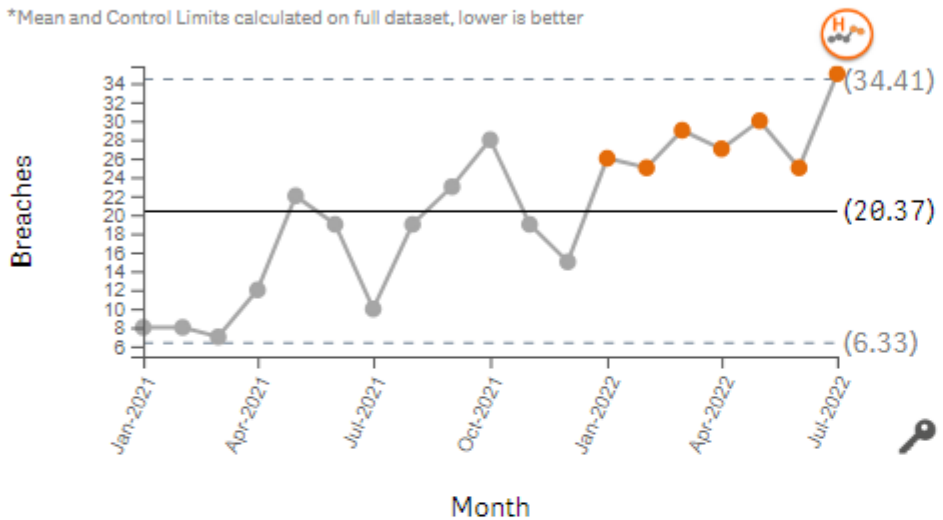
Latest
4.9%
Variance Type
Special cause variation - cause for concern (indicator where high is a concern)
Target
2%
Target Achievement
The system may achieve or fail the target subject to

Urgent & Emergency Care - 2

NHS
University Hospitals of Morecambe Bay
NHS Foundation Trust

Patients Spending over 12 hours in ED: Mental Health Reasons

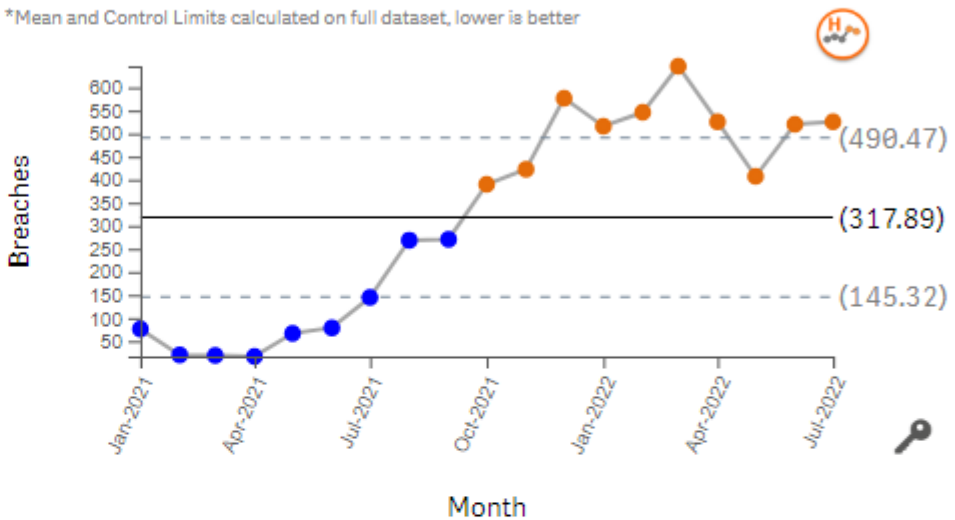
*Mean and Control Limits calculated on full dataset, lower is better



Latest
35
Variance Type
Special cause variation - cause for concern (indicator where high is a concern)
Target
N/A
Target Achievement
N/A

Patients Spending over 12 hours in ED: Physical Health Reasons

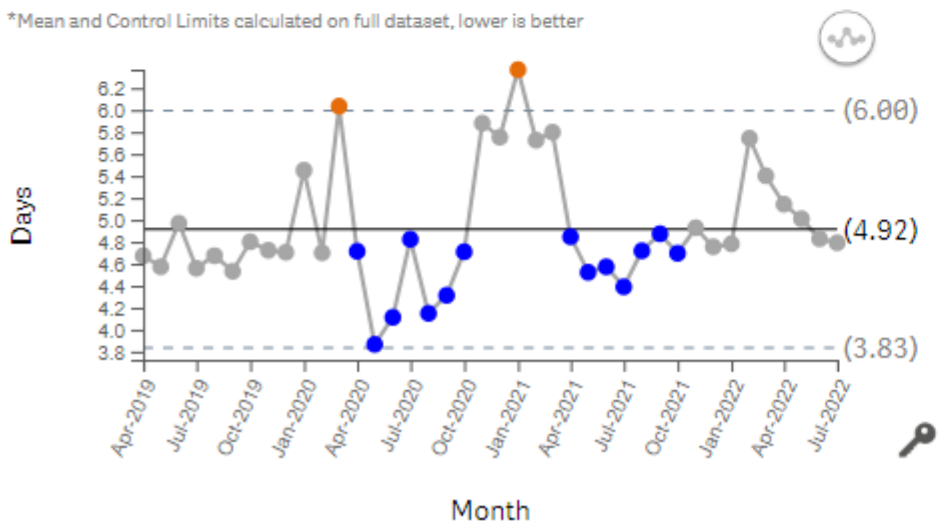
*Mean and Control Limits calculated on full dataset, lower is better



Latest
526
Variance Type
Special cause variation - cause for concern (indicator where high is a concern)
Target
N/A
Target Achievement
N/A

Non Elective - Average Length of Stay

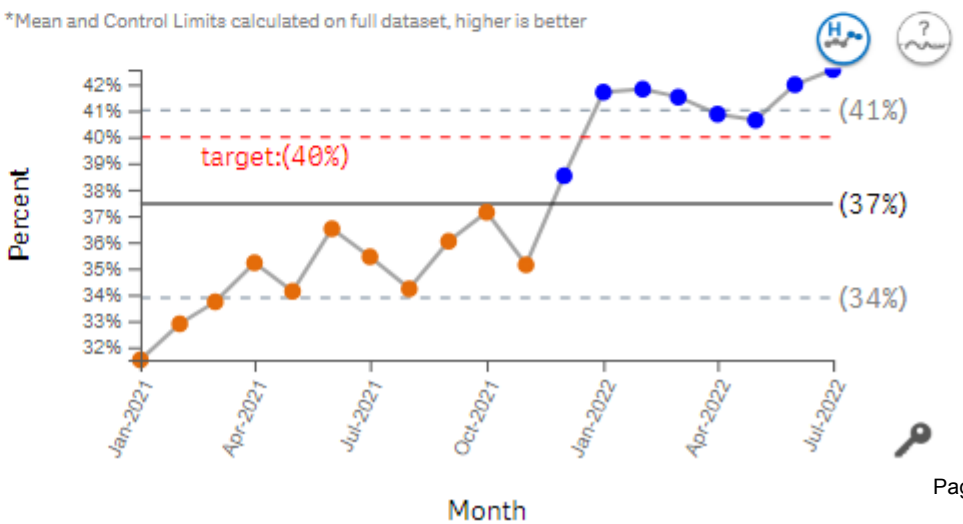
*Mean and Control Limits calculated on full dataset, lower is better



Latest
4.8
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

SDEC - Percent 0 Day LOS

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



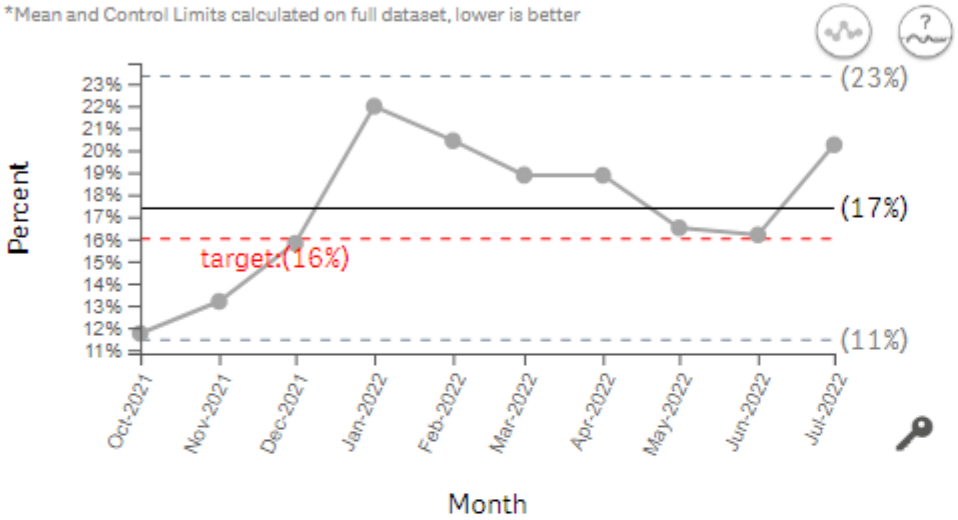
Latest
42.6%
Variance Type
Special cause variation - improvement (indicator where high is good)
Target
40%
Target Achievement
The system may achieve or fail the target subject to

Urgent & Emergency Care - 3

University Hospitals of Morecambe Bay NHS Foundation Trust

NMC2R - Percent of G&A Beds

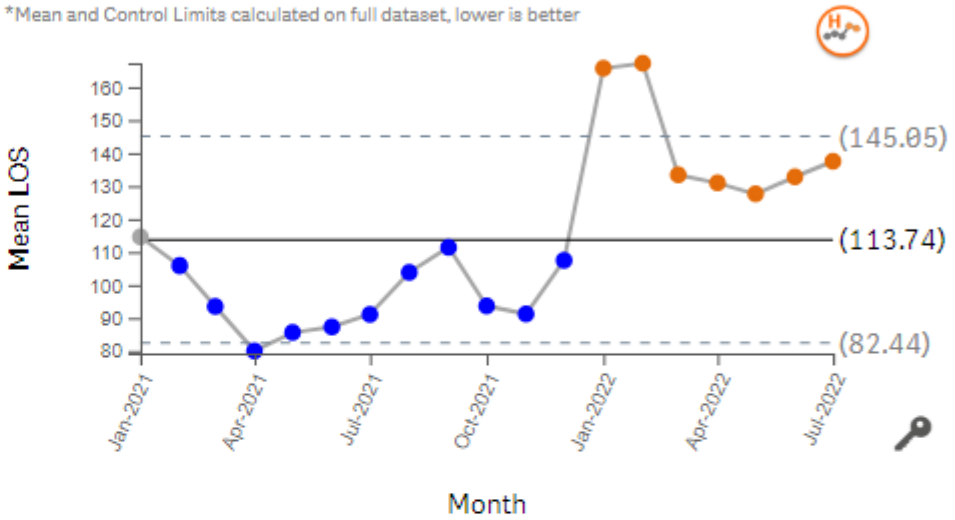
*Mean and Control Limits calculated on full dataset, lower is better



Latest
20.3%
Variance Type
Common cause variation
Target
16%
Target Achievement
The system may achieve or fail the target subject to random variation

NMC2R - 21 Day LOS Mean Value

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



Latest
138
Variance Type
Special cause variation - cause for concern (indicator where high is a concern)
Target
N/A
Target Achievement
N/A

CQC/RCS Improvement Plan Dashboards

Table1: Summary of Recommendation Allocation by Trust Care Group

Report	Trust Wide / Corporate	Medicine	Surgery	WACs	Community	Core Clinical Services	Total
RCS	0	0	7	0	0	0	**7**
CQC Must Do	7	37	1	14	0	3	**61**
CQC Should Do	0	31	6	10	0	4	**51**
Total	**7**	**68**	**14**	**24**	**0**	**7**	**119**

Table2: Summary of Recommendation Allocation by Trust Tier 1 (Committee) Meeting

Report	Trust Management Group	Audit Committee	Finance Committee	People Committee	Quality Assurance Committee	Total
RCS	0	0	0	2	5	**7**
CQC Must Do	10	0	0	8	43	**61**
CQC Should Do	9	0	3	10	29	**51**
Total	**19**	**0**	**3**	**20**	**77**	**119**

Table3: Summary of Recommendation Allocation by UHMBT Theme and Remits of Tier 1 Meetings

Tier 1 Meeting	UHMBT Theme	RCS	CQC Must Do	CQC Should Do	Grand Total
Finance & Performance Committee	Estates			1	1
	Information Governance			2	2
People Committee	Culture and Leadership		2	1	3
	Staffing: Appraisal and CSF Training	1		3	4
	Staffing: Health and Wellbeing			1	1
	Staffing: Non-CSF Training	1	3	1	5
	Staffing: Staffing Numbers		3	4	7
Trust Management Group	Clinical Governance		2		2
	Culture and Leadership			1	1
	Estates		1	5	6
	Maternity Services			1	1
	Operational Performance		3	1	4
	Safeguarding		2	1	3
	Stroke Services		2		2

Tier 1 Meeting	UHMBT Theme	RCS	CQC Must Do	CQC Should Do	Grand Total
Quality Assurance Committee	Clinical Governance	2	9	3	14
	Clinical Strategy		1	1	2
	Consent	1			1
	Corporate Governance		2		2
	EPR/Patient Records		1	1	2
	Estates			1	1
	Fundamental Care Standards		6	4	10
	Infection Prevention		1	3	4
	Information Governance		1	1	2
	Maternity Services		3	1	4
	Medicines Management		5	7	12
	Mental Capacity/Mental Health		2	2	4
	Operational Performance		2	1	3
	Patient Dignity and Respect		3	1	4
	Performance Monitoring & Reporting			1	1
	Safeguarding		1	1	2
	Sepsis		1		1
	Service Design and Delivery	2		1	3
	Staffing: Staffing Numbers		2		2
	Stroke Services		3		3

Table 4: Recommendations by Tier 1 (Committee) Meeting - alphabetical order of meeting

Report	Ref.	Tier 1 Meeting	Recommendations
CQC August 2021	SD65	Finance & Performance Committee	The trust should ensure patient records are stored securely.
CQC August 2021	SD103	Finance & Performance Committee	The trust should ensure that all records are securely stored
CQC August 2021	MD5	People Committee	The trust must continue to make improvements in the culture of the organisation, especially within maternity and trauma and orthopaedics, to enable staff to be supported to perform their duties effectively. (Regulation 18 (2) (a))
CQC August 2021	MD20	People Committee	The trust must improve the multidisciplinary working and culture between the department and specialities and speciality teams to maximise patient care and outcomes. (Regulation 12 (2) (i); Regulation 17 (2) (a))
CQC August 2021	MD52	People Committee	The trust must ensure all relevant staff have completed Paediatric Advanced Life Support when supporting paediatric provision in the emergency department. (Regulation 12(1)(2)(i))
CQC August 2021	MD53	People Committee	The trust must review the service's paediatric staffing provision, including the environment they wait in and the paediatric nursing and medical cover in line with The Royal College of Paediatrics and Child Health (RCPCH) Standards for Children and Young People in Emergency settings (2012) (Regulation 18(1))
CQC August 2021	MD66	People Committee	The service must ensure there are sufficient maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. (Regulation 18 (1)(2)(a))
CQC August 2021	MD92	People Committee	The service must ensure they deploy sufficient suitably competent and experienced staff and ensure all staff receive appropriate skills and drills training and professional development to enable them to maintain competency given the low numbers of deliveries. (Regulation 18 (1) (2) (a))
CQC August 2021	MD98	People Committee	The service must ensure nurse staffing levels meet the minimum standards of the National Institute of Health and Care Excellence. Regulation 18 (1): Staffing.
CQC August 2021	MD99	People Committee	The service must ensure medical staffing levels meet the minimum standards of the Royal College of Physicians. Regulation 18 (1): Staffing
CQC August 2021	SD34	People Committee	The trust should take appropriate actions to improve staff mandatory training, including safeguarding training in line with trust compliance targets.
CQC August 2021	SD35	People Committee	The trust should take appropriate actions to improve staff appraisal completion in line with trust compliance targets
CQC August 2021	SD93	People Committee	The service should consider protected time to allow for the completion of mandatory training
CQC August 2021	SD95	People Committee	The service should work to engage the workforce and increase visibility of the executive team

CQC July 2022	SD118	People Committee	The trust should continue to actively seek a suitable candidate for recruitment to its stroke consultant vacancy. (Regulation 12)
CQC July 2022	SD123	People Committee	The trust should ensure that the minors waiting area and the paediatric provision of the department has sufficient staffing and patient oversight after 5PM. Regulation 12(2)(a)
CQC July 2022	SD124	People Committee	The trust should consider a system to monitor staff wellbeing in relation to usage of bank and agency, to assist in the prevention of staff burnout
CQC July 2022	SD132	People Committee	The service should consider reviewing the advanced paediatric life support to make sure that all band 6 staff have the correct qualification
CQC July 2022	SD134	People Committee	The service should review the staffing levels within ACU and SDEC ensuring that staffing levels are maintained and risks to staffing establishment captured and monitored.
CQC July 2022	SD136	People Committee	The service should continue with plans to improve staffing levels medical staff to full establishment.
RCS	MD1	People Committee	Actions the Trust Must take to ensure patient safety is protected: A review of redacted clinical activity in performing unicompartmental knee replacements is required given the review may indicate an insufficient number of these procedures being undertaken to maintain the appropriate skill set required for the techniques involved.
RCS	MD2	People Committee	Actions the Trust Must take to ensure patient safety is protected: Assure evidence of redacted training in anterior approach surgery before further anterior approach hip replacements are performed.
CQC August 2021	MD1	Quality Assurance Committee	The trust must ensure that governance processes are robust and effective (Regulation 17 (1))
CQC August 2021	MD3	Quality Assurance Committee	The trust must ensure that incidents are identified, graded appropriately to reflect the level of harm and that they are acted upon and investigated in a timely way. (Regulation 12 (2) (b))
CQC August 2021	MD4	Quality Assurance Committee	The trust must improve on the timeliness of responses to complaints. (Regulation 16 (2))
CQC August 2021	MD6	Quality Assurance Committee	The trust must ensure that further development and investment in pharmacy resources should be prioritised to make sure medicines reconciliation rates and antimicrobial stewardship are improved across the trust. (Regulation 12 (2) (g))
CQC August 2021	MD10	Quality Assurance Committee	The trust must ensure that stroke patients receive treatment in line with best practice guidance and in line with the trust's stroke pathway so there are no delays to treatment. (Regulation 12 (2) (i))
CQC August 2021	MD12	Quality Assurance Committee	The trust must ensure that risk assessments and mental capacity assessments are carried out for mental health patients in line with trust policy. (Regulation 12 (2) (a))

CQC August 2021	MD13	Quality Assurance Committee	The service must ensure that there is enough staff with the right qualifications, skills, training and experience to provide care and treatment, specifically in relation to medical staffing including taking into account national guidance for the care of children and specifically paediatric emergency medicine consultant cover – This in line with the Royal College of Paediatrics and Child Health "Facing the Future – standards for children and young people in emergency care settings". (Regulation 18 (1))
CQC August 2021	MD14	Quality Assurance Committee	The service must ensure that audit information (including national audits) is submitted, up to date, accurate and properly analysed and reviewed by people with the appropriate skills and competence to understand its significance. When required, results should be escalated, and appropriate actions taken to improve. (Regulation 17 (2) (a))
CQC August 2021	MD15	Quality Assurance Committee	The trust must ensure that controlled drugs are safely prescribed, administered, recorded and stored and that registers are correctly and fully completed. The trust must ensure there is a system in place to assess and monitor formal competencies for nursing staff to administer medicines under patient group directions. (Regulation 12 (2) (g))
CQC August 2021	MD16	Quality Assurance Committee	The trust must ensure that robust action plans to improve and manage the flow of patients through the emergency department are put in place, taking into account known factors contributing to the hindrance of flow through the department and mitigating the ongoing risks and issues identified in the department. (Regulation 17 (2) (b))
CQC August 2021	MD17	Quality Assurance Committee	The department must ensure that the corridor escalation plan is adhered to and that incidents are appropriately recorded when the plan dictates. (Regulation 12 (2) (a) (b) (d))
CQC August 2021	MD18	Quality Assurance Committee	The service must ensure that privacy and dignity of patients is maintained, particularly when patients are in non-designated cubicle areas. (Regulation 10 (2) (a)
CQC August 2021	MD19	Quality Assurance Committee	The trust must ensure that patients' pain is effectively managed including that pain scores are re-assessed within 60 minutes as per trust policy. (Regulation 12 (2) (a) (b))
CQC August 2021	MD29	Quality Assurance Committee	The trust must implement an effective risk and governance system for the whole stroke pathway. (Regulation 17 (1) & (2) (a) & (b))
CQC August 2021	MD36	Quality Assurance Committee	The service must ensure staff have access to up-to-date and evidence-based guidelines and policies. (Regulation 12 (1))
CQC August 2021	MD37	Quality Assurance Committee	The service must ensure all women assessed as at risk of having sepsis receive care and treatment in line with national guidance and requirements. (Regulation 12 (1))
CQC August 2021	MD38	Quality Assurance Committee	The service must continue to develop a vision and strategy through engagement with staff, focused on sustainability and aligned to local plans within the wider health economy. (Regulation 17 (1) (2) (a) (e))

CQC August 2021	MD39	Quality Assurance Committee	The trust must ensure they establish and operate effective governance processes and systems, with robust action plans to monitor and improve the safety and quality of services and mitigate risks to women and families using the service. (Regulation 17 (1) (2) (a) (b))
CQC August 2021	MD46	Quality Assurance Committee	The trust must ensure that staff in the service adhere to trust infection prevention and control policy in the use of personal protective equipment and maintain patient and staff safety through social distancing at all times and in all areas. (Regulation 12(1)(2)(h))
CQC August 2021	MD47	Quality Assurance Committee	The service must ensure they participate in clinical audit to demonstrate the effectiveness of care and treatment. (Regulation 17(1))
CQC August 2021	MD49	Quality Assurance Committee	The trust must ensure that, patients with mental health concerns are seen in a timely way (Regulation 12(1)(2)(i))
CQC August 2021	MD50	Quality Assurance Committee	The trust must ensure pain is assessed in line with clinical standards, administered in a timely way and recorded in patient notes. (Regulation 12(1)(2)(i))
CQC August 2021	MD51	Quality Assurance Committee	The trust must ensure all patients are clinically assessed and National Early Warning Scores are documented for all patients. (Regulation 12(1)(2)(i))
CQC August 2021	MD58	Quality Assurance Committee	The trust must operate an effective clinical escalation system to ensure stroke care and treatment is assessed and implemented in a timely way. (Regulation 12 (1) & (2) (a) & (b))
CQC August 2021	MD59	Quality Assurance Committee	The trust must implement an effective system to ensure that all clinical staff have the knowledge, competence, skills and experience to care for and provide treatment to patients presenting with symptoms of stroke. (Regulation 18 (2) (a))
CQC August 2021	MD68	Quality Assurance Committee	The service must ensure risk assessments are completed and are actions taken to minimise any risks identified (Regulation 12(1)(2)(a) (b))
CQC August 2021	MD70	Quality Assurance Committee	The service must ensure appropriate systems are used for maintaining accurate, complete and contemporaneous records for service users (Regulation 17(2)(c))
CQC August 2021	MD84	Quality Assurance Committee	service must ensure staff assess the risks to women during and after birth in order to identify women at risk of deterioration. (Regulation 12 (1) (2) (a))
CQC August 2021	MD85	Quality Assurance Committee	The service must ensure that women presenting in labour have immediate access to suitable qualified and skilled midwifery staff. (Regulation 18 (1))

CQC August 2021	MD86	Quality Assurance Committee	The service must ensure staff assess and mitigate the risks to women's health and safety in an emergency situation either during home birth or at the unit. They must ensure appropriate escalation and transfer takes place. (Regulation 12 (1) (2) (a) (b))
CQC August 2021	MD88	Quality Assurance Committee	The service must ensure all equipment is properly maintained and that staff do not use equipment that is not safe nor used for its intended purpose. Specifically, they should not use a domestic bath to support water birth. All staff should be aware of the birthing pool emergency evacuation process and have access to the required equipment at all times. (Regulation 12 (1) (d) & (e))
CQC August 2021	MD91	Quality Assurance Committee	The trust must ensure they establish and operate effective governance processes and systems, with robust action plans to monitor and improve the safety and quality of services and mitigate risks to women and families using the service. (Regulation 17 (1) (2) (a) & (b))
CQC August 2021	MD96	Quality Assurance Committee	The service must ensure effective systems are in place to assess and mitigate individual patient safety risks. Regulation 12 (1)(2)(a) and (b): Safe care and treatment
CQC August 2021	MD97	Quality Assurance Committee	The service must ensure people are kept free from harm. Regulation 13(5) Safeguarding service users from abuse and improper treatment
CQC August 2021	MD100	Quality Assurance Committee	The trust must ensure there is full oversight of services offered by the care group through robust governance processes. Regulation 17(2)(a): Good Governance
CQC August 2021	MD101	Quality Assurance Committee	The service must ensure effective systems are in place to monitor discharges to prevent patients from becoming deconditioned. Regulation 17 (1)(2)(b): Good governance
CQC August 2021	MD102	Quality Assurance Committee	The service must ensure there are effective systems are in place to consistently assess, monitor and improve patient safety and the quality of care. Regulation 17 (1)(2)(a) and (b): Good governance
CQC July 2022	MD114	Quality Assurance Committee	The trust must ensure continued development and investment in pharmacy resources to make sure medicines reconciliation rates and antimicrobial stewardship are improved across the trust. (Regulation 12 (2) (g))
CQC July 2022	MD115	Quality Assurance Committee	The trust must ensure that antimicrobial prescribing guidelines are consistently followed. (Regulation 12 (2) (g))
CQC July 2022	MD121	Quality Assurance Committee	The trust must ensure that patient's privacy is upheld. Regulation 10(1)(2)(a)

CQC July 2022	MD122	Quality Assurance Committee	The trust must ensure that patient records are stored in a secure manner and can be accessed by staff. Regulation 17(1)(2)(c)
CQC July 2022	MD126	Quality Assurance Committee	The service must ensure that care and treatment is provided in a safe way by the proper and safe management of medicines. Regulation 12 (1) (2) (g)
CQC July 2022	MD127	Quality Assurance Committee	The service must ensure that patients are treated with dignity and respect. Including ensuring their privacy and having due regard to any relevant protected characteristics. Regulation 10 (1) (2) (a) (c)
CQC August 2021	SD7	Quality Assurance Committee	The trust should ensure that Patient Group Directions oversight should be strengthened to ensure sure appropriate and timely review and implementation
CQC August 2021	SD8	Quality Assurance Committee	The trust should ensure that the uptake of medicines management e-learning be prioritised to help improve medicines safety
CQC August 2021	SD9	Quality Assurance Committee	The trust should ensure that Electronic Prescribing and Medicines Administration (EPMA) auditing be strengthened to proactively identify prescribing and administration errors
CQC August 2021	SD22	Quality Assurance Committee	The trust should ensure that all staff follow infection control principles, including the use of personal protective equipment (PPE) at all times and receive refresher training in this where deemed necessary
CQC August 2021	SD24	Quality Assurance Committee	The trust should consider whether the triage service in the walk-in waiting area can be improved so that the triage nurse can observe patients in the waiting area more easily
CQC August 2021	SD25	Quality Assurance Committee	The trust should consider ensuring that there is a doctor or consultant at all safety huddles so that clinical information is not omitted from being shared with nursing staff.
CQC August 2021	SD26	Quality Assurance Committee	The trust should ensure that a more robust system of assessing skin integrity and pressure sores is put in place rather than the “safe and seen” assessment used presently.
CQC August 2021	SD27	Quality Assurance Committee	The trust should consider giving emergency department managers access to view incidents that are graded no harm or low harm, in order that there is complete oversight of incidents in the department to ensure that they have been graded correctly or may meet the criteria for a serious incident
CQC August 2021	SD28	Quality Assurance Committee	The trust should consider completing the urgent and emergency care plans that have been delayed so that these can feed into the medicine care group strategy

CQC August 2021	SD42	Quality Assurance Committee	The service should ensure the policy for cleaning of the birthing pool is ratified and implemented to control the risk of spread of infection.
CQC August 2021	SD43	Quality Assurance Committee	The service should ensure that recommendations from external incident investigations are fully considered and appropriate, robust action plans put in place
CQC August 2021	SD44	Quality Assurance Committee	The service should act to improve the assessment of women's pain in light of their clinical condition and ensure all women receive pain relief in a timely manner
CQC August 2021	SD55	Quality Assurance Committee	The trust should consider what actions the service can take to improve safeguarding adults and safeguarding children level three training rates for doctors and nurses.
CQC August 2021	SD56	Quality Assurance Committee	The trust should ensure senior leaders of the department have oversight of paediatric activity and performance in the ED.
CQC August 2021	SD64	Quality Assurance Committee	The trust should ensure that systems and processes are established and operated effectively to identify, assess, monitor, escalate and take mitigating actions, particularly in relation to the safe storage of medicine and the checking of emergency resuscitation equipment.
CQC August 2021	SD76	Quality Assurance Committee	The service should act to improve the quality of safety information shared in SBAR handover.
CQC August 2021	SD80	Quality Assurance Committee	The service should implement effective use of the whiteboard communication system on the birth centre
CQC August 2021	SD81	Quality Assurance Committee	The trust should ensure that visible information about requesting a chaperone is available to patients attending the centre.
CQC August 2021	SD83	Quality Assurance Committee	The Trust should ensure that privacy and confidentiality is maintained for patients when sharing personal information
CQC August 2021	SD104	Quality Assurance Committee	The service should ensure they complete MUST documentation
CQC July 2022	SD116	Quality Assurance Committee	The service should ensure that cleaning schedules are completed appropriately. (Regulation 12

CQC July 2022	SD117	Quality Assurance Committee	The trust should ensure that their updated policy for the management of violence and aggression should include clearer guidance about the use of medicines in line with National Institute for Health and Care Excellence (NICE) guidelines. (Regulation 17
CQC July 2022	SD119	Quality Assurance Committee	The trust should ensure it achieves its target for take-home medicines to be ready within one hour. (Regulation 12)
CQC July 2022	SD120	Quality Assurance Committee	The trust should review its higher than expected readmission rates for both elective and non-elective admissions
CQC July 2022	SD125	Quality Assurance Committee	The service should consider reviewing the arrangements for the implementation of the mental capacity act and deprivation of liberties safeguarding within the emergency department and align the trust policy to the practice
CQC July 2022	SD133	Quality Assurance Committee	The service should consider reviewing the arrangements for the implementation of the mental capacity act and deprivation of liberties safeguarding within the ED department and align the trust policy to the practice.
CQC July 2022	SD135	Quality Assurance Committee	The service should consider reviewing the opportunities for safety incident report and review when and what incidents, staff need to report and monitor that they have the support to do this in an appropriate manner.
CQC July 2022	SD138	Quality Assurance Committee	The service should further explore the opportunities for collaborative working from the emergency department, assessment units and specialist services
CQC July 2022	SD139	Quality Assurance Committee	The service should consider reviewing the arrangements for medicines held by patients particularly in relation to those on trolleys, formalise the process in place and ensure that all staff are aware of the practice needed to maintain patient safety.
RCS	MD3	Quality Assurance Committee	Actions the Trust Must take to ensure patient safety is protected: In respect of more complex cases, more effective utilisation of MDT to: (i) Improve governance in respect of clear decision making, transfer/handover of care documentation. (ii) Ensure appropriate consultant surgeon involvement.
RCS	MD4	Quality Assurance Committee	Actions the Trust Must take to ensure patient safety is protected: The consent pro-forma should ensure that the potential risks of the planned surgery are clearly documented for the patient to assimilate and space to record that these have been explained to the patient.
RCS	MD5	Quality Assurance Committee	Actions the Trust Must take to ensure the Trauma and Orthopaedic Service is improved: redacted may benefit as part of learning to reflect upon and discuss with colleagues case AXX in particular, possible reasons for the femoral notch (which was not documented in the operation note) occurring.

RCS	MD6	Quality Assurance Committee	Actions the Trust Must take to ensure the Trauma and Orthopaedic Service is improved: The Trust should take steps to improve the continuity of care for patients through their pre-operative, intra-operative and post-operative care pathway. This may include, but is not limited to, listing patients, wherever possible, on the operating surgeon clinic list.
RCS	SD7	Quality Assurance Committee	Actions the Trust Should consider as part of its development of the Trauma and Orthopaedic service: If the Trust identifies primary concerns about an individual surgeon, then a formal review of their clinical practice is recommended. If the Trust identifies concerns associated with the surgical service then a review of the service is recommended.
CQC August 2021	SD23	Trust Management Group	The trust should consider whether they can build a separate paediatric treatment area to meet best practice guidelines
CQC August 2021	MD2	Trust Management Group	The trust must ensure that risks in the organisation are correctly identified and appropriate mitigations put in place in a timely way (Regulation 17 (2) (b))
CQC August 2021	MD21	Trust Management Group	The department must ensure that all known risks are singularly identified on the risk register and that risks are supported by robust action plans that can reduce or mitigate the risks. They must also ensure that these action plans are regularly reviewed to ensure effectiveness and action plans amended where progress cannot be achieved. (Regulation 17 (2) (b))
CQC August 2021	MD30	Trust Management Group	The trust must operate an effective clinical escalation system to ensure stroke care and treatment is assessed and implemented in a timely way. (Regulation 12 (1) & (2) (a) & (b))
CQC August 2021	MD31	Trust Management Group	The trust must implement an effective system to ensure that all clinical staff have the knowledge, competence, skills and experience to care for and provide treatment to patients presenting with symptoms of stroke. (Regulation 18 (2) (a))
CQC August 2021	MD32	Trust Management Group	The trust must continue to monitor and take appropriate actions to improve average length of patient stay for patients having trauma and orthopaedics surgery. (Regulation 12 (1))
CQC August 2021	MD33	Trust Management Group	The trust must continue to monitor and take actions to improve referral to treatment waiting time performance in line with national standards. (Regulation 12 (1))
CQC August 2021	MD48	Trust Management Group	The service must ensure that care is provided in line with national performance standards for waiting times from referral to treatment and arrangements to admit, treat and discharge patients. (Regulation 12(1)(2)(i))
CQC August 2021	MD54	Trust Management Group	The trust must take action to improve safeguarding adults and safeguarding children level three training rates for doctors and nurses. (Regulation 18(1))

CQC August 2021	MD67	Trust Management Group	The service must ensure medical staff complete all required safeguarding level 3 training. (Regulation 18 (1)(2)(a))
CQC July 2022	MD128	Trust Management Group	The service must ensure that all premises and equipment used by the service provider are secure and suitable for the purpose for which they are being used. Regulation 15 (1) (b)(c)
CQC August 2021	SD41	Trust Management Group	The service should consider implementing a policy and schedule for changing the keypad code at ward entrances to maintain security
CQC August 2021	SD45	Trust Management Group	The service should continue to act to ensure women received continuity of care in line with national recommendations and targets
CQC August 2021	SD62	Trust Management Group	The trust should ensure that wards are secured to maintain patient safety
CQC August 2021	SD63	Trust Management Group	The trust should ensure that fire doors are maintained and used correctly
CQC August 2021	SD79	Trust Management Group	The service should progress actions to enable improved access within the birth centre, in context of the physical environment.
CQC July 2022	SD129	Trust Management Group	The service should consider whether the triage service in the walk-in waiting area can be improved so that the triage nurse can observe patients in the waiting area more easily
CQC July 2022	SD130	Trust Management Group	The service should continue to work closely with all system partners to tackle the capacity pressures on urgent and emergency care in the health and social care system.
CQC July 2022	SD131	Trust Management Group	The service should consider ways for staff to have oversight of children waiting to be triaged.
CQC July 2022	SD137	Trust Management Group	The service should review the perception in the ED of limited senior and executive visibility, recognition, understanding and support.

Table 5: Overview of CQC Recommendation & Actions Status and Progress – Data as at 08/09/2022

The 112 CQC Recommendations are being addressed through 193 Actions. This is because some recommendations only require a single action (e.g., Fixing damaged Fire Doors on a Surgical Wad), whereas some recommendations require multiple actions (e.g., Improving Anti-Microbial Stewardship across the Trust). The AMaT system prevents a recommendation as being be marked as complete, until all of its actions are completed and approved.

Medicine Care Group have 61% of the CQC actions recorded in AMaT, this consistent with their share of the CQC Recommendations (60%) recorded in AMaT.

The below summary table of individual actions does not include the detailed progress updates and evidence recorded in AMaT against the individual actions, just the progress status, this is because including the progress updates and evidence would result in a table that would be in excess of 150 Pages long, which is 5 times its current length.

Four actions related to the Implementation of the Governance Infrastructure proposed by the GGI review have now been marked as 'Unable to Complete', as the Trust will not be implementing the relevant findings from the GGI review.

Progress Summary of Actions by Care Group

	Number of Actions by Care Group					
Action Status	**Trust**	**Medicine Care Group**	**WACS Care Group**	**SCC Care Group**	**Pharmacy Service**	**Corporate Functions**
Not Applicable	**0**	**0**	**0**	**0**	**0**	**0**
Unable to Complete	**4**	**2**	**2**	**0**	**0**	**0**
Not Started	**0**	**0**	**0**	**0**	**0**	**0**
Behind Schedule (Partially Complete, Overdue)	**62**	**34**	**13**	**5**	**1**	**9**
In Progress (New Action)	**35**	**32**	**1**	**0**	**1**	**1**
On Schedule (Partially Complete)	**42**	**22**	**13**	**0**	**7**	**0**
Fully Completed (Awaiting Approval)	**19**	**12**	**3**	**0**	**2**	**2**
Fully Completed & Approved	**31**	**16**	**5**	**3**	**0**	**7**
Total	**193**	**118**	**37**	**8**	**11**	**19**

Progress Summary of Individual Actions

Type	CQC Recommendation	Ref	Lead Manager	Service	UHMBT Action	Progress Status
Must Do	The trust must ensure that governance processes are robust and effective (Regulation 17 (1))	MD1 /1	Mr Richard Sachs	TRUSTWIDE	The Trust will complete the recommendations from the Good Governance Institute (GGI) to deliver improved governance and assurance structures and processes from ward to board	Partially complete (Overdue)
Must Do	The trust must ensure that governance processes are robust and effective (Regulation 17 (1))	MD1 /2	Mr Stuart Bates	TRUSTWIDE	The Trust has completed an Initial Section 26 / Notice of Proposal evidence submission detailing the actions taken to address governance processes and ensure they are robust and will be sustained	Fully complete (Awaiting approval)
Must Do	The trust must ensure that governance processes are robust and effective (Regulation 17 (1))	MD1 /3	Mr Richard Sachs	TRUSTWIDE	The Trust (CEO and Director of Governance) will work with NHSE/I (Becky Southall) to review outcomes of GGI work completed in 2021/22 to identify how to refine the GGI Governance structure and to improve implementation and embeddedness of this refined governance structure within the Trust.	Fully complete (Awaiting approval)
Must Do	The trust must ensure that governance processes are robust and effective (Regulation 17 (1))	MD1 /4	Mr Paul Jones	TRUSTWIDE	Company Secretary to review and introduce a process to ensure statutory Responsibilities of Execs in highlighting issues of concern to the Trust Board	Fully complete (Approved)
Must Do	The trust must ensure that risks in the organisation are correctly identified and appropriate mitigations put in place in a timely way (Regulation 17 (2) (b))	MD2 /1	Mr Richard Sachs	TRUSTWIDE	The Trust will implement and embed a new Risk Management Strategy, new Trust Wide Risk Management Group to oversee Risk and review, update the associated Risk Management Processes and deliver Risk Management Training, to ensure this is embedded throughout the organisation. The operational elements are in place. The resource with regards to Risk Practitioner in place until December 2021.	Fully complete (Approved)
Must Do	The trust must ensure that incidents are identified, graded appropriately to reflect the level of harm and that they are acted upon and investigated in a timely way. (Regulation 12 (2) (b))	MD3 /1	Mr Richard Sachs	TRUSTWIDE	The Trust will implement a review of the existing Trust Wide Incident Reporting, Investigation and Management Policy, Procedures and Systems, in line with the new National Patient Safety Strategy and Framework, and then deliver and embed the required improvements. The infrastructure, revised Policy and systems in place by end of Q2. The embedding / reviewing by the end of Q3. Review the position by end of Q4.	Partially complete (Overdue)

Must Do	The trust must improve on the timeliness of responses to complaints. (Regulation 16 (2))	MD4 /1	Mr Richard Sachs	TRUSTWIDE	The Trust will implement an action plan to improve Complaints responses time with a target to meet regulatory standards by end of October 2021, with a stretch target of meeting Trust standards by the end of March 2022.	Partially complete (Overdue)
Must Do	The trust must continue to make improvements in the culture of the organisation, especially within maternity and trauma and orthopaedics, to enable staff to be supported to perform their duties effectively. (Regulation 18 (2) (a))	MD5 /1	Ms Claire Alexander	TRUSTWIDE	The Trust will continue to deliver its ESP Programme within the wider Trust Culture and Transformation Group workstream to make the required improvements in the WACS Care Group to enhance a positive culture and support the delivery of effective care and treatment	Partially complete (Overdue)
Must Do	The trust must continue to make improvements in the culture of the organisation, especially within maternity and trauma and orthopaedics, to enable staff to be supported to perform their duties effectively. (Regulation 18 (2) (a))	MD5 /2	Ms Claire Alexander	TRUSTWIDE	The Trust will continue to deliver its ESP Programme within the wider Trust Culture and Transformation Group workstream to make the required improvements in the T&O Speciality to enhance a positive culture and support the delivery of effective care and treatment	Partially complete (Overdue)
Must Do	The trust must continue to make improvements in the culture of the organisation, especially within maternity and trauma and orthopaedics, to enable staff to be supported to perform their duties effectively. (Regulation 18 (2) (a))	MD5 /3	Ms Beverley Edgar	TRUSTWIDE	The Trust has developed and implemented a Trust Wide Cultural Transformation Workstream which is overseen by the Director of People and Organisational Development and is monitored/reported at Workforce Assurance Committee and Trust Management Group, the Work Stream include programmes on: Just and Learning Culture, Magnet 4 Europe, Freedom to Speak Up, Medical engagement/leadership, Talent Management & Leadership Development, Workforce Transformation	Partially complete (Overdue)
Must Do	The trust must continue to make improvements in the culture of the organisation, especially within maternity and trauma and orthopaedics, to enable staff to be supported to perform their duties effectively. (Regulation 18 (2) (a))	MD5 /4	Ms Beverley Edgar	TRUSTWIDE	Within the Culture and Transformation Work Stream, the Trust has a specific programme of work to develop and implement a Cultural & Leadership Diagnostic & Dashboard, with target outcomes of; Build of UHMB Cultural Dashboard in Model Hospital, Completion of all diagnostic tools across the 6 elements of the programme, Outcomes presented to Cultural Transformation Board, Trust Management Group and Board of Directors	Partially complete (Overdue)
Must Do	The trust must continue to make improvements in the culture of the organisation, especially within maternity and trauma and orthopaedics, to enable staff to be supported to perform their duties effectively. (Regulation 18 (2) (a))	MD5 /5	Ms Beverley Edgar	TRUSTWIDE	The Trust (Led by People and Organisational Development) will work with NHSE/I to implement a cultural engagement tool to help improve staff engagement.	Partially complete (Overdue)

Must Do	The trust must continue to make improvements in the culture of the organisation, especially within maternity and trauma and orthopaedics, to enable staff to be supported to perform their duties effectively. (Regulation 18 (2) (a))	MD5 /6	Ms Beverley Edgar	TRUSTWIDE	Trust to implement an online conversation platform to enable staff to provide anonymous feedback on: - The Trust's; Vision, Values, Culture and Leadership - What changes are needed? - Our Fundamental purpose as an NHS Trust? - Acceptable behaviours to colleagues, patients, partners and the public - What is required to make these changes? The Trust will then publish the results from the conversation, then develop and implement an action plan to address the issues raised.	Fully complete (Approved)
Must Do	The trust must ensure that further development and investment in pharmacy resources should be prioritised to make sure medicines reconciliation rates and antimicrobial stewardship are improved across the trust. (Regulation 12 (2) (g))	MD6 /1	Mrs Kam Mom	Pharmacy	The Pharmacy Service will develop and submit a Business Case for the recruitment of substantive pharmacy staff to undertake medicines reconciliation in the Trust. Once approved this will be implemented and the additional capacity deployed to ensure this recommendation is met and sustained through regular monitoring.	Partially complete
Must Do	The trust must ensure that further development and investment in pharmacy resources should be prioritised to make sure medicines reconciliation rates and antimicrobial stewardship are improved across the trust. (Regulation 12 (2) (g))	MD6 /2	Mrs Kam Mom	Pharmacy	The Pharmacy Service will develop and submit a Business Case for the recruitment of substantive pharmacy staff to undertake antimicrobial stewardship in the Trust. Once approved this will be implemented and the additional capacity deployed to ensure this recommendation is met and sustained through regular monitoring.	Partially complete
Must Do	The trust must ensure that further development and investment in pharmacy resources should be prioritised to make sure medicines reconciliation rates and antimicrobial stewardship are improved across the trust. (Regulation 12 (2) (g))	MD6 /4	Mrs Kam Mom	Pharmacy	Recommendation MD115 to be reviewed with Chief Pharmacist, Medication Safety Officer and ADOp of CCS to determine; a) is the is the same recommendation as MD6 b) if it is the same recommendation, are there any new actions required? c) if no new actions are required this new recommendation will be managed through MD6	Fully complete (Awaiting approval)

Must Do	The trust must ensure that stroke patients receive treatment in line with best practice guidance and in line with the trust's stroke pathway so there are no delays to treatment. (Regulation 12 (2) (i))	MD1 0/1	Mrs Melanie Woolfall	Accident and Emergency	The Trust has developed and implemented a detailed improvement plan to address the issues identified in the Section 31 Notice, the plan includes; To meet the immediate safety concerns by 20/05/2021. To deliver the agreed improvement plan against the 8 domains by the 8-week deadline (July 2021) and to ensure improvements are sustained September 2021. This action will also be used to manage and complete any requirements of Recommendations MD29, MD30, MD31, MD 58 and MD59 (all of which relate to the provision of Stroke Care and Treatment) that fall within the scope of the 8-week plan.	Fully complete (Awaiting approval)
Must Do	The trust must ensure that stroke patients receive treatment in line with best practice guidance and in line with the trust's stroke pathway so there are no delays to treatment. (Regulation 12 (2) (i))	MD1 0/2	Mrs Melanie Woolfall	Accident and Emergency	The Medicine Care Group will work with partner organisations to deliver and submit the ICS business case for stroke services. This will ensure sufficient capacity and resources to meet best practice guidance.	Partially complete (Overdue)
Must Do	The trust must ensure that stroke patients receive treatment in line with best practice guidance and in line with the trust's stroke pathway so there are no delays to treatment. (Regulation 12 (2) (i))	MD1 0/3	Ms Jane McNicholas	Accident and Emergency	The Trust will establish and embed a Stroke Task and Finish Group to oversee the required performance improvement in Stroke Medicine to achieve the standard required to enable the successful exit from the CQC Section 31 notification. This action will also be used to manage and complete the requirements of Recommendations MD29, MD30, MD31, MD 58 and MD59, all of which relate to the provision of Stroke Care and Treatment.	Partially complete
Must Do	The trust must ensure that risk assessments and mental capacity assessments are carried out for mental health patients in line with trust policy. (Regulation 12 (2) (a))	MD1 2/1	Mrs Melanie Woolfall	Accident and Emergency	Trust Safeguarding Policy already includes MCA Risk Assessments. The Care Group will work with Safeguarding Team to ensure that assessments are carried out as part of everyday practice in line with Trust Policy and all staff understand their role and responsibilities. This will be monitored through; Quarterly DOLS/MCA Audits undertaken by Trust Safeguarding Team, reported at Safeguarding Operational Performance Group and local Spot Checks undertaken by Matrons and Unit Managers. Best Practice and learning from Monitoring to be	Partially complete

					shared from these. Maintain high quality risk / MCA assessments in line with Trust policy.	
Must Do	The service must ensure that there is enough staff with the right qualifications, skills, training and experience to provide care and treatment, specifically in relation to medical staffing including taking into account national guidance for the care of children and specifically paediatric emergency medicine consultant cover – This in line with the Royal College of Paediatrics and Child Health "Facing the Future – standards for children and young people in emergency care settings". (Regulation 18 (1))	MD1 3/1	Mr Neil Smith	Accident and Emergency	The Trust has a programme of work for reviewing compliance with the 'Facing The Future' requirements and to deliver improvements, which is reported through to the MGAG. This includes meeting national guidance for staffing requirements, including paediatrics.	Partially complete (Overdue)
Must Do	The service must ensure that there is enough staff with the right qualifications, skills, training and experience to provide care and treatment, specifically in relation to medical staffing including taking into account national guidance for the care of children and specifically paediatric emergency medicine consultant cover – This in line with the Royal College of Paediatrics and Child Health "Facing the Future – standards for children and young people in emergency care settings". (Regulation 18 (1))	MD1 3/2	Mrs Melanie Woolfall	Accident and Emergency	The Medicine Care Group has confirmed that existing arrangements for the RLI Paediatric Ward to provide overnight Paediatric Nursing Cover/Support to RLI ED on an 'as required' basis remain in place.	Partially complete (Overdue)
Must Do	The service must ensure that audit information (including national audits) is submitted, up to date, accurate and properly analysed and reviewed by people with the appropriate skills and competence to understand its significance. When required, results should be escalated, and appropriate actions taken to improve. (Regulation 17 (2) (a))	MD1 4/1	Mr Paul Smith	Accident and Emergency	The Medicine Care Group will strengthen and assure the local Audit processes and leadership to ensure audits are completed and submitted as required in line with RCEM requirements and any remedial actions are implemented.	Partially complete

Must Do	The service must ensure that audit information (including national audits) is submitted, up to date, accurate and properly analysed and reviewed by people with the appropriate skills and competence to understand its significance. When required, results should be escalated, and appropriate actions taken to improve. (Regulation 17 (2) (a))	MD1 4/2	Mr Paul Smith	Accident and Emergency	The Medicine Care Group RCEM Audit will be a standing agenda item at MGAG from January 2022 for regular monitoring.	Partially complete (Overdue)
Must Do	The service must ensure that audit information (including national audits) is submitted, up to date, accurate and properly analysed and reviewed by people with the appropriate skills and competence to understand its significance. When required, results should be escalated, and appropriate actions taken to improve. (Regulation 17 (2) (a))	MD1 4/3	Mrs Heather Pratt	Accident and Emergency	The Trust Clinical Audit team will review and update Trust Wide Clinical Audit processes, to include; Implement and Embed new Clinical Audit Governance structure as required from the Trust Wide GGI Governance Review, to ensure consistent Ward To Board processes and escalation and to appoint a National Audit Co-ordinator within the Trust Clinical Audit Team.	Fully complete (Approved)
Must Do	The service must ensure that audit information (including national audits) is submitted, up to date, accurate and properly analysed and reviewed by people with the appropriate skills and competence to understand its significance. When required, results should be escalated, and appropriate actions taken to improve. (Regulation 17 (2) (a))	MD1 4/4	Mr Paul Smith	Accident and Emergency	Clinical Director and DADOp for Urgent Care to undertake a review to ascertain if Medicine Clinical Audits are "properly analysed and reviewed by people with the appropriate skills and competence to understand its significance". The findings of the review will then be used determine if an action plane is required and if so, will be used to develop an action plan. The results of this review and any action plan will be reported to the Medicine Clinical Audit Meeting(s) and the Trust Clinical Audit Standards Group.	In progress
Must Do	The trust must ensure that controlled drugs are safely prescribed, administered, recorded and stored and that registers are correctly and fully completed. The trust must ensure there is a system in place to assess and monitor formal competencies for nursing staff to administer medicines under patient group directions. (Regulation 12 (2) (g))	MD1 5/1	Mrs Kam Mom	Accident and Emergency	The Medicine Care Group will increase vigilance/oversight of remedial actions following Controlled Drug and Enhanced control safe and secure storage audit actions as captured on the new AMaT System. Any findings or recommendations from these audits will be implemented and monitored through future regular audits.	Partially complete (Overdue)
Must Do	The trust must ensure that controlled drugs are safely prescribed, administered, recorded and stored and that registers are correctly and fully completed. The trust must ensure there is a system in place to assess and monitor formal competencies for nursing staff to administer medicines under patient group directions. (Regulation 12 (2) (g))	MD1 5/2	Mrs Kam Mom	Accident and Emergency	The Pharmacy Service will strengthen Patient Group Direction oversight. To include refresh of the policy, implementation of audit, increasing staff awareness and delivery of any required staff training.	Partially complete (Overdue)

Must Do	The trust must ensure that robust action plans to improve and manage the flow of patients through the emergency department are put in place, taking into account known factors contributing to the hindrance of flow through the department and mitigating the ongoing risks and issues identified in the department. (Regulation 17 (2) (b))	MD1 6/1	Miss Leanne Cooper	Accident and Emergency	Plans have been developed as part of the BHACP UEC Programme, it has been signed off by A&E Delivery Board and now has additional PMO support to help its delivery. A robust improvement programme that facilitates patient flow corporately is in place and delivered in line with the Urgent Care action plan.	Fully complete (Approved)
Must Do	The department must ensure that the corridor escalation plan is adhered to and that incidents are appropriately recorded when the plan dictates. (Regulation 12 (2) (a) (b) (d))	MD1 7/1	Mrs Melanie Woolfall	Accident and Emergency	The Medicine care Group ensure that the RLI ED corridor escalation plan is adhered to by staff and that incidents are recorded and escalated to the Patient Flow Team. Investigate scope for automated monitoring/recording of corridor waits.	Partially complete
Must Do	The service must ensure that privacy and dignity of patients is maintained, particularly when patients are in non-designated cubicle areas. (Regulation 10 (2) (a)	MD1 8/1	Mrs Melanie Woolfall	Accident and Emergency	The Medicine Care Group will review Processes for maintaining the privacy and dignity of (non-Cubicle) patients in RLI ED, to identify and implement improvements, to include; Staff Awareness, Matron Review/Spot Checks, Seen and Safe Process/documentation, collaborative projects with NHSE/I and NWAS colleagues	Partially complete
Must Do	The trust must ensure that patients' pain is effectively managed including that pain scores are re-assessed within 60 minutes as per trust policy. (Regulation 12 (2) (a) (b))	MD1 9/1	Mrs Melanie Woolfall	Accident and Emergency	To be managed through the fundamentals work on managing a deteriorating patient and medicines management. To be reviewed as part of RCEM audit to determine required actions Pain scores to be monitored as part of safety checks	Partially complete (Overdue)
Must Do	The trust must improve the multidisciplinary working and culture between the department and specialities and speciality teams to maximise patient care and outcomes. (Regulation 12 (2) (i); Regulation 17 (2) (a))	MD2 0/1	Ms Bongi Gbadebo	Accident and Emergency	The Medicine Care Group will review current MDT working arrangements in the RLI ED to identify and implement improvements, including the design and development of a new priority admissions unit (PAU).	Partially complete
Must Do	The department must ensure that all known risks are singularly identified on the risk register and that risks are supported by robust action plans that can reduce or mitigate the risks. They must also ensure that these action plans are regularly reviewed to ensure effectiveness and action plans amended where progress cannot be achieved. (Regulation 17 (2) (b))	MD2 1/1	Mrs Diane Smith	Accident and Emergency	The Medicine Care Group will review all risks in line with the business plan to ensure risk have been identified and properly captured on the risk registers with appropriate mitigation in place	Fully complete (Approved)

Must Do	The department must ensure that all known risks are singularly identified on the risk register and that risks are supported by robust action plans that can reduce or mitigate the risks. They must also ensure that these action plans are regularly reviewed to ensure effectiveness and action plans amended where progress cannot be achieved. (Regulation 17 (2) (b))	MD2 1/2	Ms Bongi Gbadebo	Accident and Emergency	The Medicine Care Group will ensure a regular review of risk registers is built in with the Health and Safety & Risk team to provide review and challenge, ensure a process with the Clinical Governance Team for identifying and agreeing new risks.	Partially complete (Overdue)
Must Do	The department must ensure that all known risks are singularly identified on the risk register and that risks are supported by robust action plans that can reduce or mitigate the risks. They must also ensure that these action plans are regularly reviewed to ensure effectiveness and action plans amended where progress cannot be achieved. (Regulation 17 (2) (b))	MD2 1/3	Mrs Diane Smith	Accident and Emergency	The Medicine Care Group will explore possibility of risk register workshops with the Good Governance Institute (GGI) to improve the medicine risk register and associated management	Unable to complete
Must Do	The department must ensure that all known risks are singularly identified on the risk register and that risks are supported by robust action plans that can reduce or mitigate the risks. They must also ensure that these action plans are regularly reviewed to ensure effectiveness and action plans amended where progress cannot be achieved. (Regulation 17 (2) (b))	MD2 1/4	Mr Stuart Bates	Accident and Emergency	The Trust will implement and embed new Trust Wide Risk Management Strategy, New Risk Management Group and associated Risk Management Process, to ensure this is embedded throughout the organisation.	Fully complete (Approved)
Must Do	The trust must implement an effective risk and governance system for the whole stroke pathway. (Regulation 17 (1) & (2) (a) & (b))	MD2 9/1	Mrs Melanie Woolfall	Medicine	All recommendations related to the stroke treatment pathway are being managed under the Action Plan that Trust has developed to address the section 31 improvement work, this action plan is overseen by the Chief Operation Officer and its progress is monitored at / reported to Trust Management Group and Partner Organisations.	Partially complete
Must Do	The trust must operate an effective clinical escalation system to ensure stroke care and treatment is assessed and implemented in a timely way. (Regulation 12 (1) & (2) (a) & (b))	MD3 0/1	Mrs Melanie Woolfall	Medicine	All recommendations related to the stroke treatment pathway are being managed under the Action Plan that Trust has developed to address the section 31 improvement work, this action plan is overseen by the Chief Operation Officer and its progress is monitored at / reported to Trust Management Group and Partner Organisations	Partially complete
Must Do	The trust must implement an effective system to ensure that all clinical staff have the knowledge, competence, skills and experience to care for and provide treatment to patients presenting with symptoms of stroke. (Regulation 18 (2) (a))	MD3 1/1	Mrs Melanie Woolfall	Medicine	All recommendations related to the stroke treatment pathway are being managed under the Action Plan that Trust has developed to address the section 31 improvement work, this action plan is overseen by the	Partially complete

					Chief Operation Officer and its progress is monitored at / reported to Trust Management Group.	
Must Do	The trust must continue to monitor and take appropriate actions to improve average length of patient stay for patients having trauma and orthopaedics surgery. (Regulation 12 (1))	MD3 2/2	Mr Daniel Bakey	Surgery and Critical Care Services	The Trust has established a number of Work streams in the Accelerator/ Restore and Recovery Programme to help improve (reduce) the average length of stay of patients (including T&O Patients), the Work Streams are; Cancer services, Outpatients, Diagnostics and Elective Inpatients	Partially complete (Overdue)
Must Do	The trust must continue to monitor and take actions to improve referral to treatment waiting time performance in line with national standards. (Regulation 12 (1))	MD3 3/1	Mr Scott McLean	TRUSTWIDE	The Trust has established a number of workstreams within the Covid Recovery Programme which will help improve RTT performance, these include; Cancer services, Outpatients, Diagnostics and Elective Inpatients	Fully complete (Approved)
Must Do	The trust must continue to monitor and take actions to improve referral to treatment waiting time performance in line with national standards. (Regulation 12 (1))	MD3 3/2	Miss Leanne Cooper	TRUSTWIDE	Trust RTT performance is monitored via the Trust IPR (Integrated Performance Report), Care Groups also report on their RTT performance at monthly Care Group Performance Reviews Overall, Trust RTT performance (18 week wait) at March/April 2022 was ~70% Trust will be involved in NHS Wide '2022-23 Delivery Plan for COVID-19 Elective Backlog'. Key Targets for 2022-23 are; Elimination of 104 Week Waits, Elimination of 78 Week Waits	Fully complete (Approved)
Must Do	The trust must continue to monitor and take actions to improve referral to treatment waiting time performance in line with national standards. (Regulation 12 (1))	MD3 3/3	Miss Leanne Cooper	TRUSTWIDE	Trust RTT performance is monitored via the Trust IPR (Integrated Performance Report), Care Groups also report on their RTT performance at monthly Care Group Performance Reviews Trust will be involved in NHS Wide 'Delivery Plan for COVID-19 Elective Backlog'. Key Target: Elimination of 52 Week Waits by March 2025	In progress
Must Do	The service must ensure staff have access to up-to-date and evidence-based guidelines and policies. (Regulation 12 (1))	MD3 6/1	Mrs Tracey Roberts Cuffin	Maternity Service	The Maternity Service will work with the Trust Policy Co-ordinator to Implement and deliver a review and update of the service's Procedural Documents to ensure all guidelines are up to date (outcome measures: to achieve 95% target). Priority will be	Partially complete

					given to any 'High Risk' Guidelines that are overdue for review.	
Must Do	The service must ensure staff have access to up-to-date and evidence-based guidelines and policies. (Regulation 12 (1))	MD3 6/3	Dr Owen Galt	Maternity Service	The Maternity Service will work with Trust NICE Lead to Implement and deliver a review and update of the service's Procedural Documents to ensure they are aligned with prevailing NICE Guidance Documents	Partially complete
Must Do	The service must ensure staff have access to up-to-date and evidence-based guidelines and policies. (Regulation 12 (1))	MD3 6/4	Ms Heather Gallagher	Maternity Service	To review and update any out of date, high-risk, emergency guidelines.	Partially complete
Must Do	The service must ensure all women assessed as at risk of having sepsis receive care and treatment in line with national guidance and requirements. (Regulation 12 (1))	MD3 7/1	Mr Mark Davies	Maternity Service	The Maternity Service will work with the Trust Acute Care Team and the Trust Clinical Audit Team to undertake a Re-audit of the sepsis management of all expectant mothers against national standards, a post audit action plan will be developed and implemented to address any performance issues.	Partially complete (Overdue)
Must Do	The service must ensure all women assessed as at risk of having sepsis receive care and treatment in line with national guidance and requirements. (Regulation 12 (1))	MD3 7/3	Mr Mark Davies	Women and Children's Services	The Service appointed Consultant Obstetrician will work with the Trust NICE Lead to review the sepsis guidance to ensure it is aligned with national NICE guidance.	Partially complete
Must Do	The service must continue to develop a vision and strategy through engagement with staff, focused on sustainability and aligned to local plans within the wider health economy. (Regulation 17 (1) (2) (a) (e))	MD3 8/1	Mrs Linda Womack	Maternity Service	The Maternity Service will work with patients, staff and partner organisations to undertake a sustainability focussed review and update of the Maternity Vision and Strategy. To link in local plans to ensure we are fitting with the wider health economy and any recommendations as a result of Ockenden	Partially complete
Must Do	The service must continue to develop a vision and strategy through engagement with staff, focused on sustainability and aligned to local plans within the wider health economy. (Regulation 17 (1) (2) (a) (e))	MD3 8/3	Mrs Tamsin Cripps	Women and Children's Services	OS Action - The Trust and the WACS Care Group will work in conjunction with the Maternity Safety Support Programme (MSSP) to develop and implement improvements in the Trusts Maternity Services, to include; Improvement in Maternity Dashboard Metrics, Safe escalation and transfer, Sepsis care and identification of the deteriorating patient and Implementation of CQC Must Do's Recommendations	Unable to complete

Must Do	The trust must ensure they establish and operate effective governance processes and systems, with robust action plans to monitor and improve the safety and quality of services and mitigate risks to women and families using the service. (Regulation 17 (1) (2) (a) (b))	MD3 9/1	Ms Heather Gallagher	Maternity Service	The Maternity Service will work with the Corporate Governance Team and Good Governance institute (GGI) to deliver and embed the new Trust Wide governance processes and systems within the Care Group (See also 91/1)	Unable to complete
Must Do	The trust must ensure they establish and operate effective governance processes and systems, with robust action plans to monitor and improve the safety and quality of services and mitigate risks to women and families using the service. (Regulation 17 (1) (2) (a) (b))	MD3 9/3	Ms Heather Gallagher	Maternity Service	To develop and implement a governance Maternity Risk Strategy which aligns to the wider Trust Risk Strategy	Partially complete (Overdue)
Must Do	The trust must ensure they establish and operate effective governance processes and systems, with robust action plans to monitor and improve the safety and quality of services and mitigate risks to women and families using the service. (Regulation 17 (1) (2) (a) (b))	MD3 9/4	Mrs Tamsin Cripps	Maternity Service	OS Action - The Trust and the WACS Care Group will work in conjunction with the Maternity Safety Support Programme (MSSP) to develop and implement improvements in the Trusts Maternity Services, to include; Improvement in Maternity Dashboard Metrics, Continuity of care, Safe escalation and transfer, Sepsis care and identification of the deteriorating patient and Implementation of CQC Must Do's Recommendations	In progress
Must Do	The trust must ensure that staff in the service adhere to trust infection prevention and control policy in the use of personal protective equipment and maintain patient and staff safety through social distancing at all times and in all areas. (Regulation 12(1)(2)(h))	MD4 6/1	Mrs Melanie Woolfall	Accident and Emergency	Prevailing and COVID specific IPC/PPE Policies already in place, monitoring through Spot Checks and Audits already in place. The service will re-communicate requirements to increase staff awareness and to encourage staff to actively challenge and/or report non-compliance, reported or identified incidents of non-compliance to be investigated and resolved.	Partially complete (Overdue)
Must Do	The service must ensure they participate in clinical audit to demonstrate the effectiveness of care and treatment. (Regulation 17(1))	MD4 7/1	Mr Paul Smith	Accident and Emergency	The Care Group will participate in Clinical Audit as required and the Medicine Care Group will ensure that Clinical audit is tracked through the Care Group MGAG Meeting to ensure participation, timely data submission and implementation of post Audit Action Plans. Audit Progress will also be shared with and/or reported at Trust Clinical Audit Meeting. In particular; RCEM, SSNAP and TARN Audits	Partially complete (Overdue)

Must Do	The service must ensure they participate in clinical audit to demonstrate the effectiveness of care and treatment. (Regulation 17(1))	MD4 7/2	Mrs Heather Pratt	Accident and Emergency	The Trust Clinical Audit Team will review and update Trust Wide Clinical Audit processes, to include; Implement and Embed new Clinical Audit Governance structure as required from the Trust Wide GGI Governance Review, to ensure consistent Ward To Board processes and escalation and to appoint a National Audit Co-ordinator within the Trust Clinical Audit Team.	Fully complete (Approved)
Must Do	The service must ensure that care is provided in line with national performance standards for waiting times from referral to treatment and arrangements to admit, treat and discharge patients. (Regulation 12(1)(2)(i))	MD4 8/1	Miss Leanne Cooper	Accident and Emergency	Plans has been developed as part of the BHACP UEC Programme, it has been signed off by A&E Delivery Board and now has additional PMO support to help its delivery. A robust improvement programme that facilitates patient flow corporately is in place and delivered in line with the Urgent Care action plan. (See MD16/1 also)	Fully complete (Approved)
Must Do	The trust must ensure that, patients with mental health concerns are seen in a timely way (Regulation 12(1)(2)(i))	MD4 9/1	Miss Leanne Cooper	Accident and Emergency	The Service Mental Health improvement projects are being managed within the Bay Health and Care Partners (BHACP) Urgent and Emergency Care (UEC) Improvement Programme under the Pre-Hospital/A&E avoidance programme. The BHACP UEC Improvement Plan includes input from local MH Trust (Lancashire and South Cumbria Trust) and local Police Forces.	Fully complete (Approved)
Must Do	The trust must ensure that, patients with mental health concerns are seen in a timely way (Regulation 12(1)(2)(i))	MD4 9/2	Ms Emma Fitton	Accident and Emergency	The BHACP UEC Improvement Programme includes implementation of MHUAC services, actions specific to FGH ED include: Implementation of an additional mental health post at FGH ED to support frequent attender service, introduction of Street triage service with Cumbria police in October 2021. This service will run Tues to Fri (twilight) as this is when the majority of 136s occur. This service will hopefully have a positive impact on the number of patients with mental health problems presenting at ED.	Fully complete (Approved)
Must Do	The trust must ensure pain is assessed in line with clinical standards, administered in a timely way and recorded in patient notes. (Regulation 12(1)(2)(i))	MD5 0/1	Mrs Melanie Woolfall	Accident and Emergency	The Medicine Care Group will manage this recommendation through the fundamentals work on managing a deteriorating patient and medicines management. To be reviewed as part of RCEM audit to determine	Fully complete (Awaiting approval)

					required actions Pain scores to be monitored as part of safety checks	
Must Do	The trust must ensure all patients are clinically assessed and National Early Warning Scores are documented for all patients. (Regulation 12(1)(2)(i))	MD5 1/1	Mrs Melanie Woolfall	Accident and Emergency	The Medicine Care Group will manage this recommendation through the fundamentals work on managing a deteriorating patient and medicines management	Fully complete (Awaiting approval)
Must Do	The trust must ensure all relevant staff have completed Paediatric Advanced Life Support when supporting paediatric provision in the emergency department. (Regulation 12(1)(2)(i))	MD5 2/1	Mrs Melanie Woolfall	Accident and Emergency	The Medicine Care Group will review resuscitation training requirements / standards in relation to paediatric training and develop a plan for compliance where necessary	Partially complete (Overdue)
Must Do	The trust must review the service's paediatric staffing provision, including the environment they wait in and the paediatric nursing and medical cover in line with The Royal College of Paediatrics and Child Health (RCPCH) Standards for Children and Young People in Emergency settings (2012) (Regulation 18(1))	MD5 3/1	Ms Bongi Gbadebo	Accident and Emergency	The Trust has a programme of work for reviewing compliance with the 'Facing The Future' requirements and to deliver improvements, which is reported through to MGAG. This will include Medical and Nursing staffing levels and paediatric environment at FGH ED. This Action is for Medical Staffing Levels.	Partially complete (Overdue)
Must Do	The trust must review the service's paediatric staffing provision, including the environment they wait in and the paediatric nursing and medical cover in line with The Royal College of Paediatrics and Child Health (RCPCH) Standards for Children and Young People in Emergency settings (2012) (Regulation 18(1))	MD5 3/2	Mrs Melanie Woolfall	Accident and Emergency	The Trust has a programme of work for reviewing compliance with the 'Facing The Future' requirements and to deliver improvements, which is reported through to MGAG. This will include Medical and Nursing staffing levels and paediatric environment at FGH ED. This Action is for Nursing Staffing Levels.	Partially complete (Overdue)
Must Do	The trust must review the service's paediatric staffing provision, including the environment they wait in and the paediatric nursing and medical cover in line with The Royal College of Paediatrics and Child Health (RCPCH) Standards for Children and Young People in Emergency settings (2012) (Regulation 18(1))	MD5 3/3	Ms Bongi Gbadebo	Accident and Emergency	The Trust has a programme of work for reviewing compliance with the 'Facing The Future' requirements and to deliver improvements, which is reported through to the A&E delivery Board. This will include Medical and Nursing staffing levels and paediatric environment at FGH ED. This Action is for paediatric environment.	Partially complete (Overdue)
Must Do	The trust must take action to improve safeguarding adults and safeguarding children level three training rates for doctors and nurses. (Regulation 18(1))	MD5 4/1	Mrs Melanie Woolfall	Accident and Emergency	The Medicine Care Group will review Safeguarding guidance / training requirements against current compliance and ensure robust plan in place in conjunction with the Safeguarding Team	Partially complete (Overdue)

Must Do	The trust must operate an effective clinical escalation system to ensure stroke care and treatment is assessed and implemented in a timely way. (Regulation 12 (1) & (2) (a) & (b))	MD5 8/1	Mrs Melanie Woolfall	Medicine	All recommendations related to the stroke treatment pathway are being managed under the Action Plan that Trust has developed to address the section 31 improvement work, this action plan overseen by the Chief Operation Officer and its progress is monitored at / reported to Trust Management Group.	Partially complete
Must Do	The trust must implement an effective system to ensure that all clinical staff have the knowledge, competence, skills and experience to care for and provide treatment to patients presenting with symptoms of stroke. (Regulation 18 (2) (a))	MD5 9/1	Mrs Melanie Woolfall	Medicine	All recommendations related to the stroke treatment pathway are being managed under the Action Plan that Trust has developed to address the section 31 improvement work, this action plan is overseen by the Chief Operations Officer and its progress is monitored at / reported to Trust Management Group.	Partially complete
Must Do	The service must ensure there are sufficient maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. (Regulation 18 (1)(2)(a))	MD6 6/1	Mrs Tamsin Cripps	Maternity Service	To complete a robust workforce plan agreed by Trust Board based on the outcomes of the Birth Rate Plus Review.	Partially complete
Must Do	The service must ensure there are sufficient maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. (Regulation 18 (1)(2)(a))	MD6 6/2	Ms Heather Gallagher	Maternity Service	Review and complete a maternity training plan to include Core Skills Framework, job essential training and core competency training	Partially complete (Overdue)
Must Do	The service must ensure medical staff complete all required safeguarding level 3 training. (Regulation 18 (1)(2)(a))	MD6 7/1	Mr Mark Davies	Maternity Service	The Maternity Service will ensure medical staff complete safeguarding level 3 training in a timely manner and in line with Trust targets	Partially complete (Overdue)
Must Do	The service must ensure risk assessments are completed and are actions taken to minimise any risks identified (Regulation 12(1)(2)(a) (b))	MD6 8/1	Mrs Tamsin Cripps	Maternity Service	The Maternity Service will complete its existing work programme to move all risk assessments into the Local ICS 'BadgerNet' Maternity System and to establish; an auditing process for the Risk assessments held in BadgerNet and to review and update existing escalation processes in light of the introduction of BadgerNet	Partially complete (Overdue)
Must Do	The service must ensure risk assessments are completed and are actions taken to minimise any risks identified (Regulation 12(1)(2)(a) (b))	MD6 8/2	Ms Heather Gallagher	Maternity Service	To develop a process to ensure appropriate risk assessments are carried out throughout the pregnancy journey	Partially complete (Overdue)
Must Do	The service must ensure appropriate systems are used for maintaining accurate, complete and contemporaneous records for service users (Regulation 17(2)(c))	MD7 0/1	Mrs Tamsin Cripps	Maternity Service	The Maternity Service will implement the Local ICS 'BadgerNet' Maternity System	Fully complete (Approved)

Must Do	The service must ensure appropriate systems are used for maintaining accurate, complete and contemporaneous records for service users (Regulation 17(2)(c))	MD7 0/2	Ms Heather Gallagher	Maternity Service	The Maternity Service will further strengthen existing processes for record keeping, undertake appropriate audit and external checks of these processes.	Partially complete (Overdue)
Must Do	service must ensure staff assess the risks to women during and after birth in order to identify women at risk of deterioration. (Regulation 12 (1) (2) (a))	MD8 4/1	Mrs Linda Womack	Maternity Service	The Maternity Service will undertake an Audit of MOEWS at HHCMU to confirm compliance levels with this recommendation and, if required, will then review and the relevant guidance documents for HCMU and undertake staff awareness and training that is required.	Fully complete (Approved)
Must Do	The service must ensure that women presenting in labour have immediate access to suitable qualified and skilled midwifery staff. (Regulation 18 (1))	MD8 5/1	Mrs Linda Womack	Maternity Service	Recommendation relates to the Helme Chase Maternity Unit (HCMU), which is a Mid Wife Led Unit. WACs Care Group will review the service provision at HCMU and confirm whether it is concordant with the prevailing national standards/requirements for a Mid Wife Led Maternity Unit.	Partially complete (Overdue)
Must Do	The service must ensure that women presenting in labour have immediate access to suitable qualified and skilled midwifery staff. (Regulation 18 (1))	MD8 5/2	Mrs Linda Womack	Maternity Service	The Maternity Service will look at recruitment and retention strategy for Helme Chase Maternity Unit and deliver an improved trajectory for education and training for Helme Chase Maternity Unit, as part of wider Maternity Service strategy	Partially complete (Overdue)
Must Do	The service must ensure staff assess and mitigate the risks to women's health and safety in an emergency situation either during home birth or at the unit. They must ensure appropriate escalation and transfer takes place. (Regulation 12 (1) (2) (a) (b))	MD8 6/1	Mrs Linda Womack	Maternity Service	The Maternity Service will review and update the Operational Policy Document(s) for the Helme Chase Maternity Unit and ensure the documents are aligned with relevant standards.	Partially complete (Overdue)
Must Do	The service must ensure staff assess and mitigate the risks to women's health and safety in an emergency situation either during home birth or at the unit. They must ensure appropriate escalation and transfer takes place. (Regulation 12 (1) (2) (a) (b))	MD8 6/2	Mrs Linda Womack	Maternity Service	The Maternity Service will meet with North West Ambulance Service (NWAS) to discuss and agree dates for skills drills/training to take place.	Partially complete (Overdue)
Must Do	The service must ensure all equipment is properly maintained and that staff do not use equipment that is not safe nor used for its intended purpose. Specifically, they should not use a domestic bath to support water birth. All staff should be aware of the birthing pool emergency evacuation process and have access to the required equipment at all times. (Regulation 12 (1) (d) & (e))	MD8 8/1	Mrs Linda Womack	Maternity Service	The Maternity Service have confirmed that; the domestic bath has not been used since 2014, it has been very clearly identified as being 'out of order' and will now be de-commissioned, an SOP for the evacuation of the Birthing Pool is in place, staff awareness and training took place in August 2021 - Action Completed	Fully complete (Awaiting approval)

Must Do	The trust must ensure they establish and operate effective governance processes and systems, with robust action plans to monitor and improve the safety and quality of services and mitigate risks to women and families using the service. (Regulation 17 (1) (2) (a) & (b))	MD9 1/1	Ms Heather Gallagher	Maternity Service	The Maternity Service will further strengthen local governance and assurance processes in line with the Trust's internal Governance Review and established Maternity best practice and work with the national maternity and safety improvement team to review and develop any additional improvements identified (see also 39/1)	Partially complete (Overdue)
Must Do	The service must ensure they deploy sufficient suitably competent and experienced staff and ensure all staff receive appropriate skills and drills training and professional development to enable them to maintain competency given the low numbers of deliveries. (Regulation 18 (1) (2) (a))	MD9 2/1	Mrs Tamsin Cripps	Maternity Service	The Maternity Service will implement a training plan to ensure that staff at the Helme Chase Maternity Unit have the appropriate skills and competency to provide care and treatment to the low-risk births / expectant mothers treated at the Helme Chase Maternity Unit.	Partially complete (Overdue)
Must Do	The service must ensure effective systems are in place to assess and mitigate individual patient safety risks. Regulation 12 (1)(2)(a) and (b): Safe care and treatment	MD9 6/1	Ms Bongi Gbadebo	Medicine	The Service will investigate moving one ward from Medical Unit 2 to a new purpose-built frailty unit in Medical Unit 1 (action under review in reference to the recommendation)	Partially complete
Must Do	The service must ensure effective systems are in place to assess and mitigate individual patient safety risks. Regulation 12 (1)(2)(a) and (b): Safe care and treatment	MD9 6/2	Mrs Emily Henry-Farncombe	Medicine	The Service will undertake additional building work on the existing wards in Medical Unit 2 to enhance the accommodation	Partially complete (Overdue)
Must Do	The service must ensure people are kept free from harm. Regulation 13(5) Safeguarding service users from abuse and improper treatment	MD9 7/1	Mrs Melanie Woolfall	Medicine	The Medicine Care Group will review Safeguarding guidance / training requirements against current compliance and ensure robust plan in place in conjunction with the Safeguarding Team to ensure service users are kept free from harm	Partially complete (Overdue)
Must Do	The service must ensure nurse staffing levels meet the minimum standards of the National Institute of Health and Care Excellence. Regulation 18 (1): Staffing.	MD9 8/1	Mrs Melanie Woolfall	Medicine	The Service will recruit a new Advanced Nurse Practitioner to improve the care offered to patients. This will form part of a wider staffing review to ensure there is adequate nursing staffing within the service.	Partially complete (Overdue)
Must Do	The service must ensure nurse staffing levels meet the minimum standards of the National Institute of Health and Care Excellence. Regulation 18 (1): Staffing.	MD9 8/2	Mr Tony Crick	Medicine	Improving the care offered to patients by employing two new physiotherapists, to support Medical Wards in Medical Unit 2	Fully complete (Approved)
Must Do	The service must ensure medical staffing levels meet the minimum standards of the Royal College of Physicians. Regulation 18 (1): Staffing	MD9 9/1	Mr Scott Bremner	Medicine	To service will undertake a medical staffing review to ensure staffing levels are meeting RCP minimum standards. Findings to be reported via MGAG with	Fully complete (Approved)

					actions put in place to recruit to roles where necessary.	
Must Do	The trust must ensure there is full oversight of services offered by the care group through robust governance processes. Regulation 17(2)(a): Good Governance	MD1 00/1	Mr Richard Sachs	Medicine	The Trust will complete the GGI review of Governance Meeting Structures, Reporting and Escalation	Fully complete (Awaiting approval)
Must Do	The trust must ensure there is full oversight of services offered by the care group through robust governance processes. Regulation 17(2)(a): Good Governance	MD1 00/2	Mr Stuart Bates	Medicine	The Trust has completed an Initial Section 26 / Notice of Proposal evidence submission detailing the actions taken to address governance processes and ensure they are robust and will be sustained	Fully complete (Approved)
Must Do	The service must ensure effective systems are in place to monitor discharges to prevent patients from becoming deconditioned. Regulation 17 (1)(2)(b): Good governance	MD1 01/1	Ms Bongi Gbadebo	Medicine	The service will review current systems in place for patient discharges and seek to improve the monitoring and escalation processes to help prevent patients from becoming deconditioned.	Partially complete (Overdue)
Must Do	The service must ensure effective systems are in place to monitor discharges to prevent patients from becoming deconditioned. Regulation 17 (1)(2)(b): Good governance	MD1 01/2	Mr Paul Smith	Medicine	Clinical Director and/or Director Nursing of Medicine Care Group to issue a communication to Medicine Care Group staff who work in Medical Unit 2, to instruct that non-Trust system (e.g., Whats App) cannot be used as tools for communication about patients or for the escalation of concerns regarding patients. Any practical issues with the communication about patients or for the escalation of concerns regarding patients located in Med Unit 2 at the RLI should be escalated to the Trust's Chief Information Officer and Chief Clinical Information Officer and alerted to the Trust Management Group for immediate action and resolution.	In progress
Must Do	The service must ensure there are effective systems are in place to consistently assess, monitor and improve patient safety and the quality of care. Regulation 17 (1)(2)(a) and (b): Good governance	MD1 02/1	Mrs Diane Smith	Medicine	Review the systems and processes that are in place to assess and monitor safety and quality of care	Partially complete
Must Do	The service must ensure there are effective systems are in place to consistently assess, monitor and improve patient safety and the quality of care. Regulation 17 (1)(2)(a) and (b): Good governance	MD1 02/2	Mrs Melanie Woolfall	Medicine	Medical Care Group to ensure that there are improvements in the completion and review of monitoring assessments and risk assessments for individual patients on the Medical Wards in Med Unit 2 from August 2021 to December 2022.	In progress

Must Do	The service must ensure there are effective systems are in place to consistently assess, monitor and improve patient safety and the quality of care. Regulation 17 (1)(2)(a) and (b): Good governance	MD1 02/3	Mrs Melanie Woolfall	Medicine	Medicine Care to ensure that the escalation of concerns on the Medical Wards in Med Unit 2 can be appropriately integrated into and reported through the Care Group and Trust Governance structures.	In progress
Must Do	The service must ensure there are effective systems are in place to consistently assess, monitor and improve patient safety and the quality of care. Regulation 17 (1)(2)(a) and (b): Good governance	MD1 02/4	Ms Debbie Crawford	Medicine	Medicine Care Group to work with Radiology to improve the performance in achieving the 1 Hour Target for Stroke CT's for patients located in the Medical Wards in Medical Unit 2 at the RLI.	In progress
Must Do	The trust must ensure continued development and investment in pharmacy resources to make sure medicines reconciliation rates and antimicrobial stewardship are improved across the trust. (Regulation 12 (2) (g))	MD1 14/1	Mrs Kam Mom	Pharmacy	Recommendation to be reviewed with Chief Pharmacist, Medication Safety Officer and ADOp of CCS to determine; a) is the is the same recommendation as MD6 b) if it is the same recommendation, are there any new actions required? c) if no new actions are required this new recommendation will be managed through MD6	Partially complete
Must Do	The trust must ensure that antimicrobial prescribing guidelines are consistently followed. (Regulation 12 (2) (g))	MD1 15/1	Mrs Kam Mom	Pharmacy	Recommendation reviewed with Chief Pharmacist, Medication Safety Officer and ADOp of CCS, to consider whether this recommendation is already being addressed through Recommendation MD6 and/or MD114 (The trust must ensure continued development and investment in pharmacy resources to make sure medicines reconciliation rates and antimicrobial stewardship are improved across the trust.)	Partially complete
Must Do	The trust must ensure that antimicrobial prescribing guidelines are consistently followed. (Regulation 12 (2) (g))	MD1 15/2	Mrs Kam Mom	Pharmacy	Anti-Microbial Stewardship Pharmacists and Pharmacy Technicians to undertake a review of the Trust Antimicrobial prescribing Guidelines to ascertain if the documents are up to date and fit for purpose, if the review identifies any changes that are required the Anti-Microbial Stewardship Pharmacists and Pharmacy Technicians will then liaise with the Document Authors and the Procedural Document Team to ensure the documents are promptly updated and re-issued. PHARM/GUID/003 - Antimicrobial Paediatrics Guideline CORP/GUID/060 - Antibiotic Prescribing in Surgery CORP/GUID/061 - Antibiotic Prescribing for Medicine	In progress

Must Do	The trust must ensure that antimicrobial prescribing guidelines are consistently followed. (Regulation 12 (2) (g))	MD1 15/3	Mrs Kam Mom	Pharmacy	Pharmacy to complete Audit 2763 Audit of Agreed Antimicrobial Use, results of Audit to reported at Medication Safety Group and shared with Care Groups, Audit results will confirm if antimicrobial prescribing guidelines are being followed. Pharmacy to investigate if data collected for 2022/23 Qtr1 could be used to provide a preliminary assessment to identify any high-risk issues or high-risk areas, so that interim remedial actions can be undertaken.	Partially complete
Must Do	The trust must ensure that antimicrobial prescribing guidelines are consistently followed. (Regulation 12 (2) (g))	MD1 15/4	Ms Jane McNicholas	Pharmacy	Chief Pharmacist, in conjunction with Chief Medical Officer and the Director of Infection Prevention and Control, will issue an immediate communication to all prescribers to inform them that the CQC Inspection Report contains a Must Do Recommendation on 'Ensuring that antimicrobial prescribing guidelines are consistently followed' and that as prescribers they should ensure they are aware of the Trust's antimicrobial prescribing guidelines and ensure they followed, with any clinical concerns and issues with the guidelines being appropriately escalated.	In progress
Must Do	The trust must ensure that patient's privacy is upheld. Regulation 10(1)(2)(a)	MD1 21/1	Ms Bongi Gbadebo	Accident and Emergency	Compliance and Assurance Team and Medicine Care Group Triumvirate to undertake review Recommendation MD121 to determine if this recommendation is a 'duplicate' of the existing Recommendation MD18 from the August 2021 Inspection report. If it is determined that recommendation MD121, it will then be decided if the existing action plan to address Recommendation MD18 is sufficient to address both Recommendations, or if Recommendation MD121 requires an independent action plan.	Partially complete
Must Do	The trust must ensure that patient records are stored in a secure manner and can be accessed by staff. Regulation 17(1)(2)(c)	MD1 22/1	Mrs Melanie Woolfall	Accident and Emergency	Medicine Care Group Action Plan to improve IG compliance at FGH ED Issue Immediate communication to FGH ED staff to inform them that the CQC have issued a Must Do Recommendation to improve Information Governance in the Department.	Partially complete

Must Do	The trust must ensure that patient records are stored in a secure manner and can be accessed by staff. Regulation 17(1)(2)(c)	MD1 22/2	Mrs Melanie Woolfall	Accident and Emergency	Medicine Care Group Action Plan to improve IG compliance at FGH ED Continue with ongoing communication to maintain staff awareness of Information Governance and Patient Confidentiality.	In progress
Must Do	The trust must ensure that patient records are stored in a secure manner and can be accessed by staff. Regulation 17(1)(2)(c)	MD1 22/3	Mrs Melanie Woolfall	Accident and Emergency	Medicine Care Group Action Plan to improve IG compliance at FGH ED Continue with spot checks of IG compliance through Matron Audits and Service Reviews.	In progress
Must Do	The trust must ensure that patient records are stored in a secure manner and can be accessed by staff. Regulation 17(1)(2)(c)	MD1 22/4	Mrs Melanie Woolfall	Accident and Emergency	Medicine Care Group Action Plan to improve IG compliance at FGH ED Undertake an Audit of IG compliance at FGH ED, by end of August 2022, with results to reported by to Care Group Governance meeting and Care Group Management Meeting In September 2022 Any Items of significant concern will also be escalated to the Information Governance & Data Quality Group.	Partially complete
Must Do	The trust must ensure that patient records are stored in a secure manner and can be accessed by staff. Regulation 17(1)(2)(c)	MD1 22/5	Mrs Melanie Woolfall	Accident and Emergency	Medicine Care Group Action Plan to improve IG compliance at FGH ED Schedule a Re-Audit of IG Compliance in the FGH ED, to take place in 2023, to monitor for improvements. Audit specification to state that; results to be reported by to the Care Group Governance meeting and Care Group Management meeting, and any Items of significant concern will also be escalated to the Information Governance & Data Quality Group.	In progress
Must Do	The service must ensure that care and treatment is provided in a safe way by the proper and safe management of medicines. Regulation 12 (1) (2) (g)	MD1 26/1	Mrs Kam Mom	Accident and Emergency	To Recruit and deploy Pharmacists and Pharmacy Technicians dedicated to support and to improve Medicine Management within the Emergency Departments at FGH and RL 2 FTE Pharmacist(s) at FGH ED 2 FTE Pharmacy Technicians at FGH ED 1 FTE Pharmacist(s) at RLI ED 2 FTE Pharmacy Technicians at RLI ED	Partially complete
Must Do	The service must ensure that care and treatment is provided in a safe way by the proper and safe management of medicines. Regulation 12 (1) (2) (g)	MD1 26/2	Mrs Kam Mom	Accident and Emergency	Medicine Care Group and Pharmacy to work together to develop and implement a business case to replace the Mediwell Drug storage systems used in the Emergency Departments at FGH and RLI.	Partially complete

Must Do	The service must ensure that patients are treated with dignity and respect. Including ensuring their privacy and having due regard to any relevant protected characteristics. Regulation 10 (1) (2) (a) (c)	MD1 27/1	Ms Bongi Gbadebo	Accident and Emergency	Compliance and Assurance Team to review this recommendation with members of the Medicine Care Group Triumvirate to determine if it is a 'duplicate' of Recommendation MD121, and if it is a duplicate whether a separate action is required or not.	Partially complete
Must Do	The service must ensure that all premises and equipment used by the service provider are secure and suitable for the purpose for which they are being used. Regulation 15 (1) (b)(c)	MD1 28/1	Ms Bongi Gbadebo	Accident and Emergency	In light of the prevailing Capital situation and the physical constraints on the RLI site, Medicine Care Group to liaise with CEO, COO and CFO to identify any practical options and associated timescales for 'ensuring that RLI ED Premises are suitable for the purpose for which they are being used', these will then be reported back to Trust Board and the CQC Engagement Meeting. Non-Estates solutions to improvement Patient Safety Adult and Paediatric Waiting Areas and the Paediatric Treatment Areas are being investigated under Actions MD128/2 and MD128/3.	In progress
Must Do	The service must ensure that all premises and equipment used by the service provider are secure and suitable for the purpose for which they are being used. Regulation 15 (1) (b)(c)	MD1 28/2	Mrs Melanie Woolfall	Accident and Emergency	Medicine Care Group will investigate alternative solutions (not Estates Works) to improve clinical observation of Adult Patients and clinical oversight of Paediatric Patients in the waiting areas. Consideration to be given to some form of regular intentional rounding of the ED Waiting Areas by clinical staff. Risks to be updated on the risk register	In progress
Must Do	The service must ensure that all premises and equipment used by the service provider are secure and suitable for the purpose for which they are being used. Regulation 15 (1) (b)(c)	MD1 28/3	Mrs Melanie Woolfall	Accident and Emergency	Medicine Care Group will investigate alternative solutions (not Estates Works) to improve the safety of Patients in the Paediatric Treatment Area.	In progress
Should Do	The trust should ensure that Patient Group Directions oversight should be strengthened to ensure sure appropriate and timely review and implementation	SD7/ 1	Mrs Kam Mom	TRUSTWIDE	Chief Pharmacist, Trust Procedural Document Team and Chair of Drugs, Therapeutics and Medicines Management Group to continue and complete existing programme of work to review and improve the processes for the review, approval and implementation of Patient Group Directives (PGDs)	Fully complete (Approved)
Should Do	The trust should ensure that the uptake of medicines management e-learning be prioritised to help improve medicines safety	SD8/ 1	Mrs Kam Mom	TRUSTWIDE	The Pharmacy Service will implement proactive scrutiny of medicines management e-learning compliance via the Medication Safety Group and plan improvements with the Care Groups	Partially complete (Overdue)

Should Do	The trust should ensure that Electronic Prescribing and Medicines Administration (EPMA) auditing be strengthened to proactively identify prescribing and administration errors	SD9/1	Mrs Kam Mom	TRUSTWIDE	As part of GGI Governance review, confirm that Electronic Prescribing and Medicines Administration (EPMA) auditing will be part of remit of EPMA Steering Group and complete review of EPMA Steering Group Terms of Reference to including Auditing of EPMA. Chair of EPMA Steering Group to work with Trust Clinical Audit Team to establish programme of Audits with results reported back to EPMA Steering Group for post audit action plans to be developed in conjunction with Care Groups.	Fully complete (Approved)
Should Do	The trust should ensure that all staff follow infection control principles, including the use of personal protective equipment (PPE) at all times and receive refresher training in this where deemed necessary	SD2 2/1	Mrs Amy Mbuli	Accident and Emergency	Prevailing and COVID specific IPC/PPE Policies already in place, monitoring through Spot Checks and Audits already in place. The service will re-communicate requirements to increase staff awareness and to encourage staff to actively challenge and/or report non-compliance, reported or identified incidents of non-compliance to be investigated and resolved.	Partially complete (Overdue)
Should Do	The trust should consider whether they can build a separate paediatric treatment area to meet best practice guidelines	SD2 3/1	Ms Bongi Gbadebo	Accident and Emergency	The Trust has a programme of work for reviewing compliance with the 'Facing The Future' requirements and to deliver improvements, which is reported through to the A&E delivery Board. This will include a review provision of paediatric services at RLI ED to determine most appropriate service design	Partially complete (Overdue)
Should Do	The trust should consider whether the triage service in the walk-in waiting area can be improved so that the triage nurse can observe patients in the waiting area more easily	SD2 4/1	Mr Richard Vallely	Accident and Emergency	The Medicine Care Group will, in conjunction with the RLI Estates Team, undertake a review of the RLI ED triage area and develop improvement plan	Fully complete (Awaiting approval)
Should Do	The trust should consider ensuring that there is a doctor or consultant at all safety huddles so that clinical information is not omitted from being shared with nursing staff.	SD2 5/1	Ms Bongi Gbadebo	Accident and Emergency	The Medicine Care Group will review records of Medical attendance at Safety huddles and consider the feasibility of requiring Medical attendance at all safety huddles at RLI ED. The Service will then undertake a review of the safety huddle process and will review and update the Safety Huddle SOP if required.	Partially complete (Overdue)
Should Do	The trust should ensure that a more robust system of assessing skin integrity and pressure sores is put in place rather than the “safe and seen” assessment used presently.	SD2 6/1	Mrs Melanie Woolfall	Accident and Emergency	The Medicine Care Group will undertake comparative Audits of the 'Waterlow' risk assessments against the 'Seen & Safe' risk assessments to identify the most appropriate documentation method. The more robust method for assessing Tissue Viability will then be	Partially complete (Overdue)

					implemented, with procedural documents to updated accordingly	
Should Do	The trust should consider giving emergency department managers access to view incidents that are graded no harm or low harm, in order that there is complete oversight of incidents in the department to ensure that they have been graded correctly or may meet the criteria for a serious incident	SD27/1	Mrs Melanie Woolfall	Accident and Emergency	Incident Management Policy already in place which contains detailed guidance on the grading of the harm level of incidents. Review of Incident Management System has confirmed that; ED managers already have access rights to all incidents in the ED, have access rights to re-grade the harm level of these incidents and have access rights to flag these incidents as a 'Serious Incident'. ED Managers have been offered further training in the Incident Management System and grading the harm level of incidents. All Incidents graded with a Harm level of Moderate or above are also independently reviewed at the Trust Wide Weekly Patient Safety Summit.	Fully complete (Approved)
Should Do	The trust should consider giving emergency department managers access to view incidents that are graded no harm or low harm, in order that there is complete oversight of incidents in the department to ensure that they have been graded correctly or may meet the criteria for a serious incident	SD27/2	Mrs Melanie Woolfall	Accident and Emergency	RLI ED Matron to work Medicine Care Group Patient Safety Team and Trust Patient Safety Team to produce a summary of the various Patient Safety systems, processes and meetings that are in place in Medicine Care Group and the Trust which help to ensure that there is "complete oversight of incidents in the department".	In progress
Should Do	The trust should consider completing the urgent and emergency care plans that have been delayed so that these can feed into the medicine care group strategy	SD28/1	Miss Leanne Cooper	Accident and Emergency	Plans have been developed as part of the BHACP UEC Programme and signed off by A&E Delivery Board. Additional PMO support allocated to help delivery. A robust improvement programme that facilitates patient flow corporately is in place and delivered in line with the Urgent Care action plan.	Fully complete (Approved)
Should Do	The trust should consider completing the urgent and emergency care plans that have been delayed so that these can feed into the medicine care group strategy	SD28/2	Mrs Diane Smith	Accident and Emergency	Bay/Trust Wide elements being managed through Action SD28/1 by Leanne Cooper Medicine Care group are responsible for implementing two elements of the Urgent and emergency care plans; 'Front Door' and 'ED'.	Fully complete (Approved)

Should Do	The trust should take appropriate actions to improve staff mandatory training, including safeguarding training in line with trust compliance targets.	SD3 4/1	Mrs Carol Park	Surgery and Critical Care Services	The Surgery Care Group has improved Mandatory training compliance and is currently meeting Trust targets, the Surgery Care Group will review compliance again in 3 months' time and if compliance remains high, action can be closed.	Fully complete (Approved)
Should Do	The trust should take appropriate actions to improve staff appraisal completion in line with trust compliance targets	SD3 5/1	Mr Daniel Bakey	Surgery and Critical Care Services	The Surgery Care Group will take steps to improve appraisal compliance through: weekly monitoring of performance at SMG, monthly monitoring at Governance Meeting, red flagging of Hot Spots, discussion in 1-to-1's with Clinical Leads and Dept/Ward Managers.	Partially complete (Overdue)
Should Do	The service should consider implementing a policy and schedule for changing the keypad code at ward entrances to maintain security	SD4 1/1	Mrs Linda Womack	Maternity Service	The Maternity Service at RLI will work with the Estates Team and the Security to undertake a review of the security systems, to establish the practical feasibility and implementation of Swipe Card Access, or the continuation of Key Pad Access, if Key Pad access continues a schedule of code changes will then be established and implemented.	Fully complete (Approved)
Should Do	The service should ensure the policy for cleaning of the birthing pool is ratified and implemented to control the risk of spread of infection.	SD4 2/1	Mrs Linda Womack	Maternity Service	The Maternity Service will review and update the organisational policy for the cleaning of the birthing pools and ensure the document complies with relevant standards	Fully complete (Approved)
Should Do	The service should ensure that recommendations from external incident investigations are fully considered and appropriate, robust action plans put in place	SD4 3/1	Ms Heather Gallagher	Maternity Service	The WACS Care Group Triumvirate will review recommendations from external incident investigations (including the Ockenden Report) and will then ensure that remedial action plans are robust, are monitored at Triumvirate meetings and that evidence is provided against each action.	Partially complete
Should Do	The service should act to improve the assessment of women's pain in light of their clinical condition and ensure all women receive pain relief in a timely manner	SD4 4/1	Mrs Claire Bowman	Maternity Service	The Maternity Service will carry out a Pain Management Audit and will develop an improvement plan once audit results are available	Partially complete
Should Do	The service should continue to act to ensure women received continuity of care in line with national recommendations and targets	SD4 5/1	Mrs Ruth Deery	Maternity Service	The Maternity Service will develop a continuity of care model by locality, the care model will be aligned with national recommendations and targets.	Partially complete
Should Do	The trust should consider what actions the service can take to improve safeguarding adults and safeguarding children level three training rates for doctors and nurses.	SD5 5/1	Ms Bongi Gbadebo	Accident and Emergency	The Medicine Care Group will review guidance / training requirements against current compliance and ensure robust plan in place in conjunction with the Safeguarding Team (Action links to MD54)	Partially complete (Overdue)

Should Do	The trust should ensure senior leaders of the department have oversight of paediatric activity and performance in the ED.	SD5 6/1	Mr Neil Smith	Accident and Emergency	The Medicine Care Group will work with the Business Intelligence Team to include data on the ED paediatric activity within the Trusts command and control centre platform, and will undertake a review of the ED Safety Huddle SOP to ensure that includes ED paediatric activity.	Partially complete (Overdue)
Should Do	The trust should ensure that wards are secured to maintain patient safety	SD6 2/1	Ms Sarah Maguire	Surgery and Critical Care Services	The Surgery Care Group will obtain quote(s) to improve security on Surgery Wards at FGH. Quote obtained on day of Inspection, funding in place, need to confirm progress of Works.	Partially complete (Overdue)
Should Do	The trust should ensure that fire doors are maintained and used correctly	SD6 3/1	Mrs Carol Park	Surgery and Critical Care Services	Met with staff and ward managers. Responsibilities and accountabilities made clear and staff will be held to account re standards for their ward/ department. Daily matron checks in place Action completed	Fully complete (Approved)
Should Do	The trust should ensure that systems and processes are established and operated effectively to identify, assess, monitor, escalate and take mitigating actions, particularly in relation to the safe storage of medicine and the checking of emergency resuscitation equipment.	SD6 4/1	Ms Sarah Maguire	Surgery and Critical Care Services	The Surgery Care Group has existing processes to ensure that Resuscitation equipment is checked daily and monitored via the AMaT system. Action complete	Partially complete (Overdue)
Should Do	The trust should ensure that systems and processes are established and operated effectively to identify, assess, monitor, escalate and take mitigating actions, particularly in relation to the safe storage of medicine and the checking of emergency resuscitation equipment.	SD6 4/2	Ms Sarah Maguire	Surgery and Critical Care Services	Trust Wide Safe and secure storage of medicine (SSSM) policies and procedures already in place, annual SSSM audit undertaken by Pharmacy and reported to Medication Safety Group. Spot checks on SSSM undertaken by Matrons and Ward Managers. SSSM data collection/audit to be moved to AMAT system to enable more rigorous monitoring by Matrons and Ward Managers. The Service will communicate to staff to reiterate the importance of the SSSM and will continue with monitoring and escalation.	Partially complete (Overdue)
Should Do	The trust should ensure patient records are stored securely.	SD6 5/1	Ms Sarah Maguire	Surgery and Critical Care Services	Briefings held with staff to staff to reinforce IG and privacy requirements Daily matron checks in place, Information Governance included in Service Reviews. The majority of patient records are now electronic, Minimal paper notes remaining within locked trollies for security.	Fully complete (Approved)

Should Do	The service should act to improve the quality of safety information shared in SBAR handover.	SD7 6/1	Mrs Holly Parkinson	Maternity Service	The Maternity Service will undertake a review and update of the SOP / Guideline for SBAR Handover and ensure it is aligned with National Standards.	Partially complete
Should Do	The service should act to improve the quality of safety information shared in SBAR handover.	SD7 6/2	Mrs Linda Womack	Maternity Service	The Maternity Service will undertake a review practice of current SBAR Handover processes and identify if/how these can be re-implemented / re-energised	Partially complete
Should Do	The service should act to improve the quality of safety information shared in SBAR handover.	SD7 6/3	Mrs Linda Womack	Maternity Service	The Maternity Service will work with the Trust Clinical Audit team to undertake an annual Audit to measure compliance with SBAR guideline/ SOP and will develop remedial action plans if required undertake a yearly audit to provide assurance	Partially complete
Should Do	The service should progress actions to enable improved access within the birth centre, in context of the physical environment.	SD7 9/1	Mrs Linda Womack	Maternity Service	There are two lifts for access to the South Lakes Birth Centre; one for emergency access for trolley patients, one for ambulatory patient/family access. The Maternity Service will ensure the induction training of all new staff includes information on how to enable access the delivery suites in an emergency.	Partially complete (Overdue)
Should Do	The service should implement effective use of the whiteboard communication system on the birth centre	SD8 0/1	Mrs Tamsin Cripps	Maternity Service	The Maternity Service, in conjunction with I3 Service, will undertake a post Badger Net implementation review of the whiteboards at the South Lakes Birth Centre	Partially complete
Should Do	The trust should ensure that visible information about requesting a chaperone is available to patients attending the centre.	SD8 1/1	Mrs Diane Smith	Accident and Emergency	The Medicine Care Group will develop and implement posters/signage so patients attending the Kendal Urgent Treatment Centre are made aware that they can request a chaperone to be present during their treatment	Fully complete (Approved)
Should Do	The Trust should ensure that privacy and confidentiality is maintained for patients when sharing personal information	SD8 3/1	Mrs Melanie Woolfall	Accident and Emergency	The Medicine Care Group will brief staff at the Kendal Urgent Treatment Centre to re-iterate the importance of maintaining patient confidentiality and will then undertake a review as part of the regular matron audit to confirm compliance with patient privacy / confidentiality requirements, ensure staff are up to date with IG training. Regular monitoring at MCGAG to be established.	Partially complete (Overdue)
Should Do	The service should consider protected time to allow for the completion of mandatory training	SD9 3/1	Mrs Linda Womack	Maternity Service	The Maternity Service already schedule 4 compulsory mandatory training days per annum for all staff in Maternity Services, to help ensure ongoing compliance with mandatory training. Additional protected time for the completion of mandatory training is available to	Partially complete (Overdue)

					staff at the discretion of Department/Unit/Ward Managers.	
Should Do	The service should work to engage the workforce and increase visibility of the executive team	SD95/1	Mr Paul Jones	Maternity Service	The Trust will maintain and enhance Executive Directors presence on all sites, through a schedule of planned Executive visits/presence.	Fully complete (Approved)
Should Do	The trust should ensure that all records are securely stored	SD103/1	Mrs Melanie Woolfall	Medicine	The Medicine Care Group will brief staff at RLI Medical Unit 2 to re-iterate the importance of maintaining patient confidentiality and will then undertake a review as part of the regular matron audit to confirm compliance with patient privacy / confidentiality requirements. Also check compliance with IG core skills training on Medical Unit 2 Wards	Fully complete (Approved)
Should Do	The service should ensure they complete MUST documentation	SD104/1	Mrs Melanie Woolfall	Medicine	The Medicine Care Group will manage this recommendation through the fundamentals work on managing a deteriorating patient and medicines management. Matrons will maintain regular oversight through assurance checks.	Fully complete (Awaiting approval)
Should Do	The service should ensure that cleaning schedules are completed appropriately. (Regulation 12	SD116/1	Mrs Melanie Woolfall	Medicine	Medicine Care Group, with support from Infection Prevention and Facilities, will, issue an immediate communication to FGH Ward/Unit Managers and FGH Matrons informing that the CQC have issued a Should Recommendation to improve the completion Cleaning Schedule and that the immediate action should be taken to ensure Cleaning Schedules are completed.	In progress
Should Do	The service should ensure that cleaning schedules are completed appropriately. (Regulation 12	SD116/2	Mrs Melanie Woolfall	Medicine	Medicine Care Group, with support from Infection Prevention and Facilities, will, review and update the cleaning schedules on the Medical Wards at FGH, progress will be monitored by regular audit and re-audit of compliance with the revised cleaning schedules. Progress will be reported at the Care Group Governance meeting and the Trust Infection Prevention Control Group.	In progress
Should Do	The trust should ensure that their updated policy for the management of violence and aggression should include clearer guidance about the use of medicines in line with National Institute for Health and Care Excellence (NICE) guidelines. (Regulation 17	SD117/1	Mrs Kam Mom	Medicine	Recommendation reviewed with Chief Pharmacist, Medication Safety Officer and ADOp of CCS. Confirmed that Pharmacy are already leading on the review of the rapid tranquilisation policy.	Fully complete (Awaiting approval)

Should Do	The trust should ensure that their updated policy for the management of violence and aggression should include clearer guidance about the use of medicines in line with National Institute for Health and Care Excellence (NICE) guidelines. (Regulation 17	SD1 17/2	Mrs Kam Mom	Medicine	Trust NICE Lead to facilitate a re-baseline assessment of NG10, with input from Medicine Care Group, Pharmacy, Security and Safeguarding to be completed by end of October 2022. Progress and completion of re-baseline assessment will be reported to Trust Clinical Audit & Standards Group. Outcomes from re-baseline assessment to be used in subsequent review and update of Procedural Documents CORP/POL/016, CORP/POL/044 and CORP/PROT/011- see action SD117/3, SD117/4 and SD117/5	Partially complete
Should Do	The trust should ensure that their updated policy for the management of violence and aggression should include clearer guidance about the use of medicines in line with National Institute for Health and Care Excellence (NICE) guidelines. (Regulation 17	SD1 17/3	Mr Mark Lippett	Medicine	Following completion of re-Baseline Assessment of NICE Guideline NG10 lead by Trust NICE Lead (target date October 2022), the author of Trust Procedural Document CORP/POL/044 (Behaviour Management and Supportive Intervention), will use outcomes from the re-Baseline Assessment of NICE Guideline NG10 to inform a review and update of Trust Procedural Document CORP/POL/044 with support from Pharmacy, Safeguarding and Care Groups. Progress will be monitored/reported at Trust Procedural Documents and Patient Information Leaflet Meeting	In progress
Should Do	The trust should ensure that their updated policy for the management of violence and aggression should include clearer guidance about the use of medicines in line with National Institute for Health and Care Excellence (NICE) guidelines. (Regulation 17	SD1 17/4	Mr Dan Willis	Medicine	Following completion of re-Baseline Assessment of NICE Guideline NG10 lead by Trust NICE Lead (target date October 2022), the author of Trust Procedural Document CORP/POL/016 (Violence & Aggression), will use outcomes from the re-Baseline Assessment of NICE Guideline NG10 to inform a review and update of Trust Procedural Document CORP/POL/016 with support from Pharmacy, Safeguarding and Care Groups. Progress will be monitored/reported at Trust Procedural Documents and Patient Information Leaflet Meeting	In progress

Should Do	The trust should ensure that their updated policy for the management of violence and aggression should include clearer guidance about the use of medicines in line with National Institute for Health and Care Excellence (NICE) guidelines. (Regulation 17	SD1 17/5	Mrs Nicola Askew	Medicine	Following completion of re-Baseline Assessment of NICE Guideline NG10 lead by Trust NICE Lead (target date October 2022), the author of Trust Procedural Document CORP/PROT/011 (Lancashire and South Cumbria Shared Care Protocol for the Management of Children and Young People Attending University Hospitals of Morecambe Bay with Emotional, Behavioural and Mental Health Needs. Appendix 9 Rapid Tranquilisation Policy), will use outcomes from the re-Baseline Assessment of NICE Guideline NG10 to inform a review and update of Trust Procedural Document CORP/PROT/011 with support from Pharmacy, Safeguarding and Care Groups. Progress will be monitored/reported at the WACS Care Group Governance Meeting and the Trust Procedural Documents and Patient Information Leaflet Meeting	In progress
Should Do	The trust should continue to actively seek a suitable candidate for recruitment to its stroke consultant vacancy. (Regulation 12)	SD1 18/1	Ms Bongi Gbadebo	Stroke Medicine - GenMed	Medicine Care Group will continue to take steps to recruit a Stroke Medicine Consultant at FGH.	Partially complete
Should Do	The trust should continue to actively seek a suitable candidate for recruitment to its stroke consultant vacancy. (Regulation 12)	SD1 18/2	Ms Bongi Gbadebo	Stroke Medicine - GenMed	Medicine Care Group to provide overview of mitigations that are in place to ensure that Patient safety and the quality of Patient Care and Treatment in Stroke Medicine at FGH is being maintained and developed and this is reflected in the risk on the risk register. Mitigations such as; Cross Bay Consultant cover/working, recruitment of additional Junior Doctors, Recruitment of ANPs/CNSs	Partially complete
Should Do	The trust should ensure it achieves its target for take-home medicines to be ready within one hour. (Regulation 12)	SD1 19/1	Mrs Kam Mom	Pharmacy	Pharmacy to review all documents that contain reference to internal Targets to provide greater clarity on the nature of these targets; - Is it - Informal internal operational target, or formal performance target - Detailing where different targets used for different departments/wards - 1 Hour for Emergency Medicine, 2 Hours for other Departments/Wards	In progress

Should Do	The trust should ensure it achieves its target for take-home medicines to be ready within one hour. (Regulation 12)	SD1 19/2	Mrs Kam Mom	Pharmacy	This action is also part of an action to address Recommendation MD 126 To Recruit and deploy Pharmacists and Pharmacy Technicians dedicated to support and to improve Medicine Management within the Emergency Departments at RLI 2 x FTE Pharmacist(s) at RLI ED 2 FTE Pharmacy Technicians at RLI ED	Partially complete
Should Do	The trust should review its higher-than-expected readmission rates for both elective and non-elective admissions	SD1 20/1	Mr Paul Smith	Medicine	Compliance and Assurance Team to review this recommendation with members of the Medicine Care Group Triumvirate to determine if it is best managed within Medicine Care Group or managed at a corporate level with input from Medicine Care Group.	Fully complete (Awaiting approval)
Should Do	The trust should review its higher-than-expected readmission rates for both elective and non-elective admissions	SD1 20/2	Ms Bongi Gbadebo	Medicine	Medicine Care Group to undertake a review of readmission rates for Medical elective Patients and Medical non-elective admissions, this review will; - confirm the scale of the higher than average re-admission rates within Specialties and/or in Treatment Pathways - investigate the internal and external causes of the the higher than average re-admission rates - identify potential actions to address the higher than average re-admission rates - Implement any Trust Internal Actions to address the higher than average re-admission rates - Ensure that any system wide actions are communicated to the relevant partner organisations for them to review Progress to be reported to the Trust Clinical Effectiveness Group	In progress
Should Do	The trust should ensure that the minors waiting area and the paediatric provision of the department has sufficient staffing and patient oversight after 5PM. Regulation 12(2)(a)	SD1 23/1	Mrs Melanie Woolfall	Accident and Emergency	Medicine Care Group, with support from Paediatrics, to undertake of a review of the paediatric staffing provision of FGH ED to identify potential actions to ensure that staffing provision is maximised and that safe care and treatment is maintained as well as it practically possible.	Partially complete

Should Do	The trust should ensure that the minors waiting area and the paediatric provision of the department has sufficient staffing and patient oversight after 5PM. Regulation 12(2)(a)	SD1 23/2	Ms Bongi Gbadebo	Accident and Emergency	Medicine Care Group to submit a Business Case to improve Triage facilities/service at FGH ED to improve oversight of patients in the Paediatric waiting area, subsequent to approval, Medicine Care Group, with support from Estates, will then implement the requirements of Business Case.	Partially complete
Should Do	The trust should ensure that the minors waiting area and the paediatric provision of the department has sufficient staffing and patient oversight after 5PM. Regulation 12(2)(a)	SD1 23/3	Mrs Melanie Woolfall	Accident and Emergency	Medicine Care Group to liaise with Safeguarding Team to undertake review of process for overseeing patients in the paediatric waiting areas at FGH ED, to identify any areas of concern and to help ensure that these are addressed and that there is appropriate safeguarding of these patients whilst in the Paediatric Waiting area	In progress
Should Do	The trust should ensure that the minors waiting area and the paediatric provision of the department has sufficient staffing and patient oversight after 5PM. Regulation 12(2)(a)	SD1 23/4	Mrs Melanie Woolfall	Accident and Emergency	FGH ED Management Team to undertake a review of the current mechanisms for clinical observation and observation of patients in the minors waiting area after 5PM, to identify practical solutions to improve the observation and observation of patients to help ensure patient safety in the minors waiting area.	In progress
Should Do	The trust should consider a system to monitor staff wellbeing in relation to usage of bank and agency, to assist in the prevention of staff burnout	SD1 24/1	Ms Bongi Gbadebo	Accident and Emergency	Medicine Care Group to undertake review of the utilisation of Overtime, Bank Staff and Agency Staff to fulfil staffing requirements at FGH ED over the last 12 months to identify; - Is the Trust compliant with Working Time regulations - Is the Trust compliant with safe staffing standards - if there is a chronic/persistent issue with under staffing due low head count - if there are sporadic periods of under staffing due to short term absence etc. The results of the review will then be used to determine next steps, if no significant issue is identified, this may require a request for further clarification from the CQC on the basis of this recommendation.	Partially complete
Should Do	The service should consider reviewing the arrangements for the implementation of the mental capacity act and deprivation of liberties safeguarding within the emergency department and align the trust policy to the practice	SD1 25/1	Ms Bongi Gbadebo	Accident and Emergency	Compliance and Assurance Team to review this recommendation with with members of the Medicine Care Group Triumvirate to determine if Recommendation SD133 it is a 'duplicate' of this recommendation, and if it is a duplicate whether a	Fully complete (Awaiting approval)

					separate action is required or not to address Recommendation SD133.	
Should Do	The service should consider reviewing the arrangements for the implementation of the mental capacity act and deprivation of liberties safeguarding within the emergency department and align the trust policy to the practice	SD1 25/2	Mrs Melanie Woolfall	Accident and Emergency	Medicine Care Group to work with Trust Safeguarding Team to review the implementation of the Mental Capacity Act (MCA) in the ED's at FGH and RLI compared to Trust Policy and to identify potential actions, Medicine will address any identified issues of ED staff awareness, training and practice of the MCA. The Safeguarding Team will address any issued identified with the Trust Policy related to the MCA ED staff awareness, training and practice of the MCA.	In progress
Should Do	The service should consider reviewing the arrangements for the implementation of the mental capacity act and deprivation of liberties safeguarding within the emergency department and align the trust policy to the practice	SD1 25/3	Ms Liz Thompson	Accident and Emergency	Compliance and Assurance Team to confirm with Safeguarding Team the legal applicability of Depravation of Liberties Safeguards (DoLS) to patients attending at an Emergency Department, as opposed to Patient's admitted to an In-Patient Ward/Unit, Need to consider the status of Patients with DTA, but who have been in ED for more than 12 hours as, in effect, they have become inpatients. If it is confirmed that DoLS has no legal applicability to patients attending at an Emergency Department, then the Compliance and Assurance Team will raise a query with the CQC to seek clarification regarding the DoLS element of this recommendation.	Partially complete
Should Do	The service should consider whether the triage service in the walk-in waiting area can be improved so that the triage nurse can observe patients in the waiting area more easily	SD1 29/1	Ms Bongi Gbadebo	Accident and Emergency	Compliance and Assurance Team to review this recommendation with with members of the Medicine Care Group Triumvirate to determine if it is a 'duplicate' of Recommendation SD24, and if it is a duplicate whether a separate action is required or not.	Partially complete
Should Do	The service should consider whether the triage service in the walk-in waiting area can be improved so that the triage nurse can observe patients in the waiting area more easily	SD1 29/2	Mrs Melanie Woolfall	Accident and Emergency	Medicine Care Group will investigate alternative solutions (not Estates Works) to improve observation of Patients in the triage and waiting areas, consideration to be given to some form of regular intentional rounding of the ED Waiting Areas.	In progress

Should Do	The service should continue to work closely with all system partners to tackle the capacity pressures on urgent and emergency care in the health and social care system.	SD1 30/1	Ms Bongi Gbadebo	Accident and Emergency	Compliance and Assurance Team to review this recommendation with with members of the Medicine Care Group Triumvirate to determine if it is best managed within Medicine Care Group or managed at a Corporate level with input from Medicine Care Group	Fully complete (Awaiting approval)
Should Do	The service should continue to work closely with all system partners to tackle the capacity pressures on urgent and emergency care in the health and social care system.	SD1 30/2	Mr Scott McLean	Accident and Emergency	The Trust will continue to work with system partners to deliver the Bay Health and Care Partners (BHACP) Urgent and Emergency Care (UEC) Improvement Plan for 2022-23, progress against the the BHACP UEC Improvement Plan is monitored at the A&E delivery Board with Escalation to the Trust Board and System Improvement Board.	Partially complete
Should Do	The service should continue to work closely with all system partners to tackle the capacity pressures on urgent and emergency care in the health and social care system.	SD1 30/3	Ms Bongi Gbadebo	Accident and Emergency	Medicine Care Group to undertake a review of lessons learnt from ED RLI when operating well at OPEL 4 and what can be learned from this to improve performance at lower levels. Outcomes from this review will be reported to Care Group Management Meeting and to the A&E Delivery Board.	In progress
Should Do	The service should consider ways for staff to have oversight of children waiting to be triaged.	SD1 31/1	Mrs Melanie Woolfall	Accident and Emergency	Medicine Care Group will investigate alternative solutions (not Estates Works) to improve observation and clinical oversight of Paediatric Patients in the waiting areas, consideration to be given to some form of regular intentional rounding of the ED Waiting Areas.	In progress
Should Do	The service should consider reviewing the advanced paediatric life support to make sure that all band 6 staff have the correct qualification	SD1 32/1	Mrs Melanie Woolfall	Accident and Emergency	Medicine Care Group will undertake a review, with support from Resus practioneers of the two training courses used for paediatric life support; advanced paediatric life support (APLS) and European paediatric life support (EPLS), to ensure that both courses are of the required standard. If they are of the required standard, then Medicine will review relevant documentation, monitoring and reporting to ensure that both APLS and EPLS training is recorded when assessing paediatric life support competency for Nursing staff.	In progress

Should Do	The service should consider reviewing the advanced paediatric life support to make sure that all band 6 staff have the correct qualification	SD1 32/2	Mrs Melanie Woolfall	Accident and Emergency	Medicine Care Group to consider introducing a White Board system that lists the staff members on duty/shift who have paediatric life support qualifications/training, this will ensure that all staff (especially Bank/Agency) can easily identify and locate them in an emergency situation.	In progress
Should Do	The service should consider reviewing the arrangements for the implementation of the mental capacity act and deprivation of liberties safeguarding within the ED department and align the trust policy to the practice.	SD1 33/1	Ms Bongi Gbadebo	Accident and Emergency	Compliance and Assurance Team to review this recommendation with with members of the Medicine Care Group Triumvirate to determine if it is a 'duplicate' of Recommendation SD125, and if it is a duplicate whether a separate action is required or not.	Partially complete
Should Do	The service should review the staffing levels within ACU and SDEC ensuring that staffing levels are maintained and risks to staffing establishment captured and monitored.	SD1 34/1	Ms Bongi Gbadebo	Accident and Emergency	Medicine Care Group to develop and, if approved, implement a business case to improve staffing levels on the RLI ACU and SDEC	In progress
Should Do	The service should review the staffing levels within ACU and SDEC ensuring that staffing levels are maintained and risks to staffing establishment captured and monitored.	SD1 34/2	Ms Bongi Gbadebo	Accident and Emergency	Medicine Care Group to ensure that staffing levels within ACU and SDEC are captured within the Care Group Risk on 'Staffing Levels' by reviewing and updating Risk 2805 (RLI ED Staffing Levels) and that processes are in place for Risk 2805 to be regularly monitored at the Care Group Governance and/or Management Team meetings and that any issues of concern are escalated to the Trust Risk Management Group	In progress
Should Do	The service should consider reviewing the opportunities for safety incident report and review when and what incidents, staff need to report and monitor that they have the support to do this in an appropriate manner.	SD1 35/1	Mrs Melanie Woolfall	Accident and Emergency	Medicine Care Group to work with Trust Patient Safety Team to review Incident reporting in RLI ED to ensure that all incidents are reported and there is a new focus on the four incident types specifically identified by the CQC; Staffing Levels, Long Waits, Paediatric Triage and Inappropriate GP Referrals. Consideration will be given to identifying any barriers to staff reporting incidents and where practical removing or reducing these barriers. The Outcome of this review will be reported at the Trust Quality, Governance & Patient Safety Group.	Partially complete
Should Do	The service should continue with plans to improve staffing levels medical staff to full establishment.	SD1 36/1	Ms Bongi Gbadebo	Accident and Emergency	The Medicine Care Group will implement the recruitment plan improve Medical Staffing levels at RLI ED towards full establishment levels and ensure that risk 2805 (RLI ED Staffing) is regularly reviewed and	In progress

					updated , with regular monitoring at Care Group meeting and escalation to Trust Management Group.	
Should Do	The service should review the perception in the ED of limited senior and executive visibility, recognition, understanding and support.	SD1 37/1	Mrs Lynne Wyre	Accident and Emergency	The Executive Chief Nurse has a scheduled Walkaround of all clinical areas at RLI every Friday morning, this includes RLI ED, these will continue to help maintain/increase the visibility of Executive and Senior Nursing staff at RLI ED.	Partially complete
Should Do	The service should review the perception in the ED of limited senior and executive visibility, recognition, understanding and support.	SD1 37/2	Ms Bongi Gbadebo	Accident and Emergency	Medicine Care Group will undertake a review of staff perceptions in ED in relation to the visibility, recognition, understanding and support from Executives and Senior Management, this will take place in September 2023. The findings of this review will then be used to identify potential solutions that can then be developed into an Action Plan.	In progress
Should Do	The service should further explore the opportunities for collaborative working from the emergency department, assessment units and specialist services	SD1 38/1	Ms Bongi Gbadebo	Accident and Emergency	Compliance and Assurance Team to review this recommendation with with members of the Medicine Care Group Triumvirate to determine if it is best managed within Medicine Care Group or managed at a Corporate level with input from Medicine Care Group.	Fully complete (Awaiting approval)
Should Do	The service should further explore the opportunities for collaborative working from the emergency department, assessment units and specialist services	SD1 38/2	Mr Paul Smith	Accident and Emergency	Medicine Care Group to undertake a review of engagement between Emergency Medicine with the Other Medical and Surgical Specialities (and tertiary services), the review will include a review of the current Trust Process for collaboration and the relevant professional standards documentation. The outcomes of the review will be shared with the Trust Clinical Effectiveness Group	In progress

Should Do	The service should consider reviewing the arrangements for medicines held by patients particularly in relation to those on trolleys, formalise the process in place and ensure that all staff are aware of the practice needed to maintain patient safety.	SD1 39/1	Mrs Kam Mom	Accident and Emergency	The Trust will undertake a best practice review with input from other ICS Pharmacy Teams to review the arrangements for medicines held by patients and to investigate potential solutions that would be appropriate for ED attendance and all subsequent patient movements, this will then be used to update the Patients own Medicine sections of Procedural Document CORP/POL/039 (Administration, Safe Storage, Supply, Disposal and Monitoring of Medicines).	In progress

Table 6: RCS Improvement Plan Dashboard

Inspection	Recommendation	Action Ref	SRO	Oversight Meeting	Service	Action	Progress Status
RCS Report	Actions the Trust Must take to ensure patient safety is protected: A review of redacted clinical activity in performing unicompartmental knee replacements is required given the review may indicate an insufficient number of these procedures being undertaken to maintain the appropriate skill set required for the techniques involved.	MD1/1	Ms Claire Alexander		Trauma and Orthopaedics	OS Action - 1. Request data for all Unicompartmental knee replacement procedures carried out by surgeon 1 from 2015 - 2018 - 5 cases identified between 2015 and 2018. Awaiting Clinical Review. 2. Request data for all anterior approach to hip replacement - This cannot be done as anterior / posterior isn't currently coded separately - Total Number of Hip cases is 105. (25 cases for further review) 3. Request data for all no complex total Hip and total Knee replacement procedures completed by Surgeon 1 - Total Number of Knee cases is 216. (A sample of 25 cases for further review) 4. Complete a case note review of all Unicompartmental knee replacement procedures carried out by surgeon 1 from 2015 - 2018. Links to 1 5. Complete a case note review of all anterior approach procedures carried out by surgeon 1 from 2015 - 2018. Links to No 2 6. Complete a randomised case note review of non-complex THR and TKR procedures carried out by surgeon 1 from 2015 - 2018. Links to 2 and 3	In progress
RCS Report	Actions the Trust Must take to ensure patient safety is protected: Assure evidence of redacted training in anterior approach surgery before further anterior approach hip replacements are performed.	MD2/1	Mr Harry Rogers		Trauma and Orthopaedics	OS Action - Surgeon 1 working under full supervision with a detailed training plan - (Practitioner Performance Advice PPA) in place based on identified themes in the RCS Report	In progress

RCS Report	Actions the Trust Must take to ensure patient safety is protected: In respect of more complex cases, more effective utilisation of MDT to: (i) Improve governance in respect of clear decision making, transfer/handover of care documentation. (ii) Ensure appropriate consultant surgeon involvement.	MD3/1	Mr Harry Rogers		Trauma and Orthopaedics	"OS Action - ADOP Surgery is currently completing these 2 items by the end of March 2022. SEE ALSO NICHE/R41??"	In progress
RCS Report	Actions the Trust Must take to ensure patient safety is protected: The consent pro-forma should ensure that the potential risks of the planned surgery are clearly documented for the patient to assimilate and space to record that these have been explained to the patient.	MD4/1	Mr Harry Rogers		Trauma and Orthopaedics	OS Action - ADOP Surgery is currently completing these 2 items by the end of March 2022. SEE ALSO NICHE/R18	In progress
RCS Report	Actions the Trust Must take to ensure the Trauma and Orthopaedic Service is improved: redacted may benefit as part of learning to reflect upon and discuss with colleagues case AXX in particular, possible reasons for the femoral notch (which was not documented in the operation note) occurring.	MD5/1	Mr Harry Rogers		Trauma and Orthopaedics	OS Action - Completed	In progress
RCS Report	Actions the Trust Must take to ensure the Trauma and Orthopaedic Service is improved: The Trust should take steps to improve the continuity of care for patients through their pre-operative, intra-operative and post-operative care pathway. This may include, but is not limited to, listing patients, wherever possible, on the operating surgeon clinic list.	MD6/1	Mr Harry Rogers		Trauma and Orthopaedics	The trust should take steps to improve the continuity of care for patients through their pre-operative, Intra-operative and post-operative care pathway. This may include, but is not limited to, listing patients, wherever possible, on the operating surgeon clinic list.	In progress

RCS Report	Actions the Trust Should consider as part of its development of the Trauma and Orthopaedic service: If the Trust identifies primary concerns about an individual surgeon, then a formal review of their clinical practice is recommended. If the Trust identifies concerns associated with the surgical service then a review of the service is recommended.	SD7/1	Ms Jane McNicholas		Trauma and Orthopaedics	OS Action - The Director of Governance and the Medical Director will draft a Standard Operating Procedure that articulates clearly and transparently the process associated with instigating a formal review of individual practice and the criteria for triggering a review of a surgical or medical service based on triangulated intelligence, evidence and patient feedback. Timescale TBC.	In progress

Perinatal Quality Surveillance Model

CQC Maternity Rating	Overall	Safe	Effective	Caring	Well-Led	Responsive
RLI	Requires Improvement	Good	Requires Improvement	Good	Requires Improvement	Good
FGH	Inadequate	Requires Improvement	Inadequate	Good	Inadequate	Good
WGH	Inadequate	Inadequate	Requires Improvement	Not rated	Inadequate	Requires Improvement

Maternity Safety Support Programme Yes	Yes

	January	February	March	April	May	June	July	August	September	October	November	December	January	February	March
Findings of review of all perinatal deaths using the real time data monitoring tool	None - meeting cancelled due to staff shortages/ sickness	1 Review completed - IUD. Issues identified - no CO monitoring performed, maternal pulse not recorded when ausculatating fetal heart, missed opportunities to refer for a growth scan from GROW chart.	2 Reviews completed: 1 NND - Issue identified with mums psychological care in the postnatal period. NND due to fatal abnormality not detectable in the ante-natal period. 1 IUD - review identified 'No issues with care identified'	0 Reviews completed due to annual leave and half term giving limited availability for midwifery and clinical staff to support with the reviews	1 review completed IUD - review identified no issues with care	1 twin Stillbirth 35/40_ PMRT outstanding, been to ERG no identified care delivery issues	0 reviews completed	2 PMRT reports completed. 1 New PMRT case reported, 72 hour review identified learning. Case has been StEIS reported for SI							
Findings of the review of all cases eligible for referral to HSIB	0	0	0	1 Neonatal Death. HSIB awaiting parents consent to progress with the investigation.	0	0	0	0							
The number of incidents logged graded as moderate or above	1 Moderate Harm	4 Moderate Harm	6 Moderate Harm	4 Moderate Harm (3 PPH's >2000mls & 1 Term baby admission to NNU), 1 Neonatal Death	6 Moderate Harm including: 3 PPH's >2000mls 2 Term admissions to NNU 1 Thrombectomy	10 Moderate Harm including: 3 PPH's 2 Poor clinician documentation 1 Shoulder Dystocia 1 unsuccesful forceps 1 low cord gas 1 neonatal seizure 1 term admission to NNU	1 Severe Harm: Maternal Blood loss 10 Moderate Harm: 3 x Maternal - Blood Loss >1500mls 6 x Neonatal - Term Baby Admitted To NNU 1 x Fetal - Stillbirth	1 x Neonatal Death - 26+5 weeks gestation. 1 x Severe Harm - externally reported: Birth Trauma (already linked to PSI 275993 which has had an RCA, and steis reported). 13 x Moderate Harms: 5 x Blood Loss >1500mls, 2 x Intensive Care Admission, 2 x Term Baby Admitted To NNU, 1 x Anaesthetic Complications, 1 x Care - Incorrect Care, 1 x Shoulder Dystocia, 1 x Safeguarding Referral Made							
Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training															
SBLCBv2	61%	72.80%	Midwives 79.7% Doctors 33.3% Total 75.3%	Midwives 74.7% Doctors 56.5% Total 72.9%	Midwives 66% Doctors 37.8% Total: 66%	Midwives 65% Doctors 38.9% Total: 60.4%	Midwives 69% Doctors 36.6% Total: 64%	Midwives 69% Doctors 25%							
GAP and GROW Training			Midwives 83%% Doctors 75% Total 82.3%	Midwives 78.8%% Doctors 76.5% Total 78.5%	Midwives 74.7% Doctors 76.5% Total 74.9%	Midwives 75.4% 84% Doctors Total 76.6%	Midwives 86.5% Doctors 80.8% Total: 85.7%	Midwives 90.3% Doctors 76.9% Total 88.5%							
Fetal Surveillance in Labour	63%	75.90%	K2 Competency assessment Midwives 87.7% Doctors 73.9% Total 86% 90.2% of staff have completed face to face training	K2 Competency assessment Midwives 87.7% Doctors 73.9% Total 86% 90.2% of staff have completed face to face	K2 Compliance assessment: 88.6% Midwives - 88% Doctors - 72.2% Total 85.1%	K2 Competency assessment: 90.9% Midwives - 92.5% Doctors - 80.8% Total inc.Face to face training - 86%	K2 Competency Assessment: 84.9% Midwives: 89.4% Doctors: 68.6% Total inc face to face:86%	K2 competency assessment: 84.7% Midwives: 88.2% Doctors: 64.3%							
Maternity Emergencies and Multiprofessional training	47%	70.70%	Midwives/MSW's 79.9% Doctors 65.2% Total 78.3%	Midwives 77% MSW's 80% Doctors 61% Anaesthetists 32% Total 69%	Midwives 77.2% MSWs 83.3 Doctors 57.6% Anaesthetists 45.5% Total 69.6%	Midwives 81% 71.4% MSWs Drs 61.8% Anaesthetists 35.6% Total: 70.9%	Midwives 90.1% MSWs 87.2% Doctors 56% Anaesthetists 48% Total 72.6%	Midwives 90.1% MSWs 87.2% Doctors 56% Anaesthetists 48% Total 72.6%							
Personalised Care	64%	73.40%	Midwives # MSW's 83.9% Doctors 52.2% Total 80.9%	Midwives 74.7% MSWs # Doctors 56.5% Total 72.9%	Midwives 73.5% MSW's 78.2% Doctors 58.1% Total 72.7%	Midwives 74.9% 80% MSWs Doctors 62.5% Total 74.5%	Midwives 82.2% MSWs 83% Doctors 69.7% Total 76.1%	Midwives 82.2% MSWs 83% Doctors 69.7% Total 76.1%							
Care during Labour and the Immediate Postnatal Period	61%	72.80%	Midwives/MSW's 79.7% Doctors 33.3% Total 75.3%	Midwives/MSW's 78.7% Doctors 37.5% Total 74.7%	Midwives 75.3% MSWs 85.5% Doctors 58.8% Total 75.3%	Midwives 79.8% 85.5% MSWs Doctors 65.7% Total 79.2%	Midwives 84.4% MSWs 92.5% Doctors 65.6% Total 83.3%	Midwives 84.4% MSWs 92.5% Doctors 65.6% Total 83.3%							
Newborn Life Support	80%	92.70%	Midwives 93.2% Doctors 90.5% Total 92.9%	Midwives 94% Doctors 90.5% Total 93.7%	Midwives 94.6% Doctors 92.3% Total 93.9%	Midwives 94.7% Doctors 92.3% Total 94.4%	Midwives 93% MSWs 96% Doctors 91.3% Total 93.4%	Midwives 94.6% MSWs 95.8% Doctors 88% Total :94.1%							
Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite, gaps in rotas	100%	100%	100%	100%	100%	100%	100%	100%							
Minimum midwife safe staffing															
Midwifery Staff average fill rate	RLI 93.21% FGH 83.27%	RLI 86.46% FGH 88.4%	RLI 87.22% FGH 85.49%	RLI 88.22% FGH 87.09%	RLI 87.2% FGH 84.63%	RLI 89.09% FGH 87.97%	RLI 91.25% FGH 85.39%	RLI 88.83 % FGH 79.46 %							
Midwifery bank usage	RLI 1152.58 hrs FGH 161 hrs	RLI 1264.52 hrs FGH 267.42 hrs	RLI 1144.58 hrs FGH 266.91 hrs	RLI 1092.66 hrs FGH 286.92 hrs	RLI 1359.5 hrs FGH 340.42 hrs	RLI 881.25 hrs FGH 254.92 hrs	RLI 1034 hrs FGH 247.5 hrs	RLI 1621.33 hrs FGH 548.83 hrs							
Midwifery agency usage	RLI 187 hours FGH 725.5 hrs	RLI 221.5 hours FGH 710.08 hrs	RLI 88 hours FGH 892.17 hrs	RLI 119 hrs FGH 996.5 hrs	RLI 250.75 hrs FGH 1064 hrs	RLI 427.58 hrs FGH 987.25 hrs	RLI 385.42 hrs FGH 1088.5 hrs	RLI 235.33 hrs FGH 826.25 hrs							
Service User Voice Feedback	Midwife led unit provision, decorative order Choice available continuity of antenatal care Reliability of provision	Request to extend the dashboard information for public view, Agreement to provide this on the website	Infant Feeding support Antenatal Education (face to face and publicity of provision).	An online antenatal education package is being introduced across the LMNS with MVP support,	MVP 15 steps undertaken at RLI- positive feedback from service users. Parts of environment praised (art work), concern raised about estates ie LW flooring/visitors toliet and 'non welcoming environment on entering into Womens building. Awaiting written report.	Visiting arrangements have been reviewed in line with trust and national guidance and the introduction of sibling visiting now available. With a plan to review further in July.	Themes around not being listended to and not receiving individualised care.	Feedback from a younger mum in relation to poor staff communication. Next MVP face to face meeting to be arranged at a Young Mum's Group.							

Staff feedback from frontline champions and walk abouts	Homebirth bags heavy and not standardised	12 Homebirth Bags ordered	MSSP Engagement event with doctors. Clinicians highlighted issues with mandatory fields within BadgerNet, digital support offered.	Speciality specific training commenced with junior obstetricians and being developed for other staff groups.	MVP 15 steps undertaken at RLI (with NED)- staff discussed the reduced availability of support for women throughout the pandemic. Visiting provision currently under review. Awaiting written report.	Staff have escalated the environmental conditions on ward 17 at RLI (extreme heat). Estates team adding reflective film to windows w/c 18.7.22. Arranging for twice daily temperature monitoring. On risk register.	Walk about by DOM, WGH staff raised concerns about night shifts at Helme Chase. Listening event to be arranged with HOM and Consultant Midwife.	Clinical Staff asking for increased communication - HOM's to implement new drop-in/update staff sessions. Communication strategy in progress. Feedback on Ward that no Band 2 MSW. No TC nurses.							
HSIB/ NHSR/ CQC or other organisation with a concern or request for action made directly with Trust	0	Each baby Counts Thematic review received from NHS Resolution	0	0	0	1 action plan requested from a thematic review	0	1 CQC							
Coroner Regulation 28 made directly Trust	0	0	0	0	0	0	0	0							
Progress in Achievement of CNST			Evidence requested for year 2 submission	Scheme restarted	Year 4 on-going assessment against new criteria.	Benchmarking taking place of year 2, 3 and 4 criteria. Currently 3/10	Evidence requested for year 1 submission	CNST Year 1 declaration submitted. 5/10 compliance with Year 4 to date							
Situations in which a Consultant MUST ATTEND	Data in arrears						15 out of 15								
Unless the most senior doctor present has documented evidence as being signed off as competent	Data in arrears						11 out of 11								

Proportion of Midwives responding with 'Agree or Strongly Agree' on whether they would recommend their Trust as a place to work or receive treatment	67%
Proportion of speciality trainees in Obstetrics and Gynaecology responding with 'excellent or good' on how they would rate the quality of clinical supervision out of hours (National 79.3%, 2019)	RLI 90.91% FGH 91.25%

Latest available annual figures used	**UHMBT**	**National**
Stillbirth Rate	2.87 per 1000 2021/22	3.8 per 1000 (2020)
Neonatal Death Rate	1.2 per 1000 2021/22	1.3 per 1000 (2019)
Perinatal Mortality Rate	3.88 per 1000 (2019)	4.96 per 1000 (2018)

Stillbirths after 24 weeks gestation and excluding termination of pregnancy
Neonatal deaths after 24 weeks gestation

Appendix 2 Governance Improvement Action Plan

Issues		Key Tasks to Deliver Action		Target Date	Evidence of Progress and Completion	Monitoring and Evaluation group	Date Action Completed
1.	Maternity Risk Management Strategy is out of date	The Maternity Quality Governance Accountability Framework	Donna Southam Quality, Safety and Assurance Lead Midwife Heather Gallagher Director of Midwifery (DOM)	30/9/2022	Approved Policy	CGGAG/ TMG	
2.	Lack of awareness amongst the multidisciplinary team of the Maternity incident trigger list and not referenced in the Trust's main Risk Strategy	Refresh the incident trigger list and include in the Maternity Quality Governance Accountability Framework	Donna Southam Quality, Safety and Assurance Lead Midwife	30/9/2022	Approved in policy and displayed on the quality and safety boards	CGGAG	
3.	There is no system for ensuring all incidents are reported (i.e., PPH, babies transferred to NICU, babies transferred out to another unit, maternal admissions to ITU)	Twice weekly report to be generated from BadgerNet	Donna Southam Quality, Safety and Assurance Lead Midwife	30/8/2022	Reports from BadgerNet	Monitored by Quality, Safety and Assurance Lead Midwife	1/9/2022

4.	There is no Obstetric lead for Governance The Maternity Self-Assessment tool states there must be a Consultant Obstetrician governance lead (Min 2PA's) 4.108 The Trust executive team must ensure an appropriate level of dedicated time and resources are allocated within job plans for midwives, obstetricians, neonatologists, and anaesthetists to undertake incident investigations (Ockenden Final report, 2022).	1. Allocated named Obstetric Lead Consultant 2. In the interim add PA time for consultants to oversee the risk management activities (incident reviews, 72-hour reviews, ERG)	Mark Davies Clinical Director for Obstetrics and Gynaecology (CD)	1. 1/9/2022 2. 29/7/2022	1. Named Lead Consultant with job description 2. Allocated PA in job plan	Update to Medical Director, Executive Chief Nurse, and Director of Governance	2. 1/8/2022
5.	There are no PA sessions allocated for PMRT and ATAIN There is no named Obstetric and Paediatric lead for ATAIN and PMRT	Allocate named Obstetric Consultant Lead and Consultant Paediatric Lead	Mark Davies CD Linda Womack Associate Director of Operations (ADOP) Dr Sen Neonatal Lead Consultant	30/8/2022	Named Lead Consultant	Update to Medical Director, Executive Chief Nurse, and Director of Governance	Update on 5/9/2022 ATAIN Consultant had been allocated and included in their job plans. Consultant Obstetricians allocated to support PMRT in the interim
6.	The staff feedback there was a lack of MDT approach to closing incidents. 4.108 The Trust executive team must ensure an appropriate level of dedicated time and resources are allocated within job plans for midwives, obstetricians, neonatologists, and anaesthetists to	Dedicated Consultant PA time for risk	Mark Davies Clinical Director for Obstetrics and Gynaecology Linda Womack Associate Director of Operations	30/8/2022	Allocated PA in job plan	Update to Medical Director, Executive Chief Nurse, and Director of Governance	

	undertake incident investigations (Ockenden Final report, 2022).						
7.	No dedicated Anaesthetic and Paediatric support for governance	Named Anaesthetic Consultant and Paediatric Consultant link	Linda Womack Associate Director of Operations Mark Davies Clinical Director for Obstetrics and Gynaecology Dr Sen Neonatal Lead Consultant	30/8/2022	Named Lead Consultant	Update to Medical Director, Executive Chief Nurse, and Director of Governance	Update 5/9/2022 Clinical Lead for Anaesthetic's is the lead.
8.	72-hour reviews are rarely done within the time frames due to clinician and midwifery dedicated time 4.108 The Trust executive team must ensure an appropriate level of dedicated time and resources are allocated within job plans for midwives, obstetricians, neonatologists, and anaesthetists to undertake incident investigations (Ockenden Final report, 2022).	Allocated Midwifery time and dedicated Obstetric and Paediatric PA allocated to risk	Heather Gallagher DOM Linda Womack ADOP Mark Davies CD Dr Sen Neonatal Lead Consultant	29/7/2022	Allocated PA time for Consultants	Update to Medical Director, Executive Chief Nurse, and Director of Governance	1/8/2022

9.	There is one ERG meeting a week and no direct way to escalate an SI prior to this. Serious Incidents are not always reported within 2 working days from when the incident was identified.	1. Increase frequency of ERG. Consider three times a week to ensure Serious Incidents are declared timely. 2. Process agreed for a SI being declared outside of ERG (maternal death, never event)	Richard Sachs Director of Governance	1. 26/8/2022 2. 30/8/2022	ERG meeting increased from once a week Agreed process included in the serious incident policy	Quality Committee	1. 30/8/2022
10.	Director of Midwifery and Clinical Director for Obstetrics are not responsible and accountable for governance in maternity. The structure sits under the Director of Governance Robust maternity governance team structure, with accountability and line management to the DoM and CD with key roles identified and clearly defined links for wider support and learning to corporate governance teams (Maternity self-assessment tool)	Maternity Governance team structure accountable to Director of Midwifery and Clinical Director for Obstetrics.	Bridget Lees Executive Chief Nurse (ECN) Richard Sachs Director of Governance Heather Gallagher DOM	30/9/2022	Structure in the Maternity Quality Governance Accountability Framework	Structure in the Maternity Quality Governance Accountability Framework	1. 30/8/2022 the structure was agreed by the Director of Governance. To be included in the framework.
11.	The team expressed there was silo working with the risk managers, audit, education, guidelines, and QI. 4.138 The review team discussed with NHS England that the National Maternity Assessment Tool recommends the following minimum staffing levels for governance teams: • Maternity governance lead (who is a midwife registered with the NMC) • Consultant obstetrician governance	The Risk managers, audit, education, guidelines, and QI to be led under the quality and safety team. All specialist leads report to the Quality, Safety and Assurance Lead Midwife. This does not include the Business Partner. The Quality, Safety and	Bridget Lees ECN Richards Sachs Director of Governance Heather Gallagher DOM	29/7/2022	Structure in the Maternity Quality Governance Accountability Framework	Structure in the Maternity Quality Governance Accountability Framework	

	lead (Minimum 2 PAs) • Maternity safety manager (who is a midwife registered with the NMC or relevant transferable skills). • Maternity clinical incident leads • Audit midwife - a lead midwife for audit and effectiveness • Practice development midwife • Clinical educators, to include leading preceptorship programme • Appropriate governance facilitator and administrative support within the maternity department	Assurance Lead Midwife reports to the Director of Midwifery.					
12.	Harm grading is based on harm caused and gaps in care rather than the harm has occurred. This is stated within the SI policy and Ulysses training package. An example would be a woman who has a stillborn baby with no gaps in care would be graded as no harm. A woman who had a 4litre PPH and ITU admission who had no gaps in care would be graded as no harm. 4.107 Incidents must be graded appropriately, with the level of harm recorded as the level of harm the patient actually suffered and in line with the relevant incident framework (Ockenden Final Report, 2022).	1. All stillbirths to be graded as death regardless of gaps in care 2. Serious Incident Policy to be amended to reflect harm occurred rather than caused 3. Ulysses training package to be updated to reflect harm occurred rather than gaps in care	Richard Sachs Director of Governance	1. 24/7/22 2. 30/10/22 3. 30/8/22	Serious Incident Policy to be updated, including grading of stillbirths Ulysses training to updated	Quality Committee	1.This has been implemented immediately when reviewing the incidents. SI policy and training to be updated to reflect harm grading based on the harm occurred.

13.	The risk managers and Midwifery managers have not received training on managing incident investigations and governance activities 4.113 All members of the governance team who lead on incident investigations should attend regular appropriate training courses not less than three yearly. This should be included in local governance policy. These training courses must commence within the next 12 months (Ockenden Final Report, 2022).	Training to be implemented once the Ulysses package has been updated	Donna Southam Quality, Safety and Assurance Lead Midwife	30/9/2022	Register of all trained staff	CGGAG	
14.	Risks for the risk register are approved at the CGGAG meeting and cannot be uploaded until the minutes from CGGAG are sent to the patient safety team	The QUAD and the Quality, Safety and Assurance Lead Midwife to be given access to enable risks to be added and removed from the register in line with all relevant risk management processes.	Richard Sachs Director of Governance	30/8/2022	Agreed new process and access granted	CGGAG	

15.	Risks can be added by anyone and are pending until approved. The focus at the WACS CGGAG meeting is those beyond their review/completion date. There is no separate risk meeting for maternity or Paediatrics and often, actions identified do not address the risk. There is a lot of duplication of similar risks on the register. There is no focus on the actions to manage and mitigate the risk.	Risk Register care group monthly meeting to be established. Meeting to be joint with Paediatric, Neonates and Maternity (like the guideline group). The group will discuss new risks, monitor existing risks, and agree closing risks. This will feed into the Trust Risk meeting.	Donna Southam Quality, Safety and Assurance Lead Midwife	30/9/2022	ToR, minutes of meeting and action log	CGGAG	1. 1/9/2022
16.	Responsibility for investigations and action plans for all Maternity cases to be led and coordinated in WACS (Maternal death in the hospital outside maternity)	Responsibility for investigations and action plans for all Maternity cases to be led and coordinated in WACS (Maternal death in the hospital outside maternity)	Donna Southam Quality, Safety and Assurance Lead Midwife	18/7/2022	New process agreed and Patient Safety team to cascade to Care Groups	CGGAG	1. 8/8/2022
18.	Business Partner for WACS and Risk Managers do not have access to the backend of Ulysses system. This means they must email Patient Safety team to reopen incidents or investigations. This is adding to delays	Access granted to Quality, Safety and Assurance Lead Midwife and Business Partner for WACS	Richard Sachs Director of Governance	30/8/2022	New process agreed and access granted	CGGAG	
19.	Feedback to families after panel, during the investigation process and once the report is finished rarely takes place. SI and concise reports are not routinely shared with families	1. Communication log to be commenced for all ongoing investigations to be led by the Risk Managers to ensure families are kept in the loop of communications at all stages of the investigation process.	Donna Southam Quality, Safety and Assurance Lead Midwife	1. 30/7/2022	1. Communication logs	CGGAG	1. 30/8/22 2. 30/7/22

	Despite families being asked to contribute to the investigation they were not actively involved or empowered to do so. This is in stark contrast to the recommendations from NHS Resolution that women and their families should be actively involved in investigations. Best practice from HSIB shows that with a dedicated focus on actively encouraging families to be involved, 86% of families within maternity investigations will engage with investigations (Ockenden Final Report, 2022). 4.116 The needs of those affected must be the primary concern during incident investigations. Patients and their families must be actively involved throughout the investigation process. 4.117 All feedback to families after an incident investigation has been conducted must be done in an open and transparent manner and conducted by senior members of the clinical leadership team, for example Director of Midwifery and Consultant obstetrician meeting families together to ensure consistency and that information is in-line with the investigation report findings. 4.118 The maternity governance team must work with their Maternity Voices Partnership (MVP) to improve how families are contacted, invited, and encouraged to be involved in incident investigations (Ockenden Final Report, 2022).	2. All families to be offered a meeting with DOM or HOM and appropriate Consultant lead depending on the incident. 3. Co-production with the MVPs to review the process of working with families.		2. 30/7/2022 3. 30/11/2022	Letter sent to each family after completion of an RCA offering a face-to-face appointment Co-production evaluation completed, and new process agreed		
20.	There is no consistent approach with	SOP for process/ PMA support	Donna Southam	30/10/2022	SOP	CGGAG	

	supporting staff when a Serious Incident has occurred	for staff following SI	Quality, Safety and Assurance Lead Midwife				
21.	Obstetric CTG leads are not always involved in investigations when there are incidents involving the CTG trace The leads should work on the review of cases of adverse outcome involving poor FHR interpretation and practice (Ockenden, 2020)	Fetal Monitoring leads to be invited to round tables, incident reviews and 72-hour reviews. Fetal Monitoring leads to provide their opinion on all RCAs which include CTG concerns	Donna Southam Quality, Safety and Assurance Lead Midwife	30/7/2022	Names added to the 72-hour review, minutes of round table, RCAs, and incident reviews	CGGAG	30/7/2022
22.	Process for identifying HSIB cases and the Early Notification Scheme are not robust	1. Reports to be pulled from BadgerNet twice a week. 2. SOP to be developed which includes working with legal department on notifying the Early Notification scheme of HSIB cases	Donna Southam Quality, Safety and Assurance Lead Midwife	1. 29/7/2022 2. 30/9/2022	Report from BadgerNet and SOP detailing process for identifying cases and notifying early notification scheme	CGGAG	1. 30/8/22
23.	There is no process/ SOP for investigations which require an external review other than HSIB and no external reviews have been undertaken	Maternity to have a SOP for investigations which require an external review	Donna Southam Quality, Safety and Assurance Lead Midwife	30/9/2022	SOP	CGGAG	

24.	There is no oversight of actions arising out of HSIB investigations in any forum	All HSIB reports to have an action plan developed and shared at CGGAG. This will be monitored by CGGAG until the actions are complete. Include in SOP	Donna Southam Quality, Safety and Assurance Lead Midwife	30/8/2022	Minutes from CGGAG and reports submitted. SOP to include process	CGGAG	Weekly RCA action plan set up from 1.9.22
25.	Lack of oversight of action plans from RCAs. These are not taken through the WACS governance meeting. Actions are not always SMART	1.All action plans from RCAs to be monitored at CGGAG. 2. Check and challenge from the QUAD to ensure actions are SMART	Heather Gallagher DOM Linda Womack ADOP Mark Davies CD Dr Sen Neonatal Lead Consultant	18/7/2022	Minutes from CGGAG and reports submitted.	CGGAG	1. 1.9.22
26.	Weekly governance meeting is chaired by the Director of Governance	To be chaired by Director of Midwifery or designated deputy i.e., Quality, Safety and Assurance Lead Midwife	Richard Sachs Director of Governance	18/7/2022	ToR to be amended	CGGAG	Meeting has been disbanded 1.9.22
27.	Safeguarding do attend the CGGAG meeting however do not present a report	Report from safeguarding to be added to the CGGAG agenda	Donna Southam Quality, Safety and Assurance Lead Midwife	30/8/2022	Minutes from CGGAG and report	CGGAG	In place from 1.9.22

28.	The Neonatal BadgerNet system does not link to the maternity system. An upgrade is required but has not approved	1. Escalate to Board Level Safety Champions to raise at Board 2. Upgrade to be approved	Heather Gallagher DOM Nicola Askew Associate Director of Nursing &Therapies for Children and Young People Linda Womack ADOP Mark Davies CD	30/9/2022	Upgraded completed	CGGAG	
29.	No process for identifying PMRT cases	1. Report to be pulled from BadgerNet twice weekly 2. Process to be included in the PMRT guideline	Donna Southam Quality, Safety and Assurance Lead Midwife	1. 29/7/22 2. 30/9/22	Report from BadgerNet PMRT guideline approved	PMRT group and CGGAG	1. 1.8.22 2. On guideline agenda 16.9.22

30.	No process for sending out PMRT information to parents	1. PMRT leaflets to be given out prior to discharge. The family to be contacted by the PMRT lead Midwife prior to PMRT to discuss PMRT and ascertain any questions. 2. Process to be included in the PMRT guideline	Donna Southam Quality, Safety and Assurance Lead Midwife	1. 30/7/22 2. 30/9/2002	1. Monitored at PMRT and monthly reports sent to CGGAG, and quarterly reports sent to quality committee. 2. Approved PMRT guideline	PMRT group and CGGAG	1. 1.9.22 2. On guideline agenda 16.9.22
31.	Of the 50 PMRT cases only 6 have been finalised. The remainder are either not published/ in draft and not shared. Not clear if this has been shared with board.	1. A review to be undertaken of the stage of the review the cases are. Ensure all families have been communicated with regarding the delay. 2. All reviews to be completed and all families to have had an opportunity for a meeting and sharing of the report 3. PMRT report to be sent to Quality Committee in August and then private board (Part B)	Donna Southam Quality, Safety and Assurance Lead Midwife	1. 30/9/22 2. 30/10/22 3. 30/9/22	Review of all PMRT cases in progress and ensure all families have been communicated with All reviews to be completed and families invited to meet and receive the report and feedback. PMRT report presented at quality committee	PMRT group and CGGAG	1. Awaiting report to be discussed at Trust on September 22 3. On QAC agenda in September 22

32.	No minutes and action log are taken at the PMRT meeting	1. Allocate administrative support. Bank in the interim whilst appointing to appoint in substantive role. 2. Minutes and action logs to be taken going forward	1. Donna Southam Quality, Safety and Assurance Lead Midwife 2. Kristie Charlton WACS Risk and Governance Manager	30/8/2022	1. Dedicated Admin support for PMRT included in job description. 2. Minutes and action log form PMRT	PMRT group and CGGAG	1. Appointed admin support to start in September 2022 2. Minutes and action log started in September 22
33.	No triangulation of data from incidents, RCA, complaints, claims. Lack of thematic investigation into themes/trends in incidents 4.122 Complaints themes and trends should be monitored at the maternity governance meeting, with actions to follow and shared with the MVP (Ockenden Final Report, 2022).	The Maternity quality and safety report to be refreshed to include the triangulation of data	Donna Southam Quality, Safety and Assurance Lead Midwife	30/8/2022	Monitored at CGGAG	CGGAG	1. NHS scorecard report presented in August 22. NHSR thematical review presented in August 22
34.	Lack of use of Maternity Dashboard with service quality/safety indicators and no covering report identifying exceptions and actions needed in response. Nobody identified as being responsible for producing this. No Statistical Process Control (SPC) charts presented or used	Dashboard to be refreshed with SPC charts. Dashboard to include regional metrics and an exception report. The dashboard, SPC charts and exception report to be presented at the CGGAG meeting and include some metrics and exception report in IPR slides	Donna Southam Quality, Safety and Assurance Lead Midwife	30/9/2022	Approved dashboard for metrics. Presented at CGGAG and within the IPR slides	CCGAG	

35.	The Practice Development Midwife is having to undertake a lot of administration and is subject to different reporting requirements for different meetings and has to default to an excel spreadsheet. No process for removing staff when they move on/change roles. Lack of sanctions for staff that do not attend training. Staff who have not completed NLS and CTG training outside of 12 months continue to work on Labour ward Clinicians must not work on labour wards or provide intrapartum care in any location without appropriate regular CTG training and emergency skills training. This must be mandatory (Ockenden Final Report, 2022)	1. Provide administration support 2. A standard template for reporting training requirements 3. TNA to include expectation of staff when training not completed within 12 months 4. Staff removed from intrapartum areas if they have not completed CTG and NLS training	1. Donna Southam Quality, Safety and Assurance Lead Midwife 2. Helena Brown Practice Develop. Midwife 3. Helena Brown Practice Develop. Midwife 4. Heather Gallagher DOM 5. Linda Womack ADOP 6. Mark Davies CD	30/9/2022	1. Administrator to support the Education team 2. Report template covering all the reporting requirements for CGGAG and the LMNS 3. Approved TNA and 4. staff removed from intrapartum areas if they have not completed CTG and NLS training	CGGAG	1. 1/9/22 2. 1/8/22
36.	Insufficient access to life support training as the resuscitation team is small; not all midwives are trained in Newborn Life Support (NLS)	1. Obtain the compliance with NLS training. If training <90% a recoverin plan to be implemented. 2. Training compliance to be reported to CGGAG monthly and included in IPR slides 3. TNA to include expectation of staff when training not completed within 12 months	1. Helena Brown Practice Development Midwife 2. Donna Southam Quality, Safety and Assurance Lead Midwife 3. Helena Brown Practice Development Midwife	1. 28/7/2022 2. 30/8/2022 3. 30/9/2022	1. Report sent to Quality, Safety and Assurance Lead Midwife Compliance rates with NLS included in CGAGG/ IPR 2. Approved TNA 3. As per action 35, staff removed		1. 1.9.22 2. 1.9.22

					from intrapartum areas if they have not completed CTG and NLS training		
37.	Current core mandatory training programme agreed with the LMNS but there is no maternity specific risk management training for staff. The core competency training should include: Training targeted at local learning. Sharing of local maternal and neonatal outcomes (including learning from in-situ simulation) and ideally benchmarked against other units. These data may be local from Serious Incidents, Near Misses, Never Events or from National programmes e.g., National Maternity Perinatal Audit (NMPA), Getting It Right First Time (GIRFT) and others (NSH England, 2020). 4.115 Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan (Ockenden Final Report, 2022)	1. Include a risk management presentation, including lessons leant on the mandatory training. 2. Undertake a review of all the mandatory training to ensure all the core competency training modules are included	1. Donna Southam Quality, Safety and Assurance Lead Midwife 2. Donna Southam Quality, Safety and Assurance Lead Midwife	1. 30/9/2022 2. 30/10/2022	1. Presentation included in mandatory training 2. On review of the mandatory training update the DoM on the findings and any immediate actions	CGGAG and LMNS	

38.	Some training is still delivered via Teams with no plan to go back to face to face.	1. Undertake a scoping exercise to assess the feasibility of returning to face to face.	Donna Southam Quality, Safety and Assurance Lead Midwife	30/9/2022	Provide an update at the CGGAG meeting and the maternity and neonatal safety champions meeting on the plan on when to return face to face	CGGAG	
39.	There is no multidisciplinary faculty for training	Allocate Obstetric and Anaesthetic leads for education	Linda Womack ADOP Mark Davies CD	30/9/2022	Leads supporting the training program	CCGAG	
40.	Lack of linkage with education team to ensure that guidelines are effectively rolled out and that any training needs are met.	Practice Development Midwife to attend the guideline meeting	1. Helen Brown Practice Development Midwife	30/7/2022	Representation of evidence in minutes going forward	Guideline group	1.9.22

41.	There is not a substantive midwife for guidelines. Guideline Group in place chaired by Obstetric Consultant. 4.129 There must be (senior) midwifery and obstetric co-leads for developing guidelines. (Ockenden Final Report, 2022)	1. Review all specialist midwives' roles and allocate a lead guideline midwife 2.Consultant Midwife to be actively involved in the procedural documents group to ensure that guidelines are evidence based and women centered	1. Donna Southam Quality, Safety and Assurance Lead Midwife 2. Heather Gallagher DOM	30/8/2022	Named person allocated to lead on guidelines and included within job description	CGGAG	1.8.22
42.	Nobody is identified as being accountable in the Care Group for the HSIB/MBRRACE reports or for undertaking baseline assessments against NICE guidance.	1.Review all specialist midwives' roles and allocate a lead for being responsible for the NICE baseline assessments 2.Quality, Safety and Assurance Lead Midwife in post to lead on national benchmarking of report (HSIB, NICE)	1-2 Donna Southam Quality, Safety and Assurance Lead Midwife	30/10/22 Completed	1. Named person and included within job description	CGGAG	

43.	No process for review of guidelines outside their scheduled review date e.g., to reflect any changes in practice nationally. 4.130 A process must be put in place to ensure guidelines are regularly kept up-to-date and amended as new national guidelines come into use (Ockenden Final Report, 2022).	New process of horizon scanning has been agreed. To include in a SOP	Donna Southam Quality, Safety and Assurance Lead Midwife	30/9/2022	SOP	CGGAG	
44.	No MVP representation with guidelines and leaflets or complaints responses	MVP invited to attend. Discuss with the MVP the process going forward of the review of guidelines and leaflets to include the MVP input	Donna Southam Quality, Safety and Assurance Lead Midwife	30/9/2022	SOP	CGGAG	
45.	There is no Terms of Reference for the audit meeting	Terms of Reference to be written and approved at CGGAG	Claire Bowman Audit Lead Midwife	30/9/2022	Audit meeting ToR	CGGAG	
46.	There is no report around clinical audit in the Care Group Governance & Assurance meeting Engagement with audit is not good from Medical and Midwifery perspective.	1. Monthly report to be sent to CGGAG 2. Improve attendance from clinical Midwives, Specialist Midwives and Midwifery Management. 3. Allocate Midwives and Medical staff to undertake audits	1. Claire Bowman Audit Midwife 2. Donna Southam Quality, Safety and Assurance Lead Midwife 3. Donna Southam Quality, Safety and Assurance Lead Midwife/ Consultant Leads for Audit	1. 30/8/2022 2. 30/9/2022 3. 30/9/2022	Audit meeting and CGAGG	CGGAG	1. 1.8.22

47.	No flexibility within the audit plan to accommodate issues that might arise in-year from SI's and any requirements arising from national publications. Themes from claims, HSIB, SI, themes form incidents are not included in the audit program. Inability to present and discuss all audits because there are six audit meetings per year. Actions arising are not always identified so falls to the Maternity Audit Lead, not always discussed, and are not followed up There is no robust process for developing the maternity clinical audit plan. Audits are a mixture of national audits, areas agreed for reaudit in the previous plan and then opinion of the obstetric lead. Not linked to themes of issues identified in incidents/ risks/complaints. Not linked to CQC Maternity Framework or Ockenden. 4.126 Any action that arises from a SI that involves a change in practice must be audited to ensure a change in practice has occurred. 4.127 Audits must demonstrate a systematic review against national/local standards ensuring recommendations address the identified deficiencies. Monitoring of actions must be conducted by the governance team. 4.128 Matters arising from clinical incidents must contribute to the annual	1. Undertake a look back to January 2021 of Serious Incidents, themes from incidents, HSIB, claims and NHS resolution to identify priority audits for the audit program. 2. All audit actions to be presented in the audit report presented at CGGAG and monitored going forward.	Claire Bowman Audit Midwife/ Donna Southam Quality, Safety and Assurance Lead Midwife	/22 .22	Refreshed audit program to be approved at CGGAG Audit report at CGGAG	CGAGG	

	audit plan (Ockenden Final Report, 2022).						
48.	Handovers/Huddles are not MDT on all sites as clinician engagement on one site is not good. Felt to be due to a mixture of covid and behaviours	Monitoring of handovers and huddles	Donna Southam Quality, Safety and Assurance Lead Midwife Alison Mayor Head of Midwifery (HOM) Tamsin Cripps HOM	Ongoing	Report to CGGAG		
49.	No one reporting to UKOSS. There is an allocated Obstetric and Anaesthetic Lead.	Audit Midwife allocated to lead on UKOSS	Donna Southam Quality, Safety and Assurance Midwife	29/7/2022	Confirmation from UKOSS	CGGAG	1. 1.9.22
50.	Women's feedback is not triangulated from FFT/ complaints, CQC in patient survey, MVP, debrief clinic and RCA's	Women's experience report to be collated at CGGAG	Tamsin Cripps and Alison Mayor (HOMs) Chantelle Winstanley Consultant Midwife	paper to CGGAG	30/9/2022	CGGAG	

51.	No ATAIN reports and action plans shared at governance, quality committee, Board, LMNS and ICS.	1. Monthly ATAIN report to presented at CGGAG 2. Quarterly ATAIN report to be presented at Maternity Safety Champions and Quality Committee, Board, LMNS and ICS	1. Holly Parkinson Quality improvement Midwife 2. Donna Southam Quality, Safety and Assurance Lead Midwife	30/9/2022	1. Report and minutes from CGAGG 2. Quality Committee/ LMNS/ Board/ ICS minutes	CGAGG/ LMNS/ Quality Committee/ Board/ ICS	

Appendix 3 MSSP Feedback

KEY ISSUE 1 (Leadership)												
Month/Year	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 22	Feb 22	Mar 22	Apr 22
Rating	GOOD	GOOD	Good	Good								

KEY ISSUE 2 (Strategy and Vision)												
Month/Year	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 22	Feb 22	Mar 22	Apr 22
Rating	NONE	NONE	Little	Good								

KEY ISSUE 3 (Governance and Safety)												
Month/Year	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 22	Feb 22	Mar 22	Apr 22
Rating	LITTLE	LITTLE	Good	Good								

Minutes of the Finance Committee held on Monday 8 August 2022 via Microsoft Teams

Present:	Steve Ward Karen Deeny Liz Sedgley Chris Adcock Scott McLean	Non-Executive Director (Chair) Non-Executive Director Non-Executive Director Chief Financial Officer Chief Operating Officer
In attendance:	Tim Povall Joanne Myers Ian Lacey Suzanne Hargreaves Kelly Heys Melanie Waszkiel Karen Brown (22/52 only) Diane Smith (22/54 only) Nicola Crossman	Operational Director of Finance Acting Head of Financial Management Acting Deputy Director of Finance Associate Director of Strategy & Transformation Head of Information Head of EPR Programmes New Hospitals Programme Head of Finance Transformation Lead, Urgent & Emergency Care Minute Secretary
22/44	**Welcome and Introductions** **Apologies for Absence** Apologies were noted from Bridget Lees, Richard Sachs and Andy Wicks. **Declarations of Conflicts of Interest** It was noted that a business case relating to pressure mattresses was listed in the 3As report from the Investment & Priorities Group. LS declared a conflict of interest due to her husband being employed as Financial Controller for a company that supplies these products to the NHS. This was noted as not affecting any Committee decisions.	
22/45	**Minutes of the Finance Committee held on 27 June 2022** **Decision:** The Minutes of the meeting held on 27 June 2022 were agreed as an accurate record.	
22/46	**Action Sheet and Matters Arising from the Finance Committee held on 27 June 2022** CA had recently received SIRO training and a comprehensive update would be included in the Cyber Security deep dive session. For the information and context of new members, SW outlined the purpose of a cyber deep dive was to provide oversight and assurance of controls operating at a time of elevated risk. SW had met with the Chief Information Officer and Chief Clinical Information Officer separately to discuss having a Committee meeting to explain the Digital strategy, identifying how UHMB met ICS and National objectives.	

	An update had been provided against the CNST sign-off action and it was agreed that this response was sufficient, and the action would be closed. The Committee requested an update from the Director of Governance at the next meeting on CQC actions allocated to the Committee for oversight. In relation to the finance leadership structure, CA confirmed that feedback from the away day on 11 July was being consolidated. The newly appointed Finance Director was engaged in this and once in post in October, would be heavily involved in development of the future structure and the Committee would be updated on progress. **Action: RS to provide an update on CQC actions allocated to the Committee for oversight at the next meeting.** **Decision:** The Committee noted the progress against the actions.
22/47	**Director of Finance Report** CA provided an overview of the report noting three key themes. The first two related to risks in plans and the in-year financial position and the third related to the on-going development of the financial control environment. In respect of financial risk and system / national escalations, the paper described a significant increase in interest and attention to our financial position and the associated risks. CA recognised that the key risk indicators were valid and reflect concerns about productivity generally across the NHS and needed to be addressed. CA had responded to a line of enquiry from the national team on 5 August, which was consistent with the information provided in the report and was also copied to ICB and regional team finance directors to reinforce the joint approach of the system to work through issues relating to financial plans. In addition, the Integrated Care Board (ICB) has commissioned an independent review, to be undertaken by Bill Gregory, of UHMB's financial risk to increase clarity of the current risks and help the system focus on priority actions required to support an overall balance position for the current financial year. This review will also consider wider system aspects such as the potential allocative issues though the pandemic that may have led to disproportionate levels of financial risk in the Trust's position. The review was being embraced and could highlight issues the Trust would also want to raise, and the Committee would be kept informed of developments. Although this review was specific to UHMB, it was noted the ICB had also commissioned Bill Gregory to do some work relating to the position being handed over from the Clinical Commissioning Groups. The report highlighted arrangements to mitigate the Integrated Care System (ICS) stretch target income risk. It had become clear that there was not a consistent interpretation of the agreement to support the collaborative programme of work which had therefore not sufficiently progressed to determine an assured position for inclusion in individual financial reports. Clarification of the agreement had

	since been sought and would be brought back to each organisation's Finance Committees in due course seeking reinforcement of the agreement. The system financial roadmap had been established specifically targeting what must be delivered across the system to achieve the balanced plan. Nominated ICB leads for components of the plan had been identified. CA was leading the development of the roadmap and the prosecution of the risk management framework and was working with Provider Collaborative Board (PCB) colleagues to develop an accountability structure to ensure every organisation reports consistently and transparently with a paper of recommendations of how the system will deliver against the target to the PCB and ICB. An output report will be provided to the Committee from that process. The grip and control checklist recommendations had been agreed by Executive Directors Group and Trust Management Group and were now progressing as set out in the report. In consideration of the report the following points were raised: 1. SW sought confirmation that the cost of the review would be covered by the ICB. CA confirmed that this was his assumption although committed to check and confirm. 2. KD queried whether individual Care Group plans had identified cross cutting themes. CA confirmed that plans being developed affected multiple Care Groups. The Financial strategy document commissioned at the end of last year provides a detailed understanding of the underlying financial position and makes specific recommendations tied to analytical comparative benchmark information, which CA agreed to brief KD on separately. In addition, SH outlined a piece of work that had commenced to refresh the clinical strategy, with a current focus on outcomes of care. This work links to the financial sustainability document and an overarching clinical strategy document was scheduled to be report to Board by the end of December 2022. **Action: CA to check and confirm where the cost of the independent review would be charged.** **Action: A briefing on financial strategy and clinical strategy to be provided to KD** **Decision:** The Committee noted the content of the Director of Finance report.
22/48	**Month 3 Financial Performance Report**

IL outlined the Financial Performance Report that detailed the Trust's financial performance to the end of June 2022, noting this was the first report based on the resubmitted plan.

Key items highlighted included:

- Reported position to the end of June was a deficit of £4.2m against a planned deficit of £3.5m including the £8.5m stretch income accrual.
- In relation to the Cost Improvement Programme (CIP), £7.3m of Care Group savings had been identified, with further opportunities of around £6m being verified. Meetings continue with Care Group leadership and SFIP teams to identify further savings. Centrally identified savings of £9.8m had also been identified bring the total to £17.1m. A gap of £5.9m remained to deliver in full.
- The Elective Recovery Fund (ERF) income was included in the position reported at month 3 at planned levels and confirmation had been received from national bodies that there would be no clawback from months 1-3.
- After removing the impact of COVID and out of scope costs, Care Groups were reporting a year to date overspend of £2.8m. £1.35m is unachieved CIP indicating a trading deficit that must be immediately addressed.
- The Capital Programme budget had been reduced to £31.3m due to reduction from the New Hospitals Programme and £0.5m relating to elective recovery. Spend to month 3 was £1.8m behind plan, however the forecast for capital was still to deliver in full and would be managed across the system.
- Following discussions relating to high-cost agency staff, a Pay Control Board had been recommended and Terms of Reference were being finalised. In addition, clarification around annual leave payments for agency staff had been communicated to Care Groups.
- Agency is still high and a 10% reduction target from last years outturn had been set nationally. A secondary target to deliver in line with plans submitted to the NHSI as part of the re-submission required a 37% reduction in cost of agency for the Trust. Although this was unlikely to be achieved, if CIP was achieved as planned, agency spend would reduce by more than 10% over the previous year's plan.

The following points were raised in consideration of the report:

1. SW requested an update on balancing agency spend with challenges around recruitment and sickness levels.

2. In relation to the levels of variance in Care Group positions, KD queried whether there was a wider concern around the Medicine Care Group financial performance and how this was being addressed.

   From a financial position perspective, Medicine was significantly impacted by not meeting criteria to reside issues and it would be important to work with the Care Group to capture and report on the value of what had been achieved.

3. Following her query relating to corporate costs and comparisons with other organisations, it was agreed that a briefing pack, to include model hospital data, etc. would be provided to KD.

4. LS queried the impact of inflation rates.

	IL outlined the expected run rate increase as a result of the electricity price increases in the second 6 months of the year but noted that accruals were already being made to cover the £1.5m when the changes come into place. Procurement colleagues will pull together all contracts and associated inflation rates but there are some complexities around identifying and reporting CIP as prices were higher due to inflation rates. The Trust were given clear instructions around inflation assumptions, and it would therefore be important to capture and report that externally. CA confirmed that he would write to the ICB to request further guidance specifically around the electricity contract that would have to be confirmed in the coming weeks. An additional point about agency rate inflation was raised and IL confirmed that as a result of regional and national focus on agency premium, comparison data for agency volume and price was being collated for 2019/20 to identify whether there is an inflationary aspect to agency spend or if more agency staff were being utilised on the ground. 5. Reflecting on the questions raised, SW asked IL to highlight variances and causes to illustrate where reality had not aligned with assumptions provided to inform future plans. 6. SW requested an update on the recurrent vs non-recurrent CIP. Of the £23m total CIP, £11.6m was forecast to be achieved recurrently. **Action: IL to provide a financial position briefing pack for KD, to include comparisons and benchmarking information such as model hospital data.** **Decision:** The Committee noted the content of the report.
22/49	**Operational Performance Report** SM outlined the Operational Performance report which covered data for May and June 2022 which was accepted as read. The following key points for the attention of the Committee: Urgent Care performance continued to show normal variation against the mean, between 72% - 76% for the 4-hour standard and 95%-96% for 12-hour performance. In relation to cancer, a healthy position was reported for the 104-day standard and an improving position for the 78 week referral to treatment (RTT) standard, although emerging work across the Integrated Care Board (ICB) around mutual aid in 78 weeks, was likely to impact on the trajectory. Work to identify the potential impact across the ICB was ongoing and would be reported back in due course. The following points were raised in consideration of the report: 1. SW re-emphasised the Committee's concerns during the development of plans about ensuring the results of the safe staffing review were properly

	reflected in recruitment plans and budgets and the importance of the visibility of variance to safe staffing review recommendations being reported. 2. LS noted previous concerns relating to the provision of care for patients that can't return home affecting ability to discharge and asked SM for insight from other organisations of a similar size. SM would like to discuss the potential for a Board Development session with the Chief Executive and Chair. There were often comparisons with organisations across the system, but consideration of structure for running an acute system at current occupancy levels including outflow and the significant ask of inpatient rehabilitation was required. SM also signalled his intent to approach newly appointed place-based directors to discuss opportunities around the intermediate care model. A bi-weekly meeting with directors of adult services had been established to focus attention on social care workforce capacity being the cause of not meeting criteria to reside issues. **Decision:** The Committee noted the report.
22/50	**Performance Accountability Framework** SH outlined a report to seek approval to implement the Performance Accountability Framework. The report was accepted as read with the following key points raised for the attention of the Committee: The Committee had been made aware of the development of the framework previously and it was noted that it had already been used in the July performance review cycle. The framework had been shared at a Trust Management Group workshop for further refinement and in consideration of the significant change in approach, it was agreed to test the principles during July and August with a further workshop to be held to gather feedback and potentially refine further, following which, a further update would be brought to the Committee. The following points were raised in consideration of the report: 1. Although from a principle point of view the framework was accepted, SW raised a challenge around the likelihood of the majority of Care Groups with the exception of Integrated Community Services, falling into segment rating 4, requiring intensive support questioning what impact this would have with the level of stress already on the organisation and what levers were available to accountable managers to solve some of the issues. SH confirmed that for the July and August period, the Care Groups would not be rated. Questions were focussed on each segment and a formal letter had been written to each Care Group documenting feedback and formal actions that would follow through into the next review meeting. It was important that this was an opportunity for Care Groups to signal where support was required individually and also where mutual support could be provided. Once the review had taken place, the matrix and segmentation scoring would be implemented, from September onwards. However,

	where there was a failure of a metric, if leadership skills and behaviours to drive forward with action plans to address could be demonstrated, that wouldn't automatically put them into a segment rating of 4. 2. KD requested further information to understand what support looks like and it was agreed that SH would provide a further briefing outside of the meeting. CA emphasised the focus on the behavioural aspect of the framework, and it would be beneficial to go through a couple of cycles working together. There was not a one size fits all approach to support. The organisation has learned from being placed in SOF4 and aspires to be quite targeted, depending on specific issues leading to categorisation in segment 4. The Committee will receive a further update following the September reviews. The Committee approved the Performance Accountability Framework recognising that a further report on progress would be received following the September reviews. **Action: SH to provide a briefing on the Performance Accountability Framework and support provision to KD.** **Decision:** The Committee approved the Performance Accountability Framework
22/51	**I3 Highlight Report** KH and MW presented the I3 highlight report noting the following points for the Committee's attention: From an information, IG and Cyber perspective: • I3 moved under the Chief Medical Officer portfolio, however it was noted that CA remained the Senior Information Risk Owner (SIRO). • Templar Executives, a cyber and information risk consultancy have provided SIRO training and are working with information asset owners to assess the structure and understand where the passing of information to the SIRO can be optimised to improve visibility of cyber risks. • The annual data protection toolkit was submitted for 2021/22. The toolkit submission was audited and given a substantial assurance rating. • During the reporting period, one high security incident came through the NHS and digital care alert system but there was no action to be taken. • The licence for Vector, a monitoring system rolled out across the ICS in 2020, was due to expire in April 2023. Working with ICS colleagues to assess next steps due to potential funding gap of £300k. A business case will be submitted to the Investment and Priorities Group for consideration in due course. • In May, the Trust recorded a peak uncoded activity backlog of approximately 2,500 discharges. A two-month recovery plan was implemented which has reduced the number of uncoded discharges to 200 and no further uncoded backlog had been recorded during June and July, however it was noted that the Priority Patient Discharge Unit (PADU)

	and discharge lounges remained the principle contributors and a working group was being established to address this. In relation to Electronic Patient Record (EPR) programmes: • A high severity incident was experienced in May for which Dedalus received a fine. However, since the time of writing the report, three further outages had been experienced and a root cause analysis was being carried out. • Further to previous updates regarding Dedalus ceasing development of Lorenzo, the final Lorenzo update would be released in September. The current contract expires in July 2025 and work was ongoing with the ICS to procure a core EPR with the development of a pan-ICS strategic outline case. Procurement was expected to commence in October and an EPR procurement board and digital clinical design authority had been established in support. **Decision:** The Committee noted the content of the report
22/52	**New Hospitals Programme Report** The Committee received an update report on the New Hospitals Programme budget for 2022/23 and was asked to approve a reallocation within the budget. Funds had moved from pay budget to contingency to reflect staff turnover and the plans had been amended to reduce the spend on planned staffing. **Decision:** The Committee noted the content of the report and approved the budget reallocation of £149k for 2022/23
22/53	**Investment and Priorities Group 3As Report** The Investment and Priorities summary report was included for information and accepted as read. In consideration of the report, LS queried delays reported in relation to the Stroke service and the impact on the pace of improvement particularly noticeable in the RLI Stroke rating. In addition, relating to the seven-day frailty business case, the alert regarding the number of ANPs leaving the service and the impact of that. SM highlighted the time sequencing, the scoring, and the lag with reporting Stroke data. Clinical leadership colleagues were satisfied that nothing clinically important was being missed and were sustaining stroke improvement mainly by protecting some of the stroke inpatient capacity. In relation to seven-day frailty, SM confirmed that like for like recruitment of ANPs was expected, however would work from new posts and deploy the workforce differently and better. Above that the Medicine leadership triumvirate were in the process of refining at pace what the composite frailty offer is which was expected to improve performance against plans.

	DS clarified that the business case being referred to for Stroke is to have a purpose-built therapies area to be developed at RLI as part of the Huggett Suite. **Decision:** The Committee noted the content of the report
22/54	**Oncology RLI Estate Plan** DS was in attendance to present the business case outlining the background and drivers for the RLI Oncology build. The report was accepted as read. The business case was included in the overall capital programme for 2022/23 and the funding had been identified as part of that plan previously considered by the Committee and Board of Directors. Due to the value of £5m, now spread over two years, it was brought to the attention of the Committee for further recommendation to the Board of Directors. The business case contains £5m for oncology, £2.18m in 2022/23 and then £2.81 in 2023/24. The total costs associated were circa £5.3m, however there were opportunities to bring the project back within budget by achieving a good tender return and value engineering. In addition, the use of charitable funds was being explored. Revenue charges associated with the capital plan is £297k per year and there were no staffing or other ongoing costs. Noting that the business case had been subject to prioritisation processes, and the expectation that the margin over budget was managed, the Committee recommended the business case for approval by the Board of Directors. **Decision:** The Committee recommended the business case to progress for approval by the Board of Directors.
22/55	**Schedule of Business** It was noted that the schedule of business required further review to ensure topics aligned with the appropriate meeting to allow the Committee to focus on the financial performance quarterly to allow space in intervening meetings to spend more quality time on specific projects, with the initial aim of doing that for I3. **Decision:** The Committee noted the schedule of business.
22/56	**Attendance Monitoring Register** **Decision:** The Committee noted the Attendance Monitoring Register.
22/57	**3As Report and Meeting Effectiveness**
22/58	**Any Urgent Business** The Committee requested sight of the multi-year capital schedule at the next meeting for oversight on Capital costs. TP provided a verbal update to the Committee highlighting the following key points: • Elective recovery bid of £7.6m for two additional theatres at Kendal had been approved by the national committee. Work ongoing with the Estates team to expedite the works.

	• Two bids for community diagnostic centres approved regionally and sent to the national team for consideration. £5m for a second MRI at Barrow and a second part of the bid to replace the modular MRI and CT scanners at Kendal with permanent facilities. • Work with GPs to move some testing off acute sites to GP surgeries. • An indicative budget for replacing the EPR had been received, however the national funding contribution was less than 50% so this is a challenging project which the Committee would receive further information on in due course. SW requested a more detailed briefing on the capital budget be provided for KD and noted that it was worth the Committee committing time to satisfy itself on judgements being made on capital projects. **Action: An update on the capital schedule to be provided for the next meeting for oversight on Capital costs. Lead - TP**
	Date, Time and Venue of Next Meeting It was noted that the next meeting of the Finance Committee would be held on 26 September 2022 via Microsoft Teams.

Minutes of the Quality Assurance Committee Meeting held on Monday 18th July 2022

Present:	Hugh Reeve (HR) Bridget Lees (BL) Jane McNicholas (JMc)	Deputy Chair & Non-Executive Director Executive Chief Nurse Chief Medical Officer
In attendance:	Richard Matthews (RM) Simon Bradley (SBr) Sue Bishop (SBi) Heather Gallagher (HG) Kim Crabtree (KC) Lorraine Crossley-Close (LCC) Ameeta Joshi (AJ) Anna Smith (AS) Gregg Peers (GP) Daniel Bakey (DB) Linda Womack (LW) Barry Rigg (BR) Nicola Askew (NA) Lorriane Crossley-Close (LCC) Paul Jones (PJ) Louise Corlett (LC) Lorna Pritt (LP) Sarah Maguire (SM) Suzanne Hargreaves (SH) Scott McLean (SMc) Emily Sidebottom (ES) Rhiannon Tinson (RT) Hannah Chandisingh (HC) Jackson Stubbs (JS) Georgina Barber (GB)	Governance Business Partner, Governance Quality Improvement Lead, Morecambe Bay CCG Head of Quality, Morecambe Bay CCG Director of Midwifery Associate Director of Nursing, ICC Governor Deputy Medical Director Head of Risk & Safety Governance Business Partner, S&CC Deputy Associate Director of Operations ADOP, WACS Head of Patient Experience Head of Children and Young People Governor Company Secretary Associate Director of Operations Associate Chief Nurse Associate Director of Nursing, S&CC Associate Director of Strategy and Transformation Chief Operating Officer Clinical Site Manager, T&O Head of Performance and Cancer Lead Head of Inclusion and Diversity Patient Safety Manager Executive Assistant to the Chief Nurse
69	**Welcome and Introductions** Hugh Reeve opened the meeting at 13.00 and performed welcome introductions. **Apologies for Absence** Apologies were noted from Janet Pitman, Jane Jones, Richard Sachs, and Jill Stannard. **Declarations of Conflicts of Interest** No Declarations of Interest were declared.	
70	**Minutes of the Quality Assurance Committee Meeting held on 20.06.2022** The minutes of the meeting held on 20.06.2022 were accepted as a true and accurate reflection. **Decision:** 1. That the Minutes of the meetings held on 20.06.2022 be agreed as an accurate record.	

71	**Action Sheet and Matters Arising from the Minutes of the Quality Assurance Committee on 20.06.2022** The Committee reviewed the action tracker and noted the updates. **Decision:** 1. That the Quality Assurance Committee had considered the tracker sheet.
72	**Integrated Performance Report** The Committee considered the monthly IPR (Integrated Performance Report) report which was presented by Bridget Lees (BL). The report provided advice and assurance on issues related to the Quality and Safety IPR. During a summary of the report the following key points were highlighted: - Progress was now being seen following commencement of quality initiates for falls and pressure ulcers - FFT results continued to be of concern; a deep dive had been requested and had been included further on the agenda - Fractured neck of femur work had continued with an in-depth report included further on the agenda - One complaint had breached the 6 months regulatory timeframe and BL asked for further information on this. It was noted that from April 2023 BL would be advising a reduction in complaint turnaround times to 60 days - A rise in moderate and above harms had been seen and were attributed to hospital acquired Covid-19 infections During deliberation of the item the following points were made in discussion: HR (NED) queried the rise in moderate and above harms, questioning if Covid-19 reasons had been stripped out to ensure that the rise was due to the pandemic. BL and HR discussed an increase in maternity numbers, grading, and the need for more in-depth reporting for greater assurance. BL requested that further narrative and breakdown of data be included in the IPR going forwards. HR (NED) requested an update be provided prior to the Board meeting planned for the 27th of July 2022. Decision: 1. That the report be noted. 2. That the report be approved for submission to the Board of Directors Action: 1. Further information for the FFT results related to an increase in moderate and above incidents be provided to HR prior to the Board meeting of 27.07.2022. 2. Further narrative and breakdown of FFT data should be included in the IPR going forwards.
73	**Monthly CQC (Care Quality Commission), Niche & RCS (Royal College of Surgeons) (Royal College of Surgeons) Update** The Committee considered the monthly regulatory update which was presented by Richard Matthews (RM).

	The report summarised the Trust's current position and progress of the various improvement plans to address CQC must and should do recommendations, Niche report recommendations and Royal College of Surgeons recommendations. During a summary of the report the following key points were highlighted: - Progress on actions was noted to have plateaued a little with limited progress seen in the report; it was explained sequencing of the support and review meetings had been brought forward and further progress was expected by the end of the week - Work continued to ensure improved articulated of risks and difficult to do asks - Following the CQC visit in March, the draft report had been received for factual accuracy and the finalised report was expected to be received imminently - The Ockenden report had been received and the care group were working hard to review actions and recommendations; these would be checked and mapped against current plans - The Niche review continued to progress through ongoing review of evidence. The work was being assisted by NHSEI and further feedback would be provided at the September meeting During deliberation of the item the following points were made in discussion: HR (NED) flagged a change in the number of actions fully completed but not signed off, noting a significant drop from 49 to 22. RM would check the data but felt this could be attributed to panel reviews when full assurance was not provided and the action therefore moved back to 'in progress' HR (NED) questioned further review dates for Surgery and Critical Care, noting that there did not appear to have been one held since May. RM assured that at the May meeting excellent progress had been seen with only two recommendations which could not be signed off, these had both required estates work to be completed and therefore once this had been carried out a further review would be arranged. JMc advised that other work continued and progress for these was reported through NHSEI, noting that the support panels were purely for CQC actions. HR (NED) asked RM to ensure that this was made clear on the front cover sheet of the report going forwards for clarity. Decision: 1. That the report be noted.
74	**External Reviews, Accreditations & Returns Quarterly Report** The Committee considered the quarterly report which was presented by Richard Matthews. The report provided an update on external agency visits, inspections, and accreditations in the last six month (January – June 2022). During a summary of the report the following key points were highlighted: - The report was accepted as read During deliberation of the item the following key points were made in discussion:

	HR (NED) highlighted the visit in March from the Human Tissue Authority when two major shortfalls were noted. HR (NED) requested further information on these and what actions had been taken to mitigate. GB was asked to check previous minutes to ascertain if the concerns had already been discussed. Reassurance for the September meeting was requested. Decision: 1. That the updated be noted. Actions: 1. That further information and assurance be provided on the risks identified during the March visit from the Human Tissue Authority.
75	**Monthly Maternity Assurance Report** The Committee considered the monthly update which was presented by Heather Gallagher. The report summarised maternal and neonatal progress made over the last month and was brought to each meeting for review and approval for submission to the Board of Directors meeting. During a summary of the report the following key points were highlighted: - A retrospective audit into PMRT had been undertaken and 30 cases had been reviewed. A full report and action plan would be presented to the QAC in September 2022 - A slight improvement had been seen in training compliance - Anaesthetic compliance with PROMPT had dropped further and the CD for the care group had been asked to escalate for action. Discussions were underway to consider how the problems could be mitigated with a plan being made to improve the trajectory - Anaesthetics had been asked to report directly to the QAC to provide assurance around staffing levels which were being negatively impacted by continued sickness within the team - The Ockenden report had been received and a more detailed update had been included further on the agenda - Midwifery Continuity of Carer plans had been paused in line with the NHSEI request; a more detailed update had been included further on the agenda During deliberation of the item the following points were made in discussion: HR (NED) highlighted the staffing issues affecting the anaesthetic team. DB confirmed that conversations with clinical leads had taken place and an MDT approach would be taken. Decision: 1. That the report be noted. 2. That the update be approved for submission to the Board of Directors
76	**Midwifery Continuity of Carer** The Committee considered the report which was presented by The report provided an update on the implementation plan for Midwifery Continuity of Carer (MCoC).

	The report was accepted as read with HG confirming that the plan was reliant on sufficient midwifery staffing levels and as this had not yet been achieved the plan had been suspended on advice of the NHSEI until correct staffing secured. During deliberation of the item the following points were made in discussion: HR (NED) discussed the apprenticeship scheme in relation to staffing difficulties, highlighting that it would be an important source of new midwives and querying if the current blocks to the business case could be cleared. HG confirmed that the business case was cross care group but that WACS had gone out at risk to the scheme with BL approval. HR (NED) also discussed outliers, querying if they were picked up on maternity IPR. HG confirmed they were monitored on the maternity dashboard and that work was ongoing on the IPR both at care group level and above. Decision: 1. That the report be noted.
77	**Ockenden Final Report (part 2)** The Committee considered the report which was presented by Heather Gallagher. The report offered an update on the Ockenden final reports (2022) on the 15 immediate and essential actions required. During a summary of the report the following key points were highlighted: - A national steer into the 15 actions had not yet been received and was expected in September - The care group would be working on the actions prior to the national steer but it was expected that they would change - Further updates would be brought to the Committee for consideration once received During deliberation of the item the following points were made in discussion: BL noted the need for continued guidance, next steps, and focus. The pressure that the care group were under was acknowledged and it was not expected to abate over the coming months. Key work around systems and processes was discussed at some length and the need to move from the current reactive approach to a proactive one was highlighted. RM discussed the multiple CQC actions that sat with the WACS care group, noting the need to articulate the tasks in the governance framework and to smartly join them up to prevent duplication. HR (NED) suggested that an approach similar to that taken for Niche & RCS could be considered. Decision: 1. That the report be noted.
78	**Care Group Quarterly Report – Women and Children** The Committee considered the report which was presented by Linda Womack.

	The report provided an update on quarter 4 activity in the WACS care group. During a summary of the report the following key points were highlighted: - The care group QR summary had been split by maternity and CYP - Midwifery staffing levels had seen an 8% reduction compared to the same period in 2020. Daily staffing huddles were being held to support the services - International recruitment and apprenticeships were being looked at to help reduce the fragility of the workforce and a number of students were set to qualify in September - Midwife to birth ratio was directly linked to staffing but 1:1 support in labour had continued to be provided - Recruitment was underway for O&G at RLI and FGH to provide a more robust service. Two consultants had been recruited to for O&G (1 each at RLI and FGH) - Work continued to strengthen governance processes - The care group had a planned Ockenden review on 21/22 July - Perinatal mortality rate was updated and it was confirmed the Trust were not an outlier - CYP had seen an increase in inpatient admissions - Paediatric attendances at ED had increased - There had been an increase in children and young people with complex emotional and health and wellbeing needs - The Trust did not have a neonatal critical care services and babies who required critical care were transferred to a tertiary unit; based on this the Trust had not taken part in the ICCQIP audit - BAPIO recruitment of two middle grades who had commenced in post - Four student midwives had been recruited - Three international midwives had been recruited (for SLBC) - All women in maternity had been set up on Badgernet - The Picker Survey showed good results with high satisfaction by service users - Work continued on the Clinical Operating Model - The National Paediatric Diabetes Audit had been carried out with 94% of cases audited During deliberation of the item the following points were made in discussion: SBi noted a lack of information in the report about the amount of safeguarding work that had been undertaken, reflecting that this would be a helpful addition. SBi also raised the issue of paediatric staffing and acuity on the wards, querying what work was being undertaken and if it was still an ongoing risk. LW acknowledged that the safeguarding work had not been included and that in terms of paediatric staffing and risk, a meeting with NHSEI had taken place and data would be benchmarked against the standards for emergency staffing for acute Trusts and for the short stay assessment and observation units. This work would identify any shortfalls and gaps in staffing and potential new models of care that could be used. BL highlighted the vast amount of work that the care group needed to undertake, reflecting that the presentation only detailed a small percentage. HR (NED) acknowledged the work being undertaken and the improvement seen in terms of leadership stability.

	HR (NED) raised the issue of the higher number of children being seen in the service with mental health issues, observing that this cohort of patients often ended up in A&E and acute paediatric wards due to lack of specialised services. NA agreed with the Chair's observations, commenting that this was a known national problem with long waits for tier 4 beds. NA updated that a new training package had been externally funded and rolled out to ED and security staff to help support young people in mental health crisis. Close working with LCSFT was confirmed. Decision: 1. That the report be noted.
79	**Care Group Quarterly Report – Surgery & Critical Care** The Committee considered the quarterly update which was presented by Sarah Maguire, Gregg Peers and Danny Bakey. The report provided an update on quarter 4 activity in the S&CC Care Group. During a summary of the report the following key points were highlighted: - Actions from the previous report were discussed and it was confirmed that a diabetic task and finish group had been set up to look at current issues and a diabetic thematic review had been undertaken by Cathy Hay (Deputy Medical Director), the results of which would be reported at the care group SGAG in August. Specialised posters had been designed and had been displayed in the doctors and teams' offices and training videos and targeted training sessions had been arranged - A new matron was in post and was supporting progress in a number of areas which had been identified as having some clinical variation, these had included tracheostomy and central line management - A regular patient story was presented at SGAG and was well received - All overdue incidents had been closed - Two consultant posts at FGH had been recruited to, ensuring the IC unit was less fragile - A further 5 SAS doctors for FGH and a local consultant for the RLI had also been recruited for the anaesthetic teams - The thematic review of falls, pressure ulcers and 104 day breaches was underway - There had been six months of continued improvement in relation to pressure ulcers and a process was in place to validate as they came in - The unplanned return to theatre SOP had been finalised alongside a dashboard. Some duplication of data had been identified and was being reviewed - A Fractured Neck of Femur workshop had been held and four key priorities had been identified - The CQC action plan was progressing as expected with actions outstanding which related to estates - A 12 month audit in Ophthalmology was being planned in response to an incident related to a patient who had a biopsy undertaken with no awaiting results pathway created. A sample of 25 patients were being reviewed and GP and DB had met with I3 and pathology colleagues to progress - Issues related to consent and the use of stickers was noted; the problems had been discussed at a SGAG meeting and GP confirmed that consents and practises for surgical specialities had now been listed. Work continued and eventually it was planned that E consent would be used in place of the stickers

	- A number of SI actions remained overdue and regular update statements were received and discussed at SGAG - Some strained working relationships within Ophthalmology were confirmed and the team were working with People and OD to provide support During deliberation of the item the following points were made in discussion: BL discussed monitoring of actions related to Ophthalmology and pointed out that findings would need to be routed through the Committee. Decision: 1. The update be noted.
80	**Care Group Quarterly Report – Integrated Community Care Group** The Committee considered the quarterly update which was presented by Louise Corlett, Kim Crabtree, and Sarah Hamer. The report provided an update on During a summary of the report the following key points were highlighted: - A number of concerns around the speech and language team were discussed and it was noted that the workforce was fragile. A deep dive was being undertaken to understand all elements and five key risks had been identified and added to the risk register. - Work to progress virtual wards was detailed and it was confirmed that this was part of an NHS response to planning guidance, The ICs trajectory was for 150 beds by the end of quarter 2 in 2023 with an aim for 96 by the end of the current financial year. The work had been started against a baseline of zero and the Trust were working closely with the ICS and national experts to ensure safe and sustainable roll out - Appraisal progress was noted. An internal target to have all 2020/21 appraisals completed by the end of June had not been reached but the care group were at 97% which reflected all but one staff member not having been appraised, this was planned for the end of July when they intended to return to work following sickness absence - A drop in BLS compliance was flagged (83%) and a number of challenges detailed including inconsistency of training and access to venues. A productive meeting with Emma Fitton had been held and the group would now have their own key trainers in community which would allow training to be completed in a timely manner whilst reducing travel time - An End of Life suite had opened at Abbey View in the last month. This offered patients and their families the opportunity to spend time together at end of life. A standardisation of end of life care was being reviewed and it was hoped that the work undertaken at Abbey View would be replicated across the Trust - Validation of all falls and pressure ulcers was undertaken and presented at a weekly Harm Free Care group - No moderate harms had been reported since January 2021 - Work was ongoing with Rebecca Southall from NHSEI around governance restructure; the care group had received revised terms of reference and agenda templates and these would be rolled out and embedded During deliberation of the item the following points were made in discussion:

	HR (NED) discussed the work being undertaken on Virtual Wards and asked for a further update on progress in the next care group quarterly updated. BL noted the new risks related to the speech and language team, querying if there was anything related to quality that the Committee needed to be aware of. It was confirmed that the issues were being work through with an action plan developed and a repeat audit was being considered. HR (NED) requested an update on risks associated with the service to be included in the next quarterly care group report. Decision: 1. That the update be noted. Action: 1. The next quarterly report should include specific updates related to virtual ward progress and risks associated with the speech and language service.
81	**VTE Update Report** The Committee considered the report which was presented by Ameeta Joshi The report provided an update on the current completion rates of VTE risk assessment across the Trust. During a summary of the report the following key points were highlighted: - Combined VTE assessment currently sat at 89% which was below the national requirement of 95% - Day case compliance was low at 17.7% and required more work - To ensure accurate reflection of the figures all patients who received treatment under a local anaesthetic were cleansed from the data, this was in line with neighbouring Trusts where VTE was not routinely included for patients undergoing procedures under a local anaesthetic except when there would be known limited mobility - A chart had been included in the report which identified the areas were effort needed to be concentrated - IT were assisting to rectify and clarify a number of erroneous wards within the data - Meetings were planned with the care groups in August to discuss the data and improvements - A weekly focus on VTE along with ward walkaround had been commenced to raise awareness - A number of junior doctors had become VTE Champions and it was hoped that nurse colleagues would also come forward During deliberation of the report the following key points were highlighted: SBi discussed the monitoring dashboard which was detailed in the report. AJ confirmed that this would be available for every individual but currently was being mostly utilised by the nurse managers. HR (NED) discussed the ongoing work and suggested a further update later in the year with AJ four months would be good time to present an update. Decision: 1. The update was noted.

	Action: 1. That an update be brought to the Committee in four months (November 2022).
82	**Update on Fractured Neck of Femur Improvement Work** The Committee considered the report which was presented by Emily Sidebottom and Danny Bakey. The report provided an update on the work and progress of the fractured neck of femur and to assurance of actions undertaken to improve the #NOF pathway and associated mortality within the Trust During a summary of the report the following key points were highlighted: - A mid-term NOF workshop was held in May with good engagement - Efforts had been focused since the workshop on four main areas, Pain assessment and management and prioritising NOF throughout the whole pathway, taking lessons learned from the stroke pathway, the clear assessment and management of delirium and mobilisation, optimum times, and rehab - A summary of key work already undertaken was detailed in the report - Hip precaution guidelines had been recently reviewed which would support in early mobilisation and improved length of stay - PA allocation for the site trauma leads had been increased to reflect the additional work they were being asked to support - Training had been delivered in the ED department for spinal blocks; this was felt to be very important in getting patients to surgery within 36 hours and improving patients experience, pain management and length of stay - An E Whiteboard was being developed; this had been split into different stages. IT were assisting - Improved access to ortho-geriatric care was planned and this was considered a key action in supporting the work - There are plans to review the pain management pathway and a number of matrons had made contact with pharmacy to discuss ensuring the right medications were being prescribed at the right time (pre and post-surgery) - Champions were planned at FGH to support use of the Abbey pain tool During deliberation of the report the following points were considered: SB queried when it was anticipated that actions would start to positively affect mortality rates and hip fracture data. ES and GP there was a lag in the data and reporting time scales were being reviewed but that it wasn't expected that actions recently put in place would be positively affecting data as yet. BL discussed the importance of the work being undertaken, not only in relation to the fractured neck of femur pathway but also with its wider applicability across the Trust. HR (NED) discussed the monitoring of actions and outcomes in a way which would more identify progress more quickly with a suggestion of perhaps quarterly updates which would not only show mortality data but other indicators such as patient experience. ES discussed the NHFD database, confirming that this data would be annually but informing that other data from a dashboard could be used. HR (NED) requested a further full report to assure on actions and progress and this was requested for the September meeting of the QAC.

	Decision: 1. The update was noted. Action: 1. A further update report should be submitted to the Committee in September 2022.
83	**Safer Staffing Report** The Committee considered the report which was presented by The report provided an update position on the two bi-annual reports about the establishment setting. During a summary of the report the following key points were highlighted: - The report had been submitted to the People Committee earlier in the day - The report provided an update between the two bi-annual reports - In terms of data collection they were now on the second cycle and this would be analysed and reported on in the next bi-annual report in September - The ED team had been included in the data and licences were being awaited to be able to start collecting data from the community teams - Modelling for winter pressures was included in the report - Concerns against the modelling data related to anticipated leavers was concerning - Healthcare Support work data showed significant gaps and recruitment work was planned to address - Recruitment and retention was detailed in the report with an apprenticeship scheme in place for which a business case had been mapped for a ten year staffing model for nurse, allied health professionals and midwives During deliberation of the report the following key points were highlighted: HR (NED) received the report, noting that the People Committee would monitor impact. Decision: 1. The report was noted.
84	**Minimising Potential Harm due to Delays in the Elective Pathway** The Committee considered the report which was presented by Rhiannon Tinson. The report provided an update on During a summary of the report the following key points were highlighted: - Improvements in elective waiting times were highlighted - There were currently only three patients waiting over 104 weeks, all of which had been unfit for treatment - If there was a delay in follow up at OPA then patients were assessed for harm and categorised - Moderate or above harms were discussed with patients directly, captured on the Ulysses system and would follow the harms process During deliberation of the report the following key points were highlighted: SB queried if a level of harm had been identified with RT explaining that any identified themes would be reported on a separate report which would be submitted to the Committee and on to Board. HR (NED) added that themes and harm were also reported

	through the Serious Incident (SI) panel along with planned actions. RT would bring an updated paper to the QAC meeting in September for assurance around harm reviews and risk stratification and a decision would then be taken as to the frequency of subsequent updates. SMc commented on the usefulness of the papers in clearly describing the current position in context of coming out of the pandemic and noted that with efficiencies and additional activity more could and would be achieved. It was however acknowledged that further fundamental change would be required and the newly launched Clinical Strategy would help move this forwards. Decision: 1. That the update be noted.
85	**SI 3A Report** The Committee noted the report. Decision: 1. The report was noted.
86	**QGPS 3A Report** The Committee noted the report. Decision: 1. The report was noted.
87	**Executive Review Group 3A Report** The Committee noted the report. Decision: 1. The report was noted.
88	**Patient Safety 3A Report** The Committee noted the report. Decision: 1. The report was noted.
89	**Patient Experience Report** The Committee considered the report which was submitted by Barry Rigg. The report provided an update on update on patient experience across the Trust and progress in working towards “Patients First”. Due to technical difficulties BR was unable to present and BL provided a brief overview in his absence. - BL confirmed that the Committee had asked at the previous meeting for a deep dive into data from the Friends and Family test and that report had provided an overview of it and added context. - The Trust’s work with the veteran society was acknowledged and praised - The Trust had committed to the next phase of the rainbow badge scheme During deliberation of the report the following key points were highlighted:

	BL discussed the longer plans for the service, the aspirations and future plans and advised that it would be useful to have these in future reports. Decision: 1. That the update be noted.
90	**Inpatient Survey 2021 Report** The Committee considered the report which was presented by Barry Rigg. Due to technical difficulties Barry Rigg was unable to present the paper and the Chair requested that it be deferred to the September meeting. BL and HR discussed the report, noting the poor performance in relation to response and it was felt that a way of improving results could be to encourage better engagement with patients whilst they were being treated (on-site rather than following discharge). BL acknowledged the work going on in the service to improve the ratings but highlighted that the paper did not provide information on what was being done in response to the findings. It was agreed that the Committee needed to understand what the current plants were and how progress would be monitored and assured. Bl would speak with BR outside of the meeting to request the report be updated and resubmitted to the September meeting. Decision: 1. That the report be deferred to the September meeting. Action: 1. That the report be updated and resubmitted to the September meeting.
91	**Positive Difference Action Plan 2022/23** The Committee considered the report which was presented by Hannah Chandisingh. The report provided an update on During a summary of the report the following key points were highlighted: - The plan had been discussed and approved at the People Committee earlier in the day - Parts 4 and 5 had been brought to the QAC Committee as they affected service provision - The plan was hoped to improve and amplify the voices of those who were most likely to have a poor quality of care experience - The plan would usually be presented alongside the Annual report but this had been pushed back until September - Sections 4 and 5 highlighted for QAC committee, two parts which affect service provision, meeting minimum standards as well as pursuing more aspirational standards - Amplifying voices of those mor likely to have poor quality of care - Usually with annual report but pushed back o September During deliberation of the report the following key points were highlighted:

	BL noted the need for clarity of aspirations and the need to integrate the plan into business as usual. Decision: 1. The update be noted.
92	**Risk Register Report** The Committee considered the report which was presented by Anna Smith. The report provided an update on quality domain risks that sit within the BAF trust wide risk register along with information in the high value risks being managed by the care groups of which there were 31 in total. During a summary of the report the following key points were highlighted: - There were 6 risks relevant to the Quality on the risk register and 31 high value risks being managed by the care groups Decision: 1. The update be noted.
93	**Review of BAF** The Committee considered the report which was presented by Paul Jones and Suzanne Hargreaves. The report provided an update on progress made in quarter 1 against the Trust's key areas of focus. During a summary of the report the following key points were highlighted: - The presentation had been taken to the TMG last week and had been brought to the QAC prior to submission to Board - 2022/23 proprieties were discussed in relation to quality and safety - Key areas of focus and actions underway were discussed - The work on VTE, the reduction in falls and pressure ulcers and the work being undertaken on the mortality review were highlighted along with the progress on the fractured neck of femur pathway - TMG review and feedback were shared on the slides and included improvements in elective recovery, senior leadership recruitment, appointments to CD's and ADOP's and improvements across fundamentals of care and the safe staffing review. Areas of concern were reported to be pace of delivery, financial performance and CIP, productivity levels across clinical services, NMC2R numbers, pace of improvements in some RSP workstreams, colleague sickness and fatigue, elective backlogs, and disruption to leadership at ICB and Place due to ongoing system reform - Key actions to be reviewed in the quarter 2 period were detailed which included the clinical strategy During deliberation of the report the following key points were highlighted: The group were asked for feedback on the points shared prior to submission to Board. HR raised the work of the Hive group and the quality improvement work they undertook, which addressed two of the key areas around pressure ulcers and falls but also introducing people on a broader scale across the organisation into different ways of working, including a greater sharing of lessons learned.

	BL discussed the need for a collective approach to sustainable improvements and that this was reflected in the QAC agenda. Paul Jones discussed the BAF where elements of the Q1 framework would be featured. It was informed that the Board had undertaken a strategic review earlier in the year and had been populating the BAF since. The BAF submitted was confirmed to be a work in progress and comments received today would be taken into consideration before the discussion at Board on the 27th of July. HR (NED) requested that any chances or additions PJ wished to make be emailed over to him for consideration outside of the meeting. Decision: 1. The update was noted.
94	**Quality Assurance Cycle of Business** Noted
95	**Attendance Monitoring Register** Noted.
96	**Any Other Business**
97	**3A Report for Board** Alert - Ongoing pressures in staffing in Maternity services. The Maternity Continuity of Carer initiative has been placed on hold until more resilient staffing levels are in place across the service. This is in response to national advice and is the situation in many maternity services across the country. Assurance - The rise in moderate and above incidents was noted and this was attributed to hospital acquired Covid-19 infection. Further breakdown of the data was requested to ensure there were no other underlying causes for this rise. Advise - Work on creating the new community virtual wards was detailed with the aim of 19 virtual beds being in place by March 2023. · - The Committee received and considered an update report on the ongoing work related to improving the outcomes for patients with fractured neck of femur. Detailed work is underway, an action plan is in place and the Committee will carefully monitor progress over the coming months. - The Committee received and considered an update on VTE compliance across the Trust. Progress was noted and would be carefully monitored by the Committee over the next few months. - The Inpatient Survey 2021 (embargoed) was deferred to September due to technical difficulties in presenting by the team
98	**Date, Time, and Venue of Next Meeting**

	It was noted that the next meeting of the Quality Assurance Committee would be held on Monday 19th September 2022, 13.00 – 15.00 via Teams.

UHMB NHS Trust NHSE EPRR Annual Assurance 2022-2023

Change Log	
Number of Applicable Standards (2021-22)	46
New/Returning Standards	21
Standards Amended	26
Standards Removed/Amalgamated	4
Total Changes	**51**
Core Standards reduced in 21/22 due to the events of 2020, NHS England have now undertaken the tri-annual review.	

Compliance: Substantial	
Number of Applicable Standards (2022-23)	64
Fully Compliant	57
Partially Compliant	7
Non-compliant	0
Percentage	**89%**
The organisation is fully compliant against **89-99%** of the relevant NHS EPRR Core Standards.	

No.	Standard	Detail	Evidence	Self-Assessment	Action Plan
Domain 1 Governance					
1	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	Outlined in the UHMB EPRR and Business Continuity (Service Resilience) Corporate Policy.	Fully Compliant	Policy Review Date 2024
2	EPRR Policy Statement	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	Outlined in the UHMB EPRR and Business Continuity (Service Resilience) Corporate Policy, and the UHMB Major Incident Plan.	Fully Complaint	Policy Review Date 2024

3	EPRR Board Report	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	Resilience reports into the Emergency Planning and Resilience Group (EPRG), chaired by the Emergency Accountable Officer; and the Trust Management Group (TMG). The EPRG meets every six weeks. Annual EPRR Assessment presented at Public Board meeting.	Fully Compliant	
4	EPRR Work Programme	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	The annual EPRR work programme is guided by; the EPRR Framework Action Plan, post incident debriefs - lessons learned and/or post exercise reports, corporate, community and national risk registers.	Fully Compliant	**NEW Standard**
5	EPRR Resources	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	Outlined in the UHMB EPRR and Business Continuity (Service Resilience) Corporate Policy.	Fully Compliant	Policy Review Date 2024
6	Continuous Improvement Process	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	Outlined in the UHMB EPRR and Business Continuity (Service Resilience) Corporate Policy. Standardised debrief process and template in all new and revised Incident Response Plans.	Fully Compliant	Policy Review Date 2024
Domain 2 – Duty to Risk Assess					
7	Risk Assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	EPRR risks are regularly considered, recorded and revised on the Corporate Risk Register. Risks are periodically reviewed at EPRG.	Fully Compliant	
8	Risk Management	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	Outlined in the UHMB Risk Management Policy 2021 – 2022.	Fully Compliant	
Domain 3 - Duty to Maintain Plans					
9	Collaborative Planning	Plans and arrangements have been developed in collaboration with relevant stakeholders to ensure the whole patient pathway is considered.	All plans are subject to consultation with stakeholders and subsequent validation by the Emergency Planning Resilience Group before ratification.	Fully Compliant	**NEW Standard**

10	Incident Response	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework	Outlined in the UHMB Major Incident Plan; Incident Response Plan – Major, Critical and Level 1 Business Continuity Initial Operational Response principles.	Fully Compliant	**Policy Review Date 2021**
11	Adverse Weather	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heatwave on the population the organisation serves and its staff.	UHMB Adverse Weather Plan & CPFT Severe Weather Plan are presently being reviewed and integrated, supplemented by the NHS England Heatwave/Cold Weather Plan - the Trust has sufficient resources in place to ensure an effective incident response.	Fully Compliant	Adverse Weather Plan integration and review to continue.
12	Infectious Disease	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	UHMB Outbreak Management Policy in Place	Fully Compliant	**NEW Standard** Policy Review date 2023
13	New and Emerging Pandemics	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	UHMB Outbreak Management Policy and Influenza Management Policy in Place.	Fully Compliant	**NEW Standard** Policy Review date 2023
14	Countermeasures	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	***Waiting for feedback from Pharmacy.***		**New Standard**
15	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	UHMB Major Incident Plan outlines the Initial Operational Response principles; this is supplemented by NHS England Concept of Operations for managing Mass Casualties and the Guidance for managing mass casualty events in the Lancashire and South Cumbria Major Trauma Network the Trust has sufficient resources in place to ensure an effective incident response. Action Cards and Local Emergency plans include principles for creating capacity/managing mass casualties.	Fully Compliant	Major Incident Plan Review Date 08/2021. Mass Casualty principles to be included in the appendix.
16	Shelter and Evacuation	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Risk relating to the evacuation of patients has been high on the Corporate Risk Register for some time; this risk has been managed effectively through individual risk assessment of patients, estates and facilities solutions. Hospital Evacuation Kits and supporting policies in place; local emergency plans and NHS Planning for the Shelter and Evacuation of people in a healthcare setting are available to responding staff.	Fully Compliant	Policy Review Date 2023

17	Lockdown	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	UHMB Lockdown Policy remains under review due to complex fire safety vs lockdown issues Local Lockdown Plans in place.	Fully Compliant	Policy Review Date 2021 Under Continued Review by LSMS
18	Protected Individuals	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs), high profile patients and visitors to the site.	UHMB VIP and Celebrity Visits Policy in place.	Fully Compliant	Policy review Date NOV 2022
19	Excess Fatalities	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	The mortuary Senior Team are members of mass fatalities and death management sub-groups of the LRFs; contributing and working to LRF plans.	Fully Complaint	**NEW Standard**
Domain 4 - Command and Control					
20	On-Call Mechanism	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	Strategic and Tactical On-call process in place; the Trust is presently moving to a Mobile App to Cascade, and access action cards. The present SMS system remains in place although its lack of resilience has been identified dur a recent incident.	Fully Compliant	Continue Mobile App Implementation
21	Trained On-call Staff	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	All Strategic, Tactical and Operational Commanders have received training in defensible decision making, incident command and control and action planning in 2022.	Fully Complaint	**NEW Standard**
Domain 5 - Training and Exercising					
22	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	Training remains one of the biggest EPRR risks within the organisation; while Command and Control staff have all received training – not all frontline staff have any received training. There is not formal training schedule in place at present.	**Partially Compliant**	**NEW Standard** Formulate a local Training Schedule with frontline staff.
23	EPRR Exercising and Testing Programme	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	The annual Exercise and Testing week takes place every SEP. Two members of the Patient Flow & resilience Team have qualified as Senior Instructors from EMERGO in 2022.	Fully Complaint	**NEW Standard**

24	Responder Training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	All Tactical Commanders self-assess against the NOS Responding to an Emergency at the Tactical Level. Training has been provided to Strategic, Tactical and Central Operations Team (in-hours incident response team) staff by an external provider in 2022 – inline with NOS. Responding staff are provided with on-call packs providing information and acting as a portfolio to use as a part of the annual appraisal process.	Fully Complaint	**NEW Standard** Training to be aligned to NEW Occupational Standards for EPRR JUN 22
25	Staff Awareness & Training	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	All staff have access to awareness training via their managers, Local Emergency Plans (Lockdown, Fire and Evacuation and Major Incident) and Business Continuity Plans are held locally to guide staff these form a part of service reviews.	Fully Complaint	**NEW Standard**
Domain 6 - Response					
26	Incident Coordination Centre	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	The Trust has invested in a dedicated Tactical Command Centre at RLI; Strategic Command remains at WGH with Incident Control Room at FGH and WGH being implemented when required.	Fully Compliant	FGH Incident Control Room needs relocating and exercising with CSM Team.
27	Access to Planning Arrangements	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Local Emergency Plans (Lockdown, Fire and Evacuation and Major Incident) and Business Continuity Plans are held locally to guide staff these form a part of service reviews.	Fully Compliant	**New Standard**
28	Management of Business Continuity Incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Outlined in the UHMB Major Incident Plan; Incident Response Plan – Major Critical and Level 1 Business Continuity Initial Operational Response principles. New Business Continuity Template published.	Fully Compliant	Review of Compliance with New Template Required.

29	Decision Logging	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24-hour access to a trained Loggist(s) to ensure support to the decision maker	All responding staff are issues with personal Decision Logs, ICCs hold Incident and Decision Logs – with an Aide Memoir available in the Mobile App. Defensible Decision Making and Logging during an Incident is available from the EPRR Team There is a small cohort of Loggist within the Central Operations Team, this is limited by the availability of HAS Training.	Fully Compliant	**NEW Standard** Identify date for Loggist Train-the-Trainer Training.
30	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	UHMB presently work to the NHSE process and definitions for the daily situation report web form, this is available via external internet site and available to staff in the major incident app. Trust has sufficient resources in place to ensure an effective incident response	Fully Compliant	Major Incident Plan Review Date 08/2021. Sitrep process to be included in the appendix.
31	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	ED have Guidelines available in the departments; also links to external intranet site and available to clinical staff in Major Incident App	Fully Compliant	
32	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)	ED have Guidelines available in the departments; also links to external intranet site and available to clinical staff in Major Incident App	Fully Compliant	
Domain 7 - Warning and Informing					
33	Warning and Informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	Outlined in the UHMB Media Strategy, UHMB EPRR and Business Continuity (Service Resilience) Corporate Policy, UHMB Major Incident Policy, and UHMB Social Media Policy.	Fully Compliant	
34	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.	Outlined in the UHMB Media Strategy, UHMB EPRR and Business Continuity (Service Resilience) Corporate Policy, UHMB Major Incident Policy, and UHMB Social Media Policy.	Fully Compliant	**NEW Standard**

35	Communication with Partners and Stakeholders	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	Outlined in the UHMB Media Strategy, UHMB EPRR and Business Continuity (Service Resilience) Corporate Policy, UHMB Major Incident Policy, and UHMB Social Media Policy.	Fully Compliant	
36	Media Strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	Outlined in the UHMB Media Strategy, UHMB EPRR and Business Continuity (Service Resilience) Corporate Policy, UHMB Major Incident Policy, and UHMB Social Media Policy.	Fully Compliant	
Domain 8 - Cooperation					
37	LHRP Engagement	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	Accountable Emergency Officer Attends	Fully Compliant	**NEW Standard**
38	LRF / BRF Engagement	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	The Trust is represented at a number of LRF sub-groups for both Lancashire and Cumbria. The Trust is represented at Local ESAG (Event Safety Advisory Group) and local multiagency meetings.	Fully Compliant	**NEW Standard**
39	Mutual Aid Arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Discussed in the UHMB Major Incident Plan. Specialised Memoranda of Understandings exist within specialised and/or multiagency plans some held by the Local Resilience Forum, available via Resilience Direct. Requests for Military Aid to the Civil Authorities (MACA) from the NHS in England is available via external internet and in the Major Incident App. Trust has sufficient resources in place to ensure an effective incident response.	Fully Compliant	Major Incident Plan Review Date 08/2021. More detail surrounding mutual aid to be included.
43	Information Sharing	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	Outlined in UHMB Information Governance Policy and Framework, UHMB EPRR and Business Continuity (Service Resilience) Corporate Policy and UHMB Major Incident Policy.	Fully Compliant	
Domain 9 - Business Continuity					

44	BC Policy Statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	Outlined in the UHMB EPRR and Business Continuity (Service Resilience) Corporate Policy.	Fully Compliant	
45	BCMS Scope and Objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	Outlined in the UHMB EPRR and Business Continuity (Service Resilience) Corporate Policy.	Fully Compliant	
46	Business Impact Analysis/Assessment (BIA)	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	BIA is included within Care Group BCP, although this is not reviewed annually. They are on a 3-year cycle as per plans and policies or significant changes.	Partially Compliant	
47	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Outlined in the UHMB Information Systems Toolkit & Business Continuity Pack	Fully Compliant	
48	Business Continuity Plans	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	BCP Plans Complaint is low; a New BCP template has been produced and is being implemented into the Trust, with priority for review focused on those areas where no period of disruption is tolerated, extensive work has been done to identify single points of failure. Trust has sufficient resources in place to ensure an effective incident response.	Partially Compliant	Review all BCP plans; and implement for all level two, level three and where no tolerable period of disruption or single point of failure has been identified.
49	Testing and Exercising	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	The annual Exercise and Testing week takes place every SEP; this usually includes a Tier 3 business continuity exercise. There is little or no evidence of testing or exercising BCP Tier 2 (care group) or Tier 1 (departmental) level.	Partially Compliant	**NEW Standard**
50	BCMS Monitoring and Evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	Areas providing Level 2 and/or 3 care are to be monitored by the ERRR manager and included in the EPRR Managers update to EPRG.	Partially Compliant	**NEW Standard** EPRR Manager to include BCP update to EPRG.

51	BC Audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	Outlined in the UHMB EPRR and Business Continuity (Service Resilience) Corporate Policy. External Audit and Single Points of Failure have been reported to the Emergency Planning Group.	Fully Compliant	
52	BCMS Continuous Improvement Process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Outlined in the UHMB EPRR and Business Continuity (Service Resilience) Corporate Policy.	Fully Compliant	
53	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	Outlined in the UHMB EPRR and Business Continuity (Service Resilience) Corporate Policy.	Fully Compliant	
Domain 10: CBRN					
55	Telephony advice for CBRN exposure	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.	Information included in Clinical Guidelines and UHMB Hazmat and CRBN Policy.	Fully Compliant	
56	HAZMAT / CBRN Planning Arrangement	There are documented organisation specific HAZMAT/ CBRN response arrangements.	Outlined in the UHMB Major Incident Policy and UHMB HazMat and CBRN Policy.	Fully Compliant	Policy Review Date 2024
57	HAZMAT / CBRN Risk Assessments	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.	Outlined in the UHMB Major Incident Policy and UHMB HazMat and CBRN Policy.	Fully Compliant	Policy Review Date 2024
58	Decontamination Capability Availability 24 /7	The organisation has adequate and appropriate decontamination capability to manage self-presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week.	UHMB do not have sufficiently trained staff; a training plan lead by the EPRR Team has commenced and longer-term training plan needs to be formulated by the Medicine Care Group.	Partially Complaint	Continue Training Programme

59	Equipment and Supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Acute - see Equipment checklist: https://www.england.nhs.uk/ourwork/eprr/hm/ Community - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	This equipment checklist is being used by both Emergency Departments and the Urgent Treatment Centre. The IOR principles are available to all UHMB staff via eLearning in the Trusts Training Management System.	Fully Compliant	
60	**PRPS Availability**	The organisation has the expected number of PRPS (sealed and in date) available for immediate deployment. There is a plan and finance in place to revalidate (extend) or replace suits that are reaching their expiration date.	24 PRPS suits are held by each ED. A system is in place to monitor and maintain the suits.	Fully Compliant	**New Standard**
61	Equipment Checks	There are routine checks carried out on the decontamination equipment including: • PRPS Suits • Decontamination structures • Disrobe and Re-robe structures • Shower tray pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks	Routine checks on Equipment Carried out by relevant departments. PRPS suits audited and NHSE to supply replacement suits. Specialist Equipment has been serviced by Regional Centre. Equipment replacement needs identified. The Trust has sufficient equipment in place to respond to a Hazmat/CBRN Incident.	Fully Compliant	
62	Equipment Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • PRPS Suits • Decontamination structures • Disrobe and Re-robe structures • Shower tray pump • RAM GENE (radiation monitor) • Other equipment	PRPS suits provided by NHSE – service contacts included. RAM-GENE – maintained by Christies NHS Trust Other equipment is monitored, maintained or replaced as required, this is managed by the EPRR Team. The Trust has sufficient equipment in place to respond to a Hazmat/CBRN Incident.	Fully Compliant	
63	PPE Disposal Arrangements	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.	Outlined in the UHMB Waste Management Policy and UHMB HazMat and CBRN Policy	Fully Compliant	
64	HAZMAT / CBRN Training Lead	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training.	A dedicated Practice Educator for Urgent & Emergency Care, hold appropriate qualifications and training.	Fully Compliant	

65	Training Programme	Internal training is based upon current good practice and uses material that has been supplied as appropriate. Training programmes should include training for PPE and decontamination.	A limited training programme has been put in place to rapidly address issues regarding PRPS training is presently underway. No formal/ongoing training programme in place. IOR is now delivered via eLearning.	Partially Compliant	**New Standard** Formalise a Training Programme and align to Occupational Standards.
66	HAZMAT / CBRN Trained Trainers	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.	The trust has five Train-the Trainers with updated training in 2022. This is a small faculty other staff have received the but may need some support to return to training. Joint training across the ICB is also being considered.	Fully Compliant	
68	Staff Training - Decontamination	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	IOR Principle are aimed at all reception and triage staff at both Emergency Departments and the Urgent Treatment– an eLearning Package has been developed.	Fully Compliant	
69	FFP3 Access	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7.	Outlined in UHMB Infection Prevention Precautions Policy, UHMB Outbreak Management Policy and Influenza Management Policy.	Fully Compliant	

No.	Standard	Detail	Evidence	Self-Assessment	Action Plan
Deep Dive: Domain – Evacuation and Shelter					
DD1	Up to date plans.	The organisation has updated its evacuation and shelter arrangements since October 2021, to reflect the latest guidance. https://www.england.nhs.uk/publication/shelter-and-evacuation-guidance-for-the-nhs-in-england/	UHMB Mass Evacuation of Inpatient Facilities ratified NOV 21 aligned to new standards.	Fully Compliant	
DD2	Activation	The organisation has defined evacuation activation arrangements, including the decision to evacuate and/or shelter by a nominated individual with the authority of the organisation's chief executive officer.	Outlined in UHMB Mass Evacuation of Inpatient Facilities	Fully Complaint	
DD3	Incremental Planning	The organisation's evacuation and shelter plan clearly defines the incremental stages of an evacuation, including in situ sheltering, horizontal, vertical, full building, full site and off-site evacuation.	Outlined in UHMB Mass Evacuation of Inpatient Facilities	Fully Compliant	
DD4	Patient Triage	The organisation has a process in place to triage patients in the event of an incident requiring evacuation and/or shelter of patients.	Outlined in UHMB Mass Evacuation of Inpatient Facilities with TSG Associated SMARTEvacuation System in place. The system is design for adults therefore there is some need to make local variations to the system such as Women's and Children's Care Group.	Partially Compliant	Variation for use in Women's and Children's Care Group
DD5	Patient Movement	The organisation's arrangements, equipment and training includes the onsite movement of patients required to evacuate and/or shelter.	Outlined in UHMB Mass Evacuation of Inpatient Facilities with TSG Associated SMARTEvacuation System in place. Training programmes have been in place for the use of specialist evacuation equipment.	Fully Compliant	
DD6	Patient Transport	The organisation's arrangements, equipment and training includes offsite transportation of patients required to be transferred to another hospital or site.	Outlined in UHMB Mass Evacuation of Inpatient Facilities with TSG Associated SMARTEvacuation System in place.	Fully Compliant	
DD7	Patient Dispersal and Tracking	The organisation has an interoperable patient tracking process in place to safely account for all patients as part of patient dispersal arrangements.	Outlined in UHMB Mass Evacuation of Inpatient Facilities with TSG Associated SMARTEvacuation System in place.	Fully Compliant	
DD8	Patient Receiving	The organisation has arrangements in place to safely receive patients and staff from the evacuation of another organisations inpatient facility. This could with little advanced notice.	The TSG Associates SMARTEvacuation System is in place across all inpatient facilities within the ICB/Reginal footprint.	Fully Compliant	
DD9	Community Evacuation	The organisation has effective arrangements in place to support partners in a community evacuation, where the population of a large area may need to be displaced.	Outlined in UHMB Mass Evacuation of Inpatient Facilities	Fully Compliant	

DD10	Partnership Working	The organisation's arrangements include effective plans to support partner organisations during incidents requiring their evacuation.	Outlined in UHMB Mass Evacuation of Inpatient Facilities	Fully Compliant	
DD11	Communications – Warning and Informing	The organisation's evacuation and shelter arrangements include resilient mechanisms to communicate with staff, patients, their families and the public, pre, peri and post evacuation.	There is no alternative to warning and informing from the fire alarm system. The Mass Evacuation Group are presently looking at alternatives such as the Peoplesafe Alert; evacuation is presently ordered manually.	Partially Compliant	Continue exploring solutions.
DD12	Equality and Health Inequalities	The organisation has undertaken an Equality and Health Inequalities Impact Assessment of plans to identify the potential impact evacuation and shelter arrangements may have on protected characteristic groups and groups who face health inequalities.	The plan has been subject to an Equality Impact Assessment, and includes information regarding Personal Emergency Evacuation Plans (PEEP) when required.	Fully Compliant	
DD13	Exercising	The evacuation and shelter arrangements have been exercised in the last 3 year. Where this isn't the case this will be included as part of the organisations EPRR exercise programme for the coming year. Please specify.	This has not been exercised in the last 3 years; planned for next testing and exercise cycle.	Fully Compliant	

Emergency Preparedness, Resilience and Response (EPRR) Core Standards Action Plan 2022 -23

Organisation: University Hospitals of Morecambe Bay NHS Trust

Plan owner: Stuart Hosking-Durn

No.	Core Standard reference	Core Standard description	Improvement required to achieve compliance	Action to deliver improvement	Deadline
1	10	Incident Response Plan	Policy Review	Review Major Incident Plan	MAR 23
2	11	Adverse Weather Plan	Policy Review	Integrate Adverse (Acute) and Severe Weather (Community) Plans	MAR 23
3	15	Mass Casualty	Policy Addendum	Include Mass Casualty Principles into Major Incident Plan	MAR 23
4	17	Lockdown	Policy Review	Review Lockdown Policy	MAR 23
5	20	On-call Mechanism	Implement New System/Technology	Operationalise Adjutant Mobile App	MAR 23
6	22	EPRR Training	Training Plan	Formulate a local Training Schedule with frontline staff.	MAR 23
7	24	Responder Training	Training Plan	Training - aligned to NEW Occupational Standards for EPRR	MAR 23
8	26	Incident Coordination Centre	Testing and Exercising	Relocate and Exercise Incident Control Room at FGH Site	MAR 23
9	28	Management of Business Continuity Incidents	Maintain Plans	EPRR Manager to include BCP update to EPRG	MAR 23
10	29	Decision Logging	Training Plan	Identify date for Loggist Train-the-Trainer Training.	MAR 23
11	30	Situation Report	Policy Addendum	Include Sitrep Process in Major Incident Plan	MAR 23
12	39	Mutual Aid	Policy Addendum	Include more detail on Mutual Aid in Major Incident Plan	MAR 23
13	48	Business Continuity Plans	Maintain Plans	Implement Strategy for updating BCP Plans.	MAR 23
14	50	BCMS Monitoring and Evaluation	Maintain Plans	As Core Standard 28.	MAR 23
15	58	Decontamination Capability Availability 24/7	Training Plan	Medicine Care Group to Develop Training Plan	MAR 23
16	65	CBRN – Training Programme	Training Plan	Formalise Training Programme / align to NOS	MAR 23
17	DD4	Shelter & Evacuation – Patient Triage	Policy Addendum	Variation for use in Women's and Children's Care Group	MAR 23
18	DD11	Shelter & Evacuation – Warning and Informing	Implement New System/Technology	Continue exploring solutions.	Ongoing

Lancashire and South Cumbria Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance 2022-2023

STATEMENT OF COMPLIANCE

University Hospitals of Morecambe Bay NHS Trust has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool v1.0

Where areas require further action, Scott McLean, Chief Operating Officer will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Substantial (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.

Signed by the organisation's Accountable Emergency Officer

20/09/2022

Date signed

28/09/2022	28/09/2022	
Date of Board/governing body meeting	Date presented at Public Board	Date published in organisations Annual Report

We are UHMBT

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

NHS
University Hospitals of Morecambe Bay
NHS Foundation Trust

Positive Difference Annual Report 2021-2022

BAY HOSPITALS CHARITY supporting life's journey together

Bay Health & Care Partners delivering | bettercare together

Contents

Foreword

We approved the Positive Difference inclusion strategy in November 2021, setting out how embedding the crucial work we do on diversity and inclusion will enable us to be a great place to be cared for, and a great place to work. We must all take responsibility for diversity and inclusion in our own roles, and take meaningful, intentional action.

We set some ambitious commitments and I am delighted to see how we have already started working towards achieving them throughout this first annual report. I am confident that if we all continue to strive to make a positive difference through our daily actions, that UHMBT will be a truly inclusive employer and health care service provider; creating an environment and culture that celebrates inclusion and diversity, dignity and respect, which values, nurtures, and harnesses difference for the benefit of our patients and their families and carers, our colleagues, and the communities we serve across Morecambe Bay.

We have experienced ongoing pressures on our services over the last 12 months and so I would also like to take this opportunity to thank you all for your ongoing commitment to this important work - particularly those involved in our colleague networks, who have been a vital support for each other as well as driving forward the change we need to make our ambition become our reality.

Aaron Cummins

Chief Executive

Executive Summary

University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBT) strives to be a great place to work and a great place to be cared for.

In this report we will highlight our key achievements and activities over the last 12 months, striving to embed inclusion in everything we do by working towards the commitments we set out in Positive Difference.

You can view annual reports for previous years on our website **https://www.uhmb.nhs.uk/our-trust/inclusion-and-diversity.**

Just and Learning

We will have a just and inclusive organisational culture, where all colleagues will feel able to confidently speak up knowing that they will be treated with fairness and compassion.

Our Cultural Transformation Programme was established in March 2021, with a goal of creating a just and learning culture at Morecambe Bay.

What is Just Culture?

Just culture seeks to understand who is hurt, what their needs are and whose obligation it is to meet those needs. Accountability comes from a deeper understanding of what has occurred and repairing trust and relationships that have been harmed. This approach to justice and accountability is by its nature more inclusive than a retributive culture, where individuals often fear blame.

Our Cultural Transformation Programme was established in March 2021, with a goal of creating a just and learning culture at Morecambe Bay.

Moving Forwards

When embarking on this programme we stopped to really listen and understand how our colleagues feel. **We listened through our 'Moving Forwards' digital discussion which saw 9677 contributions from 1474 individual colleagues, broadly representative of our workforce in terms of ethnicity, disability, and sexual orientation.** This engagement has steered and formed the basis for our cultural improvement work.

Developing skills in restorative practice, and sharing learning

23 colleagues participated in the Northumberland University Restorative Just Culture Programme, establishing an active internal community of practice to support the development of a Just and Learning Culture for all colleagues at Morecambe Bay.

All Northumberland University alumni were given access to a national community of practice, providing continued support, challenge and reflection as alumni began to use the restorative approach in practice, and as they supported the development of other teams.

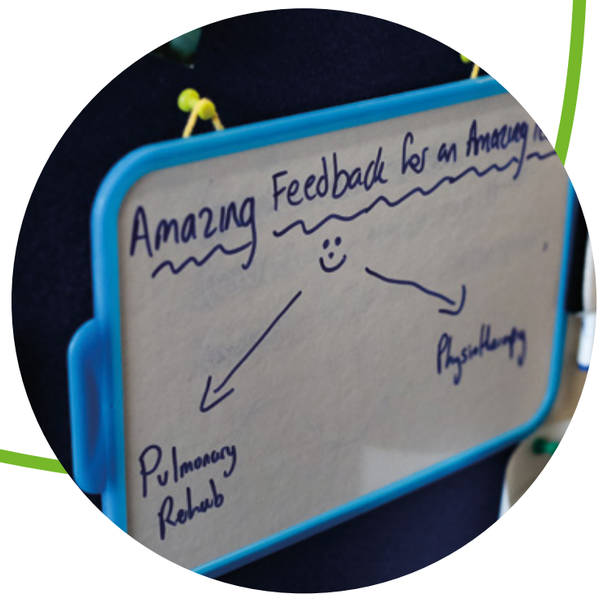
To enable a supportive, fair, and compassionate approach at colleagues' first point of contact in People & OD, Northumberland alumni first delivered restorative just and learning skills development with People Advisors through structured training and coaching.

To introduce colleagues to the principles of restorative practice in a safe and supportive environment, 72 colleagues registered to take part in Restorative Thinking at Work training, which included e-CPD, small-group workshops and one-to-one coaching for all participants. Training commenced in April 2022 in areas including Maternity, with further colleagues due to take part in the pilot running to December 2022.

Civility at Work toolkit

To support the development of better working relationships, and as a result better patient care, we developed a Civility at Work toolkit and a Civility at Work training module. So far, this pilot has helped teams across Theatres and Maternity to practically consider how respect and civility in their teams impacts on patient care and support each other to have a better experience at work.

To support the development of better working relationships, and as a result better patient care, we developed a Civility at Work toolkit and a Civility at Work training module.



Inclusive Leadership and Behaviours

We will be an organisation where all colleagues and leaders exemplify inclusive values and behaviours.

Case Study: Neurodiversity Project
Funded by the WDES Innovation Fund 2021/22.

Awarded **£15,000**
from the
WDES Innovation fund

Supported **21**
neurodiverse colleagues through
12 hours
of group coaching

Neurodiversity training sessions
with **22**
leaders and managers

Celebrated colleagues
via a short film sharing the
personal stories of
6
neurodiverse colleagues

We did...

Group coaching

Coaching for neurodiverse colleagues was focused on providing support and value for individuals - deepening understanding of different diagnoses, understanding how neurodiversity can impact different people, and exploring mechanisms for self-management. This included practical advice and support such as possible adjustments; how to ask for adjustments; and how to talk to colleagues about your neurodiversity.

How did it make a difference?

Colleagues who took part told us that they felt more confident, positive, and engaged in their work, and felt valued and invested in by their employer. The Disability Network now also includes a strong Neurodiversity sub-group – an actively engaged group of neurodiverse colleagues who are confident and willing to provide suggestions and support to other colleagues.

We did...

Training for leaders and managers

A neurodiverse specialist trainer was commissioned to deliver a half-day training session for leaders and managers, with a focus on understanding neurodiversity and how it impacts on colleagues, and what adjustments might be appropriate. It highlighted many of strengths and benefits neurodiversity can offer in an optimal environment, and how to create a positive working environment for all colleagues.

How did it make a difference?

Managers who took part told us that the training challenged them to think about their own leadership styles and the small changes that could help make a positive difference for neurodiverse colleagues.

We did...

A neurodiversity film campaign

Part of the project involved production of a 45-minute film to give colleagues across the organisation an insight and deeper understanding of neurodiversity. The film featured six colleagues with neurotypes including autism and ADHD and explored the benefits of neurodiverse ways of working, and how adjustments can enable neurodiverse colleagues to work to their best ability.

How did it make a difference?

This was a powerful opportunity to amplify the voices and share the experiences of this group of colleagues, to celebrate their contribution to our workplace, and was premiered at a celebratory event attended by over 30 managers and is now available to watch on the intranet. In 2022-23 this film will help to improve understanding of neurodiversity for colleagues across the organisation.

Improving experience for ethnic minority nurses

We undertook focused improvement work with nurse teams across the organisation to address known issues, resulting in a reduction in informal cases arising related to bullying behaviours in nursing and midwifery.

We supported nurses joining us from across the world by providing personal pastoral care through our diverse International Retention team, often with small things making a big difference. This included food baskets on arrival, links with a range of support networks at induction, and personal support with securing housing, driving lessons, and support with job applications and interview technique.

Recognising data and feedback showing a poorer experience for nurses with Filipino heritage, we took action and held two engagement sessions in partnership with the Filipino Nurses Association UK to listen, support and drive our understanding to take proactive action. More than 60 nurses attended the events, with support including an offer of personal career coaching from the Chief Nurse or members of the senior nursing team. Feedback from these sessions will form the basis for action as part of an anti-racist nursing leadership programme to commence in August 2022, delivered by Yvonne Coghill CBE.

We supported nurses joining us from across the world by providing personal pastoral care through our diverse International Retention team, often with small things making a big difference.

Standing Up to Racism

72 colleagues participated in Standing Up to Racism training in 2021-22. Recognising the power of bystanders when they are equipped and empowered to intervene in situations of bullying, harassment and abuse, this training focused on developing the skills needed to recognise and stand up to overt and covert racism at work. 100% of attendees told us that they felt more confident to talk about race and to challenge bullying and harassment as a result of the session.

Learning and Development

The Inclusion and Engagement Team supported 17 corporate induction sessions and five international nurse inductions, welcoming over 400 new colleagues. As part of these sessions, colleagues are encouraged to get involved with our inclusion networks and signposted to useful help and support such as Access to Work.

The Learning and Development Team have facilitated 42 colleague wellbeing sessions with engagement from 224 colleagues in total.

Inclusion, diversity, and respectful behaviours have always and will continue to be a key component of the work of the learning and development team. We firmly believe that all colleagues should be respected and valued for who they are and the role they do. As a team we will continue to strive to make a positive difference for all colleagues at Morecambe Bay.

72

colleagues participated in Standing Up to Racism training in 2021-22.

42

colleague wellbeing sessions with engagement from 224 colleagues in total.

Inclusive & Representative Employment

We will encourage and empower colleagues to fulfill their potential. Our leadership will be representative of our workforce and our recruitment processes will be fair, equitable and consistent.

Diverse interview panels

Recognising acute disparities in leadership for ethnic minority nurses, in 2021 we piloted new criteria for recruitment panels for all nursing, midwifery and senior leadership posts, requiring panels to be ethnically and gender diverse. Of these 143 interview panels, 100% reported compliance. Feedback from interviewees who have been interviewed by a diverse panel has reaffirmed this is absolutely the right approach, with these criteria now being rolled out across all staff groups.

Recognising acute disparities in leadership for ethnic minority nurses, in 2021 we piloted new criteria for recruitment panels for all nursing, midwifery and senior leadership posts, requiring panels to be ethnically and gender diverse.

Health and wellbeing passport

The Health Passport is a tool that colleagues can use can be used to support discussions about reasonable adjustments at work. This year we have worked with the Disability Network to deliver training to colleagues and managers to raise awareness of the Passport and how it can help.

Carer's passport

In 2021 we launched the Carer's Passport, designed specifically for working carers to support the agreement of suitable adjustments at work and enable them to balance their caring responsibilities with their work more effectively.

Work experience

To help ensure we are attracting a wide range of applicants for work experience placements, we made changes to the work experience application form, capturing a wider range of demographic information. As a direct result of these improvements, Health Education England have now included sexual orientation in the metrics required in quarterly reporting.

Networks & Partnerships

We will be a supportive community, keeping each other safe and well, and positioned as an anchor for connections across Morecambe Bay and beyond.

Stonewall & Rainbow Badge

We have gained a better understanding of how we can best support our LGBTQ+ colleagues by participating in both the Stonewall Workplace Equality Index and the pilot phase of the Rainbow Badge assessment during the last year. Our feedback from these programmes alongside the lived experiences of our colleagues has highlighted areas of good practice, such as our inclusive policies, and areas where we can make improvements and we have used this to shape our action plan for the next 12 months.

Veteran Aware

In recognition of our commitment to improving NHS care and support for veterans, reservists, members of the Armed Forces and their families, we have been named a Veteran Aware Trust. Awarded by the Veterans Covenant Healthcare Alliance (VCHA), the Veteran Aware mark highlights NHS trusts which have made a series of pledges, such as ensuring members of the armed forces community are never disadvantaged when receiving care, training colleagues on veteran specific needs, and supporting the armed forces as an employer.

Anti-Racist Cumbria

In 2022 we formally partnered with local charity Anti-Racist Cumbria. This partnership has helped us to evaluate our Anti-Racist Programme without 'marking our own homework' and will offer us support in building our provision for Black colleagues as our work continues to grow and develop. This partnership has also offered rich links with our wider communities, to further develop UHMBT as an anchor institution, creating a positive impact in North Lancashire and South Cumbria.

Union Staff Side (USS)

USS is a collective of Industrial Relations Reps, Health & Safety Reps and Union Learning Reps from six Trade Unions (Chartered Society of Physiotherapy, GMB Union, Royal College of Midwives, Royal College of Nurses, Society of Radiographers, and Unite) that operate within UHMBT. USS work in close partnership with teams across the organisation to help us achieve objectives and by seeking to have the best terms and conditions for all employees, ensuring policies and processes are followed.

Over the past 12 months, USS have worked collaboratively on and actively contributed to several key projects including:

- International Recruitment Retention Programme Board
- Stonewall WEI and Rainbow Badge
- Policy Development
- Cultural Transformation Board
- Recovery Support Programme

USS are not only a support mechanism but a resource to be utilised and represent colleagues of all backgrounds to feel safe and thrive at work.

Patients As Partners

We will provide opportunities for our patients and citizens to share their feedback and co-design with us, and this will be valued and acted upon.

71%

citizens felt we ensured people are informed and supported to be as involved as they wish to be in decisions about their care.

3339

Our Macmillan Cancer Information and Support Service received 3339 interactions with 1254 of these being first contact.

75,859

patients and carers gave feedback on the services we delivered with 91.92% scoring their experience as very good/good.

380

sunflower lanyards distributed.

Digital health passports

A total of **771 Adult Learning Disability**, **114 Child Learning Disability**, and **87 Autism** hospital passports were uploaded to our electronic patient record system.

Our Specialist Nurse for Learning Disabilities and Autism evaluates each passport and uploads it onto the patient's electronic hospital record, creating an alert to direct colleagues to access vital holistic information that is important to the patient. A hospital passport can be completed and kept at home in case of an emergency admission, deterioration in the individual's health or can be completed prior to a planned admission when it may also be used to aid assessment and planning.

Patient stories

6 Patient Stories available to view on our website **https://www.uhmb.nhs.uk/get-involved/patient-experience/patient-stories**

Stories of colleague, patient and carer experiences and journeys enable us to redesign and improve care according to patients' needs, where every step in the patient journey is examined and improved. Stories can provide valuable insights on how we can improve on many distinct aspects of service delivery and care in our hospitals and in our community-based health care programmes. Patient stories can assist colleagues improve patient experience through education and reflection.

Interpretation services

When face-to-face interpretation services were paused during the Covid-19 pandemic, we continued to provide on-demand language interpretation via video and telephone. We secured funding to buy a further video interpretation device. In 2021/22, the languages most requested by patients were Arabic, British Sign Language, Polish, Bulgarian, Romanian, Mandarin and Turkish.

Equality Delivery System 2

A summary of the results of our EDS2 assessment for 2021-2022.

You can view the full report on our website. It outlines the positive progress we are making across our services to ensure equity of patient access, experience, and opportunities for employment.

EDS2 Goals and Outcomes

At the heart of EDS2 are 18 outcomes, grouped under four goals.

Better Health Outcomes	Patient Access & Experience
Workforce Representation & Support	Inclusive Leadership

We assess goals 1 and 2 as part of the wider UHMBT community. We assess goals 3 and 4 with our colleagues from across the organisation. Over 131 colleagues and citizens engaged and contributed to the EDS2 survey for 2021/22.

All outcomes are graded as either, undeveloped, developed, achieving, or excelling. We are not required to assess all 19 outcomes in the same year. Our gradings for other outcomes have been carried over.

Goal		Outcome	Grading 2021/22
Better Health Outcomes for All	1.1	Services are commissioned, procured, designed, and delivered to meet the health needs of local communities.	Excelling
Improved Patient Access and Experience	2.1	People, carers, and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds	Excelling
	2.2	People are informed and supported to be as involved as they wish to be in decisions about their care.	Excelling
	2.3	People report positive experiences of the NHS	Achieving
	2.4	People's complaints about services are handled respectfully and efficiently.	Developing
A representative and supported workforce	3.1	Fair NHS recruitment and selection processes lead to a more representative workforce at all levels	Developing
	3.4	When at work, staff are free from abuse, harassment, bullying and violence from any source	Achieving
Inclusive leadership	4.1	Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations	Achieving

Workforce Disability Equality Standard

WDES metrics have been nationally mandated since 2019. At UHMBT we began voluntarily reporting on these in 2017. Appendix C is the full report outlining the results and trends against each metric in more detail.

As of 31 March 2022, 72.16% of colleagues self-reported whether they have a disability on ESR. 3.56% of colleagues told us that they have a disability. 22.5% of our colleagues who responded to the annual staff survey reported that they have a long-lasting health condition or illness.

72.16%
of colleagues self-reported whether they have a disability on ESR

3.56%
of colleagues told us that they have a disability

22.5%
of our colleagues who responded to the annual staff survey reported that they have a long-lasting health condition or illness.

Improvements and sustained positive outcomes:

Indicator 2 - Disabled candidates are 0.6% less likely to be appointed from shortlisting compared to non-disabled candidates, a deterioration of 1% (within common cause fluctuation) and remaining broadly equal.

Indicator 3 - No Disabled colleagues entered the formal capability process in 2020/21-2021/22, giving a relative likelihood score of zero. However, as declaration is low this may not reflect the true numbers of Disabled colleagues entering formal capability.

Indicator 4a (ii) - 15.4% of Disabled colleagues experienced at least one incident of bullying, harassment, or abuse from their manager in the last 12 months – a 21% reduction and narrowing disparity between the experience of Disabled and non-disabled colleagues.

Indicator 4a (iii) - 24.9% of Disabled colleagues experienced at least one incident of bullying, harassment, or abuse from a colleague in the last 12 months –a 19% reduction and narrowing disparity between the experience of Disabled and non-disabled colleagues.

Indicator 4b – 52.5% of Disabled colleagues and 48.4% of non-disabled colleagues reported that they, or a colleague, reported their last incident of harassment, bullying or abuse. A 5% increase for Disabled colleagues compared with a decrease of 4% for non-disabled colleagues.

Deterioration and sustained unequal outcomes:

Indicators 1 & 10 – 0% of voting Board members have a disability, a percentage difference of -3.56% compared to the overall workforce who are Disabled.

Indicator 4a (i) - 28.1% of Disabled colleagues experienced at least one incident of harassment, bullying or abuse from patients, relatives, or the public in the last 12 months – a 17% increase, reflected in national figures.

Indicator 5 - 50.3% of Disabled colleagues believe that the organisation provides equal opportunities for career progression or promotion, a static picture, and meeting the national average.

Indicator 6 – 26.3% of Disabled colleagues and 20.2% of non-disabled colleagues have felt pressure from their line manager to come to work despite not feeling well enough. Though this has worsened for all colleagues, the disparity has reduced by 18%.

Indicator 7 - 34.5% of Disabled colleagues report that they are satisfied with the extent to which the organisation values their work. Though this follows a continued trend of deterioration for all colleagues, it does show a reducing disparity.

Indicator 8 - 74.4% of Disabled colleagues reported that the organisation has made adequate adjustments to enable them to carry out their work – a marginal 5% decrease/deterioration, above the national average and within common cause.

Indicator 9 – Staff engagement scores show consistently reducing engagement from Disabled colleagues from 2018 to 2021, against the trend for non-disabled colleagues which has fluctuated each year between 6.7-7.2 since reporting began in 2018.

Workforce Race Equality Standard

These metrics are mandated nationally to all NHS organisations in England. Appendix D details the full metrics and action plan for 2022/23.

We collected our data on 31st March 2022 when our workforce consisted of 7,278 colleagues. 11.33% were ethnic minority, 70.11% were white, and 18.56% of colleagues preferred not to say.

11.33%
were ethnic minority

70.11%
were white

18.56%
of colleagues preferred not to say.

Improvements and sustained positive outcomes:

Indicator 3 - Ethnic minority colleagues are 1.8x more likely to enter the formal disciplinary process than white colleagues. This is a slight improvement from 2.01x (2020-21). However, when considering a single year, 2021 saw an equal position at 0.87x, indicating significant positive progress.

Indicator 5 - 29% of ethnic minority colleagues and 21% of white colleagues experienced bullying, harassment or abuse from patients, relatives, or the public in the last 12 months - a 4% reduction for ethnic minority colleagues after a notable increase in 2020.

Indicator 6 - 29% of ethnic minority colleagues and 24% of white colleagues have experienced bullying, harassment, or abuse from colleagues in the last 12 months - a 27% reduction from 40% in 2020 and bringing us within 1% of the national average from an outlier position.

Indicator 8 - 18.2% of ethnic minority colleagues and 6.9% of white colleagues have personally experienced discrimination from a colleague or team leader in the last 12 months - a 14% reduction for ethnic minority colleagues in the last year.

Deterioration and sustained unequal outcomes:

Indicators 1 & 9 - Despite a growing ethnic minority workforce with 11.3% of colleagues self-reporting as BAME, we have zero ethnic minority colleagues in VSM roles. This is a further decline from 7.7% in 2021 and 16.7% in 2020. The Board's voting membership is 0% BAME, a difference of -11.3%.

Indicator 2 - White candidates are 1.3x more likely to be appointed from shortlisting than ethnic minority candidates. This is a worsening from a positive position of 0.84x in 2021, though remains better than the national average of 1.61x.

Indicator 4 - White colleagues are 3.39x more likely to access non-mandatory training and CPD than ethnic minority colleagues. This is a significant and worrying deterioration from an equal position at 0.74x in the last year.

Indicator 7 - 48% of ethnic minority colleagues and 58% of white colleagues believe that we act fairly regarding career progression. This indicator has remained static since 2017 with a wide disparity in experience; however, this is consistently above the national average.

Workforce Sexual Orientation Equality Standard

WSOES utilises similar indicators to WRES and WDES but as this is not nationally mandated, they are locally designed and agreed with our LGBT+ colleague network. A full report outlining the results and trends against each metric in more detail can be found in Appendix E.

As of 31 March 2022, 69.73% of colleagues self-reported their sexual orientation on ESR. An increase of 4.17% in the last 12 months. 2.12% of colleagues told us that they are lesbian, gay, bisexual, or another sexual orientation not listed (LGB+).

69.73%
of colleagues self-reported their sexual orientation

4.17%
increase, in the last 12 months

2.12%
of colleagues told us that they are lesbian, gay, bisexual, or another sexual orientation not listed

Improvements and sustained positive outcomes:

Indicator 2 - LGB+ candidates are 19% more likely to be appointed from shortlisting compared to heterosexual candidates, compared to being equally as likely in 2021.

Indicator 8 - In 2021/2022, we now have 5.57% of our Board voting membership that have told us they are LGB+ equating to a difference of +3.45%.

Deterioration and sustained unequal outcomes:

Indicator 1 - 2.25% of our non-clinical and 2.06% of our clinical workforce have told us that they are LGB+ on ESR which has increased year-on-year, but most of these colleagues are not in management or senior leadership roles.

Indicator 4 - LGB+ colleagues are 27% less likely than heterosexual colleagues to access non-mandatory training and CPD, compared to 24% more likely in 2021.

Indicator 5 - 58% of heterosexual colleagues, 52% of gay and lesbian colleagues, 60% of bisexual colleagues believe that we provide equal opportunities for career progression. A disparity in this deterioration is seen particularly for gay and lesbian colleagues (-8.7%) compared to heterosexual colleagues (-1.8%).

Indicator 3 - Across the 2-year reporting period, LGB+ colleagues were 36% more likely to enter the formal disciplinary process, compared to heterosexual colleagues.

Indicator 6 - 10% of heterosexual, 18% of gay and lesbian, 16% of bisexual, and 13% of colleagues of other sexual orientations experienced harassment, bullying, or abuse from their manager/s in the last 12 months.

Indicator 7 - 20% of heterosexual, 34% of gay and lesbian, 25% of bisexual, and 13% of colleagues of other sexual orientations experienced harassment, bullying, or abuse from their manager/s in the last 12 months.

Gender Pay Gap

Gender Pay Reporting is a national requirement for all large organisations. A report including the full breakdown, analysis and action plan is detailed in Appendix B.

	Women's earnings are:
Mean gender pay gap in hourly pay	27.5% lower
Median gender pay gap in hourly pay	6.4% lower
Difference in **mean bonus** payments	29.1% lower
Difference in **median bonus** payments	33.3% lower

Women earn 93p for every £1 earned by men. This is 3p closer to men's earnings than 2021.

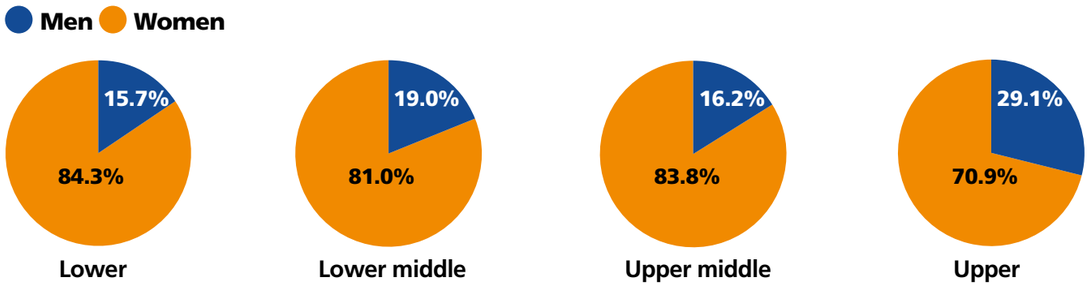
Proportion of men and women receiving a bonus payment

4.4%
Men were paid a bonus

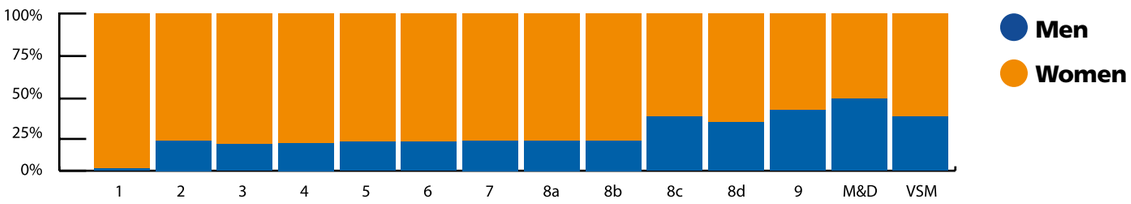
0.3%
Women were paid a bonus

Proportion of men and women in each pay quartile (%)

Women occupy 84.3% of the lowest paid, and 70.9% of the highest paid jobs. This is an almost identical picture to the pay gap recorded in 2021.



Proportion of men and women in each pay band (%)



Ethnicity Pay Gap

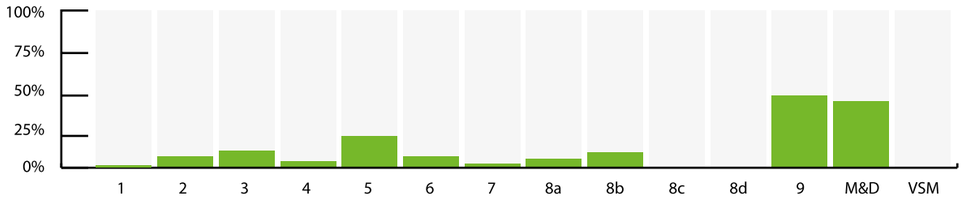
Ethnicity Pay Reporting is not a national requirement; however, we believe it is good practice to record and report against this important measure of equality to enable us to make a positive difference. The full report on this measure is included as part of the WRES 2022 in Appendix D.

	The earnings of Asian staff are:	The earnings of staff with another BAME ethnic background are:	The earnings of staff with another BAME ethnic background are:
Mean ethnicity pay gap in hourly pay	**40.0% higher**	**15.5% higher**	**2.1% lower**
Median ethnicity pay gap in hourly pay	**26.0% higher**	**6.5% higher**	**0.9% higher**

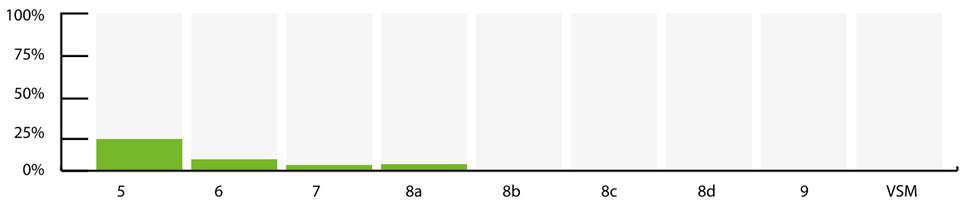
Ethnic minority colleagues at Morecambe Bay are likely to earn a higher wage than white colleagues. This is likely due to the demography of the Trust, with 48% of Medical staff identifying as Black, Asian or Ethnic Minority, compared with only 9% of non-Medical staff.

However, this aggregation of data hides a deeper pay gap, with ethnic minority colleagues from some staff groups, particularly nursing and midwifery, much less likely to work in senior leadership roles.

Proportion of ethnic minority staff in all clinical pay bands (%)



Proportion of ethnic minority registered nurses in each pay band (%)



Making a Positive Difference

Annual reporting is an essential part of making a Positive Difference for the communities we serve, both in using data to build the case for change and drive intelligent improvements, and in working openly and transparently with those communities; but on its own a report is not enough.

We recognise that these words must follow through in meaningful action that our communities can really feel, and it will take action from all of us, whatever our role at Morecambe Bay, to make this happen.

In Appendix A you can see our plan of action for the next 12 months which outlines the key actions that we will take as an organisation to make a Positive Difference.

What can you do to make a positive difference that will help to create a fair, inclusive and compassionate place to work, and to be cared for?

Appendices

Appendix A
Positive Difference Action Plan

Appendix B
Gender Pay Gap

Appendix C
Workforce Disability Equality Standard

Appendix D
Workforce Race Equality Standard

Appendix E
Workforce Sexual Orientation Equality Standard

Appendix F
Service Monitoring Report

Appendix G
Workforce Monitoring Report

We are UHMBT

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

University Hospitals of Morecambe Bay NHS Foundation Trust
Westmorland General Hospital
Burton Road, Kendal, LA9 7RG

Telephone: **01539 716 698**
Email: **TrustHQ@mbht.nhs.uk**
Twitter: **twitter.com/UHMBT**
Facebook: **Facebook.com/UHMBT**
Website: **www.uhmb.nhs.uk/**

Please do not hesitate to contact us should you require this document in an alternative format.

The information in this report is correct to the best of our knowledge as of September 2022.

BAY HOSPITALS CHARITY supporting life's journey together

If you would like to receive this information in an alternative format, please contact Trust HQ.

Stonewall DIVERSITY CHAMPION

disability confident EMPLOYER

EMPLOYER RECOGNITION SCHEME
SILVER AWARD
Proudly supporting those who serve.
ARMED FORCES COVENANT

We are UHMBT

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

NHS
University Hospitals of Morecambe Bay
NHS Foundation Trust

Positive Difference Action Plan

Annual Report July 2022

Overview

1. Just and Learning Culture
Our Cultural Transformation Programme will support the development of an organisational culture that colleagues feel is just, fair, compassionate, and inclusive.

2. Inclusive Leadership and Behaviours
We will expect all colleagues to embody the Behavioural Standards Framework in their daily interactions, and colleagues will feel encouraged, empowered, and safe to challenge behaviours that fall below our expectations. We will support leaders, managers and supervisors across the organisation to become active allies, develop their skills and understanding of inclusion, and role model inclusive and compassionate leadership. We will take focused targeted action to tackle bullying and discrimination where we recognise acute disparities in experience.

3. Inclusive and Representative Employment
We will continue to take action to reduce disparities in career progression for marginalised groups and improve representation at all levels, including our Executive Director appointments.

4. Networks and Partnerships
We will continue to develop, support and empower our inclusion networks. We will work smarter with our partner organisations across our Integrated Care Communities, Bay Health and Care Partners and Lancashire and South Cumbria Health and Care Partnership so that we can share best practice, learn from others, and optimise the use of resources.

5. Patients as Partners
We will involve our patients, service users, families, and carers as partners to continuously improve patient experience. We will develop and enhance our approach to patient engagement to ensure that services are more inclusive and individualised.

1. Just and Learning Culture

We will have a just and inclusive organisational culture, where all colleagues will feel able to confidently speak up knowing that they will be treated with fairness and compassion.

What will we do?
Our Cultural Transformation Programme will support the development of an organisational culture that colleagues feel is just, fair, compassionate, and inclusive.

How will it make a difference?
The fair treatment of staff supports a culture of fairness, openness and learning in the NHS by making staff feel confident to speak up when things go wrong, rather than fearing blame. Supporting staff to be open about mistakes allows valuable lessons to be learnt so the same errors can be prevented from being repeated. A culture where our people feel safe to speak up will allow us to continue to improve the experience of colleagues and ensure that we are providing the highest possible standards of care to our patients.

How will we achieve this?

a) **Implementation of just and learning culture across pilot areas** including Maternity and Theatres to improve the utilisation of clinical incident reports (CIRs) as a non-threatening learning tool.

b) **Development, strengthening and monitoring of support services**, such as Occupational Health, Respect Champions and Freedom to Speak Up (FTSU), increasing diversity of the support available and using data to actively improve service provision.

c) **Development of Employee Relations (ER) practice to embed a restorative approach**, improving fairness for all minoritised* colleagues, including monthly case reviews; policy review (MHPS and Disciplinary); and development of the ER decision tree towards Merseycare's four step approach.

**NB. 'Minoritised' - to make a person or group subordinate in status to a more dominant group or its members. E.g. Though women constitute a majority of staff, they are routinely minoritised, passed over for promotion, and poorly represented in upper management.*

How will we measure success after 1 year?

Improvements against bullying and harassment
- Statistically significant increase in the number of colleagues who tell us that they report incidents of bullying or harassment.
- The proportion of minoritised colleagues experiencing bullying, harassment or abuse from other colleagues will improve to a position matching or better than the national average.
- Statistically significant reduction in the proportion of colleagues overall reporting bullying, harassment and abuse from other colleagues.

Improved offer and access to wellbeing support
- Statistically significant increase over a two-year period to the proportion of minoritised colleagues accessing our wellbeing support services.
- Concerns raised by colleagues via speak up routes (FTSU, Respect etc) will reflect the demographics of the organisation.
- Support services will record and regularly report on emerging themes to enable appropriate action in a timely manner, targeted where it is most needed.

Greater fairness in incidents and formal processes
- All colleagues will be equally as likely to be progressed through formal disciplinary processes irrespective of their race. There will be a statistically significant improvement across measures for sexual orientation and disability.
- Statistically significant increase in informal and early resolution for all colleagues, but particularly those from minoritised groups; alongside a reduction in formal disciplinary processes.
- Statistically significant improvement to the likelihood of minoritised colleagues being accused of error/ behaviours/ culpable through CIRs.

2. Inclusive Leadership and Behaviours

We will be an organisation where all colleagues and leaders exemplify inclusive values and behaviours.

What will we do?

We will expect all colleagues to embody the Behavioural Standards Framework in their daily interactions, and colleagues will feel encouraged, empowered, and safe to challenge behaviours that fall below our expectations. We will support leaders, managers and supervisors across the organisation to become active allies, develop their skills and understanding of inclusion, and role model inclusive and compassionate leadership. We will take focused targeted action to tackle bullying and discrimination where we recognise acute disparities in experience.

How will it make a difference?

We will only provide the best possible care to our patients if every one of us gets our behaviours right, every day, in every contact. We have a joint responsibility to ensure that every colleague has a great day at work, every day - the evidence highlights that if this is the case, then our productivity and the quality of the services we provide will rise as a result.

How will we achieve this?

a) **Embedding inclusion at the core of the leadership programme, supported by specialist content and training opportunities** to help leaders support minoritised colleagues, including anti-racism, Deaf awareness, neurodiversity, menopause, Access to Work, and the health passport.

b) **Trust-wide anti-bullying communications campaign** through an inclusive lens, supported by a training offer of Standing Up, Civility and Respect, LGBTQ+ Awareness and Trans and Non-Binary Inclusion available to all colleagues.

c) **Delivering a six-month anti-racist nursing leadership programme** led by nursing/equalities expert Yvonne Coghill CBE, to provide focused support for ethnic minority nurses.

d) **Reshaping of the Behavioural Standards Framework** as a core element of the Cultural Transformation Programme, aligning work on civility, bullying and harassment with wider just culture and restorative principles.

e) **Providing focused support as required to programmes in the Recovery Support Programme**, where inclusive cultural improvement is identified as a requirement to meet exit criteria.

How will we measure success after 1 year?

Improvements against bullying, harassment and discrimination

- The proportion of minoritised colleagues experiencing bullying, harassment or abuse from managers, team leaders or other colleagues will improve to a position matching or better than the national average.
- There will be a statistically significant reduction in the proportion of colleagues overall reporting bullying, harassment and abuse from managers, team leaders or other colleagues. For ethnic minority colleagues, there will be a 10% reduction.
- The proportion of minoritised colleagues experiencing discrimination from managers, team leaders or other colleagues will improve to a position matching or better than the national average.
- There will be a statistically significant reduction in the proportion of colleagues overall reporting discrimination from managers, team leaders or other colleagues.
- 10% reduction in attrition of internationally experienced nurses.

Increase in skill and confidence of colleagues and leaders

- 75% of leadership programme attendees will tell us their confidence to support colleagues from diverse backgrounds has increased.
- 20% of colleagues will have attended one or more inclusion specific course or group, with over 75% of attendees feeling more confident to demonstrate related behaviours as a result.

3. Inclusive and Representative Employment

We will encourage and empower colleagues to fulfil their potential. Our leadership will be representative of our workforce and our recruitment processes will be fair, equitable and consistent.

What will we do?
We will continue to take action to reduce disparities in career progression for marginalised groups and improve representation at all levels, including our Executive Director appointments.

How will it make a difference?
If we are to best serve our communities based on individualised needs, then our workforce must also represent our communities.

How will we achieve this?

a) **Meet minimum statutory requirements** in any areas not currently met, including provision of suitable parent feeding facilities at each site.

b) **Improve fairness and experience of recruitment, selection and progression** through a dedicated and resourced programme working towards the six actions for inclusive recruitment set out by NHSEI.

c) **Develop local positive action programmes at UHMBT and ICB-wide** with an initial focus on race, starting with reciprocal mentoring, career coaching conversations and leadership of an ICB talent programme.

d) **Nurture minoritised talent through an inclusive approach to talent management**, including implementation of career conversations as part of annual colleague appraisals, and refreshed approach to Executive succession planning.

e) **Improve our data to support and inform targeted positive action** as well as benchmark progress, through campaigns and resources to help increase demographic declaration, focused particularly on sexual orientation, gender identity, and disability.

How will we measure success after 1 year?

All minimum statutory requirements will be met.

Improvements to experience of minoritised colleagues
- Trend of positive improvement across staff survey metrics related to support and wellbeing at work among women aged 20-40.

Greater fairness in recruitment, selection, progression and pay
- Statistically significant reduction in the gender pay gap for women aged 20-40.
- 50% improvement to the likelihood of minoritised colleagues being appointed from shortlisting. Recognising frequent fluctuation against this measure, this improvement will be sustained over three years.
- 50% reduction of the Race Disparity Ratio at Band 7, and 10% reduction of the overall Race Disparity Ratio.
- 10% reduction of the Gender Disparity Ratio.

Improved demographic data
- Statistically significant increase to the proportion of colleagues declaring sexual orientation, gender identity and disability via ESR.

4. Networks and Partnerships

We will be a supportive community, keeping each other safe, and well and positioned as an anchor for connections across Morecambe Bay and beyond.

What will we do?

We will continue to develop, support and empower our inclusion networks. We will work smarter with our partner organisations across our Integrated Care Communities, Bay Health and Care Partners and Lancashire and South Cumbria Health and Care Partnership so that we can share best practice, learn from others, and optimise the use of resources.

How will it make a difference?

Well supported inclusion networks will act as peer support, promote allyship, and help us to work collaboratively on programmes of work and feed back to the organisation. We recognise that strong partnerships with subject matter experts are vital if we are to meet the needs of our communities and be inclusive by default. Partners will support us to embed and integrate inclusion and diversity into our culture. Involvement in national, regional and system-wide efforts will help to improve inclusion and diversity across the NHS.

How will we achieve this?

a) **Supporting and developing inclusion networks** to build engagement, trust and psychological safety, including provision/ standardisation of dedicated time, training and development for network leads.

b) **Pursuing aspirational standards and campaigns to support diverse minoritised colleagues**, driven and supported by partnership working with inclusion networks and external partners, including Disability Confident Leader, Stonewall WEI and Rainbow Badge, Veteran Aware and Armed Forces Covenant, and the North West BAME Assembly Anti-Racist Framework.

c) **Acting as an anchor institution to work collectively towards addressing health inequalities**, including through the LGBTQ+ Health Stakeholders Group, Lancaster Equity and Justice Committee, and Anti-Racist Cumbria.

d) **Celebrating and supporting our diverse colleagues and citizens** through promotion of awareness and history events, in partnership with inclusion networks, including through a regular newsletter and annual conference.

How will we measure success after 1 year?

Improvements to experience of minoritised colleagues

- Statistically significant improvements against experiential measures in the WDES, WRES and WSOES.

Continued meaningful external recognition as an inclusive employer

- Maintain levels of accreditation currently reached.
- Achieve Disability Confident Leader accreditation.
- Close gaps towards North West BAME Assembly Anti-Racist accreditation with a view to achieving this by 2024/5.

Improvements to colleague engagement

- Statistically significant increase in National Staff Survey engagement score; in particular the proportion of responses from minoritised colleagues.
- Statistically significant increase in speak up concerns raised from minoritised colleagues, through all routes but particularly inclusion networks.

5. Patients as Partners

We will provide opportunities for our patients and citizens to share their feedback and co-design with us, and this will be valued and acted upon.

What will we do?

We will involve our patients, service users, families, and carers as partners to continuously improve patient experience. We will develop and enhance our approach to patient engagement to ensure that services are more inclusive and individualised.

How will it make a difference?

Understanding the needs of our patients, service users, families and carers will help us to provide the best possible patient care and experience. We know that some of the people in our communities who have the poorest experience of care are often also the most seldom heard.

How will we achieve this?

a) **Amplifying the voices of people most likely to have a poorer experience** of care or have difficulty accessing care, by providing meaningful opportunities for our patients, their families, carers and citizens to share feedback and co-design with us.

b) **Working in partnership to deliver great local care** with a focus on care being delivered in the right place, and moving to a focus on population health and wellbeing; developing and **embedding our Equality Impact Assessment approach** to ensure continuous equality of access to health and care services.

c) **Identifying and sharing best practice and areas of improvement** across the organisation, based on patient experience and voice, as detailed in the Patient Experience Strategy.

How will we measure success after 1 year?

Patients report positive experiences when accessing UHMBT services (EDS2).

By Q4, checkpoint five survey processes linked to the Enhanced Support Programme will prove that those ESP services are more inclusive.

By Q3, there will be an increase in quality of completed EIAs. By Q4, there will be an EIA register available on our website.

National Inpatient Survey (Q4) will see an increase in patient and service user satisfaction from 2020 to 2022 and evidence of reasonable adjustments for those patients who require this.

Gender Pay Gap Report

September 2022

University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBT) provides community and hospital services across the Morecambe Bay area, an area covering 1,000 square miles from Millom, across South Cumbria and North Lancashire.

It operates three hospital sites - Furness General Hospital in Barrow, the Royal Lancaster Infirmary and Westmorland General Hospital in Kendal, as well as numerous community healthcare premises across the area including Millom Hospital and GP Practice, Queen Victoria Hospital in Morecambe and Ulverston Community Health Centre.

UHMBT provides integrated hospital and community services, as well as working with partners across nine Integrated Care Communities in the area, grouped around GP Practices.

What is the gender pay gap?

The **gender pay gap...**

...is the difference between the average earnings of men and women, expressed relative to men's earnings.

The **mean pay gap...**

...is the difference between average hourly earnings of men and women.

The **median pay gap...**

...is the difference between the midpoints in the ranges of hourly earnings for men and women.

What about equal pay?

Equal pay deals with the pay differences between men and women who carry out the same or similar jobs. It has been a statutory entitlement since the Equal Pay Act was introduced in 1970.

Paying men and women differently for the same or like work is unlawful, however it is possible to have pay equality at the same time as having a gender pay gap.

The gender pay gap differs from equal pay as it is concerned with the differences in the average pay between men and women over a period of time no matter what their role is.

The national NHS terms and conditions 'Agenda for Change' pay system introduced in October 2004 ensures that pay in the NHS is consistent with the requirements of equal pay law. This covers **92.96%** (7,306) of the workforce at Morecambe Bay.

The remaining **7.04%** (553) of the workforce is covered by the NHS Medical and Dental contract, and the NHS Very Senior Managers contract, which also adhere to the principles of equal pay.

Reporting requirements

As part of the Trust's overarching strategic inclusion updates, workforce monitoring information is published on an annual basis for all of the protected characteristics. This includes gender monitoring information detailing workforce breakdown by application, new starter, pay band, working pattern, division and leavers.

Gender pay reporting requirements are incorporated into the wider annual UHMBT inclusion update publication cycle, published in July each year.

There are a number of specific gender pay reporting requirements (calculations)

a) Average gender pay gap as a mean average

b) Average gender pay gap as a median average

c) Proportion of men and women when divided into four groups ordered from lowest to highest pay

d) Average bonus gender pay gap as a mean average

e) Average bonus gender pay gap as a median average

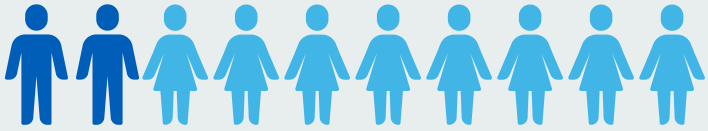
f) Proportion of men receiving a bonus payment and proportion of women receiving a bonus payment

This report compares the pay of men and women at UHMBT, but does not differentiate trans, non-binary and gender diverse colleagues due to limitations in the ESR database.

Though we are unable to provide this local data, **research by Stonewall** shows that trans individuals are subject to high levels of bias, discrimination and abuse in the workplace. It is reasonable to assume that these individuals would also be subject to pay inequality.

The data in this report shows the workforce split in a number of different ways. This illustrates that there are many possibilities for considering the gender pay gap.

Our gender pay gap 2022



We collected our data on 31st March 2022 when our workforce consisted of **1,455 men** (20%) and **5,827 women** (80%) - **7,282 in total**.

In common with the NHS as a whole, our Trust is predominantly female. Given that 80% of staff are women, it is also the case that women outnumber men at every quartile.

However, this is not the case among Medical and Dental colleagues or Very Senior Managers (VSM), with more men than women in each of these groups.

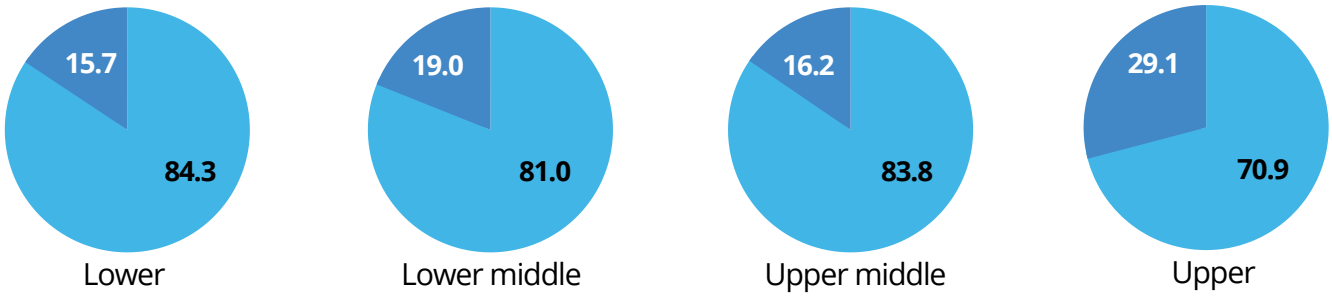
Medical and Dental and VSM staff are higher earners in the NHS so it is important to note the impact this has on the gender pay gap.

	Women's earnings are:
Mean gender pay gap in hourly pay	**27.5% lower**
Median gender pay gap in hourly pay	**6.4% lower**
Difference in **mean bonus** payments	**29.1% lower**
Difference in **median bonus** payments	**33.33% lower**

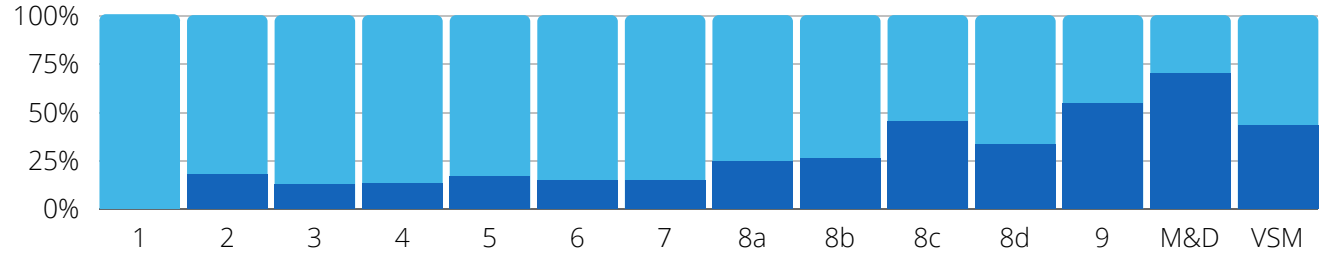
Women earn 93p for every £1 earned by men.
This is 3p closer to men's earnings than 2021.

Proportion of men and women in each pay quartile (%) Men Women

Women occupy 84.3% of the lowest paid jobs, and 70.9% of the highest paid jobs. This is an almost identical picture to the pay gap recorded in 2021.



Proportion of men and women in each pay band (%) Men Women

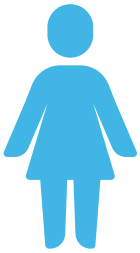


Our gender pay gap 2022

Proportion of eligible men and women who received a bonus (CEA) (as per ESR reporting template provided by the national NHS ESR team)

Men

4.4% were paid a bonus

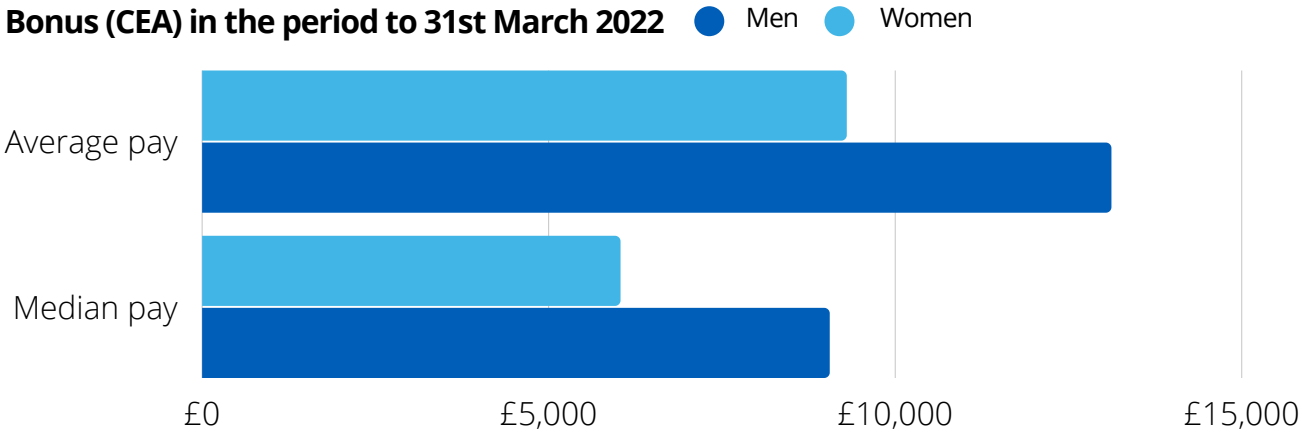


Women

0.3% were paid a bonus

Women are 14.7x less likely to be paid a bonus than men.

Bonus (CEA) in the period to 31st March 2022



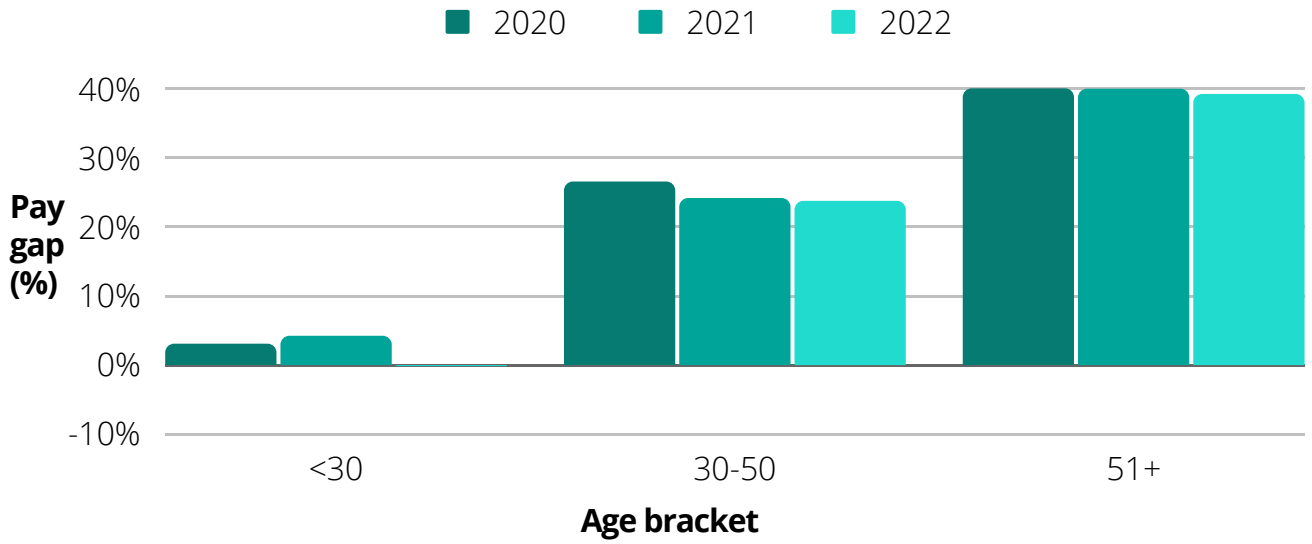
Women earn 67p for every £1 that men earn when comparing median bonus pay.

Bonuses are not typically paid to the majority of staff in the NHS, however there is a Clinical Excellence Awards Scheme (CEAS) which recognises and rewards NHS consultants and academic GPs who perform 'over and above' the standard expected of their role. Awards are given for quality and excellence, acknowledging exceptional personal contributions.

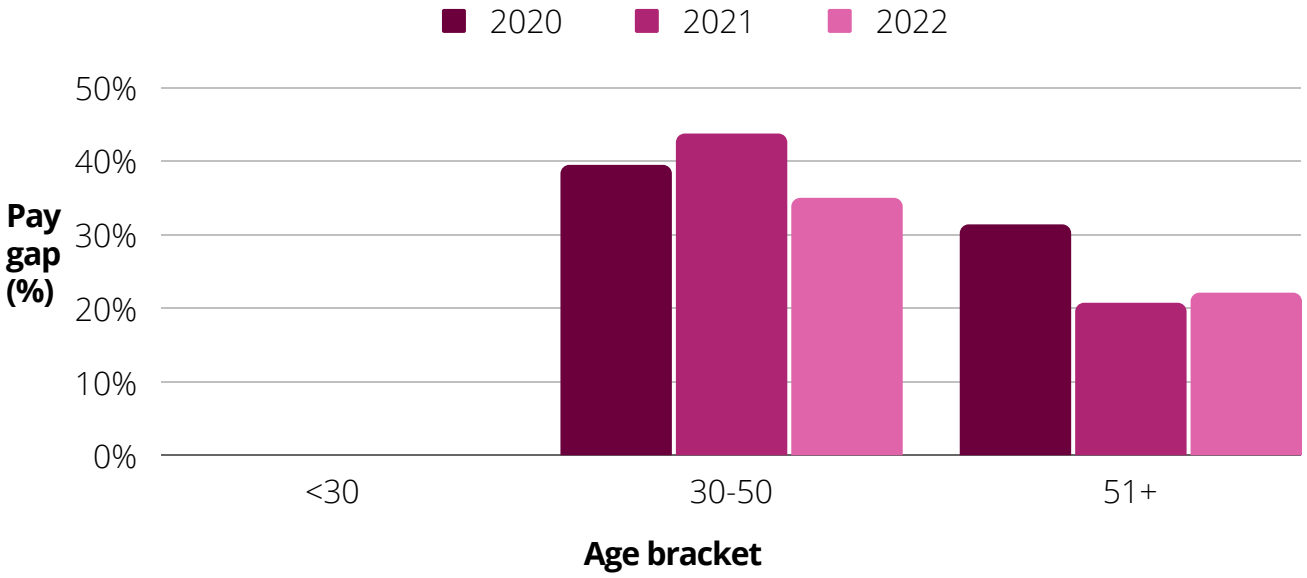
This staff group represents approximately 10% of the NHS workforce, and the charts above illustrate a breakdown by gender of the CEAs which were paid to UHMBT staff as at 31st March 2022. The details are based on the national ESR reporting tool assumption that all staff may be eligible for bonus payments. However, these payments are CEAs and therefore only available to Consultant Medical and Dental staff.

Our gender pay gap 2022 - by age

Gender pay gap by age (average hourly rate)



Gender pay gap by age (average bonus pay)

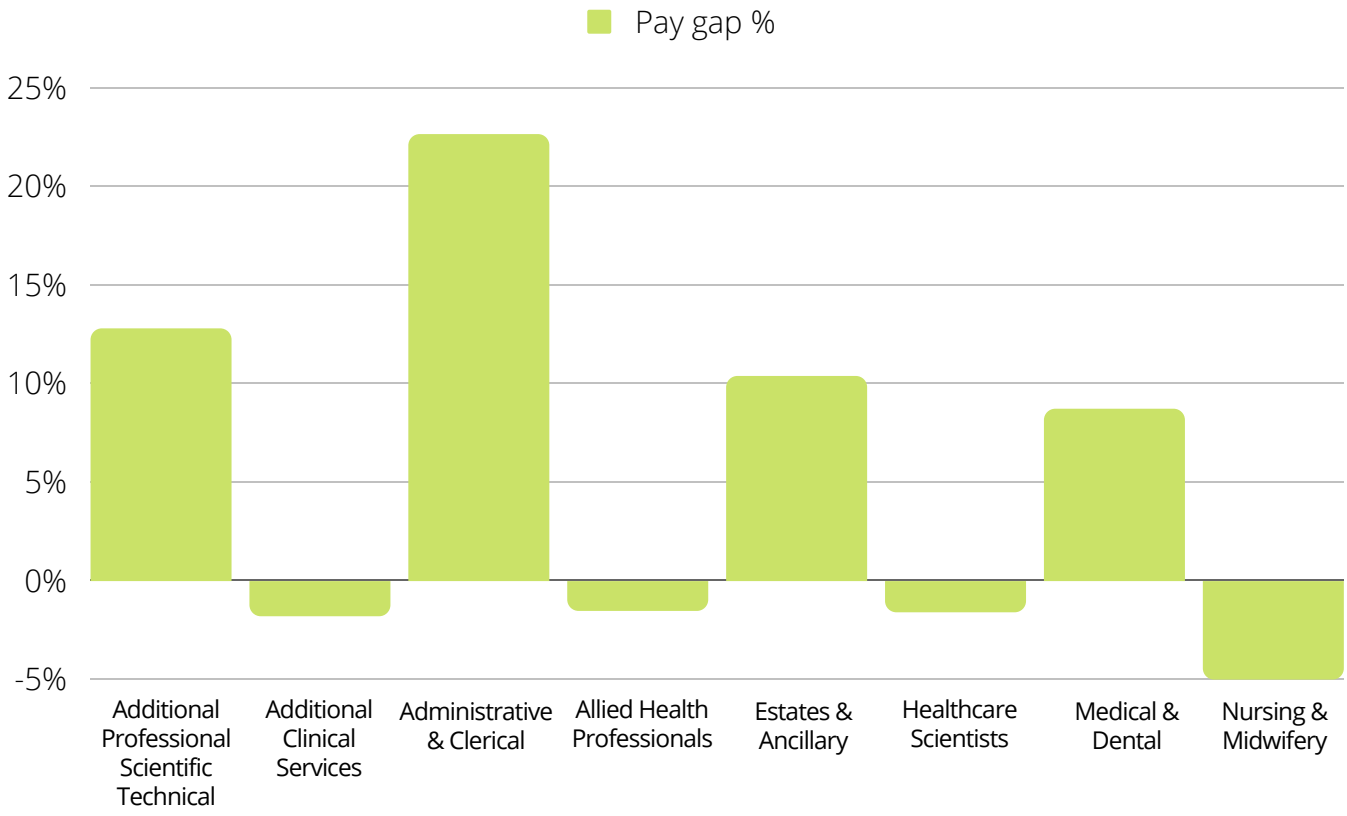


By hourly rate, the gender pay gap is smallest for women aged 30 and under, and increases with age. Women over 50, who are most likely to be in leadership roles, have the highest pay gap. The greatest improvement in-year is evident for women under 30, where the average hourly rate is now equal to men's. Seeing the smallest pay gap here is indicative that progress has been made in new and lower band roles.

Due to the pyramid nature of NHS leadership structures, colleagues are likely to stay in roles for longer and move into new roles less frequently as they get older. As a result progress towards gender pay equality in older age groups is likely to be slower. This year there has been improvement in the bonus pay gap for women aged 30-50, reflected by the more dynamic CEA bonus system.

Our gender pay gap 2022 - by staff group

Gender pay gap by staff group (average hourly rate)



When calculating the pay gap (hourly average rate) by staff group, patterns emerge which are hidden by the aggregated data.

Women in Admin and Clerical roles suffer from the highest pay gap when compared with men in the same staff group, followed by those in Additional Professional Scientific and Technical, Admin and Clerical, Estates and Ancillary, and Medical and Dental roles.

However, it should be noted that a core part of the pay gap issue is the greater likelihood of men occupying particular role types compared to women.

Though women in Nursing and Midwifery roles do not suffer from a pay gap when compared to men in the same roles, these roles are predominantly female and on average paid significantly less than Medical and Dental roles, which are disproportionately male.

Career progression disparity ratio

1 in 4 men and **1 in 4 women** progress from the lower to middle grades (Bands 1-5 to 6-7)

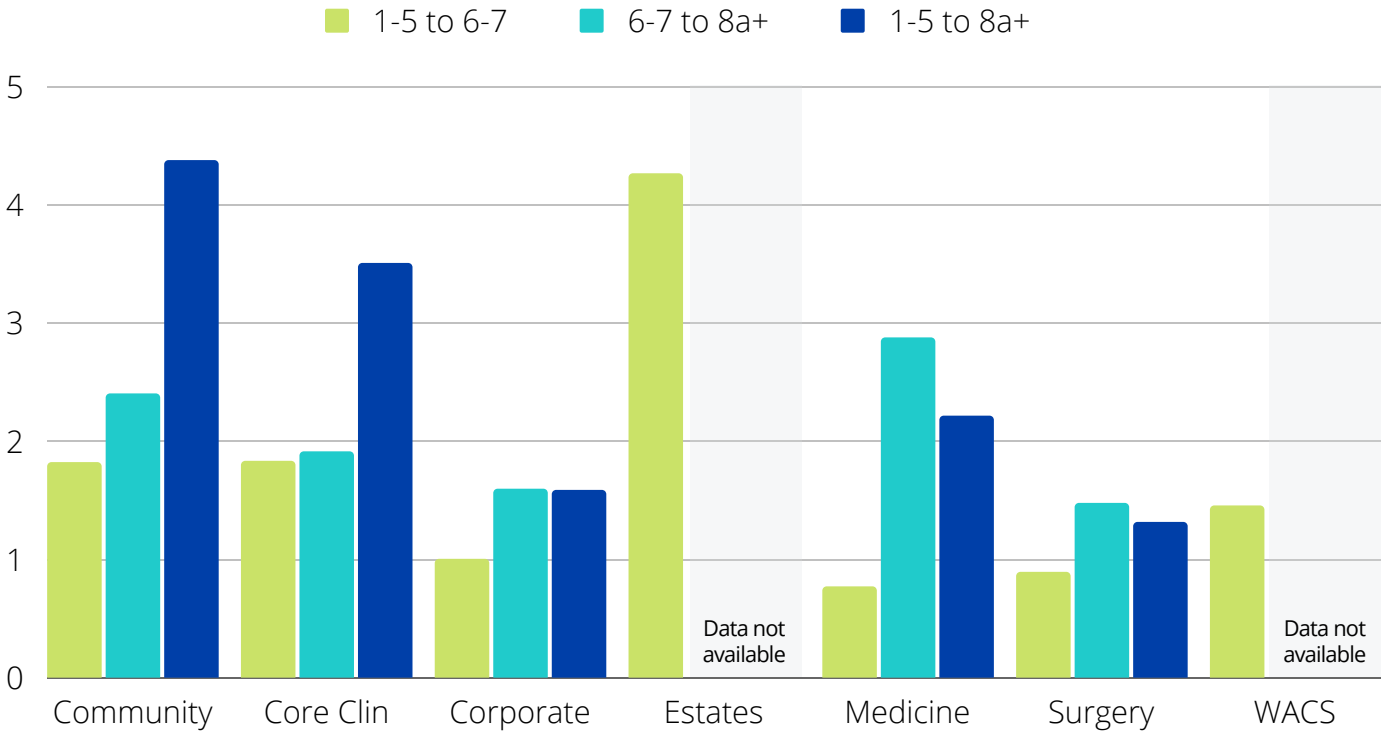
1 in 7 men and **1 in 14 women** progress from the lower to upper grades (Bands 1-5 to 8a+)

Women are 2.28x less likely to progress into leadership than men.

This shows almost no change from 2021.

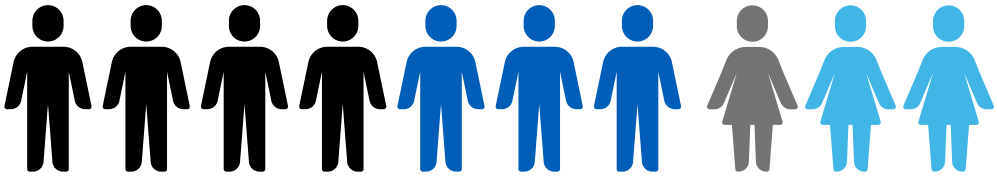
Progression disparity ratio by Care Group (AfC roles only)

Likelihood that women will progress from Bands 1-5 to 6-7; 6-7 to 8a+; and 1-5 to 8a+.



It is most difficult for women to progress into leadership in Estates and Facilities, Community and Core Clinical. In Estates, though there are 380 women in AfC roles - 58.4% of the workforce - none of them are at Band 8a or above.

Medical staff, as of 31st March 2022:



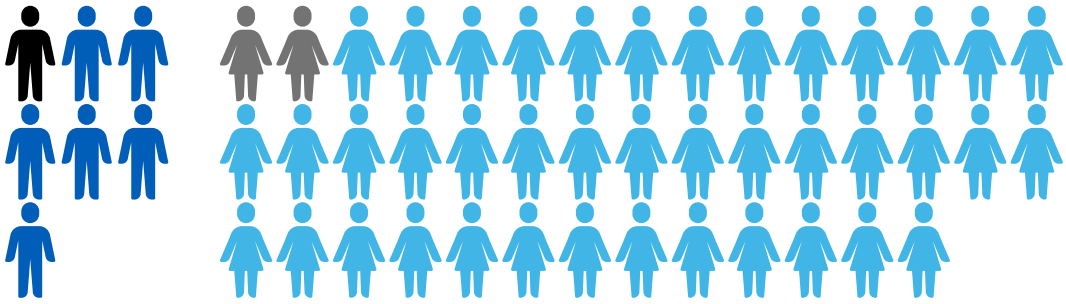
368 men (70%) and **160 women** (30%) in total, including
189 men (36%) and **58 women** (11%) of a Black, Asian or Ethnic Minority background

- **0%** of the medical workforce have disclosed their sexual orientation as LGB, with **29.4%** of colleagues preferring not to disclose their sexual orientation at all.
- Only **1.5%** of the medical workforce have disclosed a disability, with **36.4%** of colleagues preferring not to say whether they have a disability.
- In 2021 50% of medical staff chose not to disclose disability or sexual orientation, showing improvement to declaration rates.

	The earnings of women in medical roles in 2020 were:	The earnings of women in medical roles in 2021 were:
Mean gender pay gap in hourly pay	**9.5% lower**	**8.6% lower**
Median gender pay gap in hourly pay	**5.8% lower**	**3.9% lower**

The gender pay gap for women in medical roles is improving after a widened gap in 2020.

Non-Medical staff, as of 31st March 2022:



786 men (13%) and **5181 women** (87%) in total, including
139 men (2%) and **421 women** (7%) of a Black, Asian or Ethnic Minority background

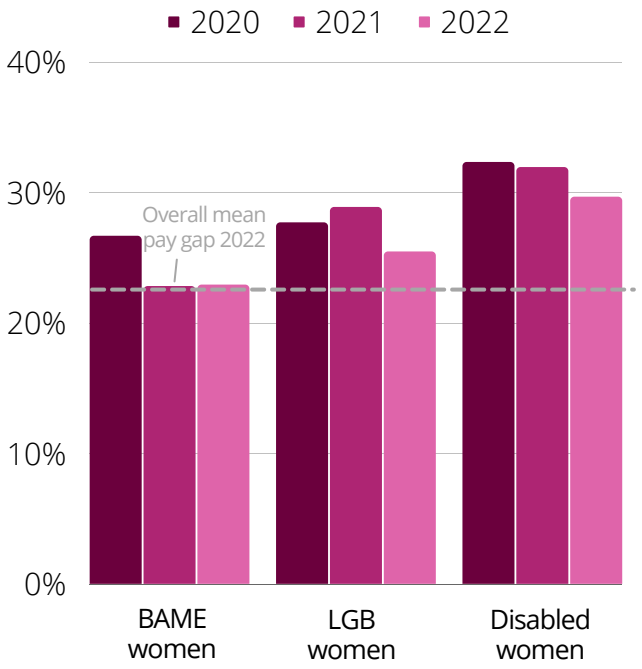
- **1.4%** of the non-medical workforce have disclosed their sexual orientation as LGB, with **25.7%** of colleagues preferring not to disclose their sexual orientation at all.
- **3%** of the non-medical workforce have disclosed a disability, with **23.3%** of colleagues preferring not to say whether they have a disability.
- This shows an improvement to declaration rates, however not as pronounced as among the medical workforce.

	The earnings of women in non-medical roles in 2020 were:	The earnings of women in non-medical roles in 2021 were:
Mean gender pay gap in hourly pay	**1.9% lower**	**2.03% lower**
Median gender pay gap in hourly pay	**2.5% higher**	**5.12% higher**

The gender pay gap for women in non-medical roles has increased only marginally, with significant improvement to median earnings.

An intersectional look

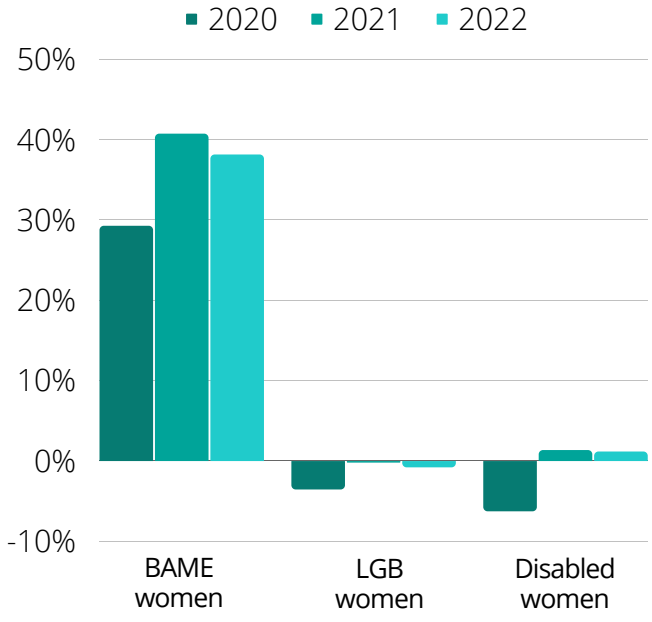
A. Mean pay gap for women in protected characteristic groups, compared with pay for all men (%)



Comparing the earnings of ethnic minority, LGB and disabled women with the earnings of all men shows a picture of progress, with no areas of rollback:

- Improvement for LGB women, whose pay gap has decreased by 3.4%.
- 2.3% improvement for disabled women, who have the highest pay gap, earning 29.6% less than all men.
- No progress or deterioration for ethnic minority women, whose pay gap remains at 22%.

B. Mean pay gap for women in protected characteristic groups, compared with pay for men in the same protected characteristic group (%)

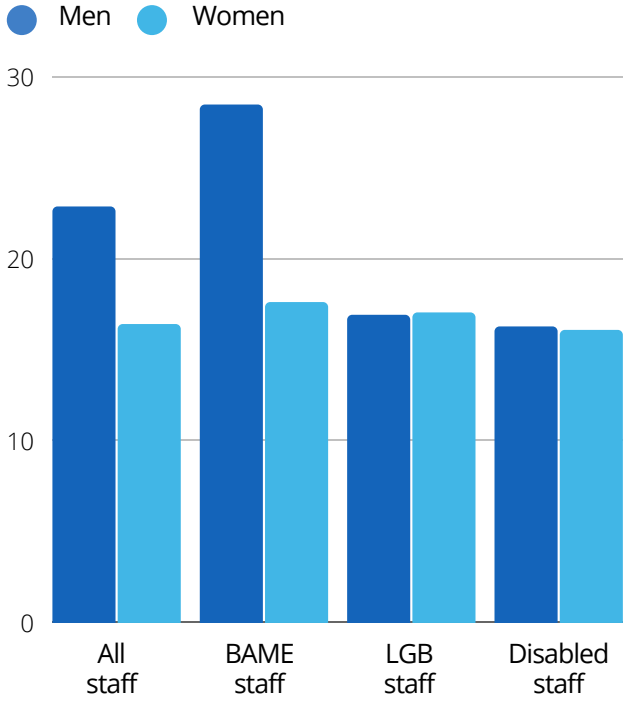


Comparing against the earnings of men from equivalent protected groups shows a slightly different picture:

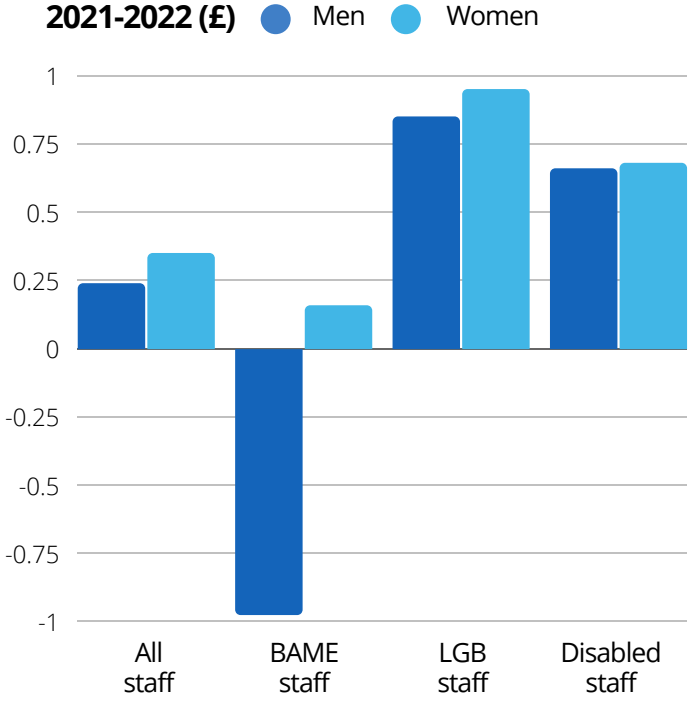
- Progress for all protected characteristic groups, with a decreasing pay gap.
- Improvements for LGB and disabled women, close to an equal position.
- Some improvement for ethnic minority women, with a still significant pay gap of 38.1% but a decrease of 2.5% in year.

An intersectional look

C. Average hourly rate, 2022 (£)



D. Increase in average hourly rate, 2021-2022 (£)



A sustained widening of the gender pay gap between ethnic minority colleagues continuing from 2021 means that in 2022 ethnic minority women were paid on average **38.1%** less than ethnic minority men (**£10.84** less per hour).

This was due to an increase in the average hourly rate for ethnic minority men in 2021, which went up by **£7.26**, compared with the rate for ethnic minority women which rose by **£1.77**.

This upswing for men was a positive result of the anti-racist work to improve ethnic minority representation in leadership. However, this improvement was very unequal, and significantly more likely to impact ethnic minority men than women.

In 2022, though representation has increased in Medical and Dental roles, it is likely that this is at the lower levels to have produced such a drop, which should be investigated further as part of the MWRES.

Though this is unsurprising given the gender makeup of the Medical and Dental staff group where much of the leadership development work has taken place (and many of the highest earners sit), this imbalance shows the importance of an intersectional approach to equality.

An important next step to address this imbalance is continuing with positive action leadership development for women in Medical and Dental roles, as well as similar work in Nursing and Midwifery.

The earnings of LGB and disabled women are roughly equal to those of LGB and disabled men, however in 2022 for both groups women were more likely to receive a greater increase in pay, and received a significantly higher increase than for all staff.

Why do we have a gender pay gap?

We recognise that equal pay has been a statutory entitlement since 1970, when the Equal Pay Act came into force, and are clear that the design of the national NHS terms and conditions 'Agenda for Change' pay system introduced in October 2004 (which covers 92.5% (6687) of the workforce) ensures that pay in the NHS is consistent with the requirements of equal pay law.

The remaining 7.5% (539) of the workforce is covered by the NHS Medical and Dental contract, and the NHS Very Senior Managers contract, which also adhere to the principles of equal pay.

Whilst assured that our national terms and conditions adhere to the principles of equal pay, we acknowledge that our local figures suggest there is a pay gap within the workforce. Partly explained by the fact that there are fewer women in the more highly paid roles than men, and partly because there is a higher proportion of women relative to men in the lower banded roles.

There are many different roles covered by the Agenda for Change pay bands (which apply to the vast majority of NHS staff) requiring different skills experience and knowledge. The robust Job Evaluation Scheme (part of Agenda for Change terms and conditions) is the process by which we ensure roles within each of the pay bands are measured and valued against the principles of equal pay for work of equal value.

Some roles more typically attract one gender over another, and may therefore have impacted on the overall gender pay position within different quartiles.

Taking action

As a part of the Trust's 5-year Positive Difference Strategy, there a number of initiatives underway which will help to understand and redress gender inequality. These include:

- Improving the working lives of new and expectant parents, including development of a handbook to support colleagues and managers (Q3, Inclusion Team, FH).
- Development and improvement of menopause education materials, including a specific menopause course for managers and allies, and intersectional working with trans and nonbinary colleagues to ensure materials feel trans-inclusive (Q3, Inclusion Team, HC).
- Further development and strengthening of the Women Leaders Network, including connecting colleagues for mentorship and coaching (Q3, Inclusion Team, HC).
- Positive action including mentoring for ethnic minority nurses to improve representation above Bands 5/6, which will address an intersectional pay gap at Trust and System level (Q3, People & OD, MF).

We are UHMBT

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

NHS
University Hospitals of Morecambe Bay
NHS Foundation Trust

Workforce Disability Equality Standard Report

September 2022

Contents

Background Information

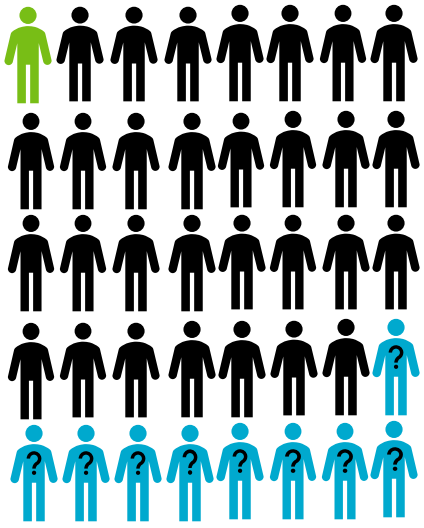
Workforce Disability Equality Standard (WDES) is a set of specific measures enabling us to compare the workplace and career experiences of our Disabled and non-disabled colleagues. We use these measures to develop and publish our action plan, to reflect on progress we have made and identify where improvements are needed.

WDES was implemented nationally in 2019 but at UHMBT we began voluntarily reporting in 2016/17 with a locally developed Disability Equality Standard.

Our Disability Staff Network was established almost seven years ago and continues to have executive sponsorship from the Director of People and OD. As a network, they have been instrumental in helping us to meet this commitment.

Our Colleagues

We collected our data on 31 March 2022 when 7,219 colleagues made up our overall workforce and **72.16%** of them had self-reported whether they have a disability on ESR. An increase of 4.95% since March 2021, meeting the target for improvement set out in the 2021 WDES.



3.56% of our colleagues had self-reported on ESR that they have a disability. As 27.84% of colleagues have not self-reported, the data we have used for these metrics may not truly reflect the experience of all Disabled colleagues.

In the NHS Staff Survey 2021, **22.5%** of colleagues who responded reported that they have a long-lasting health condition or illness. One explanation for this could be the difference in the wording of the question, but many of our colleagues have not yet self-reported for this question on ESR.

Summary of data

Improvements and sustained positive outcomes:

- **Indicator 2** - Disabled candidates are 0.6% less likely to be appointed from shortlisting compared to non-disabled candidates, a deterioration of 1% (within common cause fluctuation) and remaining broadly equal.

- **Indicator 3** - No Disabled colleagues entered the formal capability process in 2020/21-2021/22, giving a relative likelihood score of zero. However, as declaration is low this may not reflect the true numbers of Disabled colleagues entering formal capability.

- **Indicator 4a (ii)** - 15.4% of Disabled colleagues experienced at least one incident of bullying, harassment or abuse from their manager in the last 12 months – a 21% reduction, and narrowing disparity between the experience of Disabled and non-disabled colleagues.

- **Indicator 4a (iii) -** 24.9% of Disabled colleagues experienced at least one incident of bullying, harassment or abuse from a colleague in the last 12 months – a 19% reduction and narrowing disparity between the experience of Disabled and non-disabled colleagues.

- **Indicator 4b –** 52.5% of Disabled colleagues and 48.4% of non-disabled colleagues reported that they, or a colleague, reported their last incident of harassment, bullying or abuse. A 5% increase for Disabled colleagues compared with a decrease of 4% for non-disabled colleagues.

Summary of data

Deterioration and sustained unequal outcomes:

- **Indicators 1 & 10 –** 0% of voting Board members have a disability, a percentage difference of -3.56% compared to the overall workforce who are Disabled.

- **Indicator 4a (i) -** 28.1% of Disabled colleagues experienced at least one incident of harassment, bullying or abuse from patients, relatives or the public in the last 12 months – a 17% increase, reflected in national figures.

- **Indicator 5 -** 50.3% of Disabled colleagues believe that the organisation provides equal opportunities for career progression or promotion, a static picture, and meeting the national average.

- **Indicator 6 –** 26.3% of Disabled colleagues and 20.2% of non-disabled colleagues have felt pressure from their line manager to come to work despite not feeling well enough. Though this has worsened for all colleagues, the disparity has reduced by 18%.

- **Indicator 7 -** 34.5% of Disabled colleagues report that they are satisfied with the extent to which the organisation values their work. This follows a continued trend of deterioration for all colleagues, however shows a reducing disparity.

- **Indicator 8 -** 74.4% of Disabled colleagues reported that the organisation has made adequate adjustments to enable them to carry out their work – a marginal 5% decrease/deterioration, above the national average and within common cause.

- **Indicator 9 –** Staff engagement scores show consistently reducing engagement from Disabled colleagues from 2018 to 2021, against the trend for non-disabled colleagues which has fluctuated each year between 6.7-7.2 since reporting began in 2018.

Indicator 1

Representation, recruitment and progression

% of Disabled colleagues in each of the AfC Bands 1-9, Medical, and VSM compared with colleagues in the overall workforce.

Since we began reporting, the proportion of Disabled colleagues working for UHMBT has increased year-on-year. As the declaration rate has increased, we have seen a marginal increase in the proportion of Disabled colleagues making up our workforce.

2018/2019	2019/2020	2020/2021	2021/2022
2.52% (60.68%)	2.79% (62.58%)	3.18% (67.21%)	3.56% (72.16%)

Overall declaration rate of disability each year is shown in brackets.

Non Clinical	% Disabled 20/21	% Disabled 21/22	Clinical	% Disabled 20/21	% Disabled 21/22
Band 1	0.00%	0.00%	Band 1	0.00%	0.00%
Band 2	3.68%	5.08%	Band 2	4.27%	3.07%
Band 3	2.82%	3.35%	Band 3	2.14%	2.98%
Band 4	3.70%	2.34%	Band 4	0.94%	4.50%
Band 5	3.48%	5.14%	Band 5	4.04%	4.09%
Band 6	1.85%	4.24%	Band 6	3.35%	3.29%
Band 7	3.41%	3.06%	Band 7	3.63%	4.95%
Band 8a	2.41%	3.53%	Band 8a	0.59%	1.07%
Band 8b	0.00%	0.00%	Band 8b	5.26%	7.14%
Band 8c	0.00%	0.00%	Band 8c	20.00%	0.00%
Band 8d	0.00%	0.00%	Band 8d	0.00%	0.00%
Band 9	14.29%	0.00%	Band 9	0.00%	0.00%
Medical	0.00%	0.00%	Medical	1.15%	1.68%
VSM	9.09%	7.14%	VSM	0.00%	0.00%
TOTAL	**3.21%**	**3.85%**	**TOTAL**	**3.17%**	**3.44%**

NO CHANGE	0% IN POST	> 1% INC.	> 1% DEC.

Indicator 2

Representation, recruitment and progression

Relative likelihood of Disabled candidates being appointed from shortlisting compared to that of non-disabled candidates across all posts.

Disabled candidates are **0.94x** (0.6%) less likely to be appointed from shortlisting compared to non-disabled candidates, compared to being 1.06x (0.6%) more likely in 2021. A deterioration of 1%, this is within common cause and remains equal.

Indicator 10

Representation, recruitment and progression

% difference of Disabled colleagues between our Board voting membership compared to our overall workforce.

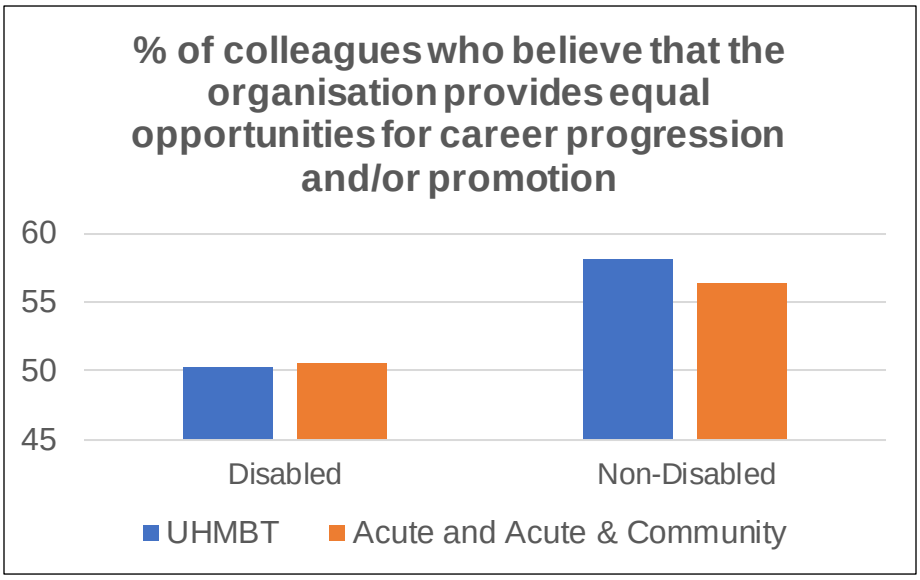
We no longer have any voting Board members who have told us they are Disabled, which equates to a difference of **-3.56**% and a decrease from 7.69% from 2021.

Amongst voting Board members, declaration of disability status is much lower than the overall workforce at 25% (compared to 72.16% overall) and due to the small number of colleagues involved, any changes in appointments will have a significant impact on reported proportions.

Indicator 5

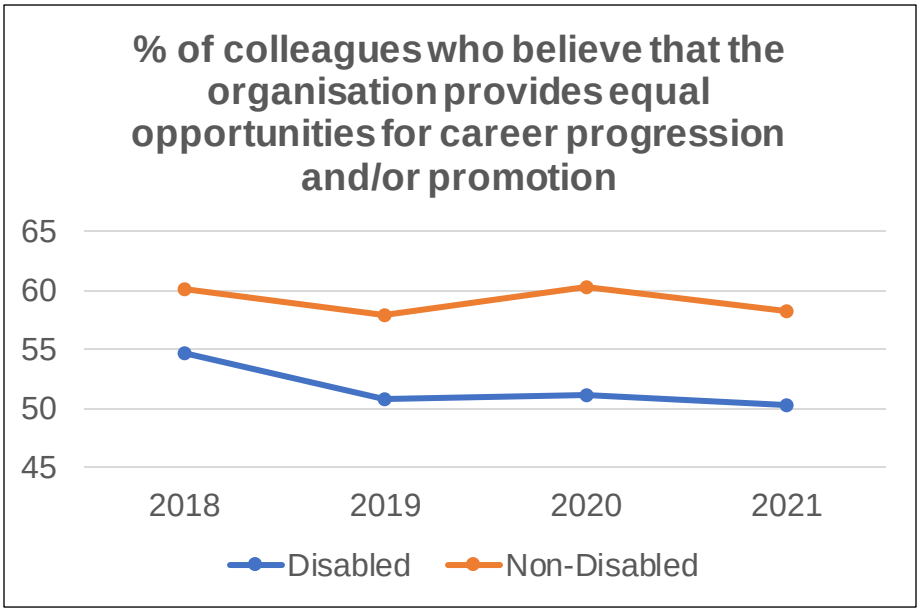
Representation, recruitment and progression

% of Disabled colleagues who believe that the organisation provides equal opportunities for career progression and/or promotion.



50.3% of Disabled colleagues believe that the Trust provides equal opportunities for career progression or promotion, a static picture, and meeting the national average.

However, non-disabled colleagues were still more likely to believe we provide equal opportunities for career progression/ promotion.



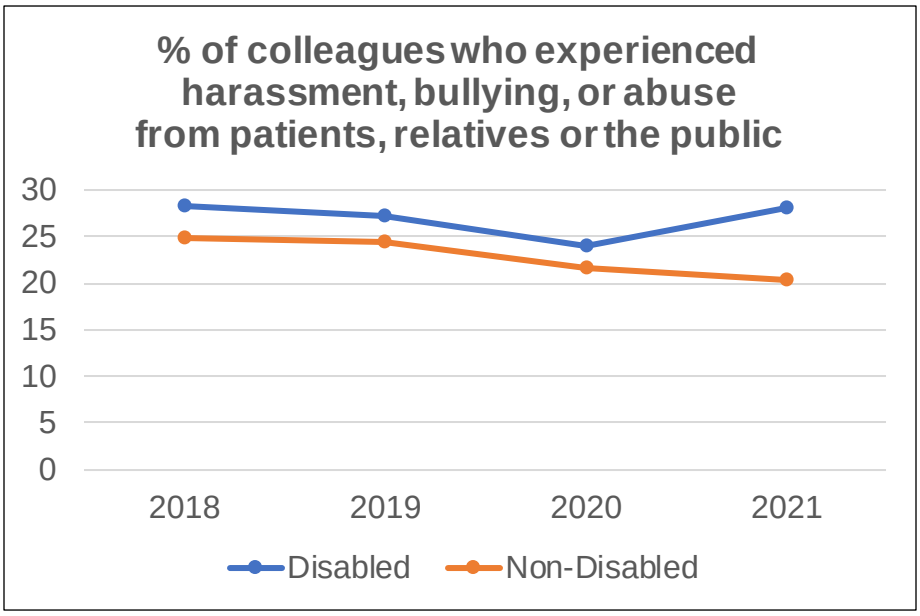
A sustained disparity of almost 10% can be seen between Disabled and non-disabled colleagues, amid slight deterioration for all colleagues.

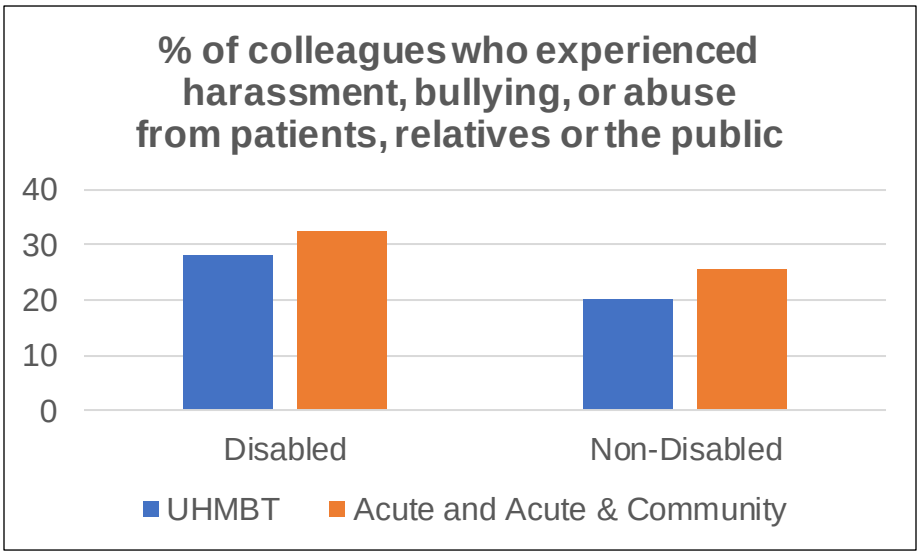
Action planned to address this metric in the WRES 2021 was delayed due to Covid pressures, and must be revisited for 2022/23.

Indicator 4a

Behaviours and discrimination

(i) % of Disabled colleagues who experienced harassment, bullying, or abuse at work from patients, relatives or the public in the last 12 months.





28.1% of Disabled colleagues experienced at least one incident of harassment, bullying or abuse from patients, relatives or the public in the last 12 months; a 17% increase, reflected in national data.

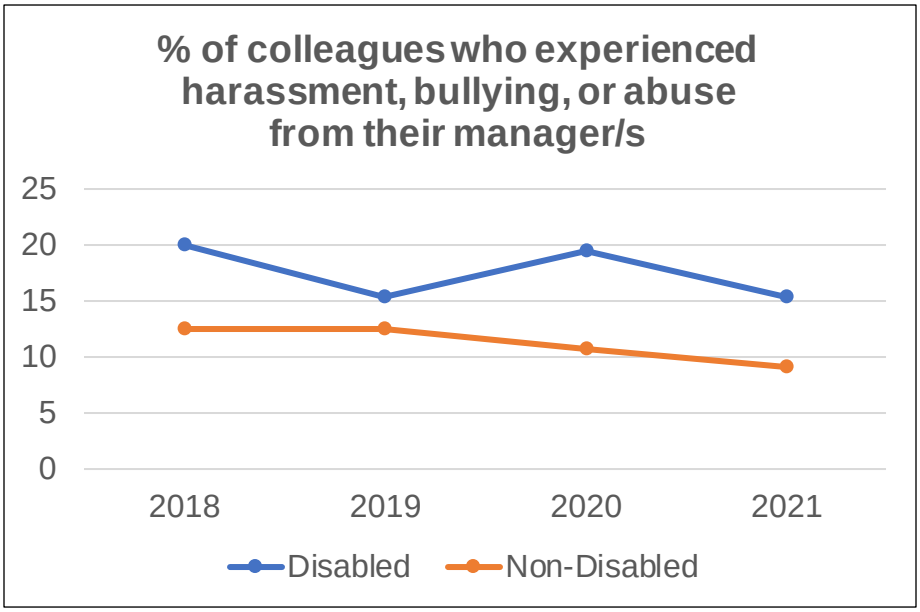
This opposes a picture of marginal improvement for non-disabled colleagues, increasing the disparity by over 200% to the widest point yet recorded.

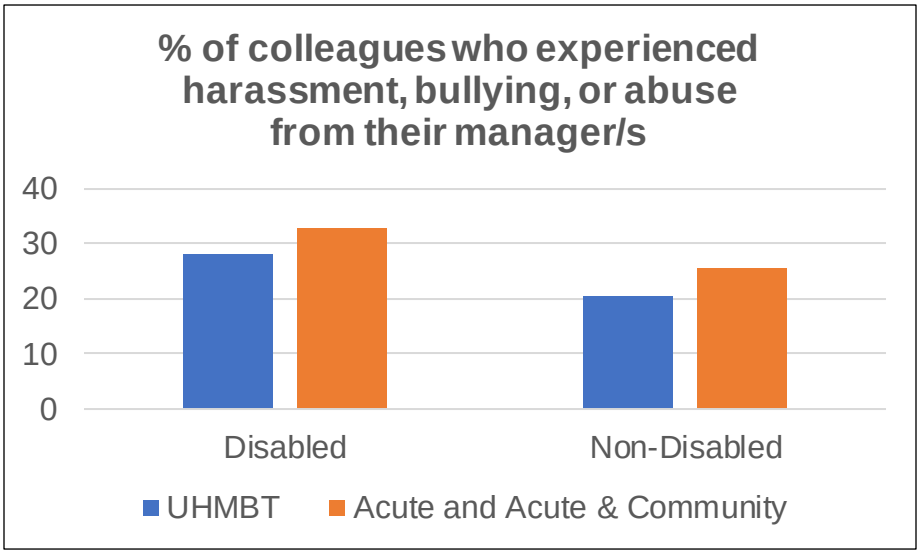
The UHMB experience remains consistently better than the national average for both Disabled and non-disabled colleagues, however the significantly widened disparity shows unusual activity which should be investigated and promptly addressed.

Indicator 4a

Behaviours and discrimination

(ii) % of Disabled colleagues who experienced harassment, bullying, or abuse at work from their manager/s in the last 12 months.





15.4% of Disabled colleagues experienced at least one incident of bullying, harassment or abuse from their manager in the last 12 months – a 21% reduction and narrowing disparity, while showing improvements for all colleagues regardless of disability.

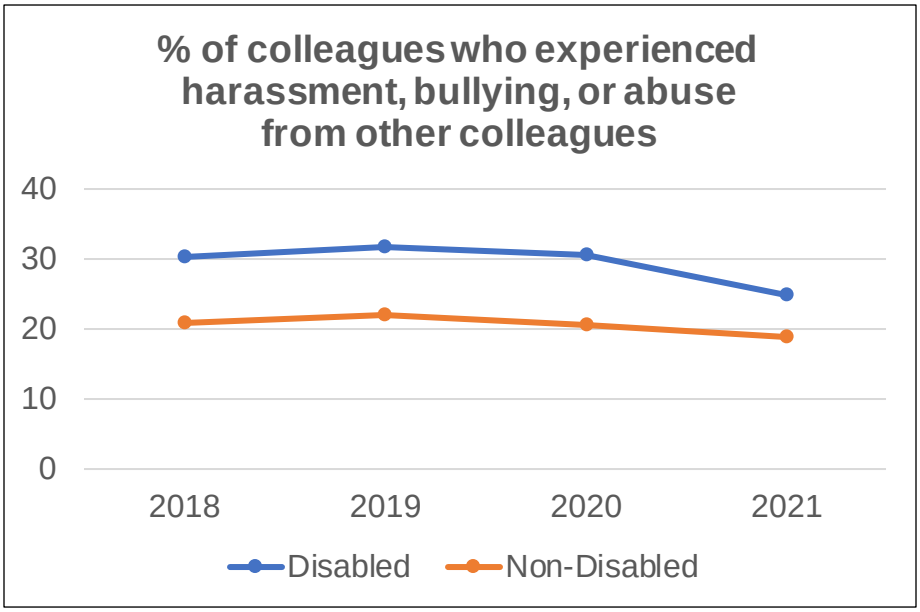
Though this meets the target for improvement set out in the UHMB WDES 2021, the disparity in experience remains significantly wider than figures from 2019, indicating the need for further targeted work to improve experience specifically for Disabled colleagues.

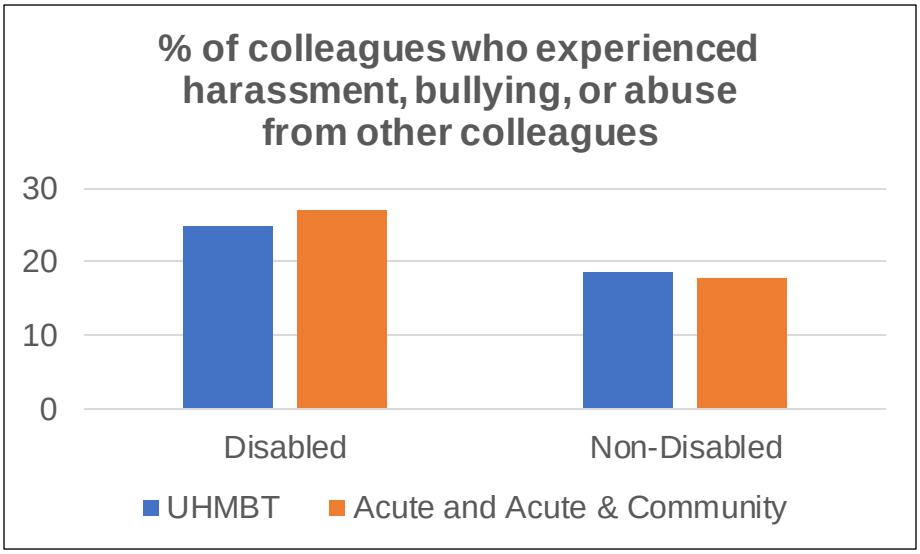
Comparing results at UHMB to the national average for Acute and Community Trusts shows that we are performing better than our peer group for this measure.

Indicator 4a

Behaviours and discrimination

(iii) % of Disabled colleagues who experienced harassment, bullying, or abuse at work from other colleagues in the last 12 months.





24.9% of Disabled colleagues experienced at least one incident of bullying, harassment or abuse from a colleague in the last 12 months –a 19% reduction and narrowing disparity.

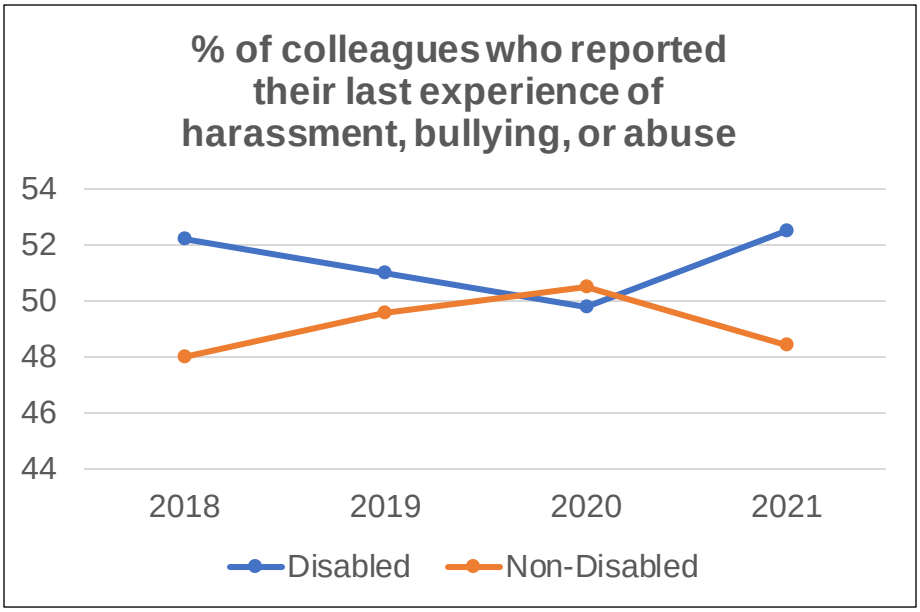
Whilst this year's results indicate an improved experience for all, there is still a disparity between the experience of Disabled and non-disabled colleagues which needs to be addressed.

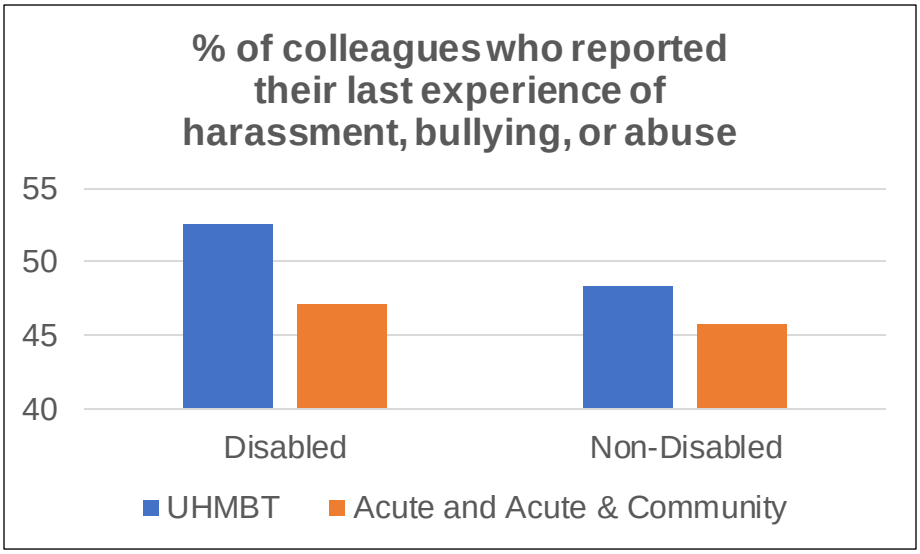
When we compare the experience of our own colleagues to the national average for Acute and Acute & Community trusts, this shows that we are performing better than our peer group for Disabled colleagues but slightly worse for colleagues without a disability.

Indicator 4b

Behaviours and discrimination

% of Disabled colleagues who say that the last time they experienced harassment, bullying, or abuse at work, they or a colleague reported it.





52.5% of Disabled colleagues and 48.4% of non-disabled colleagues reported that they, or a colleague, reported their last incident of harassment, bullying or abuse.

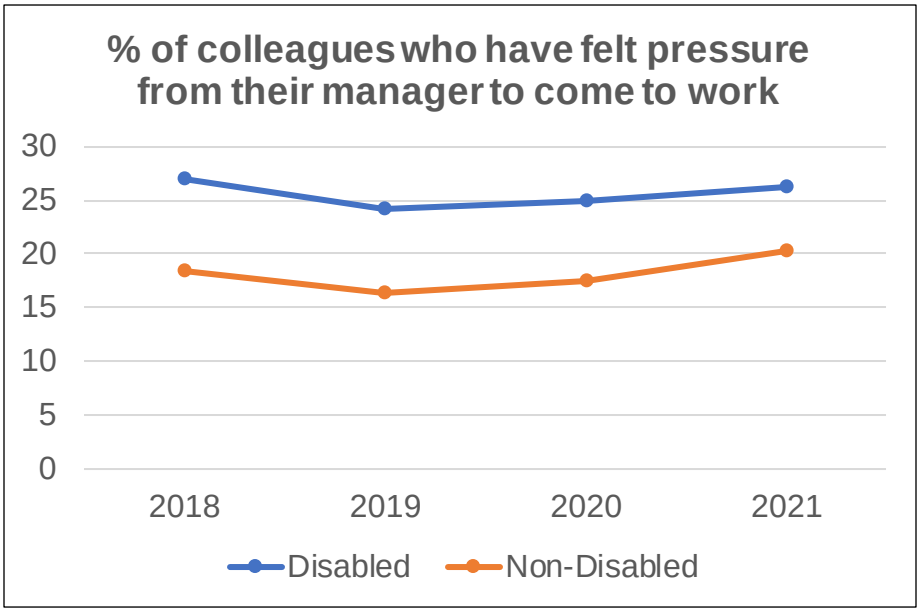
This is a 5% increase for Disabled colleagues compared with a decrease of 4% for non-disabled colleagues.

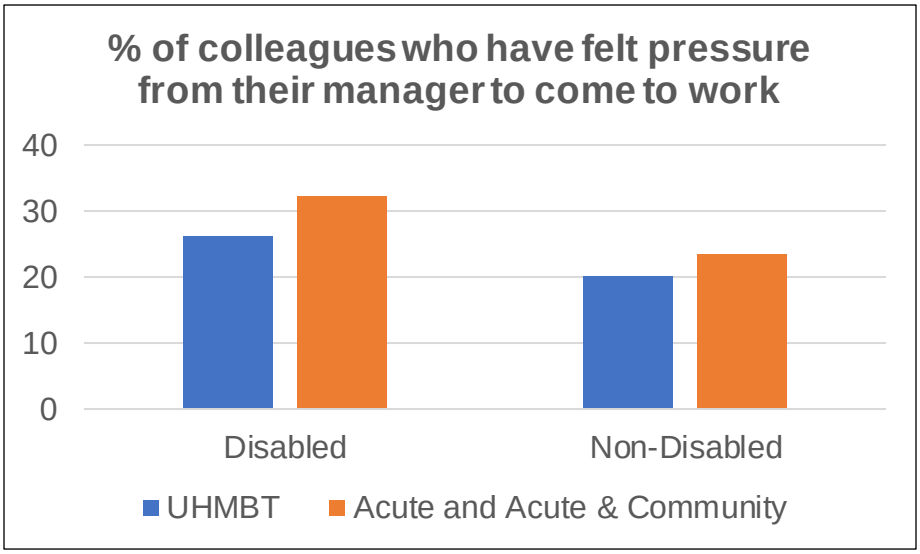
Our results indicate a higher level of reporting compared to other Acute and Acute & Community organisations nationally and mirror the disparity between Disabled and non-disabled colleagues.

Indicator 6

Behaviours and discrimination

% of Disabled colleagues who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.





26.3% of Disabled colleagues and 20.2% of non-disabled colleagues have felt pressure from their line manager to come to work despite not feeling well enough.

An increase can be seen in presenteeism for all colleagues, likely related to Covid-19 pressures.

While the disparity between Disabled and non-disabled colleagues remains wide, it has reduced by 18%.

Presenteeism increased at almost half the rate for Disabled colleagues as non-disabled colleagues, indicating that support mechanisms are effectively mitigating presenteeism for some.

However, with more than 1 in 4 Disabled colleagues feeling pressure to come to work when unwell, further work against this measure is clearly indicated.

Indicator 7

Behaviours and discrimination

% of Disabled colleagues reporting that they are satisfied with the extent to which their organisation values their work.

35% of Disabled colleagues and 41% of non-disabled colleagues report that they are satisfied with the extent to which the organisation values their work.

	2018/2019	2019/2020	2020/2021	2021/2022
Disabled	45%	41%	36%	35%
Non-Disabled	52%	48%	49%	41%

We have seen a sustained deterioration in this metric for all colleagues since 2019 with a clear disparity of experience between Disabled and non-disabled colleagues. However, in 2021/22 the disparity has reduced by 54%.

Indicator 8

Behaviours and discrimination

% of Disabled colleagues reporting that adequate adjustments have been made to enable them to carry out their work.

74% of Disabled colleagues report that adequate adjustments have been made to enable them to carry out their work. A marginal 5% decrease/deterioration, above the national average and within common cause, however not meeting the targets set out for improvement in the WDES 2021.

Overall, the national average for Acute and Acute & Community trusts in 2021 is 71%. It is worth noting that colleagues who indicate that no adjustments are needed are removed from responses for this particular question.

Indicator 9

Behaviours and discrimination

A comparison of the Staff Engagement Score for Disabled colleagues compared to non-disabled colleagues.

		2018	2019	2020	2021
Disabled	UHMBT	6.8	6.7	6.6	6.4
	National	6.6	6.7	6.7	6.4
Non-Disabled	UHMBT	7.2	6.7	7.1	6.8
	National	7.1	7.1	7.1	7.0

Staff engagement scores show consistently reducing engagement from Disabled colleagues from 2018 to 2021, against the trend for non-disabled colleagues which has fluctuated each year between 6.7-7.2 since reporting began in 2018.

Indicator 3

Formal capability process

Relative likelihood of Disabled colleagues entering the formal capability process, compared to non-disabled colleagues, as measured by entry into a formal capability process (across a 2-year reporting period).

Across the 2-year reporting period, no Disabled colleagues entered the formal capability process and so the relative likelihood is zero.

Since we began reporting on this metric in 2019, there has never been a Disabled colleague enter the formal capability process. Whilst this may initially appear to be positive, there is a possibility that a colleague who has chosen not to declare their disability has entered the process and this must be acknowledged.

Actions taken in 2021-22

- Increased the number of colleagues declaring their disability on ESR to over 70%, including through a Disability Network awareness raising campaign and provision of practical guidance on how to declare.

- Reduced the levels of bullying and harassment experienced by Disabled colleagues from their managers and colleagues by 19-21%, including through provision of focused support to teams and individuals; £15k WDES innovation fund investment in neurodiversity training, including to develop managers' understanding and approach; and piloting of the Civility and Standing Up behaviours training packages with Theatres, Maternity and junior doctors.

- Reduced the disparity in presenteeism between Disabled and non-disabled colleagues by 18%, including through development and promotion of the Disability Leave policy, flexible and home working approaches, and adequate adjustments at Care Group Health and Wellbeing Days, and via 1:1 bespoke practical support for managers.

- The planned review of succession planning and talent management approach to reduce inequalities in career progression was stepped down by the Board for 2021/22 in recognition of Covid pressures. This piece of work will be carried forwards to 2022/23.

Disability Confident Leader

In 2022-23 the Trust will work towards achieving the **Disability Confident Leader** accreditation, which will help direct and structure action to create meaningful improvement to the experience of Disabled colleagues.

The Trust will be required to meet the following criteria:

1. Actively looking to attract and recruit Disabled people.
2. Providing a fully inclusive and accessible recruitment process.
3. Offering an interview to disabled people who meet the minimum criteria for the job.
4. Flexible when assessing people so Disabled job applicants have the best opportunity to demonstrate that they can do the job.
5. Proactively offering and making reasonable adjustments as required.
6. Encouraging our suppliers and partner firms to be Disability Confident.
7. Ensuring employees have sufficient disability equality awareness training.

Priority actions for 2022-23

- Building and strengthening support for neurodiversity, including peer support; training for managers; coaching; development of the Neurodiversity Group; and an educational campaign.
- **Responsible:** Inclusion and Engagement Advisor
- **Outcome:** Statistically significant improvements to experiential indicators 4a ii, 6, 7 and 8.

- Embedding inclusion at the core of the leadership programme, supported by specialist content and training opportunities to help leaders support Disabled colleagues, including Deaf Awareness, Neurodiversity, Access to Work, Disability Leave and the Health Passport.
- **Responsible:** Head of Inclusion and Engagement & Head of Learning and Development
- **Outcome:** Statistically significant improvements to experiential indicators 4a ii, 4a iii, 4b, 6, 7 and 8.

- Development, strengthening and monitoring of support services, increasing diversity of the support available and using data to actively improve service provision, starting with Respect Champions and Occupational Health.
- **Responsible:** Head of Inclusion and Engagement
- **Outcome:** Statistically significant improvements to percentage of Disabled colleagues reporting bullying, harassment and abuse (indicator 4b); reduction in presenteeism (indicator 6), and increase in percentage of Disabled colleagues receiving adequate adjustments (indicator 8).

Priority actions for 2022-23

- Trust-wide anti-bullying campaign through an inclusive lens, supported by a training offer including Standing Up and Civility and Respect available to all colleagues.
- **Responsible:** Head of Inclusion and Engagement & Head of Culture Transformation
- **Outcome:** Statistically significant reduction in bullying, harassment and abuse of Disabled colleagues by other colleagues (indicator 4).

- Review succession planning and talent management approach to reduce inequalities in career progression opportunities between Disabled and non-disabled colleagues.
- **Responsible:** Deputy Director of People & OD
- **Outcome:** Statistically significant increase in the percentage of Disabled colleagues feeling that there are equal opportunities for career progression and promotion (indicator 5); improvement to Disability Disparity Ratio.

- Improve fairness and experience of recruitment, selection and progression for Disabled colleagues through a dedicated and resourced programme working towards the six actions for inclusive recruitment set out by NHS England and Improvement.
- **Responsible:** Head of Strategic Recruitment
- **Outcome:** Statistically significant improvements to representation of Disabled colleagues at Bands 6 and above; Disabled candidates continue to be equally likely to be appointed from shortlisting (indicator 2); statistically significant increase in the percentage of Disabled colleagues feeling that there are equal opportunities for career progression and promotion (indicator 5); improvement to Disability Disparity Ratio.

Workforce Race Equality Standard Report

September 2022

Provider Organisation:
University Hospitals of Morecambe Bay NHS Foundation Trust

Date of Report:
September 2022

Board Lead for the Workforce Race Equality Standard:
David Wilkinson, Director of People and Organisational Development

Lead Manager compiling this report:
Hannah Chandisingh, Transformation Lead for Race Equality

This report has been signed off by David Wilkinson on behalf of the Board.

Contents

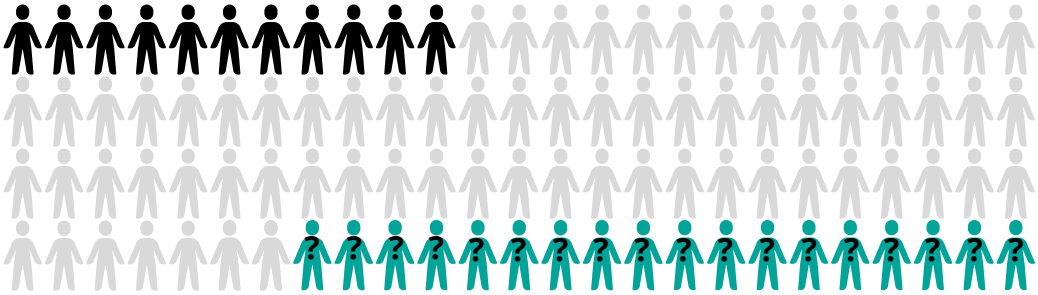
i. Background

Completeness of data:

Work continues on the Trust's training management system, to develop a true understanding of non-mandatory and continuous professional development training (indicator 4).

Reliability of comparisons with previous years:

No issues identified, however in 2021 new breakdowns were been produced to show further data and patterns by ethnic group, which have not been available in previous years. In 2022, the same data has been drawn out to provide comparison.



We collected our data on 31st March 2022 when our workforce consisted of **7,278 colleagues**. **11.33% were ethnic minority, 70.11% were white**, and **18.56% of staff preferred not to say**.

Workforce data:

The period the organisation's data refers to is: Staff in post as at 31st March 2022; Financial Year 2021/22 for all relevant indicators with the exception of Indicator 3 which may require a 2 year reporting period.

i. Background

Becoming Anti-Racist:

A Board-sponsored Anti-Racist Programme was launched in July 2020 following the pandemic which has had a disproportionate impact on ethnic minority people, and the Black Lives Matter protests which created a global social movement, both of which shone a light on the inequalities still present in our communities.

The programme is recognition that incremental change towards race equality is not enough and that transformation change is essential in order to create a great place to be cared for and a great place to work.

This programme includes dedicated resource with the appointment of a Transformation Lead for Race Equality for an additional 12 months from March 2022 to March 2023; a designated Non-Executive Director for Equality, Diversity and Inclusion; and five Task and Finish Groups to create transformational change in priority areas of race equality.

Each group is led by an Executive and Non-Executive Director and a corporate link / subject matter expert. The groups cover bullying and harassment; clinical incident reporting; formal disciplinary processes (conduct and capability); recruitment and selection; and talent management and succession planning, with an initial focus on improvements in nursing and midwifery, and embedding a just and learning culture.

The aim of the Anti-Racist Programme is not only to create equity and fairness in our systems and processes but to embed an anti-racist approach in everything that we do, not only within the EDI function but throughout the organisation.

Cultural Transformation

A UHMBT Cultural Transformation Programme launched in May 2021, taking an integrated approach to create a just, fair, inclusive and positive colleague experience.

A restorative just culture is one which seeks to understand who is hurt, what their needs are and whose obligation it is to meet those needs. Accountability comes from a deeper understanding of what has occurred and repairing trust and relationships.

Fair treatment of colleagues will support a culture of fairness, openness and learning by creating an environment where colleagues feel confident to speak up when things go wrong, rather than fearing blame. Supporting colleagues to be open about mistakes allows valuable lessons to be learnt so the same errors can be prevented from being repeated.

ii. Summary

Improvements and sustained positive outcomes:

- **Indicator 3** - Ethnic minority staff are **1.8x more likely** to enter the formal disciplinary process than white staff. This is a slight improvement from 2.01 (2020-21). However when considering a single year, 2021 saw an equal position at **0.87**, indicating significant positive progress.

- **Indicator 5** - **29%** of ethnic minority staff and **21%** of white staff have experienced bullying, harassment or abuse from patients, relatives or the public in the last 12 months - a **4% reduction** for ethnic minority staff after a notable increase in 2020.

- **Indicator 6** - **29%** of ethnic minority staff and **24%** of white staff have experienced bullying, harassment or abuse from colleagues in the last 12 months - a **27% reduction** from 40% in 2020 and bringing the Trust within 1% of the national average from an outlier position.

- **Indicator 8 - 18.2%** of ethnic minority staff and **6.9%** of white staff have personally experienced discrimination from a colleague or team leader in the last 12 months - a **14% reduction** for ethnic minority staff in the last year.

Deterioration and sustained unequal outcomes:

- **Indicators 1 & 9** - Despite a growing ethnic minority workforce with **11.3%** of colleagues self-reporting as BAME, the Trust has zero ethnic minority colleagues in VSM roles. This is a further decline from 7.7% in 2021 and 16.7% in 2020. The Board's voting membership is **0%** BAME, a difference of **-11.3%.**

- **Indicator 2** - White candidates are **1.3x more likely** to be appointed from shortlisting than ethnic minority candidates. This is a worsening from a positive position of 0.84 in 2021, though remains better than the national average of 1.61.

- **Indicator 4** - White staff are **3.39x** more likely to access non-mandatory training and CPD than ethnic minority staff. This is a significant deterioration from an equal position at 0.74 in the last year.

- **Indicator 7** - **48%** of ethnic minority staff and **58%** of white staff believe that the Trust acts fairly with regard to career progression. This indicator has remained static since 2017 with a wide disparity in experience; however this is consistently above the national average.

iii. Representation, recruitment and progression

Indicator 1 - representation

Percentage of staff in each of the AfC bands 1-9 and VSM (including executive board members) compared with staff in the overall workforce.

The proportion of Black, Asian and Minority Ethnic (BAME) staff has increased year on year since 2017. Total numbers of ethnic minority staff are very small in some clinical groupings and staff grades. To provide local context to the data, the Census reported population for South Lakes, Barrow and Lancaster areas is 4% ethnic minority (as of last census in 2011).

Improvements are being seen clinically, including at bands 8a and above, however this has not been matched in non-clinical representation or VSM appointments. Particularly large increases in numbers of ethnic minority staff at clinical band 5 were due to a successful international nurse recruitment campaign.

Key:

- 0% in post
- >1% drop
- >1% rise

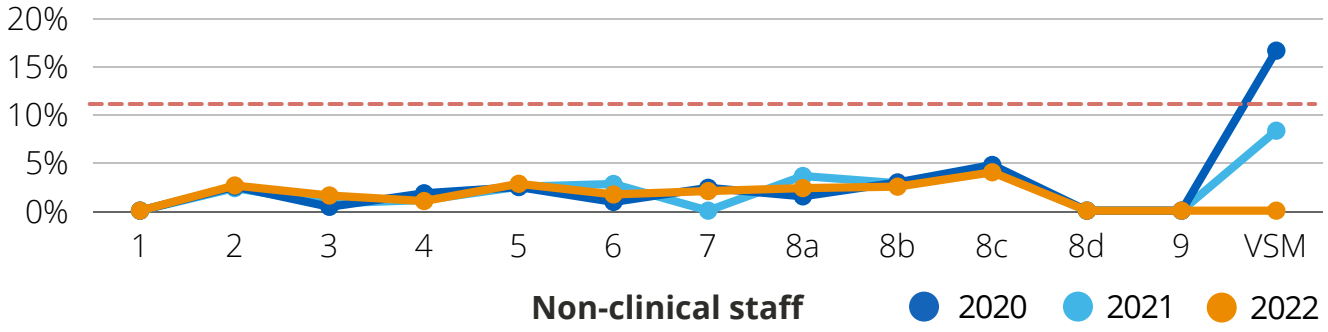
Non Clinical	% BAME 20/21	% BAME 21/22	Clinical	% BAME 20/21	% BAME 21/22
Band 1	0.00%	0.00%	Band 1	0.00%	0.00%
Band 2	2.35%	2.62%	Band 2	3.32%	4.10%
Band 3	0.75%	1.58%	Band 3	12.86%	5.77%
Band 4	1.11%	1.00%	Band 4	2.82%	2.50%
Band 5	2.49%	2.80%	Band 5	16.97%	25.58%
Band 6	2.78%	1.69%	Band 6	4.73%	6.59%
Band 7	0.00%	2.04%	Band 7	2.49%	2.57%
Band 8a	3.61%	2.35%	Band 8a	2.96%	4.28%
Band 8b	2.86%	2.50%	Band 8b	5.26%	7.14%
Band 8c	4.17%	4.00%	Band 8c	0.00%	0.00%
Band 8d	0.00%	0.00%	Band 8d	0.00%	0.00%
Band 9	0.00%	0.00%	Band 9	33.33%	50.00%
Medical	0.00%	0.00%	Medical	39.01%	46.64%
VSM	9.09%	0.00%	VSM	0.00%	0.00%
Total	**1.80%**	**2.02%**	**Total**	**11.99%**	**15.23%**

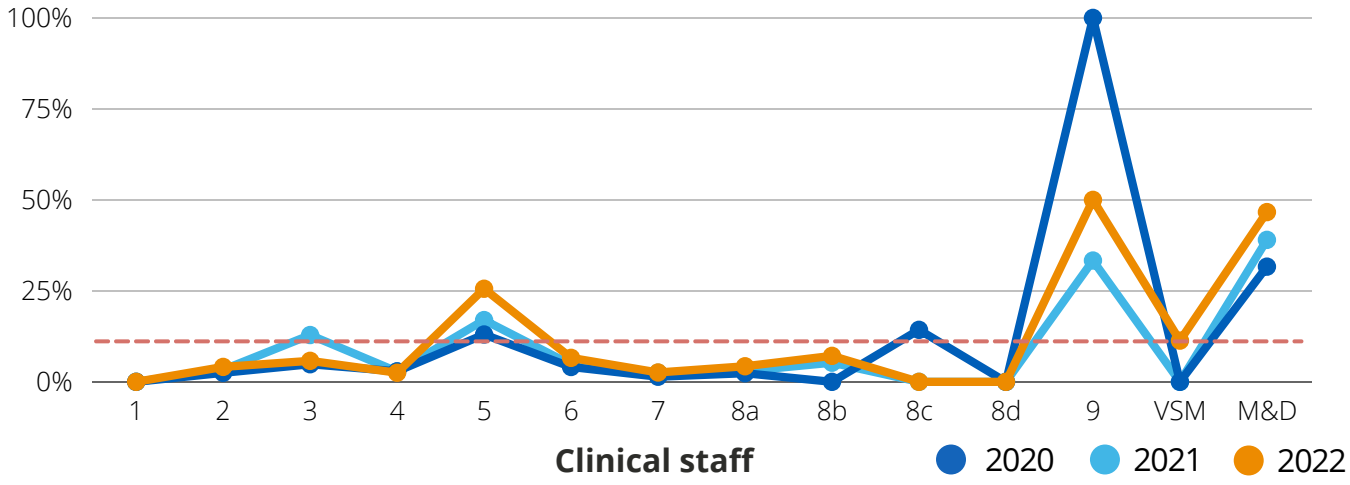
iii. Representation, recruitment and progression

Indicator 1 - representation

Percentage of staff in each of the AfC bands 1-9 and VSM (including executive board members) compared with staff in the overall workforce.

Considering AfC posts, the proportion of colleagues at Bands 6-8D is lower than the Model Employer target of 11.33%, and there are no ethnic minority colleagues at VSM level, not reflecting our diverse workforce.





Indicator 9 - voting Board membership

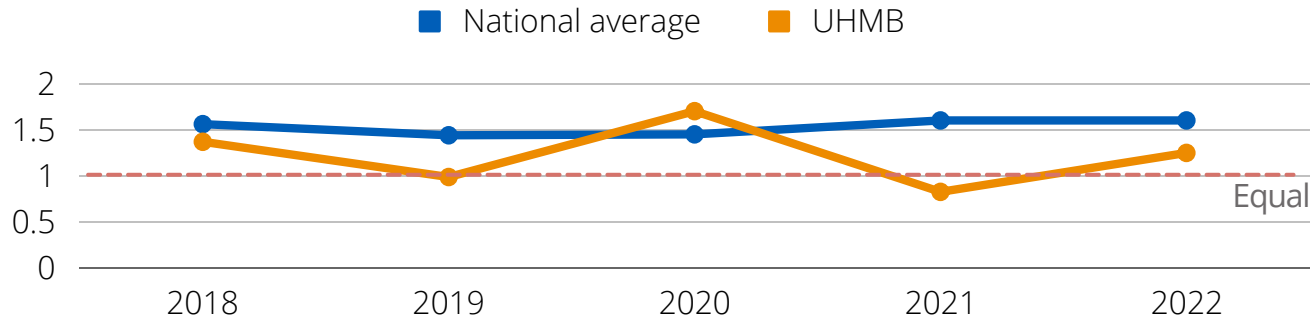
0% of the Board's voting membership has an ethnic minority background, compared with an overall workforce of 11.33% - a difference of -11.33%.

iii. Representation, recruitment and progression

Indicator 2 - likelihood of appointment from shortlisting

White candidates are 1.26x more likely to be appointed from shortlisting than ethnic minority candidates.

This is a deterioration from 2021, when white candidates were **16%** (0.84x) less likely to be appointed, though still remains close to equal and better than the national average. This indicator is an area where Morecambe Bay has frequently made improvements but struggled to maintain or sustain lasting change.



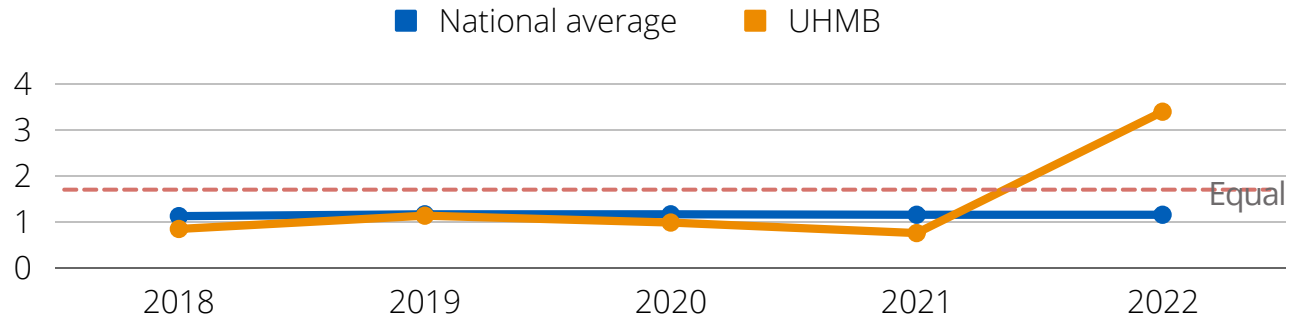
Relative likelihood of appointment from shortlisting

Indicator 4 - access to non-mandatory training and CPD

White staff are 3.39x more likely to access non-mandatory training (NMT) or continuing professional development (CPD) than ethnic minority staff.

This measure has deteriorated dramatically from 2021 to 2022 and requires further investigation. It should be noted that this indicator only measures access via the Training Management System and access to additional courses will not be captured.

One hypothesis may be that with a rise in wellbeing-related CPD and NMT courses, and BAME individuals shown to be less likely to access health and wellbeing support, this is reflected in this data. However this cannot yet be supported without further data.

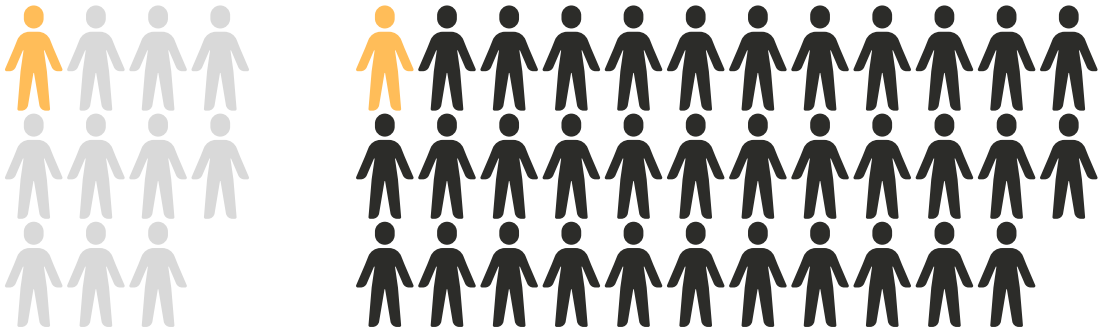


Relative likelihood of accessing CPD or non-mandatory training

iii. Representation, recruitment and progression

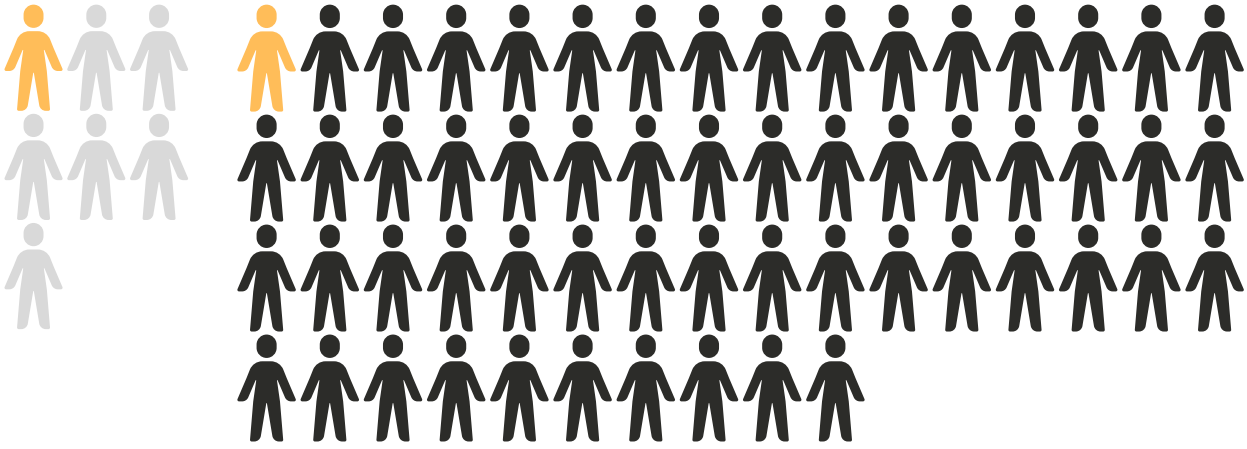
Race Disparity Ratio (RDR)

The race disparity ratio shows the relative likelihood that ethnic minority colleagues will progress through the organisation compared with white colleagues.



1 in 11 white colleagues progress from Bands 1-5 to Bands 8a, compared with **1 in 35** ethnic minority colleagues. White colleagues are **3.36x** more likely to progress.

The disparity is even greater for Nursing and Midwifery colleagues:



1 in 7 White nurses progress from Bands 1-5 to Bands 8a, compared with **1 in 58** ethnic minority nurses. White nurses are **10.39x** more likely to progress.

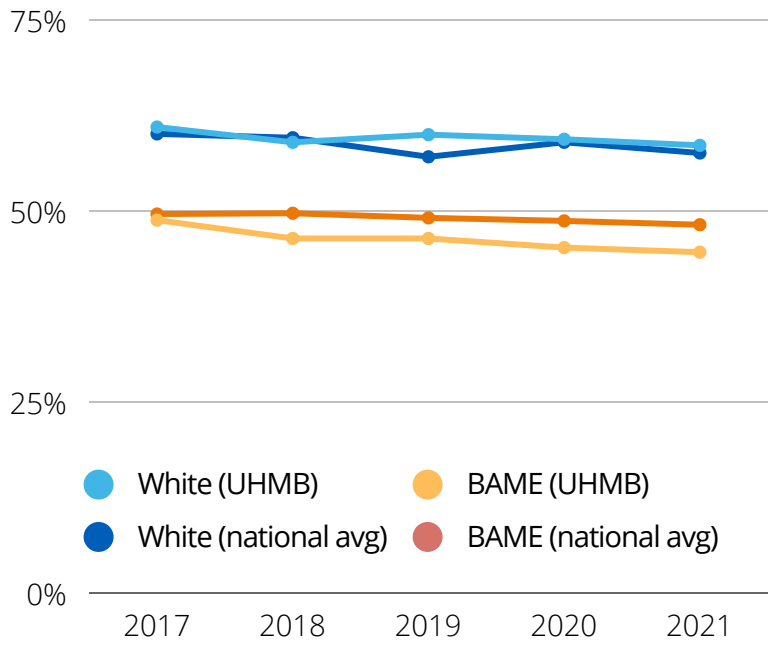
Recognising the high numbers of colleagues recruited via international recruitment campaigns in the past 12 months, these figures have been adjusted to exclude those who joined via this route in 2021/22.

iii. Representation, recruitment and progression

Indicator 7 - fairness in career progression

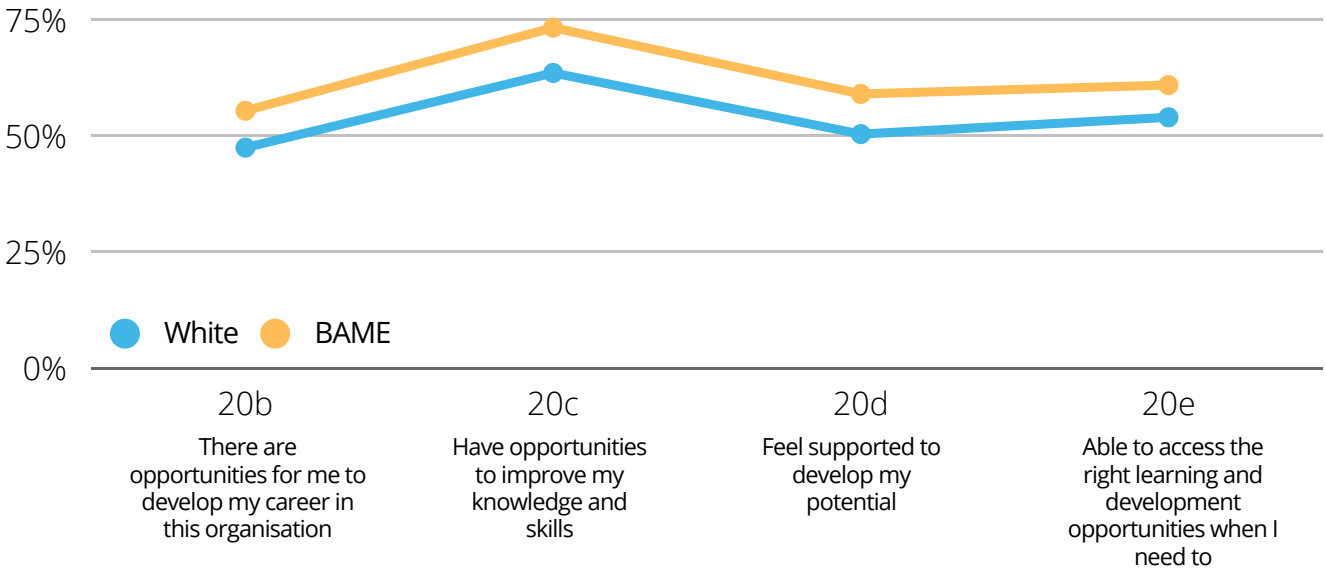
48.2% of ethnic minority staff and 57.6% of white staff believe that the Trust acts fairly with regard to career progression.

% of staff who believe that the Trust acts fairly with regard to career progression, by year



Though UHMB ranks higher than the national average, 2021 data shows almost no change in the proportion of BAME colleagues believing that the organisation provides equal opportunities for career progression, from 48.7% to 48.2%. A disparity remains, with white colleagues 1.2x more likely to feel fairness.

However, four new staff survey questions for 2021 related to career progression show that BAME colleagues on the whole are more likely than white colleagues to feel supported to develop in their careers, or to access learning and development opportunities.



The Ethnicity Pay Gap

The **ethnicity pay gap...**

...is the difference between the average earnings of white and ethnic minority people, expressed relative to the earnings of white people.

The **mean pay gap...**

...is the difference between average hourly earnings of white and ethnic minority people.

The **median pay gap...**

...is the difference between the midpoints in the ranges of hourly earnings for white and ethnic minority people.

What about equal pay?

Equal pay deals with the pay differences between white and ethnic minority people who carry out the same or similar jobs. It has been a statutory entitlement since the Equal Pay Act was introduced in 1970.

Paying people differently for the same or like work is unlawful, however it is possible to have pay equality at the same time as having an ethnicity pay gap.

The ethnicity pay gap differs from equal pay as it is concerned with the differences in the average pay between white and ethnic minority people over a period of time no matter what their role is.

The national NHS terms and conditions 'Agenda for Change' pay system introduced in October 2004 ensures that pay in the NHS is consistent with the requirements of equal pay law. This covers **92.96%** (7,306) of the workforce at Morecambe Bay.

The remaining **7.04%** (553) of the workforce is covered by the NHS Medical and Dental contract, and the NHS Very Senior Managers contract, which also adhere to the principles of equal pay.

iii. Representation, recruitment and progression

The Ethnicity Pay Gap

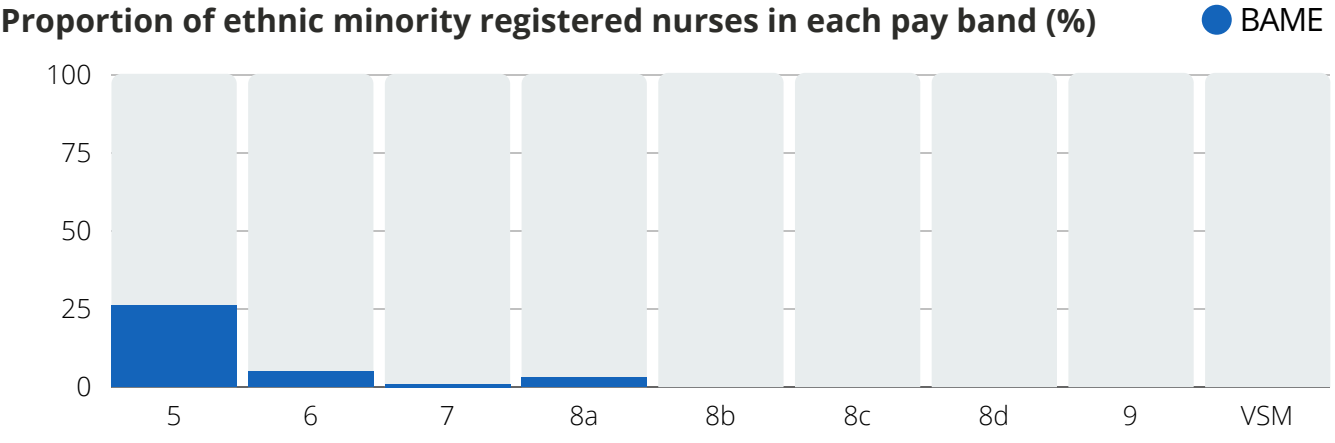
	The earnings of Asian colleagues are:	The earnings of Black colleagues are:	The earnings of colleagues with another ethnic background are:
Mean gender pay gap in hourly pay	**40.0% higher**	**15.5% higher**	**2.1% lower**
Median gender pay gap in hourly pay	**26.0% higher**	**6.5% higher**	**0.9% higher**

Ethnic minority colleagues at Morecambe Bay are likely to earn a higher wage than white colleagues. This is likely due to the demography of the Trust, with 48% of Medical staff identifying as Black, Asian or Ethnic Minority, compared with only 9% of non-Medical staff.

However, this aggregation of data hides a deeper pay gap, with ethnic minority colleagues from some staff groups, particularly nursing and midwifery, much less likely to work in senior leadership roles.

Proportion of ethnic minority staff in all clinical pay bands (%)

Proportion of ethnic minority registered nurses in each pay band (%)



iii. Representation, recruitment and progression

Narrative and action

Learning from success in medical staff development and progression, the Trust is now focusing on **representation in other groups**, in particular to achieve the WRES Model Employer aspirational targets which now stretch to Band 6 and above.

Against the background of the **continuous proactive international recruitment** of doctors and nurses, a significant number of international nurses joined the Trust in 2020-2022 during Covid-19 to support during the pandemic. This is reflected in the large increase in ethnic minority colleagues at clinical band 5 and the decrease at band 3, as colleagues have gone into ward service following completion of the OSCE.

Executive-led Task and Finish Groups were established in 2020 to transform practice in talent management and succession planning and create greater equity in leadership; and to improve recruitment and selection processes. Recognising the **high race disparity ratio in nursing and midwifery** and the disproportionate numbers of ethnic minority nurses at Band 5, this is an initial focus. Work for 2022/23 includes:

- **System level leadership programme** for 20 ethnic minority nurses at Band 5/6, including workshops, masterclasses, mentoring and step-up opportunities.
- **Job application and interview technique support** available for ethnic minority nurses and midwives at Band 5.
- **1:1 career coaching conversations** with the Chief Nurse or deputies offered to all Filipino nurses recognising national and local underrepresentation.
- **Career coaching nursing cafés** supporting a **positive action mentorship** programme for ethnic minority nurses at Band 5.
- **Anti-racist nursing leadership programme** delivered by Yvonne Coghill CBE July 22 to March 23 to empower nurse leaders to enact positive action approaches in their own practice.
- **Reciprocal mentorship cohort 3, focused on race,** supporting authentic allyship from the Board and including leadership mentoring for ethnic minority colleagues.
- **New approach to inclusion governance,** creating stepping-up opportunities and personal development with members of the Board for diverse aspirant leaders.
- **Requirement for diverse recruitment panels** to be rolled out to all colleagues,

At high bands numbers are low and high volatility can be expected in representation. However, over the past two years Board representation has dropped to zero, resulting in an all-white Board. A **refreshed approach to Executive succession planning** was stood down last year which must be followed through in 2022/23.

iii. Representation, recruitment and progression

The Anti-Racist Programme was reset by the Board in October 2021, leading to smaller set of more focused action to ensure progress at pace. Due to this, actions set out in the WRES 2021 related to succession planning were put on hold for 2021, but should be revisited in 2022. These include:

- Mandatory completion of **'Career' tab as part of e-appraisal** for colleagues at Bands 8a and above.
- **Development of a Care Group succession planning matrix** based on readiness identification in e-appraisal to formalise and standardise process, reduce bias, improve colleague support and provide monitoring for inclusion.
- Refresh and review approach to **Executive succession planning**, with support from the North West Leadership Academy.
- Introduce **Talent Panel review** during next round of Executive succession identification, to proactively seek diverse representation at VSM level and eliminate unconscious bias wherever possible.

Ensuring **fairness and consistency in recruitment and selection processes** was a 2020-21 priority and continues into 2022, aligned to the national six mandated actions for inclusive recruitment from NHSEI. Action taking place includes:

- **Requirement for race and gender diversity on panels**. Policy requirement in place for senior leadership and nursing and midwifery roles, with rollout to all staff scheduled to be complete by end 2022.
- Development of a diverse bank of '**bias interrupters**' to support selection processes and exit interviews; initial group recruited with further rollout and implementation .
- **Changes have been made to staff training** to reflect changes to process, policy and inclusive focus, now being delivered in new format.
- Improvements have been made to **basic processes**, eg. regular reporting with EDI checking of interview notes.

As outlined above, a number of actions in the Recruitment and Selection workstream of the Anti-Racist Programme were put on hold for 2021, to ensure progress at pace. The following actions should be reconsidered in 2022:

- Development of a bank of **values-based interview questions** and revision of the scoring system to support this.
- Review of commonly used selection methods such as psychometric testing, and development of alternative **scenario-based skills tests**.

iv. Formal disciplinary processes

Indicator 3 - likelihood of entering the disciplinary process

Ethnic minority staff are 1.8x more likely to enter the formal disciplinary process than white staff (2020/21 - 2021/22).

This is calculated on a 2-year rolling average and shows improvement from **2.01x** in 2019/20 - 2020/21. There has been a significant improvement in-year from **3.03x** in 2020/21 to equal footing (**0.87x**) in 2021/22.

The number of ethnic minority staff employed by the Trust has increased by **27.21%** from March 31st 2021 to March 31st 2022. Alongside this there has been a **60%** decrease in the number of ethnic minority staff entering the formal disciplinary process.

The number of white staff employed by the Trust has remained largely static, increased by only **0.65%** from 2021-2022. However the number of white staff entering the disciplinary process has increased by **10%.**

Change to these measures indicates a fairer threshold for entry.

Relative likelihood of entering the formal disciplinary process, compared with White British staff, by ethnic group (reported as single financial years, not two year average):

	2020/21		2021/22	
	BAME	White	BAME	White
No. staff in the workplace	643	5841	818	5879
No. staff entering formal disciplinary	10	30	4	33
Relative likelihood	**3.03x**		**0.87x**	

iv. Formal disciplinary processes

Narrative and action

This indicator has been particularly volatile at Morecambe Bay over the past five years, with significant progress made following work with BAPIO and the BAME Network, followed by deterioration in 2021.

A mandate to **resolve longstanding cases** was given by the Board over 2020-21, and it is important to recognise that a disproportionate number of longstanding cases over the last five years regarding ethnic minority colleagues will have skewed numbers for a single year, not necessarily reflecting standard practice in 2021. Numbers of **cases for 2021-22 have been proportional**.

An **Executive-led Task and Finish Group** was established as part of the Anti-Racist Programme to review and monitor this indicator and to instigate lasting transformational change. Following the initial data, the group focused on **Maintaining High Professional Standards (MHPS) processes** ('conduct and capability'), addressing first the processes which are most clearly inequitable, with a disproportionate threshold for entry.

A **review of previous and recent employee relations cases** including process and outcome was undertaken, with gaps immediately acted upon, including ensuring that colleagues involved received appropriate support. This is being continued as a best practice approach through **ongoing monthly case reviews.**

An **Employee Decision Tree** is in use for all new cases to guide decision makers through seriousness, early intervention and non-formal processes. The decision tree will next be developed electronically within the case management system, incorporating the recommendations made by Baroness Dido Harding to ensure compassion and support for everyone involved in formal investigations.

A **Cultural Transformation Programme** was launched in May 2021 to develop a Trust-wide just and learning culture. This approach will be a key part of developing colleagues' confidence to raise and resolve issues and conflict early, with assurance that Trust approaches will be compassionate and just. **Priority development** is taking place in pilot areas, including leadership training and support in developing a restorative practice approach.

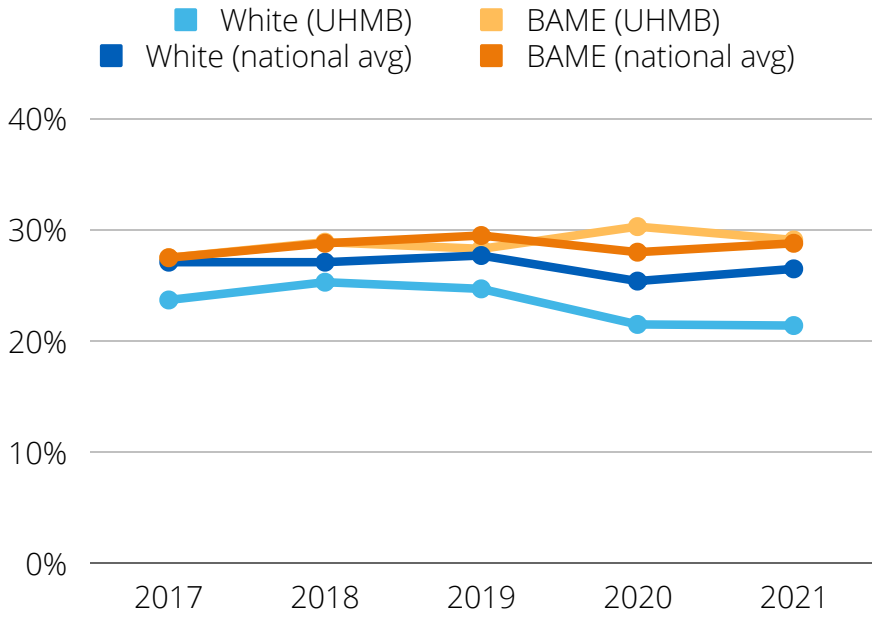
A review of MHPS and Disciplinary policies is underway to include a required process to consider restorative approaches before moving to formal process.

v. Behaviours and discrimination

Indicator 5 - bullying and harassment from the public

29.1% of ethnic minority staff and 21.4% of white staff have experienced bullying, harassment or abuse from patients, relatives or the public in the last 12 months.

% of staff who have experienced bullying, harassment or abuse from patients, relatives or the public in the last 12 months, by year

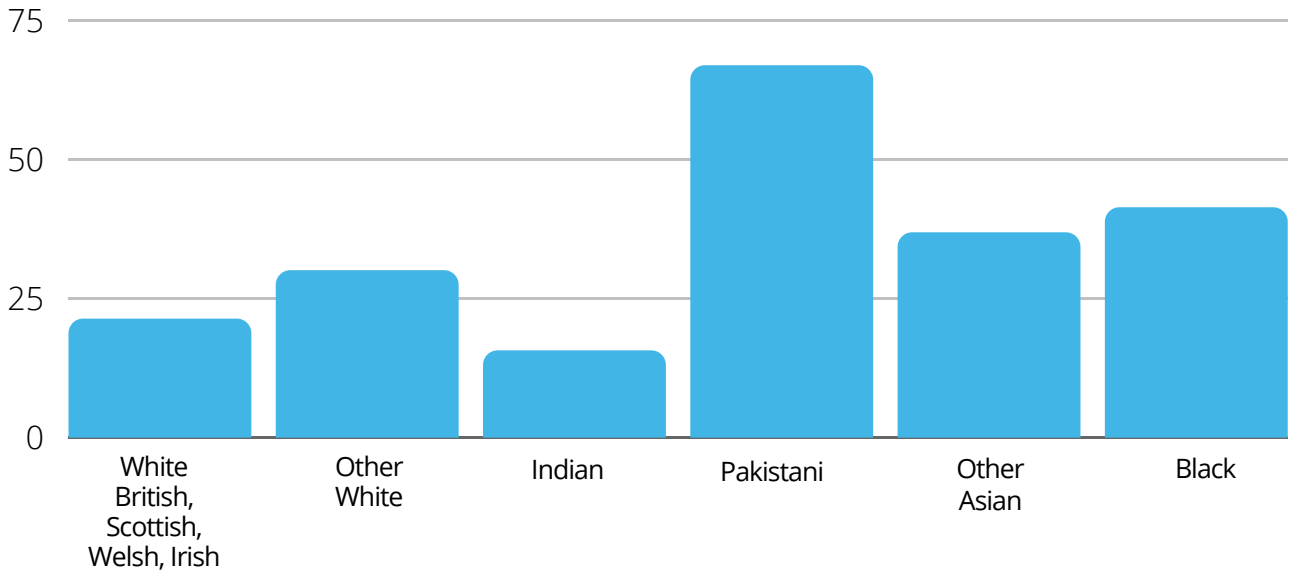


In 2020 bullying, harassment and abuse directed towards ethnic minority colleagues increased at UHMBT.

Some improvement can be seen in 2021, however much more work is required to reduce the significant disparity of experience between ethnic minority and white colleagues.

In 2021 66% of Pakistani colleagues and 39.5% of Black colleagues experienced bullying, harassment and abuse from patients and relatives, compared with only 21% of White British staff.

% of staff who have experienced bullying, harassment or abuse from patients, relatives or the public in the last 12 months, by ethnic group

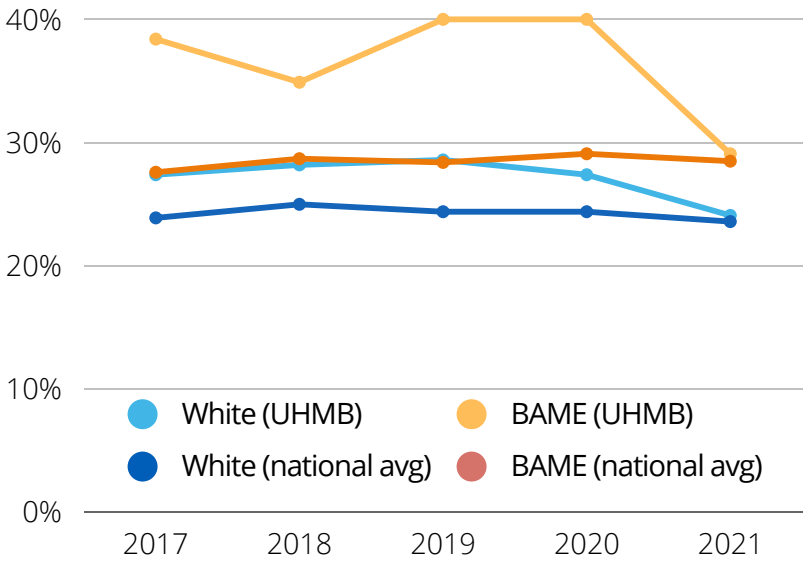


v. Behaviours and discrimination

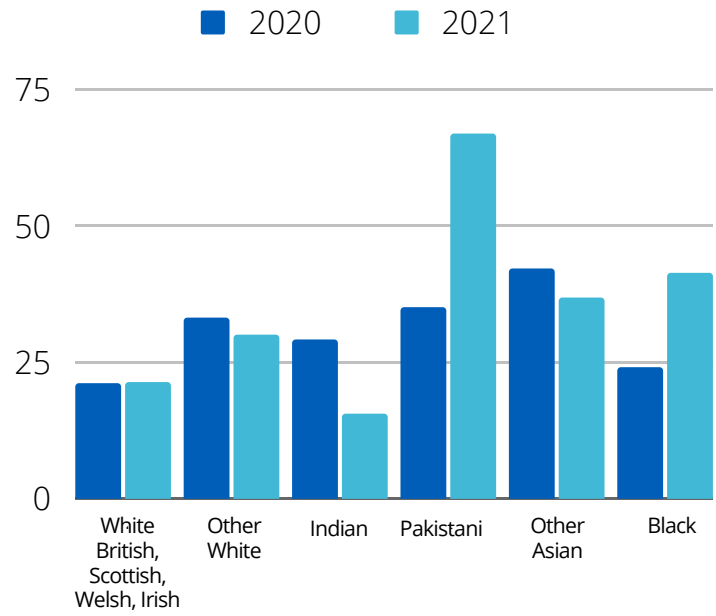
Indicator 5 - bullying and harassment from staff

29.1% of ethnic minority staff and 24.1% of white staff have experienced bullying, harassment or abuse from staff in the last 12 months.

% of staff who have experienced bullying, harassment or abuse from staff in the last 12 months, by year



% of staff who have experienced bullying, harassment or abuse from staff in the last 12 months, by ethnic group and year



Significant improvement for ethnic minority colleagues, meeting the national average and closing the gap.

2021 data shows a 27% reduction in bullying experienced by ethnic minority colleagues and improvement also for white colleagues.

This is a dramatic change from the disparity seen in 2020 when the Trust was a national outlier for this measure.

Staff from some ethnic groups are still more likely to be bullied or harassed by colleagues than others.

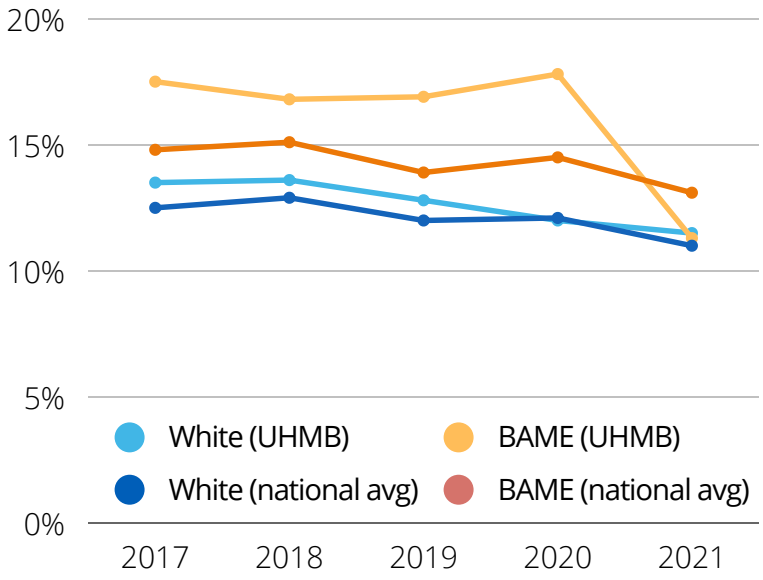
The data shows improvement for some groups, particularly Indian and Other Asian (Filipino) colleagues, but significant worsening experience for Pakistani and Black colleagues, with 66% and 41% respectively experiencing bullying and harassment from staff in the past 12 months.

v. Behaviours and discrimination

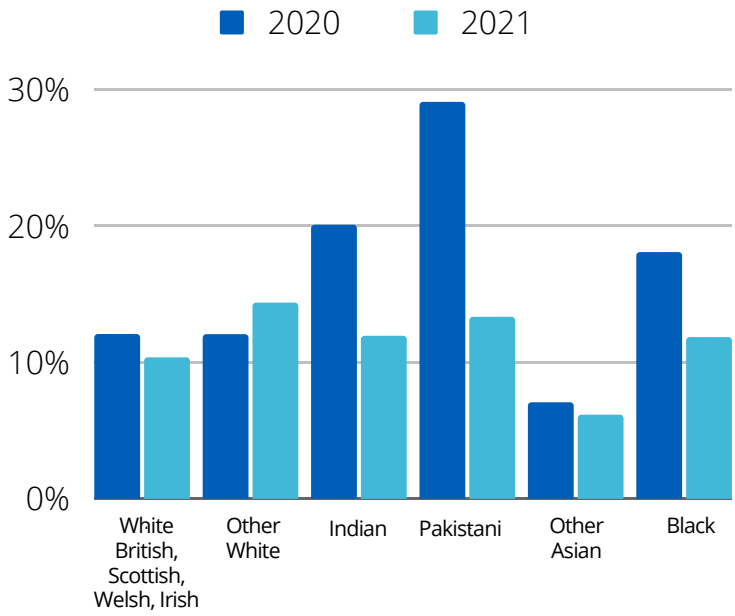
Indicator 5 - bullying and harassment from staff

11.3% of ethnic minority staff and 11.5% of white staff have experienced bullying, harassment or abuse from managers in the last 12 months.

% of staff who have experienced bullying, harassment or abuse from managers in the last 12 months, by year



% of staff who have experienced bullying, harassment or abuse from staff in the last 12 months, by ethnic group and year



Looking specifically at bullying, harassment and abuse from managers, 2021 data shows a significant improvement to the experience of ethnic minority colleagues in particular.

This is a 37% reduction, better than the national average, and shows for the first time an experience equal to that of white staff.

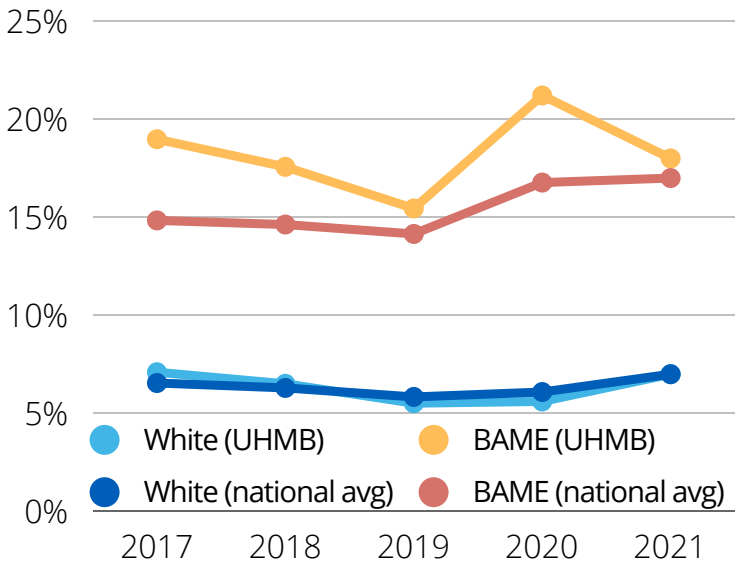
Looking at the experiences of colleagues from different ethnic groups, a reduction in bullying can be seen for all groups, particularly notable for Indian, Pakistani and Black colleagues.

The only ethnic group to see an increase in bullying was 'Other White' - the majority of this group likely consisting of colleagues from white European countries.

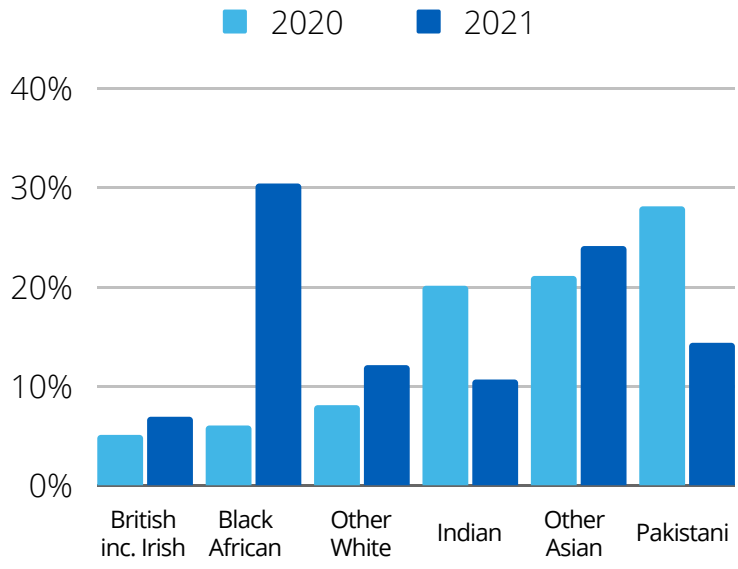
Indicator 8 - experience of discrimination

18% of ethnic minority staff and 7% of white staff have personally experienced discrimination from a colleague or team leader in the last 12 months.

% of staff who have experienced discrimination from a colleague or team leader in the last 12 months, by year



% of staff who have experienced discrimination from a colleague or team leader in the last 12 months, by ethnic group



In 2020, discrimination from colleagues and managers increased well above the national average, even in the context of a national increase. However for 2021 this has dropped to levels within 1% of the national average, against the backdrop of no improvement nationally.

It is important to note that this picture of improvement does not reflect the experience of all ethnic minority colleagues.

In 2020, only 6% of Black African colleagues reported experiencing discrimination from a colleague or manager. However this has risen to 30.3% - a 405% increase.

In the context of similar significant worsening across other measures for this group, but also much higher number of African colleagues taking part in the survey, it could be hypothesised that this is not a change in experience but the result of greater trust developed with this group, and a more realistic picture of experience.

v. Behaviours and discrimination

Narrative and action plan

Though gains have been made, one year of progress does not show sustained improvement and the indicators around behaviours remain of significant concern. Continued energy must be made in closing the gap in experience. In 2021/22 a number of actions took place in partnership across the Anti-Racist Programme and Cultural Transformation Programme to address bullying, harassment and incivility experienced by ethnic minority colleagues. These include:

- **Recruit and develop inclusive leaders**
  - Continued emphasis on values-based recruitment;
  - Inclusive and Compassionate Leadership Programme delivered to 208 out of 300 senior leaders (led by Eden Charles, national expert in equalities and leadership development) between October 2020 - April 2021;
  - Development of a new multi-format leadership programme with inclusion at its core, with delivery commencing July 2022.

- **Improve routes to speak up**
  - Review of Respect Champion roles, including diversity;
  - Delivered staff training for support colleagues to confidence talking about race and cultural sensitivity, to be continued through 2022;
  - New connections formed with external bodies such as the Filipino Nurses Association and Anti-Racist Cumbria to provide additional support and representation for minoritised colleagues.

- **Support and empower staff**
  - Designed new offering of 'Stand Up' bystander and courageous conversations training for colleagues, delivered as a pilot for a period of 4 months and now available to all colleagues via TMS;
  - Development sessions delivered to the Anti-Racism Influencers Group to help colleagues become more confident talking about race, including explicit practical training on microaggressions and courageous conversations.

- **Deliver targeted support**
  - Support and consultation provided with specific teams and staff groups identified, for example Filipino nurses listening and engagement session with over 60 attendees, and specific team interventions made at RLI;
  - Worked with and supported the RSP, with Transformation Lead for Race Equality as a core member, to empower and encourage confident conversations about race, considering the ethnic diversity of colleagues involved and improving this where possible; to continue through 2022/3.

v. Behaviours and discrimination

The **Transformation Lead for Race Equality** leads a bespoke programme responding to local issues faced by ethnic minority colleagues across the Bay. Progress includes:

- Development of the Anti-Racism Influencers Group, a network of active allies, chaired by the Chief Executive, including a learning and development session on practical tools at each meeting.
- Awareness raising and skills development with line managers and colleagues across the Trust around recognising racism – individual and structural, and micro-aggressions and developing cultural competence.
- Data analysis identifying specific areas of disproportionate experience for targeted support and intervention.
- Support provided to the BAME network to give colleagues confidence to speak up safely about issues related to racism, behaviours and discrimination.

Further support and resource includes:

- 15 Respect Champions, who offer independent advice and support to colleagues experiencing bullying or harassment.
- BAME Network Speak Up Ambassador role (1 day per week) to support with bullying and harassment as well as formal disciplinaries and early resolution.
- Trained WRES Expert advising on improving colleague experience.
- Dedicated Non-Executive Director for Equality, Diversity and Inclusion.
- International Retention Programme Board, dedicated to improving wellbeing and support for international recruits.

v. Behaviours and discrimination

Due to the Board's reset and review of the Anti-Racist Programme, a number of **actions were put on hold** to create progress at pace, to be revisited in 2022. These include:

- Data analysis to improve understanding of how ethnic minority colleagues access Occupational Health and Wellbeing services, which services are favoured and why, to improve suitability and access;
- Training and support for therapists to give them more confidence in talking about race, in order to improve therapies for colleagues;
- Strengthening links between the BAME Network and Occupational Health and Wellbeing Services to create a greater feeling of trust.
- Set expectations and empower staff with a high-level long-term consistent communications campaign with 5 key messages around what bystanders can do to prevent, intervene or report incidents of bullying and harassment.

Further planned action for 2022/23 includes:

- Cohort 3 of the Trust's Reciprocal Mentoring programme, designed to provide Board members and senior leaders allyship support while also offering leadership development to ethnic minority colleagues as a positive action measure.
- Anti-Racist Board development workshop taking place June 2022, facilitated by sector expert Yvonne Coghill CBE, former Director of the Workforce Race Equality Standard and Vice-Chair of the Royal College of Nursing.
- Six month anti-racist leadership development programme, to be delivered to 24 senior nurses and facilitated by Yvonne Coghill CBE to develop active anti-racist allies in nursing leadership, addressing bullying and harassment as well as the race disparity ratio in career progression.
- Formal partnership agreement with local charity Anti-Racist Cumbria as a "constructive friend" and also to develop trust and representation for Black staff to improve engagement and experience.
- Further action taken as a result of listening sessions undertaken with the Filipino Nurses Association UK.

WRES Action plan

	Outcome	Actions	Leads	Timescale
1	Improve understanding of local issues across the Trust, learning from current lived experience, to implement best practice responses with a full evaluation of their impact. Measures: Improvement in Indicators 2, 3, 6 and 8 by December 2023.	Continued investment in the race equality agenda through dedicated resources in the designation of a Non-Executive Director as a lead for Equality, Diversity and Inclusion; the Anti-Racism Influencers Group; extension of the BAME Network Speak Up Ambassador for a further year to Sept 2023; and a dedicated post to lead the Anti-Racist Programme.	Chief Executive / Head of Inclusion and Engagement	31st March 2023
2	Improve leadership approach and response to improve ethnic minority colleague experience through a consistent, Trust-wide approach to developing and supporting ethnic minority allies. Measures: Improvement in Indicators 5-8 by December 2023.	Delivery of Yvonne Coghill's six-month Anti-Racist Nursing Leadership Programme to 24 nurse leaders.	Head of Inclusion and Engagement	31st March 2023
		Delivery of Part 1 of the Leadership Programme, including specific content related to anti-racism as well as inclusion more widely.	Head of Learning and Development	31st July 2023
		Launch of the Trust's Reciprocal Mentoring Programme (cohort 3) with a focus on race.	Head of Inclusion and Engagement	31st March 2023
		Continued development of Anti-Racism Influencers Group to provide support to potential and developing allies, utilising the Anti-Racist Toolkit.	Chief Executive	31st December 2023
3	UHMBT colleagues consistently demonstrate inclusive behaviours, in line with the Trust's Behavioural Standard Framework. Measures: Improvement in Indicators 5 – 8 by December 2023.	Rollout of of training materials to improve support for bystanders on how to safely intervene in conflict situations and support colleagues involved, with accompanying comms campaign.	Head of Inclusion and Engagement	31st March 2023

	Outcome	Actions	Leads	Timescale
4	Building of relationships and trust with ethnic minority colleagues. Measure: Improvements in overall BAME staff engagement score (National Staff Survey) by December 2023.	Continued support for the BAME Network, including providing dedicated time for network leads, supporting in-person and social activities, and continuing to develop relationships with Occupational Health and Wellbeing teams.	Head of Inclusion and Engagement	31st March 2023
5	Improved wellbeing support for ethnic minority colleagues, particularly in relation to bullying, harassment and abuse. Measure: Improvement in indicators 5-8 and increase in proportion of colleagues accessing wellbeing and support services who are from an ethnic minority background.	Deep dive to understand ethnic minority access to wellbeing services, allowing design of better service provision.	Head of Inclusion and Engagement	31st December 2022
		Respect Champion review, providing support and training to champions, increasing diversity, and using data to tackle issues strategically and proactively.	Head of Inclusion and Engagement	31st December 2022
		Providing support to staff in roles which are directly supporting colleagues, developing confidence talking about race.	Head of Inclusion and Engagement	31st December 2022
6	Improvement to Indicator 3, with an equal and proportional number of ethnic minority staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. Measure: Improvement in Indicator 3 to no difference between BAME and white colleagues by December 2022.	Development of the ER decision tree towards Merseycare's four step approach.	Director of People & OD	31st March 2023
		Review of Disciplinary and MHPS Conduct policies to embed a restorative approach.	Director of People & OD	31st December 2022
		Implementation of just and learning culture across pilot areas including Maternity and Theatres to improve the utilisation of clinical incident reports (CIRs) as a non-threatening learning tool.	Head of Culture Transformation	31st December 2022

	Outcome	Actions	Leads	Timescale
7	Increase diverse representation in roles at Bands 6 and above to 11.3% and improve confidence in fair recruitment and promotion of diverse colleagues. Measures: Improvement in Indicators 1, 7, 9 and RDR by December 2023, and sustained positive score in Indicator 2. Meeting Model Employer targets at Bands 6 and above.	Improvements in BAME representation (and other under-represented groups) to be included as part of objectives and appraisal for VSMs, linked to IPR.	Head of Inclusion and Engagement	Scoping & consultation by 31st December 2022
		Complete rollout of requirements for diverse interview panels across the organisation, including the presence of an equality representative ('bias interrupter') who has authority to stop the selection process.	Deputy Chief Executive	31st January 2023
		Development of positive action programmes including reciprocal mentoring, career coaching conversations and leadership of an ICS talent programme.	Assistant Director of People & OD	31st March 2023
		Nurture minoritised talent through an inclusive approach to talent management, including implementation of career conversations as part of annual colleague appraisals, and refreshed approach to Executive succession planning.	Assistant Director of People & OD	31st March 2023
		Overhaul interview processes to ensure adoption of values based shortlisting and interview approach, and ensure that for Bands 8a and above, hiring managers include requirement for candidates to demonstrate EDI work/legacy during interviews.	Deputy Chief Executive	31st March 2023

We are UHMBT

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

NHS
University Hospitals of Morecambe Bay
NHS Foundation Trust

Workforce Sexual Orientation Equality Standard Report

September 2022

Contents

Background Information

Our Workforce Sexual Orientation Monitoring Standard (WSOES) utilises similar indicators to the national Workforce Race Equality and Disability Equality Standards with specific indicators agreed with our LGBT+ colleague network.

We are now in our 8th year of reporting against these metrics.

Our intention is to expand the WSOES to enable us to monitor colleague experience based on gender identity. Currently, the employee record system (ESR) does not allow identities to be recorded outside of the binary i.e. man/woman and as many of the indicators rely on this data, this is preventing us from doing so. We are actively lobbying for this to be updated nationally.

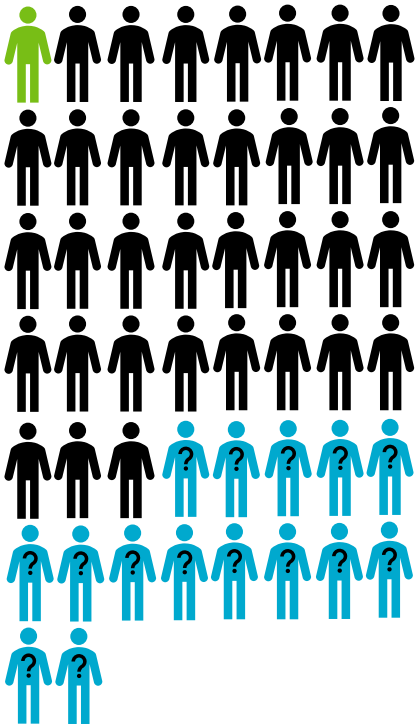
You can now self-report your gender identity as part of the NHS Staff Survey. As a result, we have the opportunity to report on the colleague experience of trans and non-binary colleagues for indicators reliant on this data. Unfortunately, this year the number of colleagues who told us that their gender identity is diverse was too small (<11) for us to access this data and so we have no been able to report.

Our Colleagues

According to staff in post data on 31 March 2022, **69.73%** of staff had self-reported their sexual orientation which equates to an increase of 4.17% since March 2021.

As 30.27% of colleagues have not self-reported their sexual orientation, data we have used for these metrics may not truly reflect the experience of all LGB+ (lesbian, gay, bisexual, and other sexual orientation) colleagues.

We collected our data on 31 March 2021 when 7,219 colleagues made up our workforce. **2.12%** of these colleagues had self-reported on ESR that they are LGB+.



Summary of data

Improvements and sustained positive outcomes:

Indicator 2 - LGB+ candidates are 19% more likely to be appointed from shortlisting compared to heterosexual candidates, compared to being equally as likely in 2021.

Indicator 8 - In 2021/2022, we now have 5.57% of our Board voting membership that have told us they are LGB+ equating to a difference of +3.45%.

Deterioration and sustained unequal outcomes:

Indicator 1 - 2.25% of our non-clinical and 2.06% of our clinical workforce have told us that they are LGB+ on ESR which has increased year-on-year, but most of these colleagues are not in management or senior leadership roles.

Indicator 4 - LGB+ colleagues are 27% less likely than heterosexual colleagues to access non-mandatory training and CPD, compared to 24% more likely in 2021.

Indicator 5 - 58% of heterosexual colleagues, 52% of gay and lesbian colleagues, 60% of bisexual colleagues believe that we provide equal opportunities for career progression. A disparity in this deterioration is seen particularly for gay and lesbian colleagues (-8.7%) compared to heterosexual colleagues (-1.8%).

Indicator 3 - Across the 2-year reporting period, LGB+ colleagues were 36% more likely to enter the formal disciplinary process, compared to heterosexual colleagues.

Indicator 6 - 10% of heterosexual, 18% of gay and lesbian, 16% of bisexual, and 13% of colleagues of other sexual orientations experienced harassment, bullying, or abuse from their manager/s in the last 12 months.

Indicator 7 - 20% of heterosexual, 34% of gay and lesbian, 25% of bisexual, and 13% of colleagues of other sexual orientations experienced harassment, bullying, or abuse from their manager/s in the last 12 months.

Indicator 1

% of LGB+ colleagues in each of the AfC Bands 1-9, Medical, and VSM compared with colleagues in the overall workforce.

Since we began reporting on sexual orientation, the proportion of LGB+ colleagues working for UHMBT overall has increased year-on-year.

2018/2019	2019/2020	2020/2021	2021/2022
1.21% (59.4%)	1.43% (61.7%)	1.72% (65.6%)	2.12% (69.7%)

Overall declaration rate of sexual orientation each year is shown in brackets.

Non Clinical	% LGB+ 20/21	% LGB+ 21/22	Clinical	% LGB+ 20/21	% LGB+ 21/22
Band 1	0.00%	0.00%	Band 1	0.00%	0.00%
Band 2	1.32%	1.85%	Band 2	3.00%	2.73%
Band 3	1.13%	1.76%	Band 3	1.61%	2.78%
Band 4	1.48%	1.34%	Band 4	0.47%	1.00%
Band 5	1.49%	1.87%	Band 5	1.73%	2.25%
Band 6	2.78%	4.24%	Band 6	2.07%	1.94%
Band 7	5.68%	3.06%	Band 7	1.15%	1.10%
Band 8a	7.23%	9.41%	Band 8a	1.78%	2.67%
Band 8b	2.86%	2.50%	Band 8b	0.00%	0.00%
Band 8c	0.00%	4.00%	Band 8c	0.00%	0.00%
Band 8d	0.00%	0.00%	Band 8d	0.00%	0.00%
Band 9	0.00%	0.00%	Band 9	0.00%	0.00%
Medical	0.38%	0.00%	Medical	0.38%	1.49%
VSM	0.00%	0.00%	VSM	0.00%	100%
TOTAL	**1.80%**	**2.25%**	**TOTAL**	**1.68%**	**2.06%**

NO CHANGE	0% IN POST	> 1% INC.	> 1% DEC.

Indicator 2

Relative likelihood of LGB+ candidates being appointed from shortlisting compared to that of heterosexual candidates across all posts.

LGB+ candidates are **1.19x** more likely to be appointed from shortlisting compared to heterosexual candidates, compared to being equally as likely in the previous year.

If we are to achieve representation, this improvement will need to be sustained.

Indicator 4

Relative likelihood of LGB+ colleagues accessing non-mandatory training and CPD, compared to heterosexual colleagues.

LGB+ colleagues are **0.73x** less likely than their heterosexual colleagues to access non-mandatory training and CPD, compared to being 1.24x more likely last year.

It should be noted however that this measure does not currently record access to wider non-mandatory training and CPD and therefore may not offer a true reflection.

As LGB+ colleagues continue to be less likely to progress through the organisation to senior leadership roles (see Indicator 1) and there has nevertheless been a marked deterioration of this indicator, further exploration is warranted.

Indicator 8

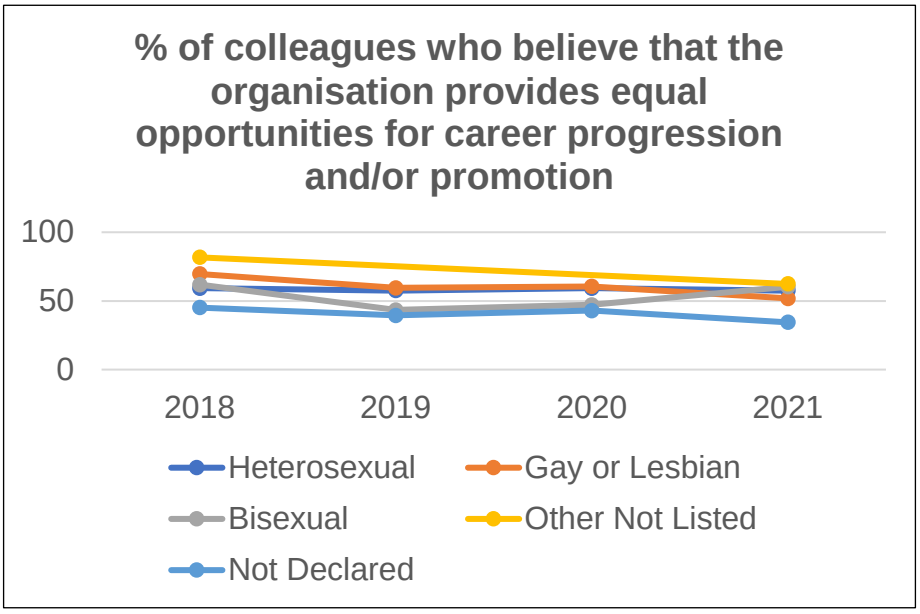
% difference of LGB+ colleagues between our Board voting membership compared to our overall workforce

Since 2018/2019 there has been no visible LGB+ representation on our Board voting membership, despite the proportion of LGB+ colleagues overall increasing consistently year-on-year. In 2021/2022, we now have 5.57% of our Board voting membership that have told us they are LGB+ equating to a difference of **+3.45%**.

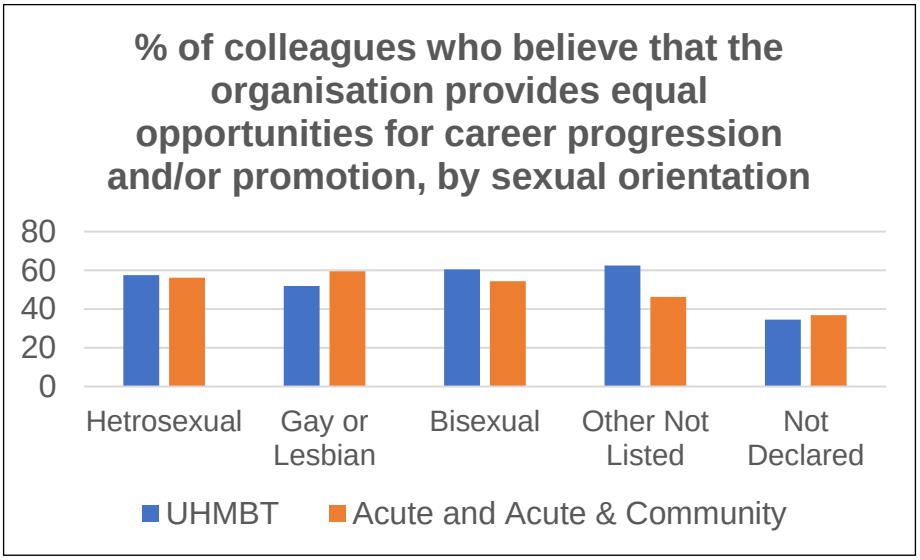
Amongst voting Board members declaration of sexual orientation is much lower at 31% (compared to 69.73% overall) and due to the small number of colleagues involved, changes in appointments has a significant impact on reported proportions.

Indicator 5

% of LGB+ colleagues who believe that the organisation provides equal opportunities for career progression and/or promotion.



A slight deterioration this year for heterosexual colleagues (-1.8%) and more so for gay and lesbian colleagues (-8.7%) whereas there has been a significant improvement in the perception of fairness of bisexual colleagues (+13.2%). As with other indicators, the poorest experience is reported by those who did not declare their sexual orientation.



When we compare the experience of our own colleagues to the national average for Acute and Acute & Community trusts, this shows that our gay and lesbian colleagues are having a much poorer experience and it is important that we explore this further with that group.

Indicator 3

Relative likelihood of LGB+ colleagues entering the formal disciplinary process, compared to heterosexual colleagues, as measured by entry into a formal disciplinary investigation (across a 2-year reporting period)

Across the 2-year reporting period, LGB+ colleagues were **1.36x** more likely to enter the formal disciplinary process, compared to their heterosexual colleagues.

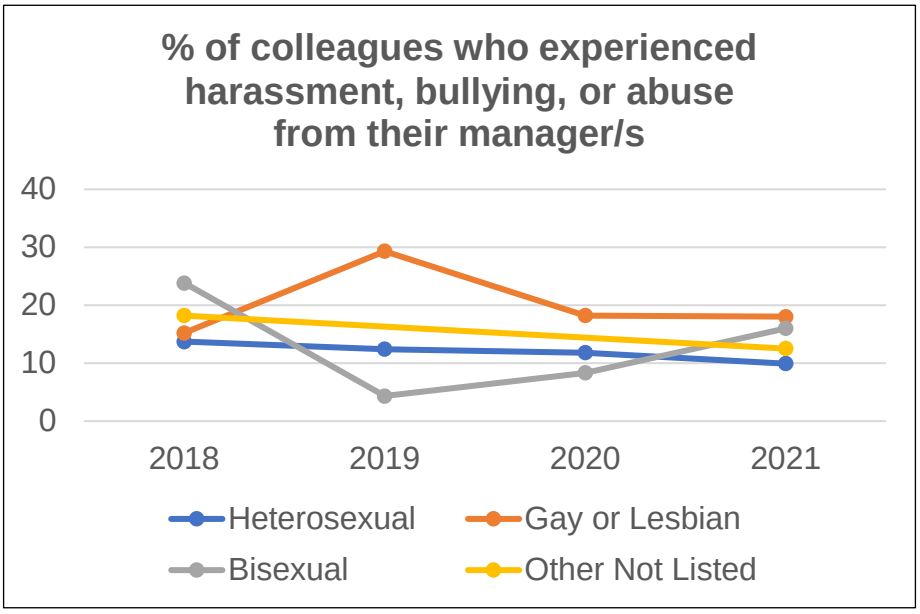
	2020/2021		2021/2022	
	LGB+	Heterosexual	LGB+	Heterosexual
No. colleagues in workplace overall	122	4537	153	4879
No. colleagues entering formal disciplinary	1	29	1	21
Relative Likelihood	1.3x		1.75x	

An improvement from 2019/20-2020/21 when LGB+ colleagues were 2.1x more likely to ensure the formal disciplinary process than heterosexual colleagues.

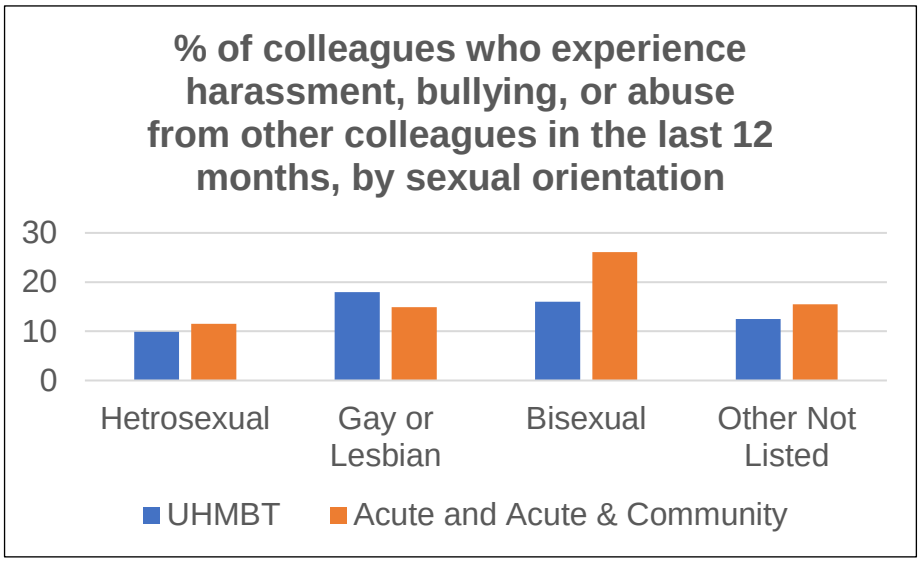
When considered year-by-year, there has been a deterioration for LGB+ colleagues between 2020/2021 and 2021/2022 but as the numbers involved are very small this is likely to result in such significant variance between each reporting year.

Indicator 6

% of LGB+ colleagues who experienced harassment, bullying, or abuse at work from their manager/s, compared to heterosexual colleagues.



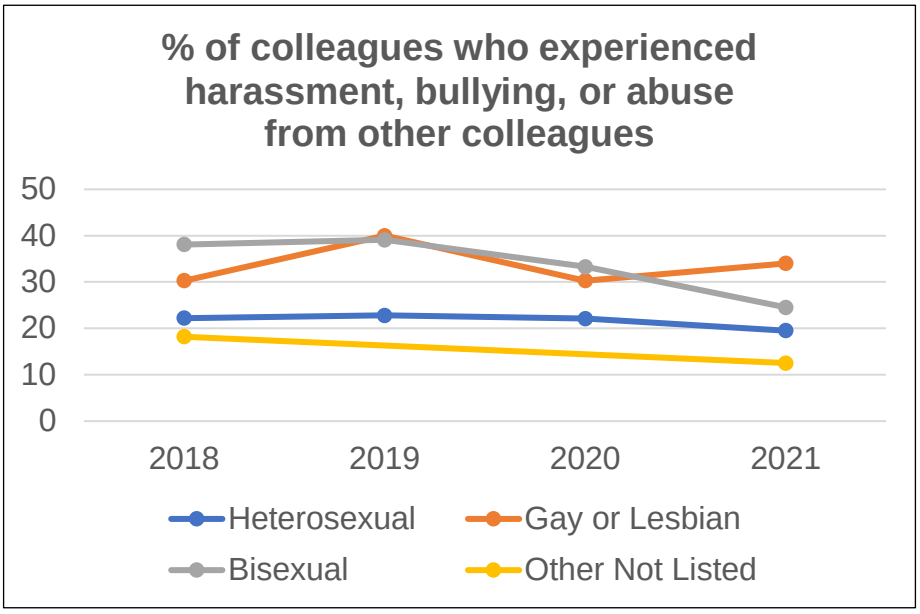
We have seen a 1.9% improvement in the proportion of our heterosexual colleagues experiencing harassment, bullying, and abuse from their manager/s, whereas this has remained fairly constant for gay and lesbian colleagues and has almost doubled for bisexual colleagues.



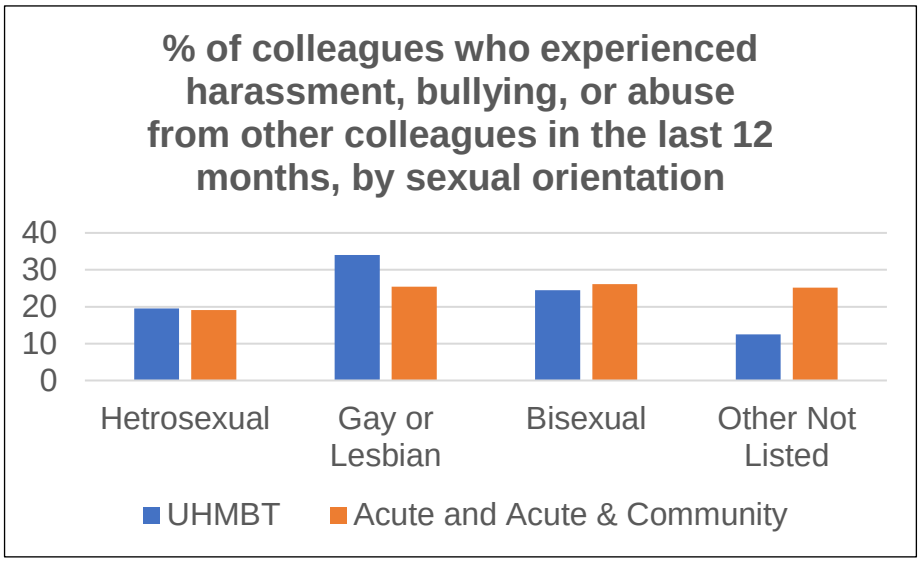
When we compare the experience of our own colleagues to the national average for Acute and Acute & Community trusts, this shows that our gay and lesbian colleagues are having a much poorer experience and it is important that we explore this further with that group.

Indicator 7

% of LGB+ colleagues who experienced harassment, bullying, or abuse at work from other colleagues, compared to heterosexual colleagues.



We have seen a marked improvement in the proportion of our colleagues experiencing harassment, bullying, and abuse from other colleagues, except for gay or lesbian colleagues where this has increased by almost 4% this year.



When we compare the experience of our own colleagues to the national average for Acute and Acute & Community trusts, this shows that our gay and lesbian colleagues are having a much poorer experience and it is important that we explore this further with that group.

Our actions in 2021/22

- We made a submission to the Stonewall Workplace Equality Index, ranking 270th out of 403 organisations and achieving the Silver award.

- We participated in the second phase pilot of the Rainbow Badge scheme, submitting further evidence of LGBTQ+ inclusion with a focus on service inclusion and a review of people-focused policies and capturing feedback from both colleagues and patients.

- We sponsored Lancaster and Morecambe Pride events and were asked to lead out the parade on both occasions, as a thank you to the hard work of NHS colleagues during the Covid-19 pandemic.

- We collaborated with colleagues from across Lancashire and South Cumbria on a programme of events for LGBT History Month, with UHMBT hosting a tweet chat on LGBTQ+ mental health.

- We refreshed our LGBT+ Awareness training materials to better reflect training needs identified with teams across the organisation. A series of tailored sessions were delivered 'on request' as part of the postgraduate education programme and to clinical teams based at the WGH Urgent Treatment Centre.

- Our LGBT+ network curated a special edition of Weekly News for LGBT History Month, sharing knowledge and resources, lived experiences, and their book, TV, film, and podcast recommendations as well as individual articles for World Aids Day and Trans Day of Remembrance.

- We have also spent time responding to several Freedom of Information requests and complaint emails, reflecting the increasing hostility towards the LGBTQ+ community in wider society. A focus of the LGBT+ network has been providing peer support to LGBTQ+ colleagues whose wellbeing has been impacted.

- Our progress on implementing the Sexual Orientation Monitoring Standard has been delayed due to technical issues at a national level which are currently preventing us taking further action. We have continued to escalate this with senior leaders in the national team to ensure progress does not stall entirely.

Our priorities for 2022/23

When setting out our priority actions, it is important that we take time to fully understand the feedback gained from both the Stonewall WEI and Rainbow Badge assessments, as well as our colleague and patient lived experiences, and the results of our NHS Staff Survey 2021.

We expect to have these reports in August 2022 and therefore the below actions may be reviewed to ensure that we are taking the right actions at the right time to improve the LGBTQ+ colleague and patient experience.

It is also important that we recognise the increasing hostility towards the LGBTQ+ community, particularly trans and non-binary people, and the impact that has on the wellbeing of our colleagues, patients, and citizens.

Action: Supporting our leaders to create an inclusive environment and nurture LGBTQ+ colleagues, by embedding inclusion at the core of the Moving Forwards leadership programme, supported by specialist content and training opportunities on LGBTQ+ inclusion.
Responsible: Head of Inclusion & Engagement and Head of Learning & Development
Outcome: Statistically significant improvements to experiential indicators 3, 5, 6 & 7.

Action: A full roll-out of LGBTQ+ Awareness and Trans & Non-Binary Inclusion training packages as part of the trust-wide anti-bullying communications campaign through an inclusive lens.
Responsible: Head of Inclusion & Engagement and Head of Culture Transformation
Outcome: Statistically significant improvements to experiential indicators 6 & 7.

Action: Improve our data to support and inform targeted positive action as well as benchmark progress, through campaigns and resources to help increase declaration of sexual orientation and gender identity.
Responsible: Strategic Lead for Inclusion & Engagement
Outcome: Statistically significant improvements to indicators 1 and 8, relating to representation and board-voting membership.

Our priorities for 2022/23

Action: Supporting the LGBT+ network to grow their membership, promote allyship and to build engagement, trust and psychological safety, including the provision of dedicated time, training and development for network leads.
Responsible: Strategic Lead for Inclusion & Engagement and LGBTQ+ Network Leads
Outcome: An increased overall network membership with regular network meetings being held. Involvement of network leads in training and development opportunities through the Network Leads Forum.

Action: Working in partnership with Stonewall and the NHS Rainbow Badge team to implement recommended actions from the 2021/22 assessment exercises to pursue aspirational standards for LGBTQ+ inclusion.
Responsible: Strategic Lead for Inclusion & Engagement
Outcome: Improvement in overall ranking and achievement of Gold award in Stonewall Workplace Equality Index.

Action: Using our position as an anchor institution to work collaboratively with local partners to address health inequalities through the LGBTQ+ Health Stakeholders Group and involvement with the Health Equity Summit.
Responsible: Strategic Lead for Inclusion & Engagement
Outcome: An established channel of communication, providing better links to, engagement with, and greater understanding of the needs of our seldom-heard local LGBTQ+ communities including representation from the Lancashire and Cumbria Health Equity Commission (HEC).

Action: Celebrating and supporting our LGBTQ+ colleagues, patients, and citizens through events such as LGBT History Month, World Aids Day, and Transgender Day of Visibility and the Positive Difference annual conference. **Responsible:** Strategic Lead for Inclusion & Engagement and LGBTQ+ Network
Outcome: Statistically significant improvements to experiential indicators 6 and 7.

University Hospitals of Morecambe Bay
NHS Foundation Trust

Service Monitoring Information

2021

Summary

The purpose of this report is to demonstrate the Trust's compliance with the Equality Act 2010 general duty across our patient services. It summarises the equality monitoring data regarding patients at the University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBT) in 2021, using statistical data taken from the Trust's electronic patient records.

Data contained in this report is routinely utilised by our colleagues when assessing the impact of new or revised policies, practices, or services against the requirements of the public sector equality duty as part of the Equality Impact Assessment.

The trust progressed its patient services equality objectives enhancing the experience of our most vulnerable patients and citizens. We continue to utilise our alert system within the patient record. Work continues to ensure our information is accessible to all our patients and their relatives and carers.

The Trust uses the NHS Equality Delivery System (EDS2) as an opportunity to look at how well we are doing in our efforts to improve equality delivery for patients and staff continually. Our latest EDS2 report is published on our website https://www.uhmb.nhs.uk/our-trust/inclusion-and-diversity

In a year which Covid has dominated the headlines, the daily realities of patient experience continued. Like other trusts across the country, Covid-19 meant our trust had to transform, overnight, the way we cared for patients and delivered services, therefore the experience team have and continue to closely monitor patient feedback with particular reference to online, video and telephone appointment clinics.

On the face of it, experience can seem quite simple. Our goal is to ensure that our patients receive the best possible care and experience when they use our services. It is, therefore, so important that we continue to listen to what our patients and their families are saying about us, and that we continue to work hard to gather and act upon feedback. We are committed to improving the experience for our patients, families, and carers. We are constantly learning from the feedback that we receive and want to actively listen to our patients to understand what matters to them.

We have set some ambitious inclusion commitments to creating an environment and culture that celebrates inclusion and diversity, dignity and respect, which values, nurtures, and harnesses difference for the benefit of our patients and their families and carers, our colleagues, and the communities we serve across Morecambe. You can read our Inclusion strategy here

https://www.uhmb.nhs.uk/application/files/3216/4701/2202/Positive_Difference_Inclusion__Diversity_Strategy_2021-2026_1.pdf

Interpretation Services

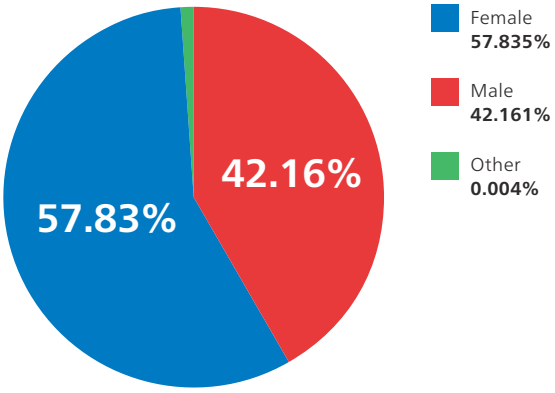
When face-to-face interpretation services were paused during the Covid-19 pandemic, we continued to provide on-demand language interpretation via video and telephone. We secured charity funding to buy a further video interpretation device. In 2021/22, the languages most requested by patients were Arabic, British Sign Language, Polish, Bulgarian, Romanian, Mandarin and Turkish.

Lynne Wyre
Deputy Chief Nurse

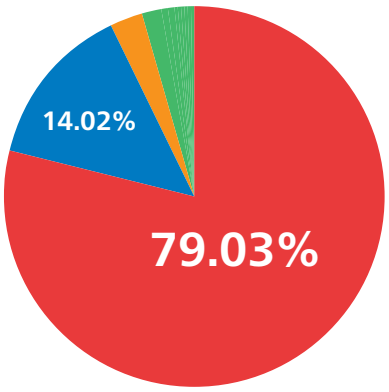
Barry Rigg
Head of Patient Experience

Outpatient Attendance

Attendance by Sex:

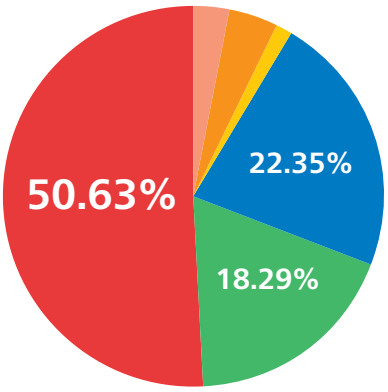


Attendance by Ethnicity:



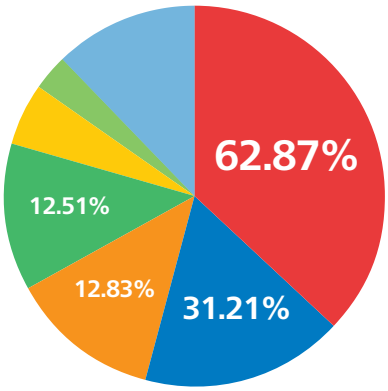
- White - British **79.03%**
- Not Stated **14.02%**
- Not Known **2.59%**
- White - Any other White background **1.63%**
- Not Recorded **0.68%**
- Any Other Ethnic Group **0.46%**
- White - Irish **0.36%**
- Asian or Asian British - Indian **6.17%**
- Asian or Asian British - Any other Asian background **4.57%**
- Other Ethnic Group - Chinese **0.11%**
- Mixed - Any other background **0.12%**
- Asian or Asian British - Pakistani **0.10%**
- Black or Black British - African **0.10%**
- Mixed - White and Asian **0.10%**
- Black or Black British - Any other Black background **0.06%**
- Mixed White and Black Caribbean **0.05%**
- Black or Black British - Caribbean **0.05%**
- Asian or Asian British - Bangladeshi **0.05%**
- Mixed - White and Black African **0.04%**

Attendance by Age:



- Age 0-5 **3.13%**
- Age 6-15 **4.20%**
- Age 16-18 **1.40%**
- Age 19-45 **22.35%**
- Age 46-60 **18.29%**
- Age 60+ **50.63%**

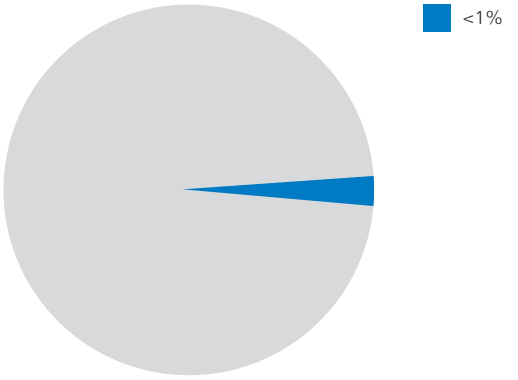
Attendance by Religion or no Religion:



- Church of England **62.87%**
- Not Specified **32.21%**
- Not Recorded **12.83%**
- Declined to give **12.51%**
- Roman Catholic Church **5.43%**
- Not Religious **3.04%**
- Atheist **2.55%**
- Christian **2.32%**
- Methodism **1.78%**
- Christian (non-Catholic, non-specific **1.30%**
- Roman Catholic **0.74%**
- Not given - patient refused **0.48%**
- Nonconformist **0.35%**
- Not Known **0.27%**
- Muslim **0.22%**
- Baptist **0.19%**
- Islam **0.16%**
- Jehovah's Witnesses **0.15%**
- Anglican **0.14%**
- Church of Scotland **0.14%**
- Patient religion unknown **0.08%**
- Methodist **0.11%**
- Quaker **0.07%**
- Agnosticism **0.07%**
- Buddhist **0.06%**
- Zen Buddhism **0.05%**
- Protestant **0.05%**
- Reformed/ Presbyterian **0.05%**

A small number of patients recorded their religion as one of the following:
Catholic: non Roman Catholic, Hinduism, Spiritualism, Christadelphian, Jehovah's Witness, Hindu, United Reform, United Reformed Church, Judaism, Greek Orthodox, Spiritualist, Pentecostal, Chinese Evangelical Christian, Jewish, Church of Ireland, Advaitin Hindu, Latter Day Saints, Humanism, Unitarian, Presbyterian, Agnostic, Radha Soami, Sikhism, Ismaili Muslim, Pagan, Church in Wales, Congregationalist, Salvation Army Member, Orthodox, Free Church, Orthodox Christian, Humanist, Paganism, Ashkenazi Jew, Free Methodist, Evangelical Christian, Mormon, Lutheran, Russian orthodox, non-Roman Catholic, Christian, Spiritualist, Infinite way, Wiccan, Unitarian-Universalism, Ahmadi, Adventist, Mennonite, Taoist, Romanian Orthodox, Eastern Catholic, Meditation, Native American religion, Scientology, Calvinist, Celtic Orthodox Christian, Pantheist, Sikh, Deist, Lightworker, Nazarene Church, Wicca, Heathen, Babi & Bahal Faiths, Animism, Baha'i, Pentecostalist, African Religions, Anabaptist, Church of Wales, Jain, Brethren, Free Christian Church, Plymouth Brethren, Reformed Protestant, Has religious belief.

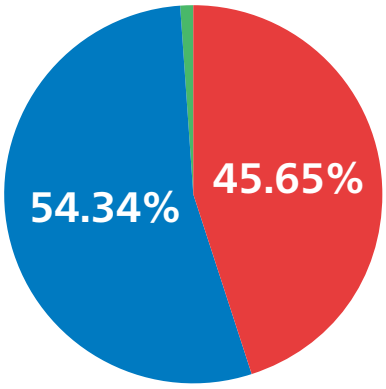
Attendance by Disability:



<1% of our patients declared a disability on their patient record.

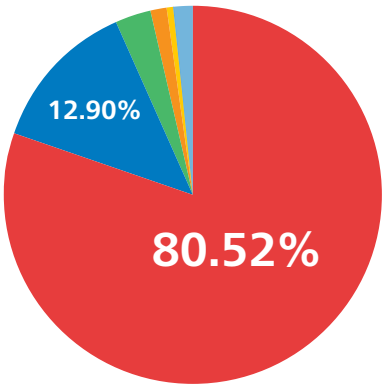
Inpatient Spells

Spells by Sex:



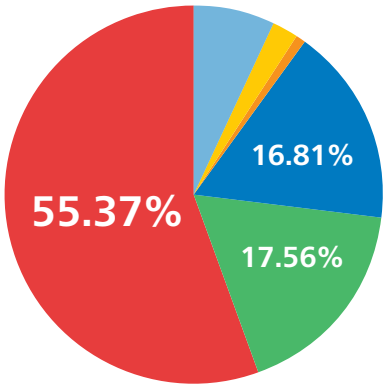
- Female **54.345%**
- Male **45.651%**
- Other **0.004%**

Spells by Ethnicity:



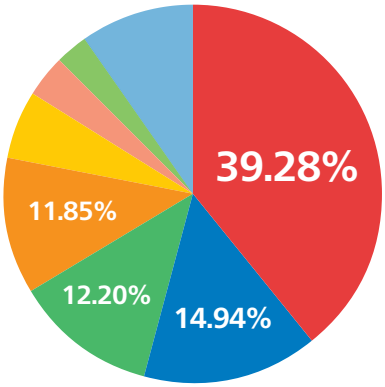
- White - British **80.52%**
- Not Stated **12.90%**
- Not Known **3.11%**
- White - Any other White background **1.44%**
- Any Other Ethnic Group **0.47%**
- White - Irish **0.36%**
- Asian or Asian British - Indian **0.20%**
- Asian or Asian British - Any other Asian background **0.15%**
- Not Recorded **0.14%**
- Mixed - Any other background **0.12%**
- Black or Black British - African **0.11%**
- Mixed - White and Asian **0.09%**
- Other Ethnic Group - Chinese **0.09%**
- Black or Black British - Any other Black background **0.09%**
- Asian or Asian British - Pakistani **0.06%**
- Asian or Asian British - Bangladeshi **0.04%**
- Mixed - White and Black Caribbean **0.04%**
- Mixed - White and Black African **0.03%**
- Black or Black British - Caribbean **0.03%**

Spells by Age:



- Age 0-5 **7.19%**
- Age 6-15 **2.13%**
- Age 16-18 **0.94%**
- Age 19-45 **16.81%**
- Age 46-60 **17.56%**
- Age 60+ **55.37%**

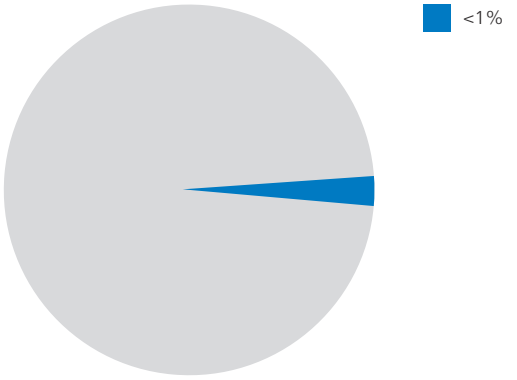
Attendance / Consultation by Religion or no Religion:



- Church of England **39.28%**
- Not Specified **14.94%**
- Declined to give **12.20%**
- Not Recorded **11.85%**
- Roman Catholic Church **5.86%**
- Not Religious **3.64%**
- Christian **2.56%**
- Atheist **2.50%**
- Methodism **1.63%**
- Christian (non-Catholic, non-specific **1.17%**
- Roman Catholic **0.86%**
- Not given - patient refused **0.55%**
- Nonconformist **0.49%**
- Not Known **0.22%**
- Baptist **0.22%**
- Patient religion unknown **0.20%**
- Church of Scotland **0.18%**
- Muslim **0.17%**
- Jehovah's Witnesses **0.16%**
- Islam **0.15%**
- Anglican **0.13%**
- Methodist **0.11%**
- Reformed/ Presbyterian **0.07%**
- Agnosticism **0.06%**
- Catholic: non-Roman Catholic **0.05%**
- Zen Buddhism **0.04%**
- Quaker **0.04%**
- Buddhist **0.04%**

A small number of patients recorded their religion as one of the following: United Reform, Jehovah's Witness, Hindu, Jewish, Spiritualist, Spiritualism, Church of Ireland, Christadelphian, United Reformed Church, Advaitin Hindu, Chinese Evangelical Christian, Congregationalist, Agnostic, Presbyterian, Judaism, Radha Soami, Animism, Ismaili Muslim, Greek Orthodox, Infinite way, Hinduism, Paganism, Orthodox Christian, Pagan, Latter Day Saints, Church in Wales, Unitarian, Free Church, Russian orthodox, non-Roman Catholic, Salvation Army Member, Humanist, Humanism, Unitarian-Universalism, Christian, Spiritualist, Evangelical Christian, Mormon, Pentecostal, Free Christian Church, Orthodox, Sikhism, Eastern Catholic, Wiccan, Mennonite, Babi & Bahal Faiths, Heathen, Native American religion, Celtic Orthodox Christian, Pentecostalist, Calvinist, Lutheran, Pantheist, Ashkenazi Jew, Taoist, Ahmadi, Brethren, African, Religions, Scientology, Adventist, Baha'i, Deist, Free Methodist, Wicca.

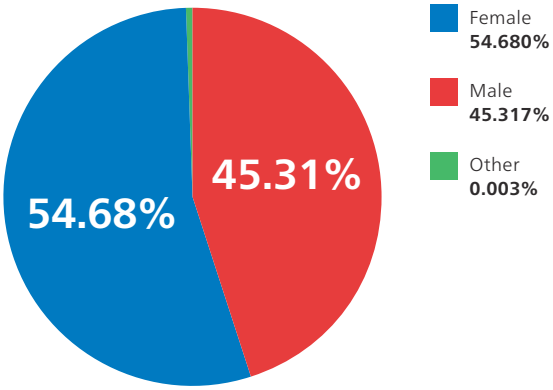
Attendance / Consultation by Disability:



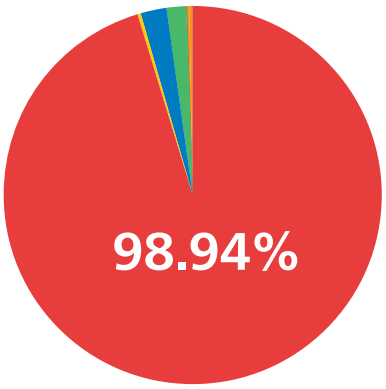
<1% of our patients declared a disability on their patient record.

Community Consultations

Consultations By Sex:

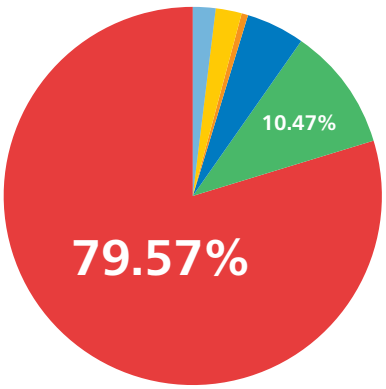


Consultations by Ethnicity:



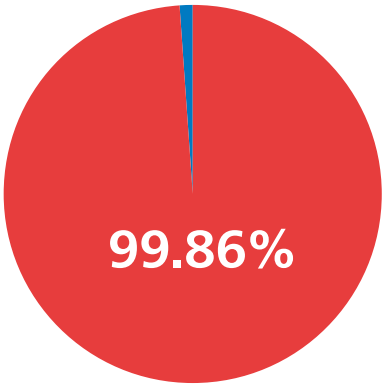
- Not Known **98.94%**
- British **0.54%**
- Not Stated **0.37%**
- Pakistani **0.05%**
- Indian **0.03%**
- Any other ethnic group **0.03%**
- Any other White background **0.02%**
- Any other Mixed background **0.01%**
- Polish - ethnic category 2001 census **0.01%**
- Chinese **0.001%**
- African **0.001%**
- White and Black Caribbean **0.001%**
- Any other Asian background **0.001%**
- Bangladeshi **0.001%**
- White and Asian **0.001%**
- Caribbean **0.001%**
- Other Asian or Asian unspecified ethnic category 2001 census **0.001%**
- Other mixed White - ethnic category 2001 census **0.001%**
- White and Black African **0.001%**
- White and Black Caribbean **0.001%**

Consultations by Age:



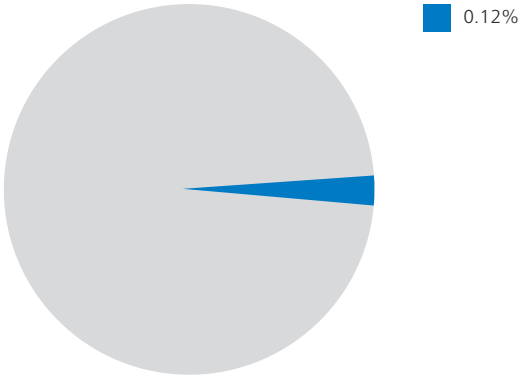
- Age 0-5 **2.14%**
- Age 6-15 **2.23%**
- Age 16-18 **0.57%**
- Age 19-45 **5.01%**
- Age 46-60 **10.47%**
- Age 60+ **79.57%**

Consultation by Religion:



- Unknown **99.86%**
- Church of England **0.40%**
- Christian **0.26%**
- Religion, None **0.23%**
- Methodist **0.05%**
- Religion **0.05%**
- Religion, Other **0.03%**
- Roman Catholic **0.02%**
- Jehovah's Witness **0.02%**
- Religion not recorded **0.01%**
- Atheist **0.01%**
- Salvation Army **0.001%**
- Salvation Army **0.001%**
- Babis Religion **0.001%**
- United Reform Church **0.001%**
- Religion not given - patient refused **0.001%**

Consultation by Disability:



Conclusion

In the past year we have made significant progress with our equality and inclusion, i.e. project and business decisions are made having considered the needs of different groups of people. We not only consider the nine protected characteristics, we also pay attention to other issues such as poverty or low income, transport, homelessness, the needs of veterans, carers and many other considerations that may impact the health needs of people.

We have also made good progress in ensuring that our services and information about our services are accessible to all people to enable equitable healthcare. Examples include our Passport and sunflower schemes, and the availability of a self-care leaflets. Equality is ensuring that we take account of the differences between people and how these affect their journey through healthcare systems. We want patients to experience the best possible care, irrespective of their personal circumstances. We are confident that our new trust vision, values, objectives and Strategy will enable us to accelerate service improvement through joined-up working that is informed by people's needs.

If you require this information in an alternative format or language or wish to discuss the content of this report in further detail please contact the Patient Experience team:

patientexperience@mbht.nhs.uk

telephone: 01229 404434

www.uhmb.nhs.uk/get-involved/patient-experience

We are UHMBT

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

NHS
University Hospitals of Morecambe Bay
NHS Foundation Trust

Workforce Monitoring

2021-2022

1. Introduction

As part of our annual reporting each year, we are required to publish data outlining the demographics of our workforce at UHMBT. Our understanding of who are colleagues are is important so that we can seek to further understand the experience of different groups of colleagues and identify areas where we can improve colleague experience.

A high-level summary is outlined in this report which will be followed by the full report, providing an overview for the organisation and a breakdown by Care Group based on colleagues who have joined us, remained with us, and left us during 2021/2022.

You can find more information, including metrics specific to colleague experience, in our other annual reports which are published each year on our website.

- Workforce Disability Equality Standard
- Workforce Race Equality Standard
- Workforce Sexual Orientation Equality Standard
- Gender Pay Gap

2. High level summary

2.1 Age

LARGEST AGE GROUP	
TRUST OVERALL	51-55
Community Services	51-55
Core Clinical Services	36-40
Corporate Services	51-55
Estates & Facilities	55-60
Medicine	31-35
Surgery & Critical Care	51-55
Women's and Children's	51-55

2.2 Disability

% DECLARED DISABILITY	
TRUST OVERALL	3.56%
Community Services	2.30%
Core Clinical Services	4.95%
Corporate Services	5.16%
Estates & Facilities	3.50%
Medicine	3.26%
Surgery & Critical Care	2.90%
Women's and Children's	3.06%

2.3 Ethnicity

% WHITE*	
TRUST OVERALL	81.44%
Community Services	77.00%
Core Clinical Services	88.08%
Corporate Services	88.86%
Estates & Facilities	94.07%
Medicine	76.19%
Surgery & Critical Care	74.22%
Women's and Children's	83.18%

** data presented based on majority group*

2.4 Religion

% CHRISTIANITY*	
TRUST OVERALL	45.42%
Community Services	43.70%
Core Clinical Services	44.27%
Corporate Services	41.97%
Estates & Facilities	43.77%
Medicine	48.46%
Surgery & Critical Care	45.95%
Women's and Children's	46.79%

** data presented based on majority group*

2.5 Marital Status

% MARRIED/CIVIL PARTNER	
TRUST OVERALL	52.49%
Community Services	57.26%
Core Clinical Services	52.61%
Corporate Services	50.06%
Estates & Facilities	52.13%
Medicine	47.73%
Surgery & Critical Care	52.97%
Women's and Children's	60.70%

2.6 Maternity

% ON MATERNITY LEAVE	
TRUST OVERALL	2.48%
Community Services	2.91%
Core Clinical Services	3.21%
Corporate Services	1.88%
Estates & Facilities	0.91%
Medicine	2.66%
Surgery & Critical Care	1.89%
Women's and Children's	3.98%

2.7 Sexual Orientation

% LGB+	
TRUST OVERALL	2.12%
Community Services	0.61%
Core Clinical Services	2.57%
Corporate Services	3.63%
Estates & Facilities	1.52%
Medicine	2.42%
Surgery & Critical Care	2.16%
Women's and Children's	1.07%

2.8 Gender

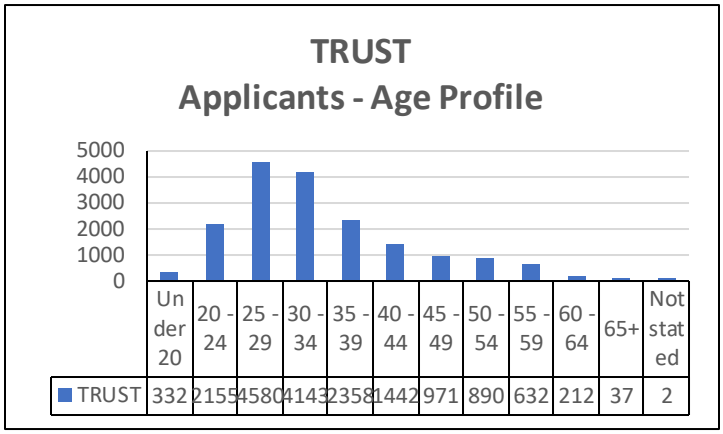
% FEMALE*	
TRUST OVERALL	80.01%
Community Services	93.10%
Core Clinical Services	81.67%
Corporate Services	70.57%
Estates & Facilities	57.45%
Medicine	81.33%
Surgery & Critical Care	79.15%
Women's and Children's	94.34%

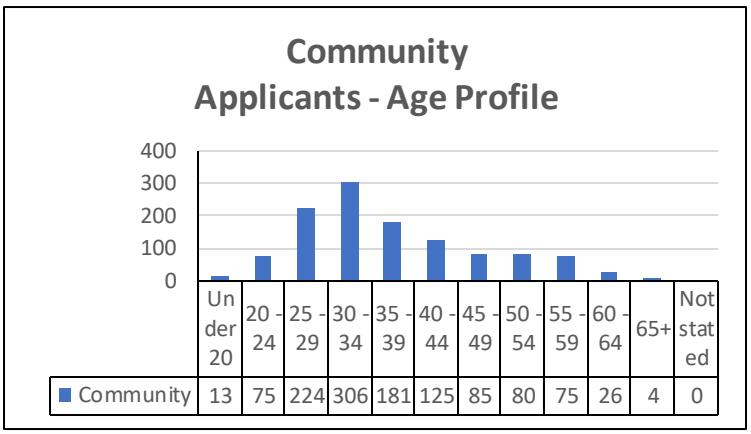
** data presented based on majority group*

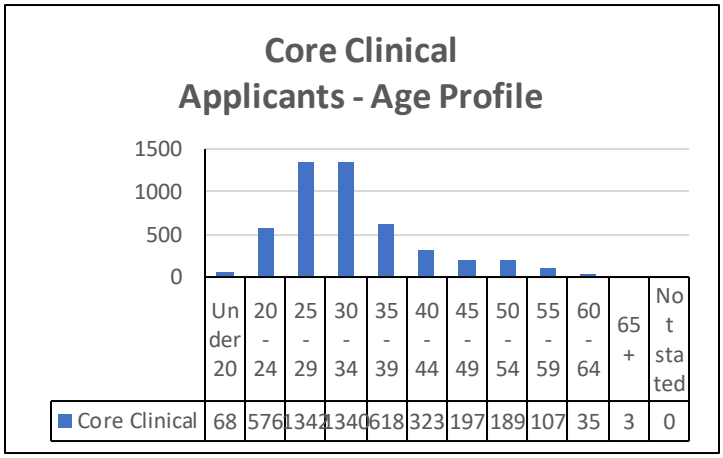
3. Applicants

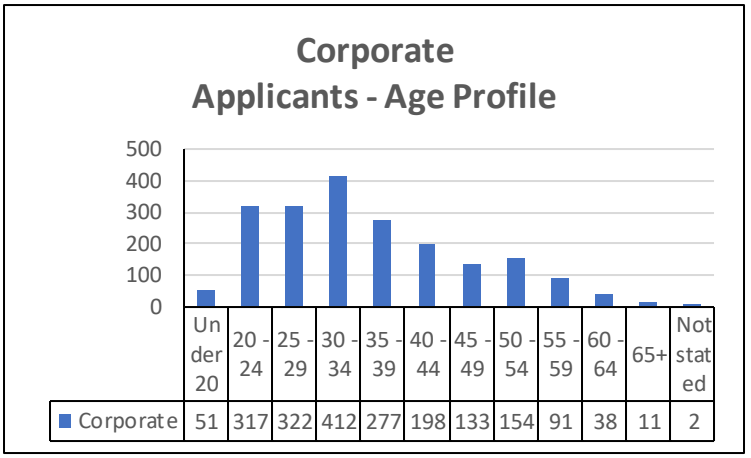
The figures presented here show applicants for roles within University Hospitals of Morecambe Bay NHS Foundation Trust during the financial year 2021/22. The figures are categorised according to the organisation as a whole and care groups within the Trust. Bank applicants are included.

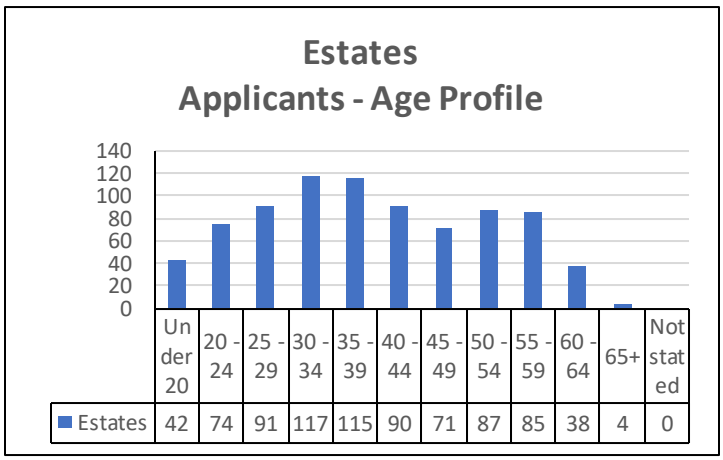
3.1 Age

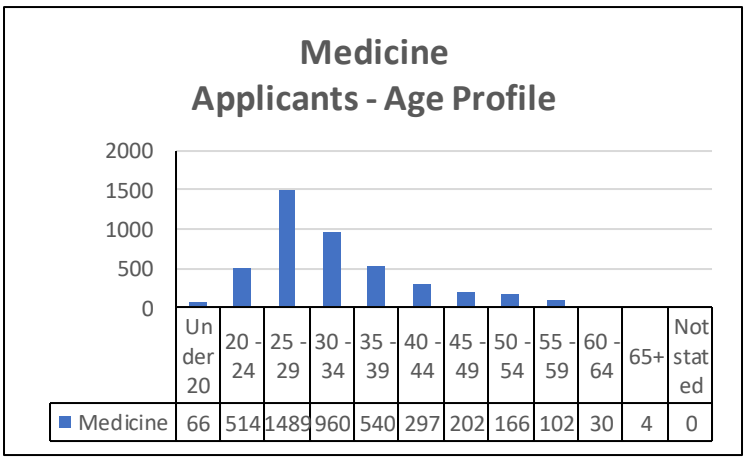


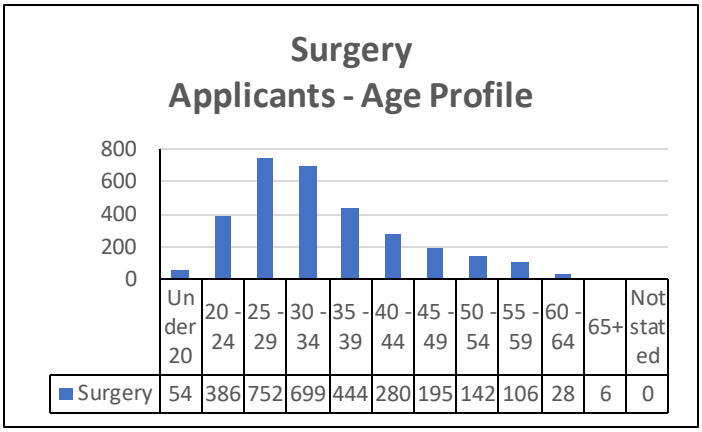


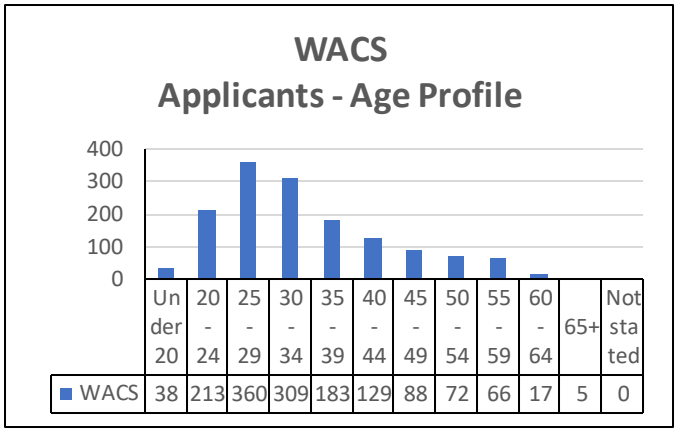




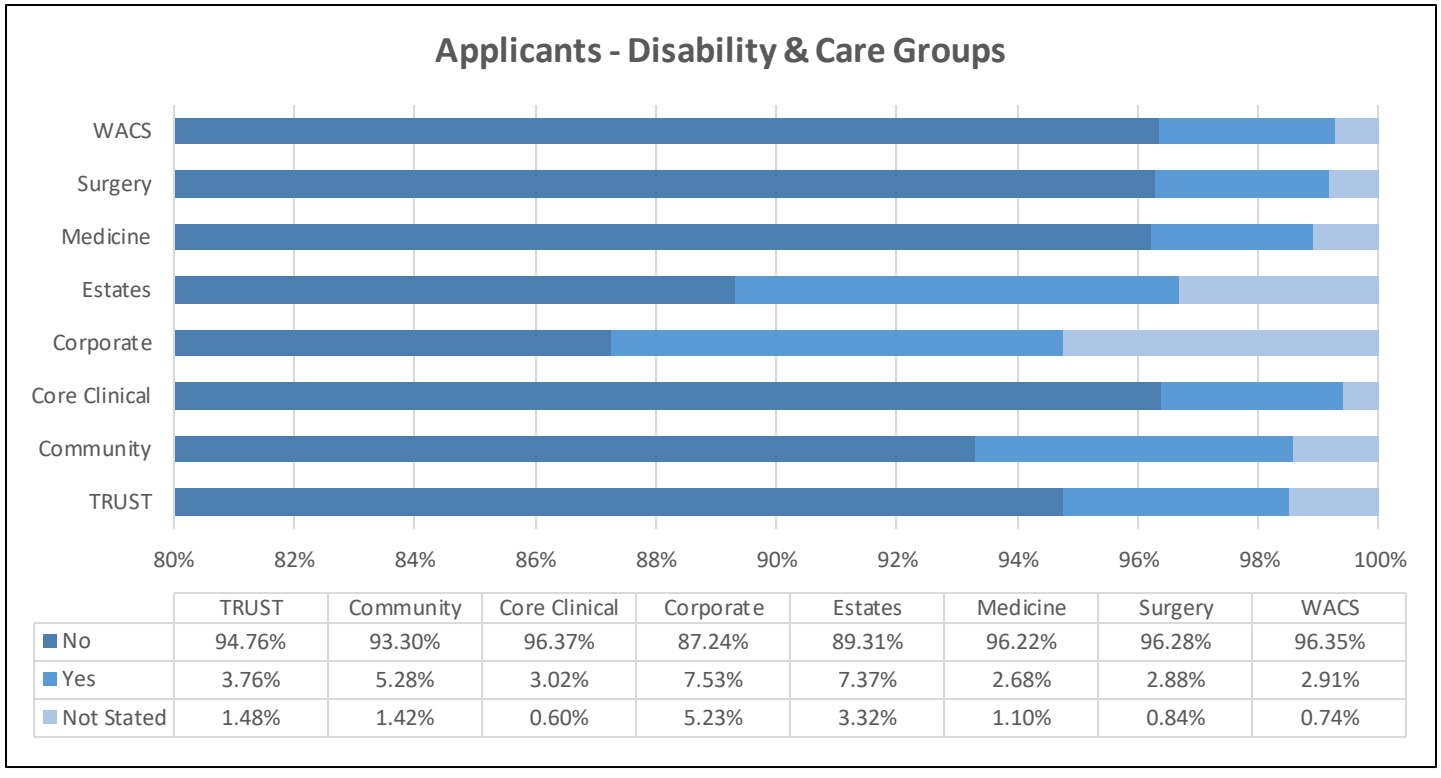






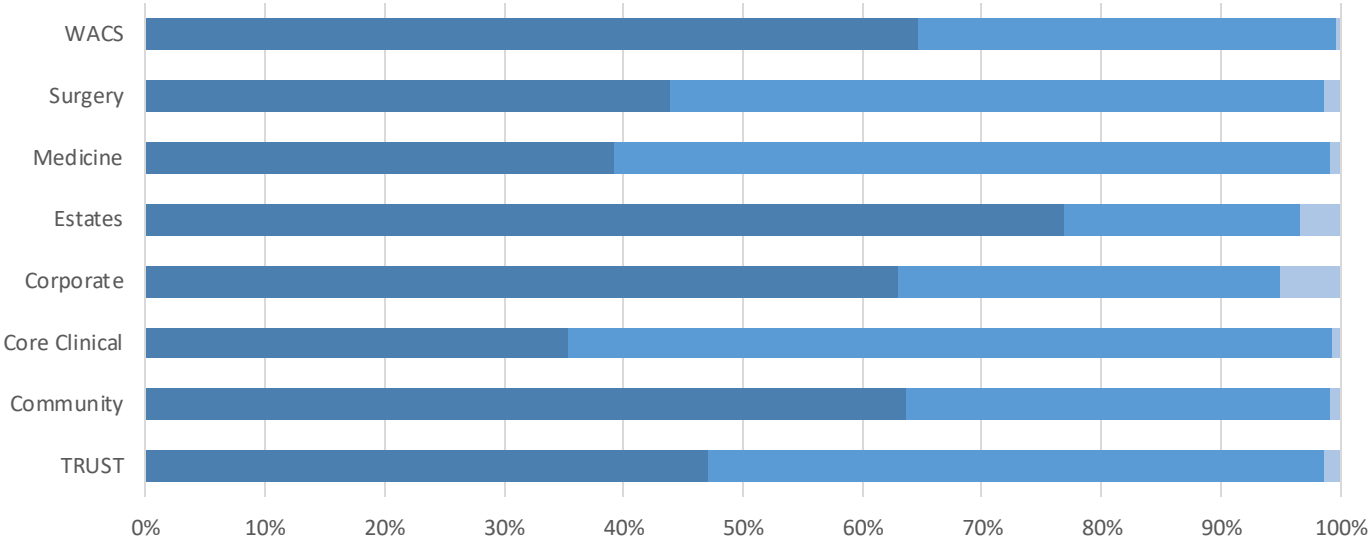


3.2 Disability



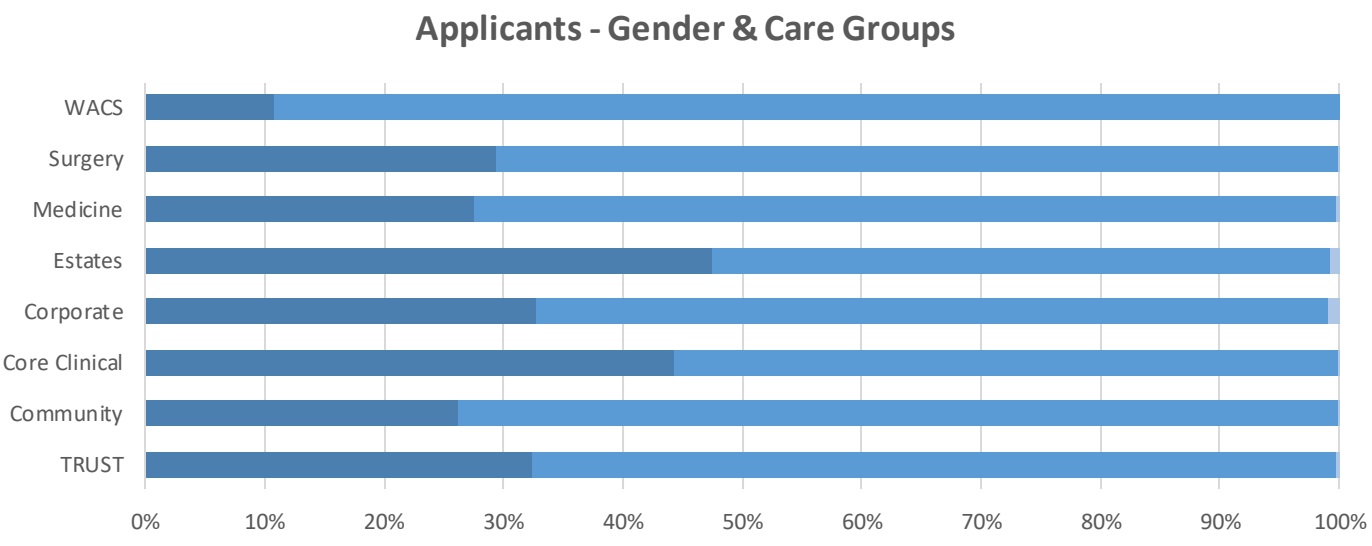
	TRUST	Community	Core Clinical	Corporate	Estates	Medicine	Surgery	WACS
No	94.76%	93.30%	96.37%	87.24%	89.31%	96.22%	96.28%	96.35%
Yes	3.76%	5.28%	3.02%	7.53%	7.37%	2.68%	2.88%	2.91%
Not Stated	1.48%	1.42%	0.60%	5.23%	3.32%	1.10%	0.84%	0.74%

3.3 Ethnic origin



	TRUST	Community	Core Clinical	Corporate	Estates	Medicine	Surgery	WACS
White	47.14%	63.65%	35.35%	63.01%	76.90%	39.18%	43.82%	64.59%
BME	51.43%	35.51%	64.05%	31.90%	19.78%	59.95%	54.79%	35.07%
Not Stated	1.43%	0.84%	0.60%	5.08%	3.32%	0.87%	1.39%	0.34%

3.4 Gender

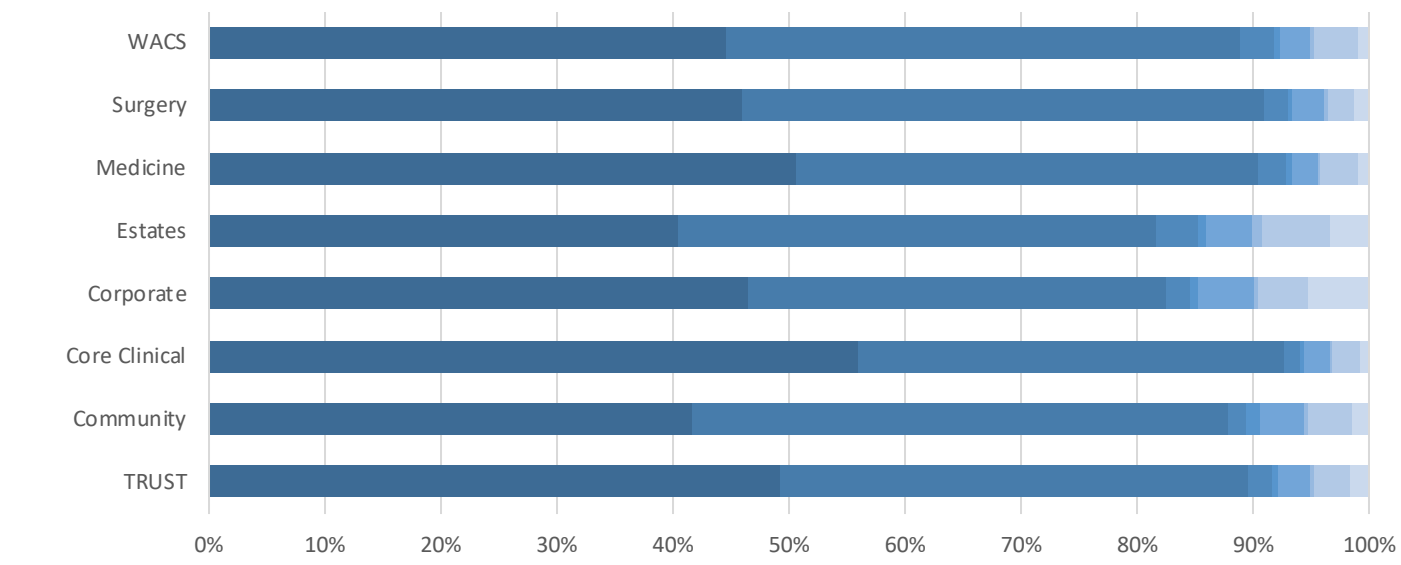


	TRUST	Community	Core Clinical	Corporate	Estates	Medicine	Surgery	WACS
Male	32.42%	26.13%	44.33%	32.70%	47.54%	27.60%	29.37%	10.74%
Female	67.34%	73.70%	55.61%	66.35%	51.72%	72.17%	70.54%	89.26%
Not Stated	0.24%	0.17%	0.06%	0.95%	0.74%	0.23%	0.10%	0.00%

3.5 Gender identity

Information on gender identity is not currently collected.

3.6 Marital status

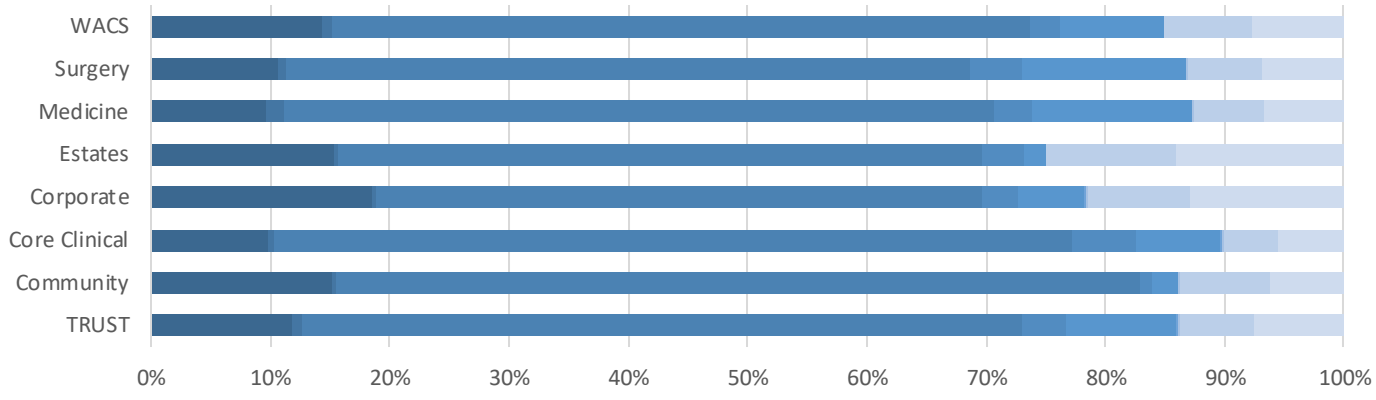


	TRUST	Community	Core Clinical	Corporate	Estates	Medicine	Surgery	WACS
Single	49.22%	41.62%	55.96%	46.51%	40.42%	50.62%	46.02%	44.59%
Married	40.40%	46.23%	36.87%	36.14%	41.28%	39.86%	45.02%	44.39%
Civil partnership	2.06%	1.68%	1.33%	2.04%	3.56%	2.43%	2.07%	2.84%
Legally separated	0.50%	1.09%	0.35%	0.55%	0.74%	0.57%	0.26%	0.61%
Divorced	2.81%	3.77%	2.15%	4.89%	3.93%	2.13%	2.85%	2.64%
Widowed	0.34%	0.42%	0.27%	0.40%	0.98%	0.32%	0.29%	0.27%
Other	3.13%	3.77%	2.38%	4.29%	5.77%	3.14%	2.26%	3.85%
Not Stated	1.53%	1.42%	0.69%	5.18%	3.32%	0.94%	1.23%	0.81%

3.7 Maternity

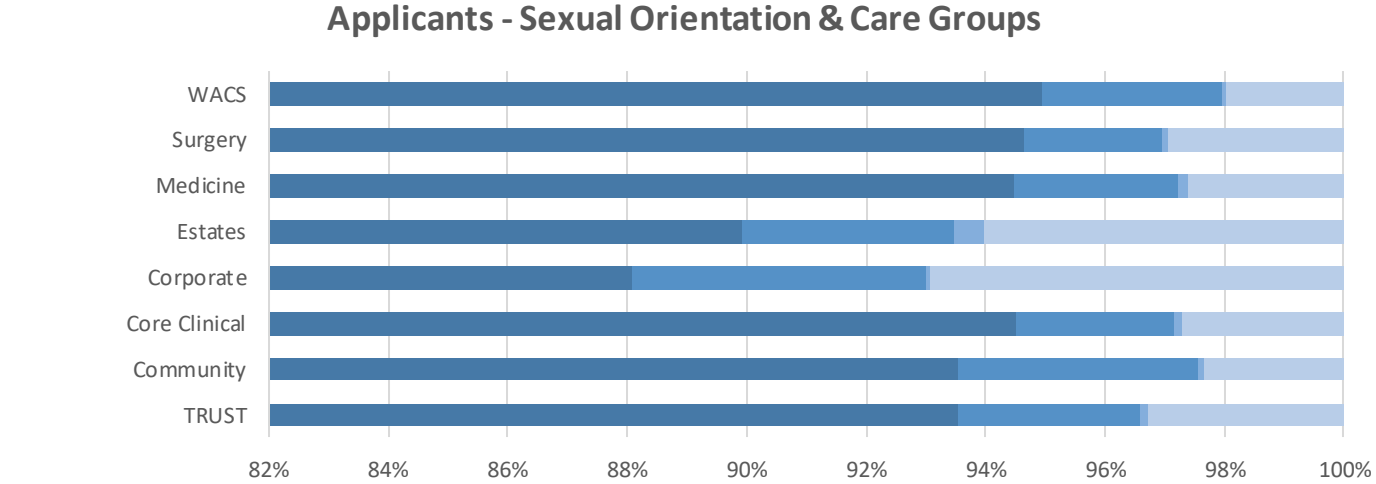
Information on gender identity is not currently collected.

3.8 Religion/belief



	TRUST	Community	Core Clinical	Corporate	Estates	Medicine	Surgery	WACS
Atheism	11.86%	15.08%	9.84%	18.54%	15.36%	9.54%	10.61%	14.26%
Buddhism	0.77%	0.42%	0.42%	0.35%	0.37%	1.56%	0.68%	0.81%
Christianity	60.38%	67.42%	67.03%	50.75%	53.93%	59.50%	57.37%	58.65%
Hinduism	3.75%	1.01%	5.29%	3.09%	3.56%	3.20%	4.30%	2.43%
Islam	9.20%	2.09%	7.09%	5.53%	1.84%	13.46%	13.75%	8.78%
Jainism	0.05%	0.08%	0.06%	0.05%	0.00%	0.05%	0.03%	0.07%
Judaism	0.03%	0.00%	0.02%	0.10%	0.00%	0.02%	0.03%	0.00%
Sikhism	0.15%	0.08%	0.23%	0.20%	0.00%	0.14%	0.13%	0.00%
Other	6.30%	7.62%	4.50%	8.42%	10.93%	5.84%	6.18%	7.30%
Not Stated	7.51%	6.20%	5.52%	12.96%	14.00%	6.70%	6.92%	7.70%

3.9 Sexual orientation

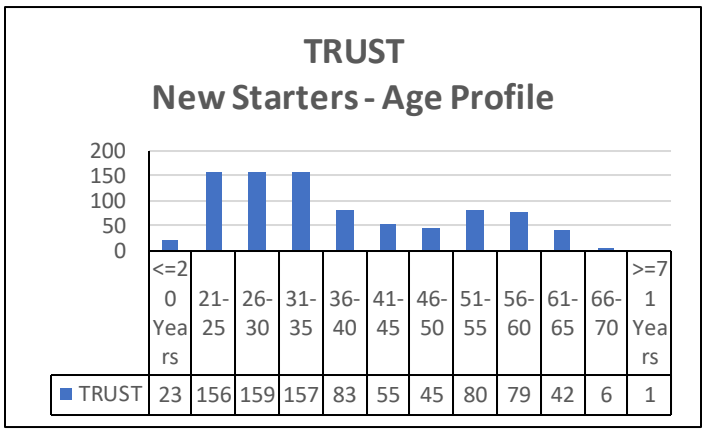


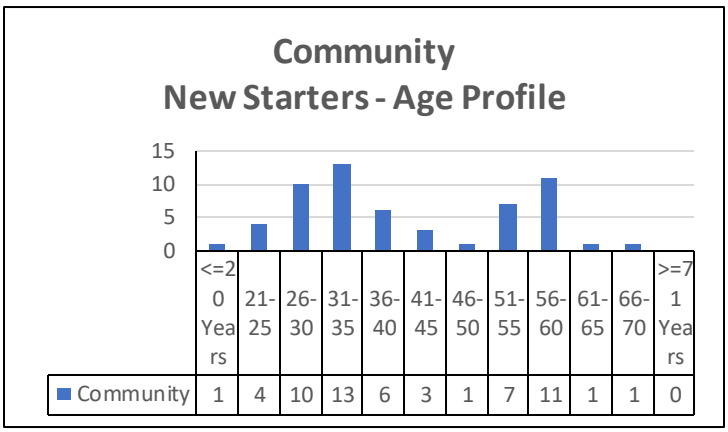
	TRUST	Community	Core Clinical	Corporate	Estates	Medicine	Surgery	WACS
Heterosexual or Straight	93.55%	93.55%	94.50%	88.09%	89.93%	94.46%	94.63%	94.93%
LBGT	3.05%	4.02%	2.67%	4.94%	3.56%	2.75%	2.33%	3.04%
Undecided	0.14%	0.08%	0.13%	0.05%	0.49%	0.18%	0.10%	0.07%
Not Stated	3.27%	2.35%	2.71%	6.93%	6.02%	2.61%	2.94%	1.96%

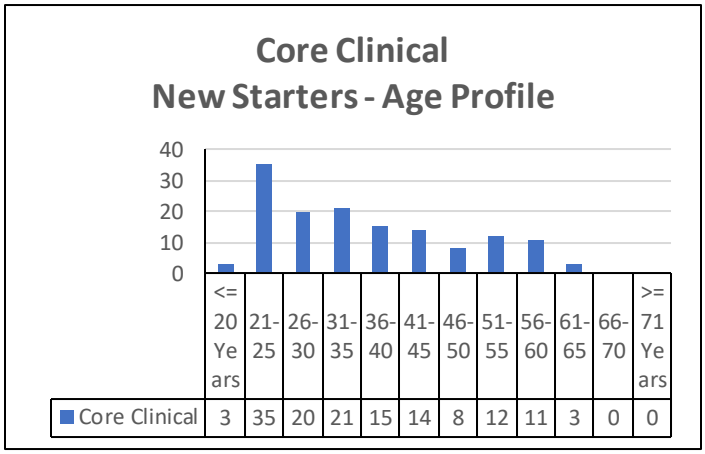
4. New starters

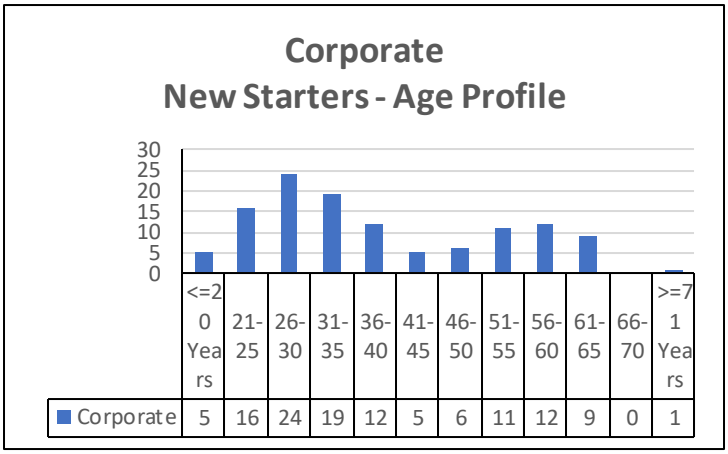
The figures presented here show the number of new starters with University Hospitals of Morecambe Bay NHS Foundation Trust during the financial year 2021/22. The figures are categorised according to the organisation as a whole and care groups within the Trust.

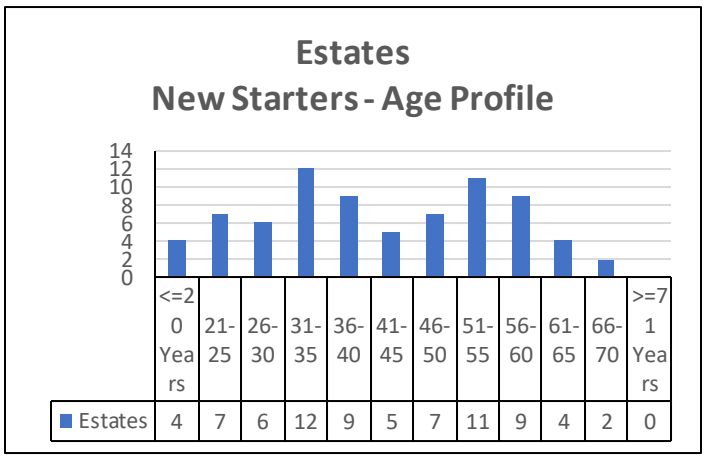
4.1 Age

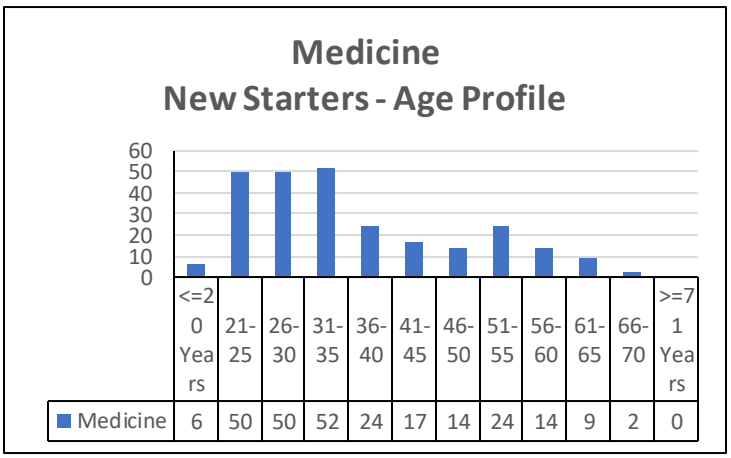


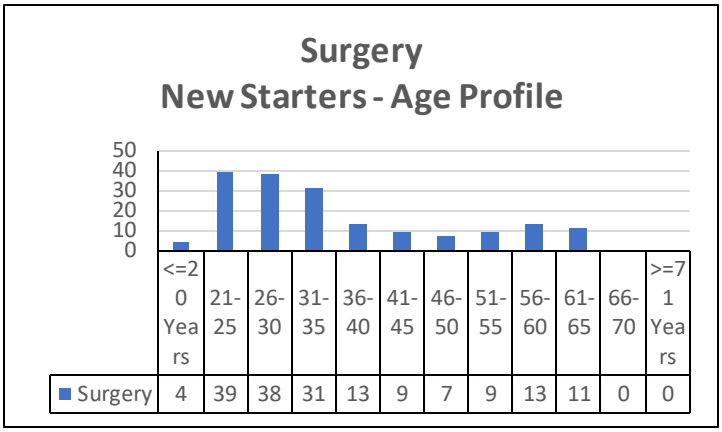


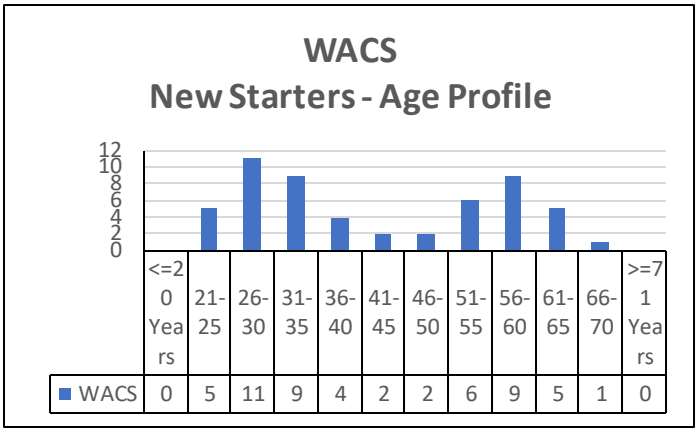




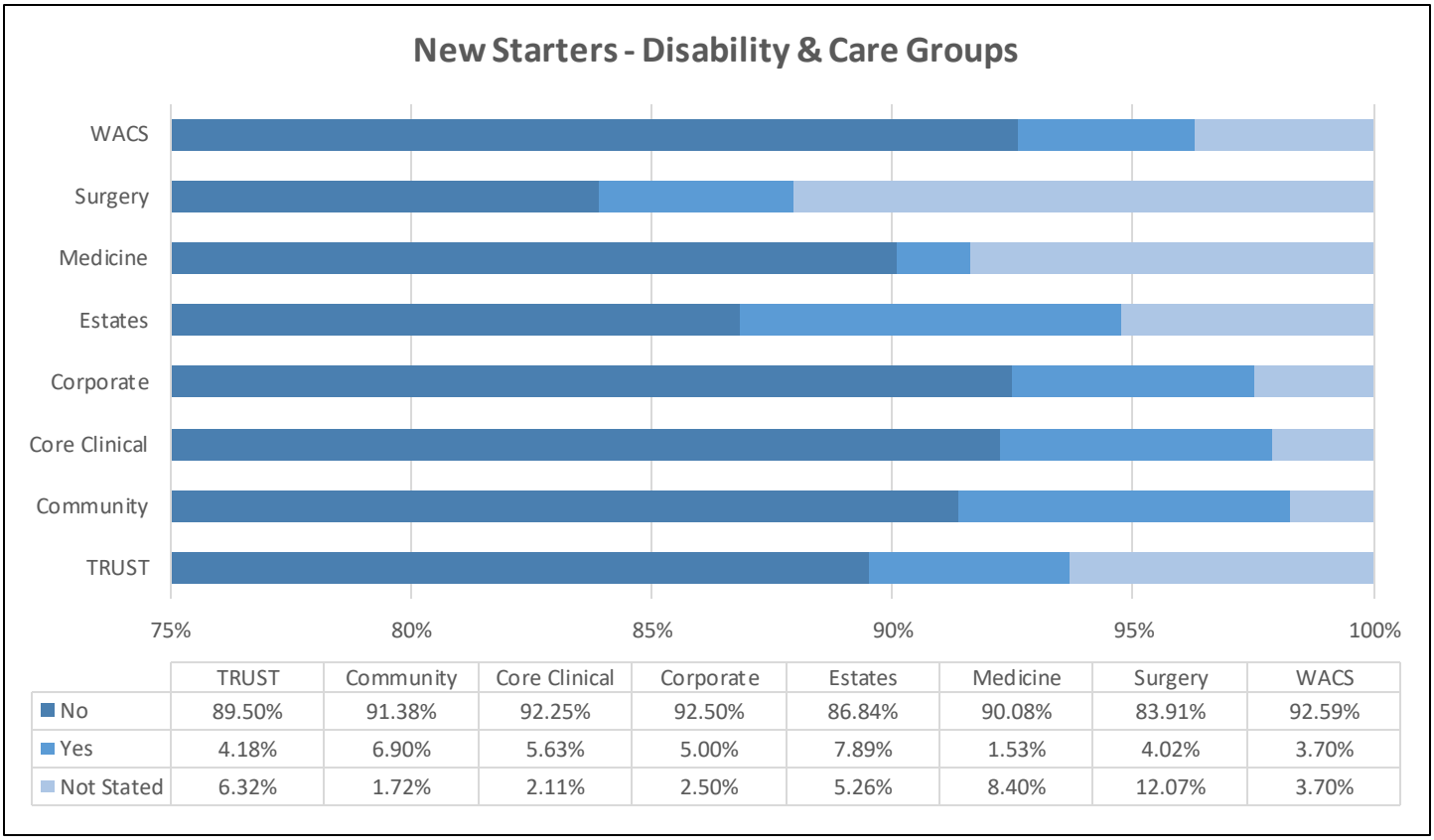








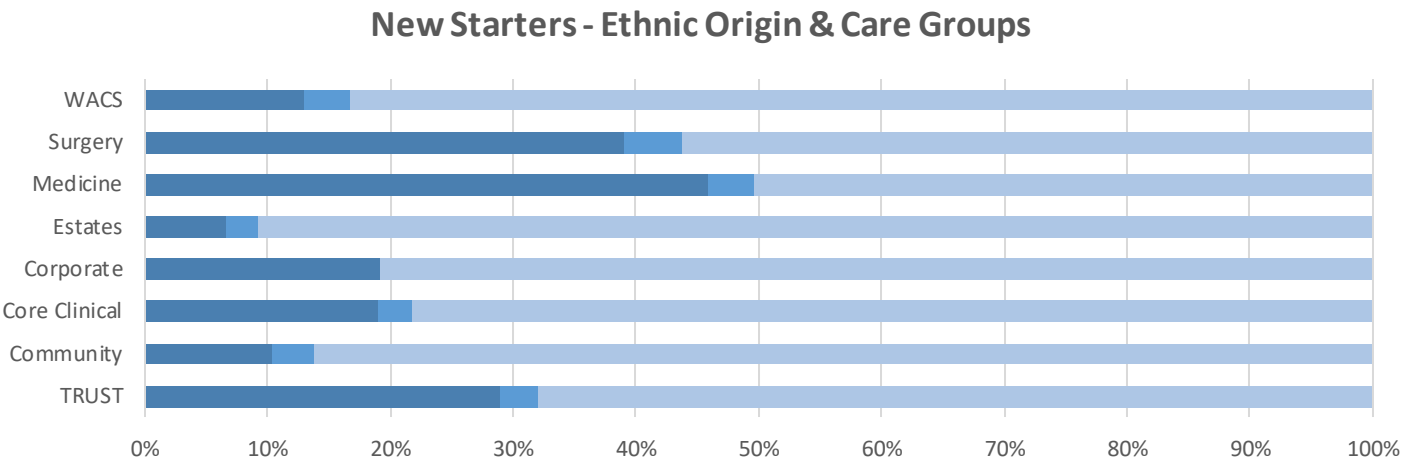
4.2 Disability



	TRUST	Community	Core Clinical	Corporate	Estates	Medicine	Surgery	WACS
No	89.50%	91.38%	92.25%	92.50%	86.84%	90.08%	83.91%	92.59%
Yes	4.18%	6.90%	5.63%	5.00%	7.89%	1.53%	4.02%	3.70%
Not Stated	6.32%	1.72%	2.11%	2.50%	5.26%	8.40%	12.07%	3.70%

Overall 4.18% of new starters considered themselves to have a disability. 6.32%chose not to disclose this information

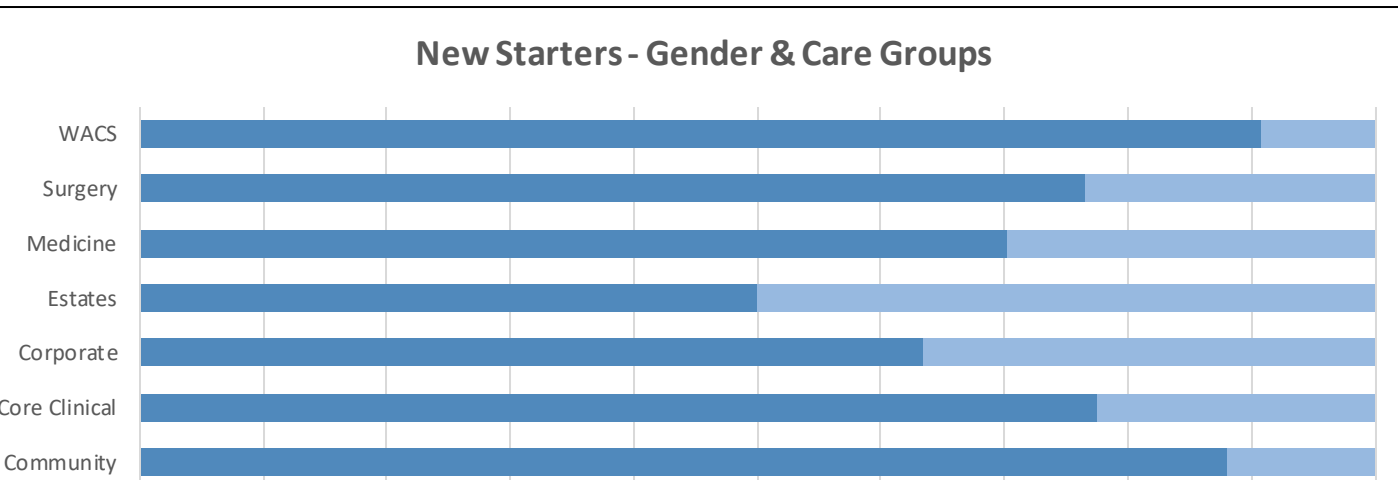
4.3 Ethnic origin



	TRUST	Community	Core Clinical	Corporate	Estates	Medicine	Surgery	WACS
BME	28.89%	10.34%	19.01%	19.17%	6.58%	45.80%	39.08%	12.96%
Not Stated	3.16%	3.45%	2.82%	0.00%	2.63%	3.82%	4.60%	3.70%
White	67.95%	86.21%	78.17%	80.83%	90.79%	50.38%	56.32%	83.33%

Overall 67.95% of new starters described their ethnic origin as “White” whilst 28.89% described themselves as belonging to a Black, Minority or Other Ethnic group. 3.16% preferred not to state their ethnic origin. Medicine (45.8%) had the largest proportion of BME new staff members.

4.4 Gender



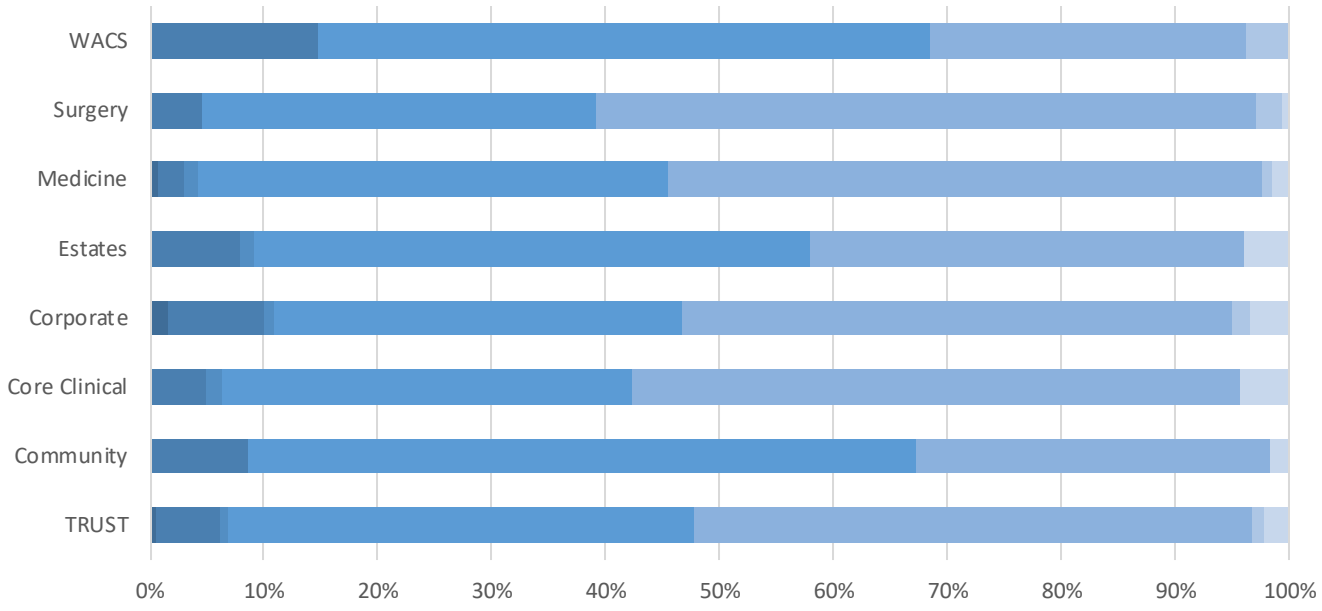
	TRUST	Community	Core Clinical	Corporate	Estates	Medicine	Surgery	WACS
Female	72.35%	87.93%	77.46%	63.33%	50.00%	70.23%	76.44%	90.74%
Male	27.65%	12.07%	22.54%	36.67%	50.00%	29.77%	23.56%	9.26%

Overall, 72.35% of new starters were female whilst 27.65% were male. The care group with the most equal male/female ratio was Estates with 50% male and 50% female. In the Women and Children's care group only 9.26% of new starters were male.

4.5 Gender identity

Information on gender identity is not currently collected.

4.6 Marital status



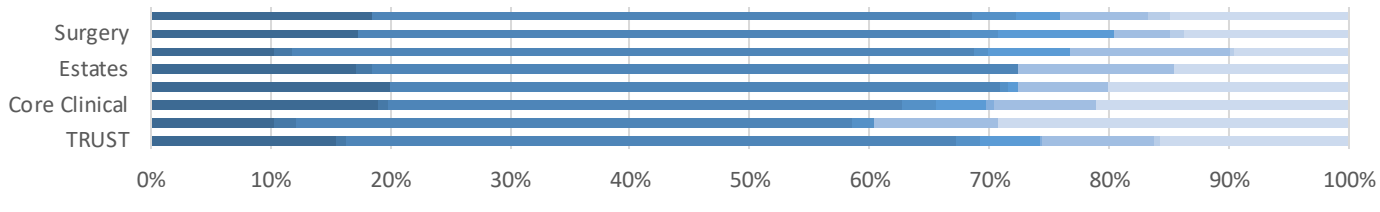
	TRUST	Community	Core Clinical	Corporate	Estates	Medicine	Surgery	WACS
Civil Partnership	0.45%	0.00%	0.00%	1.67%	0.00%	0.76%	0.00%	0.00%
Divorced	5.64%	8.62%	4.93%	8.33%	7.89%	2.29%	4.60%	14.81%
Legally Separated	0.79%	0.00%	1.41%	0.83%	1.32%	1.15%	0.00%	0.00%
Married	40.86%	58.62%	35.92%	35.83%	48.68%	41.22%	34.48%	53.70%
Single	48.98%	31.03%	53.52%	48.33%	38.16%	52.29%	58.05%	27.78%
Widowed	1.13%	0.00%	0.00%	1.67%	0.00%	0.76%	2.30%	3.70%
Not Stated	2.14%	1.72%	4.23%	3.33%	3.95%	1.53%	0.57%	0.00%

Overall, 41.31% of new starters described themselves as either married or in a civil partnership. The largest individual group amongst new starters was single which accounted for 48.98% of all new starters

4.7 Maternity

Information on Maternity is not currently collected, however new starters would not normally be on maternity leave upon commencement of post.

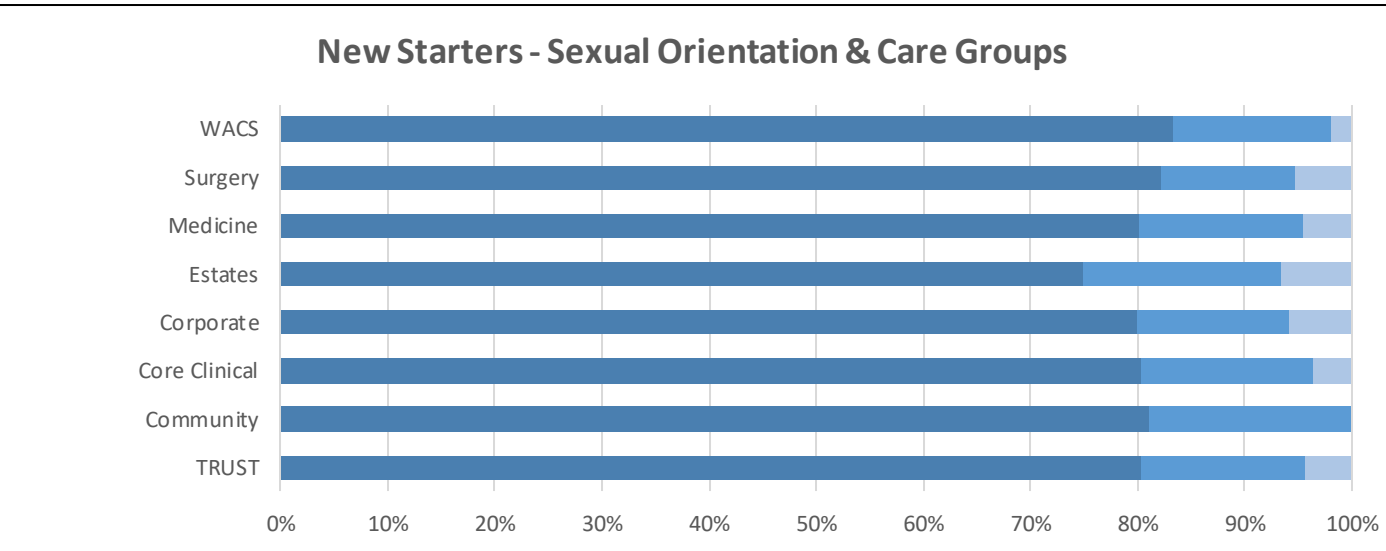
4.8 Religion/belief



	TRUST	Community	Core Clinical	Corporate	Estates	Medicine	Surgery	WACS
Atheism	15.46%	10.34%	19.01%	20.00%	17.11%	10.31%	17.24%	18.52%
Buddhism	0.79%	1.72%	0.70%	0.00%	1.32%	1.53%	0.00%	0.00%
Christianity	51.02%	46.55%	42.96%	50.83%	53.95%	56.87%	49.43%	50.00%
Hinduism	2.03%	1.72%	2.82%	0.83%	0.00%	1.15%	4.02%	3.70%
Islam	4.97%	0.00%	4.23%	0.83%	0.00%	6.87%	9.77%	3.70%
Judaism	0.11%	0.00%	0.70%	0.00%	0.00%	0.00%	0.00%	0.00%
Other	9.48%	10.34%	8.45%	7.50%	13.16%	13.36%	4.60%	7.41%
Sikhism	0.45%	0.00%	0.00%	0.00%	0.00%	0.38%	1.15%	1.85%
Not Stated	15.69%	29.31%	21.13%	20.00%	14.47%	9.54%	13.79%	14.81%

The most common religion / belief overall was Christianity which accounted for 51.02% of all new starters. The next largest group was Atheism at 15.46%. 9.48% described their religion / belief as 'Other' whilst 15.69% preferred not to disclose their religion / belief.

4.9 Sexual orientation



	TRUST	Community	Core Clinical	Corporate	Estates	Medicine	Surgery	WACS
Heterosexual or Straight	80.36%	81.03%	80.28%	80.00%	75.00%	80.15%	82.18%	83.33%
Not Stated	15.24%	18.97%	16.20%	14.17%	18.42%	15.27%	12.64%	14.81%
LBGT	4.40%	0.00%	3.52%	5.83%	6.58%	4.58%	5.17%	1.85%

Overall 4.4% of new starters described themselves as Lesbian, Gay or Bisexual. 15.24% did not wish to disclose this information.

5. Staff in post

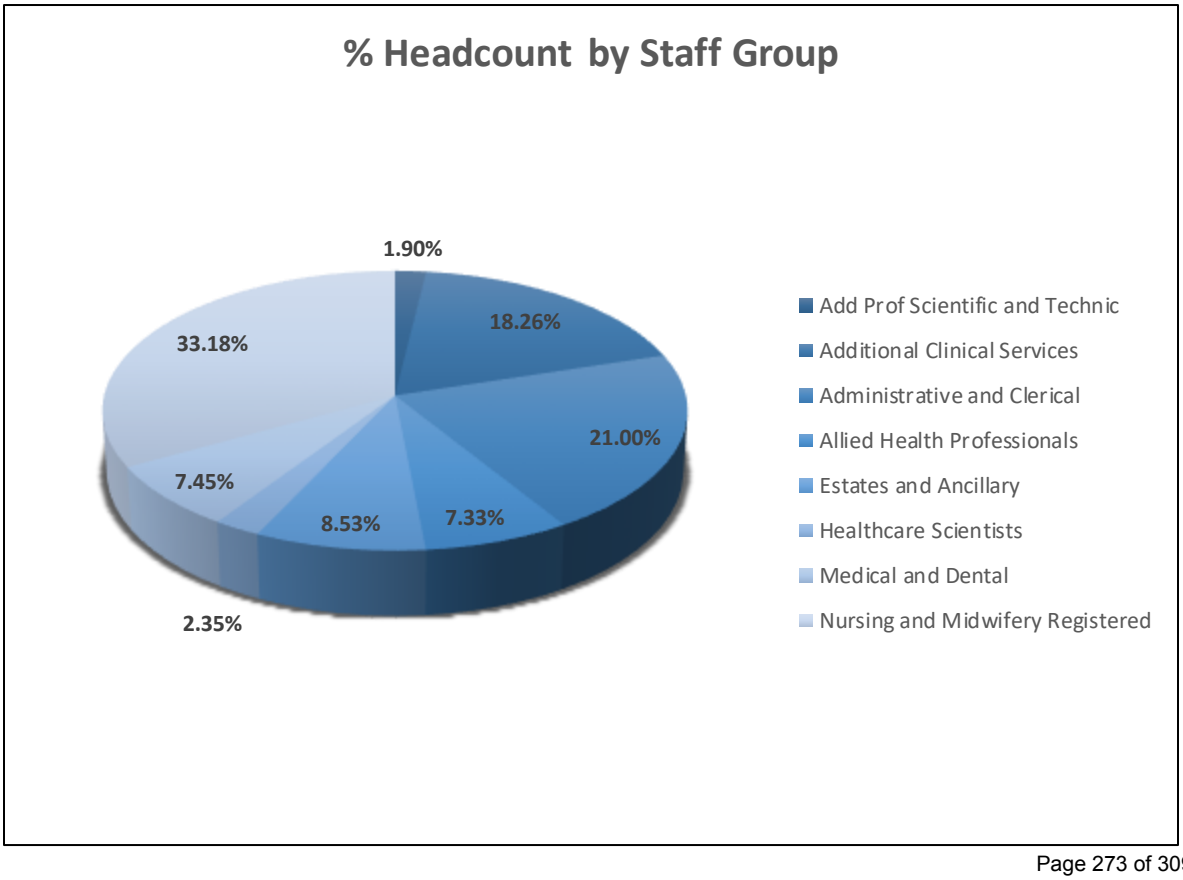
The figures presented here show the staff in post atUniversity Hospitals of Morecambe Bay NHS Foundation Trust as at 31st March 2022.

5.1 Our workforce

5.1.1 Staff groups

The largest group of staff is 'Nursing and Midwifery Registered' which accounts for a third (33.18%) of all employees. 'Administrative and Clerical' is the next largest staff group and accounts for 21.00% of the workforce. 18.26% of the workforce belongs to 'Additional Clinical Services'. These are Healthcare Support Workers and other Support staff on 'Agenda for Change' pay bands 1 to 4.

Staff Group	Headcount	FTE	%
Add Prof Scientific and Technic	137	119.90	1.90%
Additional Clinical Services	1318	1087.56	18.26%
Administrative and Clerical	1516	1299.14	21.00%
Allied Health Professionals	529	445.35	7.33%
Estates and Ancillary	616	491.15	8.53%
Healthcare Scientists	170	154.20	2.35%
Medical and Dental	538	506.38	7.45%
Nursing and Midwifery Registered	2395	2060.41	33.18%
Grand Total	7219	6164.08	100.00%



5.1 Our workforce

5.1.2 Pay bands

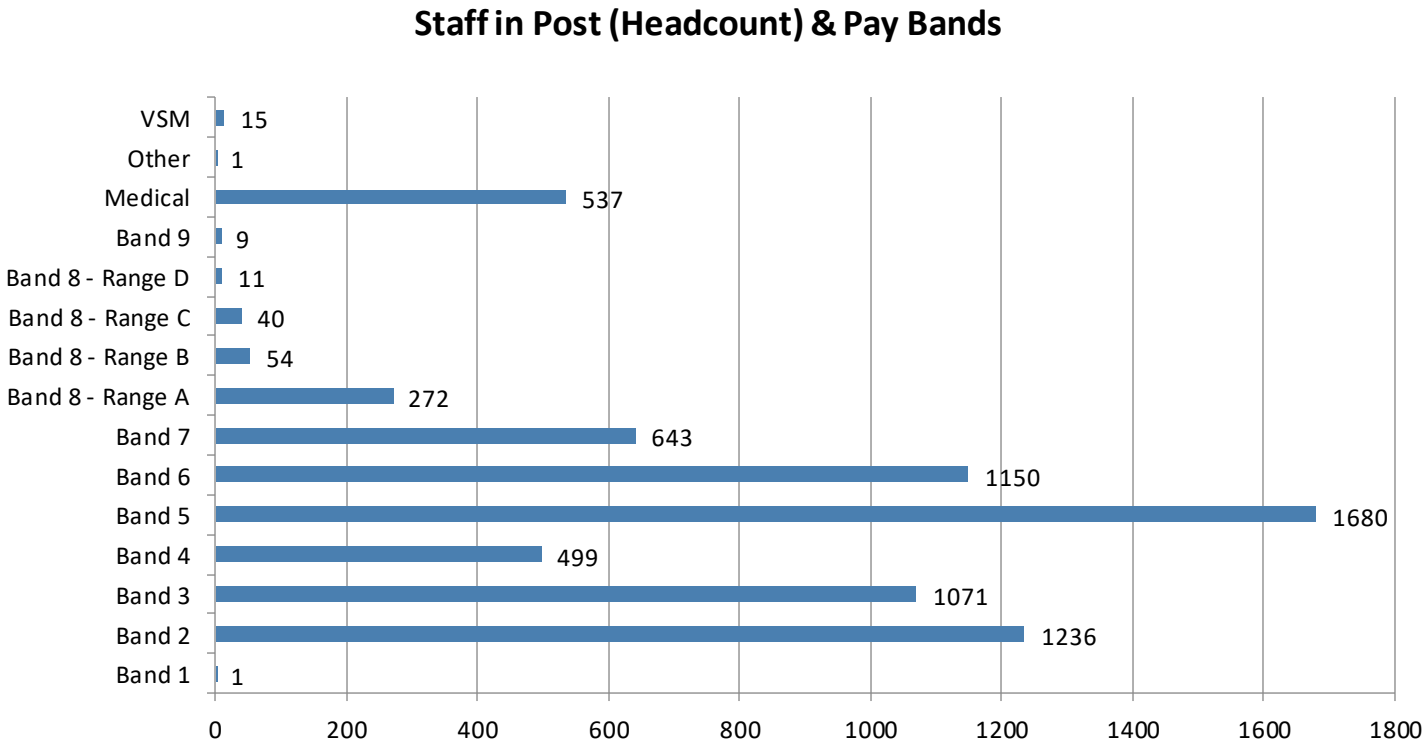
University Hospitals of Morecambe Bay NHS Foundation Trust employs their staff in line with the nationally agreed 'Agenda for Change' and Medical and Dental pay banding systems.

The largest cohort of staff are Band 5s which account for 23.27% of the workforce.

Band 1 staff make up 0.01% of the workforce and are primarily domestic assistants.

7.44% of the workforce are on Non 'Agenda for Change' pay bands. These consist of Medical Staff, and other Ad Hoc pay grades.

Pay Band	Headcount	FTE	%
Band 1	1	0.43	0.01%
Band 2	1236	960.99	17.12%
Band 3	1071	860.51	14.84%
Band 4	499	443.16	6.91%
Band 5	1680	1457.48	23.27%
Band 6	1150	981.26	15.93%
Band 7	643	578.36	8.91%
Band 8 - Range A	272	254.36	3.77%
Band 8 - Range B	54	53.79	0.75%
Band 8 - Range C	40	39.50	0.55%
Band 8 - Range D	11	11.00	0.15%
Band 9	9	8.50	0.12%
Medical	537	505.90	7.44%
Other	1	1.00	0.01%
VSM	15	7.83	0.21%
Grand Total	7219	6164.08	100.00%



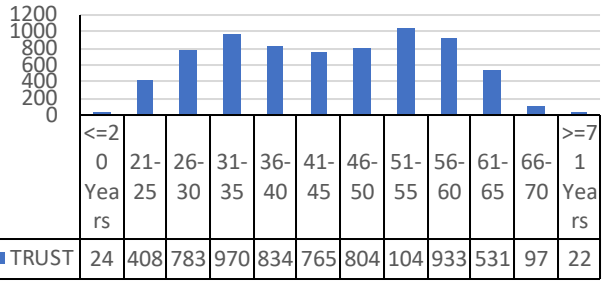
5.1.3 Working patterns

Working Pattern	Headcount	FTE	Headcount %	FTE %
Full Time	3945	3961.00	54.65%	64.26%
Part Time	3274	2203.08	45.35%	35.74%
Grand Total	7219	6164.08	100.00%	100.00%

5.2 Age - Staff In Post

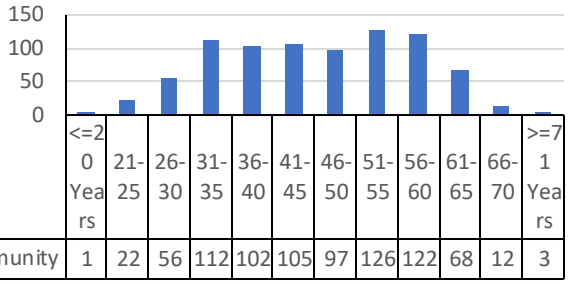
46.72% of the total workforce are in their 30s or 40s. Under 20s make up less than half a per cent (0.33%) of the workforce whilst 9.00% are aged 60 or over.

TRUST
Staff in Post - Age Profile



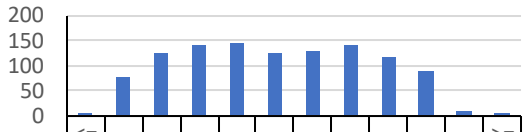
	<=20 Years	21-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70	>=71 Years
TRUST	24	408	783	970	834	765	804	104	933	531	97	22

Community
Staff in Post - Age Profile



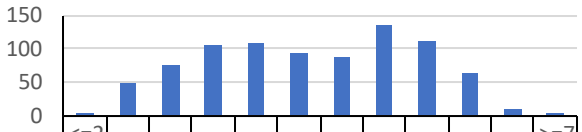
	<=20 Years	21-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70	>=71 Years
Community	1	22	56	112	102	105	97	126	122	68	12	3

Core Clinical
Staff in Post - Age Profile



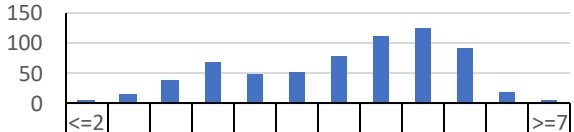
	<= 20 Years	21-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70	>= 71 Years
Core Clinical	1	75	126	140	145	126	127	140	115	87	8	1

Corporate
Staff in Post - Age Profile



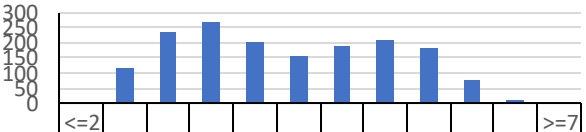
	<=20 Years	21-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70	>=71 Years
Corporate	4	48	76	106	109	95	87	135	113	63	9	1

Estates
Staff in Post - Age Profile



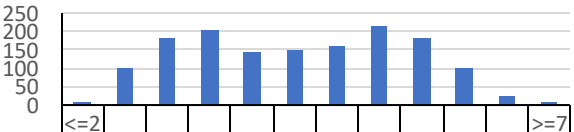
	<=20 Years	21-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70	>=71 Years
Estates	5	17	39	68	47	51	78	111	125	91	20	6

Medicine
Staff in Post - Age Profile



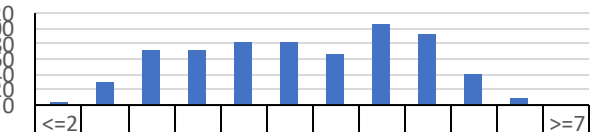
	<=20 Years	21-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70	>=71 Years
Medicine	5	118	232	265	203	155	188	209	183	79	14	4

Surgery
Staff in Post - Age Profile



	<=20 Years	21-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70	>=71 Years
Surgery	7	98	183	206	146	150	160	215	181	103	26	7

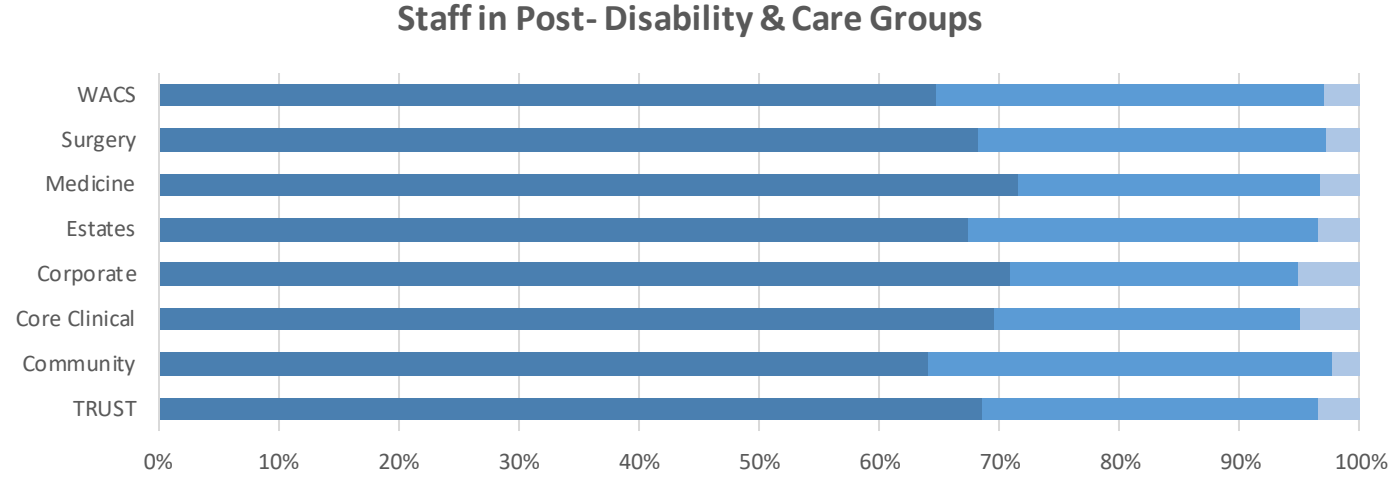
WACS
Staff in Post - Age Profile



	<=20 Years	21-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70	>=71 Years
WACS	1	30	71	73	82	83	67	105	94	40	8	0

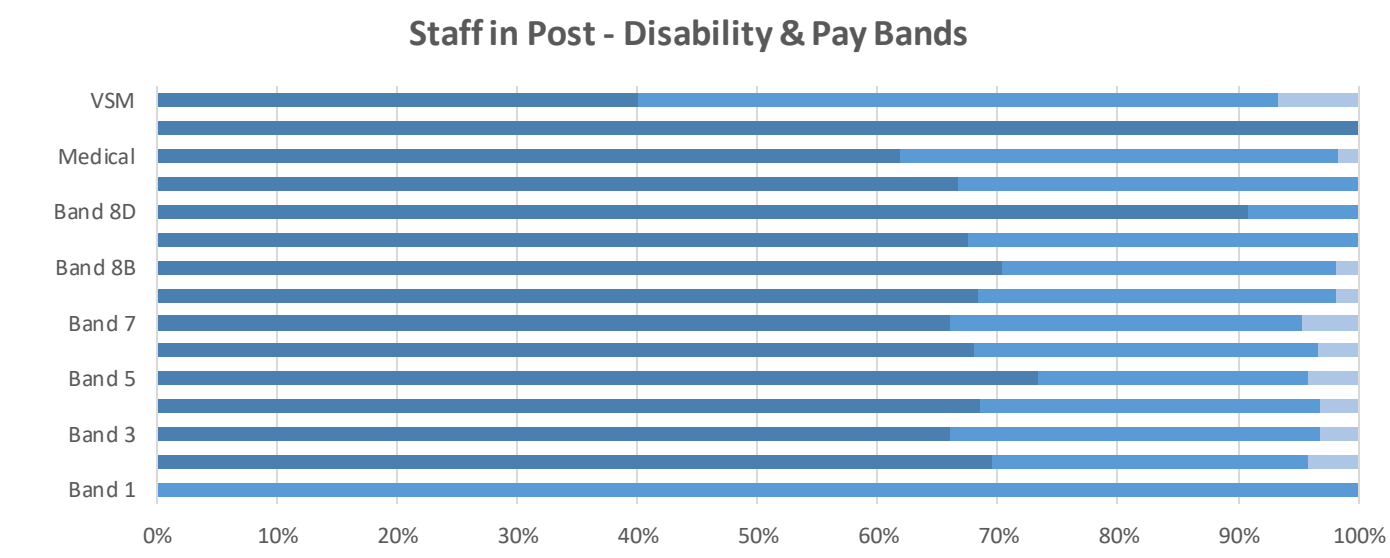
5.3 Disability // 5.3.1 Staff In Post

Overall 3.56% of the workforce consider themselves to have a disability. However, 27.84% of the workforce have not declared.



	TRUST	Community	Core Clinical	Corporate	Estates	Medicine	Surgery	WACS
No	68.60%	64.04%	69.57%	70.81%	67.33%	71.54%	68.15%	64.68%
Not Declared	27.84%	33.66%	25.48%	24.03%	29.18%	25.20%	28.95%	32.26%
Yes	3.56%	2.30%	4.95%	5.16%	3.50%	3.26%	2.90%	3.06%

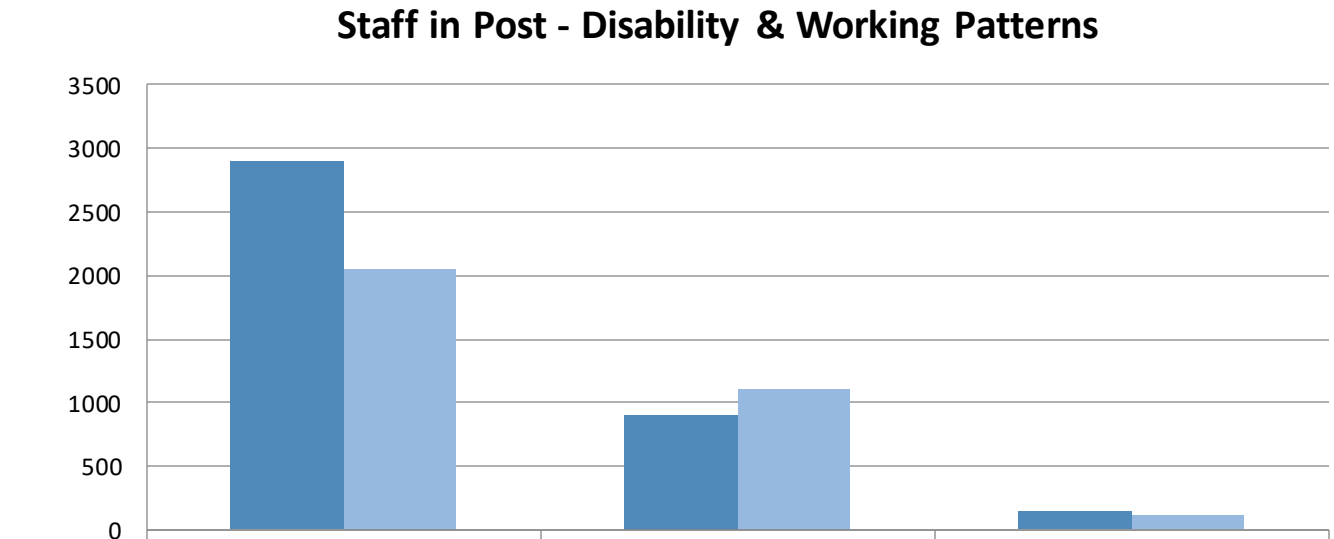
5.3.2 Disability & Pay Bands



	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8A	Band 8B	Band 8C	Band 8D	Band 9	Medical	Other	VSM
No	0.00%	69.50%	66.01%	68.54%	73.33%	68.00%	65.94%	68.38%	70.37%	67.50%	90.91%	66.67%	61.82%	100.00%	40.00%
Not Declared	100.00%	26.38%	30.81%	28.26%	22.44%	28.61%	29.39%	29.78%	27.78%	32.50%	9.09%	33.33%	36.50%	0.00%	53.33%
Yes	0.00%	4.13%	3.17%	3.21%	4.23%	3.39%	4.67%	1.84%	1.85%	0.00%	0.00%	0.00%	1.68%	0.00%	6.67%

5.3.3 Disability & Working Patterns

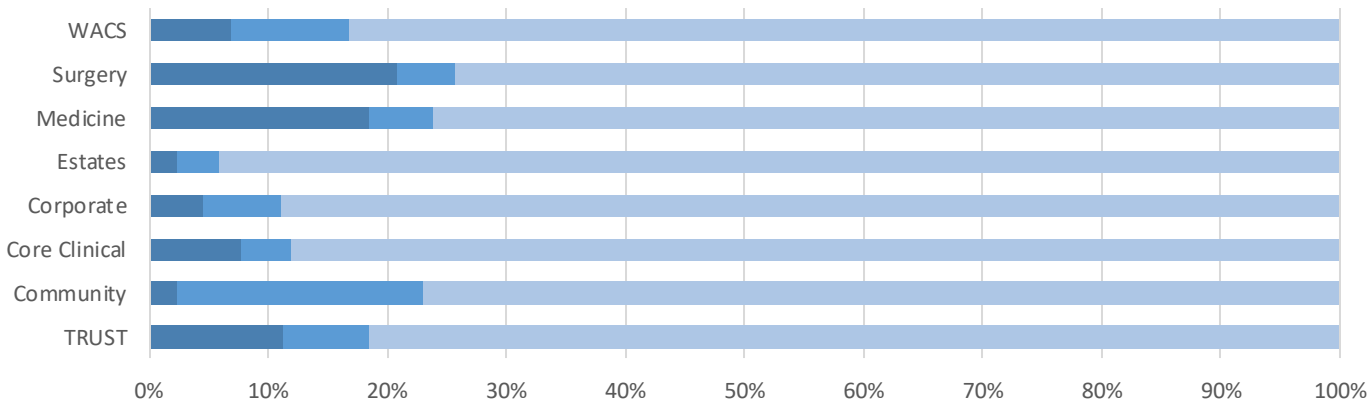
Overall, 257 members of staff consider themselves to have a disability. Of those, 142 worked full time whilst 115 worked part time.



	No	Not Declared	Yes
Full Time	2905	898	142
Part Time	2047	1112	115

5.4 Ethnic Origin // 5.4.1 Staff In Post

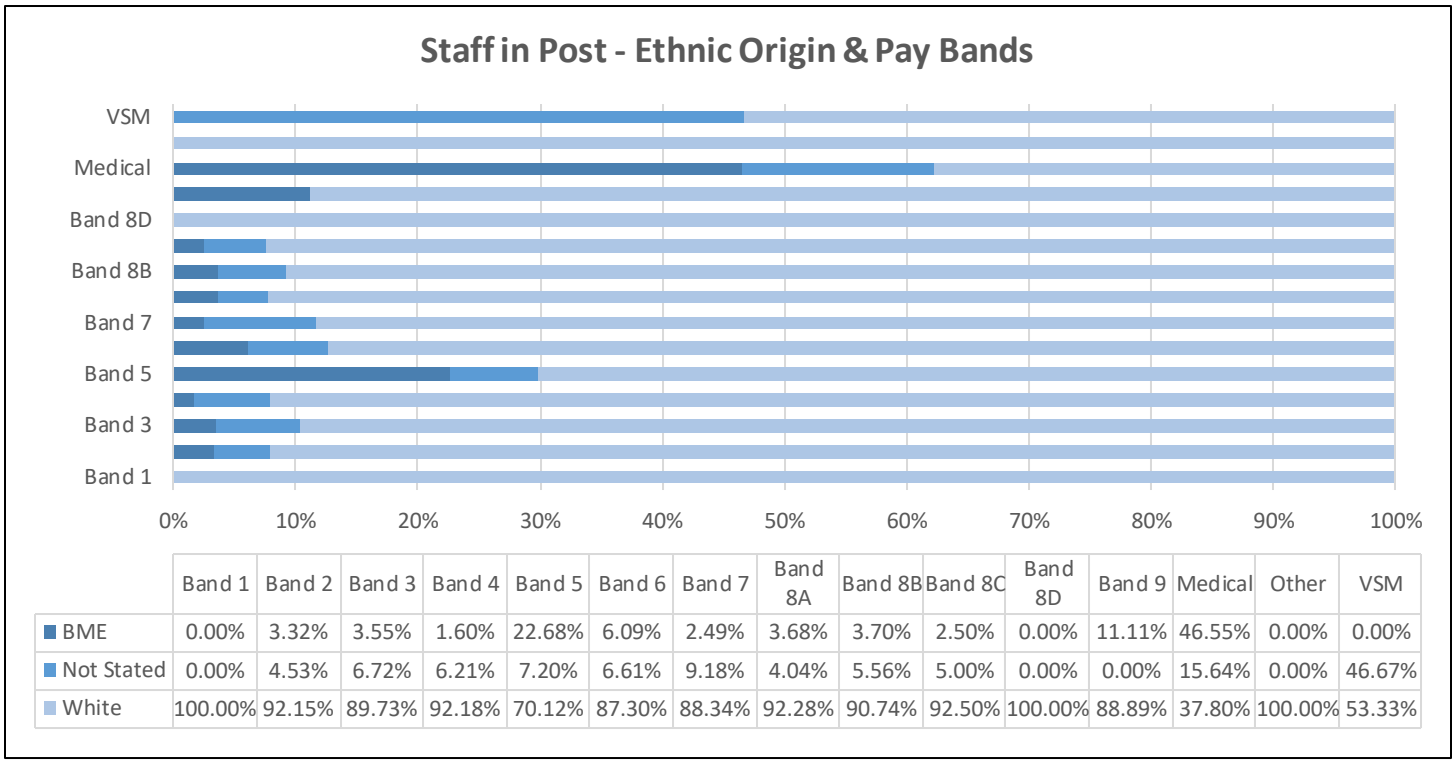
Overall 81.44% of the workforce describe their ethnic origin as White whilst 11.33% describe themselves as belonging to a Black, Asian or Ethnic Minority group. 7.23% prefer not to state their ethnic origin. The Surgical care group had the largest proportion of BAME staff members at 20.78% followed by the Medicine care group with 18.49%



	TRUST	Community	Core Clinical	Corporate	Estates	Medicine	Surgery	WACS
BME	11.33%	2.42%	7.70%	4.57%	2.43%	18.49%	20.78%	6.88%
Not Stated	7.23%	20.58%	4.22%	6.57%	3.50%	5.32%	4.99%	9.94%
White	81.44%	77.00%	88.08%	88.86%	94.07%	76.19%	74.22%	83.18%

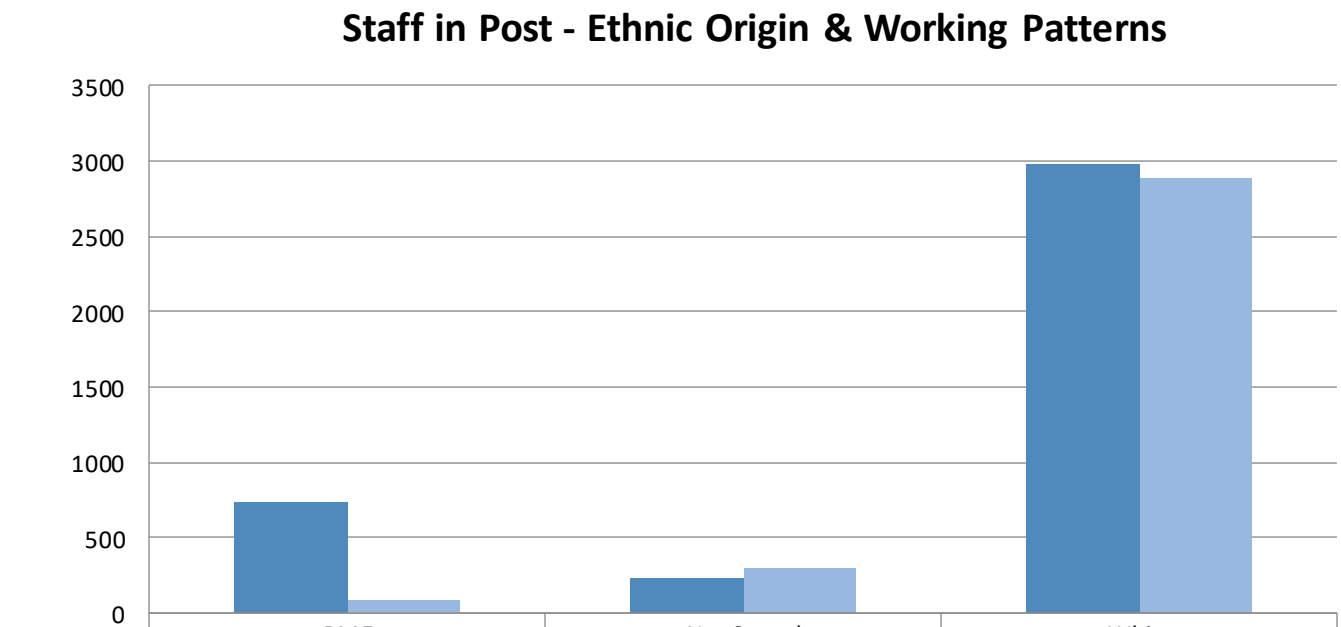
5.4.2 Ethnic Origin & Pay Bands

Ethnic minority colleagues account for 46.55% of Medical grades and 22.68% of Band 5 AfC roles.



	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8A	Band 8B	Band 8C	Band 8D	Band 9	Medical	Other	VSM
BME	0.00%	3.32%	3.55%	1.60%	22.68%	6.09%	2.49%	3.68%	3.70%	2.50%	0.00%	11.11%	46.55%	0.00%	0.00%
Not Stated	0.00%	4.53%	6.72%	6.21%	7.20%	6.61%	9.18%	4.04%	5.56%	5.00%	0.00%	0.00%	15.64%	0.00%	46.67%
White	100.00%	92.15%	89.73%	92.18%	70.12%	87.30%	88.34%	92.28%	90.74%	92.50%	100.00%	88.89%	37.80%	100.00%	53.33%

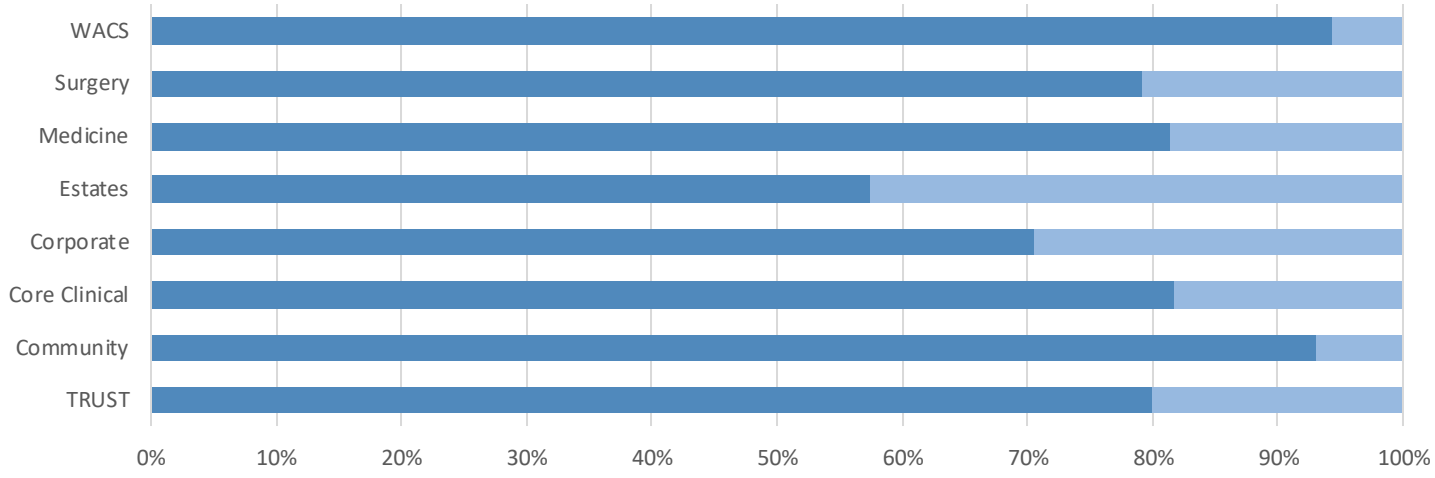
5.4.3 Ethnic Origin & Working Patterns



	BME	Not Stated	White
Full Time	735	225	2985
Part Time	83	297	2894

5.5 Gender // 5.5.1 Staff In Post

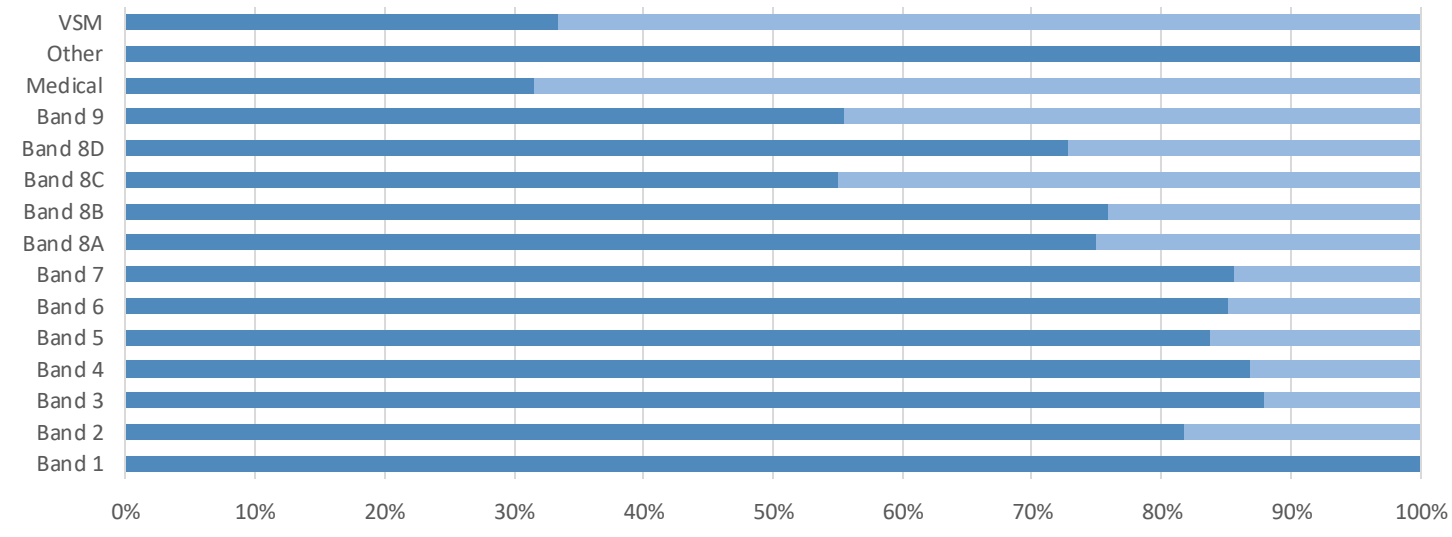
Overall 80.01% of the workforce is female. Estates and Facilities have the closest ratio of male / female staff with 57.45% female and 42.55% male. 94.34% of staff in the WACS care group are female.



	TRUST	Community	Core Clinical	Corporate	Estates	Medicine	Surgery	WACS
Female	80.01%	93.10%	81.67%	70.57%	57.45%	81.33%	79.15%	94.34%
Male	19.99%	6.90%	18.33%	29.43%	42.55%	18.67%	20.85%	5.66%

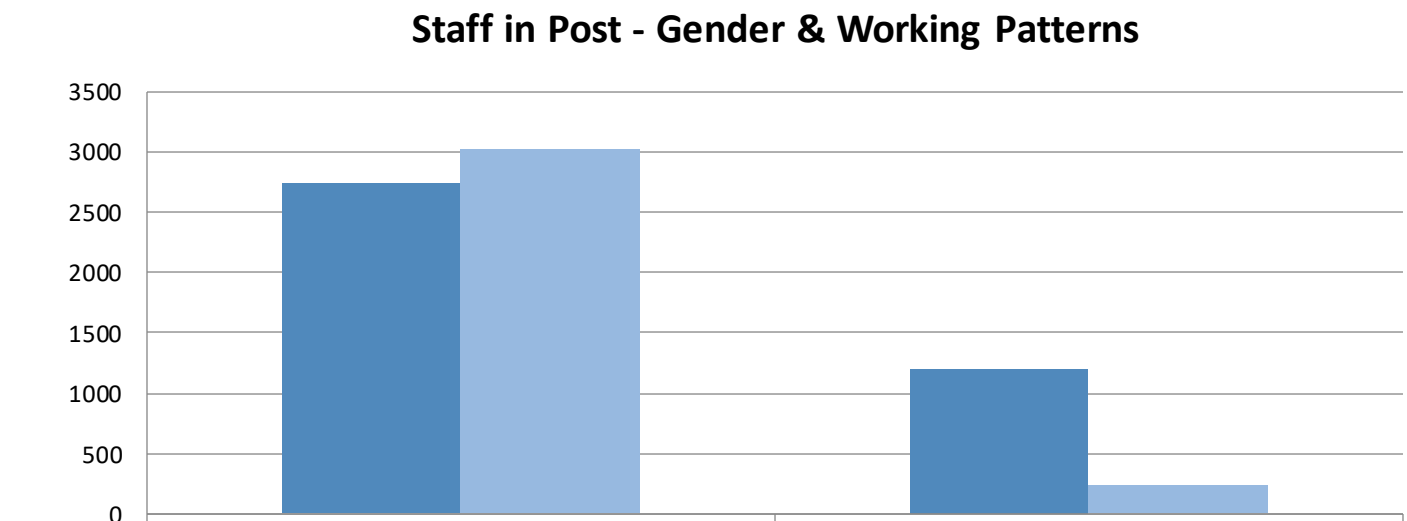
5.5.2 Gender & Pay Bands

Men account for more than 68% of staff on Medical pay scales, and more than 66% of colleagues at Very Senior Manager (VSM) level.



	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8A	Band 8B	Band 8C	Band 8D	Band 9	Medical	Other	VSM
Female	100.00%	81.72%	87.86%	86.77%	83.69%	85.22%	85.54%	75.00%	75.93%	55.00%	72.73%	55.56%	31.47%	100.00%	33.33%
Male	0.00%	18.28%	12.14%	13.23%	16.31%	14.78%	14.46%	25.00%	24.07%	45.00%	27.27%	44.44%	68.53%	0.00%	66.67%

5.5.3 Gender & Working Patterns



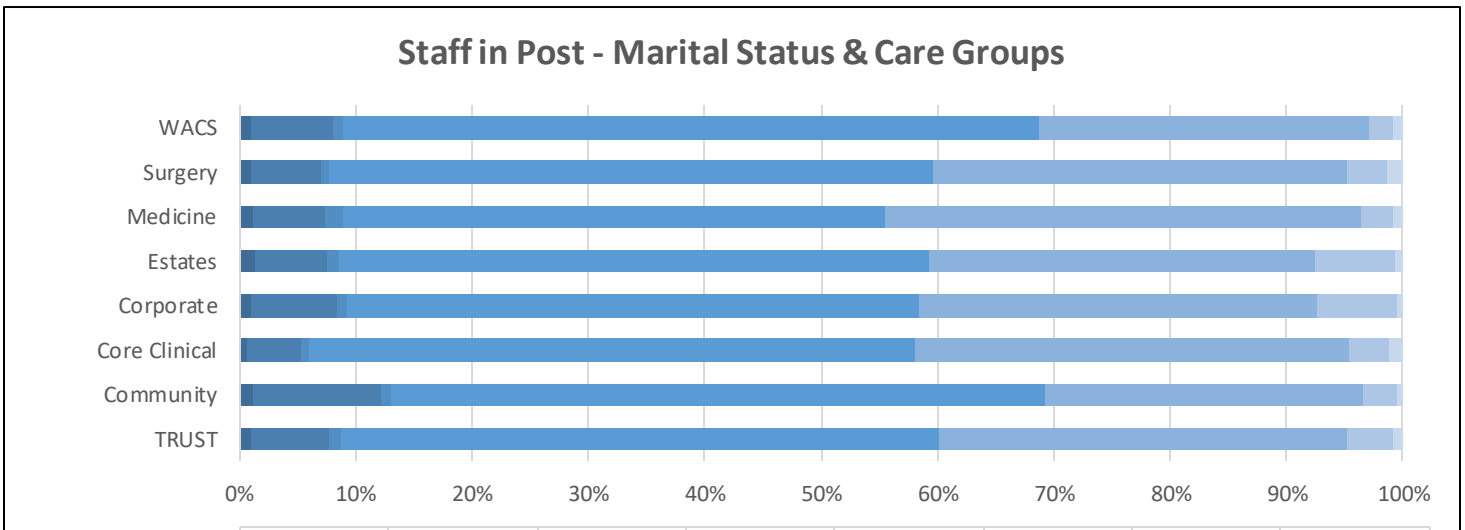
	Female	Male
Full Time	2745	1200
Part Time	3031	243

5.6 Gender Identity

Information on gender identity is not currently collected.

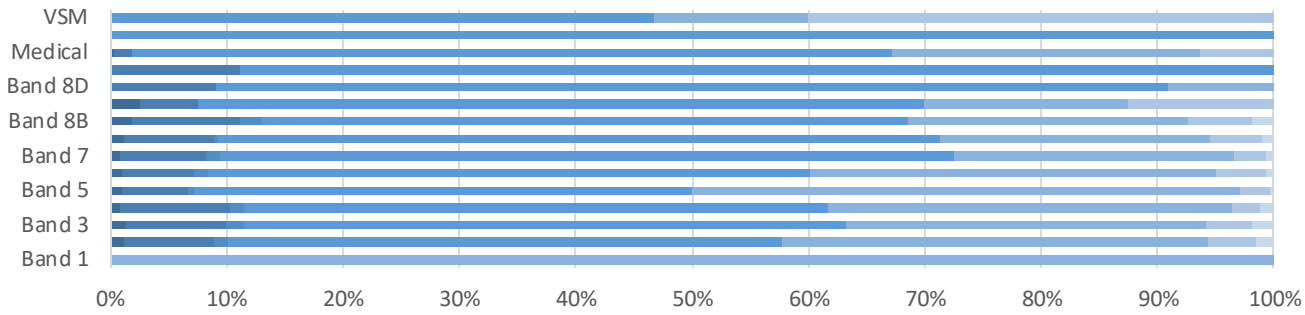
5.7 Marital Status // 5.7.1 Staff In Post

Overall 52.49% of the workforce are either married or in a civil partnership. 35.09% are single whilst 3.82% have not stated their marital status.



	TRUST	Community	Core Clinical	Corporate	Estates	Medicine	Surgery	WACS
Civil Partnership	1.01%	1.09%	0.64%	0.94%	1.37%	1.21%	0.94%	0.92%
Divorced	6.73%	11.02%	4.67%	7.50%	6.23%	6.22%	6.01%	7.19%
Legally Separated	0.94%	0.97%	0.73%	0.82%	0.91%	1.45%	0.67%	0.76%
Married	51.48%	56.17%	51.97%	49.12%	50.76%	46.53%	52.02%	59.79%
Single	35.09%	27.24%	37.40%	34.23%	33.13%	40.91%	35.56%	28.44%
Not Stated	3.82%	3.03%	3.39%	6.80%	6.84%	2.78%	3.51%	1.99%
Widowed	0.93%	0.48%	1.19%	0.59%	0.76%	0.91%	1.28%	0.92%

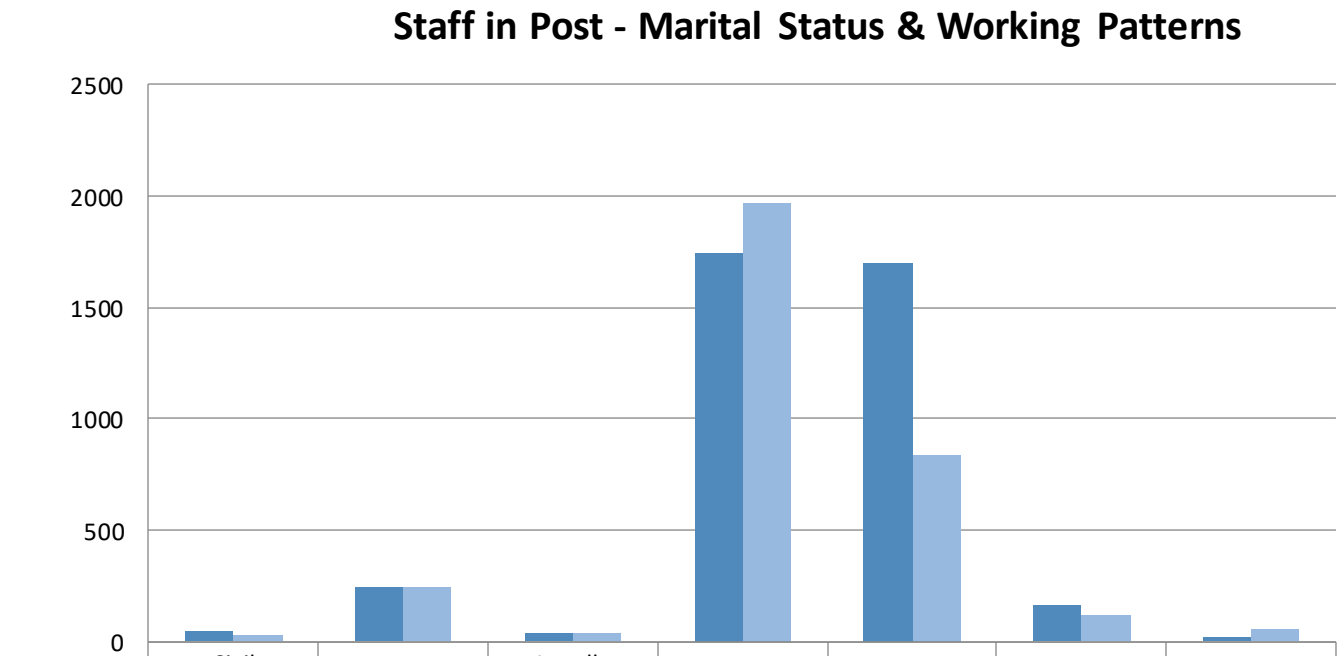
5.7.2 Marital Status & Pay Bands



	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8A	Band 8B	Band 8C	Band 8D	Band 9	Medical	Other	VSM
Civil Partnership	0.00%	1.21%	1.31%	0.80%	1.01%	0.96%	0.78%	1.10%	1.85%	2.50%	0.00%	0.00%	0.37%	0.00%	0.00%
Divorced	0.00%	7.61%	8.68%	9.42%	5.60%	6.26%	7.47%	7.72%	9.26%	5.00%	9.09%	11.11%	1.49%	0.00%	0.00%
Legally Separated	0.00%	1.21%	1.40%	1.20%	0.54%	1.13%	1.24%	0.37%	1.85%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Married	0.00%	47.65%	51.91%	50.30%	42.80%	51.83%	62.99%	62.13%	55.56%	62.50%	81.82%	88.89%	65.36%	100.00%	46.67%
Single	100.00%	36.73%	30.91%	34.67%	47.08%	34.78%	24.11%	23.16%	24.07%	17.50%	9.09%	0.00%	26.44%	0.00%	13.33%
Not Stated	0.00%	4.05%	3.92%	2.40%	2.56%	4.43%	2.80%	4.41%	5.56%	12.50%	0.00%	0.00%	6.33%	0.00%	40.00%
Widowed	0.00%	1.54%	1.87%	1.20%	0.42%	0.61%	0.62%	1.10%	1.85%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

5.7.3 Marital Status & Working Patterns

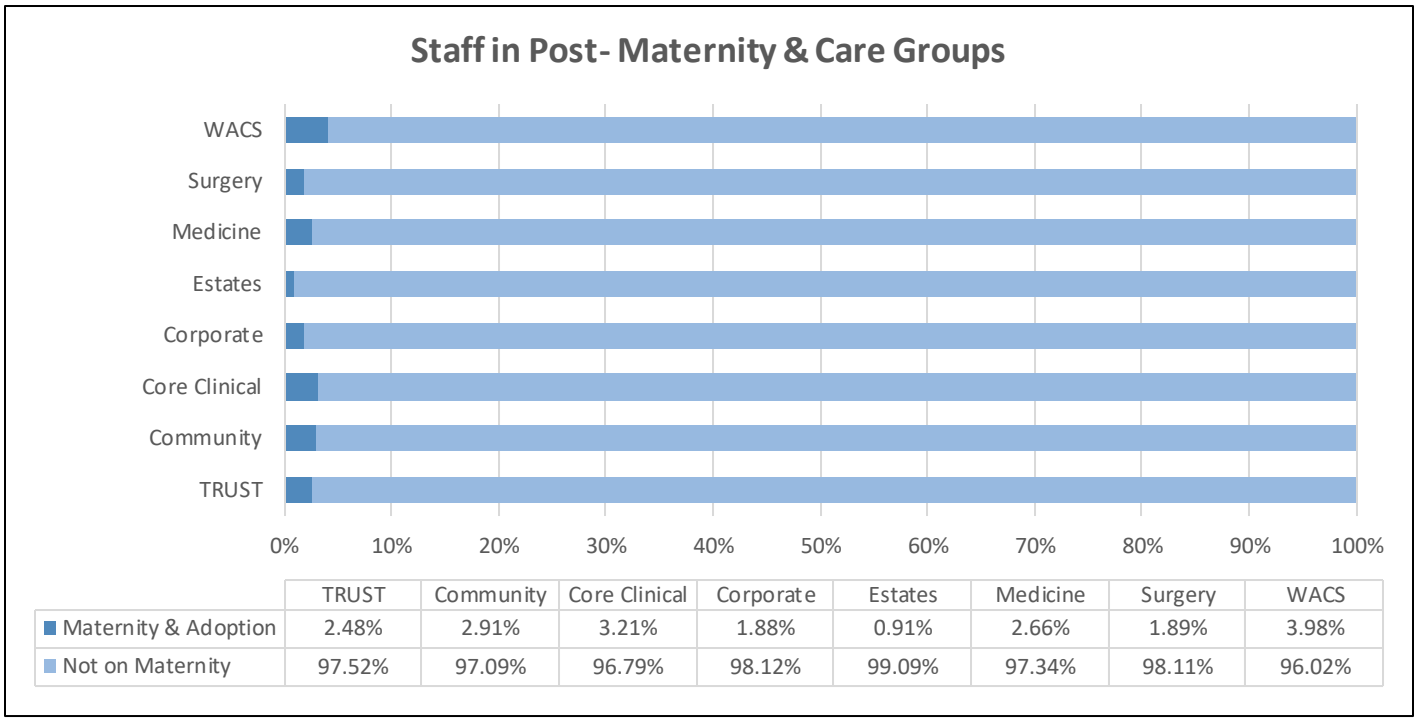
Overall 52.49% of the workforce are either married or in a civil partnership. 35.09% are single whilst 3.82% have not stated their marital status.



	Civil Partnership	Divorced	Legally Separated	Married	Single	Not Stated	Widowed
Full Time	45	241	33	1745	1701	163	17
Part Time	28	245	35	1971	832	113	50

5.8 Maternity // 5.8.1 Staff In Post

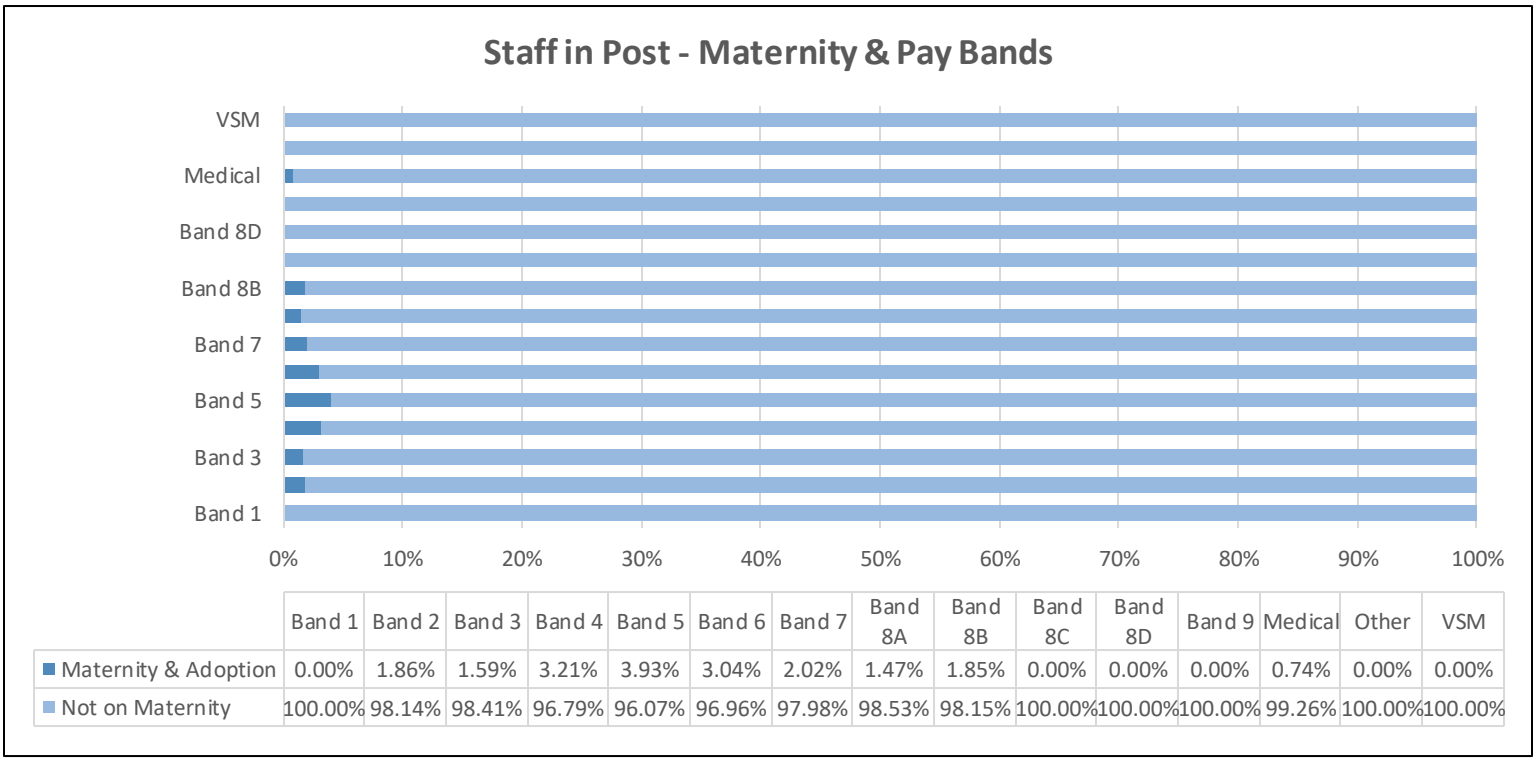
Overall 2.48% of the workforce were on maternity or adoption leave.



	TRUST	Community	Core Clinical	Corporate	Estates	Medicine	Surgery	WACS
Maternity & Adoption	2.48%	2.91%	3.21%	1.88%	0.91%	2.66%	1.89%	3.98%
Not on Maternity	97.52%	97.09%	96.79%	98.12%	99.09%	97.34%	98.11%	96.02%

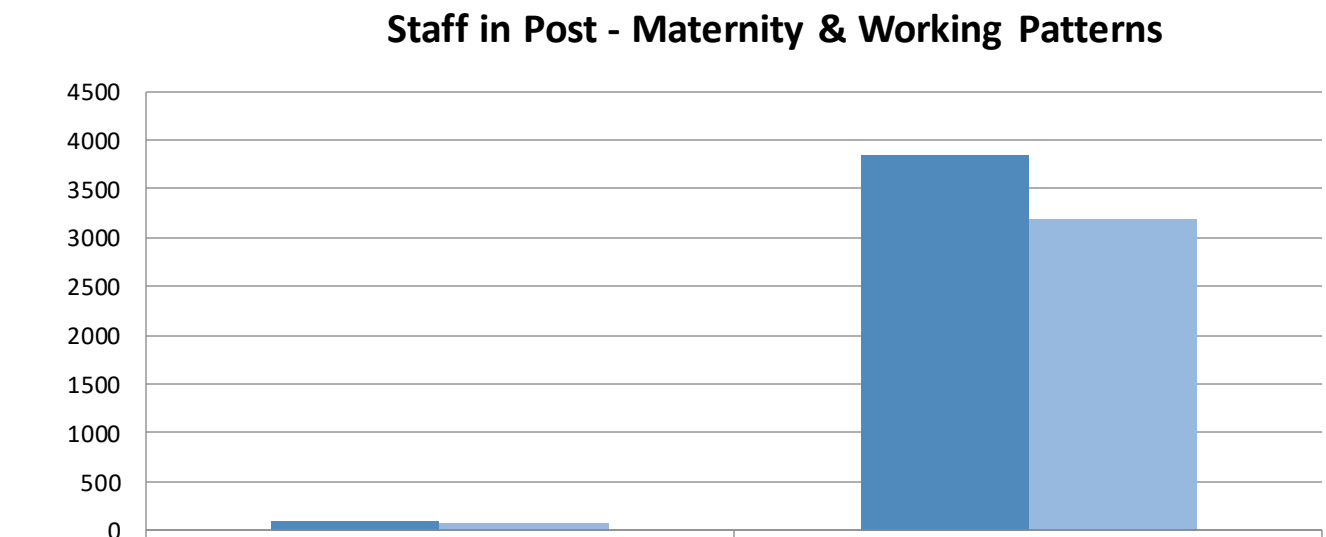
5.8.2 Maternity & Pay Bands

This graph shows that the pay band with the highest proportion of staff on maternity leave were those staff on Band 5 Agenda for Change with 3.93%. No staff members on pay bands 1, 8c, 8d, 9, other or VSM were on maternity or adoption leave.



	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8A	Band 8B	Band 8C	Band 8D	Band 9	Medical	Other	VSM
Maternity & Adoption	0.00%	1.86%	1.59%	3.21%	3.93%	3.04%	2.02%	1.47%	1.85%	0.00%	0.00%	0.00%	0.74%	0.00%	0.00%
Not on Maternity	100.00%	98.14%	98.41%	96.79%	96.07%	96.96%	97.98%	98.53%	98.15%	100.00%	100.00%	100.00%	99.26%	100.00%	100.00%

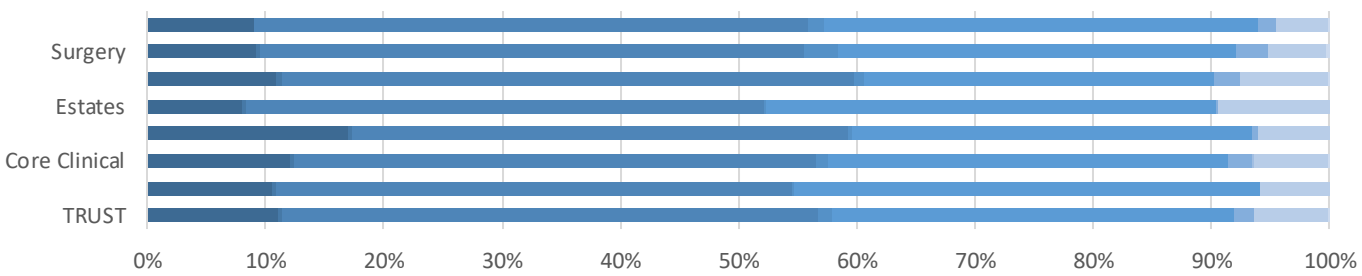
5.8.3 Maternity & Working Patterns



	Maternity & Adoption	Not on Maternity
Full Time	95	3850
Part Time	84	3190

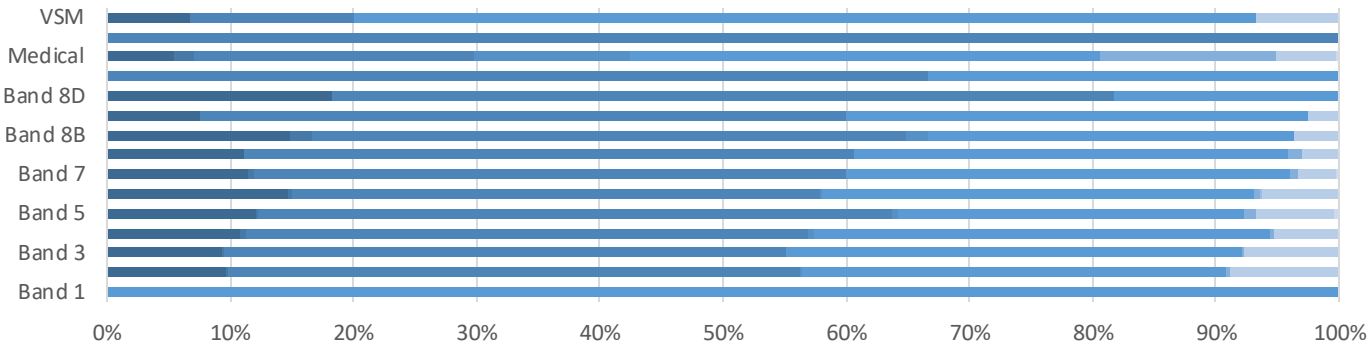
5.9 Religion & Belief // 5.9.1 Staff In Post

The most common religion / belief overall was Christianity which accounted for 45.42% of the workforce. The next largest single group was Atheism at 10.96%. 6.28% described their religion / belief as 'Other' whilst 34.08% preferred not to disclose their religion / belief.



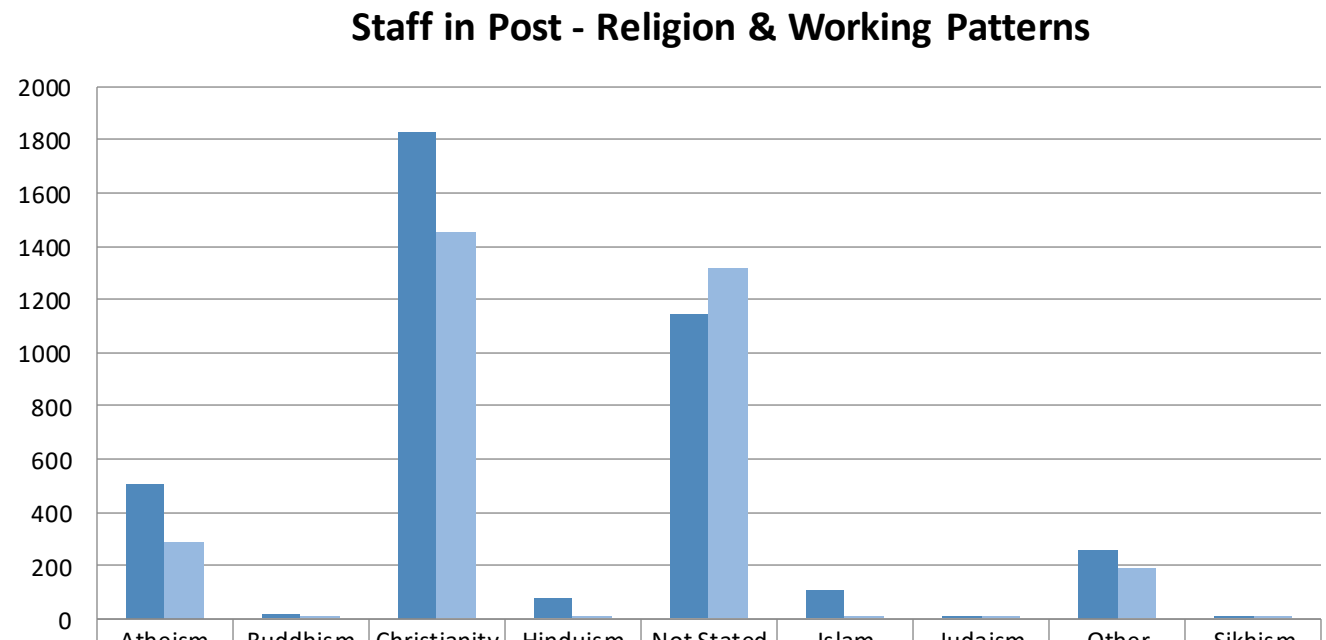
	TRUST	Community	Core Clinical	Corporate	Estates	Medicine	Surgery	WACS
Atheism	10.96%	10.53%	12.10%	16.88%	8.05%	10.88%	9.18%	9.02%
Buddhism	0.35%	0.36%	0.27%	0.35%	0.30%	0.48%	0.40%	0.00%
Christianity	45.42%	43.70%	44.27%	41.97%	43.77%	48.46%	45.95%	46.79%
Hinduism	1.15%	0.12%	1.01%	0.35%	0.15%	0.85%	2.97%	1.38%
Not Stated	34.09%	39.47%	33.73%	33.88%	38.15%	29.55%	33.54%	36.85%
Islam	1.61%	0.00%	2.11%	0.47%	0.15%	2.24%	2.77%	1.53%
Judaism	0.04%	0.00%	0.18%	0.00%	0.00%	0.06%	0.00%	0.00%
Other	6.28%	5.81%	6.23%	6.10%	9.42%	7.37%	4.93%	4.28%
Sikhism	0.11%	0.00%	0.09%	0.00%	0.00%	0.12%	0.27%	0.15%

5.9.2 Religion & Pay Bands



	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8A	Band 8B	Band 8C	Band 8D	Band 9	Medical	Other	VSM
Atheism	0.00%	9.63%	9.34%	10.82%	12.08%	14.61%	11.51%	11.03%	14.81%	7.50%	18.18%	0.00%	5.40%	0.00%	6.67%
Buddhism	0.00%	0.16%	0.19%	0.40%	0.12%	0.35%	0.47%	0.00%	1.85%	0.00%	0.00%	0.00%	1.68%	0.00%	0.00%
Christianity	0.00%	46.52%	45.56%	45.69%	51.55%	42.87%	48.06%	49.63%	48.15%	52.50%	63.64%	66.67%	22.72%	100.00%	13.33%
Hinduism	0.00%	0.16%	0.09%	0.40%	0.42%	0.17%	0.00%	0.00%	1.85%	0.00%	0.00%	0.00%	12.66%	0.00%	0.00%
Not Stated	100.00%	34.30%	36.97%	37.07%	28.10%	35.04%	36.08%	35.29%	29.63%	37.50%	18.18%	33.33%	38.18%	0.00%	73.33%
Islam	0.00%	0.32%	0.19%	0.40%	1.01%	0.61%	0.62%	1.10%	0.00%	0.00%	0.00%	0.00%	14.34%	0.00%	0.00%
Judaism	0.00%	0.00%	0.00%	0.00%	0.06%	0.17%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Other	0.00%	8.90%	7.66%	5.21%	6.31%	6.17%	3.11%	2.94%	3.70%	2.50%	0.00%	0.00%	4.84%	0.00%	6.67%
Sikhism	0.00%	0.00%	0.00%	0.00%	0.36%	0.00%	0.16%	0.00%	0.00%	0.00%	0.00%	0.00%	0.19%	0.00%	0.00%

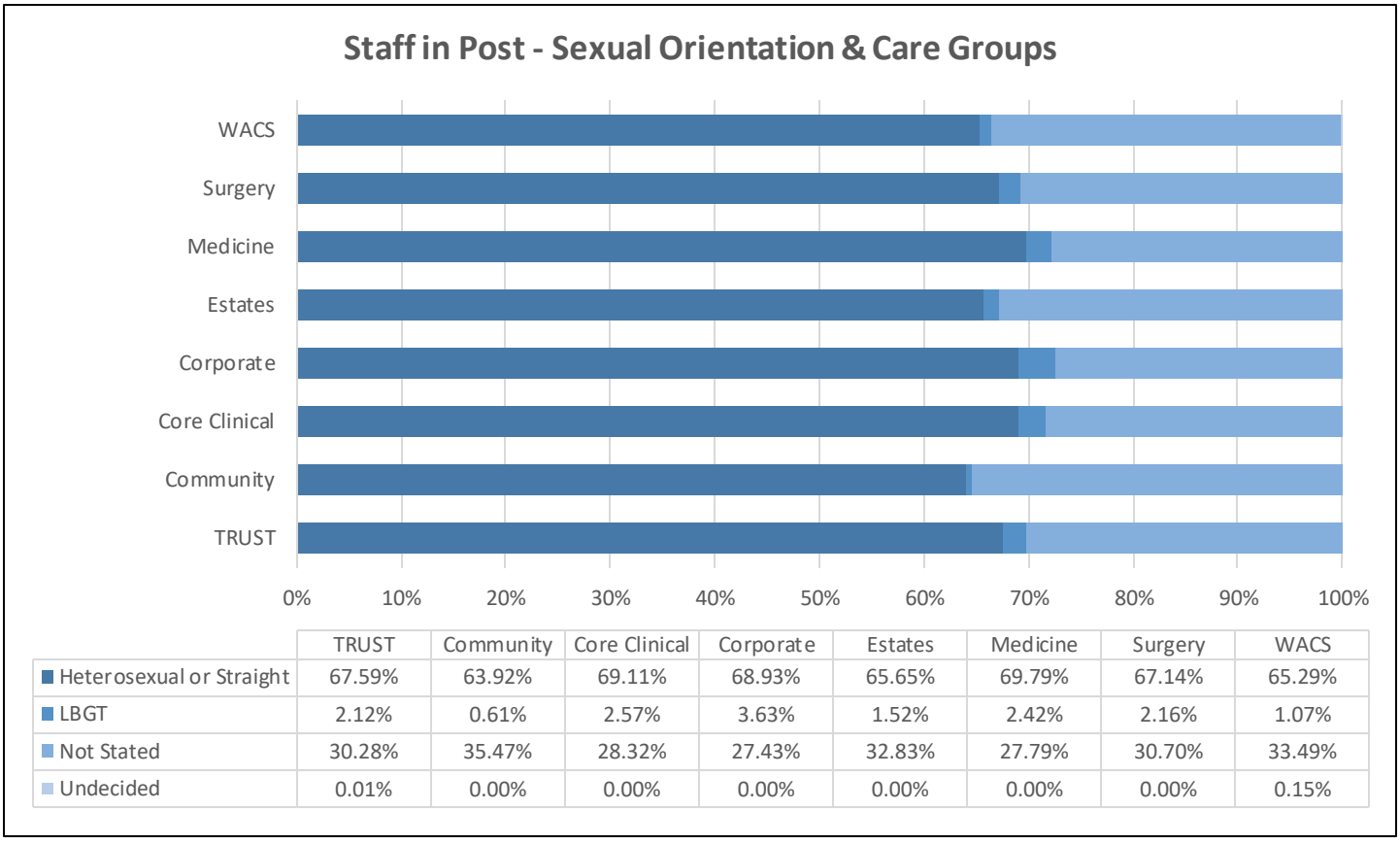
5.9.3 Religion & Working Patterns



	Atheism	Buddhism	Christianity	Hinduism	Not Stated	Islam	Judaism	Other	Sikhism
Full Time	506	15	1826	77	1146	105	2	261	7
Part Time	285	10	1453	6	1315	11	1	192	1

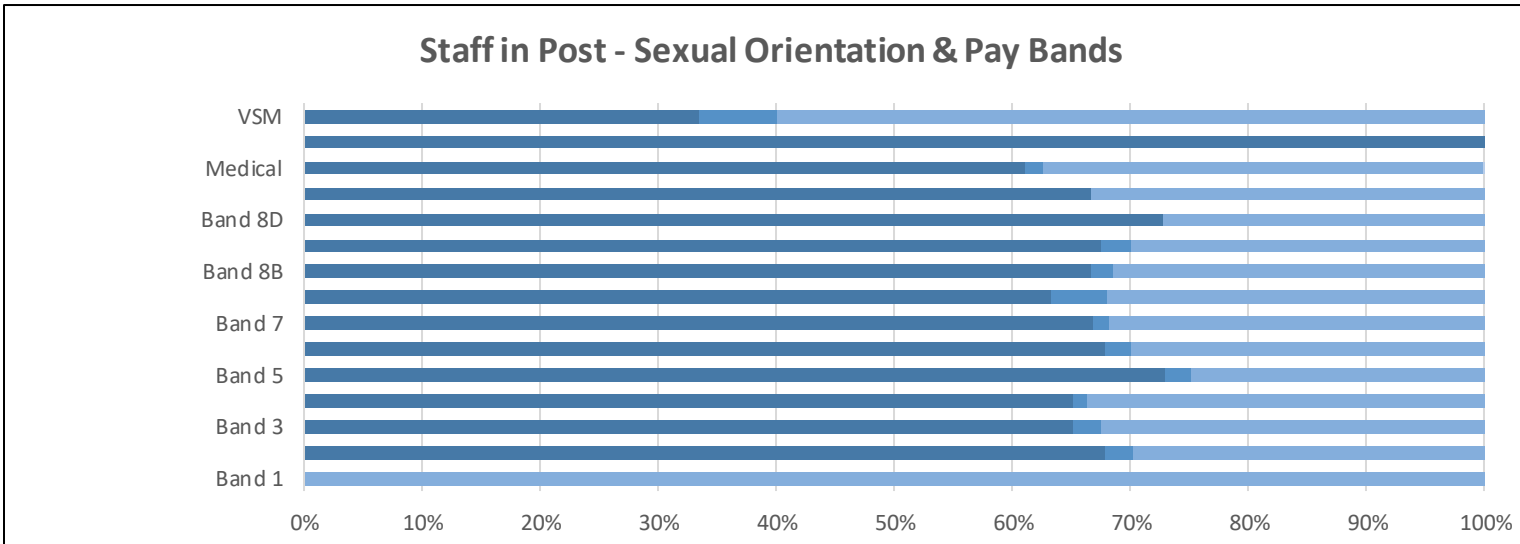
5.10 Sexual Orientation // 5.10.1 Staff In Post

Overall 2.12% of the workforce described their sexual orientation as Lesbian, Gay or Bisexual. 30.28% do not wish to disclose this information.



	TRUST	Community	Core Clinical	Corporate	Estates	Medicine	Surgery	WACS
Heterosexual or Straight	67.59%	63.92%	69.11%	68.93%	65.65%	69.79%	67.14%	65.29%
LBGT	2.12%	0.61%	2.57%	3.63%	1.52%	2.42%	2.16%	1.07%
Not Stated	30.28%	35.47%	28.32%	27.43%	32.83%	27.79%	30.70%	33.49%
Undecided	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.15%

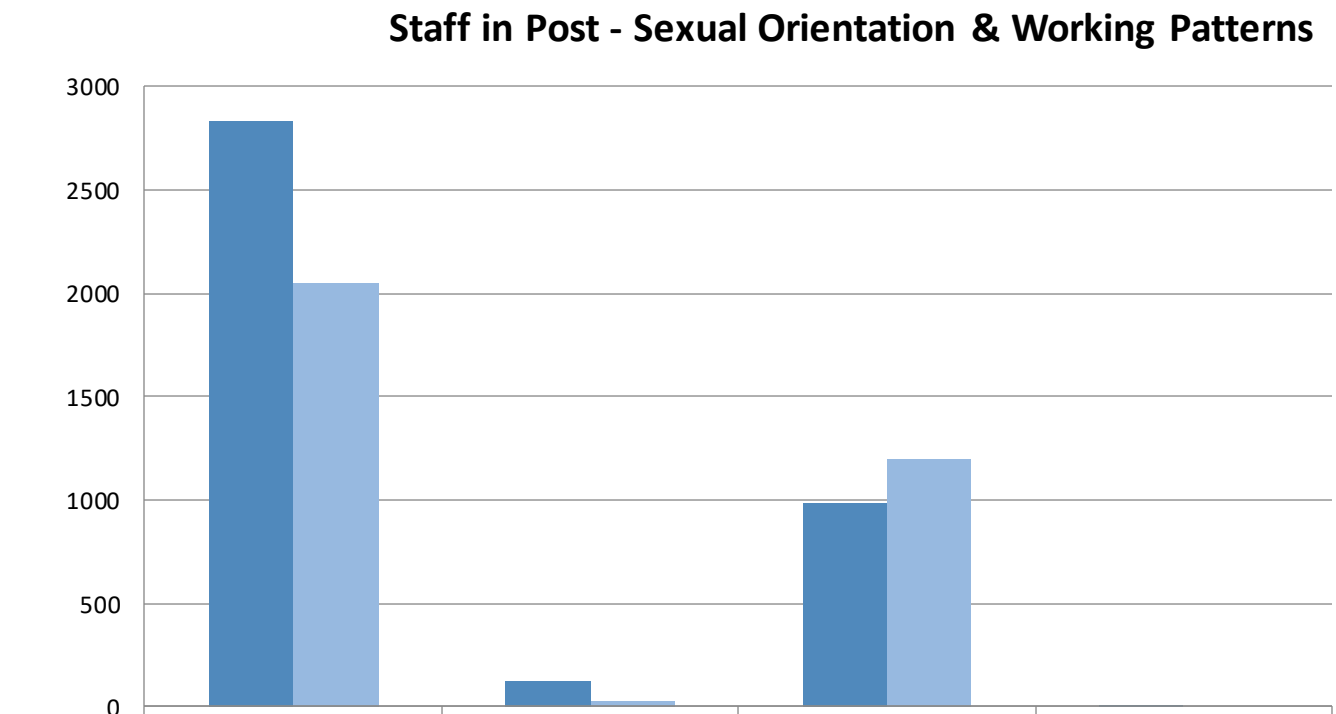
5.10.2 Sexual Orientation & Pay Bands



	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8A	Band 8B	Band 8C	Band 8D	Band 9	Medical	Other	VSM
Heterosexual or Straight	0.00%	67.88%	65.17%	65.13%	72.92%	67.83%	66.72%	63.24%	66.67%	67.50%	72.73%	66.67%	61.08%	100.00%	33.33%
LBGT	0.00%	2.27%	2.24%	1.20%	2.20%	2.17%	1.40%	4.78%	1.85%	2.50%	0.00%	0.00%	1.49%	0.00%	6.67%
Not Stated	100.00%	29.85%	32.59%	33.67%	24.88%	30.00%	31.88%	31.99%	31.48%	30.00%	27.27%	33.33%	37.24%	0.00%	60.00%
Undecided	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.19%	0.00%	0.00%

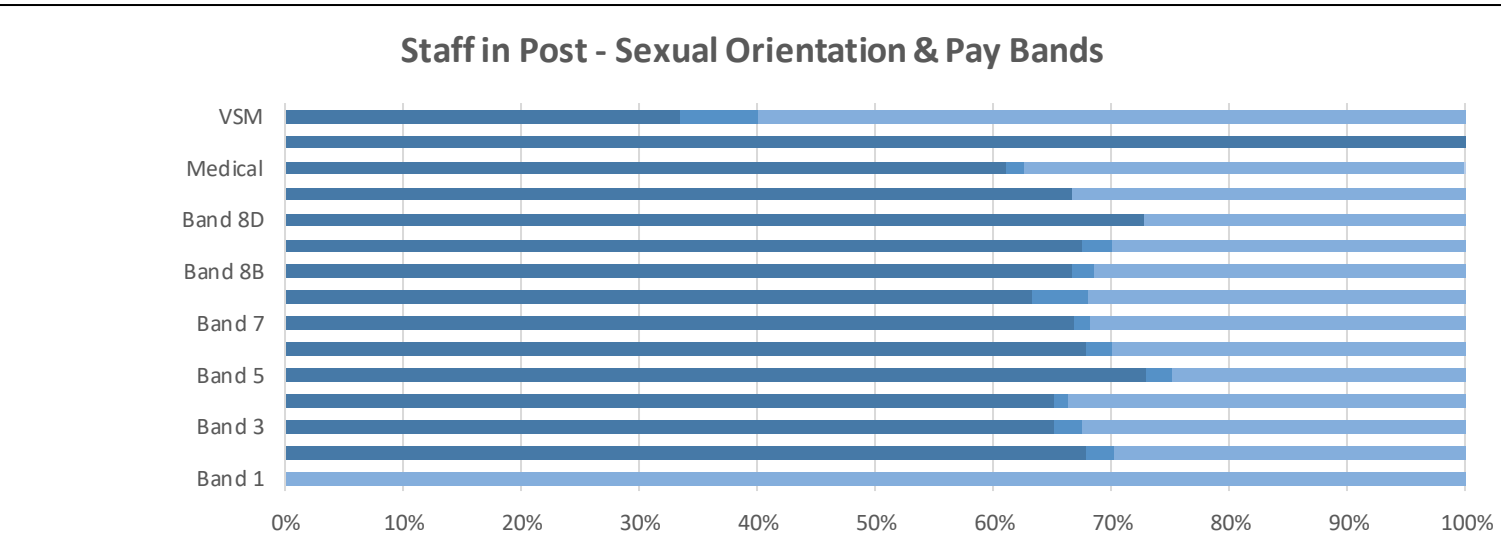
5.10.3 Sexual Orientation & Working Patterns

Overall 2.12% of the workforce described their sexual orientation as Lesbian, Gay or Bisexual. 30.28% do not wish to disclose this information.



	Heterosexual or Straight	LBGT	Not Stated	Undecided
Full Time	2831	124	989	1
Part Time	2048	29	1197	0

5.10.2 Sexual Orientation & Pay Bands

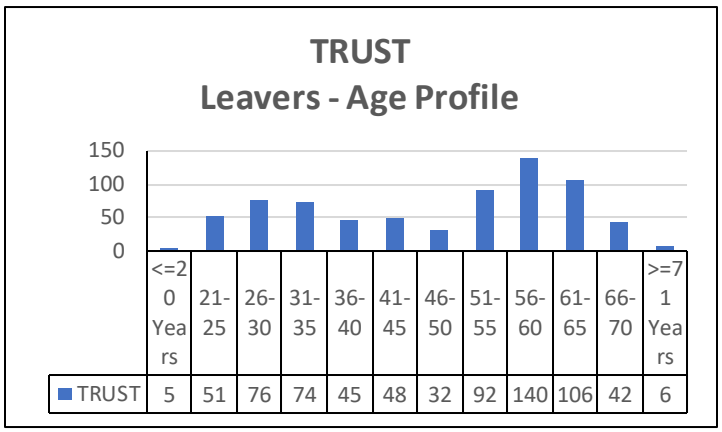


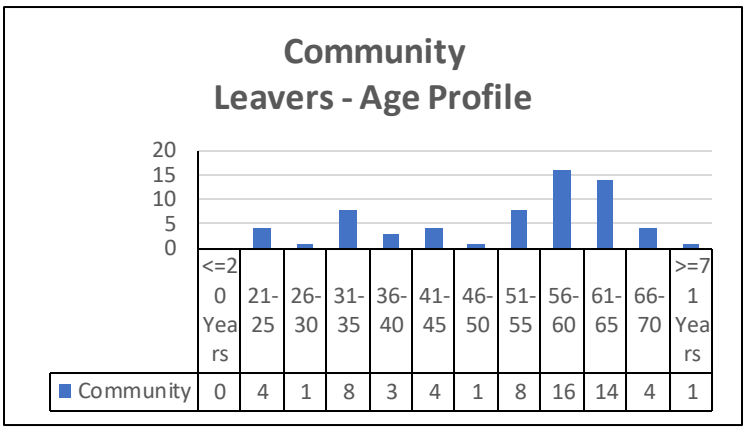
	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8A	Band 8B	Band 8C	Band 8D	Band 9	Medical	Other	VSM
Heterosexual or Straight	0.00%	67.88%	65.17%	65.13%	72.92%	67.83%	66.72%	63.24%	66.67%	67.50%	72.73%	66.67%	61.08%	100.00%	33.33%
LBGT	0.00%	2.27%	2.24%	1.20%	2.20%	2.17%	1.40%	4.78%	1.85%	2.50%	0.00%	0.00%	1.49%	0.00%	6.67%
Not Stated	100.00%	29.85%	32.59%	33.67%	24.88%	30.00%	31.88%	31.99%	31.48%	30.00%	27.27%	33.33%	37.24%	0.00%	60.00%
Undecided	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.19%	0.00%	0.00%

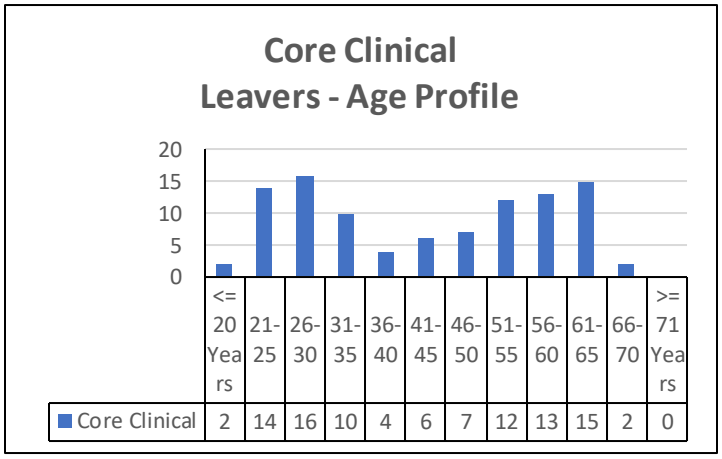
6. Leavers

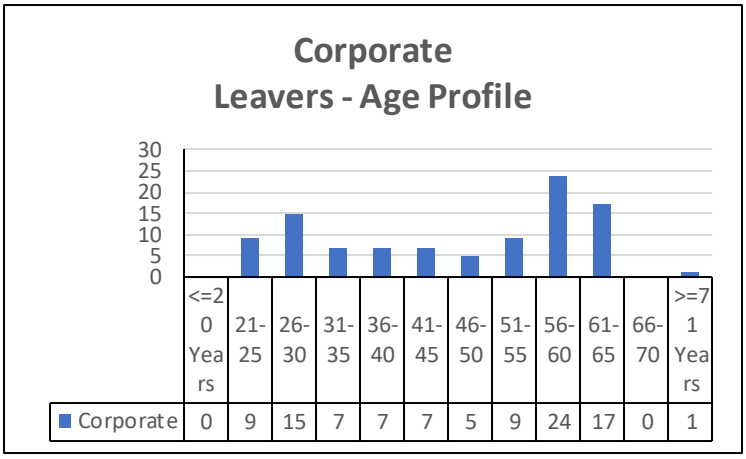
The figures presented here show the leavers with University Hospitals of Morecambe Bay NHS Foundation Trust during the financial year 2021/22. The figures are categorised according to the organisation as a whole and care groups within the Trust.

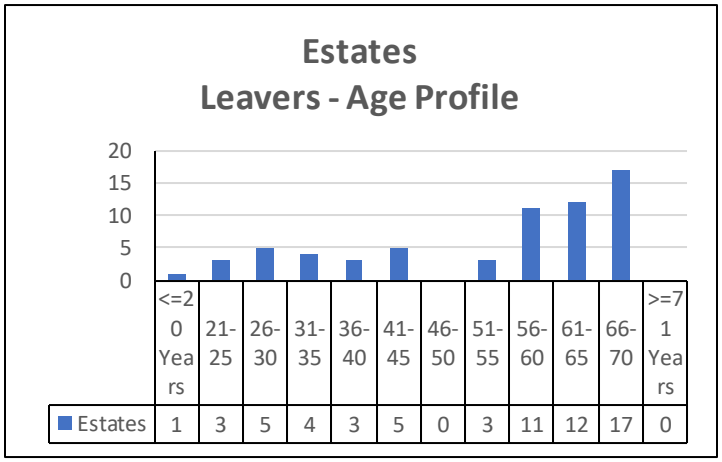
6.1 Age

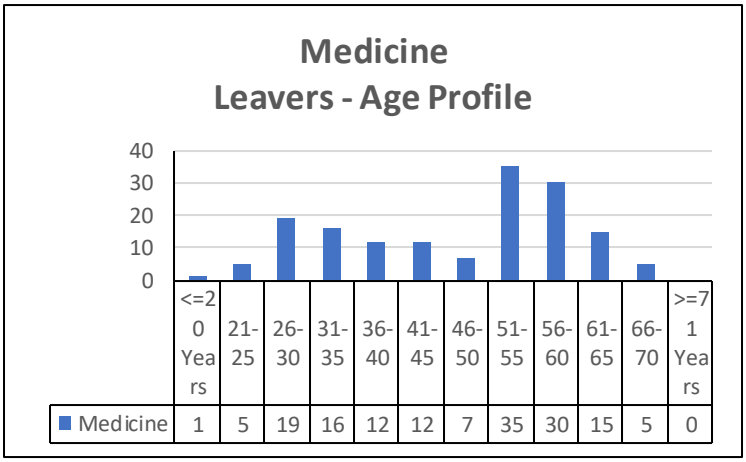


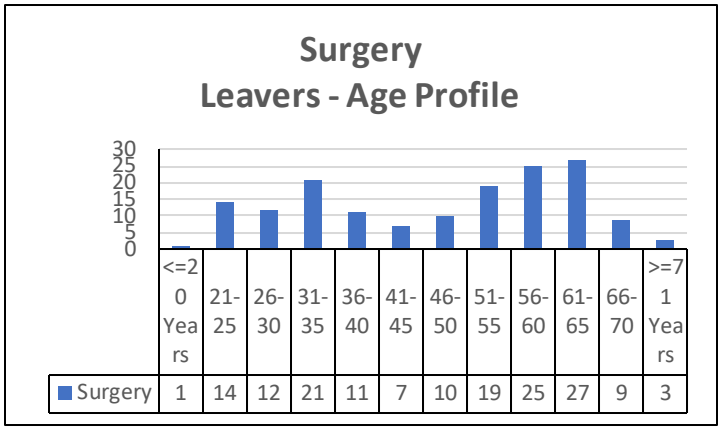


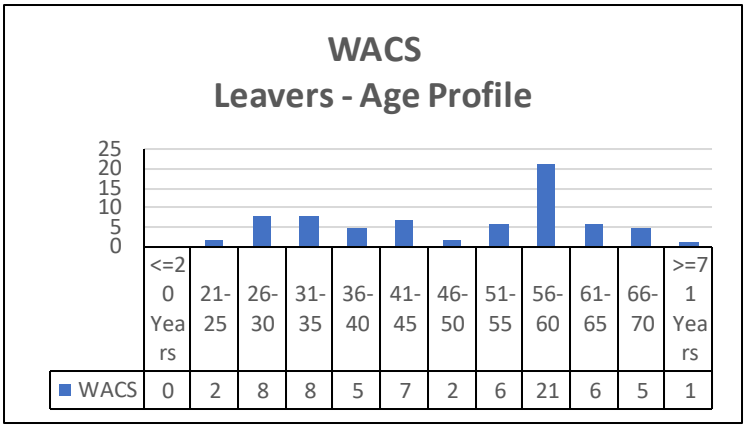




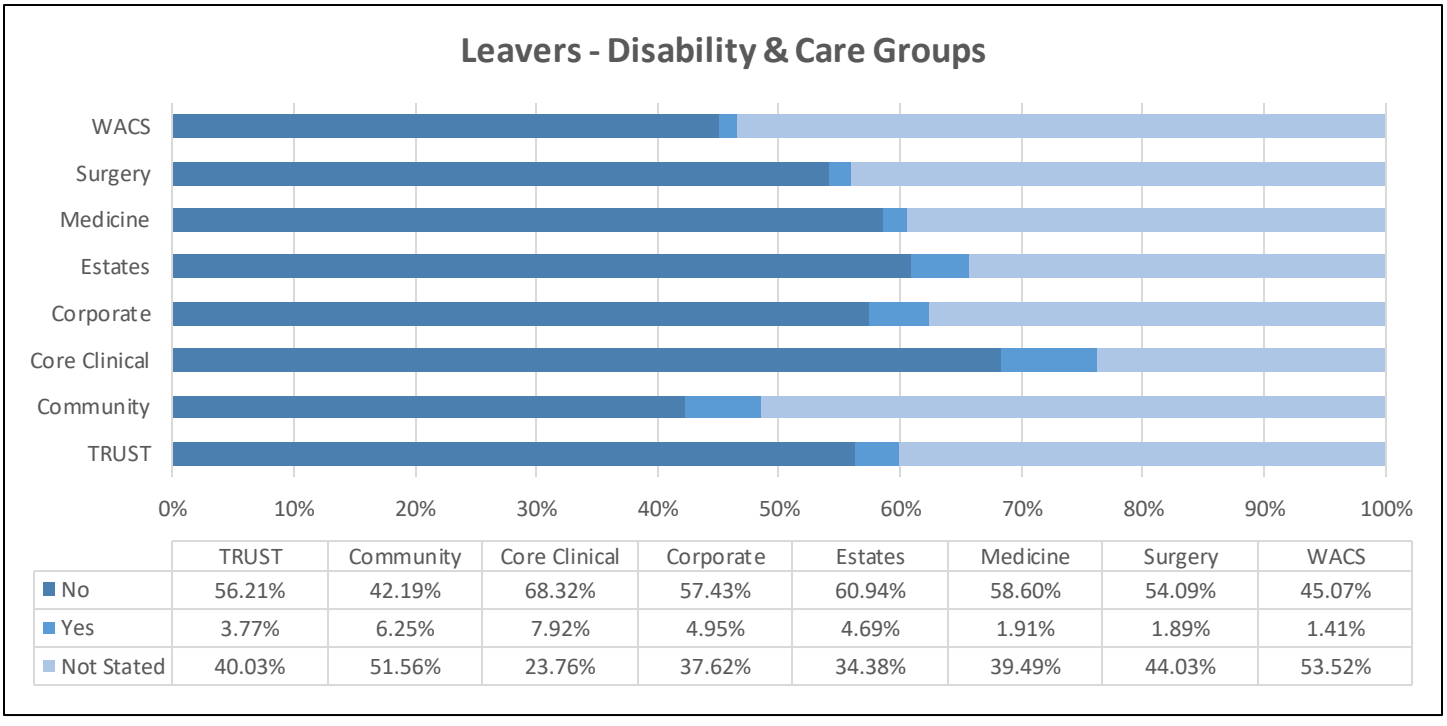






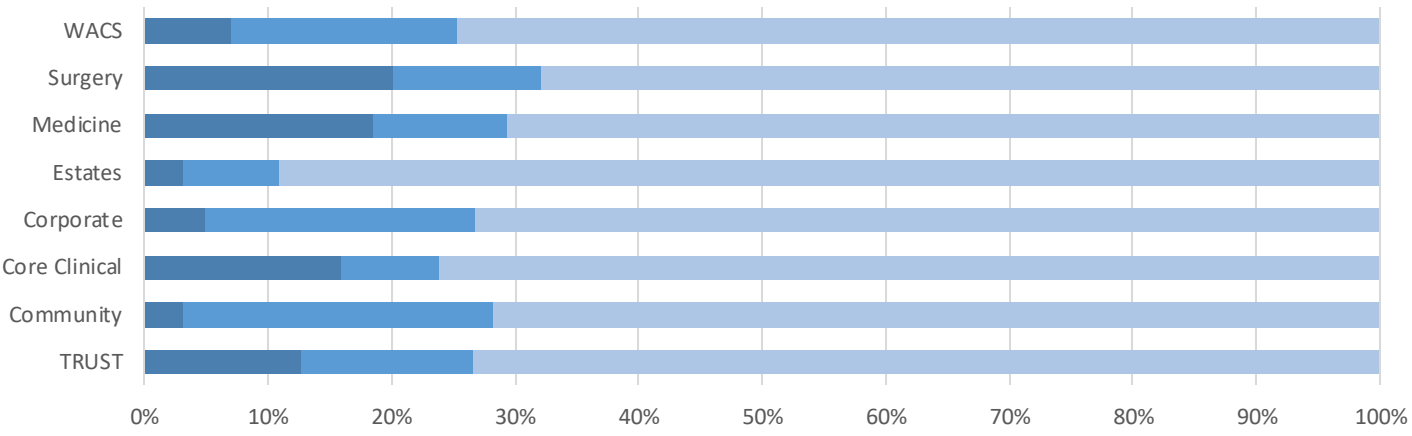


6.2 Disability



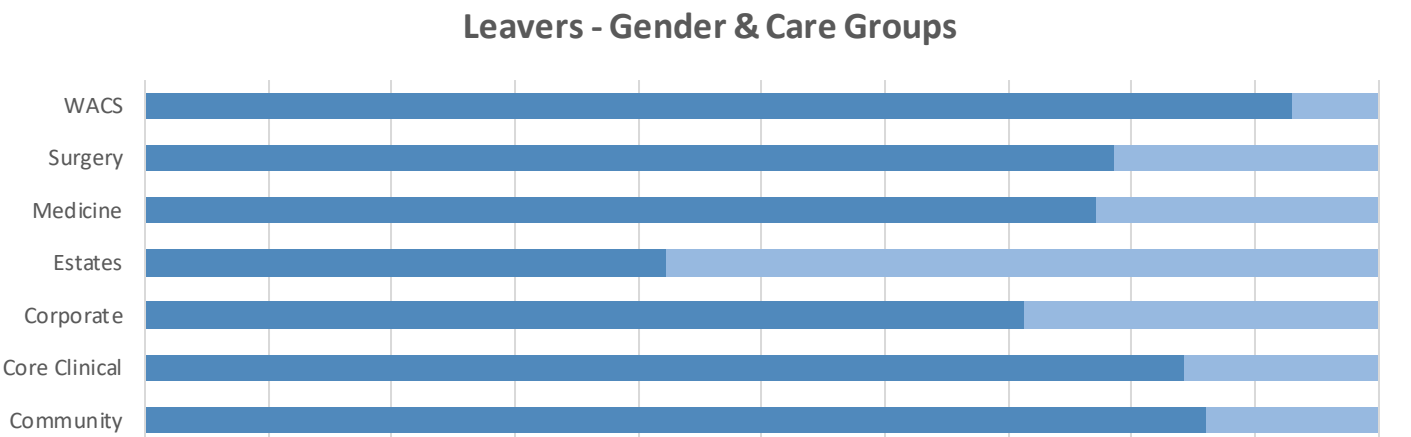
	TRUST	Community	Core Clinical	Corporate	Estates	Medicine	Surgery	WACS
No	56.21%	42.19%	68.32%	57.43%	60.94%	58.60%	54.09%	45.07%
Yes	3.77%	6.25%	7.92%	4.95%	4.69%	1.91%	1.89%	1.41%
Not Stated	40.03%	51.56%	23.76%	37.62%	34.38%	39.49%	44.03%	53.52%

6.3 Ethnic Origin



	TRUST	Community	Core Clinical	Corporate	Estates	Medicine	Surgery	WACS
BME	12.69%	3.13%	15.84%	4.95%	3.13%	18.47%	20.13%	7.04%
Not Stated	13.95%	25.00%	7.92%	21.78%	7.81%	10.83%	11.95%	18.31%
White	73.36%	71.88%	76.24%	73.27%	89.06%	70.70%	67.92%	74.65%

6.4 Gender

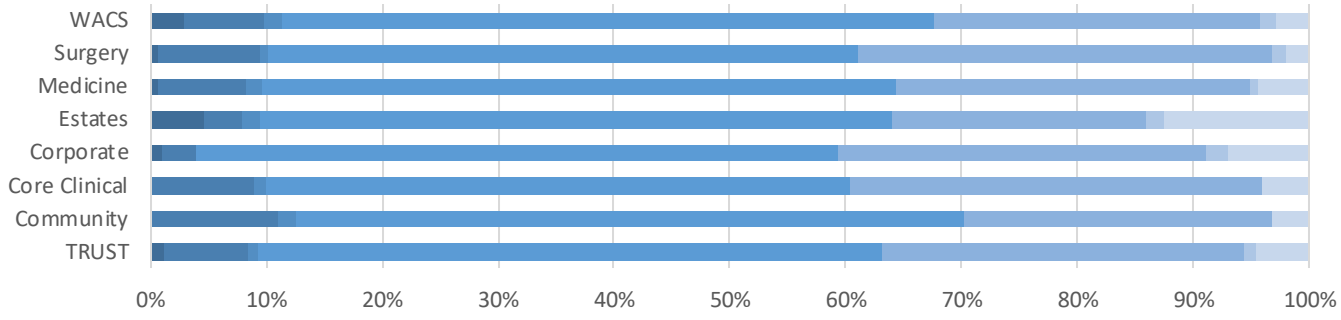


	TRUST	Community	Core Clinical	Corporate	Estates	Medicine	Surgery	WACS
Female	76.85%	85.94%	84.16%	71.29%	42.19%	77.07%	78.62%	92.96%
Male	23.15%	14.06%	15.84%	28.71%	57.81%	22.93%	21.38%	7.04%

6.5 Gender Identity

Information on gender identity is not currently collected.

6.6 Marital Status

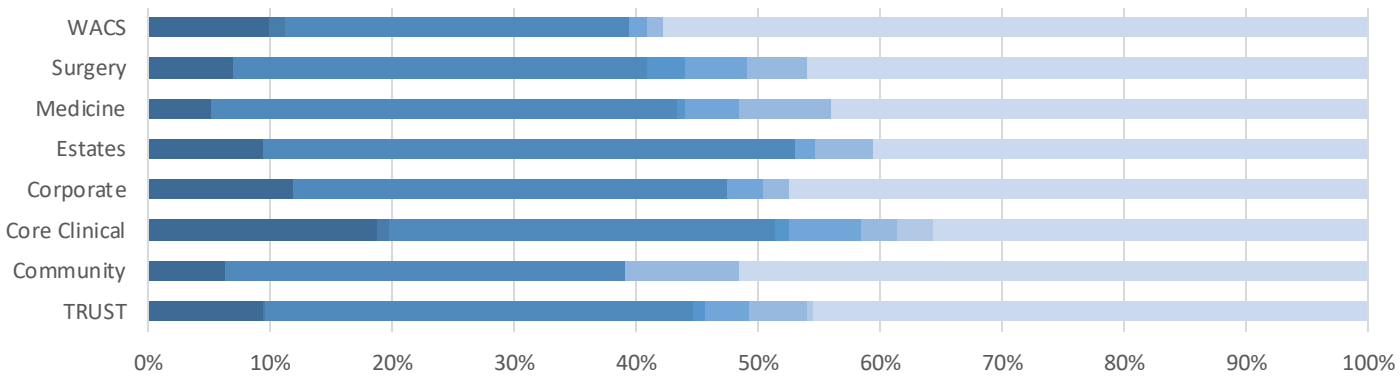


	TRUST	Community	Core Clinical	Corporate	Estates	Medicine	Surgery	WACS
Civil Partnership	1.12%	0.00%	0.00%	0.99%	4.69%	0.64%	0.63%	2.82%
Divorced	7.25%	10.94%	8.91%	2.97%	3.13%	7.64%	8.81%	7.04%
Legally Separated	0.98%	1.56%	0.99%	0.00%	1.56%	1.27%	0.63%	1.41%
Married	53.84%	57.81%	50.50%	55.45%	54.69%	54.78%	50.94%	56.34%
Single	31.24%	26.56%	35.64%	31.68%	21.88%	30.57%	35.85%	28.17%
Widowed	0.98%	0.00%	0.00%	1.98%	1.56%	0.64%	1.26%	1.41%
Not Stated	4.60%	3.13%	3.96%	6.93%	12.50%	4.46%	1.89%	2.82%

6.7 Maternity

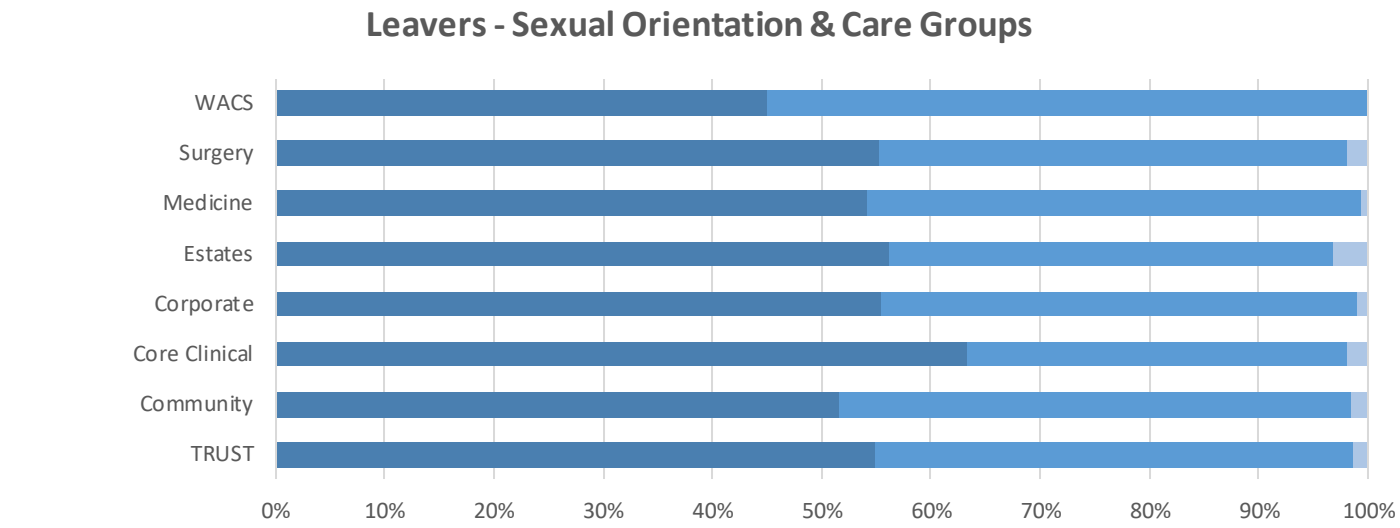
No colleagues were on maternity / adoption leave when they left in the 12 month period 2021-2022.

6.8 Religion & Belief



	TRUST	Community	Core Clinical	Corporate	Estates	Medicine	Surgery	WACS
Atheism	9.34%	6.25%	18.81%	11.88%	9.38%	5.10%	6.92%	9.86%
Buddhism	0.28%	0.00%	0.99%	0.00%	0.00%	0.00%	0.00%	1.41%
Christianity	35.01%	32.81%	31.68%	35.64%	43.75%	38.22%	33.96%	28.17%
Hinduism	0.98%	0.00%	0.99%	0.00%	0.00%	0.64%	3.14%	0.00%
Islam	3.63%	0.00%	5.94%	2.97%	1.56%	4.46%	5.03%	1.41%
Other	4.88%	9.38%	2.97%	1.98%	4.69%	7.64%	5.03%	1.41%
Sikhism	0.42%	0.00%	2.97%	0.00%	0.00%	0.00%	0.00%	0.00%
Not Stated	45.47%	51.56%	35.64%	47.52%	40.63%	43.95%	45.91%	57.75%

6.9 Sexual Orientation



	TRUST	Community	Core Clinical	Corporate	Estates	Medicine	Surgery	WACS
Heterosexual or Straight	54.95%	51.56%	63.37%	55.45%	56.25%	54.14%	55.35%	45.07%
Not Stated	43.65%	46.88%	34.65%	43.56%	40.63%	45.22%	42.77%	54.93%
LGBT	1.39%	1.56%	1.98%	0.99%	3.13%	0.64%	1.89%	0.00%

7. Conclusion

This report has summarised UHMB's workforce data in relation to protected characteristics for 2021/22.

Detailed workforce metrics, with data regarding employee experience have been published as part of the Trust's annual reporting cycle for Race, Disability, Gender and Sexual Orientation.

Through the Trust's structures and systems for Inclusion and Diversity (detailed in the Positive Difference Annual Report) these metrics are reviewed by staff and staff side, using data to drive exploration and discussion, to drive improvements in representation of our local population, and employee experience.

Equality Delivery System for the NHS

EDS2 Summary Report

Implementation of the Equality Delivery System – EDS2 is a requirement on both NHS commissioners and NHS providers. Organisations are encouraged to follow the implementation of EDS2 in accordance with the '9 Steps for EDS2 Implementation' as outlined in the 2013 EDS2 guidance document. The document can be found at: **http://www.england.nhs.uk/wp-content/uploads/2013/11/eds-nov131.pdf**

This *EDS2 Summary Report* is designed to give an overview of the organisation's most recent EDS2 implementation. It is recommended that once completed, this Summary Report is published on the organisation's website.

NHS organisation name:

University Hospitals of Morecambe Bay NHS Foundation Trust

Organisation's Board lead for EDS2:

Bev Edgar, Interim Chief People Officer

Organisation's EDS2 lead (name/email):

Barry Rigg, Head of Patient Experience (barry.rigg@mbht.nhs.uk)

Level of stakeholder involvement in EDS2 grading and subsequent actions:

In May 2022, we used an online survey and feedback system to capture citizen and colleague comments and ratings.

We have consulted with our Inclusion and Diversity Steering Group, local Equality and Diversity Groups, and our colleague inclusion networks (BAME, Carers, Disability, Forces, LGBT+, Women Leaders) for their feedback and thoughts on the evidence and ratings.

Organisation's Equality Objectives (including duration period):

We refreshed our equality objectives in 2021 with the launch of our latest five-year inclusion strategy 'Positive Difference'. As part of that strategy we have set out five commitment statements which also act as our equality objectives from 2021-2026.

Patients As Partners - We will provide opportunities for our patients and citizens to share their feedback and co-design with us, and this will be valued and acted upon.

Networks and Partnerships - We will be a supportive community, keeping each

Headline good practice examples of EDS2 outcomes (for patients/community/workforce):

Our latest five-year inclusion and diversity strategy 'Positive Difference' has been developed with our colleague inclusion networks and other key stakeholders and was approved by the Trust Board in November 2021. We are committed to working together to improve the experience of working in the NHS. All the actions we can take to make a positive difference to our colleagues are centred around the NHS People Promise. As part of this commitment, we have also created our own Morecambe Bay promise which forms the basis for our Positive Difference inclusion strategy.

We are an organisation where everybody feels that they belong, that takes action to

Publication Gateway Reference Number: 03247

Date of EDS2 grading May 2022 **Date of next EDS2 grading** May 2023

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
Better health outcomes	1.1	**Services are commissioned, procured, designed and delivered to meet the health needs of local communities** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ☑ Age; ☑ Disability; ☑ Gender reassignment; ☐ Marriage and civil partnership; ☑ Pregnancy and maternity; ☑ Race; ☑ Religion or belief; ☑ Sex; ☑ Sexual orientation **Evidence drawn upon for rating:** Evidence drawn from the New Hospitals programme including the service user survey Evidence will be collected from: Share your feedback on Lancashire and South Cumbria new hospital facilities (smartsurvey.co.uk) · Direct survey to be shared with colleagues, patients, and citizens their carers and families.	
	1.2	**Individual people's health needs are assessed and met in appropriate and effective ways** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ☐ Age; ☐ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ☐ Pregnancy and maternity; ☐ Race; ☐ Religion or belief; ☐ Sex; ☐ Sexual orientation **Evidence drawn upon for rating:** We did not assess this outcome this year and so the grade has been carried forward from 2021.	
	1.3	**Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ☑ Age; ☑ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ☑ Pregnancy and maternity; ☑ Race; ☑ Religion or belief; ☑ Sex; ☑ Sexual orientation **Evidence drawn upon for rating:** Not assessed this year, grading carried forward from 2021. Work in progress to support young people transitioning from children to adult services.	

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
Better health outcomes, continued	1.4	**When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ☐ Age ☐ Disability ☐ Gender reassignment ☐ Marriage and civil partnership ☐ Pregnancy and maternity ☐ Race ☐ Religion or belief ☐ Sex ☐ Sexual orientation Evidence drawn upon for rating: We did not assess this outcome this year and so the grade has been carried forward from 2021.	
	1.5	**Screening, vaccination and other health promotion services reach and benefit all local communities** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ☐ Age ☐ Disability ☐ Gender reassignment ☐ Marriage and civil partnership ☐ Pregnancy and maternity ☐ Race ☐ Religion or belief ☐ Sex ☐ Sexual orientation Evidence drawn upon for rating: We did not assess this outcome this year and so the grade has been carried forward from 2021.	
Improved patient access and experience	2.1	**People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ☑ Age ☑ Disability ☐ Gender reassignment ☐ Marriage and civil partnership ☑ Pregnancy and maternity ☐ Race ☐ Religion or belief ☑ Sex ☐ Sexual orientation Evidence drawn upon for rating: Evidence was collected from a direct survey shared with colleagues, patients, citizens, carers, and families. National patient survey results reviewed. FFT results reviewed. Care group alert and assurance reports were presented at the Patient Experience Group. PALS, complaints and comments reviewed by themes.	

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
Improved patient access and experience	2.2	**People are informed and supported to be as involved as they wish to be in decisions about their care** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ☑ Age; ☑ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ☑ Pregnancy and maternity; ☐ Race; ☑ Religion or belief; ☑ Sex; ☐ Sexual orientation **Evidence drawn upon for rating:** Evidence was collected from a direct survey shared with colleagues, patients, citizens, carers, and families. National patient survey results reviewed. FFT results reviewed. Care group alert and assurance reports were presented at the Patient Experience Group. PALS, complaints and comments reviewed by themes.	
	2.3	**People report positive experiences of the NHS** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ☑ Age; ☐ Disability; ☐ Gender reassignment; ☑ Marriage and civil partnership; ☑ Pregnancy and maternity; ☐ Race; ☐ Religion or belief; ☐ Sex; ☐ Sexual orientation **Evidence drawn upon for rating:** Our I3 colleagues developed a feedback engine in 2021 this captures patient satisfaction data. The system allows us to highlight and assess people's experiences of the service delivered by UHMBT. This outcome is quality assurance by the Patient Experience Group. Evidence was collected from a direct survey shared with colleagues, patients, citizens, carers, and families. National patient survey results reviewed. FFT results reviewed. Care group alert and assurance reports were presented at the	
	2.4	**People's complaints about services are handled respectfully and efficiently** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ☐ Age; ☐ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ☐ Pregnancy and maternity; ☐ Race; ☐ Religion or belief; ☐ Sex; ☐ Sexual orientation **Evidence drawn upon for rating:** Desktop assessment We developed a feedback engine in 2021 which offers all held and upheld complaints about the trust services. We will use the data to evidence if complaints are handled respectfully and efficiently. This outcome is quality assurance by the Patient Experience Group. Protective characteristics themed evidence is collected from both not upheld and upheld complaints.	

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
A representative and supported workforce	3.1	**Fair NHS recruitment and selection processes lead to a more representative workforce at all levels** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ☑ Age; ☑ Disability; ☐ Gender reassignment; ☑ Marriage and civil partnership; ☐ Pregnancy and maternity; ☑ Race; ☐ Religion or belief; ☐ Sex; ☑ Sexual orientation **Evidence drawn upon for rating:** In our colleague EDS survey, these characteristics were deemed to fare well by respondents. Our NHS Staff Survey results from 2021 indicate that 55.9% of respondents believe that we act fairly when it comes to career progression and promotion irrespective of protected characteristics. An area for improvement is representation amongst senior and board level roles in particular.	
	3.2	**The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ☐ Age; ☐ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ☐ Pregnancy and maternity; ☐ Race; ☐ Religion or belief; ☐ Sex; ☐ Sexual orientation **Evidence drawn upon for rating:** We did not assess this outcome this year and so the grade has been carried forward from 2021.	
	3.3	**Training and development opportunities are taken up and positively evaluated by all staff** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ☐ Age; ☐ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ☐ Pregnancy and maternity; ☐ Race; ☐ Religion or belief; ☐ Sex; ☐ Sexual orientation **Evidence drawn upon for rating:** We did not assess this outcome this year and so the grade has been carried forward from 2021.	

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
A representative and supported workforce	3.4	**When at work, staff are free from abuse, harassment, bullying and violence from any source** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ☑ Age; ☑ Disability; ☐ Gender reassignment; ☑ Marriage and civil partnership; ☑ Pregnancy and maternity; ☑ Race; ☐ Religion or belief; ☑ Sex; ☐ Sexual orientation **Evidence drawn upon for rating:** In our colleague EDS survey, these characteristics were deemed to fare well by respondents. A deep dive into our NHS Staff Survey results from 2021 showed significant improvements and reductions in disparity on questions relating to bullying and harassment for disabled colleagues and ethnic minority colleagues.	
	3.5	**Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ☑ Age; ☑ Disability; ☑ Gender reassignment; ☐ Marriage and civil partnership; ☑ Pregnancy and maternity; ☐ Race; ☐ Religion or belief; ☐ Sex; ☑ Sexual orientation **Evidence drawn upon for rating:** We did not assess this outcome this year and so the grade has been carried forward from 2021.	
	3.6	**Staff report positive experiences of their membership of the workforce** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ☐ Age; ☑ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ☐ Pregnancy and maternity; ☐ Race; ☐ Religion or belief; ☐ Sex; ☐ Sexual orientation **Evidence drawn upon for rating:** We did not assess this outcome this year and so the grade has been carried forward from 2021.	

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
Inclusive leadership	4.1	**Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ☐ Age; ☑ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ☐ Pregnancy and maternity; ☑ Race; ☐ Religion or belief; ☐ Sex; ☑ Sexual orientation **Evidence drawn upon for rating:** All colleague inclusion networks have an executive-level sponsor who is active in the network, uses their influence, and supports network leads to develop their networks. We have a board-sponsored Anti-Racist programme of work with each workstream led by a member of the board and/or senior leader. Some board members and senior leaders have an active presence on social media which they use to promote equality. We also used	
	4.2	**Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ☑ Age; ☑ Disability; ☑ Gender reassignment; ☐ Marriage and civil partnership; ☐ Pregnancy and maternity; ☑ Race; ☐ Religion or belief; ☑ Sex; ☑ Sexual orientation **Evidence drawn upon for rating:** We did not assess this outcome this year and so the grade has been carried forward from 2021.	
	4.3	**Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ☑ Age; ☑ Disability; ☑ Gender reassignment; ☐ Marriage and civil partnership; ☑ Pregnancy and maternity; ☐ Race; ☐ Religion or belief; ☑ Sex; ☐ Sexual orientation **Evidence drawn upon for rating:** We did not assess this outcome this year and so the grade has been carried forward from 2021.	

Public Board September 2022, Positive Difference colleague story

My experience of neurodiversity: living and working with ADHD at UHMB

This is not an easy thing to write about but I trust the person this is going to, knowing they will keep me safe in the future in my career.

Neurodiversity is a large umbrella term for several types of neurological disabilities, or as I like to say abilities!

In the year 2000 while at university I saw an educational psychologist regarding dyslexia. He diagnosed Attention Deficit Hyperactivity Disorder (ADHD), at the same time. This I denied for many many years as ADHD was just children who were naughty and ran around and were uncontrollable other than with medication, but I was not like that.

I continued to ignore and mask my symptoms for the next two decades in my work and home life, until the mask started to crack and break as job stresses increased and I could no longer control impulses and urges and gave into the dark thoughts of inadequacy. Just in case you were in the mind that his is what the hyperactivity means let me just shed some light for you: the hyperactivity is the description of thoughts and feelings going on all the time which disrupts sleep and makes small off-hand comments become huge and entirely 'your fault'.

I was bullied by a senior doctor at UHMB who repeatedly told me how stupid and inadequate I was, and how I did not deserve the title I had earned over the years. I brought this to the attention of my manager, and I was moved from the area as if I had been the person in the wrong not the locum doctor. My confidence fell even further. I moved temporarily and then stayed for just over the next few years into another department where I had support of most of the staff on the unit who again did not know my diagnosis and just thought I was good at my job although I never felt this.

When you are neurodivergent, especially with ADHD, you're constantly trying to prove yourself to be good enough and just like everyone else who is neurotypical. 'ADHD feels like you're never doing what you're "supposed" to be doing - so no matter how productive you are, it feels like not enough'. This became too much to handle and combined with home life issues, family illness and past patient contacts, threw me into an uncopeable depression and anxiety that meant I had to take time off work.

I was under Occupational Health who were supportive and did not want me back into the situation until I was ready, but my manager at that time did not understand and even said to me 'It's about time you stop enjoying having time off and got yourself back to work.' This made me feel worse and like I was letting people down so back to work I went - even though every day I was planning how I could maim myself in an accident so I did not have to go into work and be in that situation, but so people could see my illness instead of the hidden disability that I had.

Working with and masking neurodiversity to appear 'normal' is exhausting - constantly fighting an internal battle to fit in and be liked by everyone around you and proving you are normal and that you can do everything.

After 12 months this took over my wellbeing once again, and again Occupational Health and my GP signed me off work treating anxiety and depression illness. I asked Occupational Health about redeployment but thankfully they were supportive and opted to wait until I was in a better frame of mind to make this decision.

I was getting more worried about going back into my senior role and was going to give up my career then I saw a job for a secondment opportunity, in a slightly different career path. I was successful in my application!

By this point I could no longer hide my disability and was open from the outset. This turned out to be to my benefit as I had a new manager who was very supportive of my neurodiversity and thought it brought more to my role and to the benefit of others around me. Realising that they were soon to be leaving the Trust, I panicked, after finally feeling that I was in a safe place - but actually my new manager took on this support to an even higher level. They encouraged me to grow and embrace my difference.

I was also supported to take part in the neurodiversity coaching this year which was excellent and cathartic at the same time. I am still learning about myself and how to help other people understand mine and other people's diversity. I have been approached by people who have never disclosed their diversity and now feel they would like to.

In this time, I looked at a position outside the Trust and was offered it but told that I needed to be changed and taught how to communicate at a high level and basically be a different person, even though I had disclosed from the outset my disability. I declined the role, no one was going to start to change me now!

It's not perfect yet, I still run into challenges from people who deny that it is a disability or recognised difference and that I am 'just disruptive or rude', but I will continue to challenge these people. I know I cannot please and be liked by all people (this is a revelation for someone with ADHD who takes all little criticism to heart).

This is a positive story now, but only because of the support and love I have received from colleagues and my team embracing my neurodiversity. As a Trust we still have some way to go to help make minor adjustments for the neurodiverse, but I do think we have embarked upon that journey.

Risks Closed on the TRR since July 2021

Risk Number	Title	Current Score	Closed	Reason
Risk 2101 Corporate Business	Delivery of NHS Constitutional Standards	20 Almost Certain 5 x Major 4	12/01/2022	Risk discussed at EDG Jan 2022 and agreed to be closed and replaced with separate risks – Risk 3000 and Risk 3001.
Risk 2753 Corporate Business, Finance	2020/21 H1 balanced position not achieved and no long-term Financial Strategy	12 Possible 3 x Major 4	09/09/2021	Risk agreed to be closed as covered in Risk 2860 below.
Risk 2860 Corporate Business, Finance	H1 & H2 Financial balance	12 Possible 3 x Major 4	29/04/2022	Risk discussed at Finance Leadership 28/04/2022 and agreed to be closed – end of financial year. New risk for 22/23 to be created
Risk 2949 Corporate Business, HR	Mandatory vaccination of all frontline colleagues	4 Rare 1 x Major 4	22/04/2022	Risk discussed at People and OD following formal notification that the regulations have been revoked as of 15 March 2022 and agreed to close the risk.

Risks reduced and/or escalated since July 2021

Since July 2021,14 risks have been escalated from the RMG to TMG for awareness or for consideration as 'Corporate' risks for addition to the Trust-wide Risk Register.

Date	Risk	Action taken
July 2021	2564 - Incomplete patient records could compromise patients care and risk legislative non-compliance	TMG redirected to I3 as an Information Governance Risk. Held at Care Group Level
September 2021	2609 - Urgent Care Access standards 2903 - Skill mix of Nursing and Midwifery staff due to unfamiliarity with UHMB processes and procedures	2609 – TMG agreed risk should sit with Medicine 2903 - ACN to oversee
October 2021	2817 - Potential increase of admissions to Children's Wards cross bay due to national Respiratory Syncytial Virus (RSV) surge 2872 - The current Midwifery and Obstetrics staffing establishment is not fully recruited to and is also depleted because of sickness absence and maternity leave	2817 - TMG Informed 2872 – TMG Informed
November 2021	2931 - NHS Standard Contract 2022/23 - Clostridioides difficile toxin positive potential breach of threshold	Accepted onto the Trust wide Risk Register Exec oversight – Executive Chief Nurse
December 2021	2945 - Medical Staffing ED FGH	Accepted onto the Trust wide Risk Register Exec oversight - Chief Medical Officer
January 2022	2805 - Medical staffing in ED RLI	Accepted onto the Trust wide Risk Register Exec oversight – Chief Medical Officer
February 2022	655 - Non-compliance with medicines reconciliation Quality Standard QS120, leading to continued poor patient outcomes and reputational damage	TMG accepted business case and directed back to Core Clinical Care Group for management
April 2022	2394 - Continuing health Care (CHC) - no clear process	Accepted onto the Trust wide Risk Register Exec oversight – Executive Chief Nurse
April 2022	2443 - Impact of Staff Training in Emergency Preparedness and Emergency Skills on Business Resilience and Emergency Planning 2957 - Providing a robust and effective mask fitting service for staff and visitors at UHMB	2443 –TMG Informed 2957 –TMG Informed
May 2022	2918 - No designated vascular access services across Trust	2918 – Informed of business case in progress

Risk profile - Trust-wide risk Register

The table below shows the spread of risks on the Trust-wide risk register and this illustrates that, in line with our strategy, not all risks on the TRR are of high value.

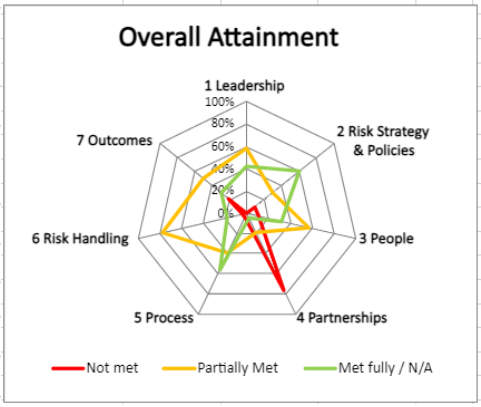
	Consequence				
Likelihood	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic					
4 Major			**2**	**3**	**4**
3 Moderate			**1**	**1**	
2 Minor					
1 Insignificant					

HM Treasury Risk Maturity Self-Assessment Framework: Overall attainment

The current assessment equates to a very strong level 3 position having attained an overall cumulative score of 57.8%.

Level	Score	Description
1	<20%	The organisation as an awareness and understanding of risk management
2	>20-40%	Approaches for addressing risks are in place and action plans for implementation being developed
3	>40-60%	Risk management applied consistently and thoroughly across the organisation
4	>60-80%	The organisation is proactive in driving and maintaining the embedding of risk management and integration in all areas of the organisation
5	>80-100%	The organisation sustains risk capacity, organisational & business resilience and commitment to excellence in risk management, leaders regarded as exemplars

Response	Not met	Partially Met	Met fully / N/A	Total
1 Leadership	0.0%	57.9%	42.1%	
2 Risk Strategy & Policies	8.7%	30.4%	60.9%	
3 People	10.7%	57.1%	32.1%	
4 Partnerships	76.2%	19.0%	4.8%	
5 Process	4.1%	39.7%	56.2%	
6 Risk Handling	4.0%	78.0%	18.0%	
7 Outcomes	20.8%	50.0%	29.2%	



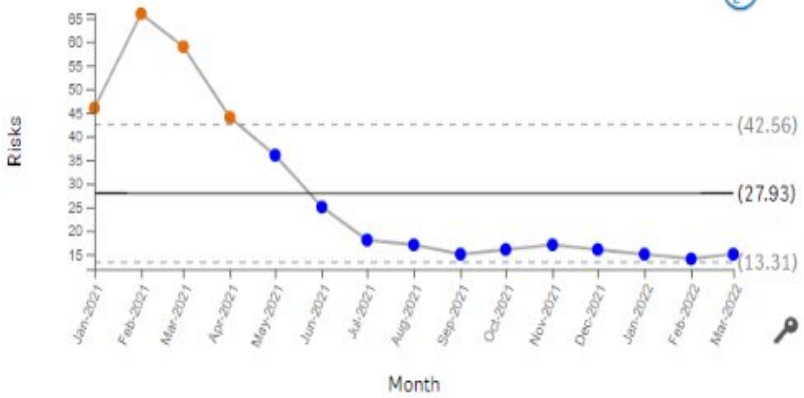
Risk KPIs – SPC Charts

Risk Management

Metric	Plan	Actual	Variation	Assurance
Extreme Risks Remaining Extreme For 12 Or More Months	N/A	15		
Risks Remaining At The Same Risk Score For 12 Or More Months	N/A	86		
Volume of Risks with a Score of 20 or 25 and a Severity of '5-Catastrophic'	N/A	2		
Volume of Risks with a Score of 5, 10 or 15 and a Severity of '5-Catastrophic'	N/A	15		
Volume Of Tolerated Risks	N/A	58		
Compliance to Risk Management Training	N/A	95.5%		
Volume Of New Risks By Month	N/A	21		
Volume Of Closed Risks By Month	N/A	15		
Risk Reviews Completed On Time	N/A	83.7%		
Risks Beyond Target Completion Date	N/A	18.8%		
Risk Actions Beyond Target Completion Date	N/A	38.7%		

Extreme Risks Remaining Extreme For 12 Or More Months

*Mean and Control Limits calculated on first 15 points of data, lower is better

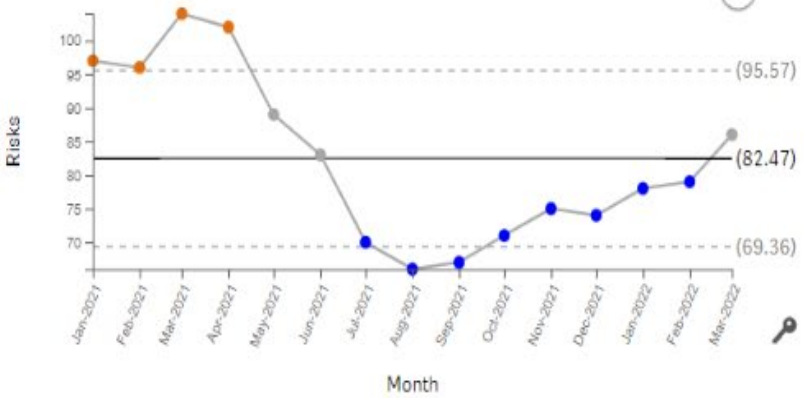


Latest
15
Variance Type
Special cause variation - improvement (indicator where low is good)
Target
N/A
Target Achievement
N/A

*Some risks are not wholly owned by the trust so will be beyond the ability of the trust to influence the score

Risks Remaining At The Same Risk Score For 12 Or More Months

*Mean and Control Limits calculated on first 15 points of data, lower is better

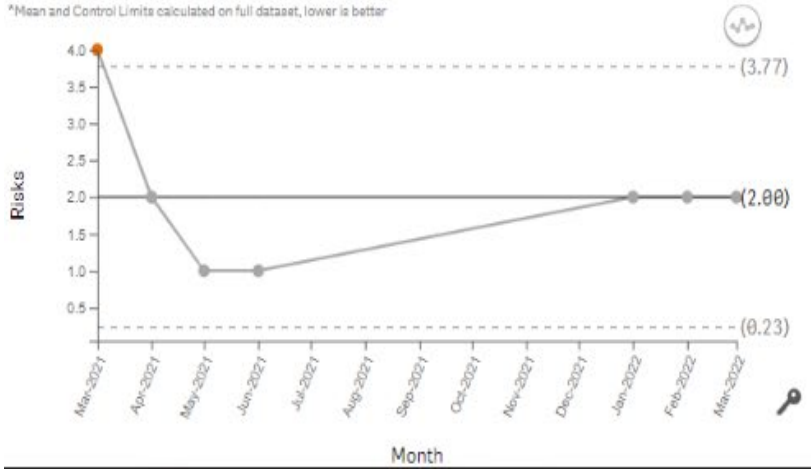


Latest
86
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

*Some risks are not wholly owned by the trust so will be beyond the ability of the trust to influence the score

Volume of Risks with a Score of 20 or 25 and a Severity of '5-Catastrophic'

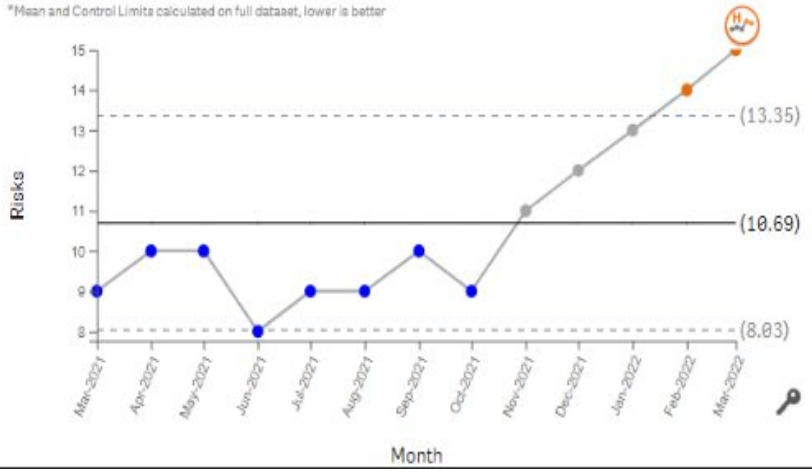
*Mean and Control Limits calculated on full dataset, lower is better



Latest
2
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Volume of Risks with a Score of 5, 10 or 15 and a Severity of '5-Catastrophic'

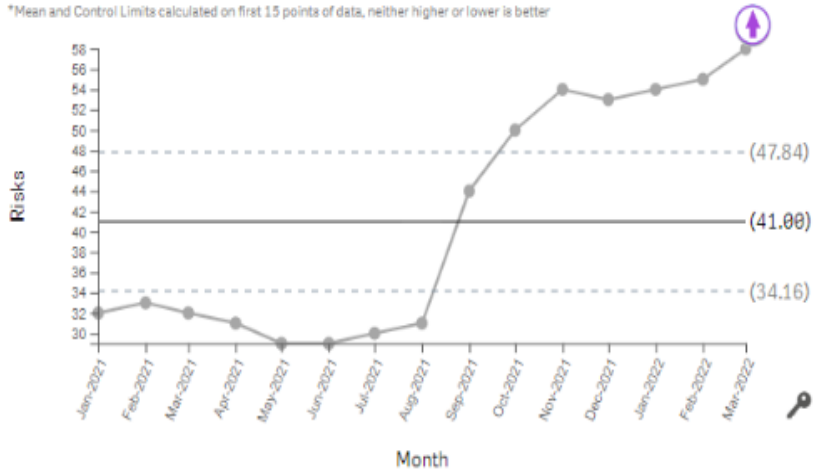
*Mean and Control Limits calculated on full dataset, lower is better



Latest
15
Variance Type
Special cause variation - cause for concern (indicator where high is a concern)
Target
N/A
Target Achievement
N/A

Volume Of Tolerated Risks

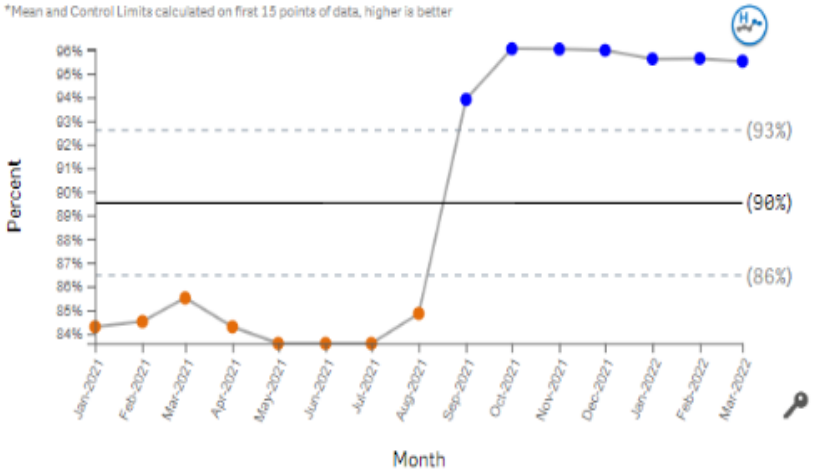
*Mean and Control Limits calculated on first 15 points of data, neither higher or lower is better



Latest
58
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Compliance to Risk Management Training

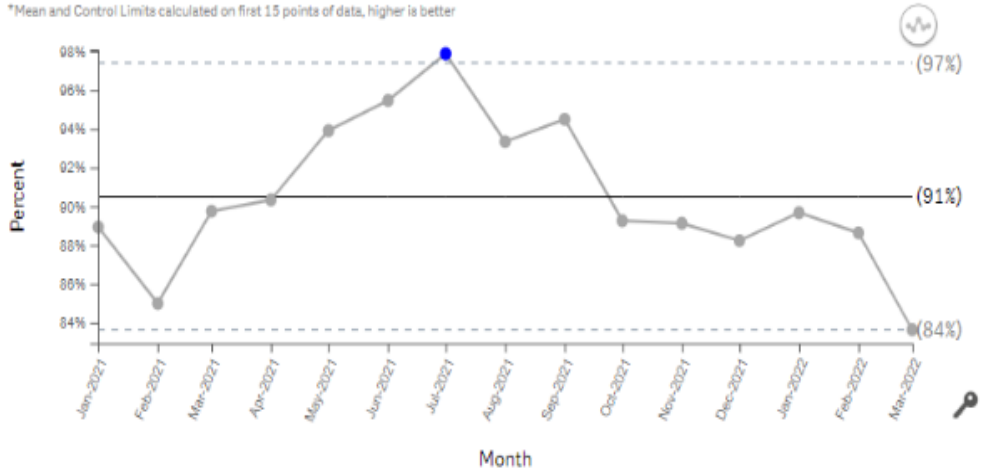
*Mean and Control Limits calculated on first 15 points of data, higher is better



Latest
95.5%
Variance Type
Special cause variation - improvement (indicator where high is good)
Target
N/A
Target Achievement
N/A

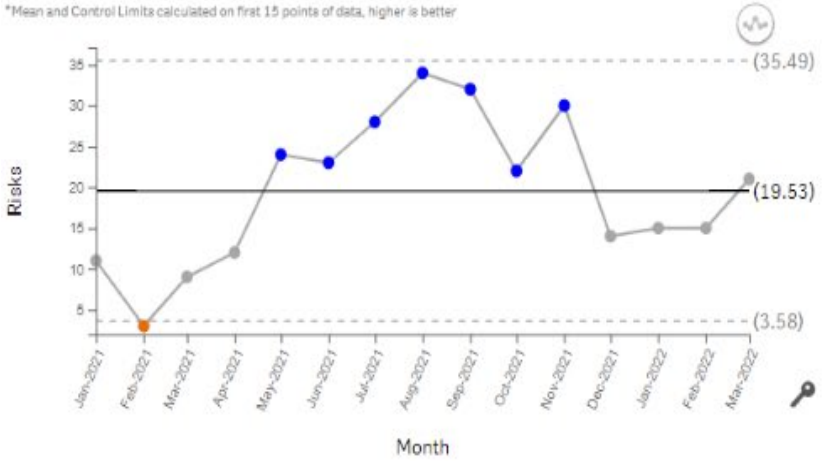
Risk Reviews Completed On Time

*Mean and Control Limits calculated on first 15 points of data, higher is better



Volume Of New Risks By Month

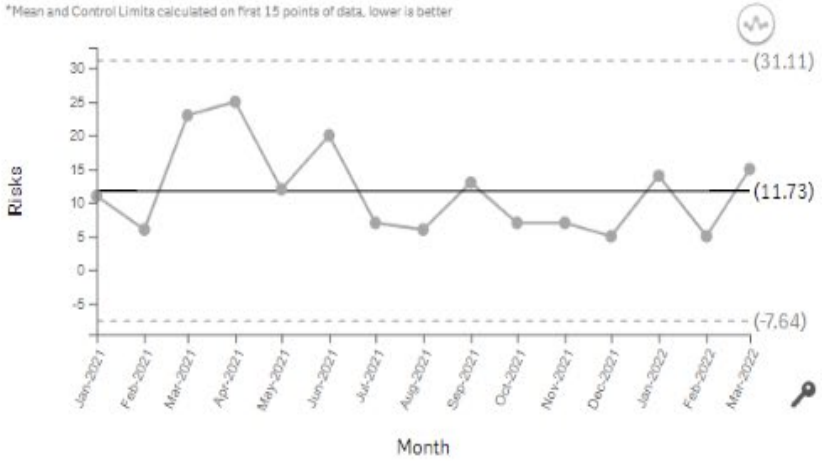
*Mean and Control Limits calculated on first 15 points of data, higher is better



Latest
21
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Volume Of Closed Risks By Month

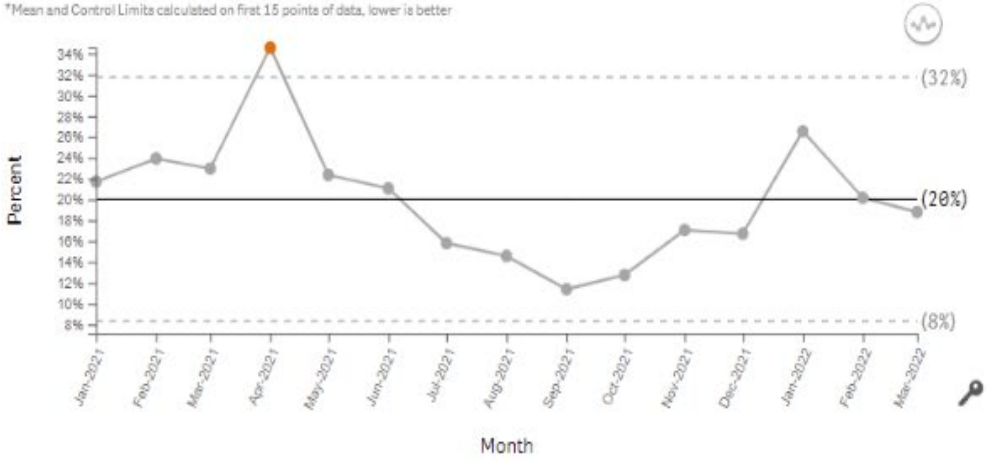
*Mean and Control Limits calculated on first 15 points of data, lower is better



Latest
15
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Risks Beyond Target Completion Date

*Mean and Control Limits calculated on first 15 points of data, lower is better



Risk Actions Beyond Target Completion Date

*Mean and Control Limits calculated on first 15 points of data, lower is better