PUBLIC TRUST BOARD OF DIRECTORS' MEETING

Wednesday 26 October 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**
People and organisational development: ***Create the culture and conditions for colleagues to be the very best they can be***			
139i	Positive Difference Annual Report 2021/22 and Colleague Story	Interim Chief People Officer	Attached
Quality and safety: ***Delivering outstanding care and experience***			
140i	Care Quality Commission (CQC) and Royal College of Surgeons (RCS) Improvement Plan	Director of Governance	Attached
142	UHMB Recovery Support Programme Metric Summary	Deputy Chief Executive	Attached
Performance and resources: **Make the best use of our physical and financial resources**			
143	Assurance Committee Minutes	Chairs of the Assurance Committees	Attached

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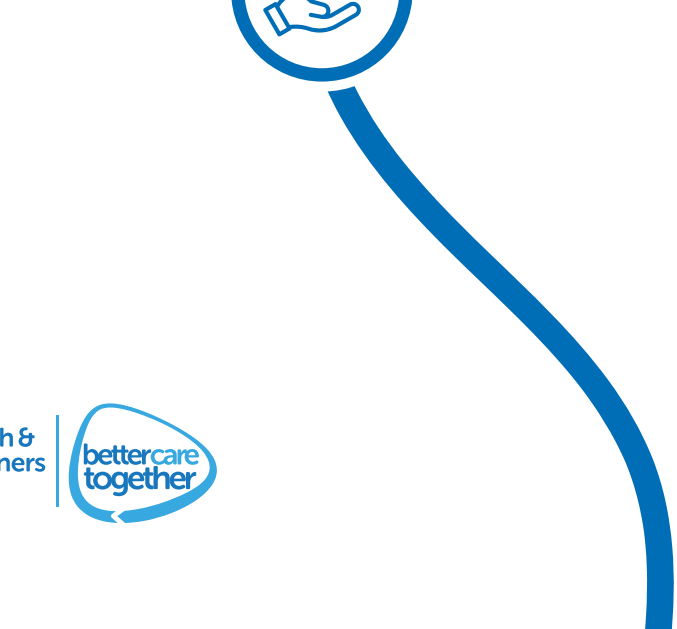
We are UHMBT

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.

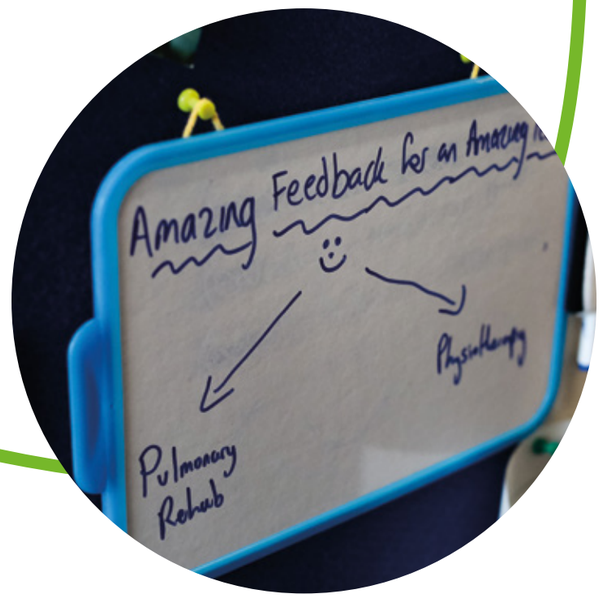
To enable a supportive, fair, and compassionate approach at colleagues' first point of contact in People & OD, Northumberland alumni first delivered restorative just and learning skills development with People Advisors through structured training and coaching.

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.

72

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

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.

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.

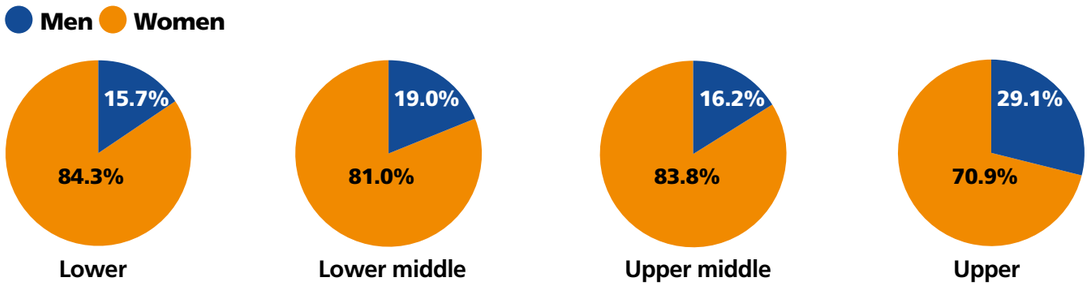
Proportion of men and women receiving a bonus payment

4.4%
Men were paid a bonus

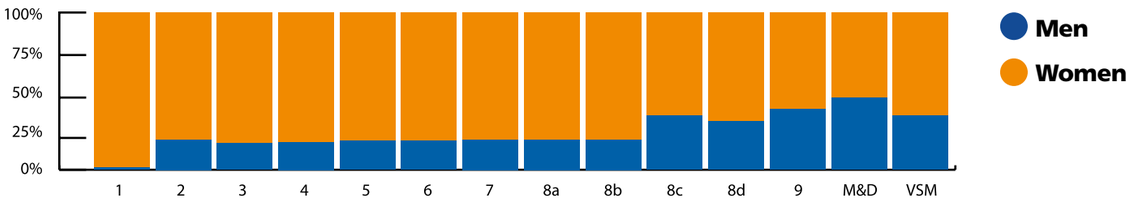
0.3%
Women were paid a bonus

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

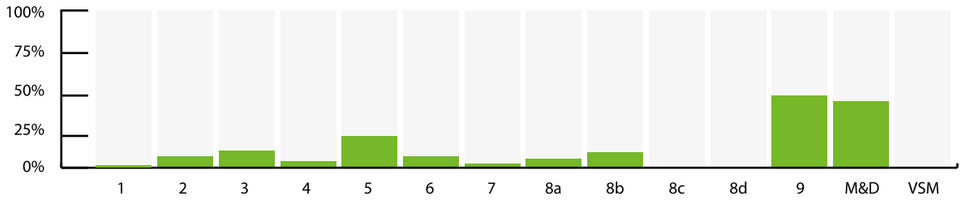
Ethnicity Pay Reporting is not a national requirement; however, we believe it is good practice to record and report against this important measure of equality to enable us to make a positive difference. The full report on this measure is included as part of the WRES 2022 in Appendix D.

	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**

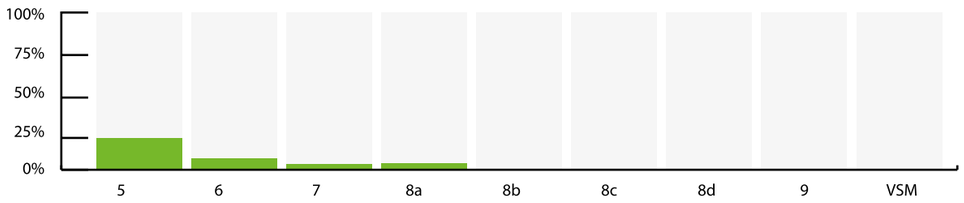
Ethnic minority colleagues at Morecambe Bay are likely to earn a higher wage than white colleagues. This is likely due to the demography of the Trust, with 48% of Medical staff identifying as Black, Asian or Ethnic Minority, compared with only 9% of non-Medical staff.

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

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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.
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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

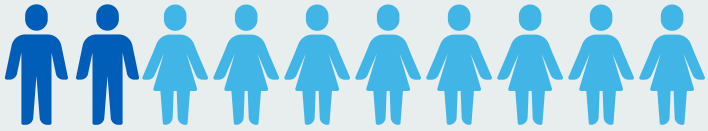
f) Proportion of men receiving a bonus payment and proportion of women receiving a bonus payment

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.

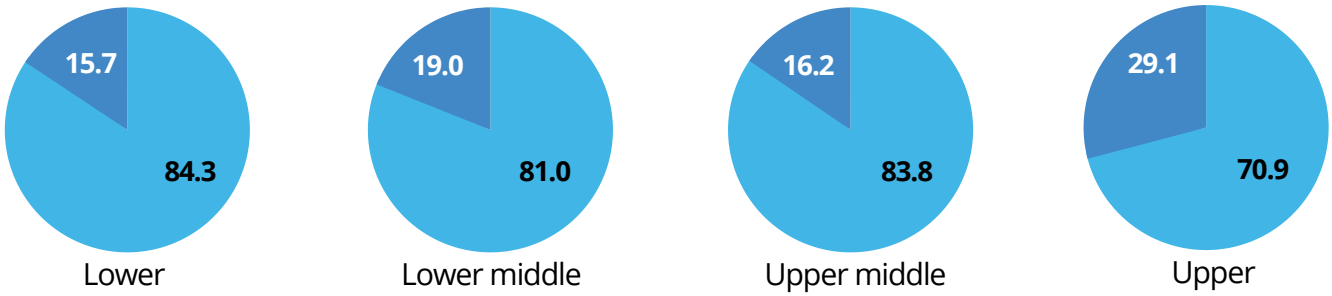
Medical and Dental and VSM staff are higher earners in the NHS so it is important to note the impact this has on the gender pay gap.

	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**

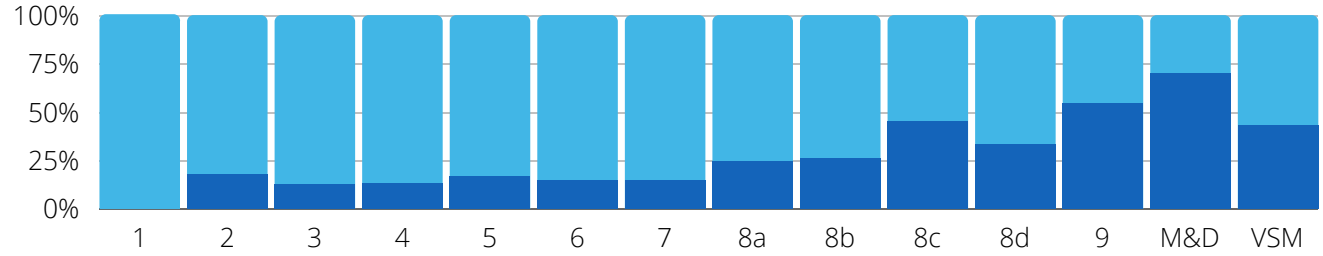
Women earn 93p for every £1 earned by men.
This is 3p closer to men's earnings than 2021.

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

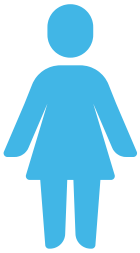


Our gender pay gap 2022

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

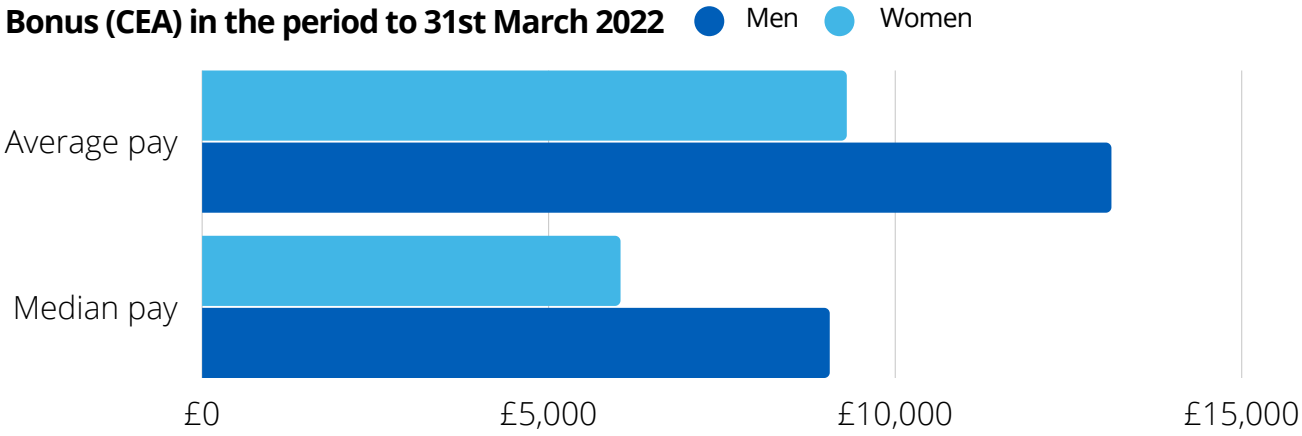


Women

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



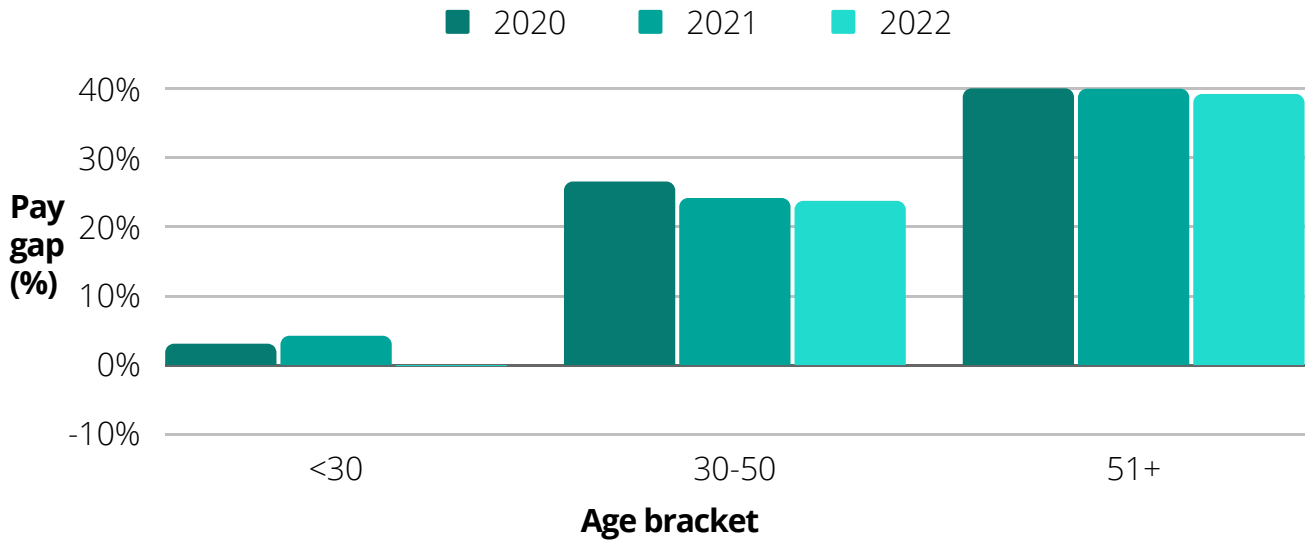
Women earn 67p for every £1 that men earn when comparing median bonus pay.

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.

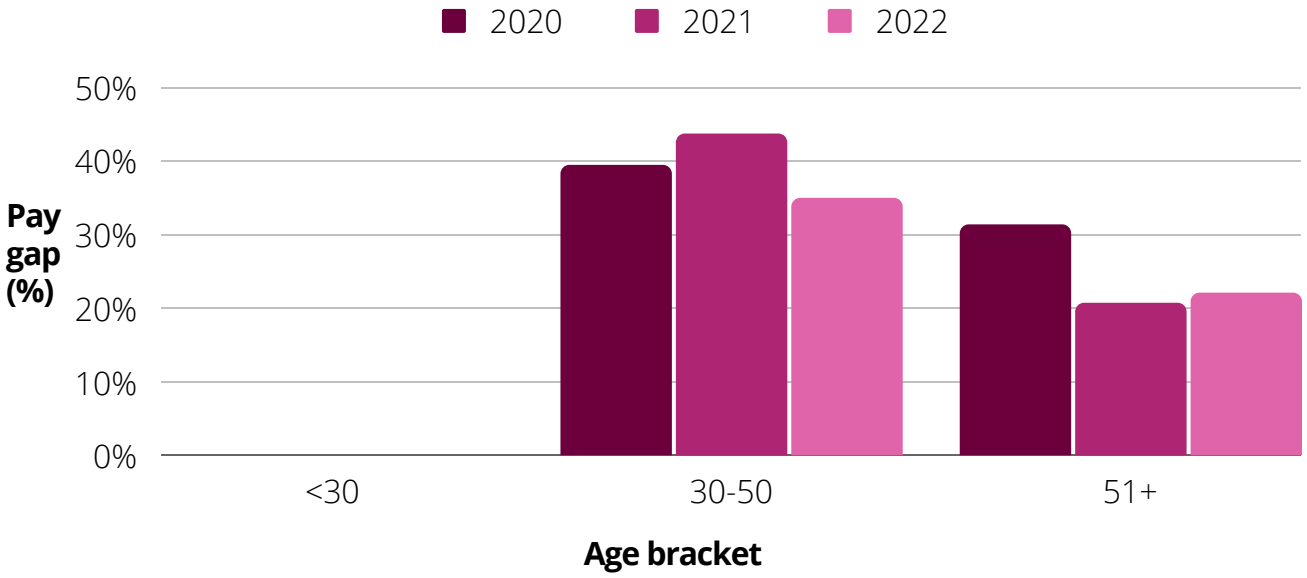
This staff group represents approximately 10% of the NHS workforce, and the charts above illustrate a breakdown by gender of the CEAs which were paid to UHMBT staff as at 31st March 2022. The details are based on the national ESR reporting tool assumption that all staff may be eligible for bonus payments.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

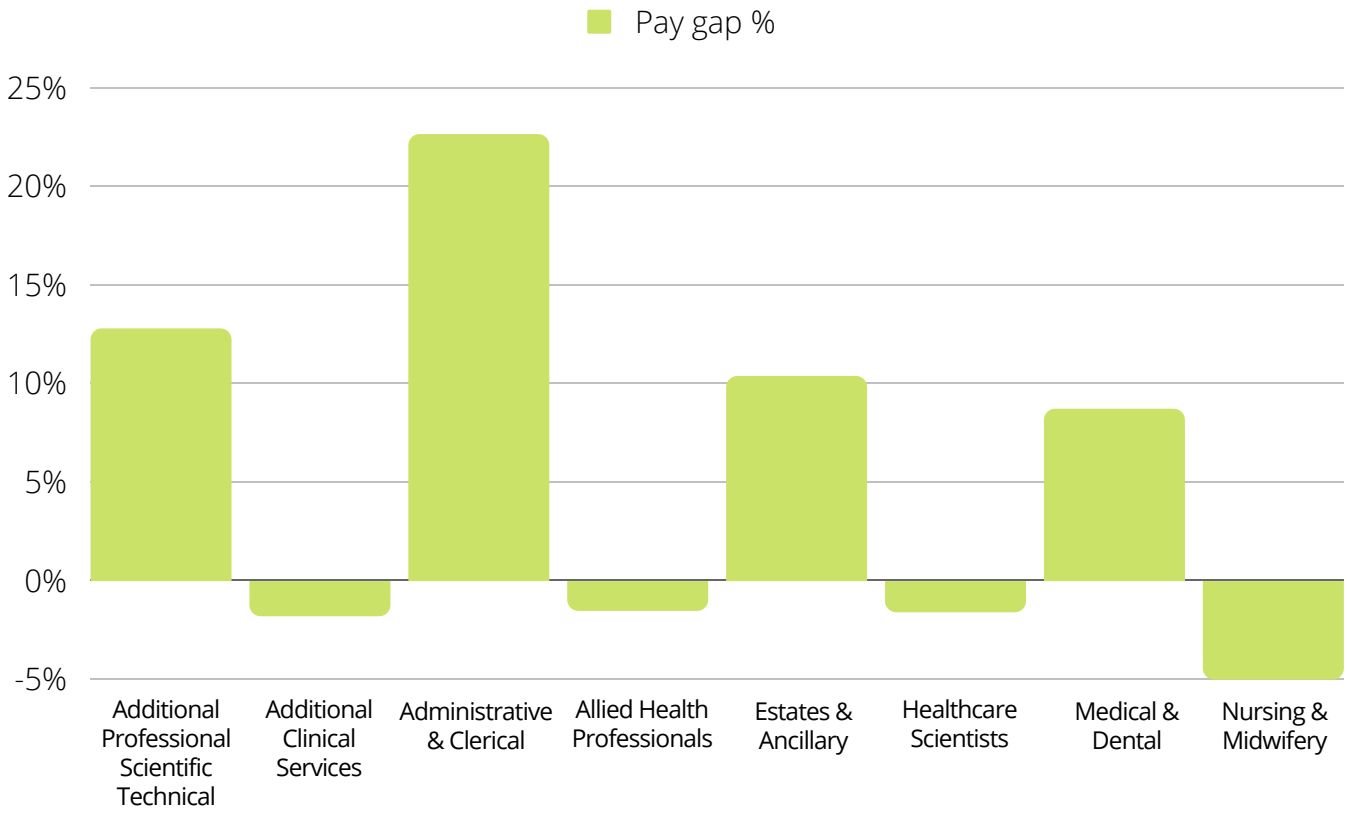


By hourly rate, the gender pay gap is smallest for women aged 30 and under, and increases with age. Women over 50, who are most likely to be in leadership roles, have the highest pay gap. The greatest improvement in-year is evident for women under 30, where the average hourly rate is now equal to men's. 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)

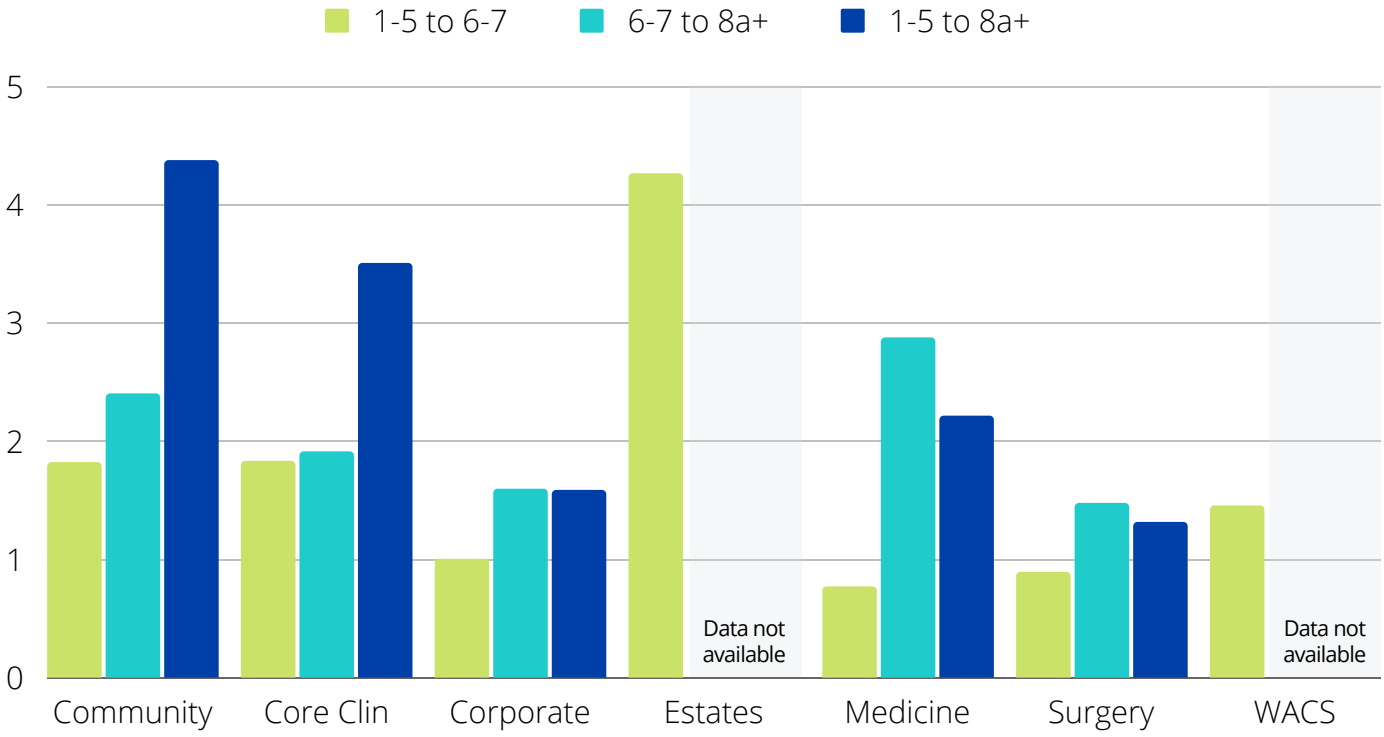
1 in 7 men and **1 in 14 women** progress from the lower to upper grades (Bands 1-5 to 8a+)

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

This shows almost no change from 2021.

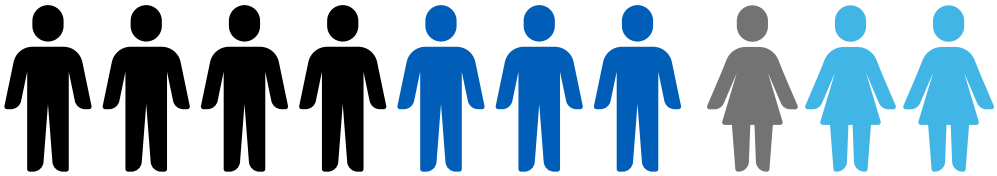
Progression disparity ratio by Care Group (AfC roles only)

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:



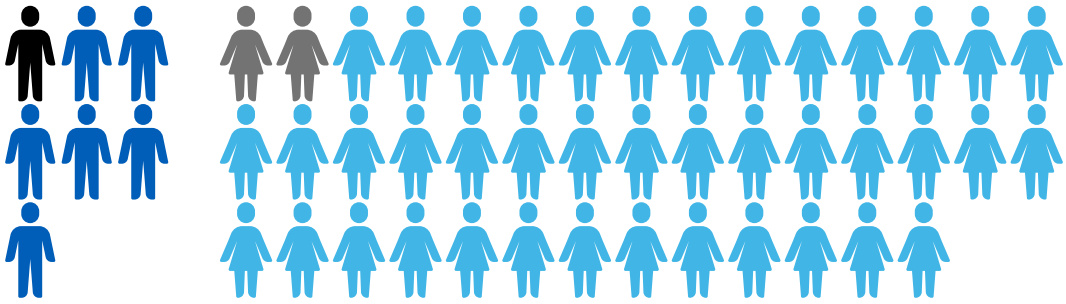
368 men (70%) and **160 women** (30%) in total, including
189 men (36%) and **58 women** (11%) of a Black, Asian or Ethnic Minority background

- **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

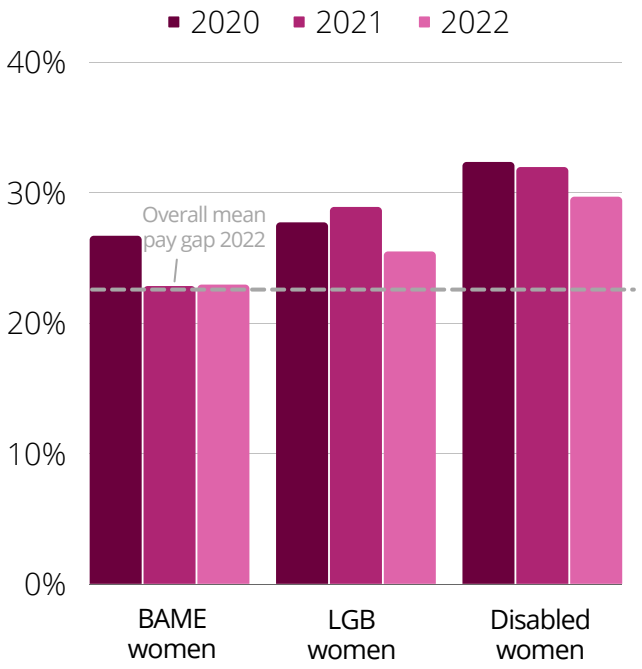
- **1.4%** of the non-medical workforce have disclosed their sexual orientation as LGB, with **25.7%** of colleagues preferring not to disclose their sexual orientation at all.
- **3%** of the non-medical workforce have disclosed a disability, with **23.3%** of colleagues preferring not to say whether 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

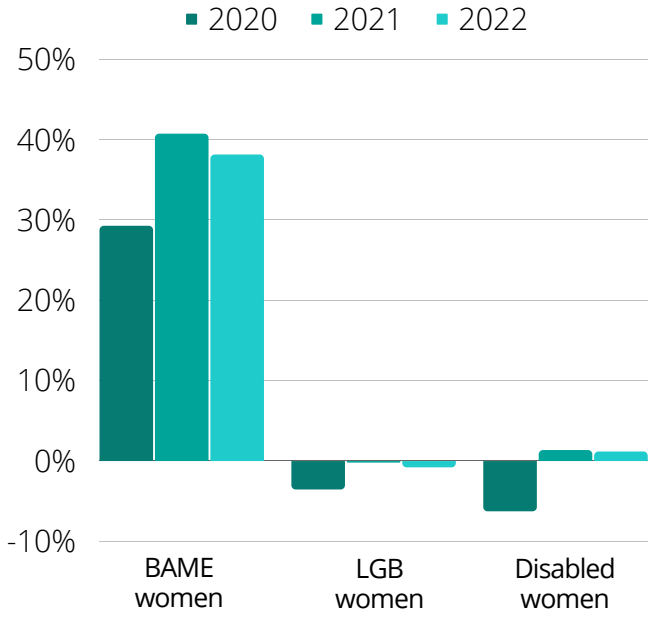
A. Mean pay gap for women in protected characteristic groups, compared with pay for all men (%)



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 (%)

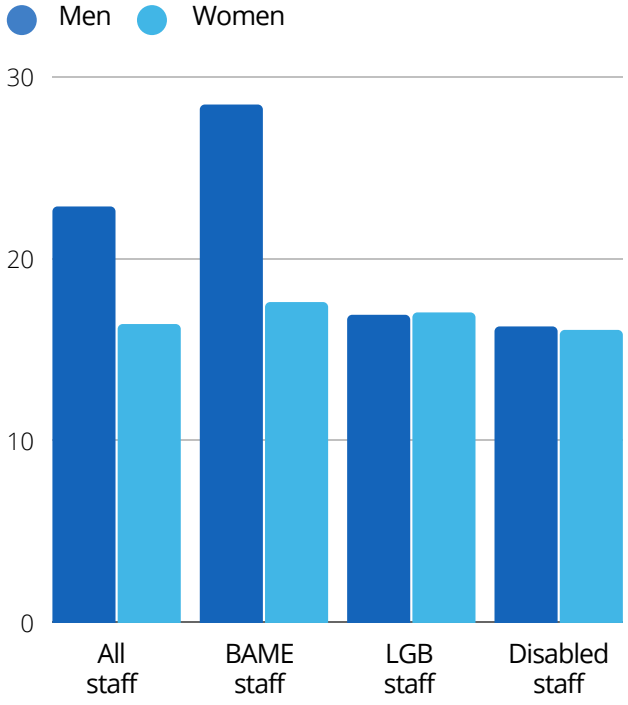


Comparing against the earnings of men from equivalent protected groups shows a slightly different picture:

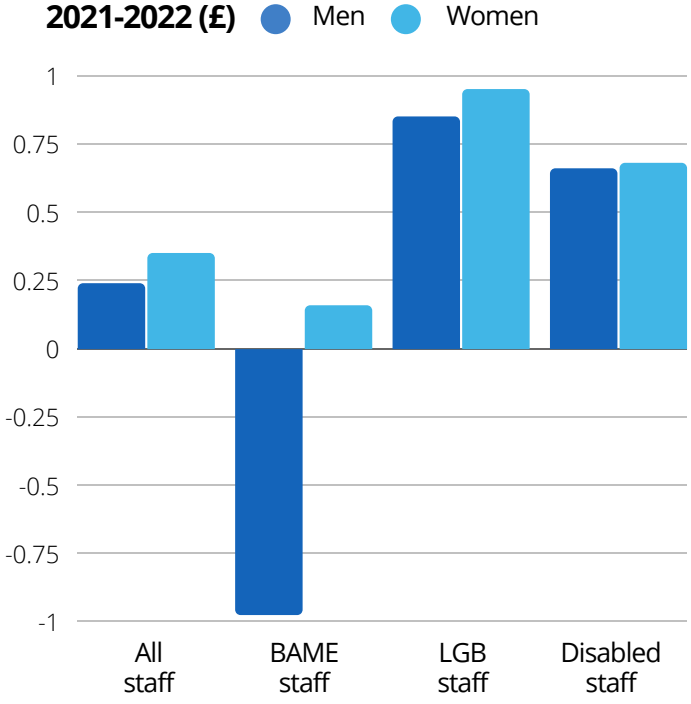
- Progress for all protected characteristic groups, with a decreasing pay gap.
- Improvements for LGB and disabled women, close to an equal position.
- Some improvement for ethnic minority women, with a still significant pay gap of 38.1% but a decrease of 2.5% in year.

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

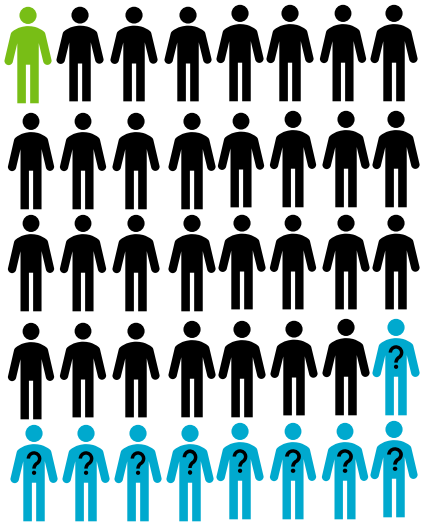
Workforce Disability Equality Standard (WDES) is a set of specific measures enabling us to compare the workplace and career experiences of our Disabled and non-disabled colleagues. We use these measures to develop and publish our action plan, to reflect on progress we have made and identify where improvements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

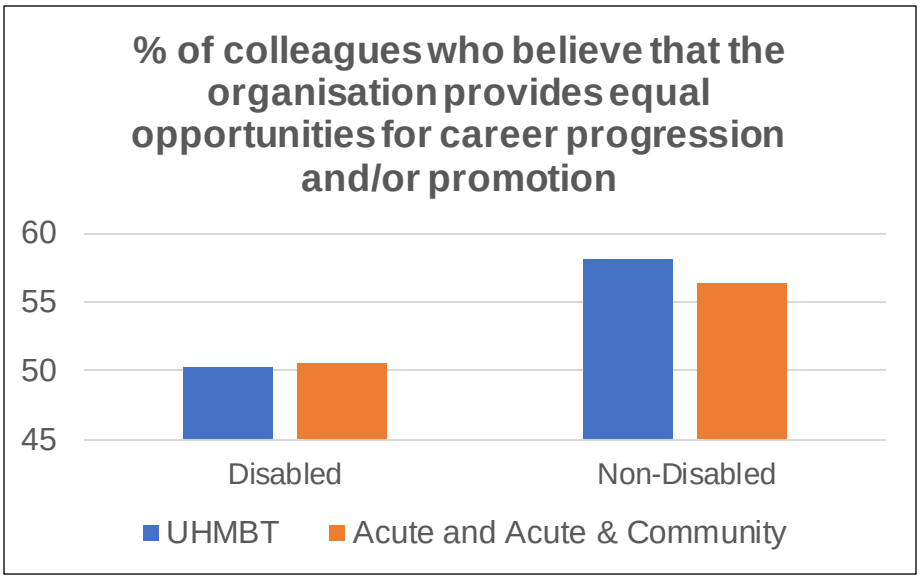
We no longer have any voting Board members who have told us they are Disabled, which equates to a difference of **-3.56**% and a decrease from 7.69% from 2021.

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

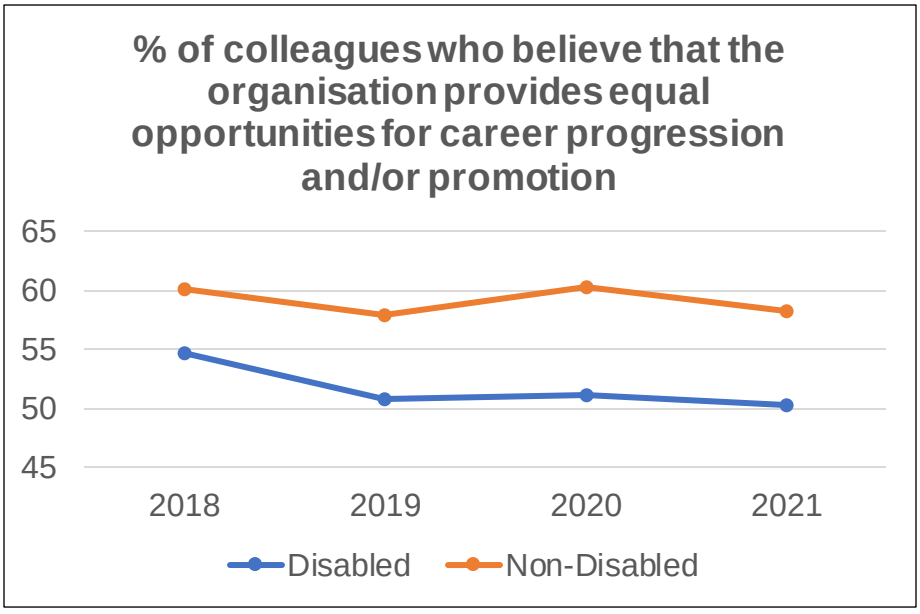
Representation, recruitment and progression

% 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.



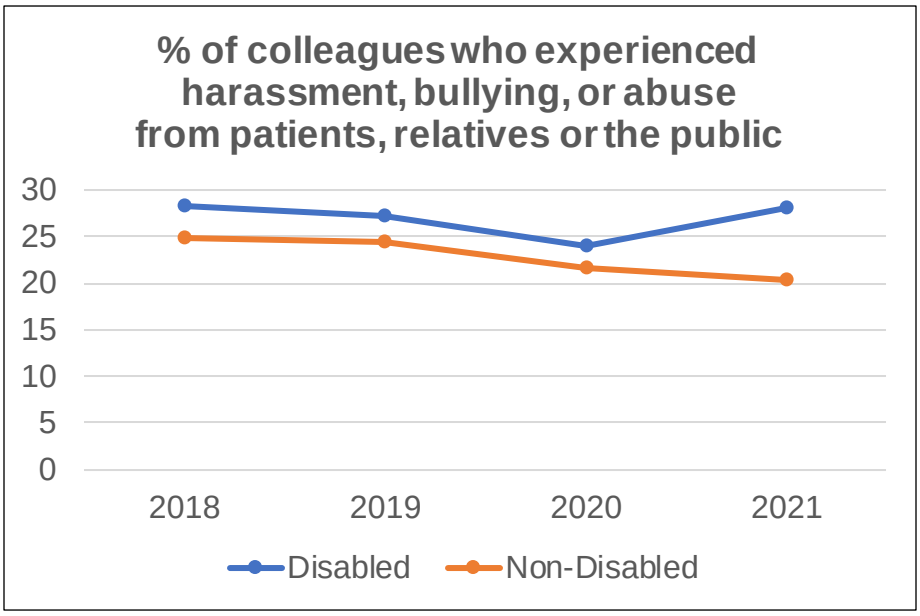
A sustained disparity of almost 10% can be seen between Disabled and non-disabled colleagues, amid slight deterioration for all colleagues.

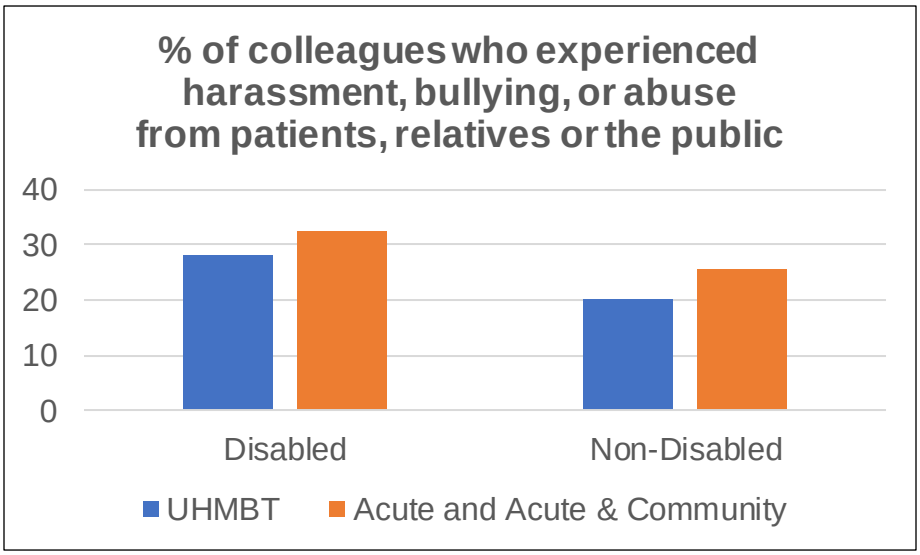
Action planned to address this metric in the WRES 2021 was delayed due to Covid pressures, and must be revisited for 2022/23.

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.

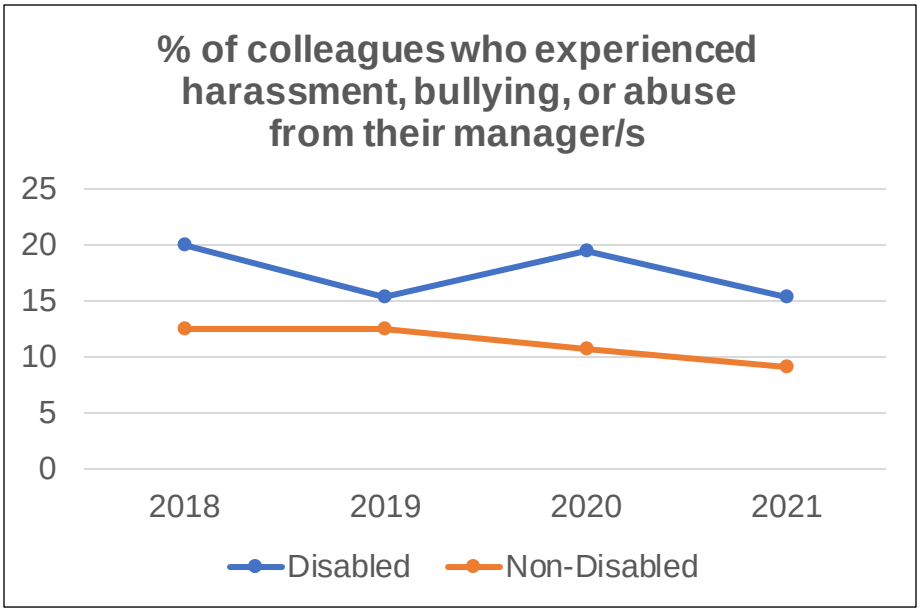
This opposes a picture of marginal improvement for non-disabled colleagues, increasing the disparity by over 200% to the widest point yet recorded.

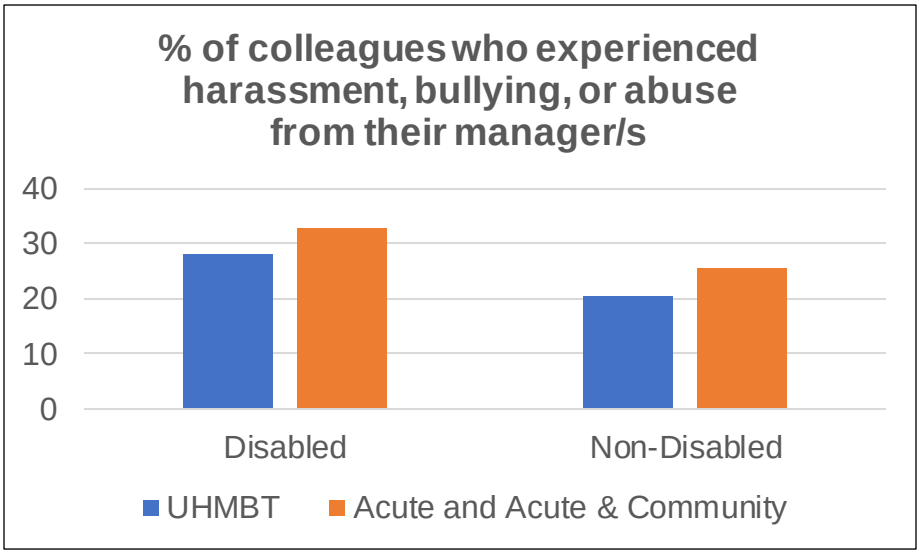
The UHMB experience remains consistently better than the national average for both Disabled and non-disabled colleagues, however the significantly widened disparity shows unusual activity which should be investigated and promptly addressed.

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.

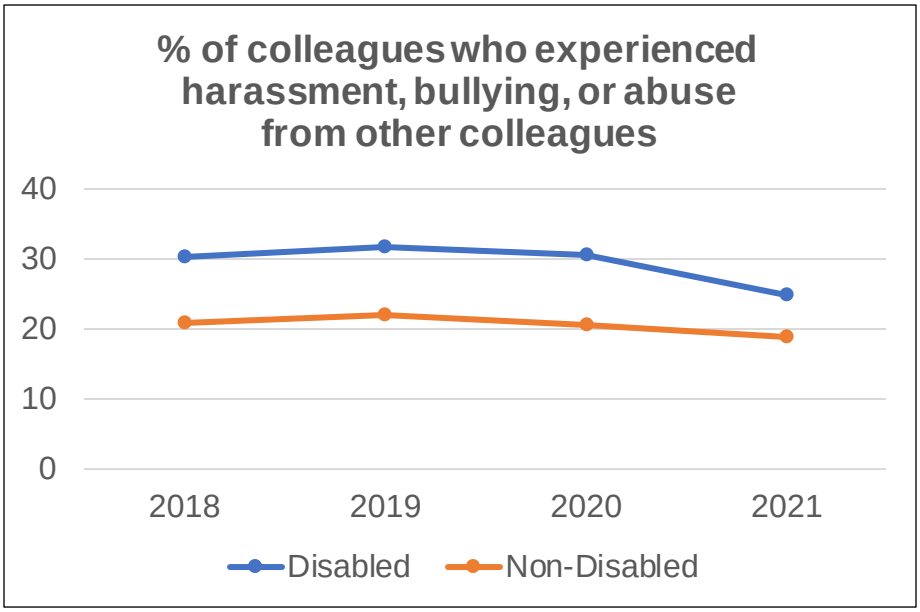
Though this meets the target for improvement set out in the UHMB WDES 2021, the disparity in experience remains significantly wider than figures from 2019, indicating the need for further targeted work to improve experience specifically for Disabled colleagues.

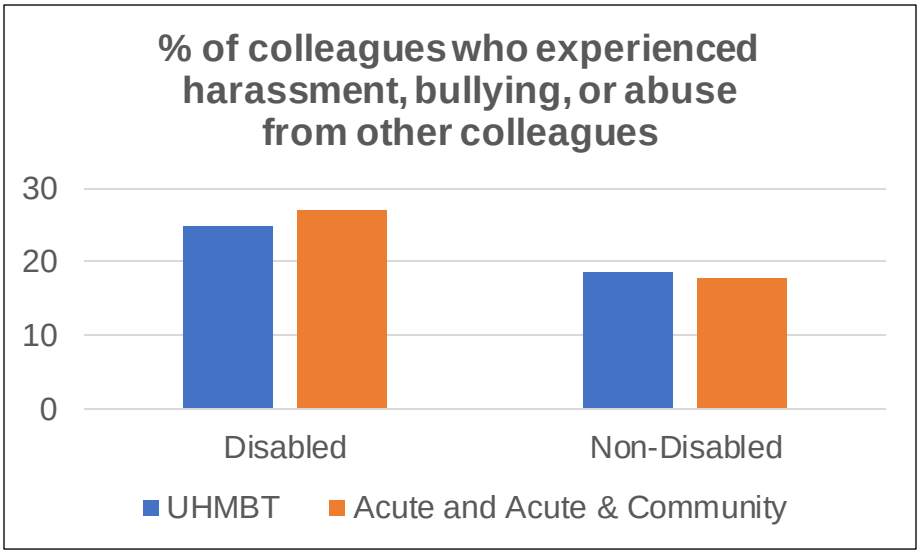
Comparing results at UHMB to the national average for Acute and Community Trusts shows that we are performing better than our peer group for this measure.

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.

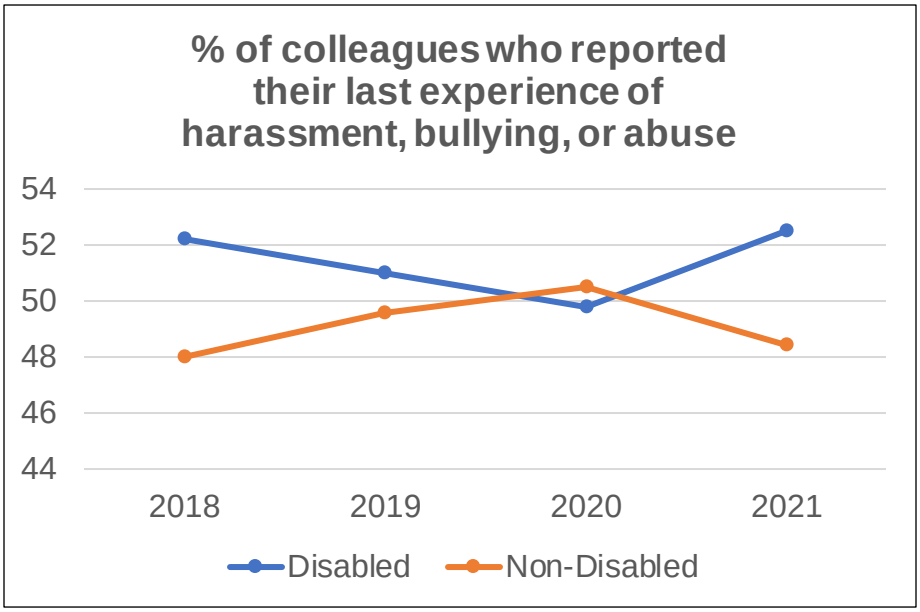
Whilst this year's results indicate an improved experience for all, there is still a disparity between the experience of Disabled and non-disabled colleagues which needs to be addressed.

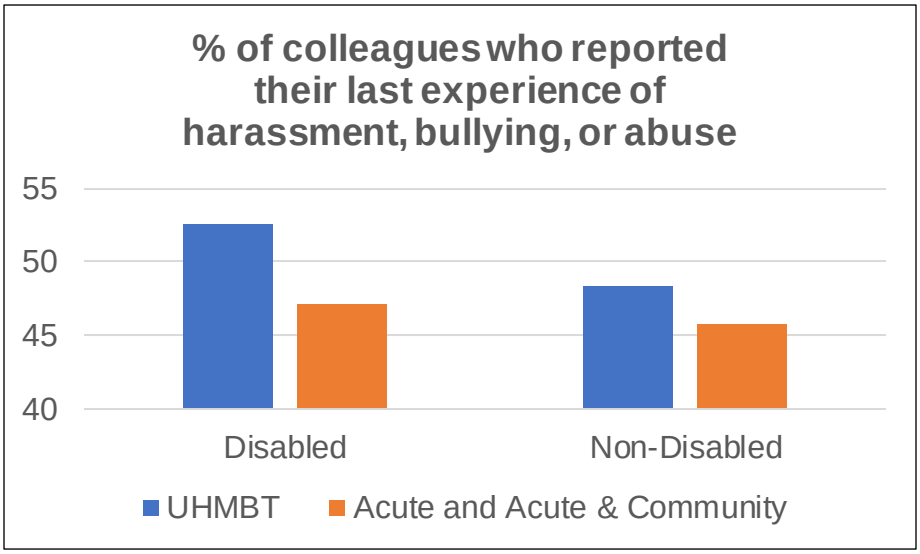
When we compare the experience of our own colleagues to the national average for Acute and Acute & Community trusts, this shows that we are performing better than our peer group for Disabled colleagues but slightly worse for colleagues without a disability.

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.

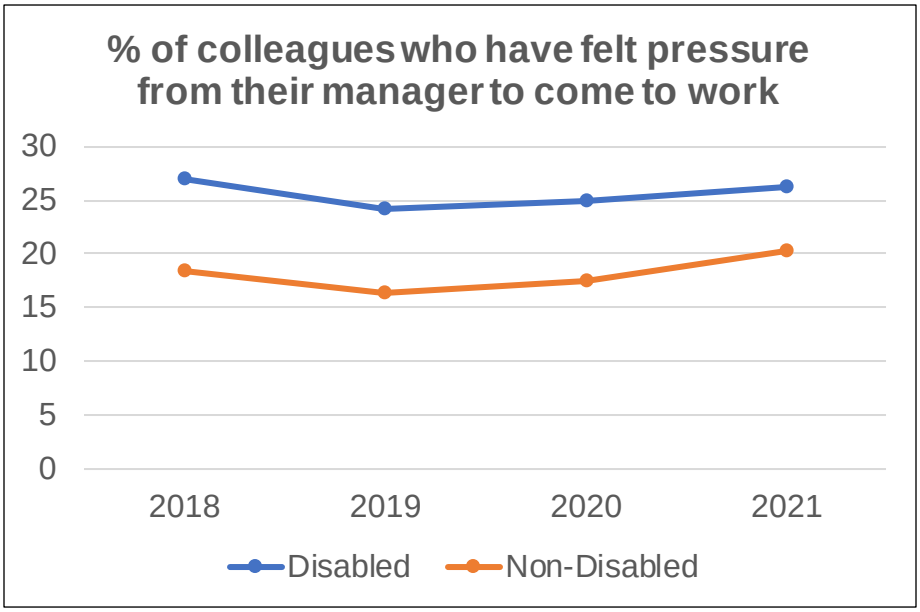
This is a 5% increase for Disabled colleagues compared with a decrease of 4% for non-disabled colleagues.

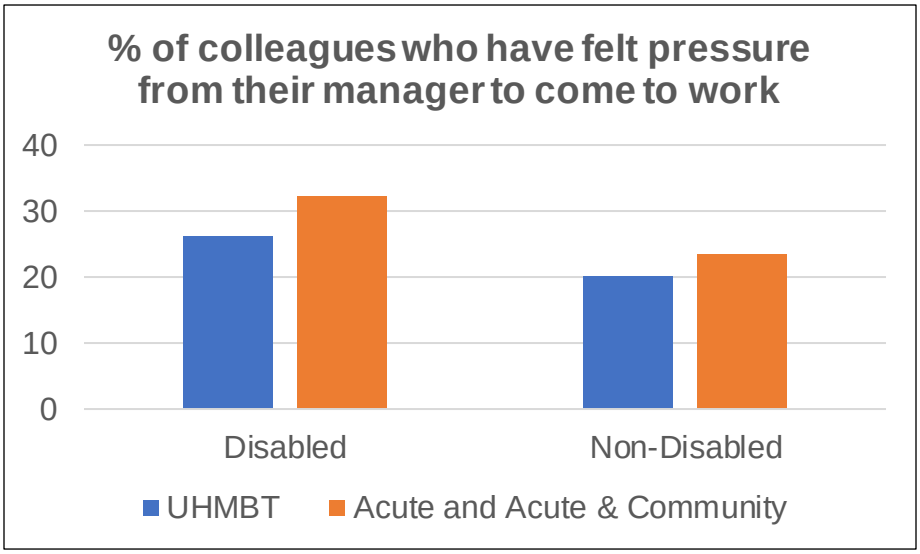
Our results indicate a higher level of reporting compared to other Acute and Acute & Community organisations nationally and mirror the disparity between Disabled and non-disabled colleagues.

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

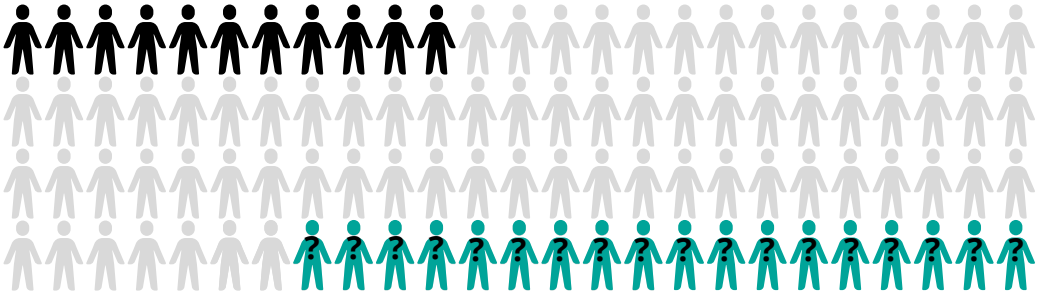
i. Background

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

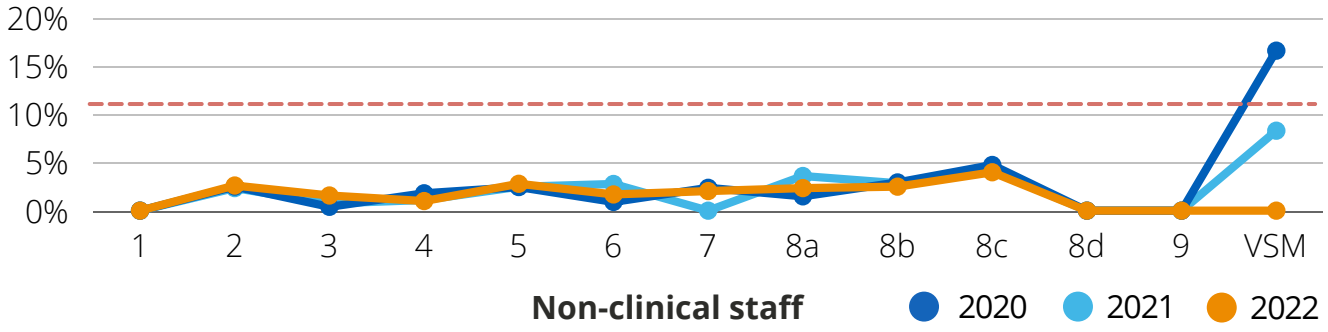
Non Clinical	% BAME 20/21	% BAME 21/22	Clinical	% BAME 20/21	% BAME 21/22
Band 1	0.00%	0.00%	Band 1	0.00%	0.00%
Band 2	2.35%	2.62%	Band 2	3.32%	4.10%
Band 3	0.75%	1.58%	Band 3	12.86%	5.77%
Band 4	1.11%	1.00%	Band 4	2.82%	2.50%
Band 5	2.49%	2.80%	Band 5	16.97%	25.58%
Band 6	2.78%	1.69%	Band 6	4.73%	6.59%
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%**

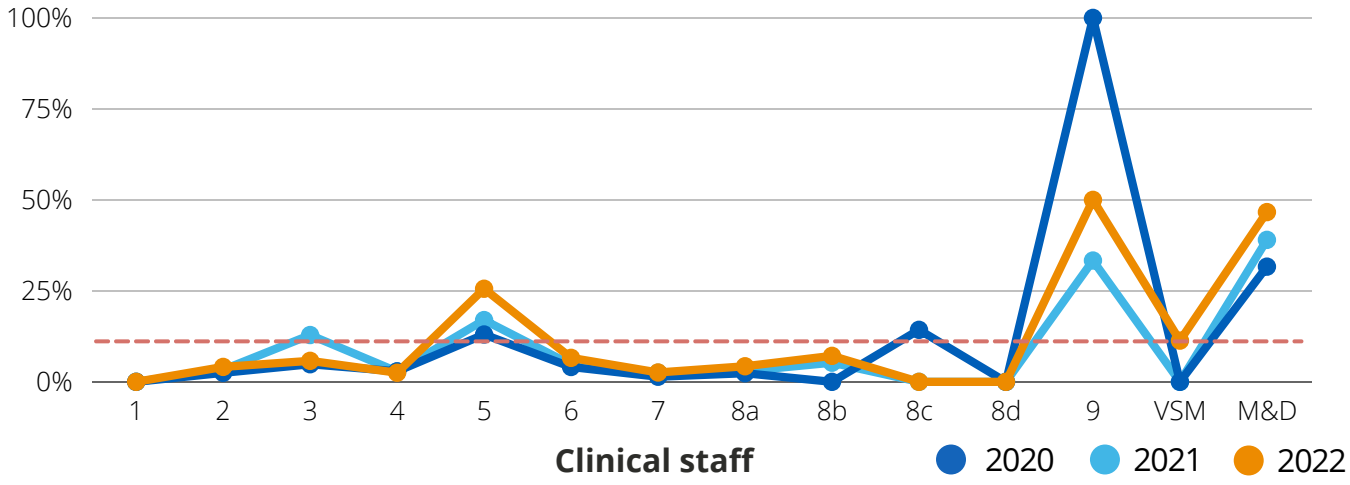
iii. Representation, recruitment and progression

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

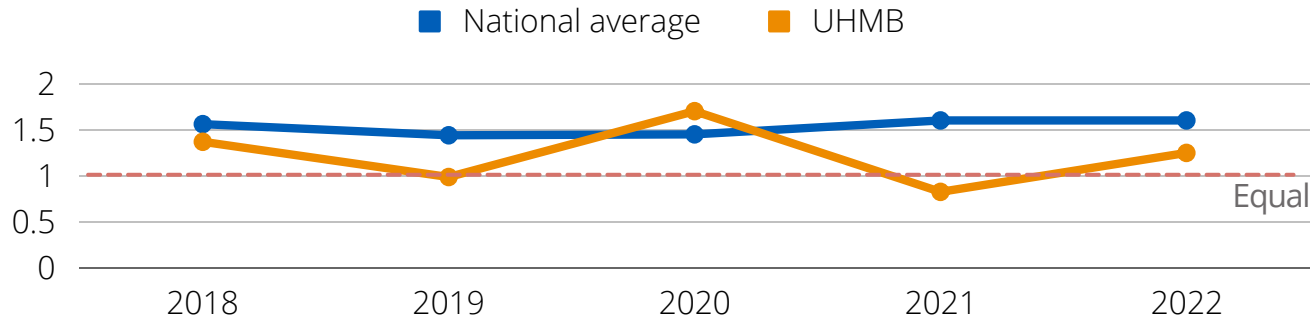
0% of the Board's voting membership has an ethnic minority background, compared with an overall workforce of 11.33% - a difference of -11.33%.

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.



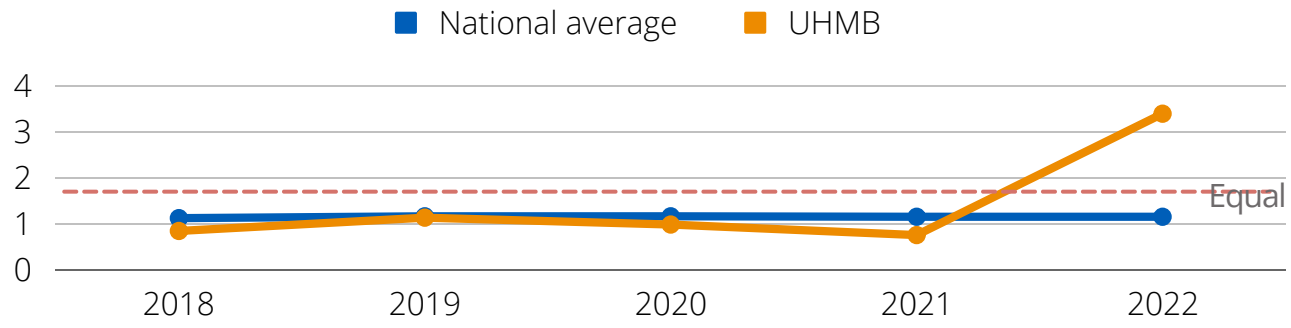
Relative likelihood of appointment from shortlisting

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.

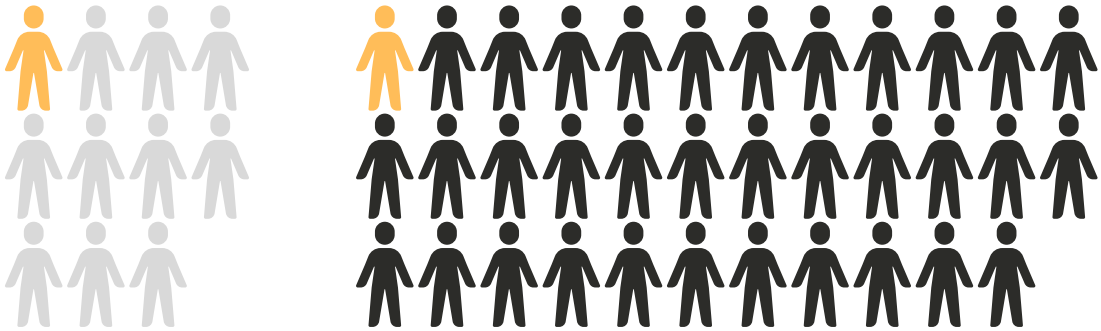


Relative likelihood of accessing CPD or non-mandatory training

iii. Representation, recruitment and progression

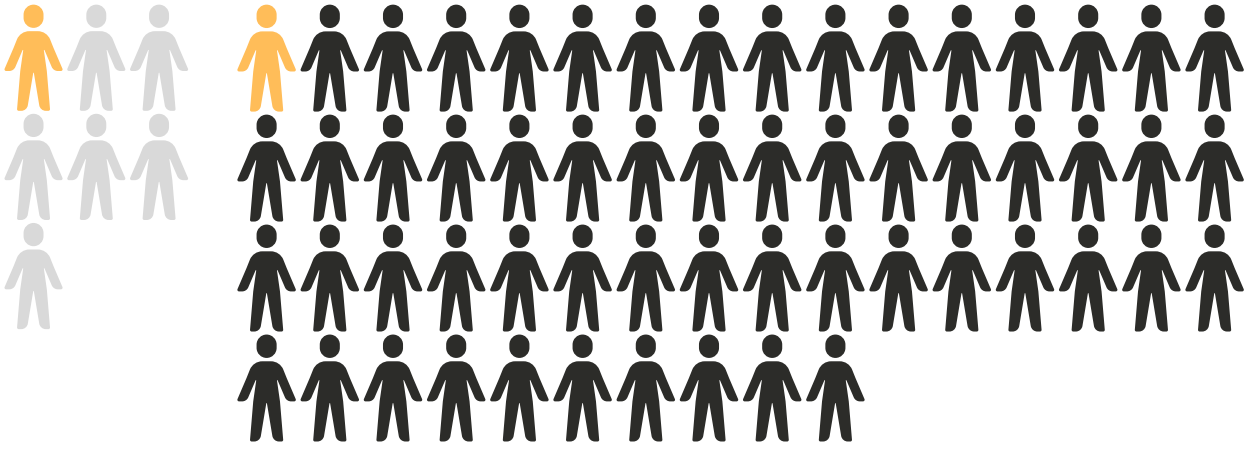
Race Disparity Ratio (RDR)

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:



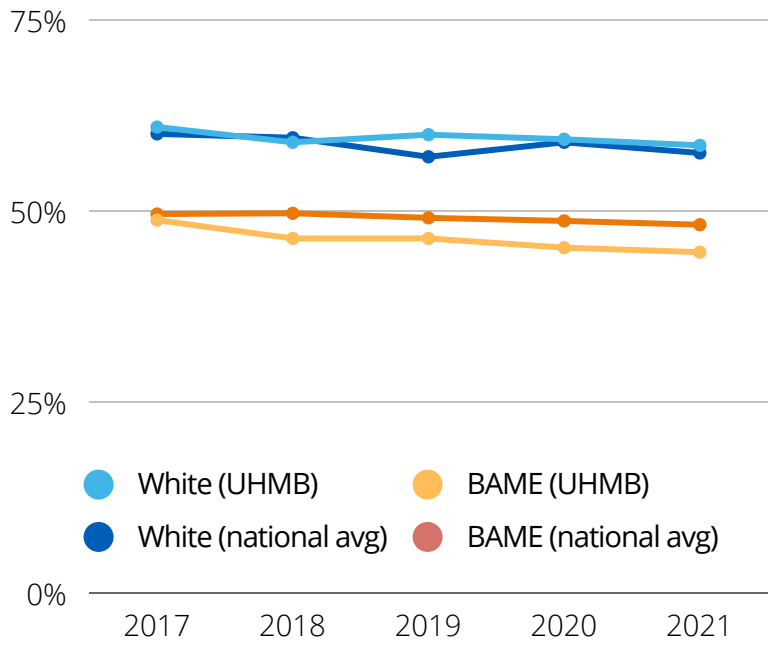
1 in 7 White nurses progress from Bands 1-5 to Bands 8a, compared with **1 in 58** ethnic minority nurses. White nurses are **10.39x** more likely to progress.

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.

Indicator 7 - fairness in career progression

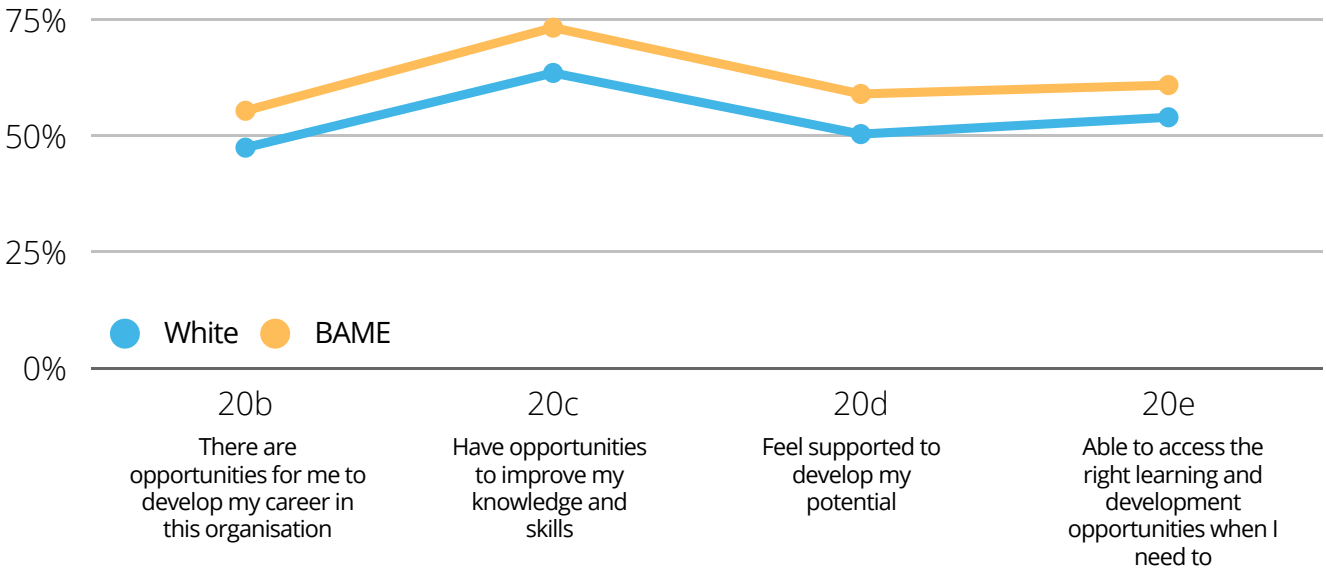
48.2% of ethnic minority staff and 57.6% of white staff believe that the Trust acts fairly with regard to career progression.

% 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

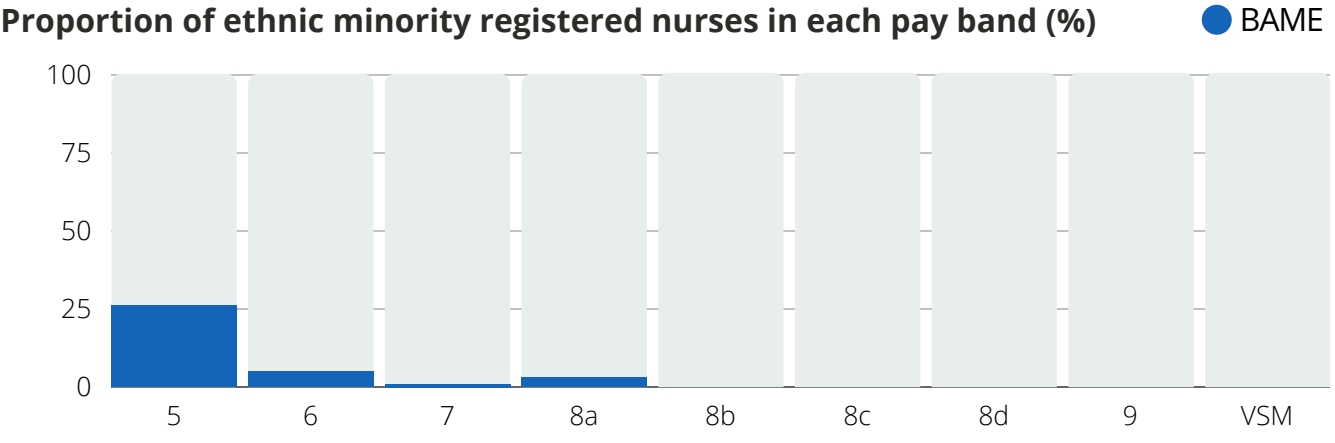
	The earnings of Asian colleagues are:	The earnings of Black colleagues are:	The earnings of colleagues with another ethnic background are:
Mean gender pay gap in hourly pay	**40.0% higher**	**15.5% higher**	**2.1% lower**
Median gender pay gap in hourly pay	**26.0% higher**	**6.5% higher**	**0.9% higher**

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.

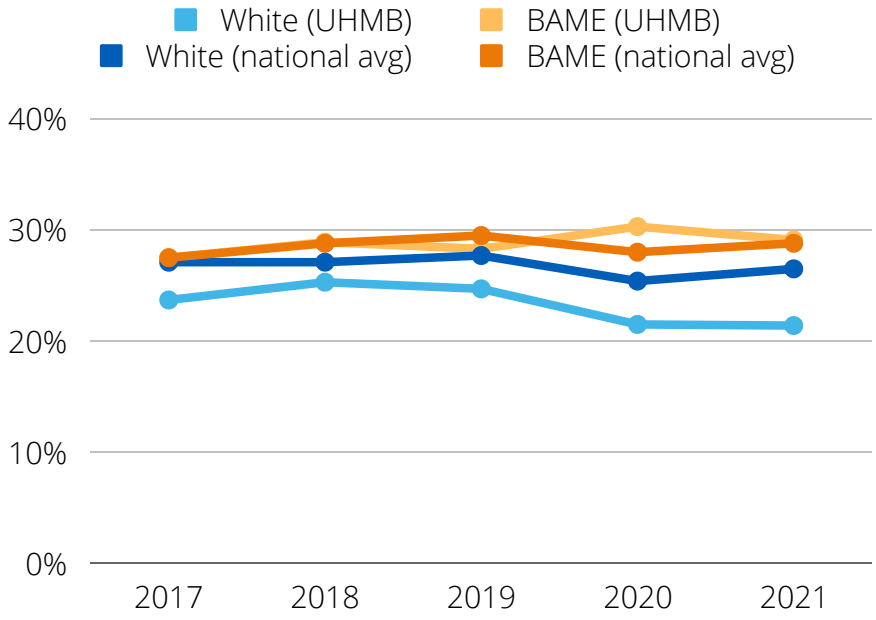
A review of MHPS and Disciplinary policies is underway to include a required process to consider restorative approaches before moving to formal process.

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

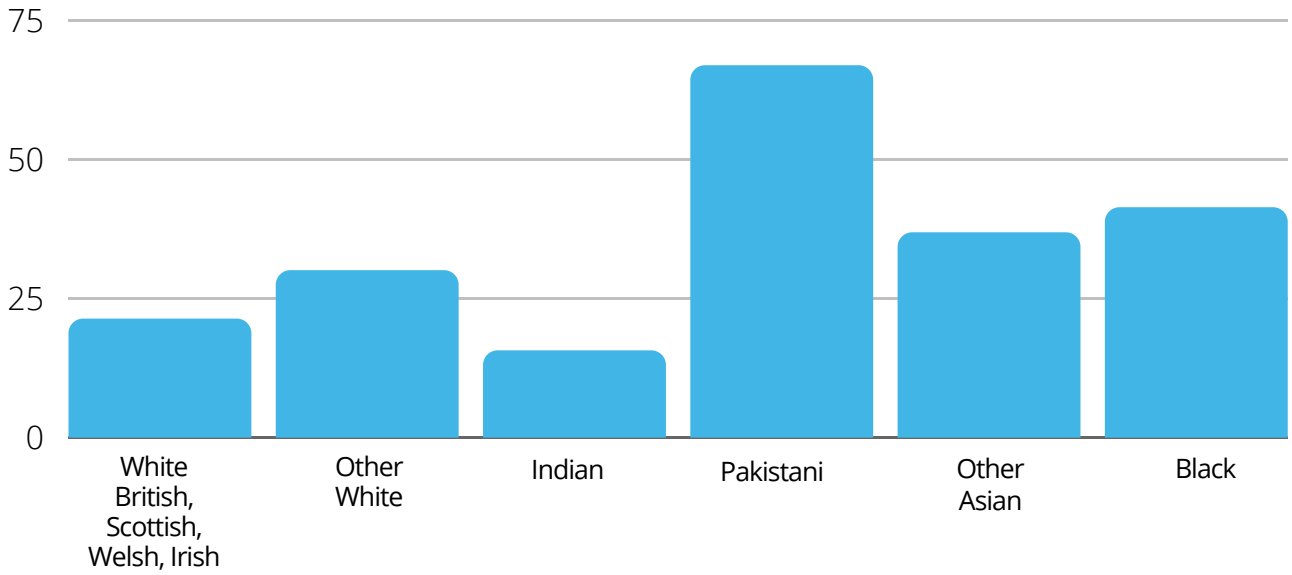


In 2020 bullying, harassment and abuse directed towards ethnic minority colleagues increased at UHMBT.

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

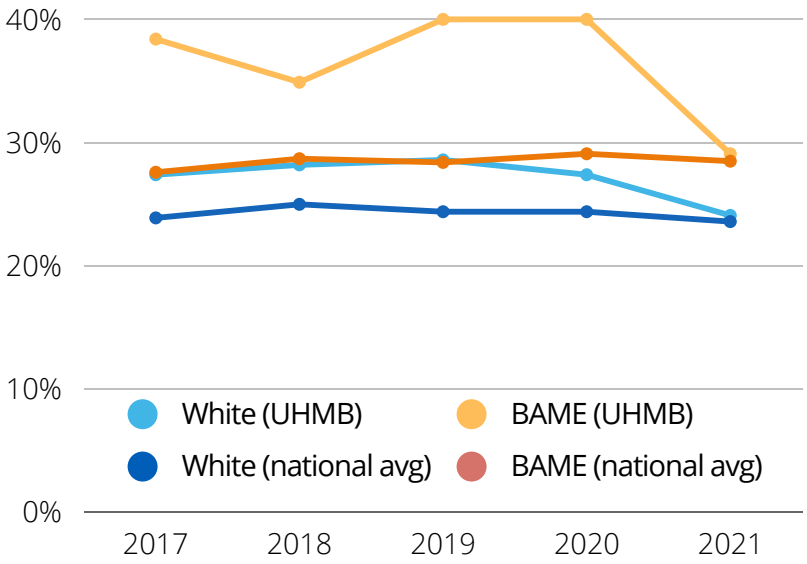


v. Behaviours and discrimination

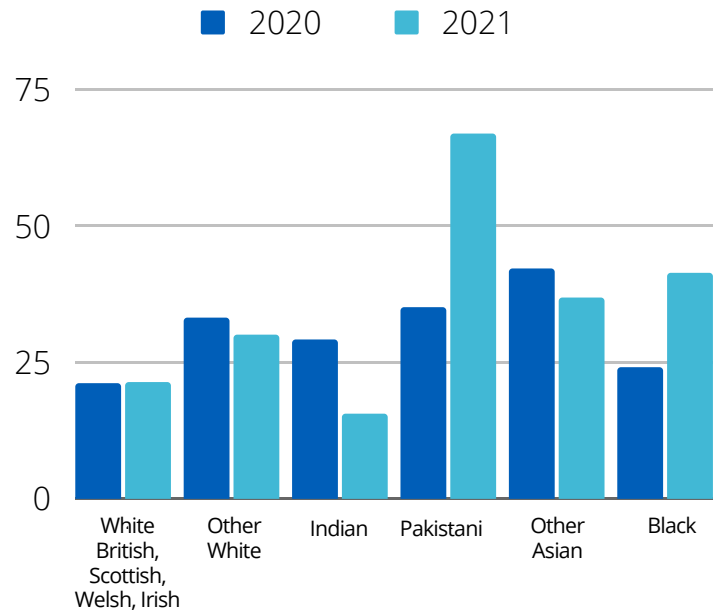
Indicator 5 - bullying and harassment from staff

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.

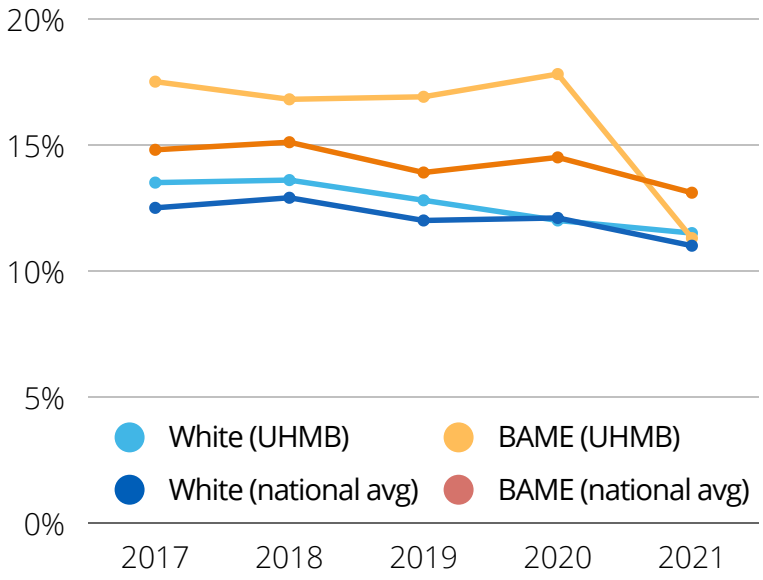
The data shows improvement for some groups, particularly Indian and Other Asian (Filipino) colleagues, but significant worsening experience for Pakistani and Black colleagues, with 66% and 41% respectively experiencing bullying and harassment from staff in the past 12 months.

v. Behaviours and discrimination

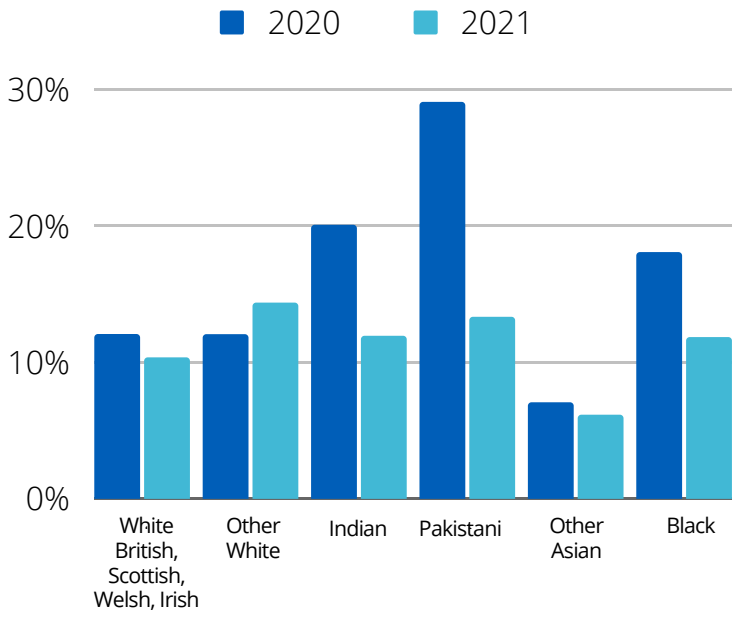
Indicator 5 - bullying and harassment from staff

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.

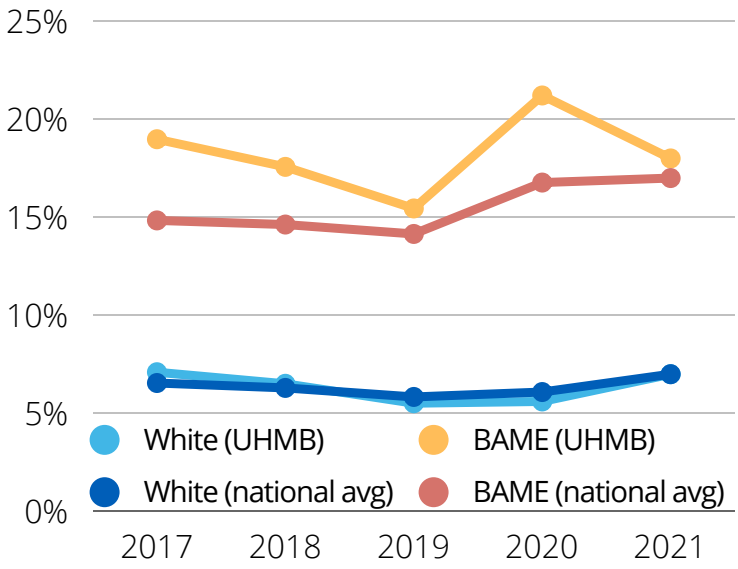
Looking at the experiences of colleagues from different ethnic groups, a reduction in bullying can be seen for all groups, particularly notable for Indian, Pakistani and Black colleagues.

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.

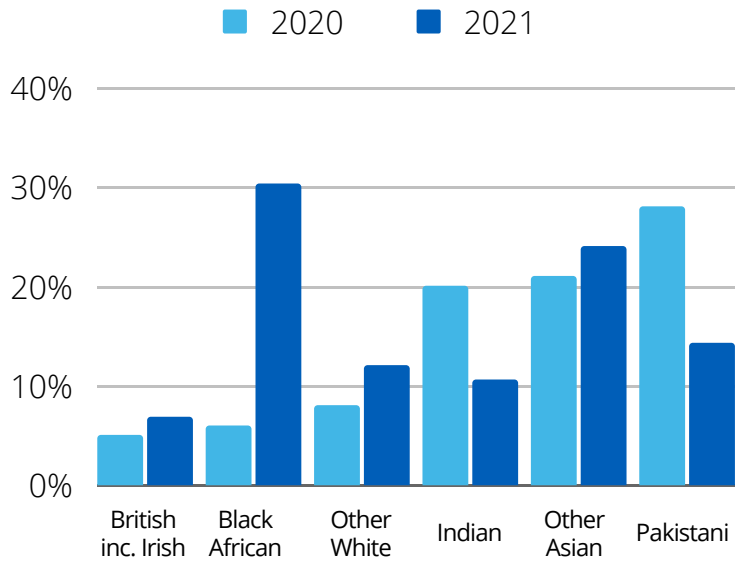
Indicator 8 - experience of discrimination

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.

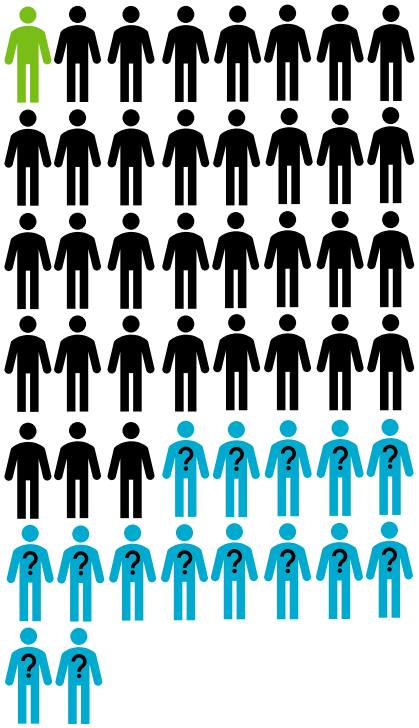
You can now self-report your gender identity as part of the NHS Staff Survey. As a result, we have the opportunity to report on the colleague experience of trans and non-binary colleagues for indicators reliant on this data. Unfortunately, this year the number of colleagues who told us that their gender 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

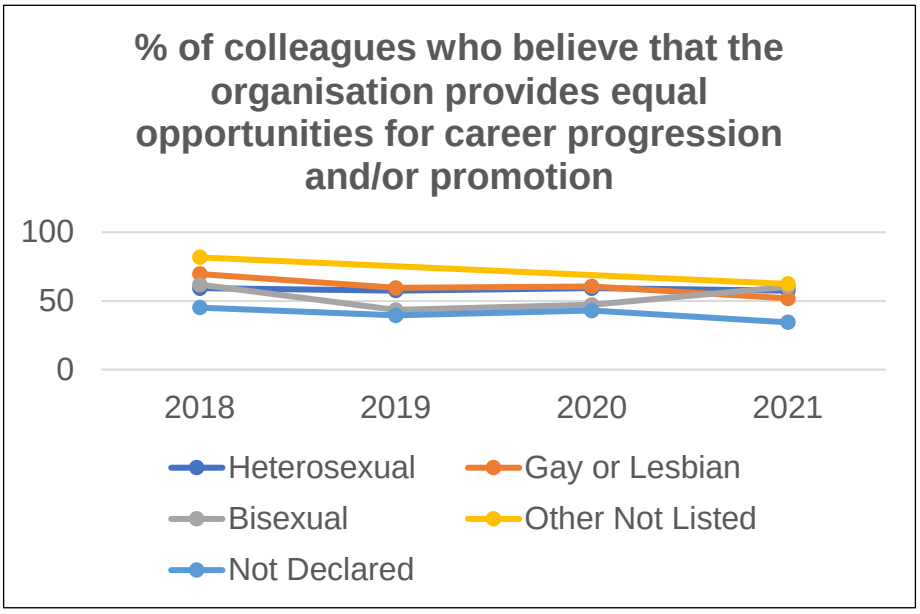
% difference of LGB+ colleagues between our Board voting membership compared to our overall workforce

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%**.

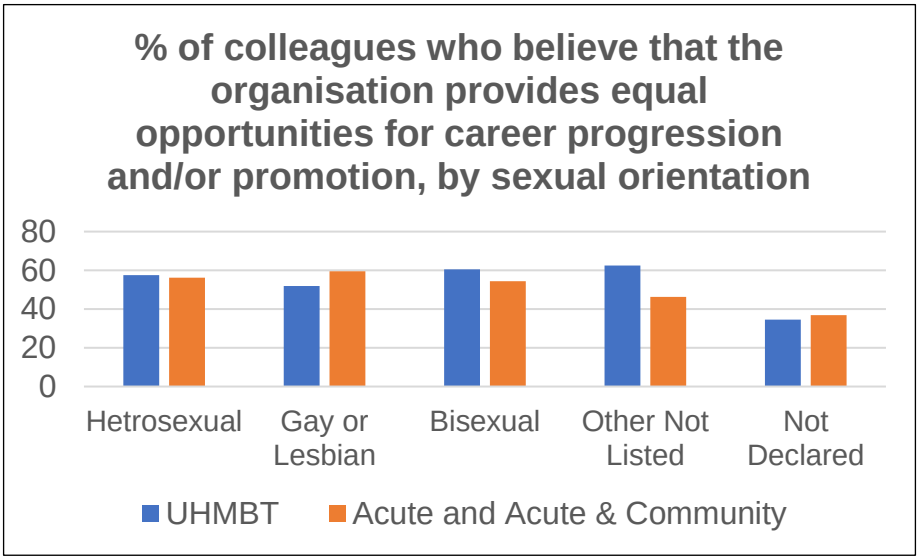
Amongst voting Board members declaration of sexual orientation is much lower at 31% (compared to 69.73% overall) and due to the small number of colleagues involved, changes in appointments has a significant impact on reported proportions.

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.

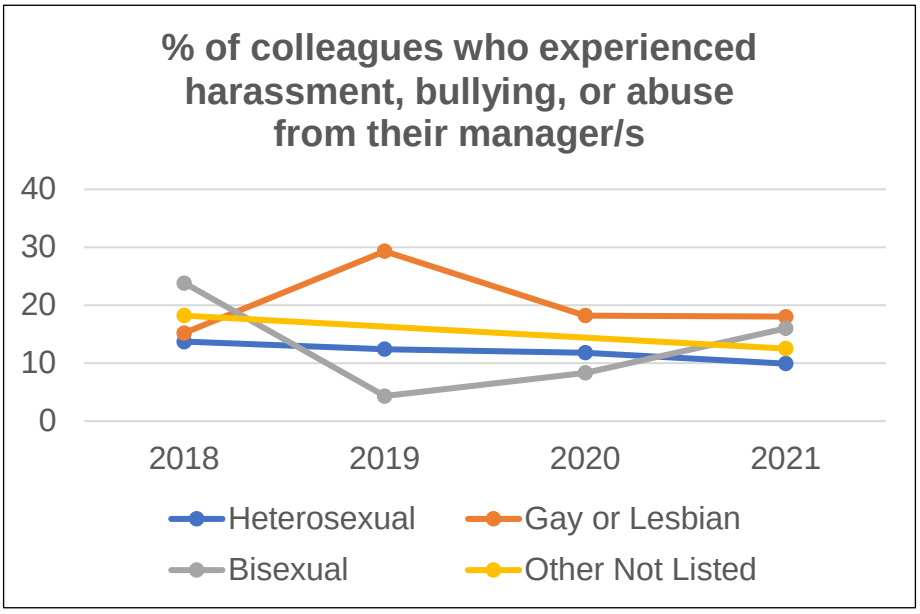
	2020/2021		2021/2022	
	LGB+	Heterosexual	LGB+	Heterosexual
No. colleagues in workplace overall	122	4537	153	4879
No. colleagues entering formal disciplinary	1	29	1	21
Relative Likelihood	1.3x		1.75x	

An improvement from 2019/20-2020/21 when LGB+ colleagues were 2.1x more likely to ensure the formal disciplinary process than heterosexual colleagues.

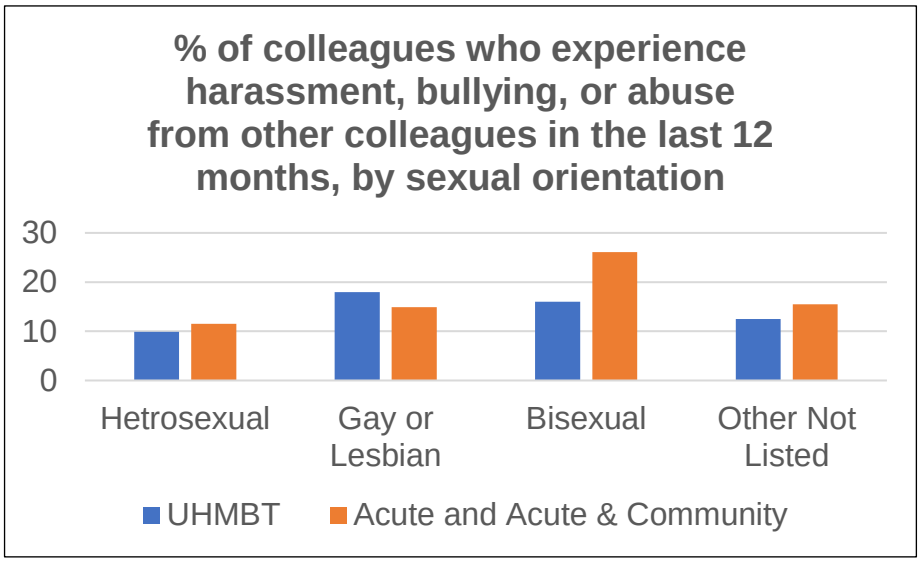
When considered year-by-year, there has been a deterioration for LGB+ colleagues between 2020/2021 and 2021/2022 but as the numbers involved are very small this is likely to result in such significant variance between each reporting year.

Indicator 6

% of LGB+ colleagues who experienced harassment, bullying, or abuse at work from their manager/s, compared to heterosexual colleagues.



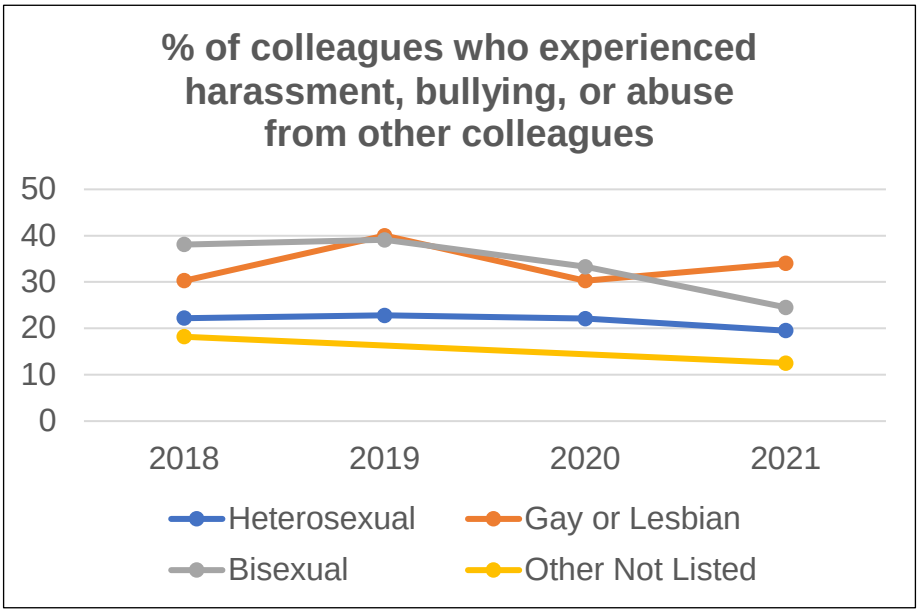
We have seen a 1.9% improvement in the proportion of our heterosexual colleagues experiencing harassment, bullying, and abuse from their manager/s, whereas this has remained fairly constant for gay and lesbian colleagues and has almost doubled for bisexual colleagues.



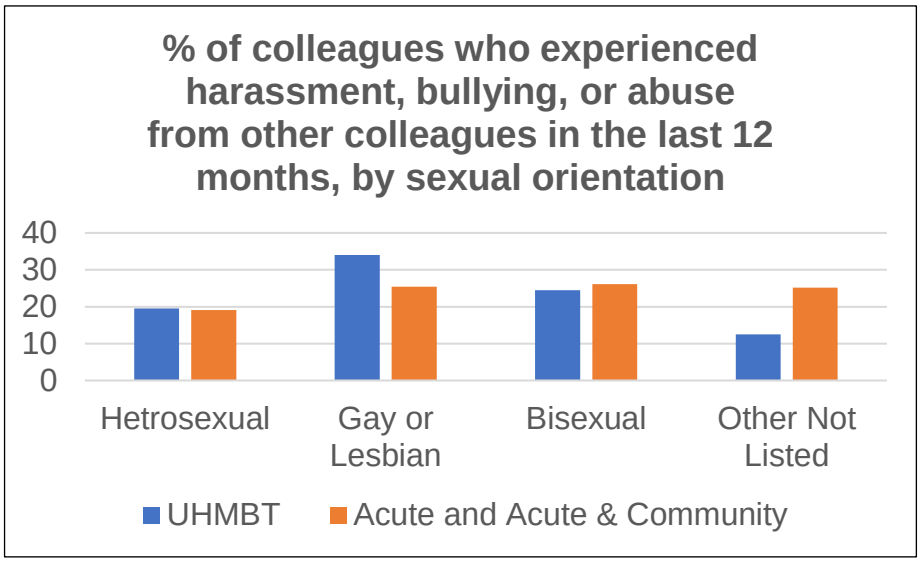
When we compare the experience of our own colleagues to the national average for Acute and Acute & Community trusts, this shows that our gay and lesbian colleagues are having a much poorer experience and it is important that we explore this further with that group.

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

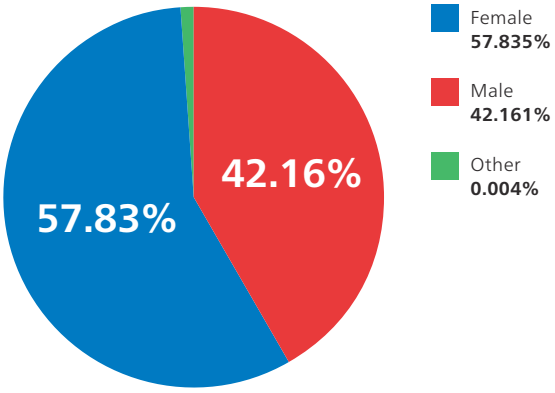
When face-to-face interpretation services were paused during the Covid-19 pandemic, we continued to provide on-demand language interpretation via video and telephone. We secured charity funding to buy a further video interpretation device. In 2021/22, the languages most requested by patients were Arabic,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

Lynne Wyre
Deputy Chief Nurse

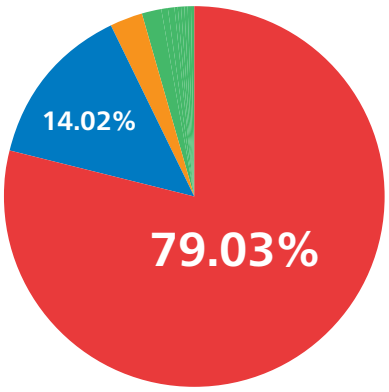
Barry Rigg
Head of Patient Experience

Outpatient Attendance

Attendance by Sex:

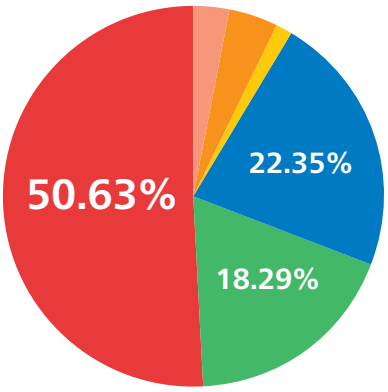


Attendance by Ethnicity:



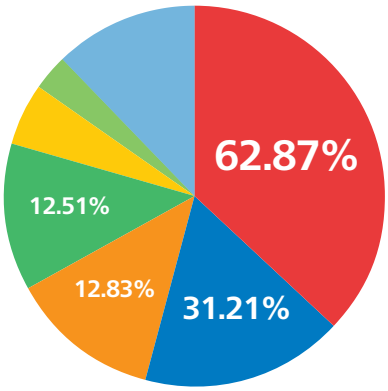
- White - British **79.03%**
- Not Stated **14.02%**
- Not Known **2.59%**
- White - Any other White background **1.63%**
- Not Recorded **0.68%**
- Any Other Ethnic Group **0.46%**
- White - Irish **0.36%**
- Asian or Asian British - Indian **6.17%**
- Asian or Asian British - Any other Asian background **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%**

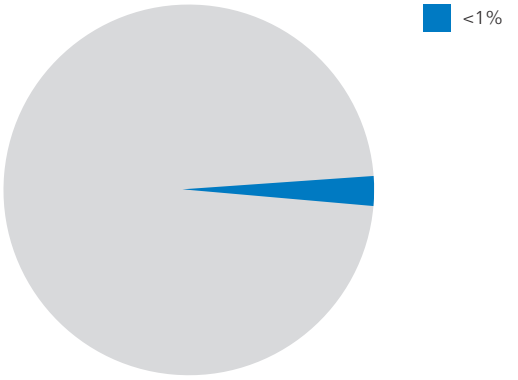
Attendance by Religion or no Religion:



- 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.

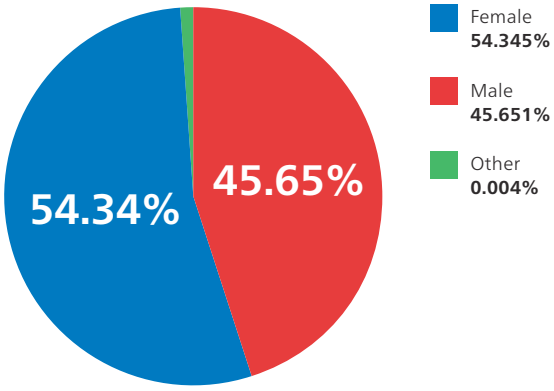
Attendance by Disability:



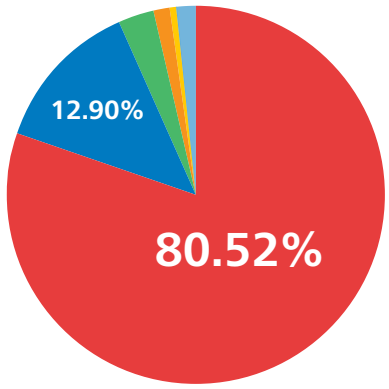
<1% of our patients declared a disability on their patient record.

Inpatient Spells

Spells by Sex:

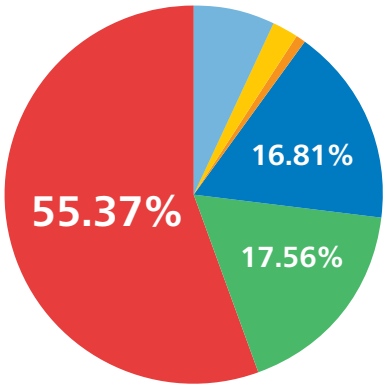


Spells by Ethnicity:



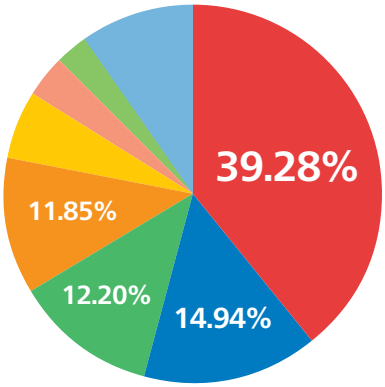
- White - British **80.52%**
- Not Stated **12.90%**
- Not Known **3.11%**
- White - Any other White background **1.44%**
- Any Other Ethnic Group **0.47%**
- White - Irish **0.36%**
- Asian or Asian British - Indian **0.20%**
- Asian or Asian British - Any other Asian background **0.15%**
- Not Recorded **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%**

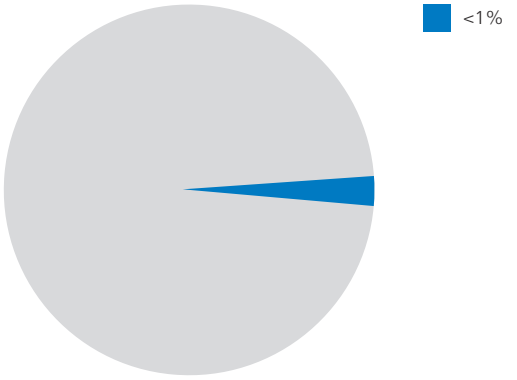
Attendance / Consultation by Religion or no Religion:



- 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.

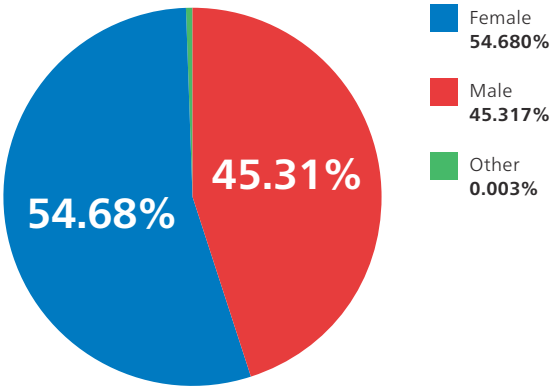
Attendance / Consultation by Disability:



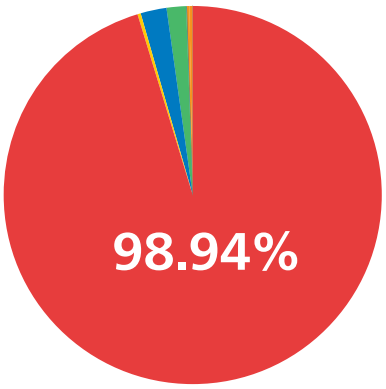
<1% of our patients declared a disability on their patient record.

Community Consultations

Consultations By Sex:

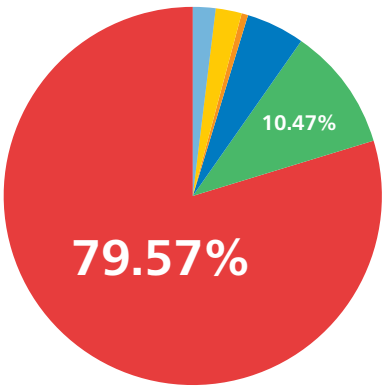


Consultations by Ethnicity:



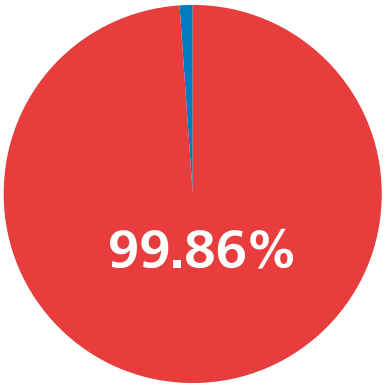
- Not Known **98.94%**
- British **0.54%**
- Not Stated **0.37%**
- Pakistani **0.05%**
- Indian **0.03%**
- Any other ethnic group **0.03%**
- Any other White background **0.02%**
- Any other Mixed background **0.01%**
- Polish - ethnic category 2001 census **0.01%**
- Chinese **0.001%**
- African **0.001%**
- 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:



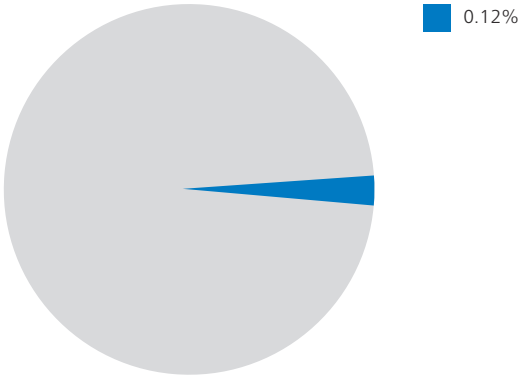
- Age 0-5 **2.14%**
- Age 6-15 **2.23%**
- Age 16-18 **0.57%**
- Age 19-45 **5.01%**
- Age 46-60 **10.47%**
- Age 60+ **79.57%**

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

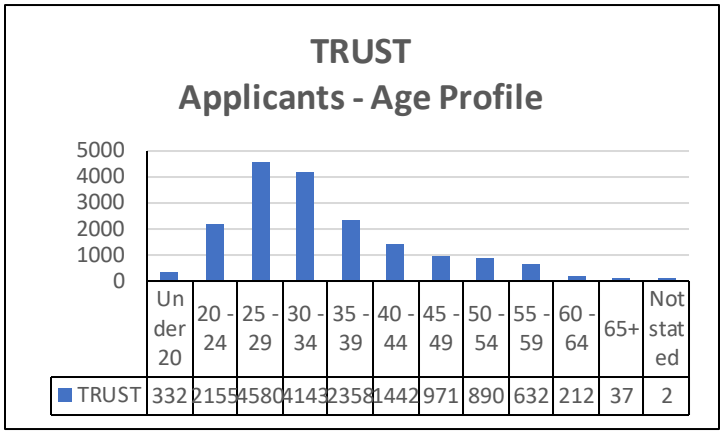
% FEMALE*	
TRUST OVERALL	80.01%
Community Services	93.10%
Core Clinical Services	81.67%
Corporate Services	70.57%
Estates & Facilities	57.45%
Medicine	81.33%
Surgery & Critical Care	79.15%
Women's and Children's	94.34%

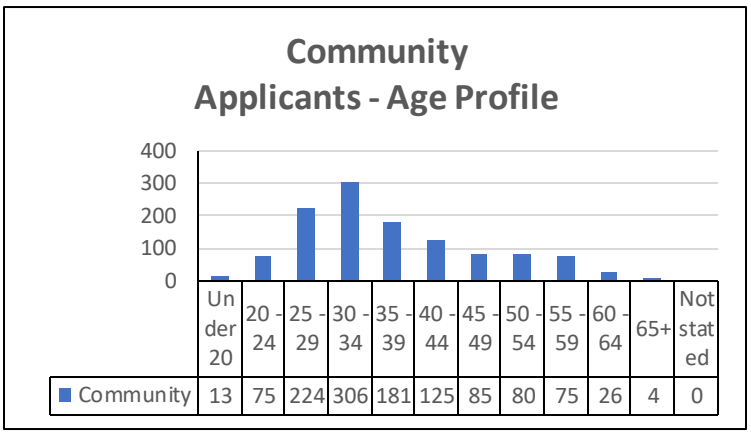
** data presented based on majority group*

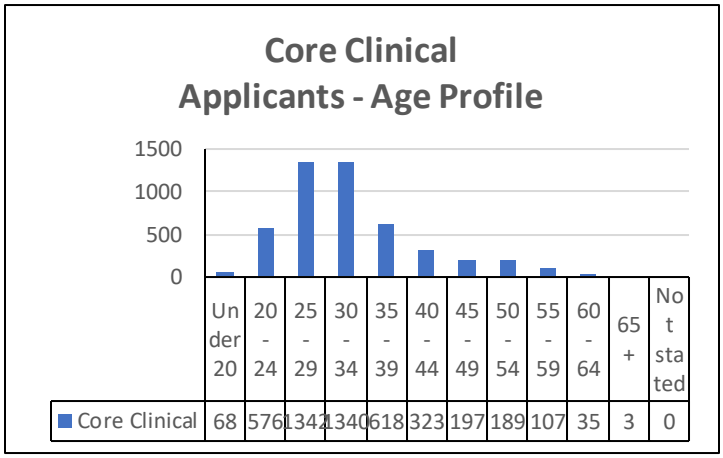
3. Applicants

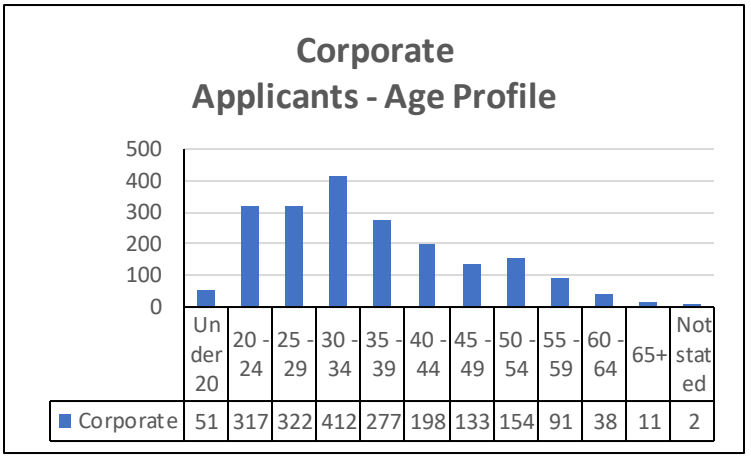
The figures presented here show applicants for roles within University Hospitals of Morecambe Bay NHS Foundation Trust during the financial year 2021/22. The figures are categorised according to the organisation as a whole and care groups within the Trust. Bank applicants are included.

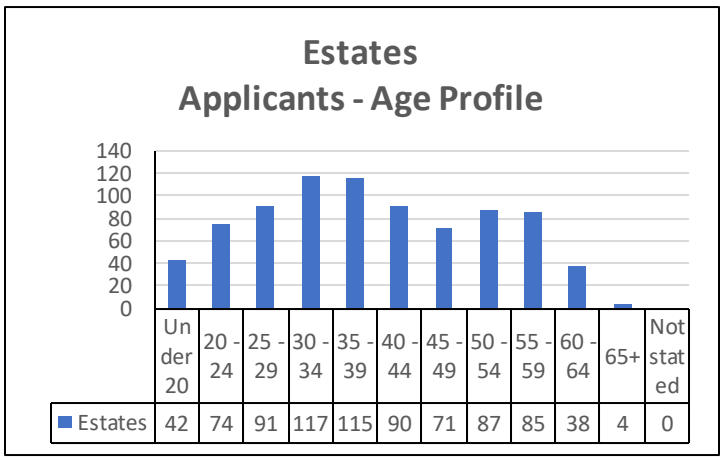
3.1 Age

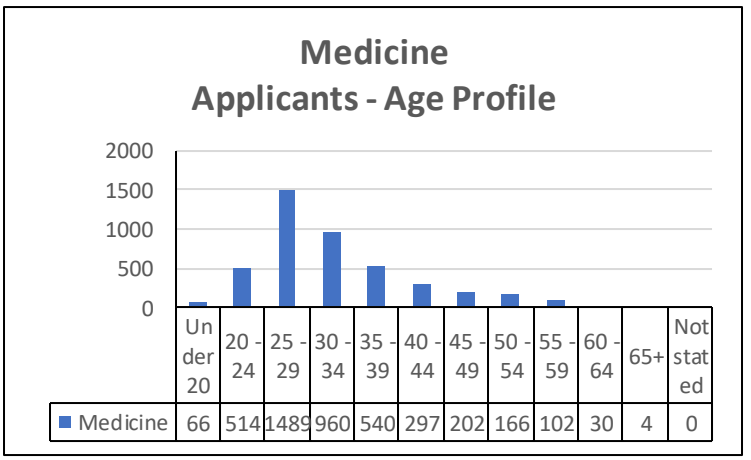


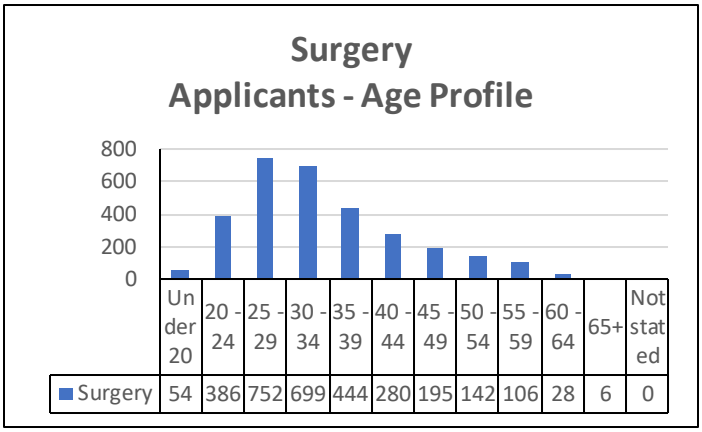


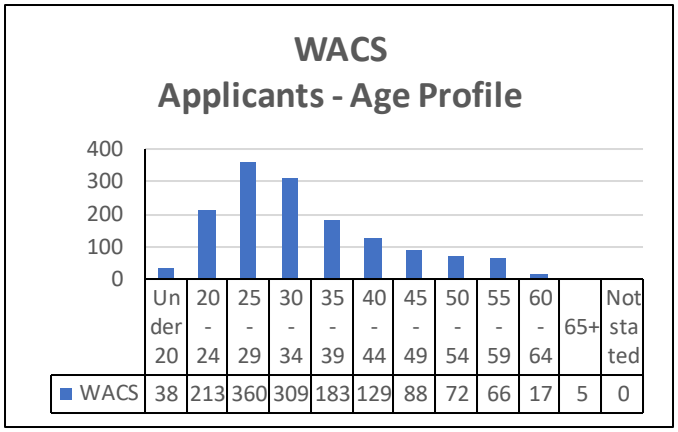




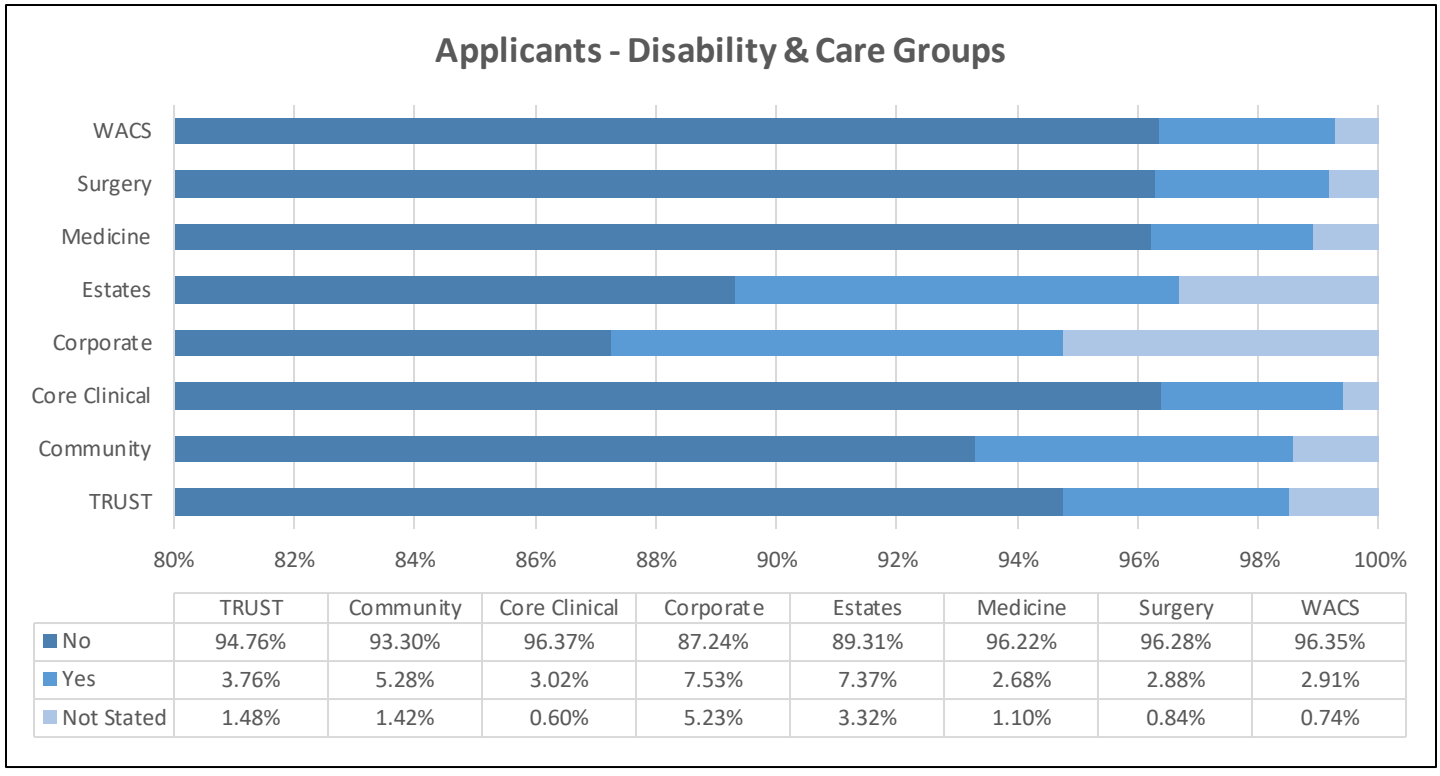






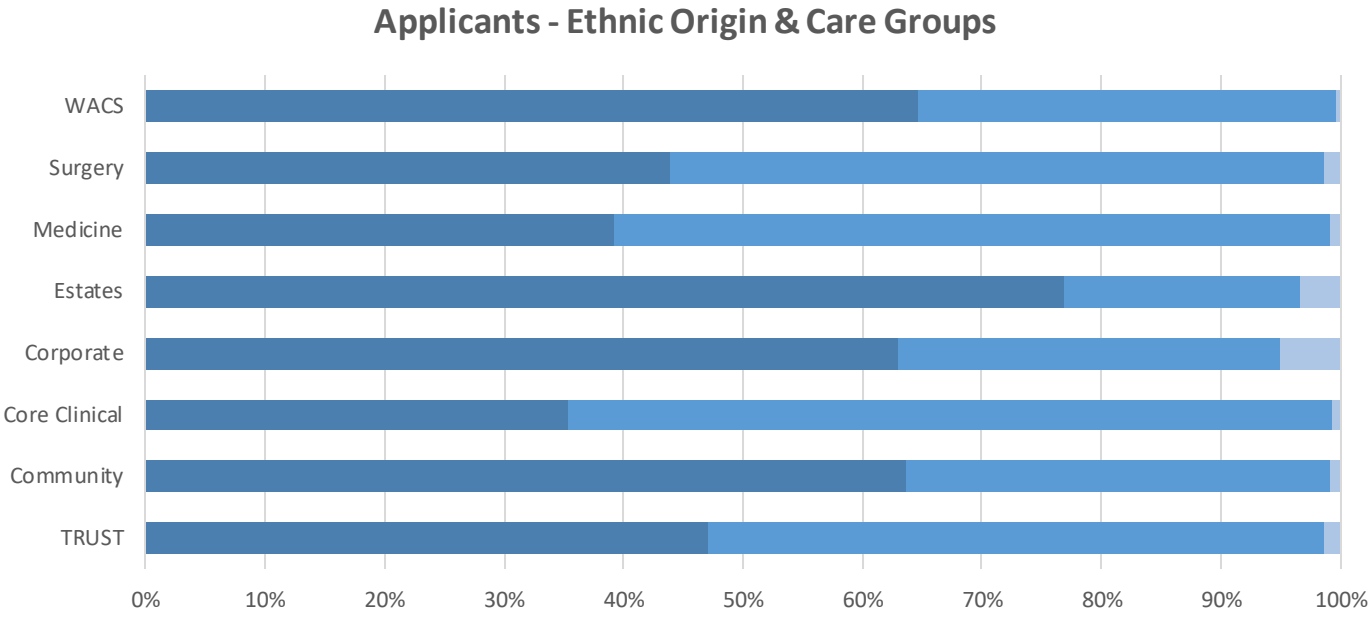


3.2 Disability



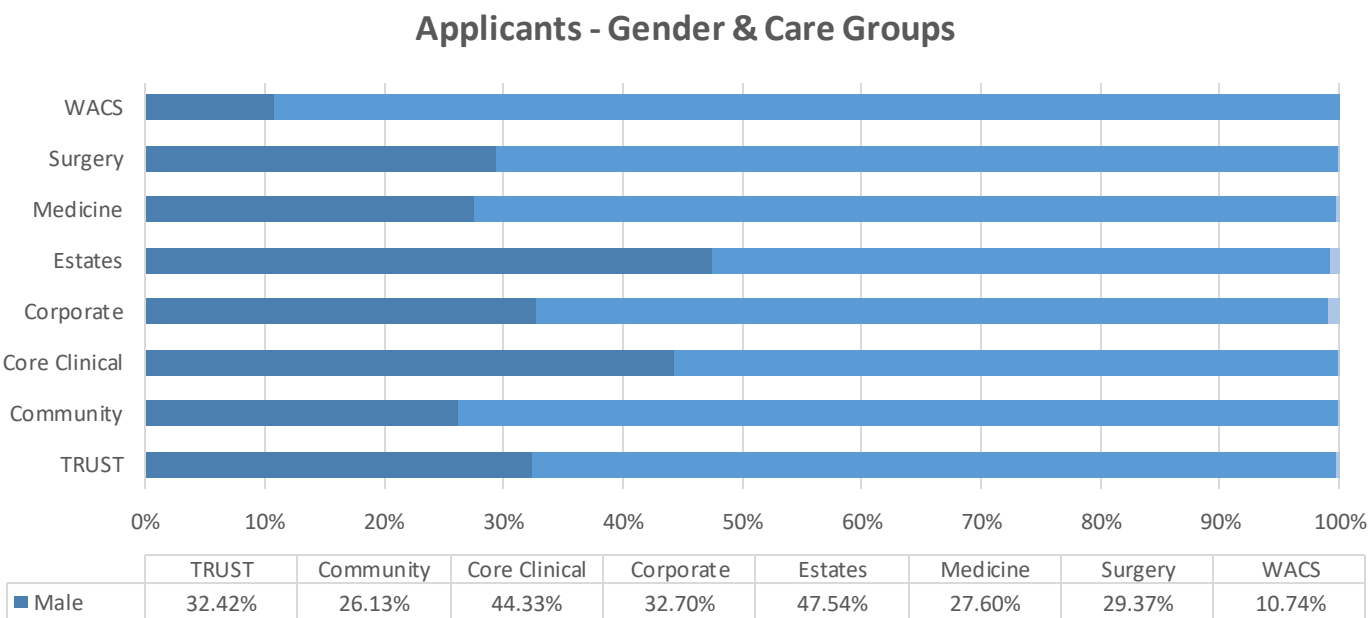
	TRUST	Community	Core Clinical	Corporate	Estates	Medicine	Surgery	WACS
No	94.76%	93.30%	96.37%	87.24%	89.31%	96.22%	96.28%	96.35%
Yes	3.76%	5.28%	3.02%	7.53%	7.37%	2.68%	2.88%	2.91%
Not Stated	1.48%	1.42%	0.60%	5.23%	3.32%	1.10%	0.84%	0.74%

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

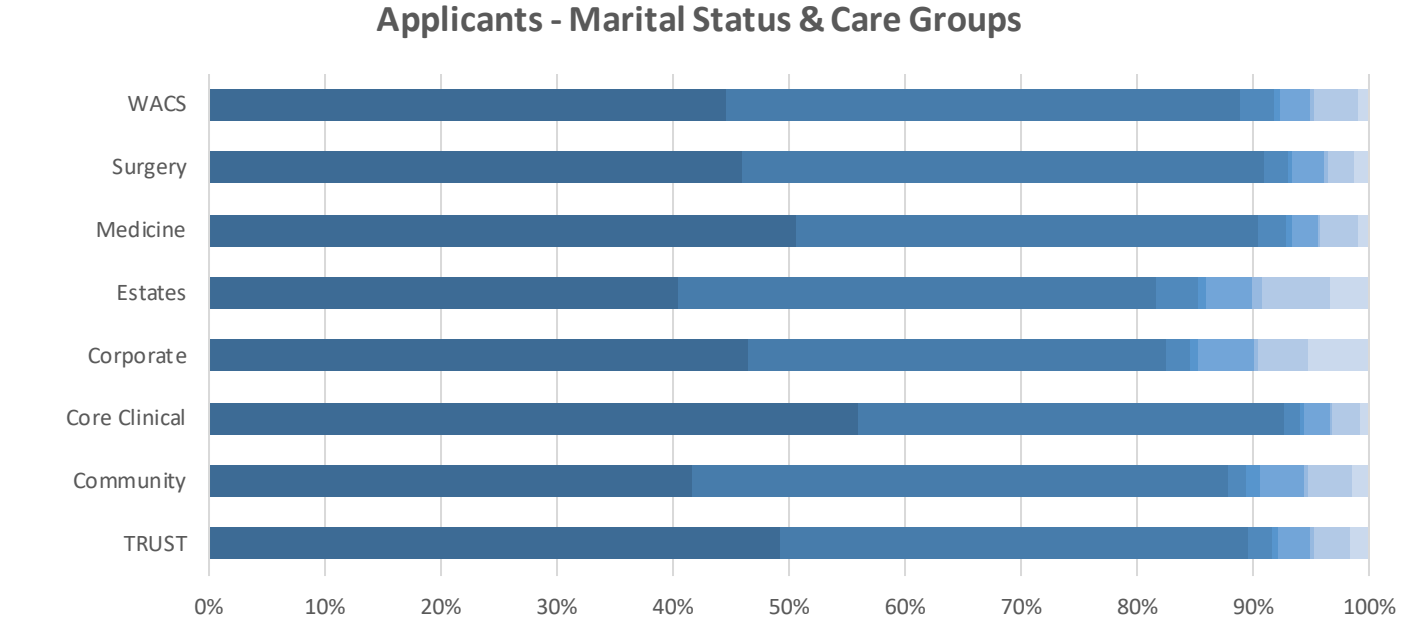


	TRUST	Community	Core Clinical	Corporate	Estates	Medicine	Surgery	WACS
Male	32.42%	26.13%	44.33%	32.70%	47.54%	27.60%	29.37%	10.74%
Female	67.34%	73.70%	55.61%	66.35%	51.72%	72.17%	70.54%	89.26%
Not Stated	0.24%	0.17%	0.06%	0.95%	0.74%	0.23%	0.10%	0.00%

3.5 Gender identity

Information on gender identity is not currently collected.

3.6 Marital status

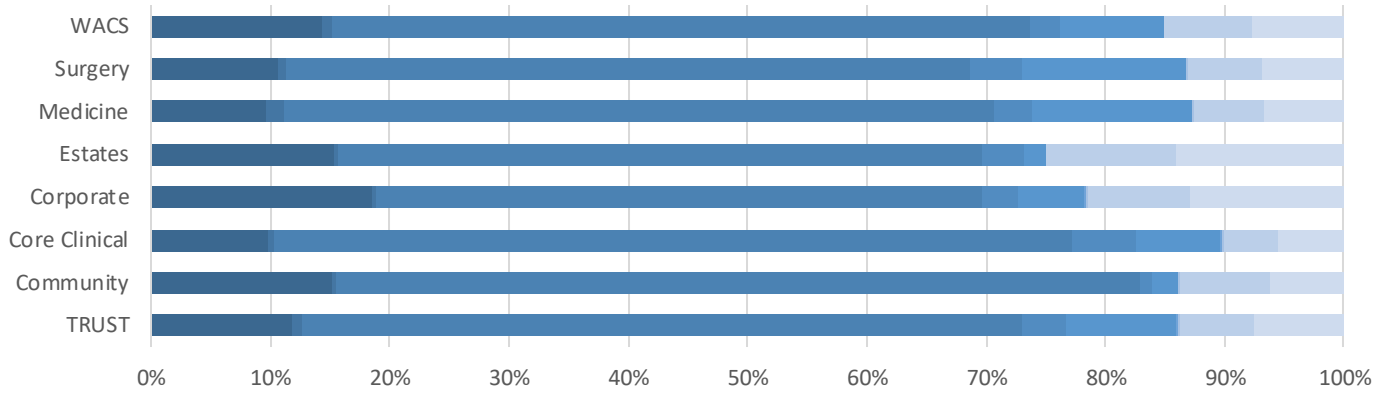


	TRUST	Community	Core Clinical	Corporate	Estates	Medicine	Surgery	WACS
Single	49.22%	41.62%	55.96%	46.51%	40.42%	50.62%	46.02%	44.59%
Married	40.40%	46.23%	36.87%	36.14%	41.28%	39.86%	45.02%	44.39%
Civil partnership	2.06%	1.68%	1.33%	2.04%	3.56%	2.43%	2.07%	2.84%
Legally separated	0.50%	1.09%	0.35%	0.55%	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

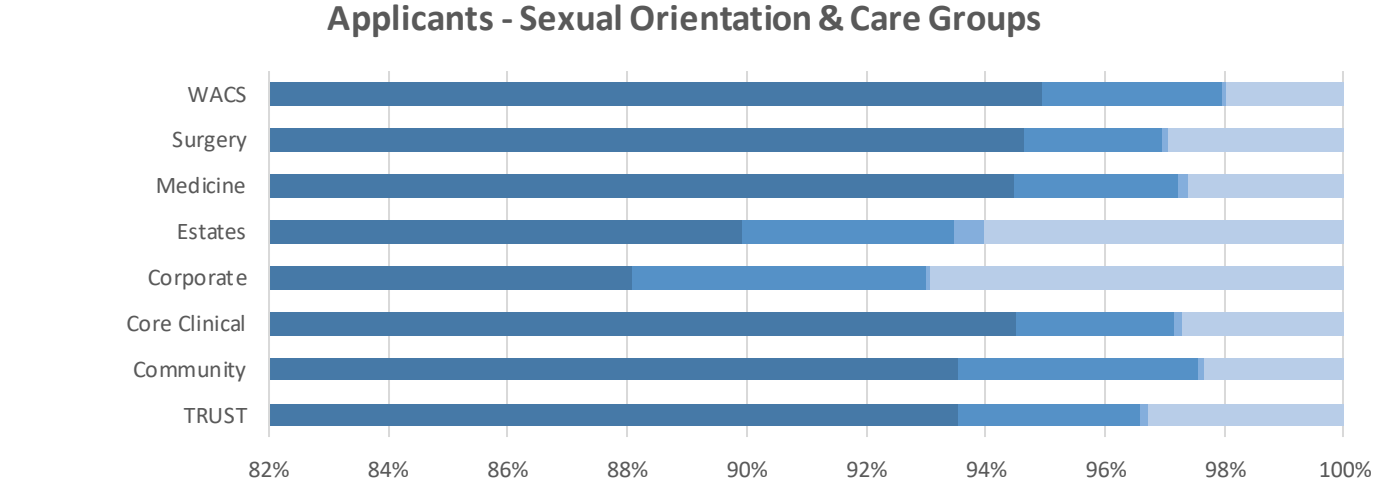
Information on gender identity is not currently collected.

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

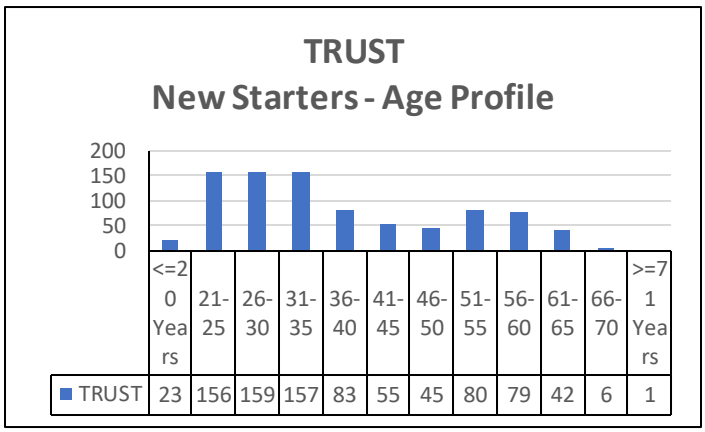


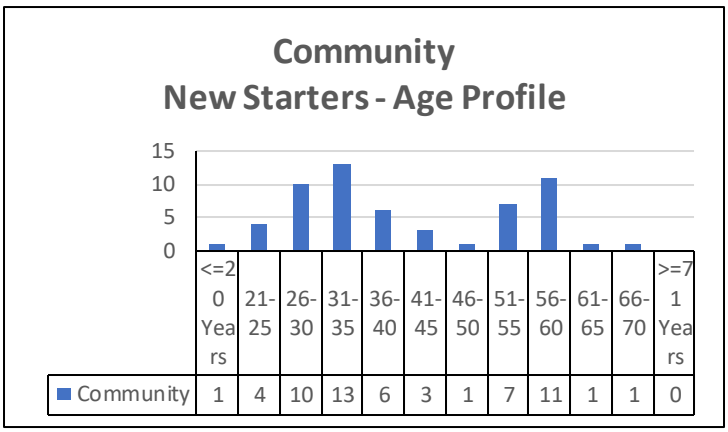
	TRUST	Community	Core Clinical	Corporate	Estates	Medicine	Surgery	WACS
Heterosexual or Straight	93.55%	93.55%	94.50%	88.09%	89.93%	94.46%	94.63%	94.93%
LBGT	3.05%	4.02%	2.67%	4.94%	3.56%	2.75%	2.33%	3.04%
Undecided	0.14%	0.08%	0.13%	0.05%	0.49%	0.18%	0.10%	0.07%
Not Stated	3.27%	2.35%	2.71%	6.93%	6.02%	2.61%	2.94%	1.96%

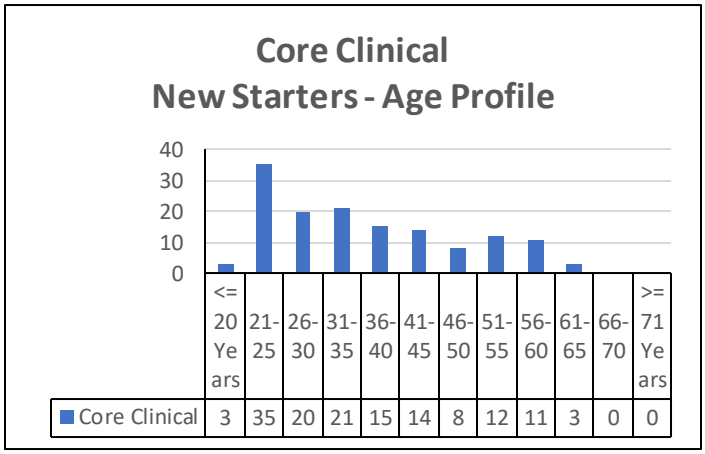
4. New starters

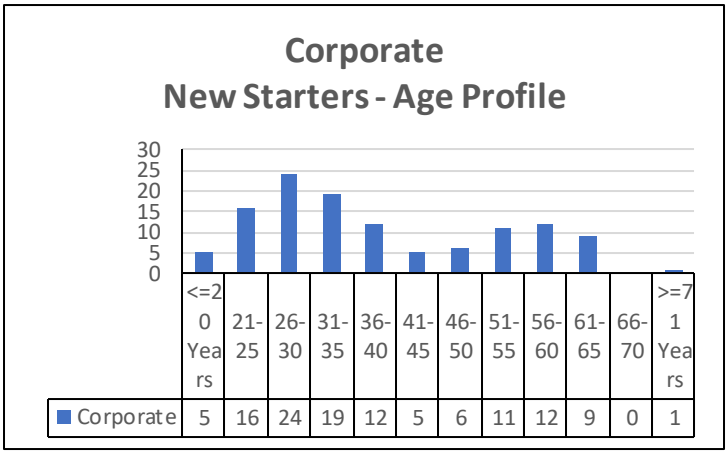
The figures presented here show the number of new starters with University Hospitals of Morecambe Bay NHS Foundation Trust during the financial year 2021/22. The figures are categorised according to the organisation as a whole and care groups within the Trust.

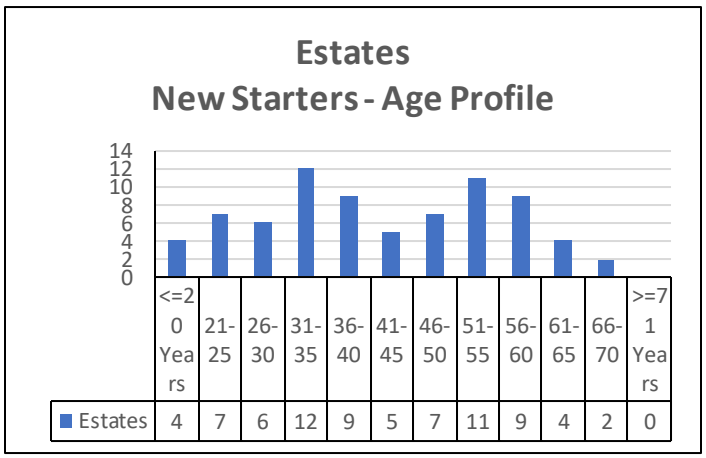
4.1 Age

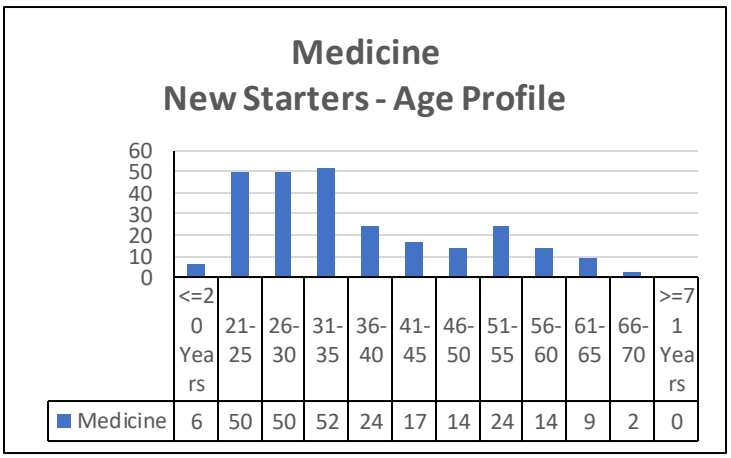


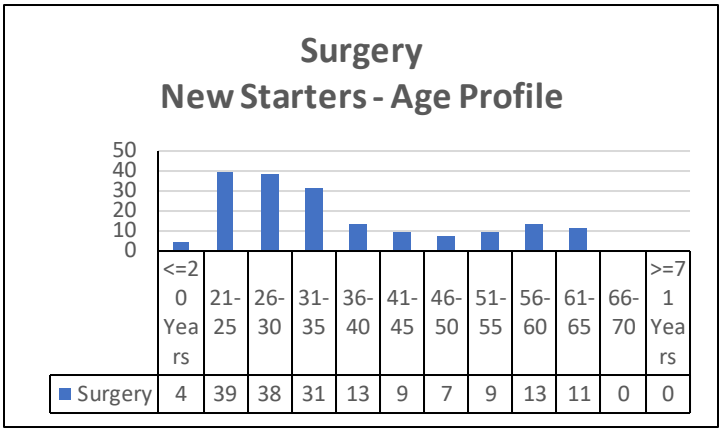


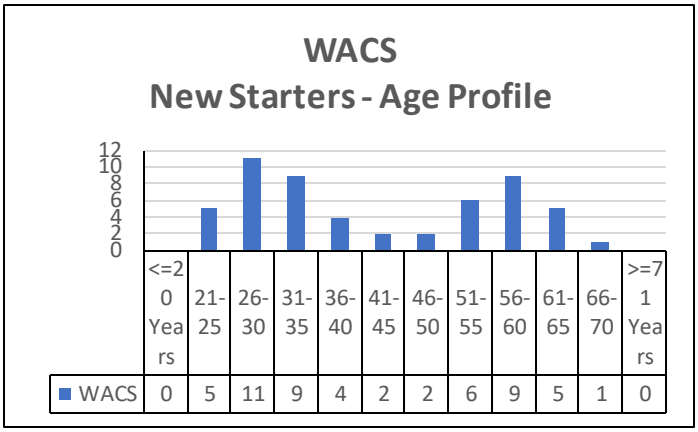




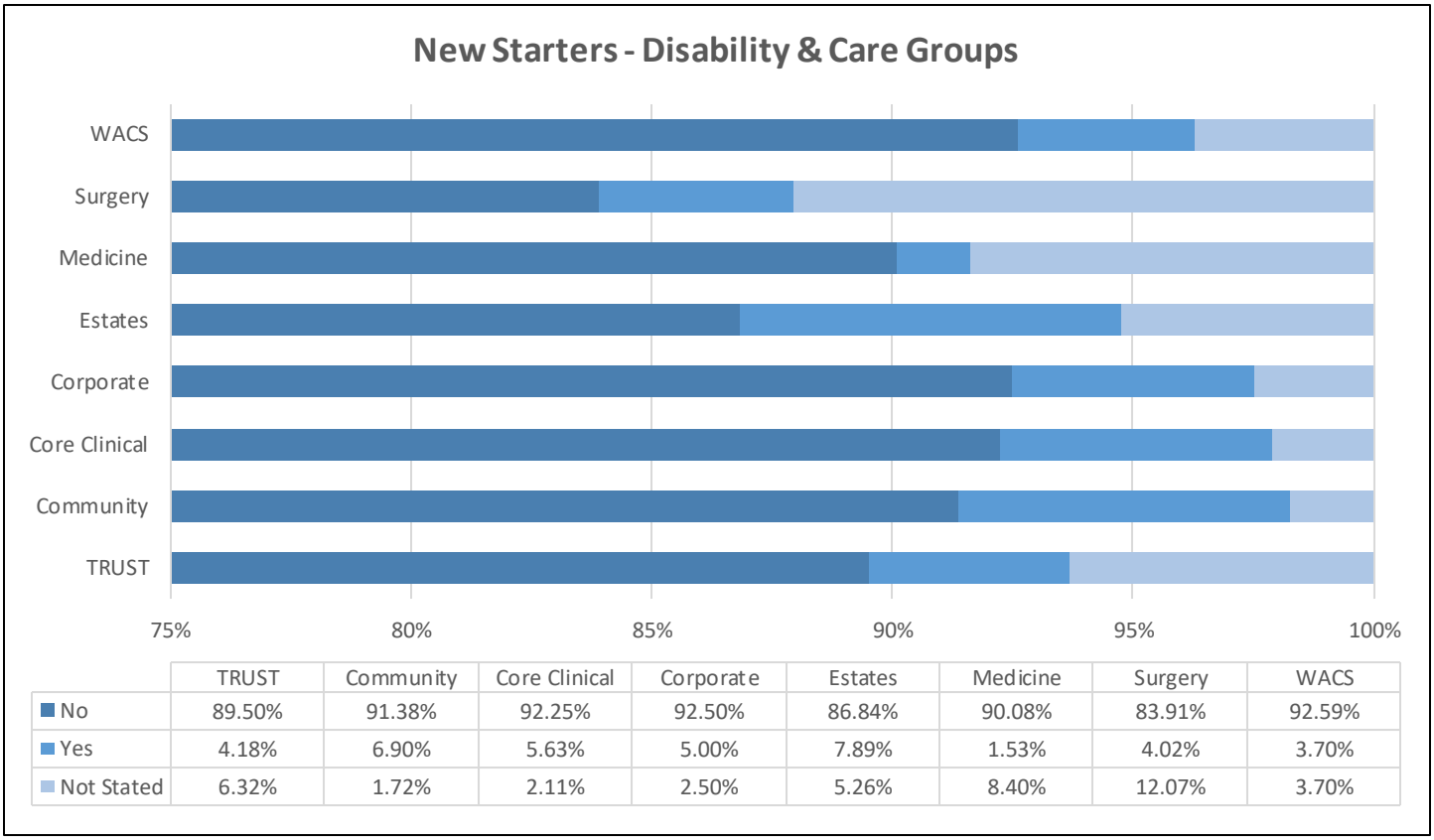








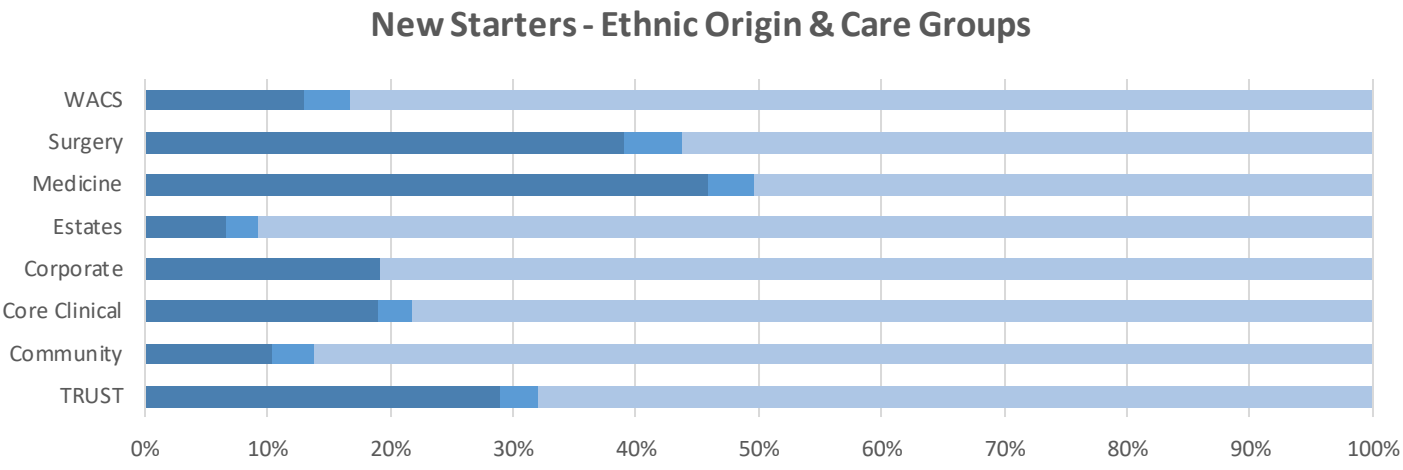
4.2 Disability



	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

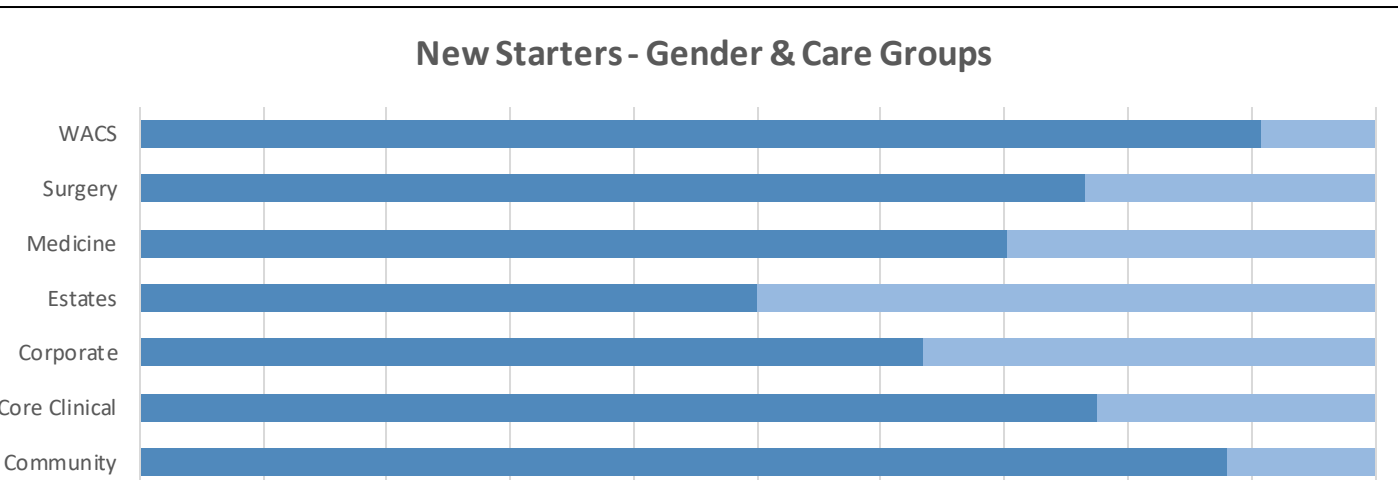
4.3 Ethnic origin



	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



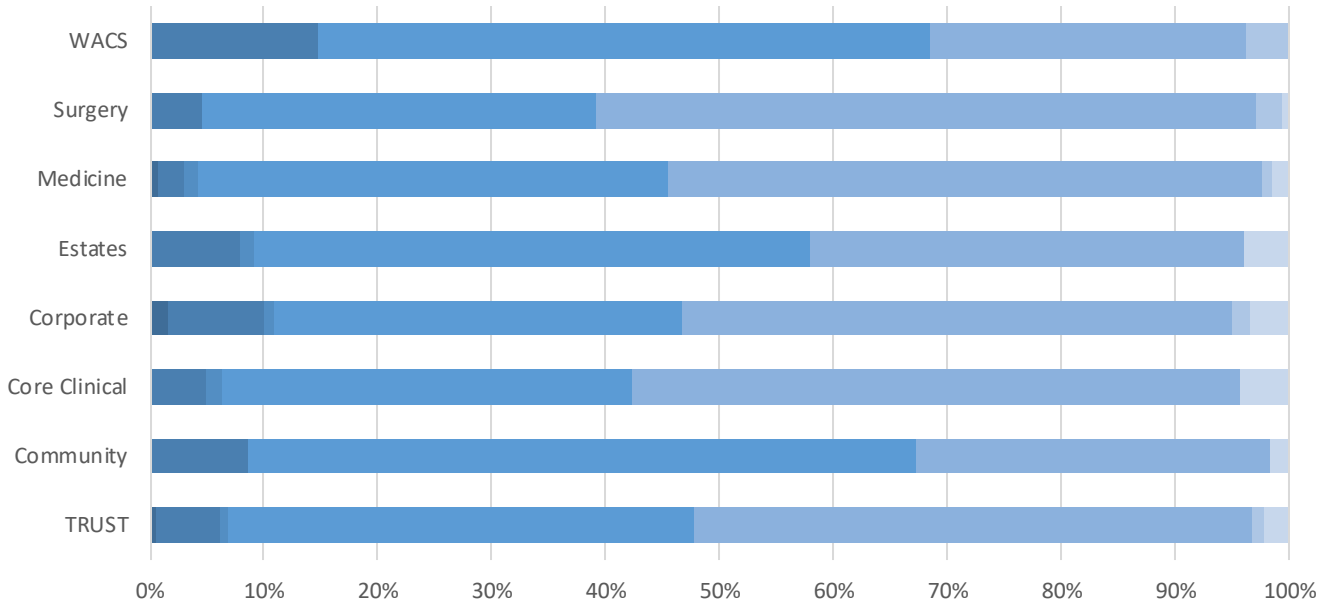
	TRUST	Community	Core Clinical	Corporate	Estates	Medicine	Surgery	WACS
Female	72.35%	87.93%	77.46%	63.33%	50.00%	70.23%	76.44%	90.74%
Male	27.65%	12.07%	22.54%	36.67%	50.00%	29.77%	23.56%	9.26%

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



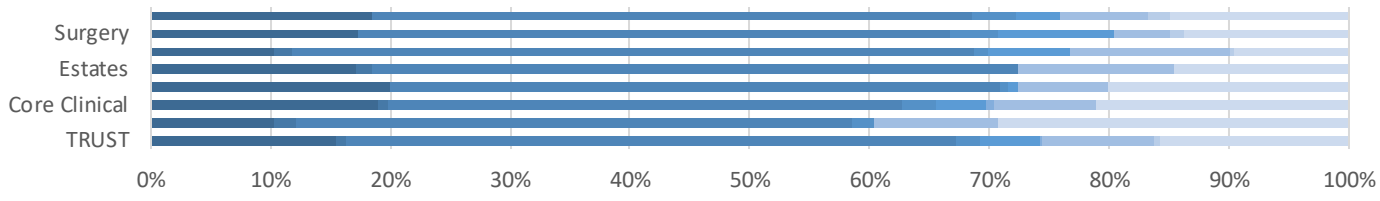
	TRUST	Community	Core Clinical	Corporate	Estates	Medicine	Surgery	WACS
Civil Partnership	0.45%	0.00%	0.00%	1.67%	0.00%	0.76%	0.00%	0.00%
Divorced	5.64%	8.62%	4.93%	8.33%	7.89%	2.29%	4.60%	14.81%
Legally Separated	0.79%	0.00%	1.41%	0.83%	1.32%	1.15%	0.00%	0.00%
Married	40.86%	58.62%	35.92%	35.83%	48.68%	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.

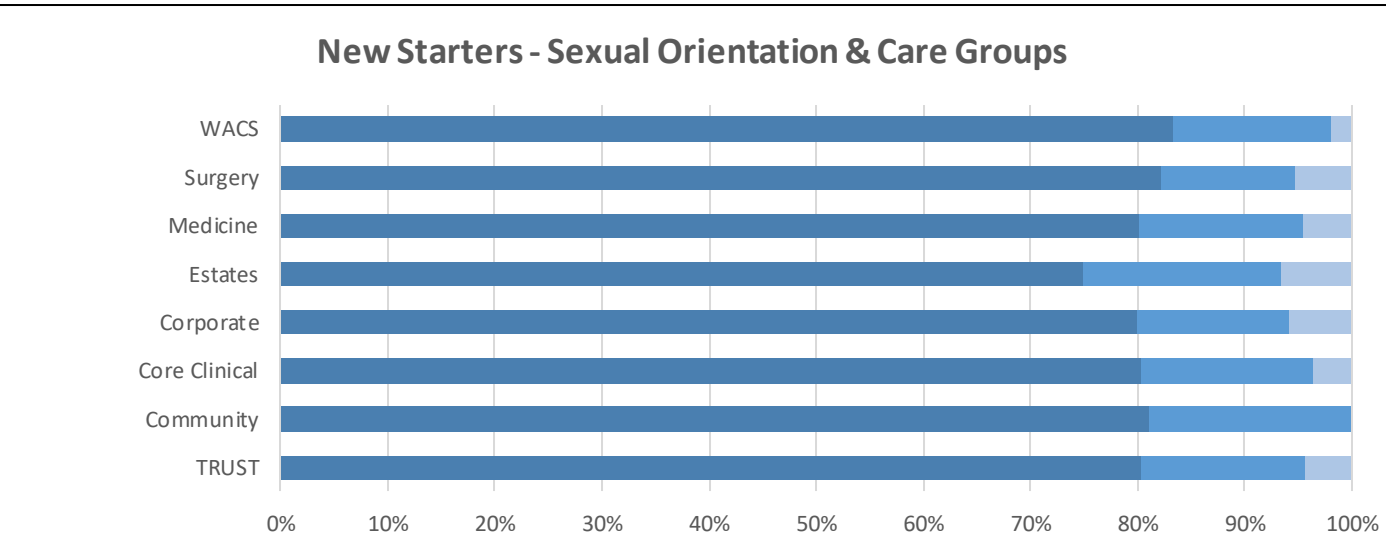
4.8 Religion/belief



	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

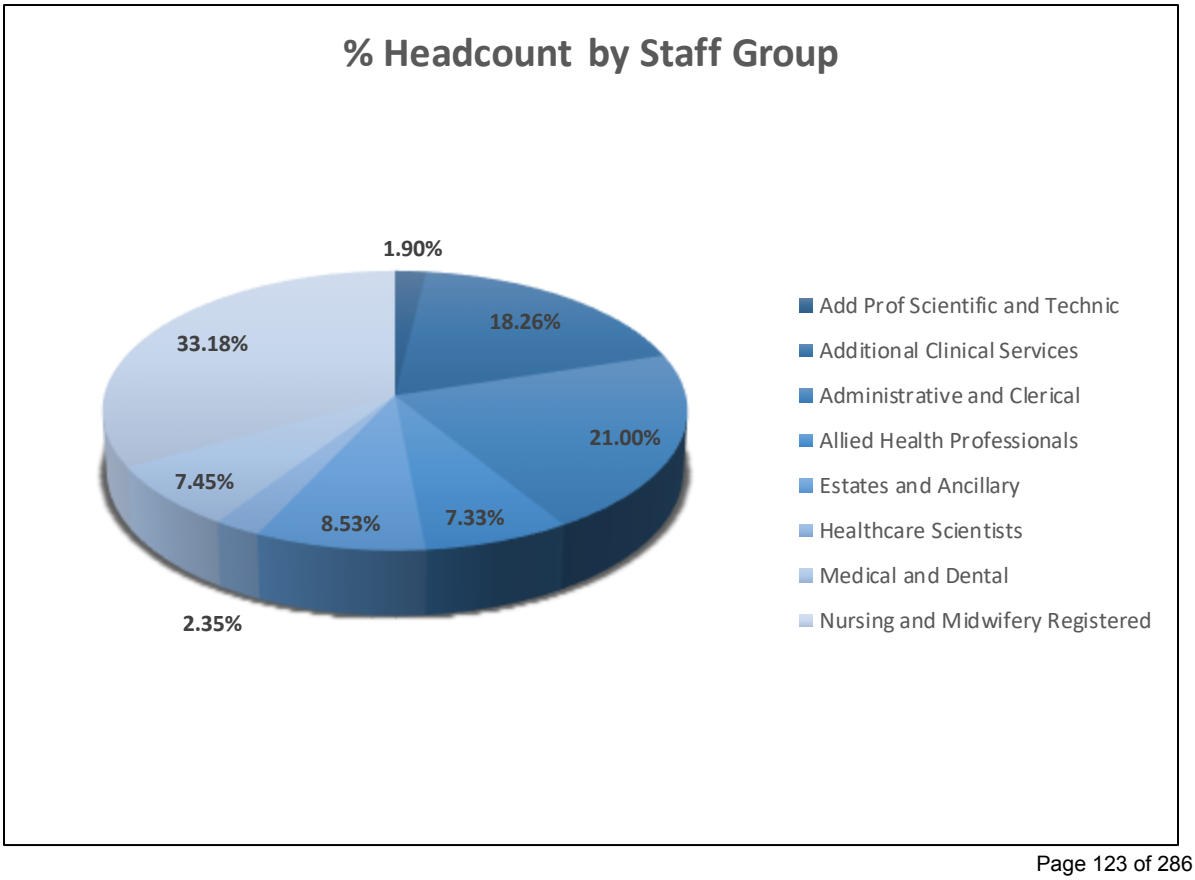
The figures presented here show the staff in post atUniversity Hospitals of Morecambe Bay NHS Foundation Trust as at 31st March 2022.

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

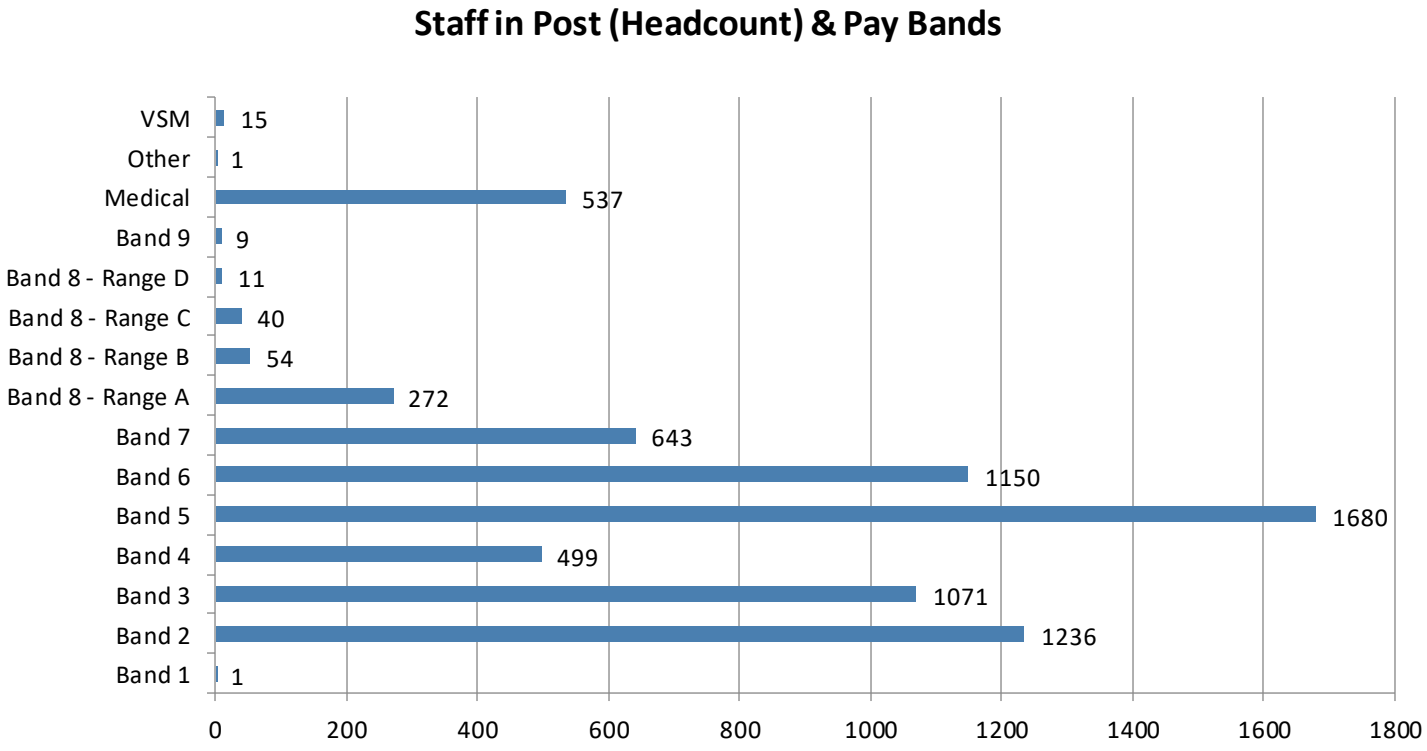
University Hospitals of Morecambe Bay NHS Foundation Trust employs their staff in line with the nationally agreed 'Agenda for Change' and Medical and Dental pay banding systems.

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%



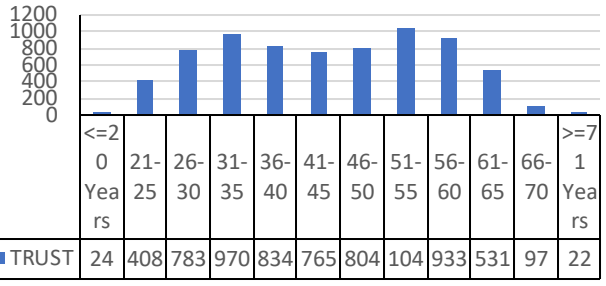
5.1.3 Working patterns

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

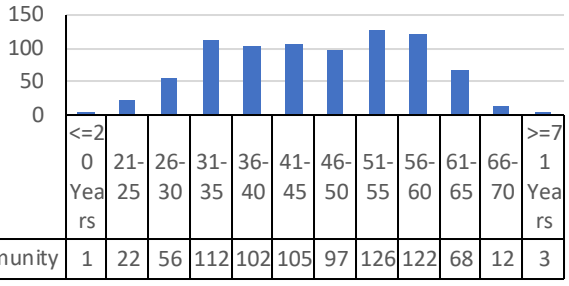
46.72% of the total workforce are in their 30s or 40s. Under 20s make up less than half a per cent (0.33%) of the workforce whilst 9.00% are aged 60 or over.

TRUST
Staff in Post - Age Profile



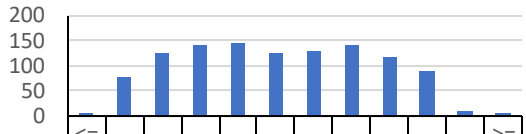
	<=20 Years	21-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70	>=71 Years
TRUST	24	408	783	970	834	765	804	104	933	531	97	22

Community
Staff in Post - Age Profile



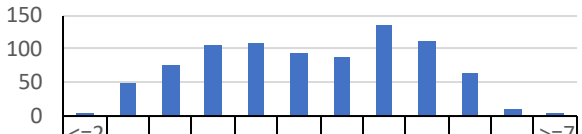
	<=20 Years	21-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70	>=71 Years
Community	1	22	56	112	102	105	97	126	122	68	12	3

Core Clinical
Staff in Post - Age Profile



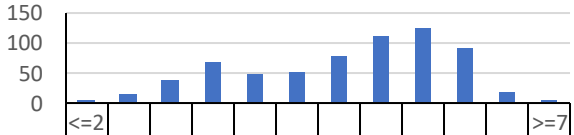
	<=20 Years	21-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70	>=71 Years
Core Clinical	1	75	126	140	145	126	127	140	115	87	8	1

Corporate
Staff in Post - Age Profile



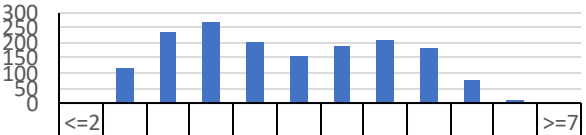
	<=20 Years	21-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70	>=71 Years
Corporate	4	48	76	106	109	95	87	135	113	63	9	1

Estates
Staff in Post - Age Profile



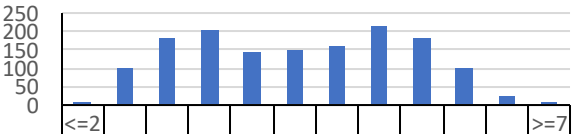
	<=20 Years	21-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70	>=71 Years
Estates	5	17	39	68	47	51	78	111	125	91	20	6

Medicine
Staff in Post - Age Profile



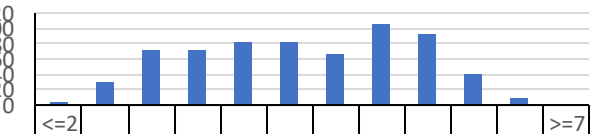
	<=20 Years	21-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70	>=71 Years
Medicine	5	118	232	265	203	155	188	209	183	79	14	4

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

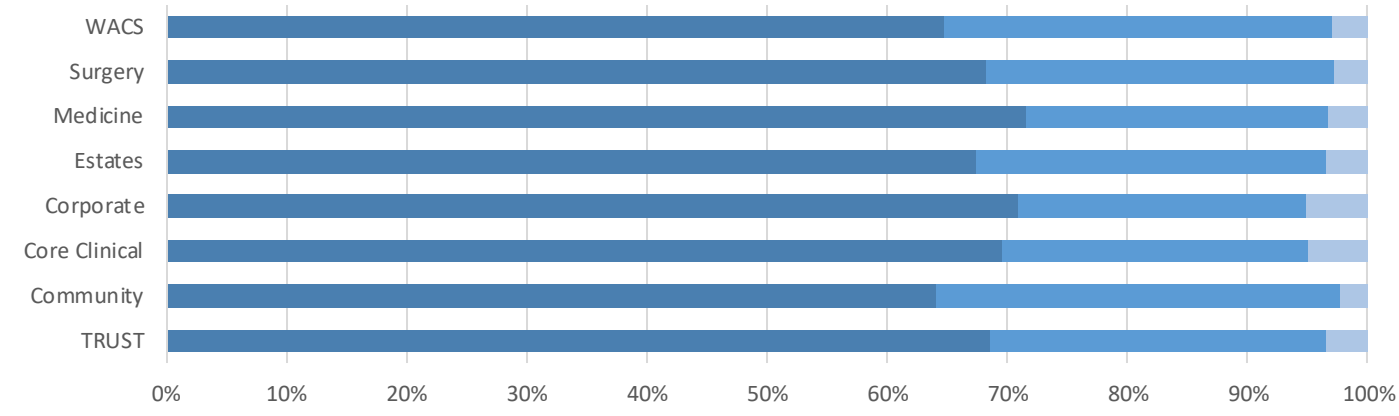
WACS
Staff in Post - Age Profile



	<=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

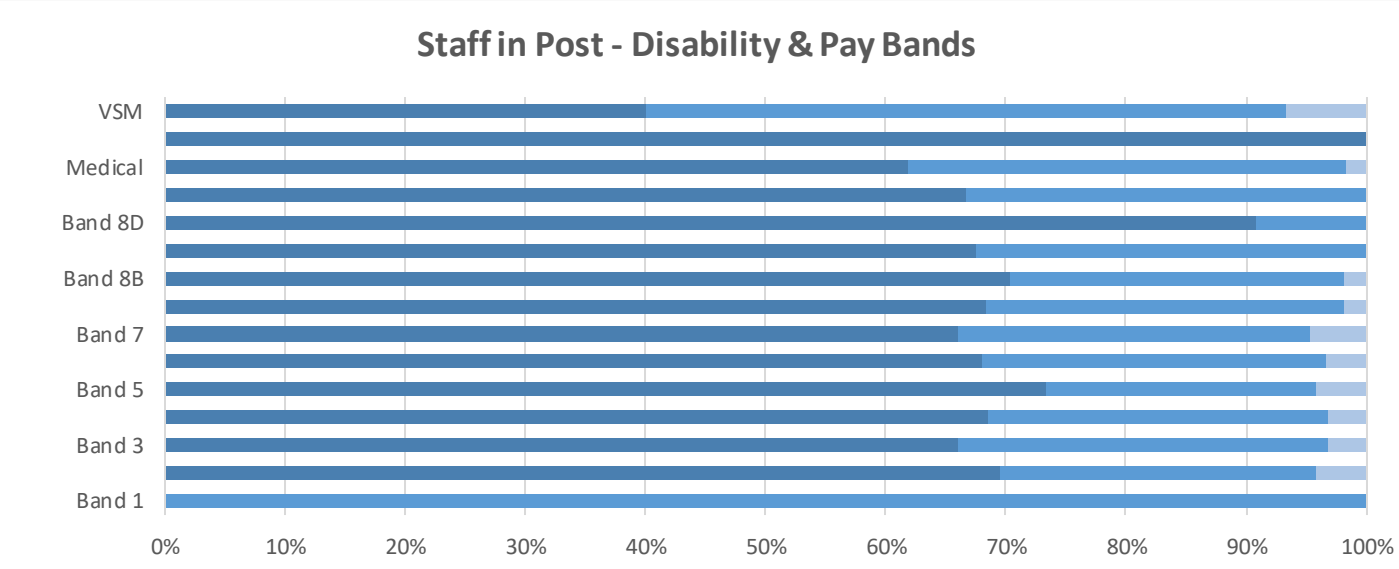
5.3 Disability // 5.3.1 Staff In Post

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%

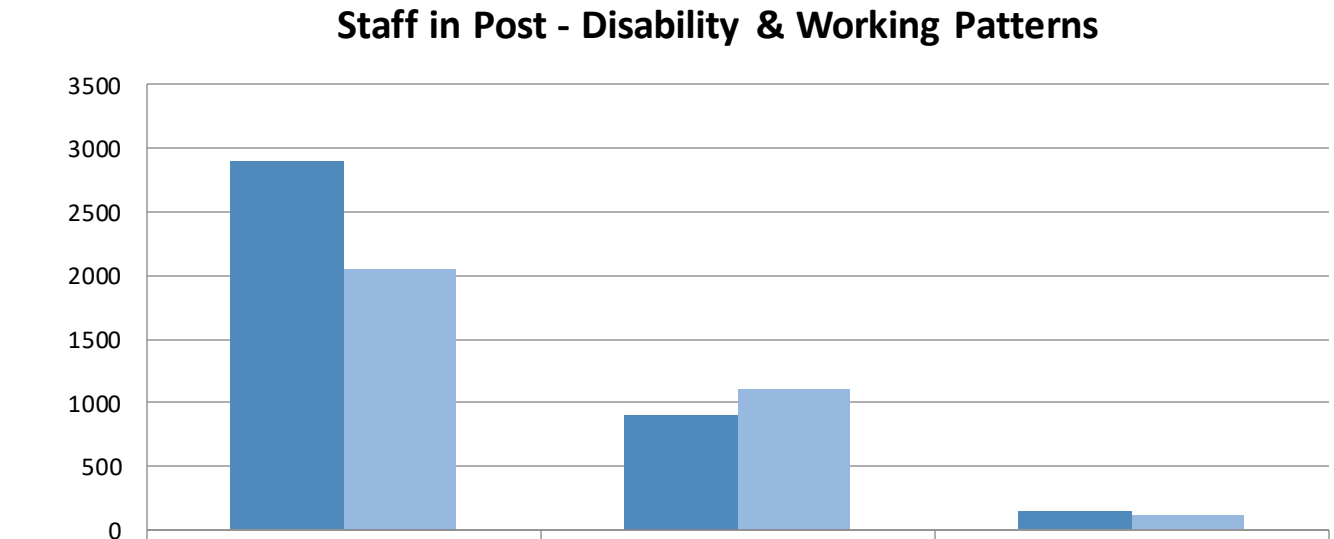
5.3.2 Disability & Pay Bands



	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

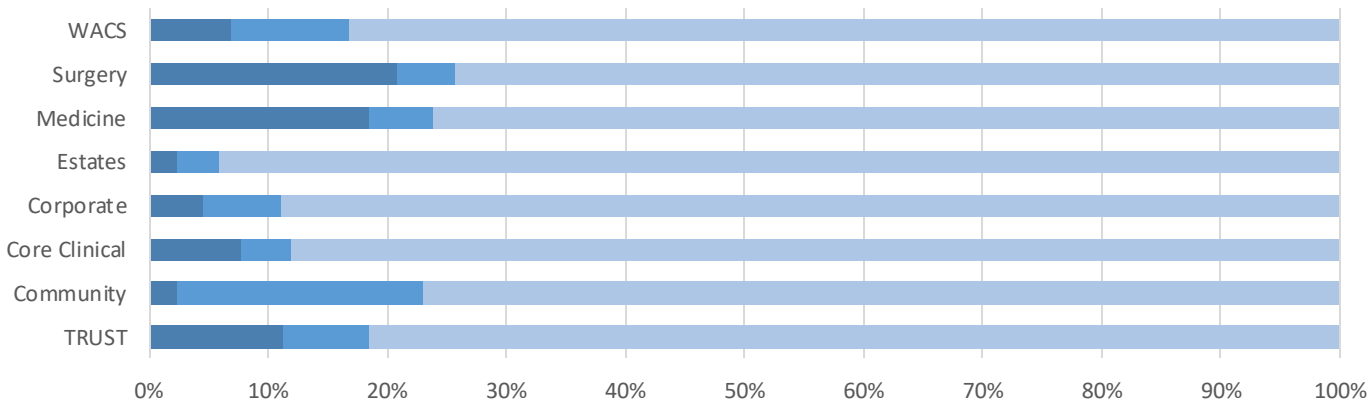
Overall, 257 members of staff consider themselves to have a disability. Of those, 142 worked full time whilst 115 worked part time.



	No	Not Declared	Yes
Full Time	2905	898	142
Part Time	2047	1112	115

5.4 Ethnic Origin // 5.4.1 Staff In Post

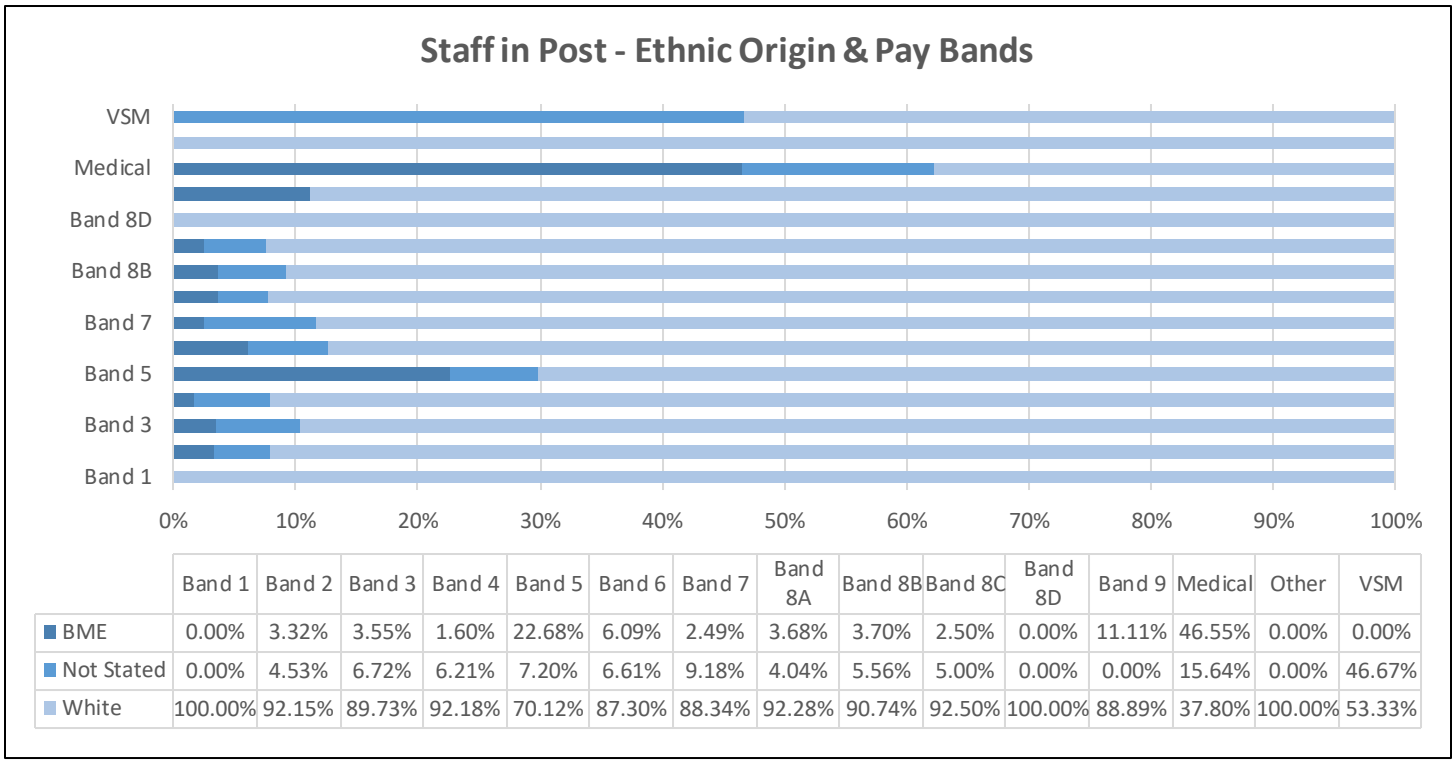
Overall 81.44% of the workforce describe their ethnic origin as White whilst 11.33% describe themselves as belonging to a Black, Asian or Ethnic Minority group. 7.23% prefer not to state their ethnic origin. The Surgical care group had the largest proportion of BAME staff members at 20.78% followed by 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%

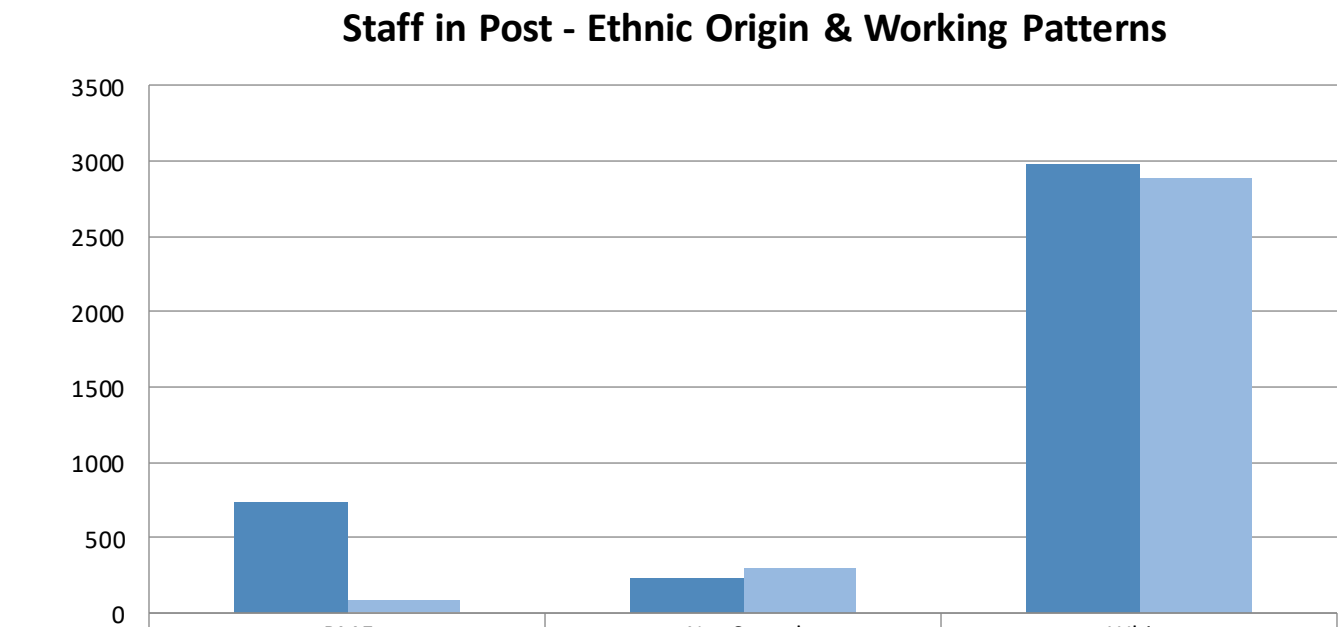
5.4.2 Ethnic Origin & Pay Bands

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%

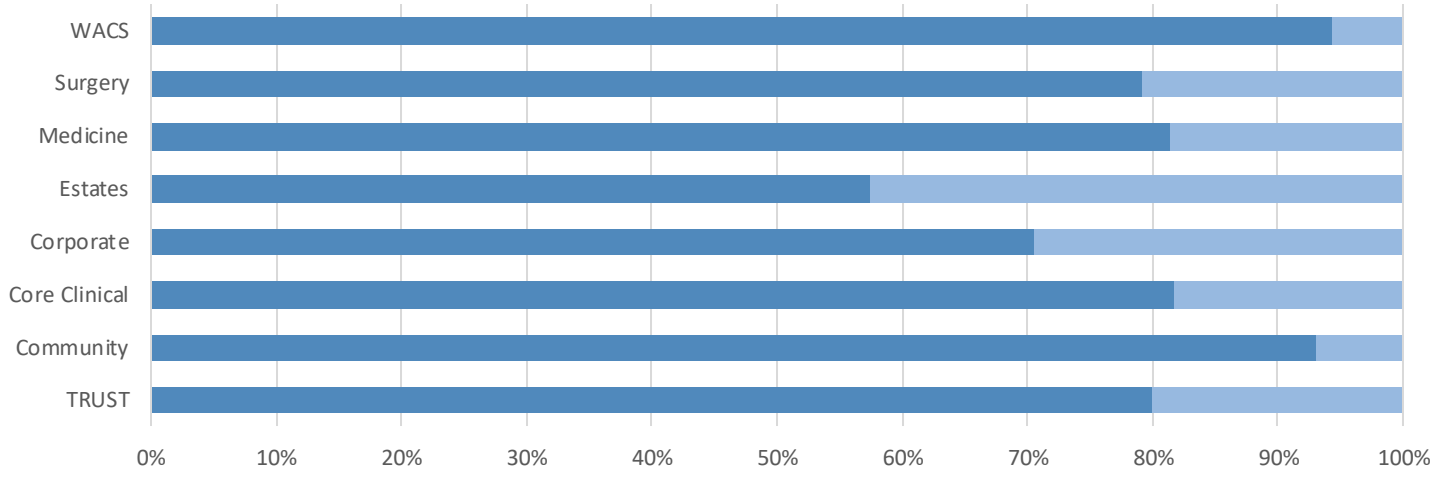
5.4.3 Ethnic Origin & Working Patterns



	BME	Not Stated	White
Full Time	735	225	2985
Part Time	83	297	2894

5.5 Gender // 5.5.1 Staff In Post

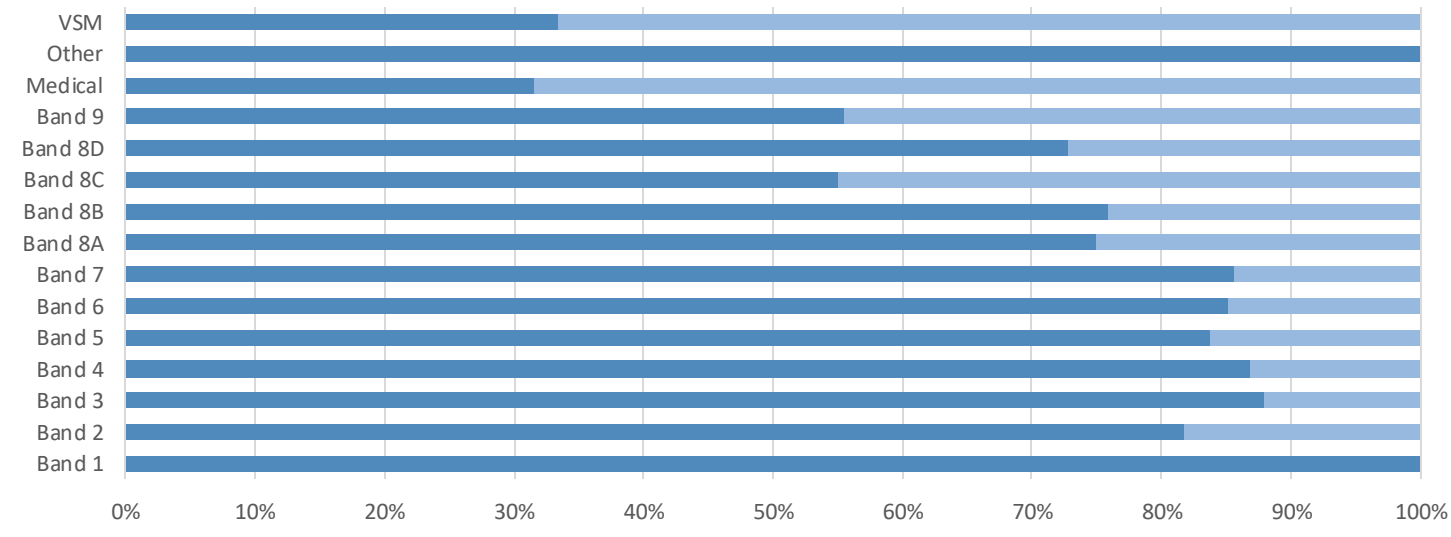
Overall 80.01% of the workforce is female. Estates and Facilities have the closest ratio of male / female staff with 57.45% female and 42.55% male. 94.34% of staff in the WACS care group are female.



	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%

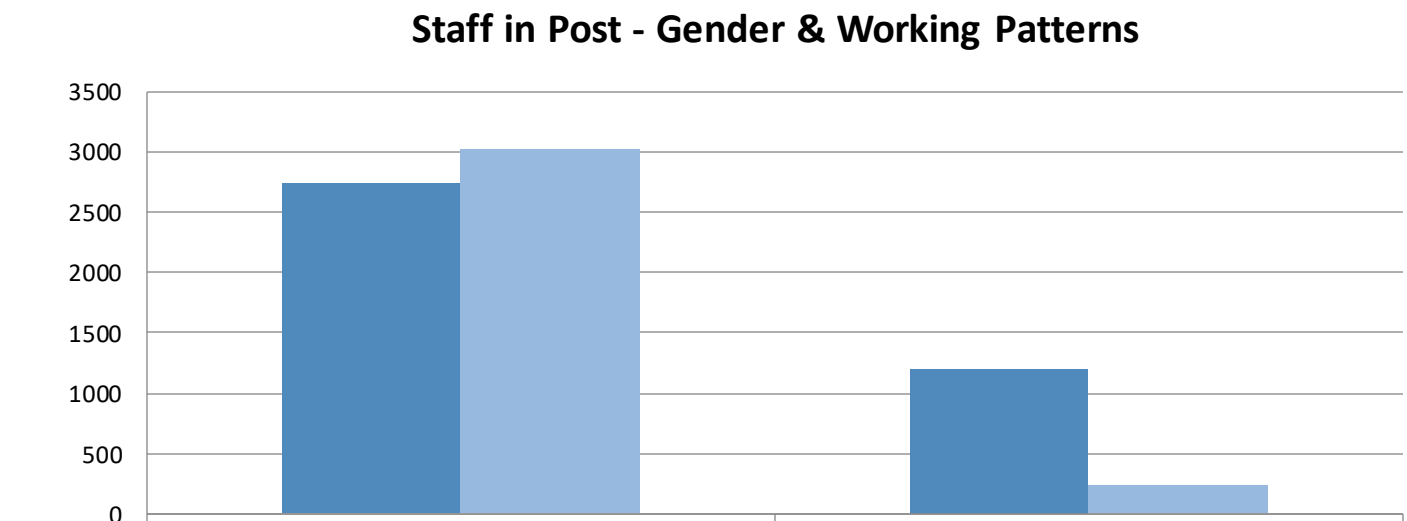
5.5.2 Gender & Pay Bands

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



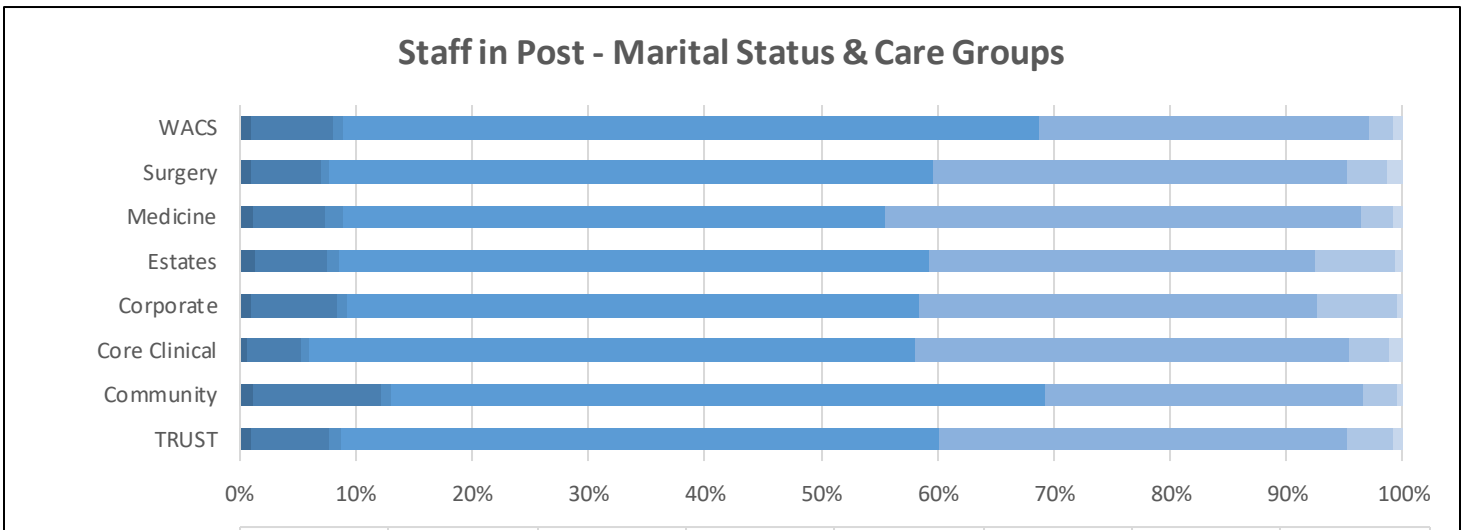
	Female	Male
Full Time	2745	1200
Part Time	3031	243

5.6 Gender Identity

Information on gender identity is not currently collected.

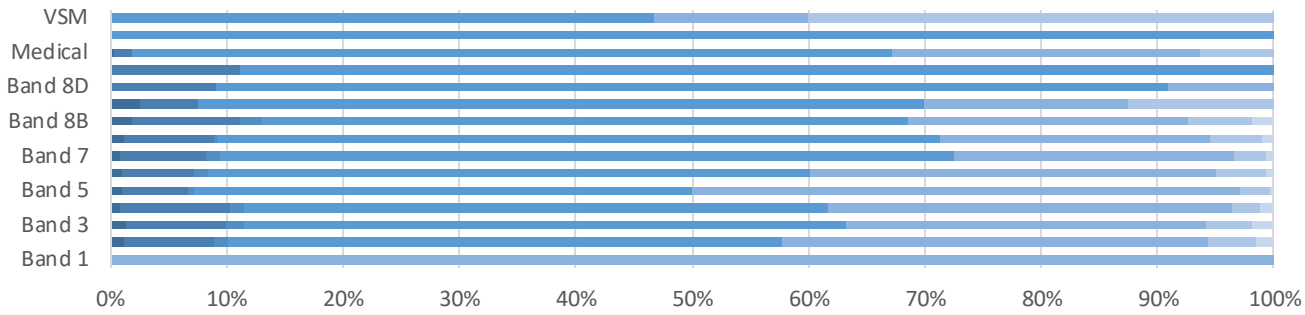
5.7 Marital Status // 5.7.1 Staff In Post

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%

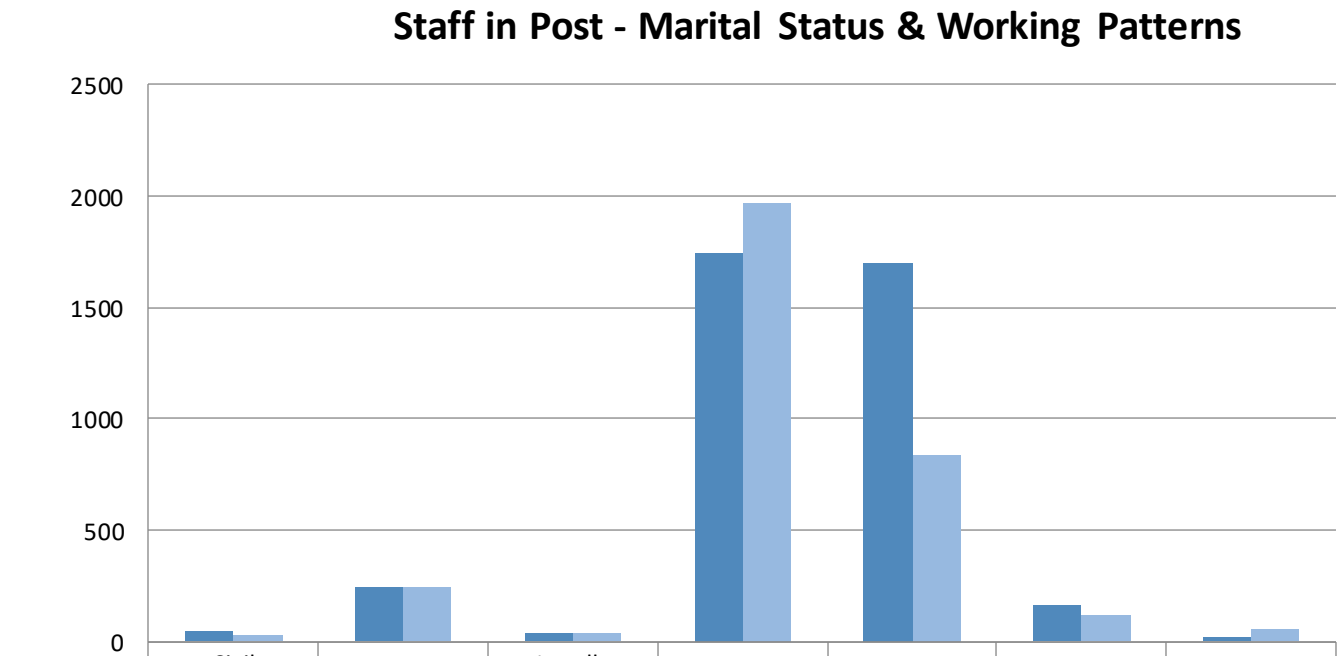
5.7.2 Marital Status & Pay Bands



	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

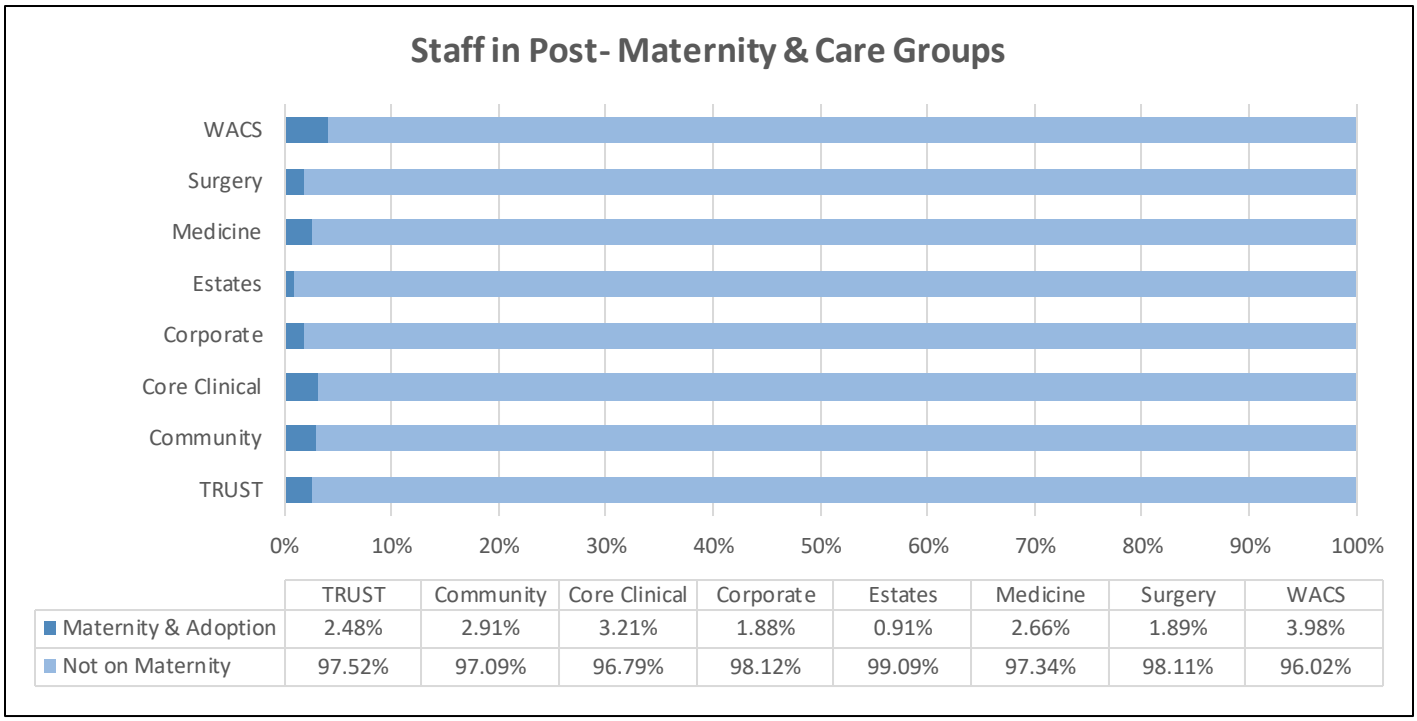
Overall 52.49% of the workforce are either married or in a civil partnership. 35.09% are single whilst 3.82% have not stated their marital status.



	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

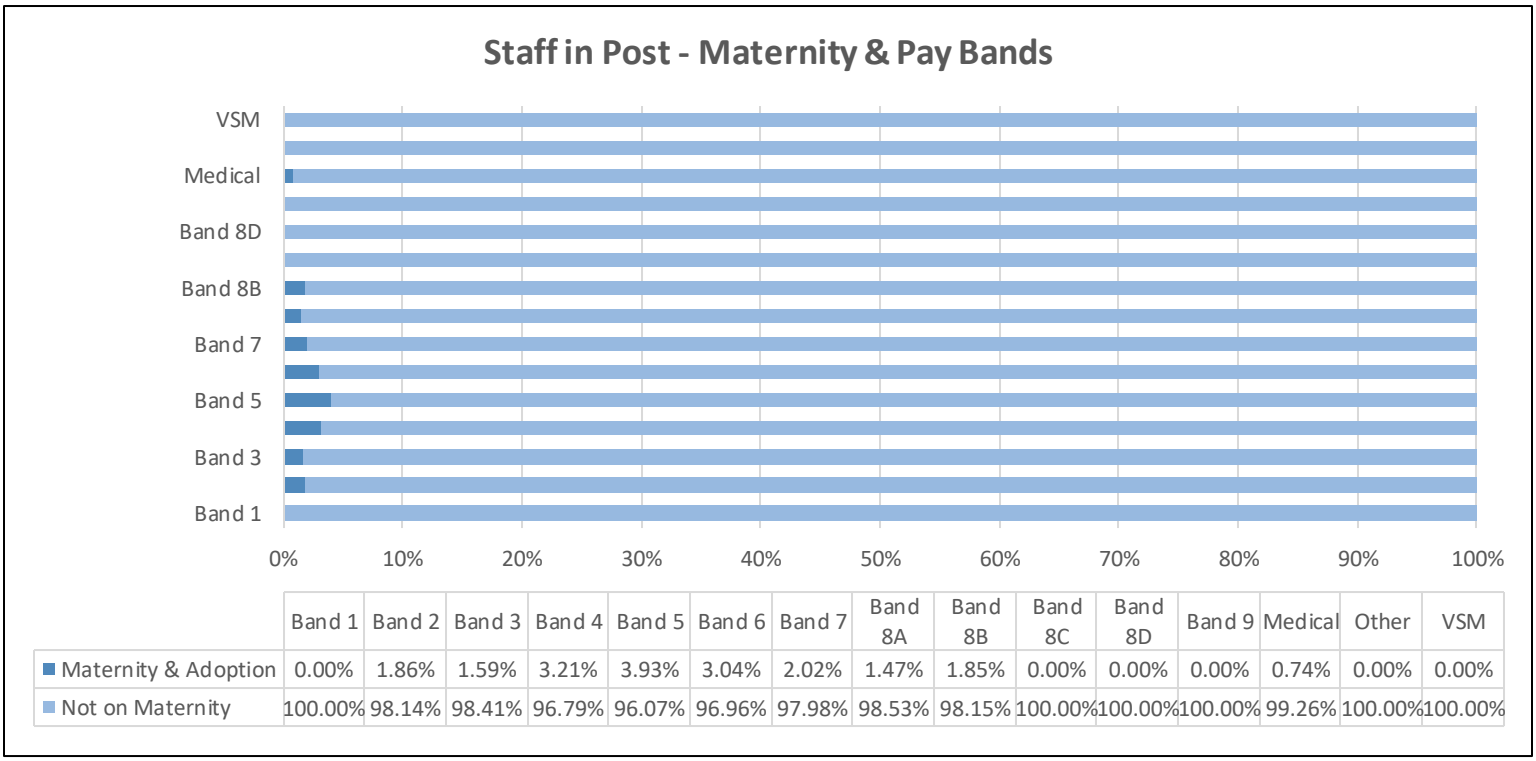
Overall 2.48% of the workforce were on maternity or adoption leave.



	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%

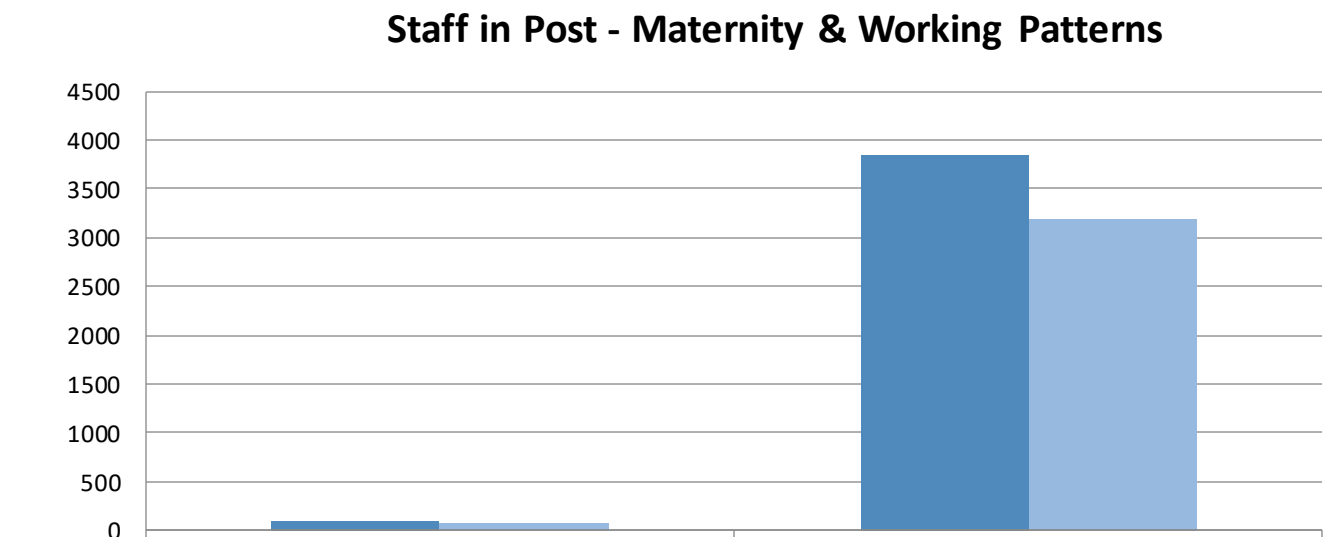
5.8.2 Maternity & Pay Bands

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%

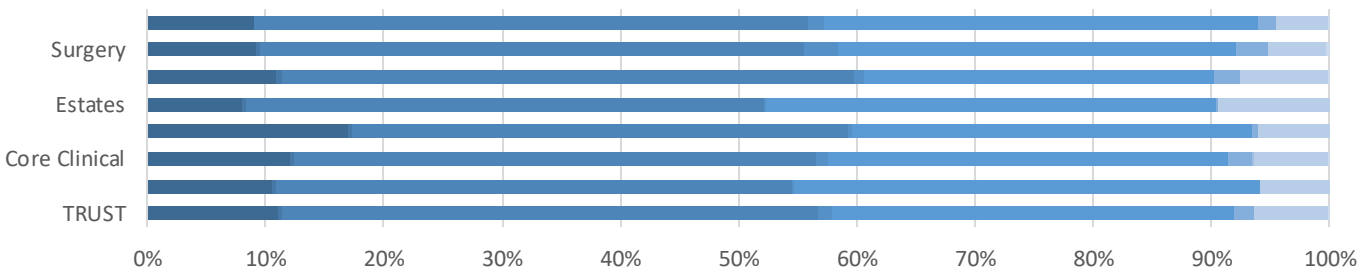
5.8.3 Maternity & Working Patterns



	Maternity & Adoption	Not on Maternity
Full Time	95	3850
Part Time	84	3190

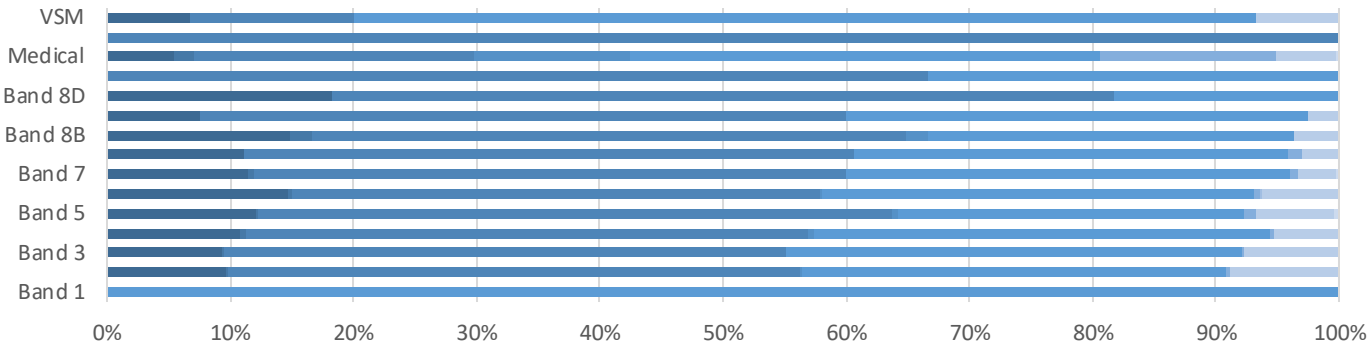
5.9 Religion & Belief // 5.9.1 Staff In Post

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.



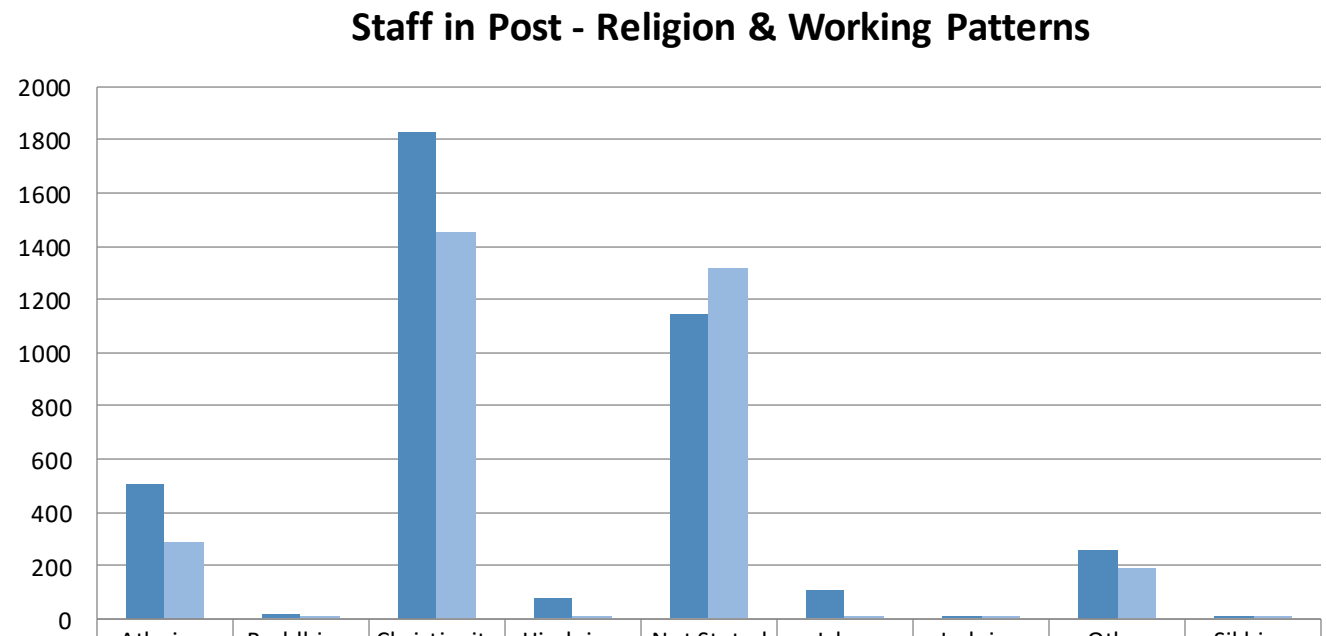
	TRUST	Community	Core Clinical	Corporate	Estates	Medicine	Surgery	WACS
Atheism	10.96%	10.53%	12.10%	16.88%	8.05%	10.88%	9.18%	9.02%
Buddhism	0.35%	0.36%	0.27%	0.35%	0.30%	0.48%	0.40%	0.00%
Christianity	45.42%	43.70%	44.27%	41.97%	43.77%	48.46%	45.95%	46.79%
Hinduism	1.15%	0.12%	1.01%	0.35%	0.15%	0.85%	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%

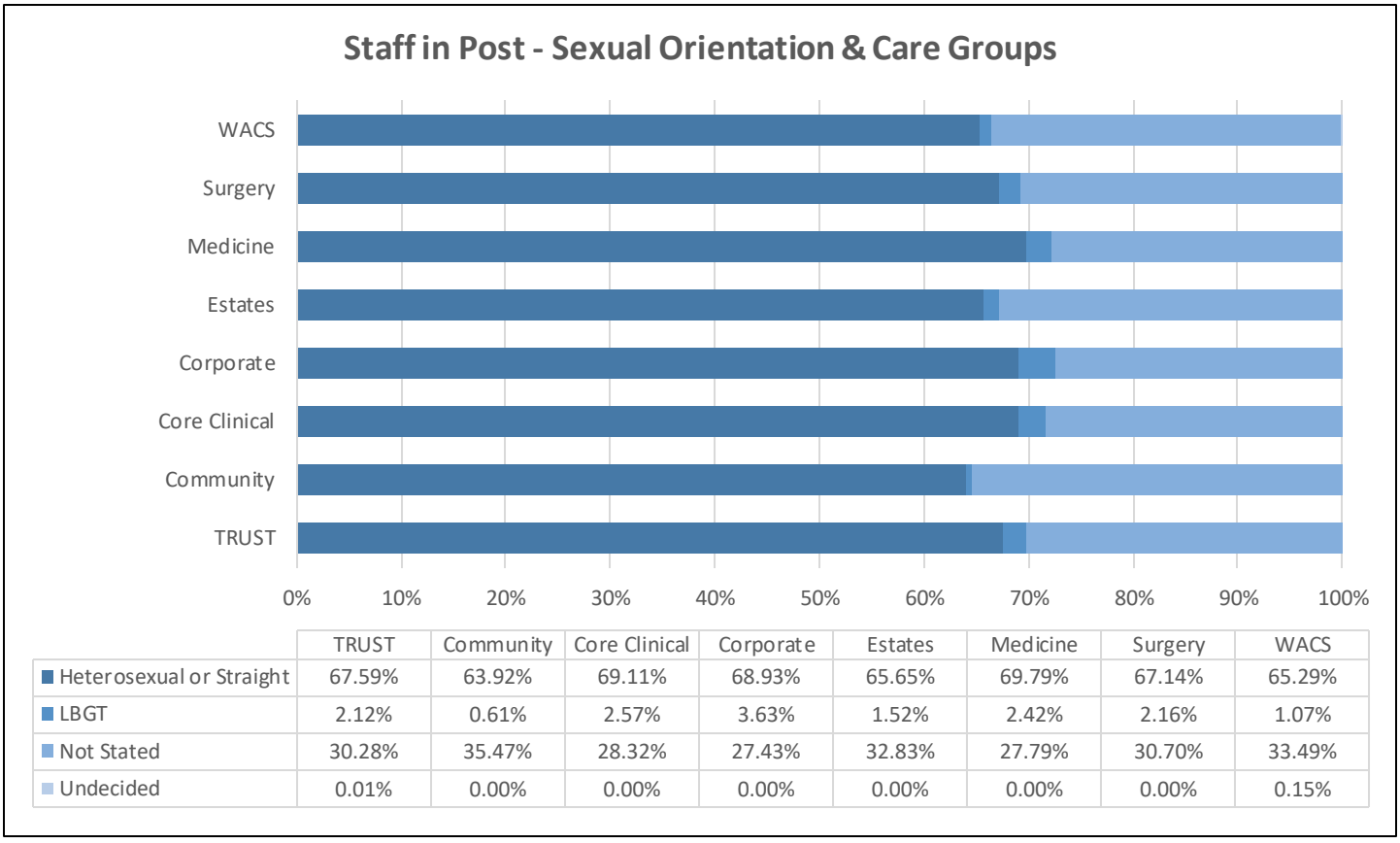
5.9.3 Religion & Working Patterns



	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

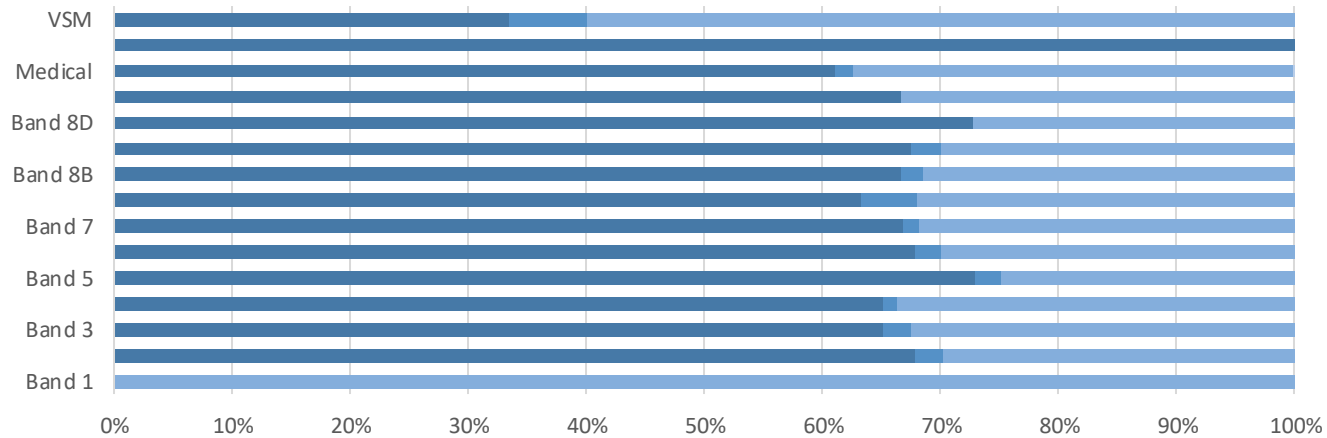
5.10 Sexual Orientation // 5.10.1 Staff In Post

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%

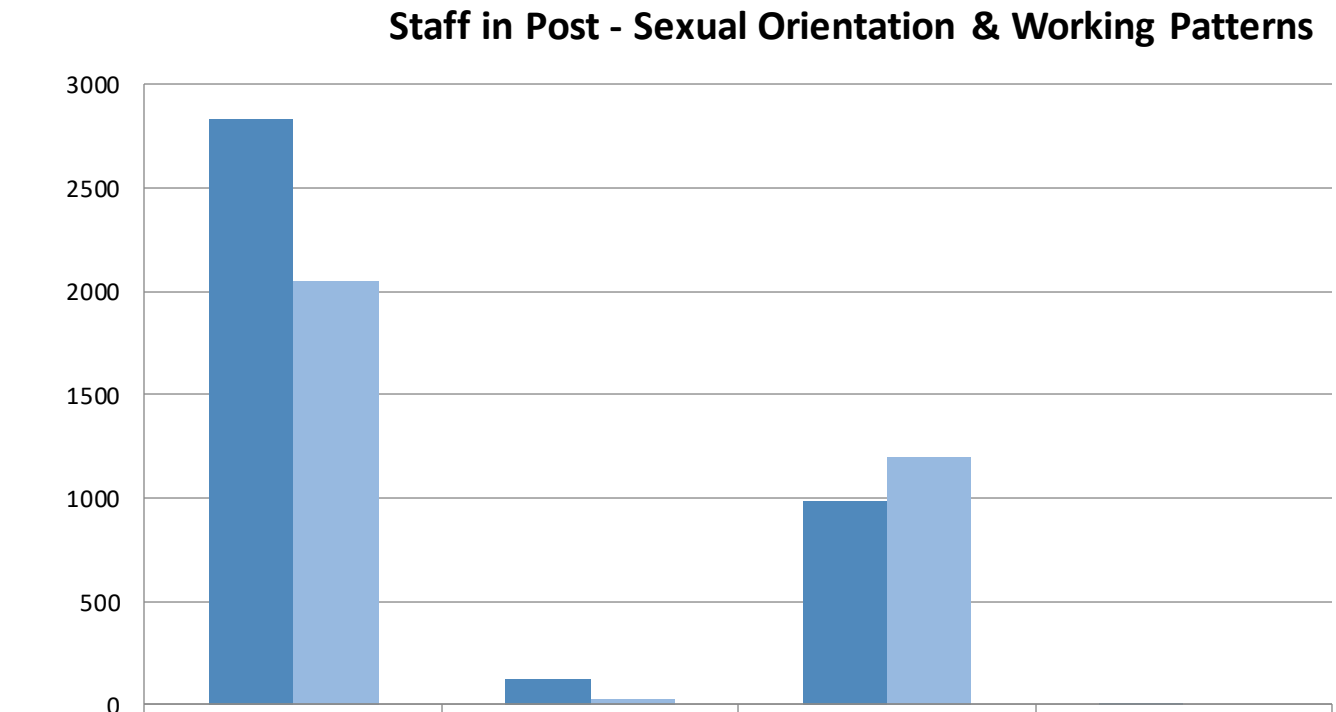
5.10.2 Sexual Orientation & Pay Bands



	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%

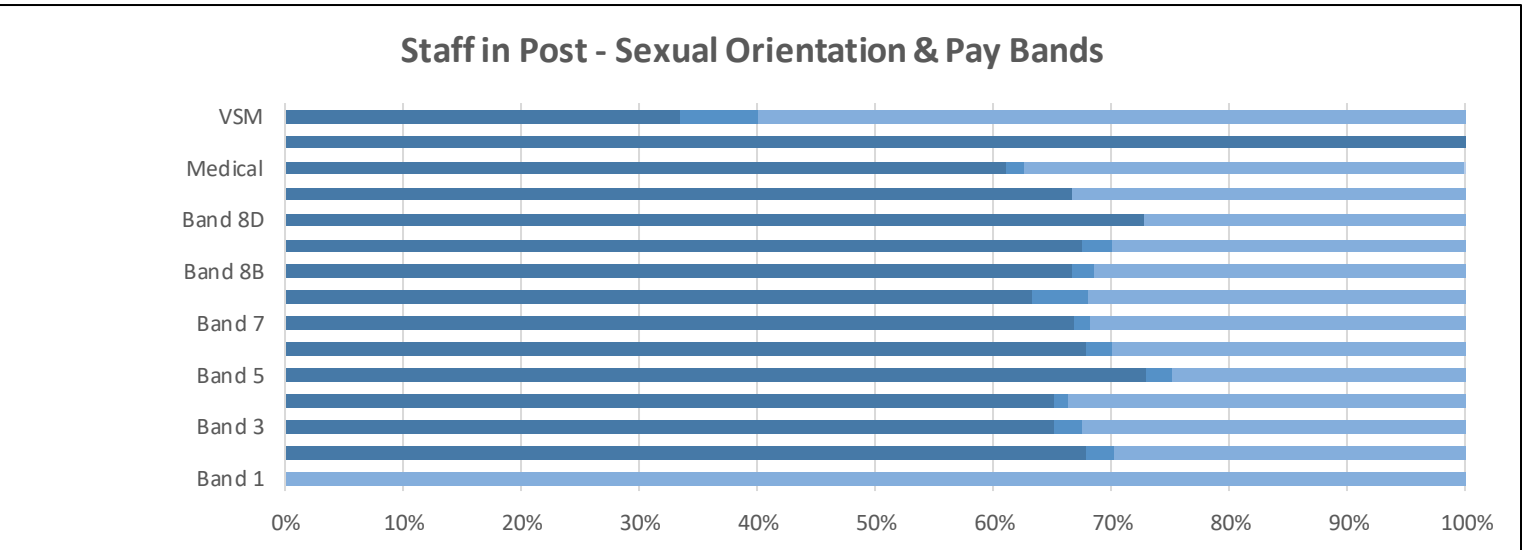
5.10.3 Sexual Orientation & Working Patterns

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

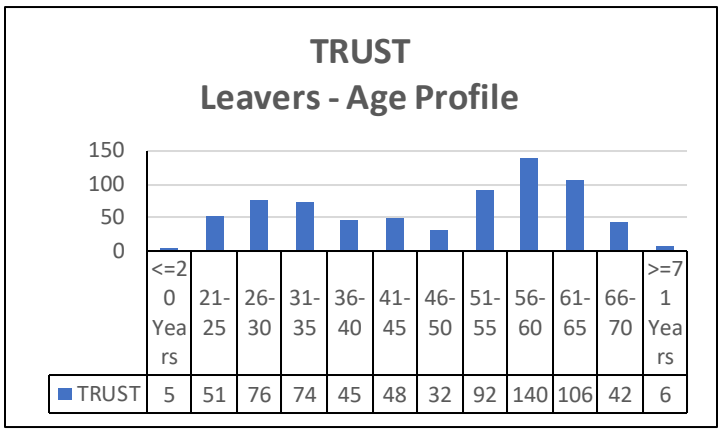


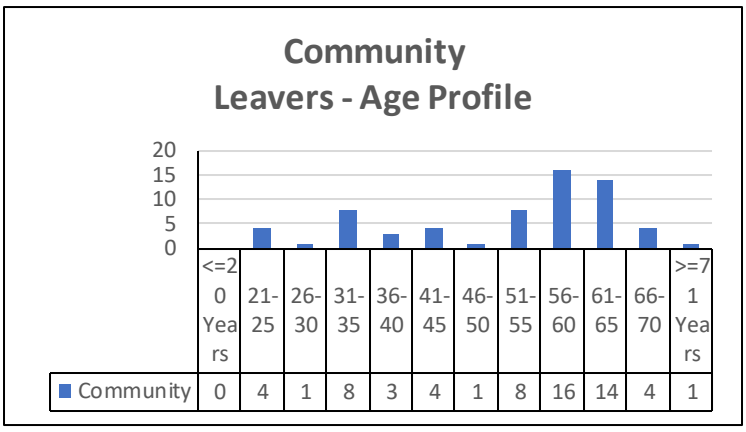
	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8A	Band 8B	Band 8C	Band 8D	Band 9	Medical	Other	VSM
Heterosexual or Straight	0.00%	67.88%	65.17%	65.13%	72.92%	67.83%	66.72%	63.24%	66.67%	67.50%	72.73%	66.67%	61.08%	100.00%	33.33%
LBGT	0.00%	2.27%	2.24%	1.20%	2.20%	2.17%	1.40%	4.78%	1.85%	2.50%	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%

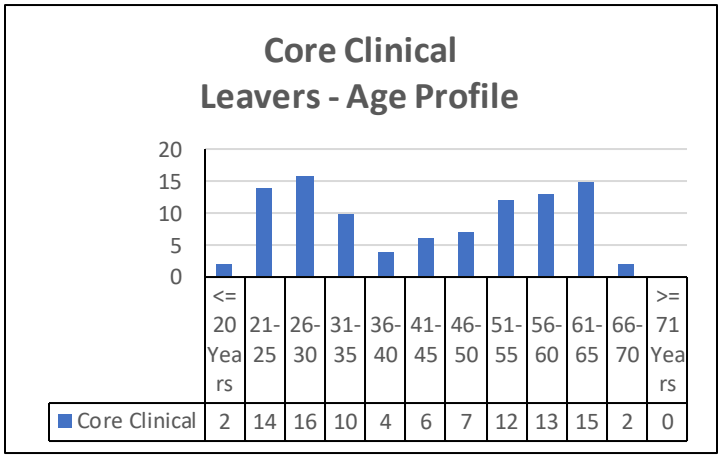
6. Leavers

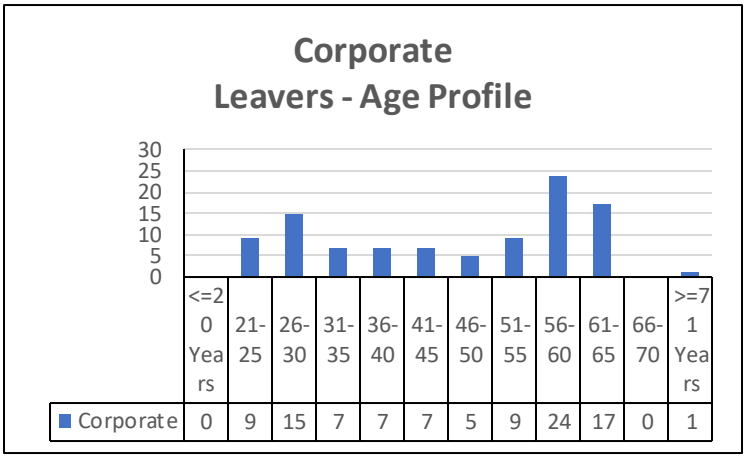
The figures presented here show the leavers with University Hospitals of Morecambe Bay NHS Foundation Trust during the financial year 2021/22. The figures are categorised according to the organisation as a whole and care groups within the Trust.

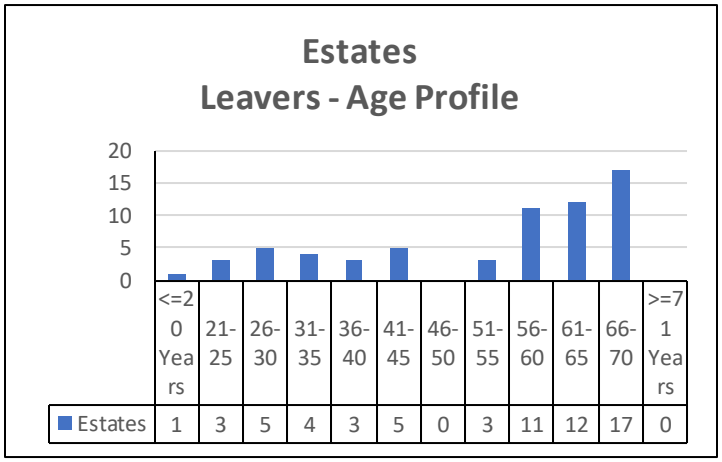
6.1 Age

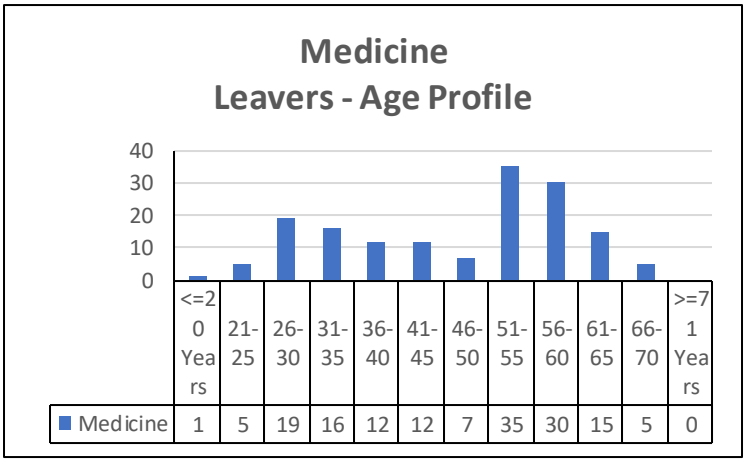


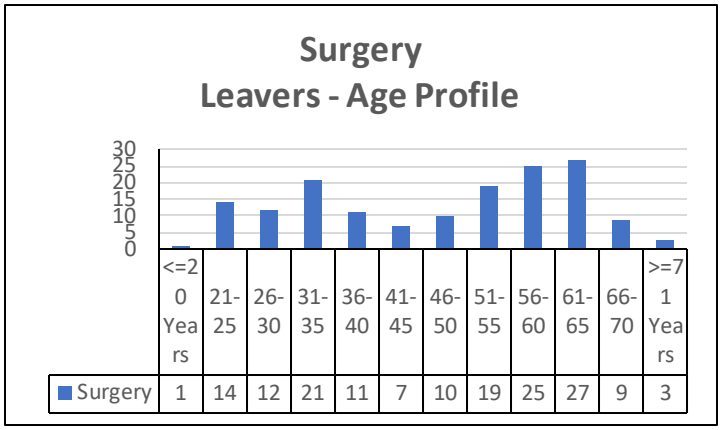


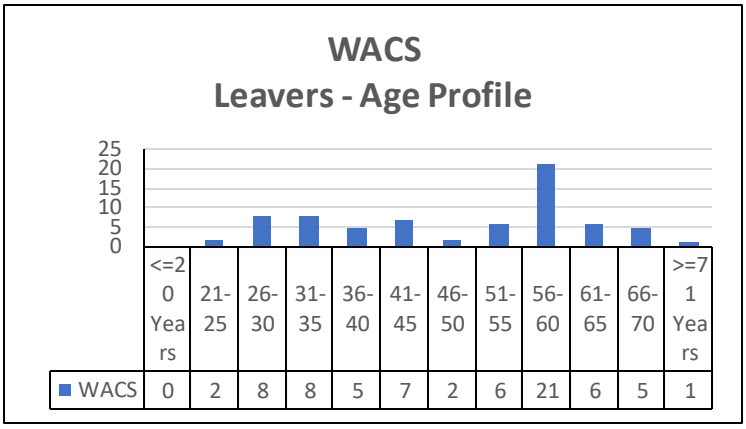




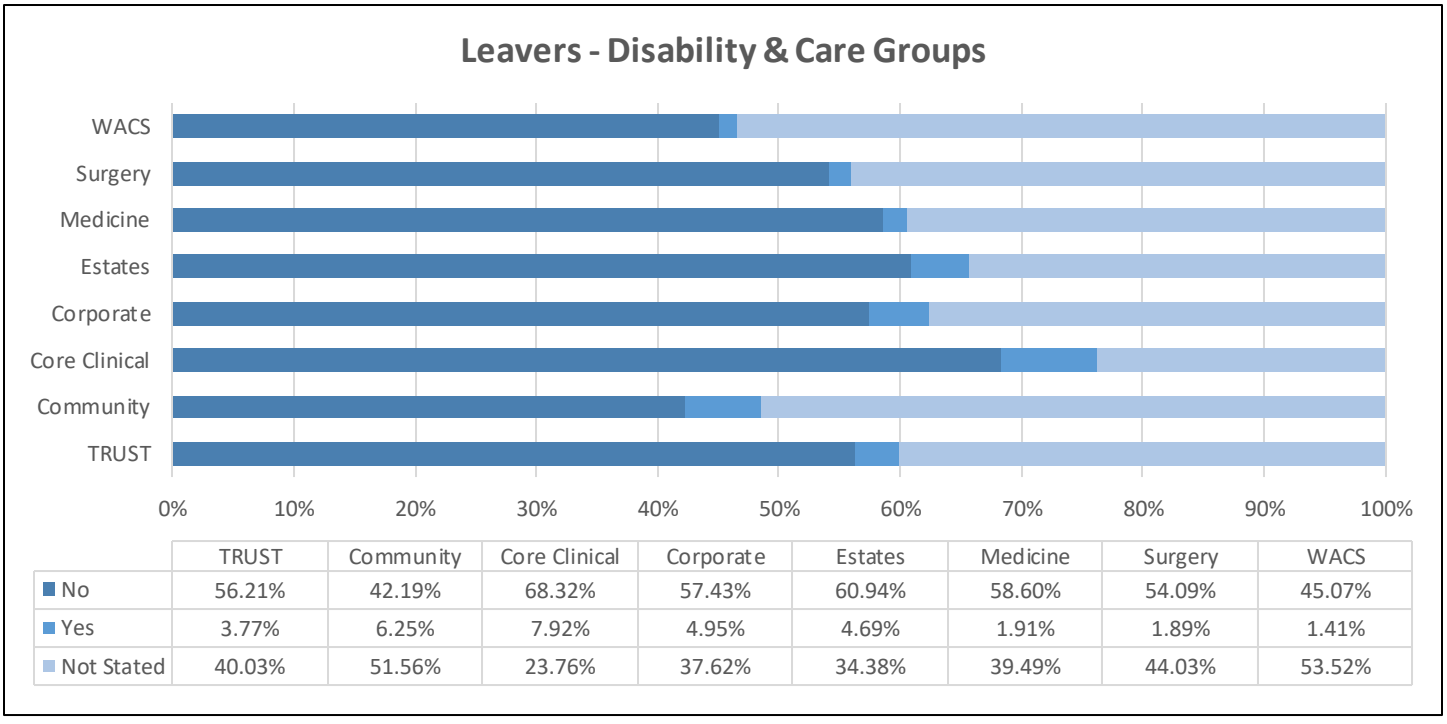






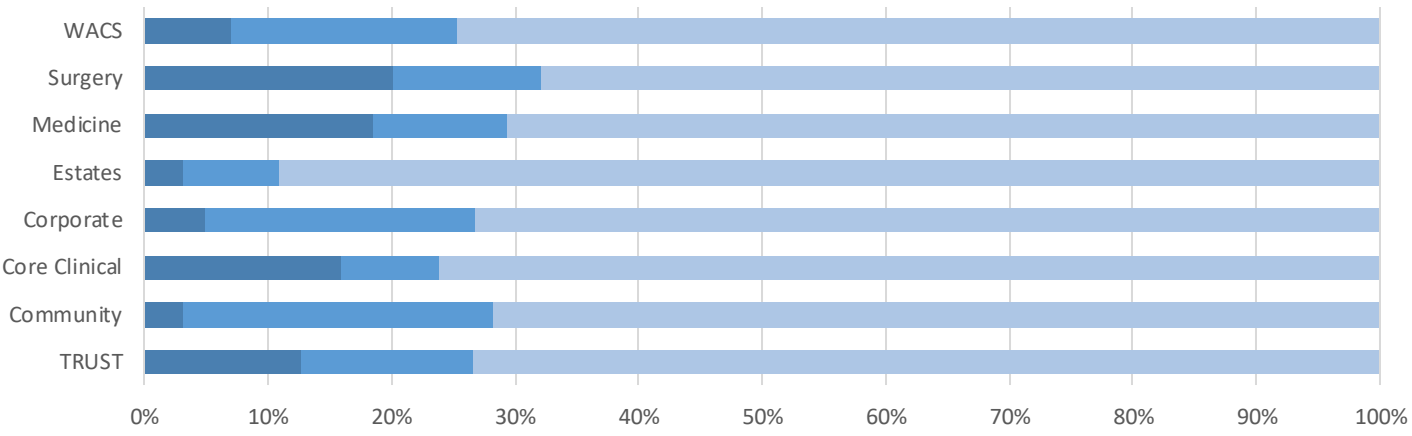


6.2 Disability



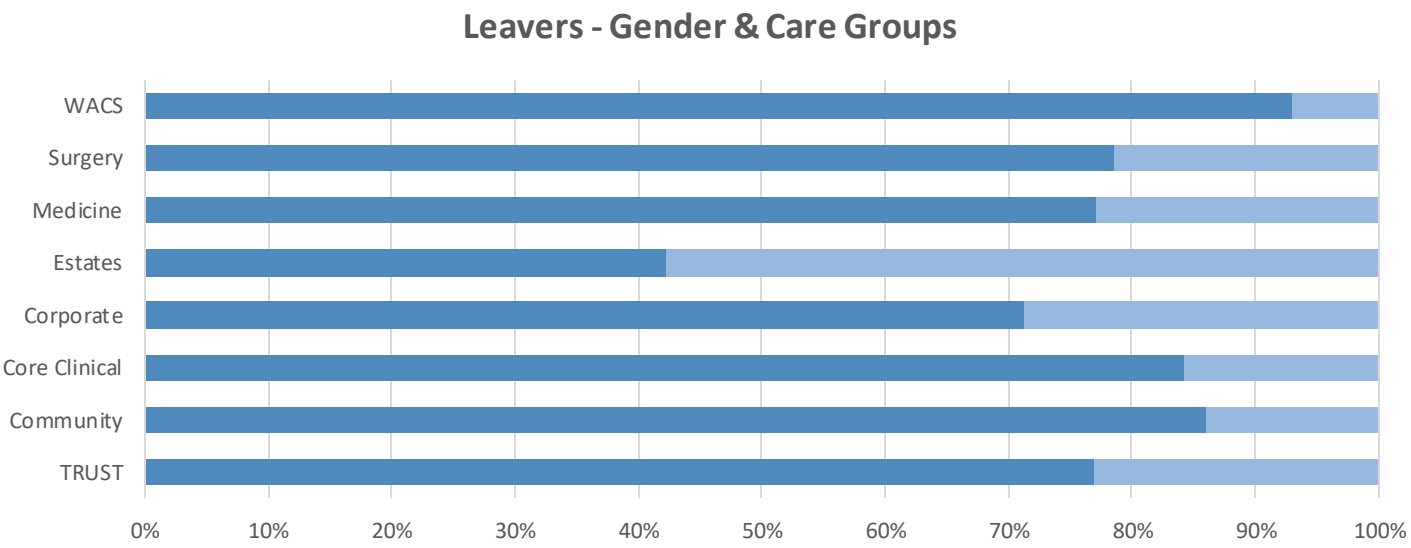
	TRUST	Community	Core Clinical	Corporate	Estates	Medicine	Surgery	WACS
No	56.21%	42.19%	68.32%	57.43%	60.94%	58.60%	54.09%	45.07%
Yes	3.77%	6.25%	7.92%	4.95%	4.69%	1.91%	1.89%	1.41%
Not Stated	40.03%	51.56%	23.76%	37.62%	34.38%	39.49%	44.03%	53.52%

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

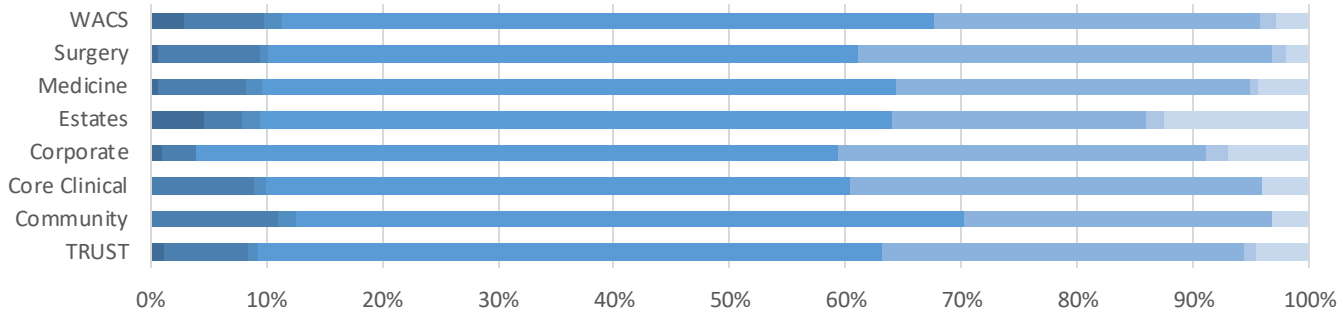


	TRUST	Community	Core Clinical	Corporate	Estates	Medicine	Surgery	WACS
Female	76.85%	85.94%	84.16%	71.29%	42.19%	77.07%	78.62%	92.96%
Male	23.15%	14.06%	15.84%	28.71%	57.81%	22.93%	21.38%	7.04%

6.5 Gender Identity

Information on gender identity is not currently collected.

6.6 Marital Status

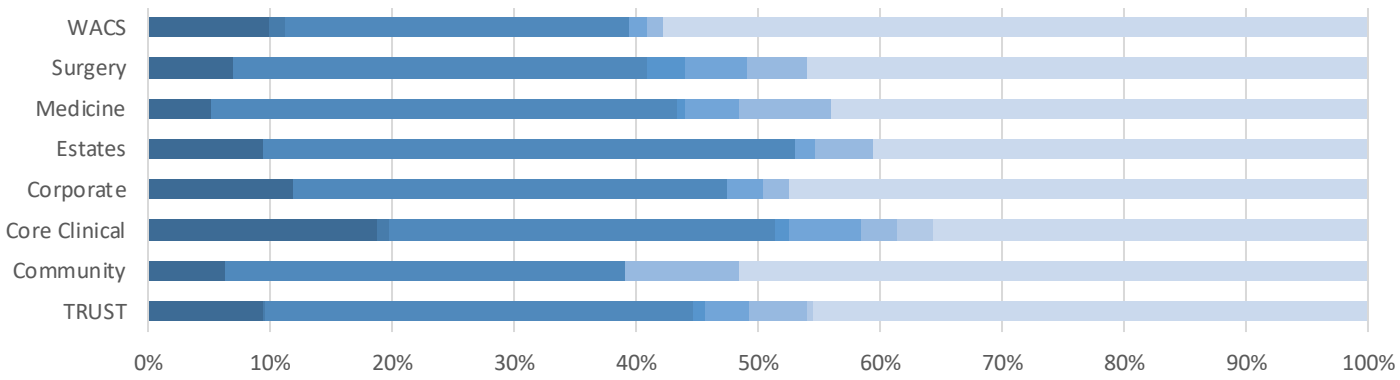


	TRUST	Community	Core Clinical	Corporate	Estates	Medicine	Surgery	WACS
Civil Partnership	1.12%	0.00%	0.00%	0.99%	4.69%	0.64%	0.63%	2.82%
Divorced	7.25%	10.94%	8.91%	2.97%	3.13%	7.64%	8.81%	7.04%
Legally Separated	0.98%	1.56%	0.99%	0.00%	1.56%	1.27%	0.63%	1.41%
Married	53.84%	57.81%	50.50%	55.45%	54.69%	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

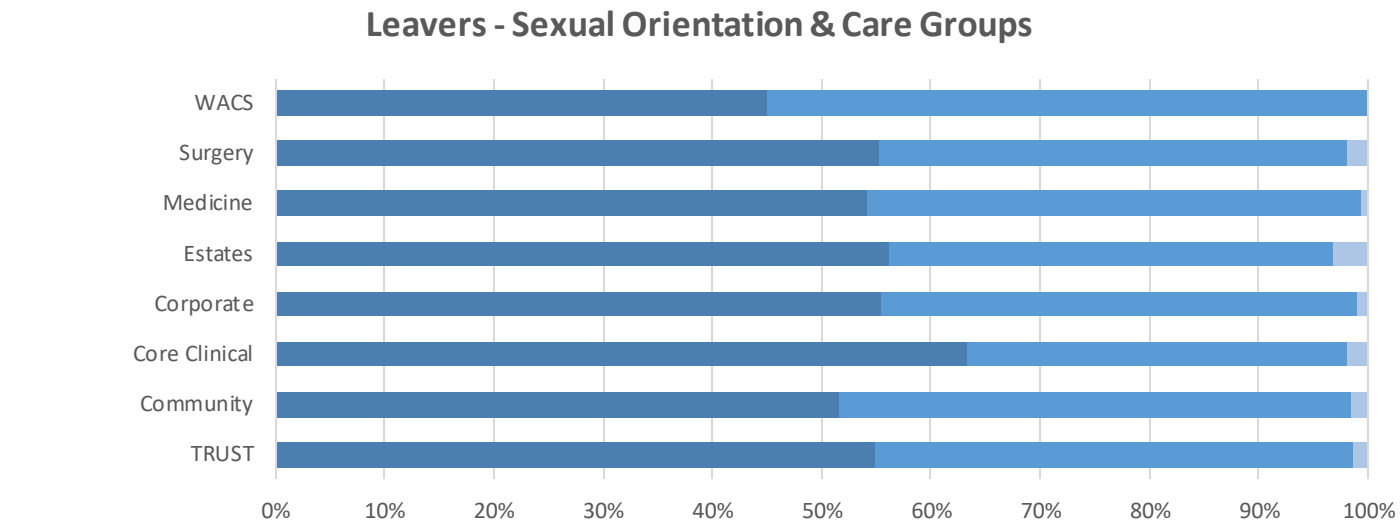
No colleagues were on maternity / adoption leave when they left in the 12 month period 2021-2022.

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; ☐ Pregnancy and maternity; ☑ Disability; ☑ Race; ☐ Gender reassignment; ☐ Religion or belief; ☑ Marriage and civil partnership; ☐ 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; ☐ Pregnancy and maternity; ☐ Disability; ☐ Race; ☐ Gender reassignment; ☐ Religion or belief; ☐ Marriage and civil partnership; ☐ 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; ☐ Pregnancy and maternity; ☐ Disability; ☐ Race; ☐ Gender reassignment; ☐ Religion or belief; ☐ Marriage and civil partnership; ☐ 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 October 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.

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 3 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	**5**	**3**	**2**	**0**	**0**	**0**
Not Started	**0**	**0**	**0**	**0**	**0**	**0**
Behind Schedule (Partially Complete, Overdue)	**66**	**31**	**20**	**5**	**3**	**7**
In Progress (New Action)	**30**	**28**	**1**	**0**	**0**	**1**
On Schedule (Partially Complete)	**32**	**22**	**4**	**0**	**6**	**0**
Fully Completed (Awaiting Approval)	**10**	**3**	**3**	**0**	**1**	**3**
Fully Completed & Approved	**54**	**34**	**8**	**3**	**4**	**5**
Total	**197**	**121**	**38**	**8**	**14**	**16**

Progress Summary of Individual CQC 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	Governance	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	Governance	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	Governance	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	Governance	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	Governance	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	Governance	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	Governance	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.	Fully complete (Awaiting approval)
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	People & Organisational Development	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	People & Organisational Development	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	People & Organisational Development	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	People & Organisational Development	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	People & Organisational Development	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	People & Organisational Development	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 form 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.	Fully complete (Awaiting approval)
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 no new actions are required this new recommendation will be managed through MD6	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))	MD6/5	Mrs Kam Mom	Pharmacy	Chief Pharmacist to implement existing Work Programmes to improve the level of Medicines Reconciliation across the Trust to over 80%	Partially complete
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))	MD10/ 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 (Approved)

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))	MD10/ 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.	Fully complete (Approved)
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))	MD10/ 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 MD58 and MD59, all of which relate to the provision of Stroke Care and Treatment. This Action is specific to Stroke Services at FGH	Fully complete (Approved)
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))	MD10/ 4	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 and MD31, all of which relate to the provision of Stroke Care and Treatment. This Action is specific to Stroke Services at RLI	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))	MD12/ 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 shared from these. Maintain high quality risk / MCA assessments in line with Trust policy.	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))	MD13/ 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))	MD13/ 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))	MD14/ 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 (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))	MD14/ 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.	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))	MD14/ 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))	MD14/ 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))	MD15/ 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))	MD15/ 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))	MD16/ 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))	MD17/ 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)	MD18/ 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))	MD19/ 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))	MD20/ 1	Ms Bongi Gbadebo	Accident and Emergency	The Medicine Care Group will implement the design and development of a new priority admissions unit (PAU) to help improve to patient care and outcomes	Fully complete (Approved)
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))	MD20/ 2	Mr Paul Smith	Accident and Emergency	The Medicine Care Group will review current MDT working arrangements in the RLI ED to identify and implement improvements with a focus on Emergency/Acute Medicine and then the wider Medicine Care Group, and the other Care Groups.	In progress
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))	MD21/ 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))	MD21/ 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.	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))	MD21/ 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))	MD21/ 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))	MD29/ 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))	MD30/ 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))	MD31/ 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.	Partially complete

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))	MD32/ 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))	MD33/ 1	Mr Scott McLean	Chief Operating Officer	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))	MD33/ 2	Miss Leanne Cooper	Chief Operating Officer	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))	MD33/ 3	Miss Leanne Cooper	Chief Operating Officer	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))	MD36/ 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 given to any 'High Risk' Guidelines that are overdue for review.	Partially complete

Must Do	The service must ensure staff have access to up-to-date and evidence-based guidelines and policies. (Regulation 12 (1))	MD36/ 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))	MD36/ 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))	MD37/ 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))	MD37/ 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 (Overdue)
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))	MD38/ 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 (Overdue)
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))	MD38/ 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))	MD39/ 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))	MD39/ 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))	MD39/ 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))	MD46/ 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))	MD47/ 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))	MD47/ 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))	MD48/ 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))	MD49/ 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))	MD49/ 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))	MD50/ 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 required actions Pain scores to be monitored as part of safety checks	Partially complete (Overdue)
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))	MD51/ 1	Mrs Melanie Woolfall	Accident and Emergency	The Medicine Care Group will manage this recommendation through the fundamentals work on managing a deteriorating patient	Partially complete (Overdue)
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))	MD52/ 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))	MD53/ 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))	MD53/ 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))	MD53/ 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))	MD54/ 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))	MD58/ 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))	MD59/ 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))	MD66/ 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 (Overdue)
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))	MD66/ 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))	MD67/ 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	Fully complete (Awaiting approval)
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))	MD68/ 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	Fully complete (Approved)

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))	MD68/ 2	Ms Heather Gallagher	Maternity Service	To develop a process to ensure appropriate risk assessments are carried out throughout the pregnancy journey	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))	MD70/ 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))	MD70/ 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))	MD84/ 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))	MD85/ 1	Mrs Linda Womack	Maternity Service	Recommendation relates to the Helme Chase Maternity Unit (HCMU), which is 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))	MD85/ 2	Mrs Linda Womack	Maternity Service	The Maternity Service will look at recruitment and retention strategy for Helme Chase Maternity Unit, as part of wider Maternity Service strategy	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))	MD85/ 3	Mrs Linda Womack	Maternity Service	The Maternity Service will deliver an improved trajectory for education and training for Helme Chase Maternity Unit, as part of wider Maternity Service strategy.	Fully complete (Awaiting approval)
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))	MD86/ 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))	MD86/ 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))	MD88/ 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 (Approved)
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))	MD91/ 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)	Fully complete (Awaiting approval)
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))	MD92/ 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. This Action will also address the training elements of Recommendation MD85	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	MD96/ 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)	Fully complete (Awaiting approval)
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	MD96/ 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	Fully complete (Awaiting approval)

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	MD96/ 3	Mrs Melanie Woolfall	Medicine	Medicine Care Group ensure effective systems are in place to assess and mitigate individual patient safety risks for Patients in Medical Unit 2	In progress
Must Do	The service must ensure people are kept free from harm. Regulation 13(5) Safeguarding service users from abuse and improper treatment	MD97/ 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.	MD98/ 1	Mrs Melanie Woolfall	Medicine	The Service will undertake a staffing review to ensure there is adequate nursing staffing within the service, this will reported/evidence through the 'Safer Staffing Report	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.	MD98/ 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	MD99/ 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 actions put in place to recruit to roles where necessary.	Fully complete (Approved)
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	MD10 0/1	Mr Richard Sachs	Medicine	The Trust will complete the GGI review of Governance Meeting Structures, Reporting and Escalation	Fully complete (Approved)
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	MD10 0/2	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	MD10 1/1	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	MD10 1/2	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.	Overdue
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	MD10 2/1	Mrs Diane Smith	Medicine	Review the systems and processes that are in place to assess and monitor safety and quality of care	Unable to 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	MD10 2/2	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	MD10 2/3	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	MD10 2/4	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.	Partially complete

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))	MD11 4/1	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 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))	MD11 5/1	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.)	Fully complete (Approved)
Must Do	The trust must ensure that antimicrobial prescribing guidelines are consistently followed. (Regulation 12 (2) (g))	MD11 5/2	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	Partially complete

Must Do	The trust must ensure that antimicrobial prescribing guidelines are consistently followed. (Regulation 12 (2) (g))	MD11 5/3	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))	MD11 5/4	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 the Trust's antimicrobial prescribing guidelines and ensure they followed, with any clinical concerns and issues with the guidelines being appropriately escalated.	Partially complete (Overdue)
Must Do	The trust must ensure that patient's privacy is upheld. Regulation 10(1)(2)(a)	MD12 1/1	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 (Overdue)

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)	MD12 2/1	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)	MD12 2/2	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)	MD12 2/3	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)	MD12 2/4	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 (Overdue)
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)	MD12 2/5	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)	MD12 6/1	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)	MD12 6/2	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.	Unable to 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)	MD12 7/1	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 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)	MD12 8/1	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)	MD12 8/2	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	In progress

					Areas by clinical staff. Risks to be updated on the risk register	
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)	MD12 8/3	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	Pharmacy	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	Pharmacy	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	Pharmacy	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	SD22/ 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	SD23/ 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	SD24/ 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 (Approved)
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.	SD25/ 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.	Fully complete (Awaiting approval)
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.	SD26/ 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 implemented, with procedural documents to updated accordingly	Partially complete (Overdue)

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".	Overdue
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.	SD34/ 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	SD35/ 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	SD41/ 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.	SD42/ 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	SD43/ 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 (Overdue)
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	SD44/ 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 (Overdue)
Should Do	The service should continue to act to ensure women received continuity of care in line with national recommendations and targets	SD45/ 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.	SD55/ 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.	SD56/ 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	SD62/ 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	SD63/ 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.	SD64/ 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.	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.	SD64/ 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.	SD65/ 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.	SD76/ 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 (Overdue)
Should Do	The service should act to improve the quality of safety information shared in SBAR handover.	SD76/ 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 (Overdue)
Should Do	The service should act to improve the quality of safety information shared in SBAR handover.	SD76/ 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 (Overdue)
Should Do	The service should progress actions to enable improved access within the birth centre, in context of the physical environment.	SD79/ 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	SD80/ 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 (Overdue)
Should Do	The trust should ensure that visible information about requesting a chaperone is available to patients attending the centre.	SD81/ 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	SD83/ 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.	Fully complete (Approved)
Should Do	The service should consider protected time to allow for the completion of mandatory training	SD93/ 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 staff at the discretion of Department/Unit/Ward Managers.	Partially complete (Overdue)
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	SD10 3/1	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 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	SD10 4/1	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 (Approved)
Should Do	The service should ensure that cleaning schedules are completed appropriately. (Regulation 12	SD11 6/1	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	SD11 6/2	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.	Partially complete
Should Do	The service should ensure that cleaning schedules are completed appropriately. (Regulation 12	SD11 6/3	Mrs Melanie Woolfall	Medicine	Medicine Care Group undertaking a review of the actual Non-CSW Hours available to undertake cleaning/hygiene duties and the budgeted Non-CSW Hours available to undertake cleaning/hygiene duties on Medical Wards at FGH. To identify if there is a shortfall between budgeted and actual, and the scale of any shortfall. The findings will be reported to the Care Group Management meeting and the IPC Matron and will be used to identify potential solutions.	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	SD11 7/1	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 (Approved)
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	SD11 7/2	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	SD11 7/3	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	SD11 7/4	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	SD11 7/5	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)	SD11 8/1	Ms Bongi Gbadebo	Stroke Medicine - GenMed	Medicine Care Group will continue to take steps to recruit a Stroke Medicine Consultant at FGH.	Fully complete (Approved)
Should Do	The trust should continue to actively seek a suitable candidate for recruitment to its stroke consultant vacancy. (Regulation 12)	SD11 8/2	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	Fully complete (Approved)
Should Do	The trust should ensure it achieves its target for take-home medicines to be ready within one hour. (Regulation 12)	SD11 9/1	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	Partially complete (Overdue)

Should Do	The trust should ensure it achieves its target for take-home medicines to be ready within one hour. (Regulation 12)	SD11 9/2	Mrs Kam Mom	Pharmacy	This actions 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	SD12 0/1	Mr Paul Smith	Medicine	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 (Approved)
Should Do	The trust should review its higher than expected readmission rates for both elective and non-elective admissions	SD12 0/2	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)	SD12 3/1	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)	SD12 3/2	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)	SD12 3/3	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)	SD12 3/4	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	SD12 4/1	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 (Overdue)

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	SD12 5/1	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 separate action is required or not to address Recommendation SD133.	Fully complete (Approved)
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	SD12 5/2	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	SD12 5/3	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	SD12 9/1	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.	Fully complete (Approved)

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	SD12 9/2	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.	SD13 0/1	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 (Approved)
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.	SD13 0/2	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.	SD13 0/3	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.	SD13 1/1	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	SD13 2/1	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	SD13 2/2	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.	Overdue
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.	SD13 3/1	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.	SD13 4/1	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.	SD13 4/2	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	Overdue

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.	SD13 5/1	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.	SD13 6/1	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 updated , with regular monitoring at Care Group meeting and escalation to Trust Management Group.	In progress
Should Do	The service should review the perception in the ED of limited senior and executive visibility, recognition, understanding and support.	SD13 7/1	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.	SD13 7/2	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	SD13 8/1	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 (Approved)

Should Do	The service should further explore the opportunities for collaborative working from the emergency department, assessment units and specialist services	SD13 8/2	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.	SD13 9/1	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).	Partially complete

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

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UHMBT Recovery Support Programme Metric Summary

Improving Together

September 2022

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

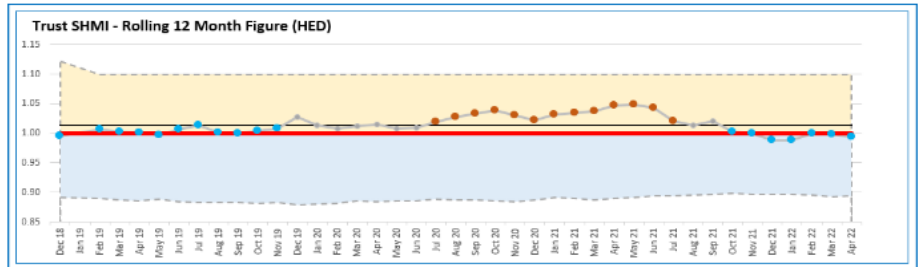
University Hospitals of Morecambe Bay NHS Foundation Trust

Fundamentals of Care

Metric	Plan	Actual	Variation	Assurance
All Inpatient Falls Per 1000 Bed Days	6.4	7.8		
Inpatient Falls (with Moderate & Above Harm) per 1000 Bed Days	0.1	0.3		
Inpatient Category 2 Pressure Ulcers (Developed) Per 1000 Bed Days	1.4	2.5		
Inpatient DTI and Unstageable Pressure Ulcers (Developed) Per 1000 Bed Days	0.2	0.4		
Number Of Inpatient Category 3 & 4 Pressure Ulcers (Developed)	0	3		
Infection Prevention - MSSA Cases Per 1000 Bed Days	N/A	0.2		
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	0.5		
Percent of Patients who have a MUST Assessment within 24 Hours of Admission	95.00%	85.91%		
Percent of Subsequent MUST Assessments Completed in 7 days	95.00%	60.57%		
Nutrition & Hydration: Dietetics Referrals Compliance	95.00%	49.41%		
Medication Incidents Per 1000 Bed Days	N/A	5.3		

Risk Management

Metric	Plan	Actual	Variation	Assurance
Extreme Risks Remaining Extreme For 12 Or More Months	N/A	21		
Risks Remaining At The Same Risk Score For 12 Or More Months	N/A	110		
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	17		
Volume Of Tolerated Risks	N/A	55		
Compliance to Risk Management Training	N/A	89.69%		
Volume Of New Risks By Month	N/A	30		
Volume Of Closed Risks By Month	N/A	4		
Risk Reviews Completed On Time	N/A	89.70%		
Risks Beyond Target Completion Date	N/A	26.56%		
Risk Actions Beyond Target Completion Date	N/A	23.99%		



Mortality

Metric	Plan	Actual	Variation	Assurance
Mortality Review with a HOGAN (preventability of death) Score of Possibly or Probably Preventable	N/A	3.70%		
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	27.78%		
Mortality Review with a NCEPOD (quality of care) Rating of Less than Satisfactory	N/A	0.00%		
Hospital Deaths Scrutinised By Medical Examiner	100.00%	87.62%		
Hospital Deaths Receiving a Mortality Review	N/A	20.95%		

Summary 2: Aug-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	33		
CT Scan Within 1hr	70.0%	69.0%		
CT Scan Within 12hrs	100.0%	100.0%		
Admitted to Stroke Unit within 4hrs	100.0%	66.1%		
Thrombolysed within 1hr	100.0%	33.3%		
Swallow Screened within 4hrs	100.0%	84.2%		
Assessed by Stroke Consultant within 24h	100.0%	87.9%		
Assessed by Specialist Nurse within 24hr	100.0%	96.6%		
Occupational Therapy Assessment within 72h	100.0%	98.0%		
Physiotherapy Assessment within 72h	100.0%	98.0%		
Speech & Language Therapist Assessment within 72hrs	100.0%	85.0%		

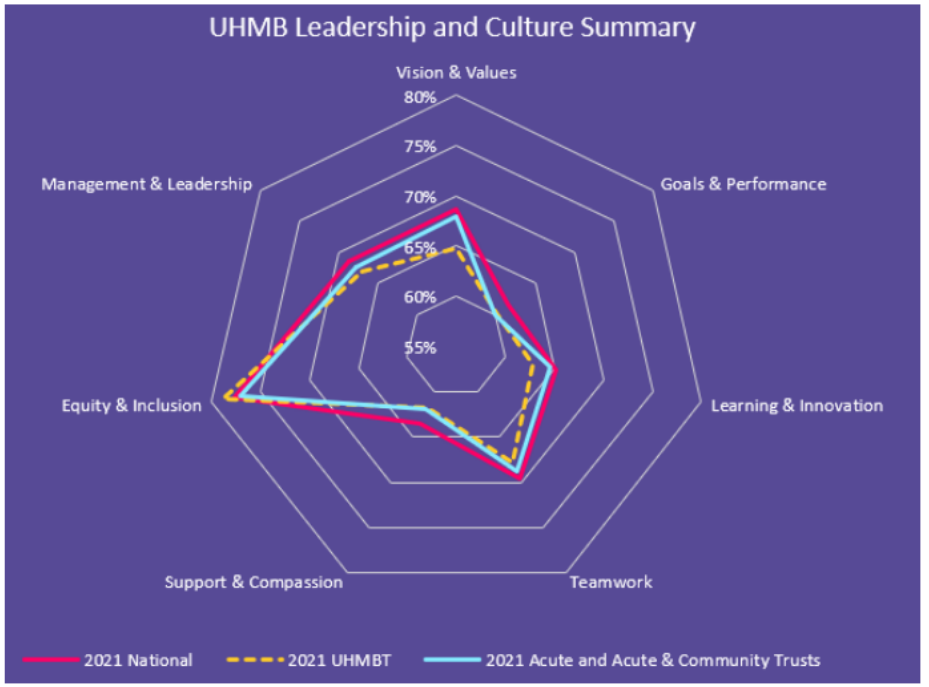
Safety Investigations

Metric	Plan	Actual	Variation	Assurance
Overdue 72 Hour Reviews	0	97		
Overdue Concise Care Group Reviews	0	59		
Overdue Comprehensive RCAs	0	86		
Duty Of Candour Completed In Time	100.0%	83.5%		
Overdue Incidents	0	1752		
Complaints - Average Working Days to Resolve	43.0	49.3		

Clinical Service Reviews

Metric	Plan	Actual	Variation	Assurance
Wards/Areas Achieving Silver Standard Or Greater	N/A	100.0%	NO SPC	
Wards/Areas Achieving Gold Standard	N/A	50.0%	NO SPC	

Leadership and Culture



Safe Staffing

Metric	Plan	Actual	Variation	Assurance
Registered Nurse Fill Rate	85.0%	92.6%		
Clinical Support Worker Fill Rate	85.0%	87.0%		

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

University Hospitals of Morecambe Bay NHS Foundation Trust

Urgent & Emergency Care

Metric	Plan	Actual	Variation	Assurance
ED 4 hrs (%)	95.0%	69.3%		
2 Hour Urgent Community Response	70.0%	95.0%		
Ambulance Average Turnaround Time (mins)	N/A	43.0		
Patients Spending over 12 hours in A&E	2.0%	6.6%		
Patients Spending over 12 hours in ED: Mental Health Reasons	N/A	22		
Patients Spending over 12 hours in ED: Physical Health Reasons	N/A	705		
Non Elective Average Length of Stay	N/A	5.1		
SDEC - % 0 Day LOS	40.0%	43.5%		
NMC2R - % of G&A Bed	16.0%	22.4%		
NMC2R - 21 Day LOS Mean Value Monthly	N/A	159.2		

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

NHS
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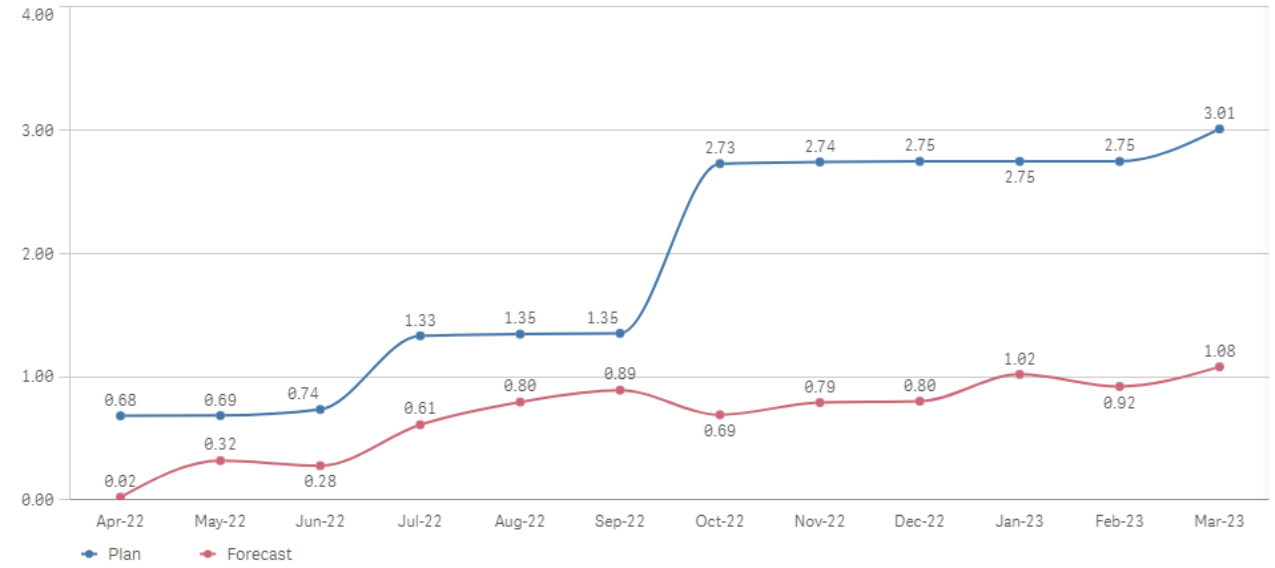
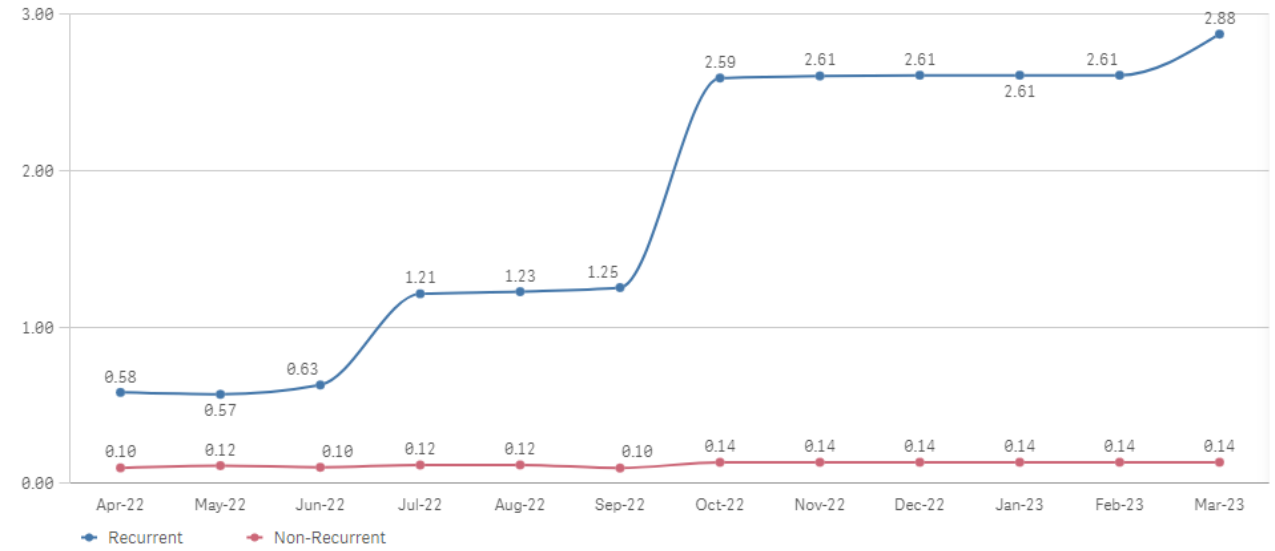
NHS Foundation Trust

Plan vs Forecast (£ million)

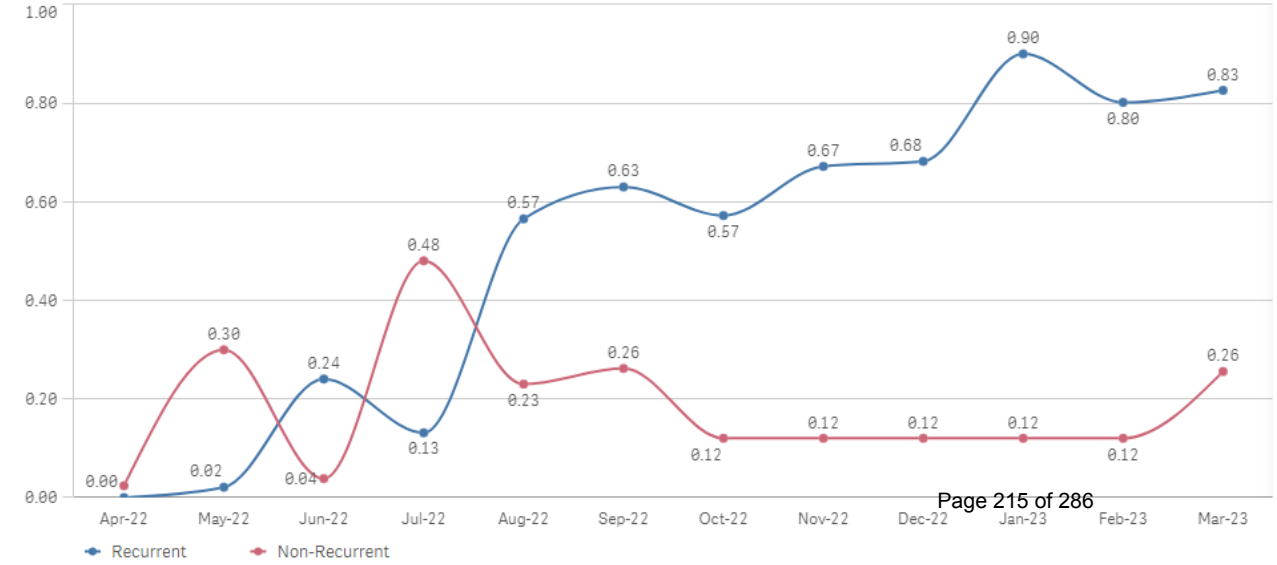


Description	Value
Target 2022/23	£ 23.00 million
Plan 2022/23	£ 23.03 million
Forecast 2022/23	£ 8.24 million
Variance 2022/23	£ 14.79 million
Value of Pipeline Schemes 2022/23 - Profiled	£ 0.34 million
Pipeline Minimum 2022/23	£ 3.24 million
Pipeline Maximum 2022/23	£ 7.43 million
Plan on a Page Required (Phase 1 schemes)	36
Plan on a Page Completed (Phase 1 schemes)	12
Quality Impact Assessment Required (Phase 1 schemes)	36
Quality Impact Assessment Completed (Phase 1 schemes)	12

Plan - Recurrent vs Non-Recurrent (£ million)



Forecast - Recurrent vs Non-Recurrent (£ million)



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

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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

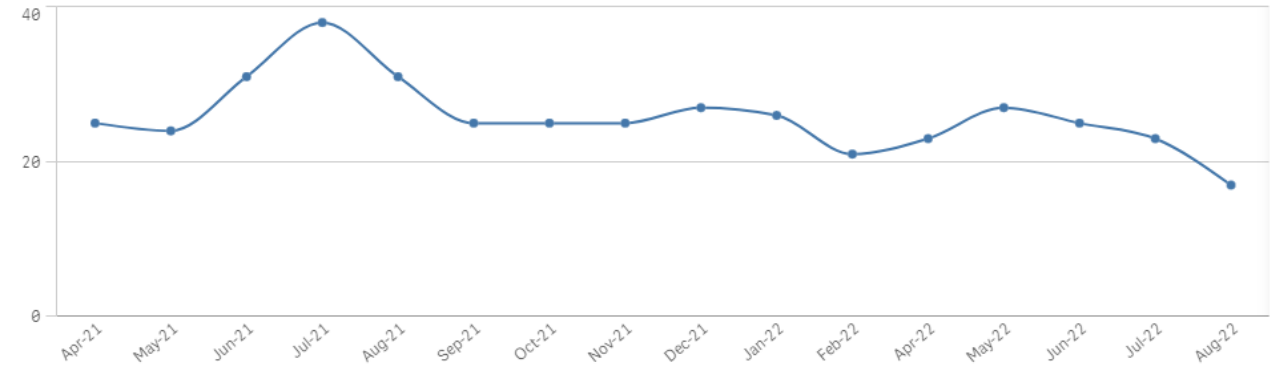
N.B. this table is included for information purposes. It is not intended as an indication of improvement

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**

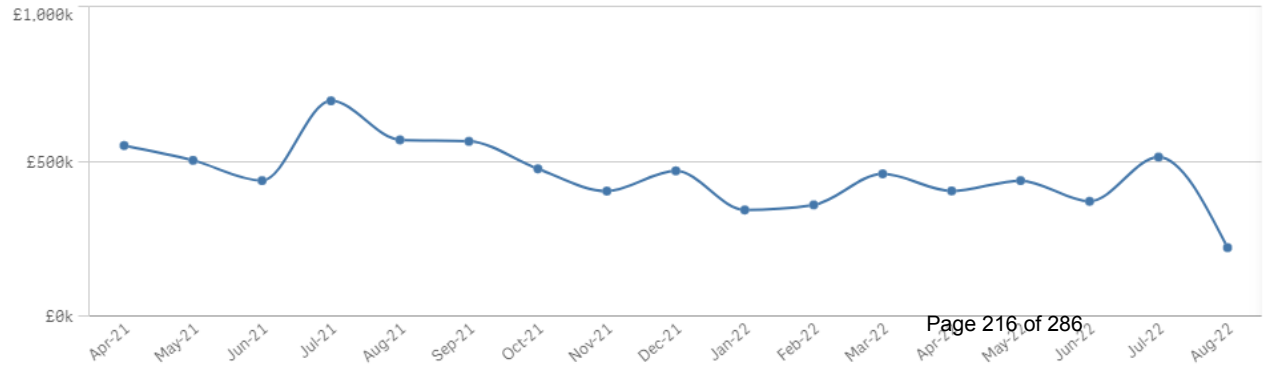
Business Cases

MiscMetric	Month				
	Apr	May	Jun	Jul	Aug
Cases under development - Financial year total as of 1st of Month	64	65	59	69	71
Capital cases - Financial year total as of 1st of Month	0	41	39	46	46
Cases in approval process - Financial year total as of 1st of Month	26	28	37	43	43
Cases in monitoring - Financial year total as of 1st of Month	31	33	29	30	35
Cases for logging (approved in care group)	1	1	0	0	2
No. of prior approvals approved to business case	4	3	7	3	5
Business cases to be submitted (PAF approved) - Financial year total as of 1st of Month	26	30	30	40	33
Grand Total Approved Business Cases - Financial year total as of 1st of Month	2	2	0	2	2
Business Cases Approved by IPG - Financial year total as of 1st of Month	2	2	0	2	2
Business Cases Approved by TMG - Financial year total as of 1st of Month	1	0	1	0	1
Business Cases Approved by FC - Financial year total as of 1st of Month	1	0	0	0	1
Business Cases Approved by Trust Board - Financial year total as of 1st of Month	0	0	0	0	0
No. cases monitored - Financial year total as of 1st of Month	1	7	7	0	5
Number people trained via TMS training - Financial year total as of 1st of Month	1	0	0	7	0
Feedback on TMS training is good or excellent - Financial year total as of 1st of Month	1	1	1	1	1

Number of High Cost Agency Doctors



Cost of High Cost Agency Doctors



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UHMBT Recovery Support Programme - Data Pack

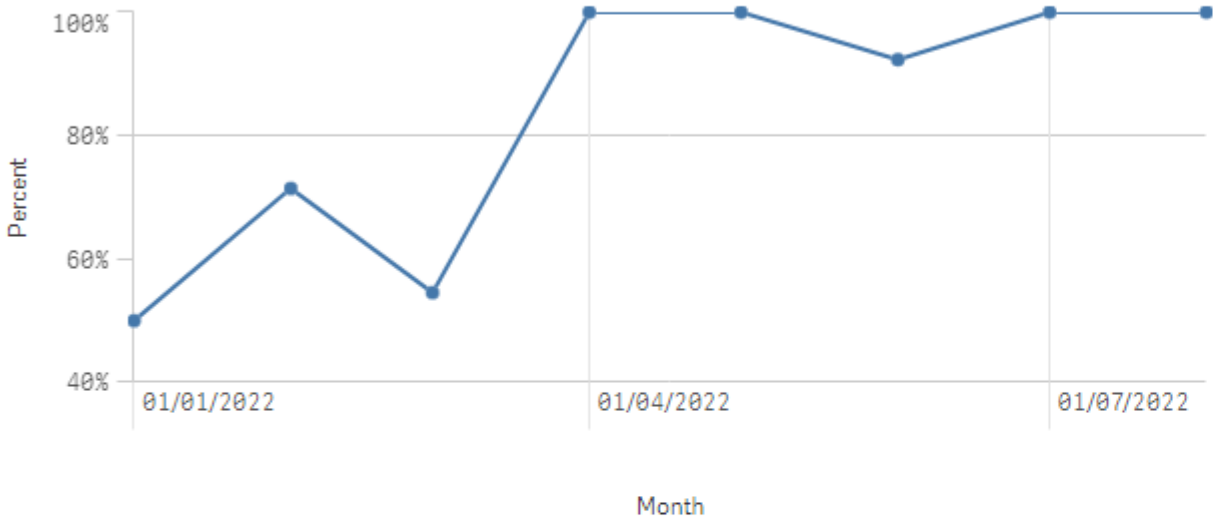
Improving Together

September 2022

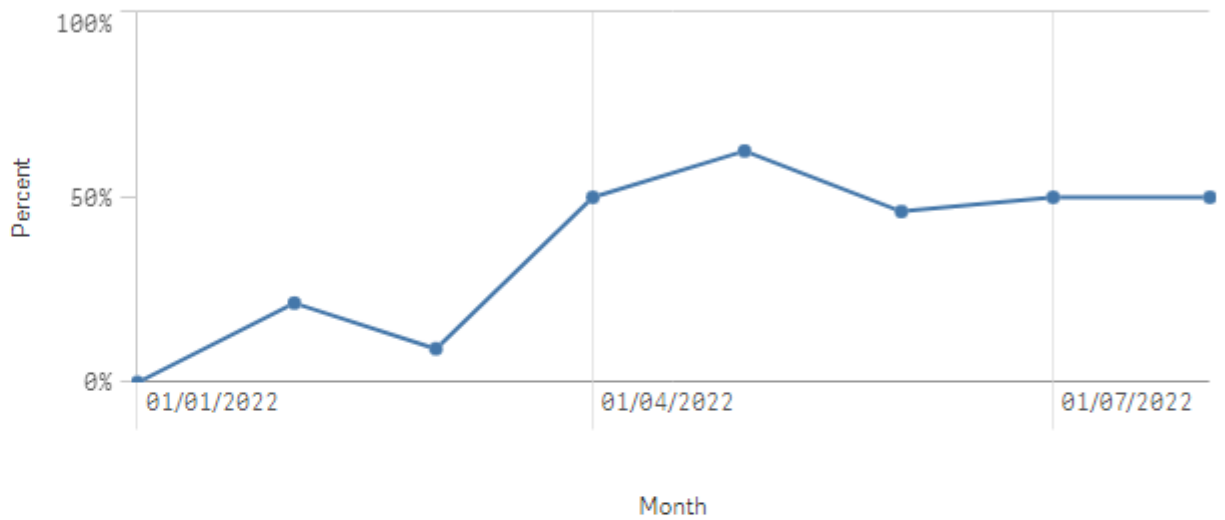
Clinical Service Reviews & Ward Manager Skills

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	**75**
Aug-2022	6
Jul-2022	8
Jun-2022	13
May-2022	8
Apr-2022	2
Mar-2022	22
Feb-2022	14

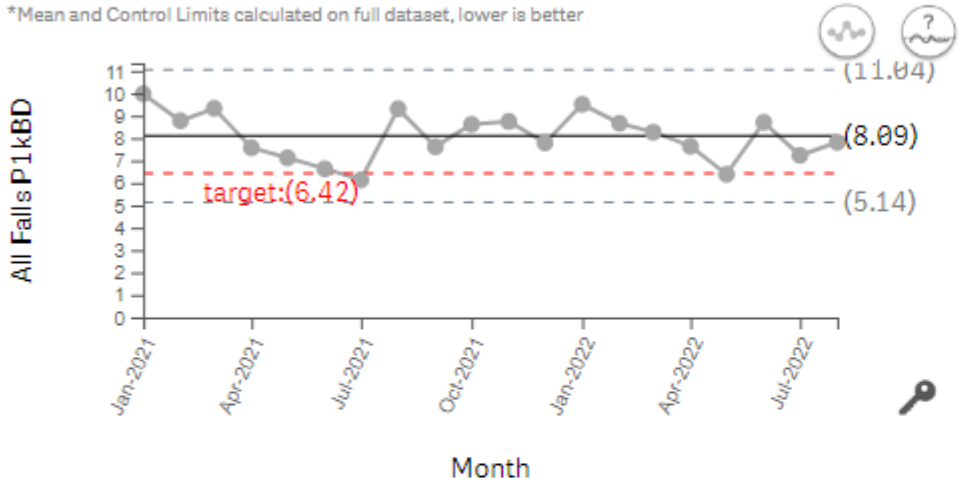
Fundamentals of Care - 1

University Hospitals of Morecambe Bay NHS Foundation Trust

All Inpatient Falls Per 1,000 Bed Days

Target to be achieved March 2023

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

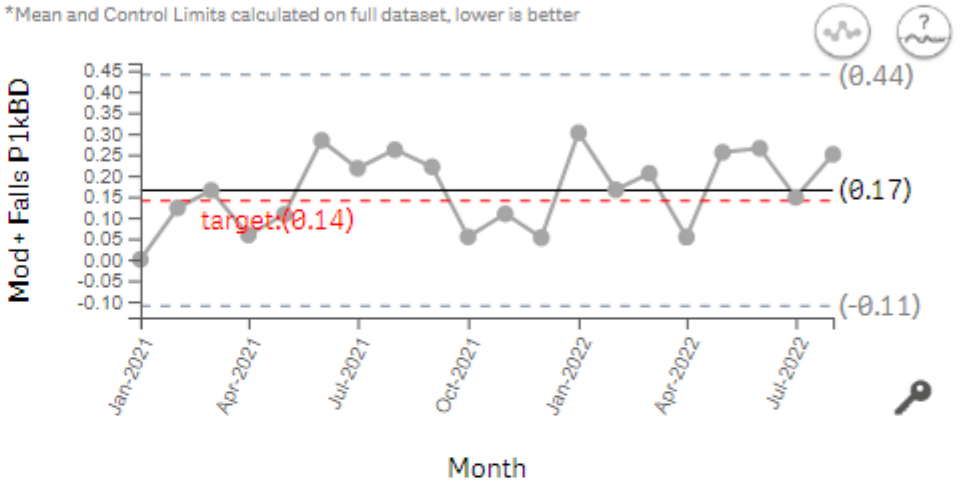


Latest
7.8
Variance Type
Common cause variation
Target
6.42
Target Achievement
The system may achieve or fail the target subject to random variation

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

Target to be achieved March 2023

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



Latest
0.25
Variance Type
Common cause variation
Target
0.14
Target Achievement
The system may achieve or fail the target subject to random variation

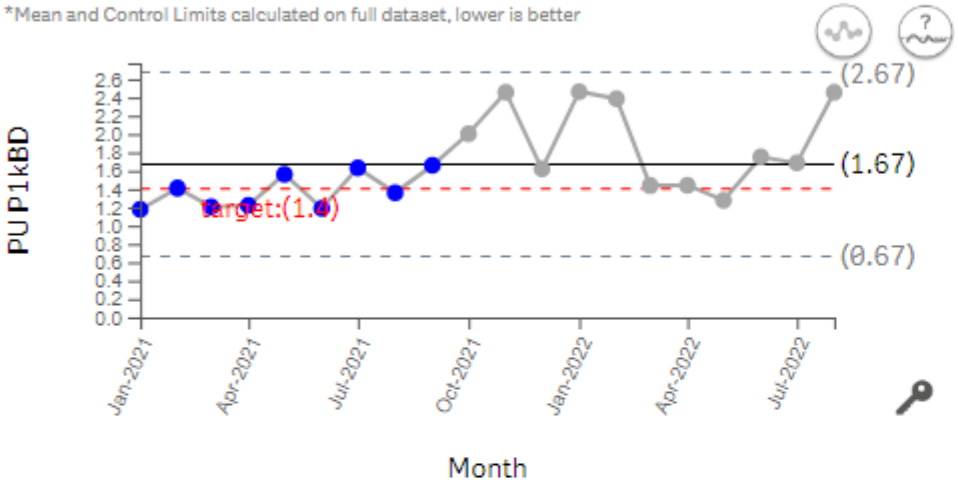
Fundamentals of Care - 2

University Hospitals of Morecambe Bay NHS Foundation Trust

Inpatient Category 2 Pressure Ulcers (Developed) Per 1000 Bed Days

Target to be achieved March 2023

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

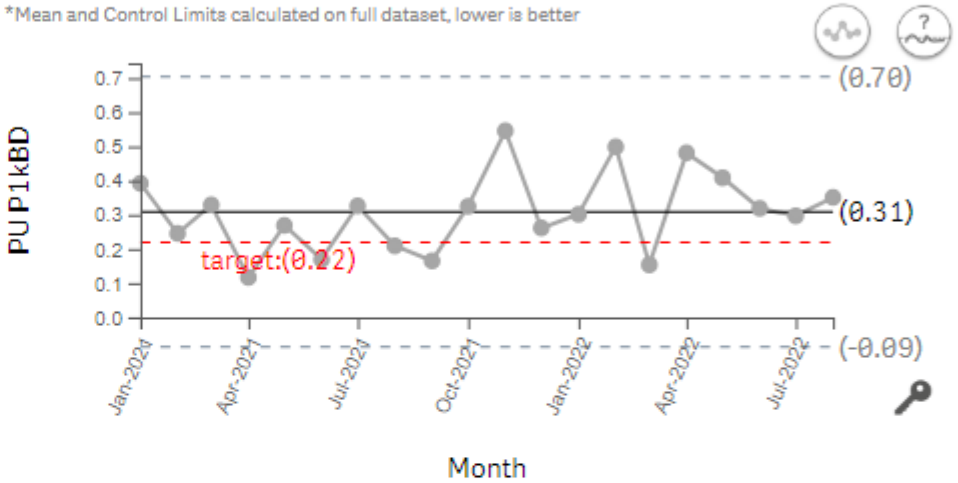


Latest
2.5
Variance Type
Common cause variation
Target
1.4
Target Achievement
The system may achieve or fail the target subject to random variation

Inpatient DTI and Unstageable Pressure Ulcers (Developed) Per 1000 Bed Days

Target to be achieved March 2023

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

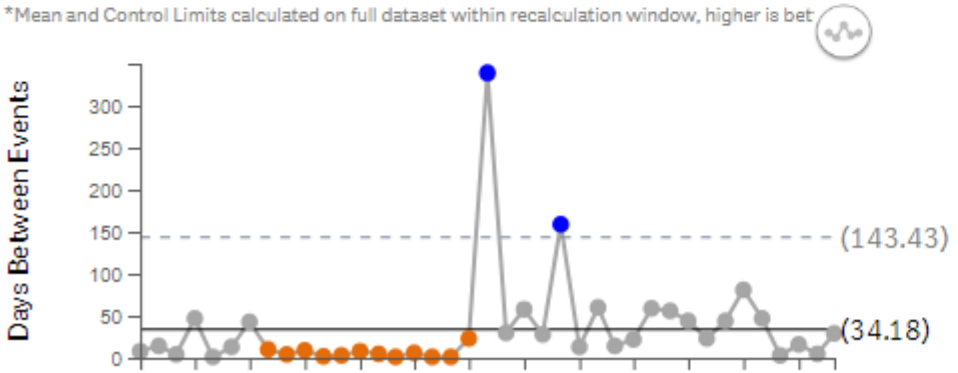


Latest
0.4
Variance Type
Common cause variation
Target
0.22
Target Achievement
The system may achieve or fail the target subject to random variation

Rare Event T-Chart - Inpatient Category 3 & 4 Pressure Ulcers (Developed)

Jan 19 onwards. Last event: 23/08/22 the final data point on the chart shows the days between then and today (21/09/22)

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



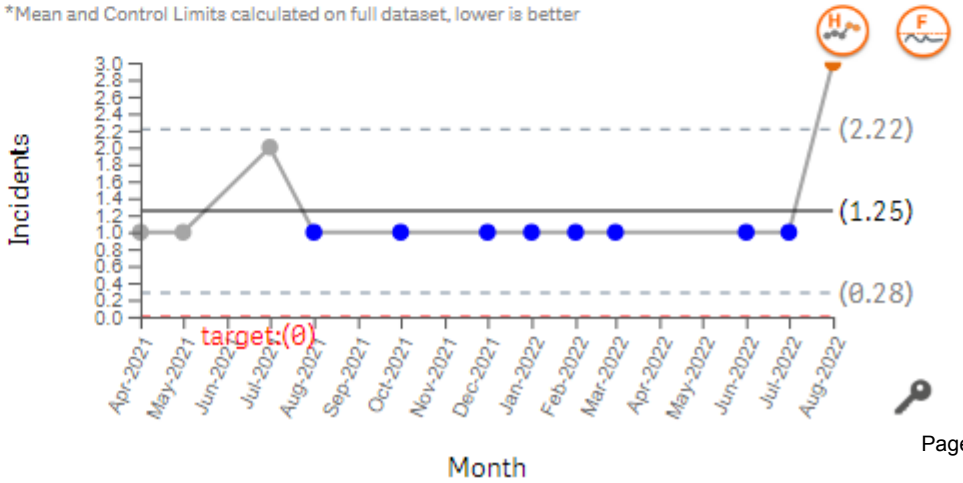
Latest
29
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

T-Charts are used to monitor rare events. They use SPC methodology on the days between events, the more days between events the better. Our current T-Charts do not show when events took place

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

Target to be achieved March 2023

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



Latest
3.000
Variance Type
Special cause variation - cause for concern (indicator where high is a concern)
Target
0
Target Achievement
The system is expected to

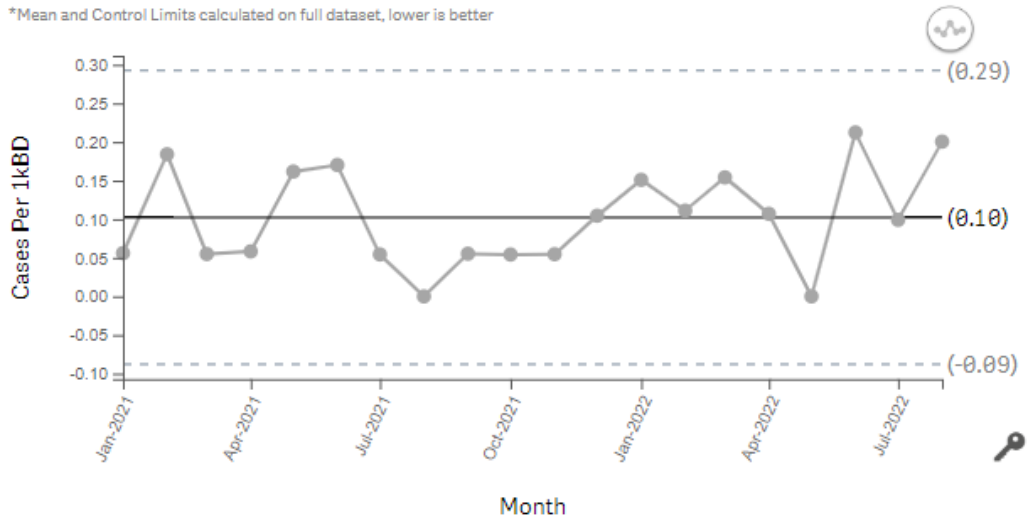
Fundamentals of Care - 3

**HOHA = Hospital-Onset Healthcare Associated*

University Hospitals of Morecambe Bay NHS Foundation Trust

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

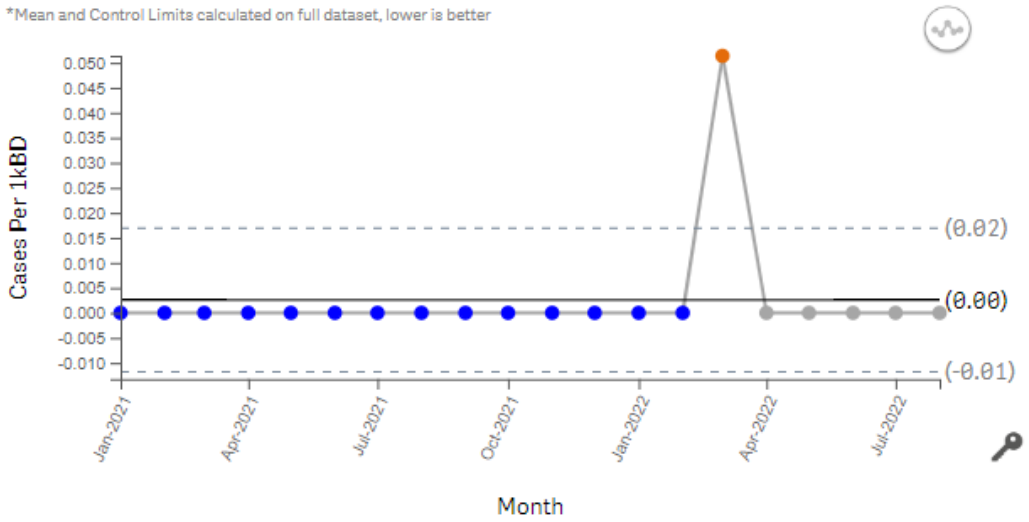
*Mean and Control Limits calculated on full dataset, lower is better



Latest
0.2
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

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

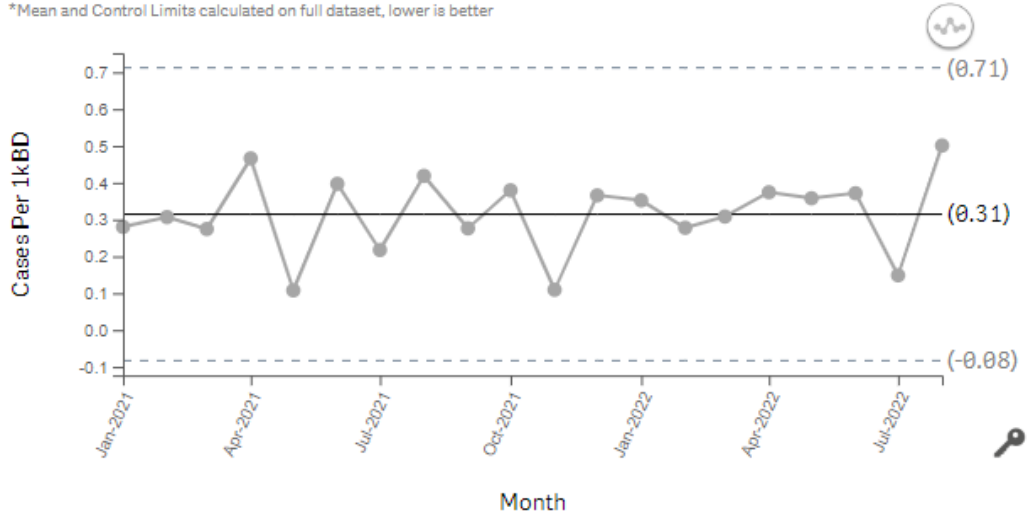
*Mean and Control Limits calculated on full dataset, lower is better



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

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

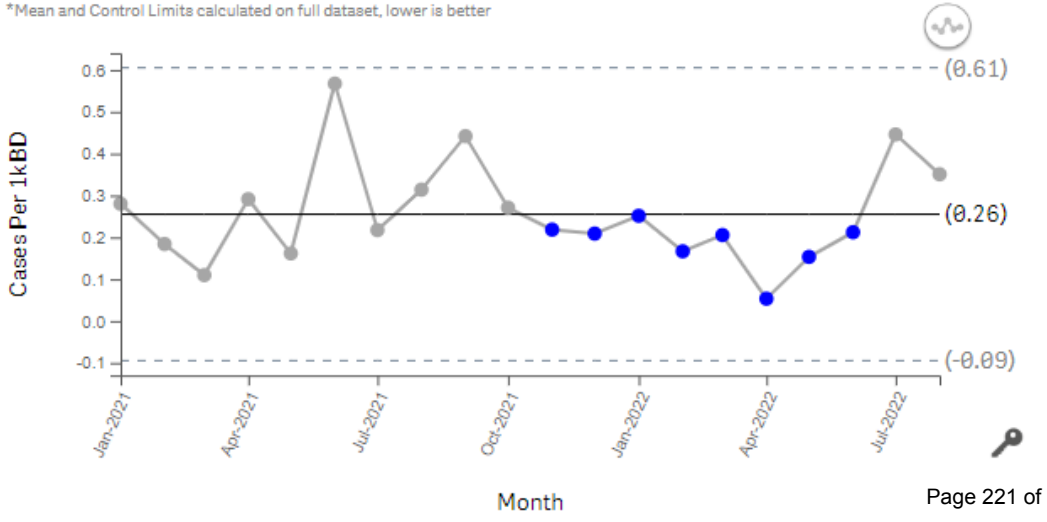
*Mean and Control Limits calculated on full dataset, lower is better



Latest
0.5
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

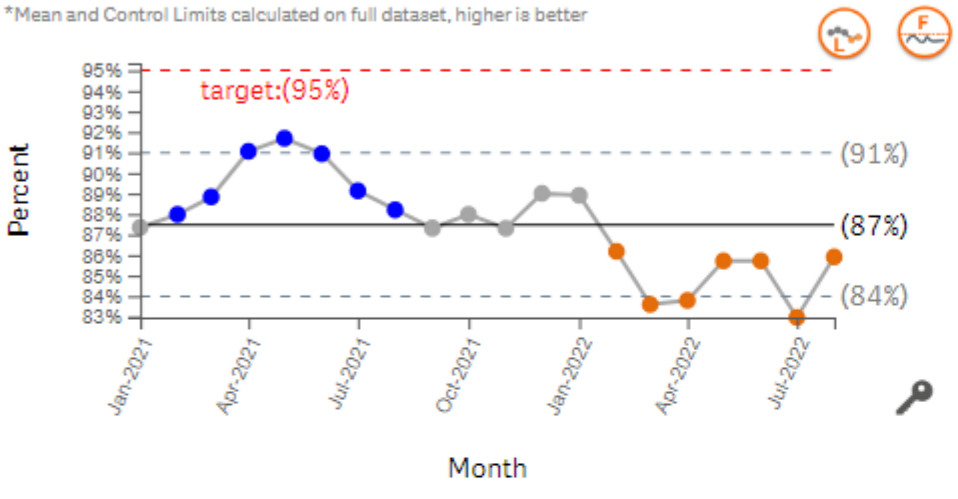
Fundamentals of Care - 4

University Hospitals of Morecambe Bay NHS Foundation Trust

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

Target to be achieved March 2023

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

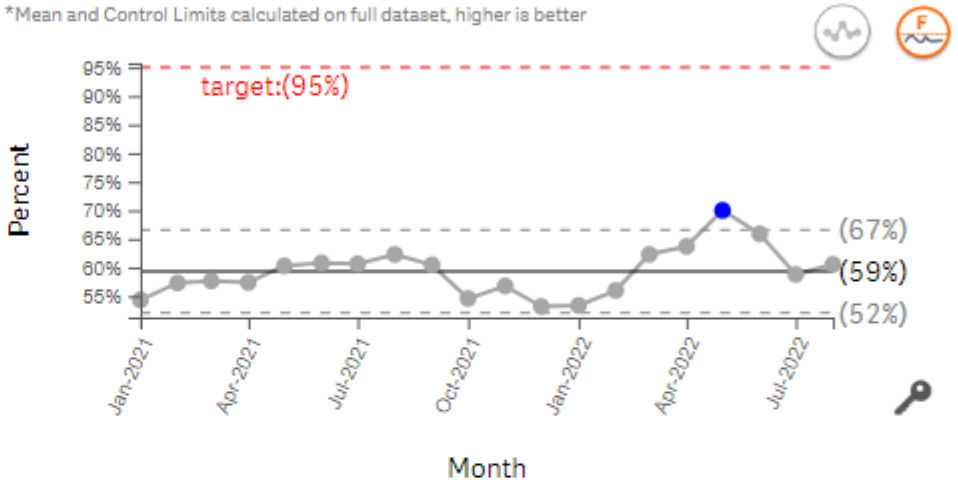


Latest
85.9%
Variance Type
Special cause variation - cause for concern (indicator where low is a concern)
Target
95%
Target Achievement
The system is expected to

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

Target to be achieved March 2023

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

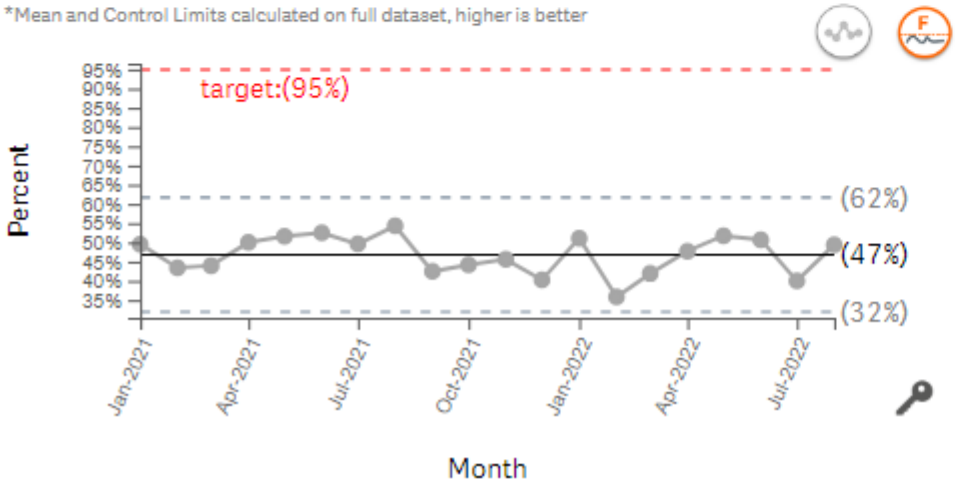


Latest
60.6%
Variance Type
Common cause variation
Target
95%
Target Achievement
The system is expected to consistently fail the target

Nutrition & Hydration: Dietetics Referrals Compliance

Target to be achieved March 2023

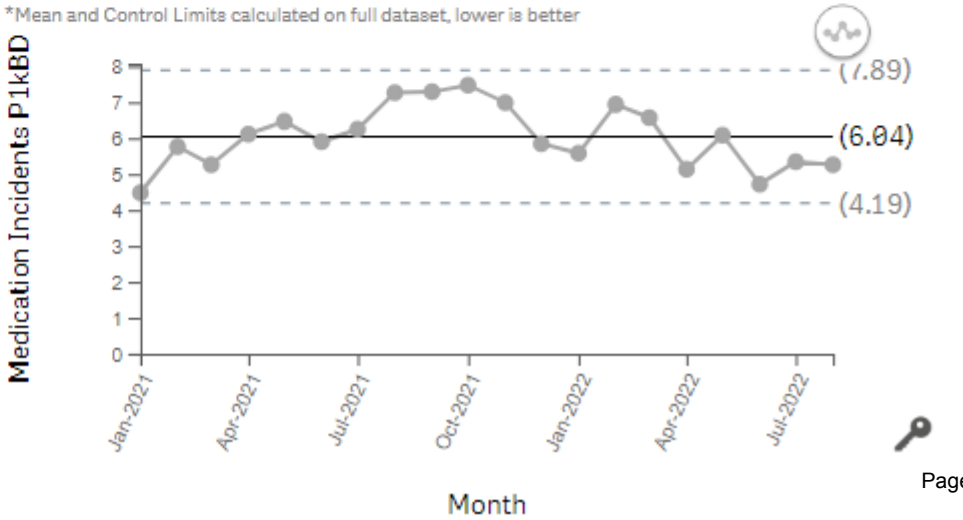
*Mean and Control Limits calculated on full dataset, higher is better



Latest
49%
Variance Type
Common cause variation
Target
95%
Target Achievement
The system is expected to consistently fail the target

Medication Incidents Per 1,000 Bed Days

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



Latest
5.3
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

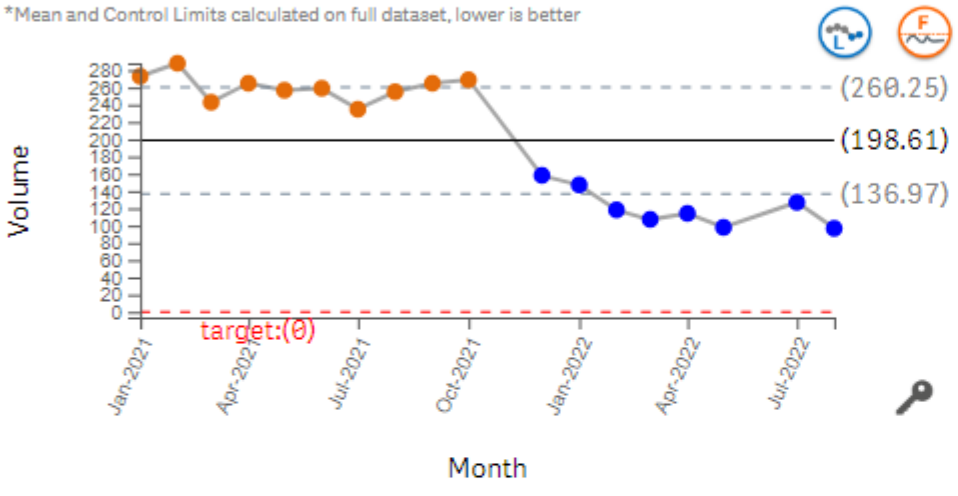
Safety Investigations - 1

University Hospitals of Morecambe Bay NHS Foundation Trust

Overdue 72 Hour Reviews

Volume overdue at the start of each month. Target to be achieved for Oct 2022

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

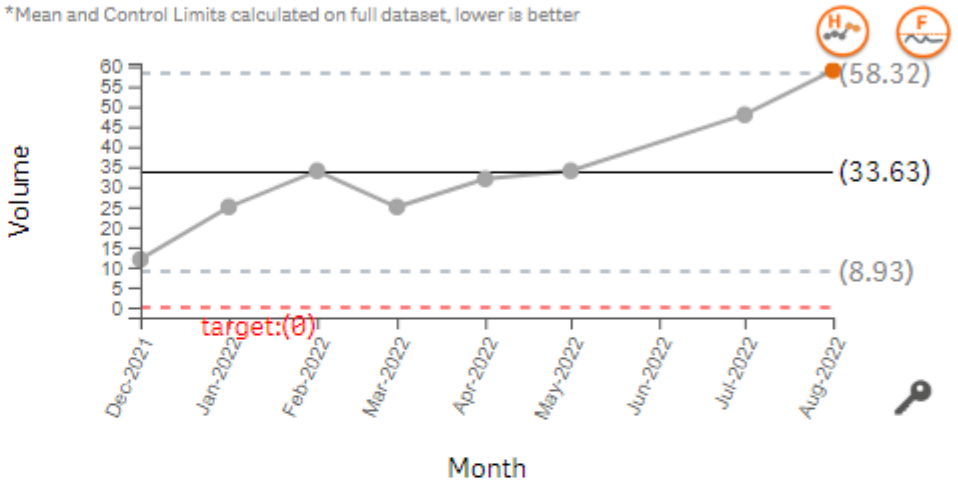


Latest
97
Variance Type
Special cause variation - improvement (indicator where low is good)
Target
0
Target Achievement
The system is expected to

Overdue Concise Care Group Reviews

Volume overdue at the start of each month. Target to be achieved for Oct 2022

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

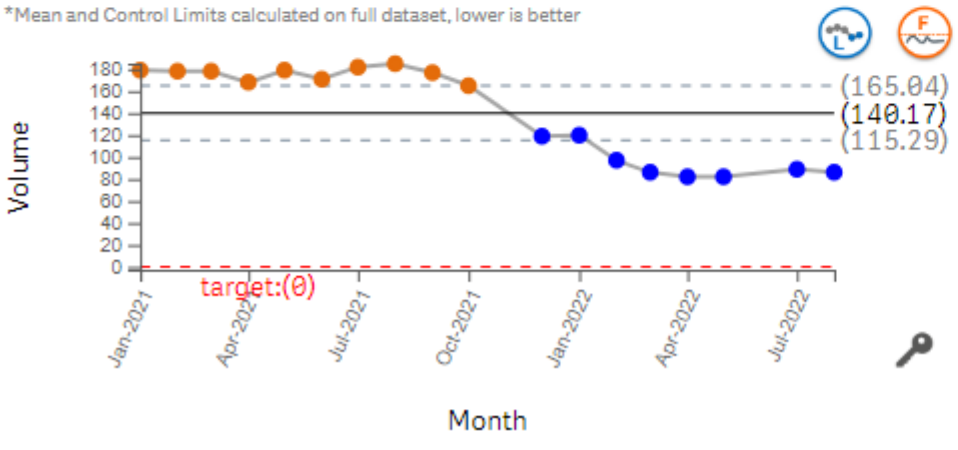


Latest
59
Variance Type
Special cause variation - cause for concern (indicator where high is a concern)
Target
0
Target Achievement
The system is expected to

Overdue Comprehensive RCAs

Volume overdue at the start of each month. Target to be achieved for Oct 2022

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

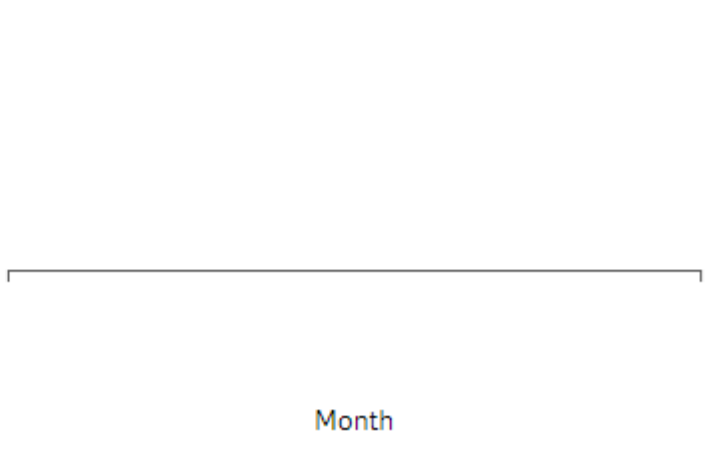


Latest
86
Variance Type
Special cause variation - improvement (indicator where low is good)
Target
0
Target Achievement

Target timeframe based on 20 working days

To Follow - Serious Incident Investigations Overdue (Over 60 working days)

Volume overdue at the start of each month



Data collection began in Jul 22 and so chart will begin when 3 months data is available

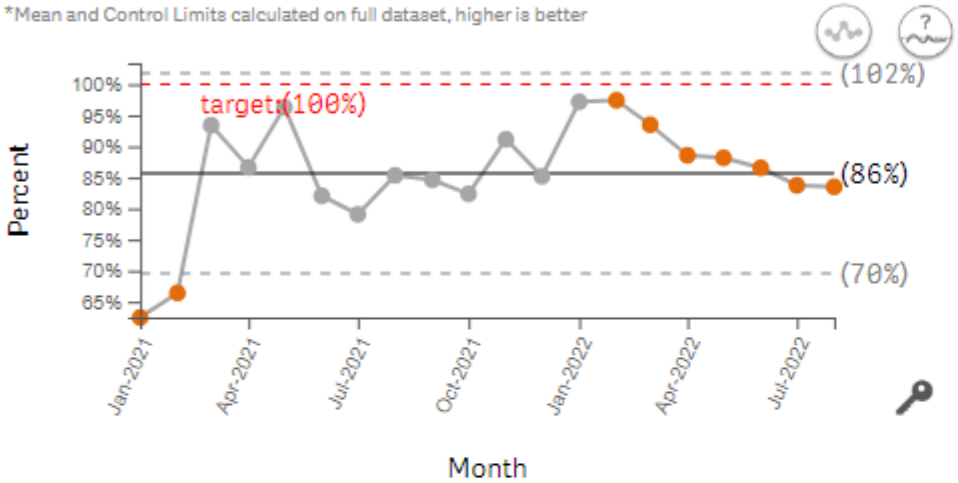
Safety Investigations - 2

University Hospitals of Morecambe Bay NHS Foundation Trust

Duty of Candour Completed Within Target (based on Target date)

Target to be achieved for Oct 2022

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

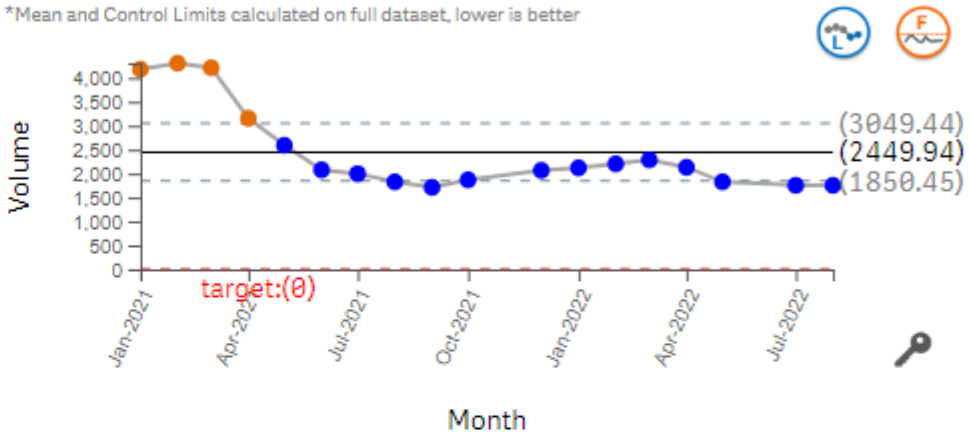


Latest
84%
Variance Type
Common cause variation
Target
100%
Target Achievement
The system may achieve or fail the target subject to random variation

Overdue Incidents

Volume overdue at the start of each month. Target to be achieved for Oct 2022

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



Latest
1,752
Variance Type
Special cause variation - improvement (indicator where low is good)
Target
0
Target Achievement
The system is

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

To follow - Overdue Incident Actions

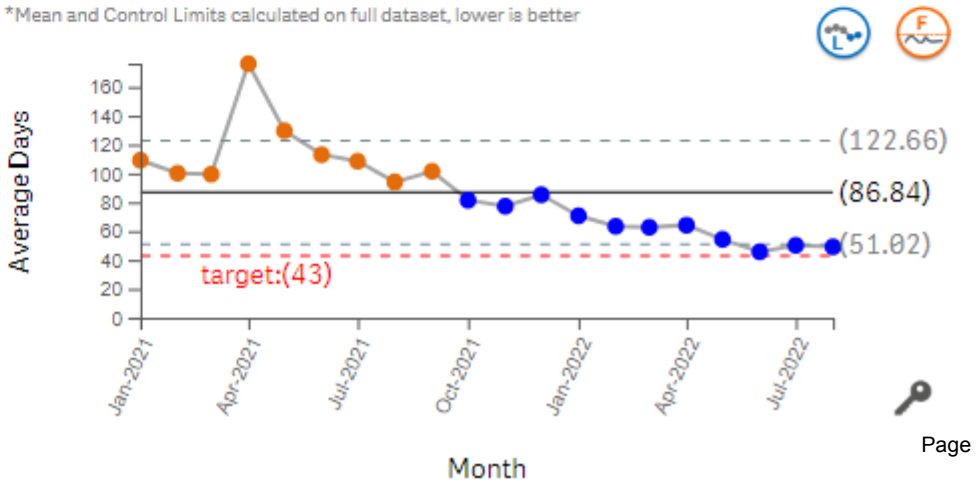
Volume overdue at the start of each month

Data collection began in Oct 22 and so chart will begin when 3 months data is available

Complaints - Average Working Days to Resolve

Target to be achieved for March 23

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



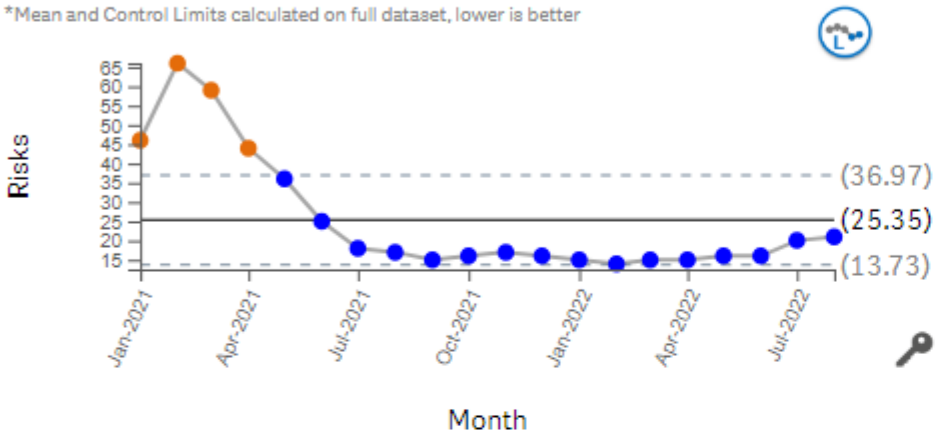
Latest
49.3
Variance Type
Special cause variation - improvement (indicator where low is good)
Target
43
Target Achievement
The system is expected to

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

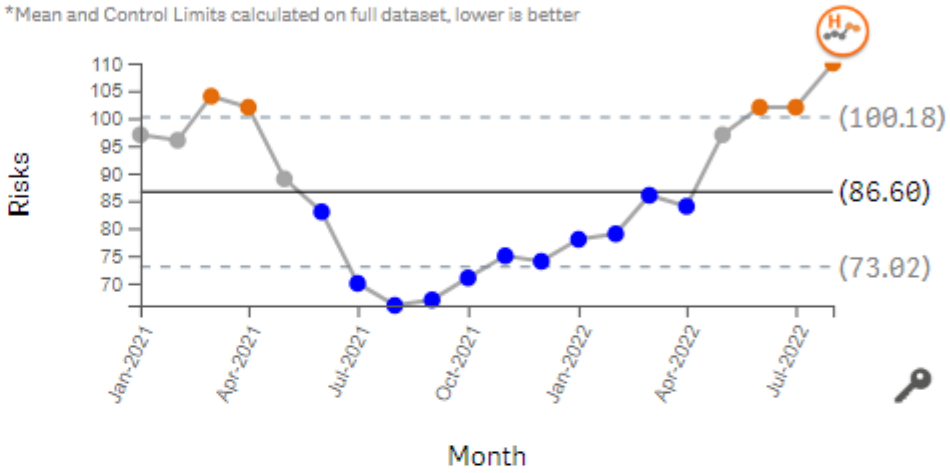


Latest
21
Variance Type
Special cause variation - improvement (indicator where low is good)
Target
N/A
Target Achievement
N/A

*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

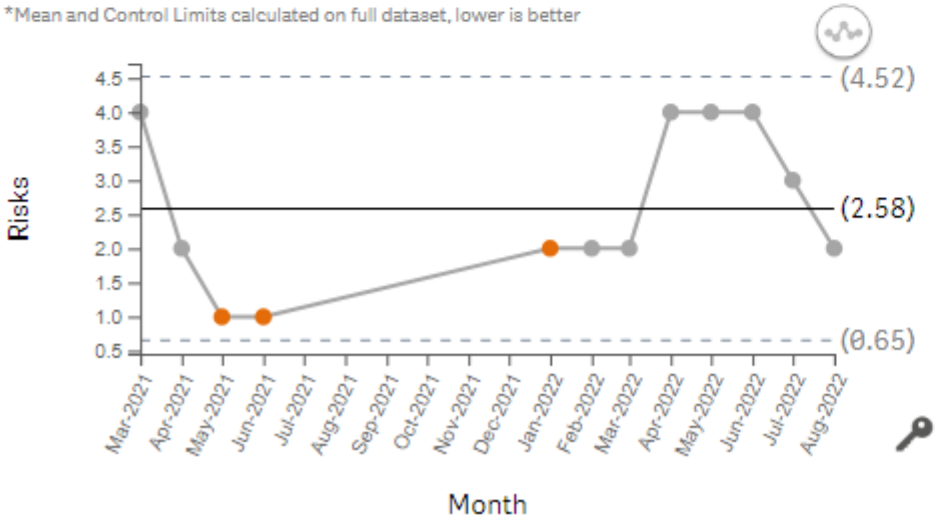


Latest
110
Variance Type
Special cause variation - cause for concern (indicator where high is a concern)
Target
N/A
Target Achievement
N/A

*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'

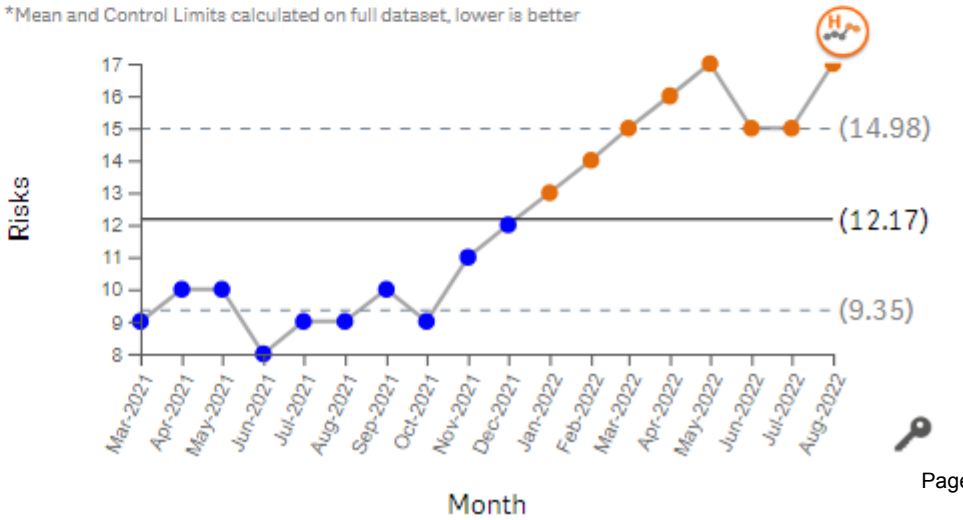
*Mean and Control Limits calculated on full dataset, lower is better



Latest
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



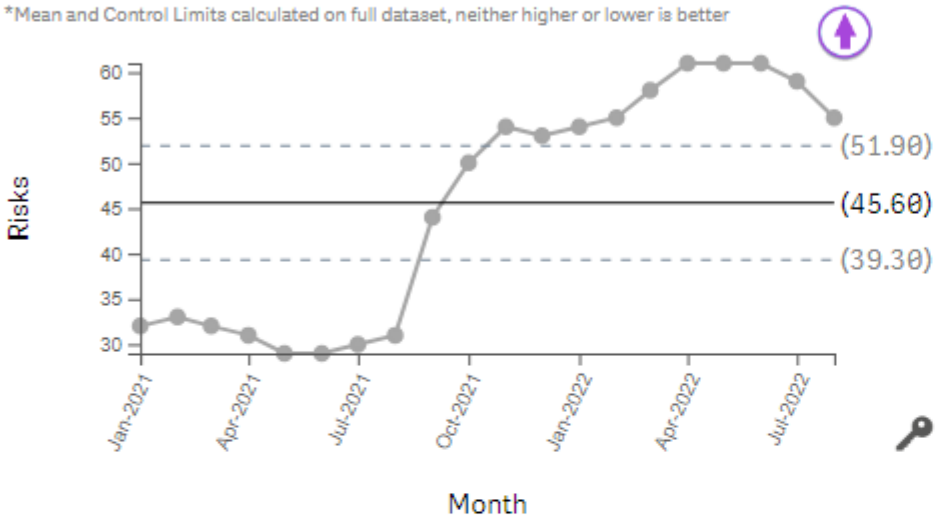
Latest
17
Variance Type
Special cause variation - cause for concern (indicator where high is a concern)
Target
N/A
Target Achievement
N/A

Risk - 2

University Hospitals of Morecambe Bay NHS Foundation Trust

Volume Of Tolerated Risks

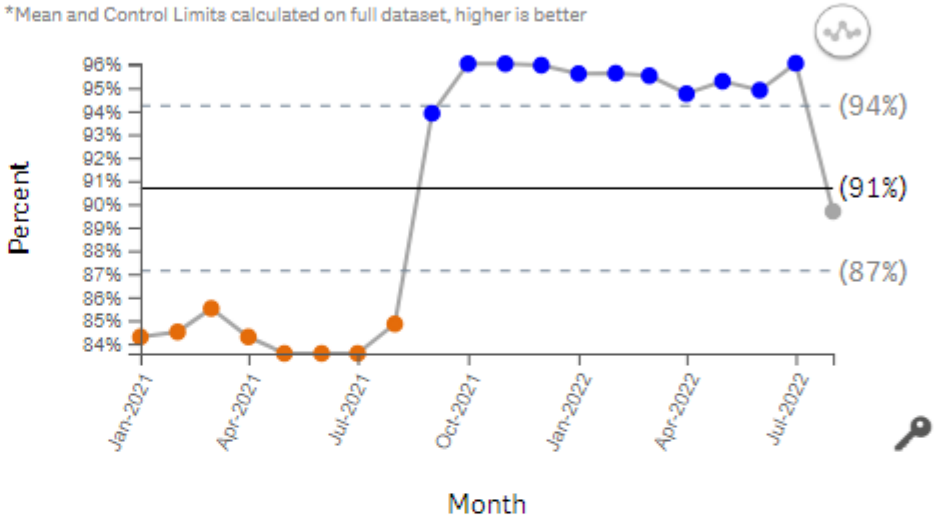
*Mean and Control Limits calculated on full dataset, neither higher or lower is better



Latest
55
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Compliance to Risk Management Training

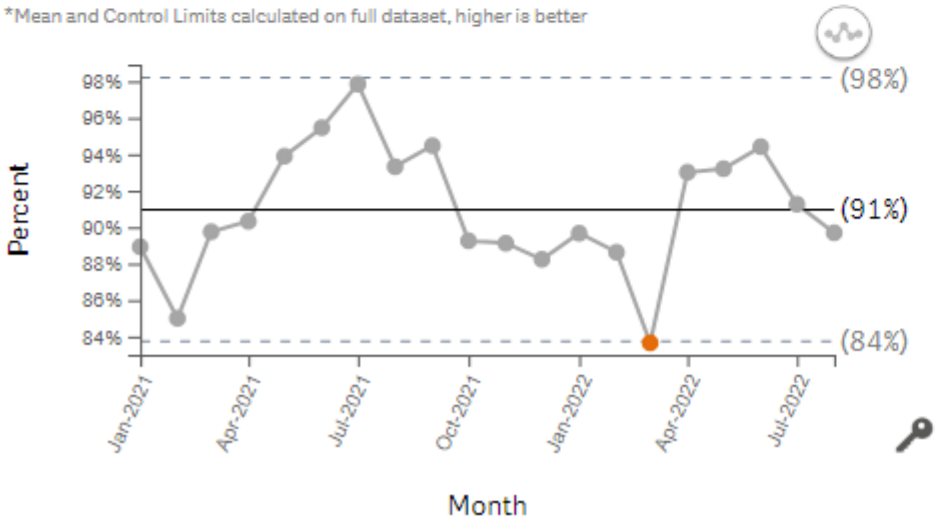
*Mean and Control Limits calculated on full dataset, higher is better



Latest
89.7%
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Risk Reviews Completed On Time

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



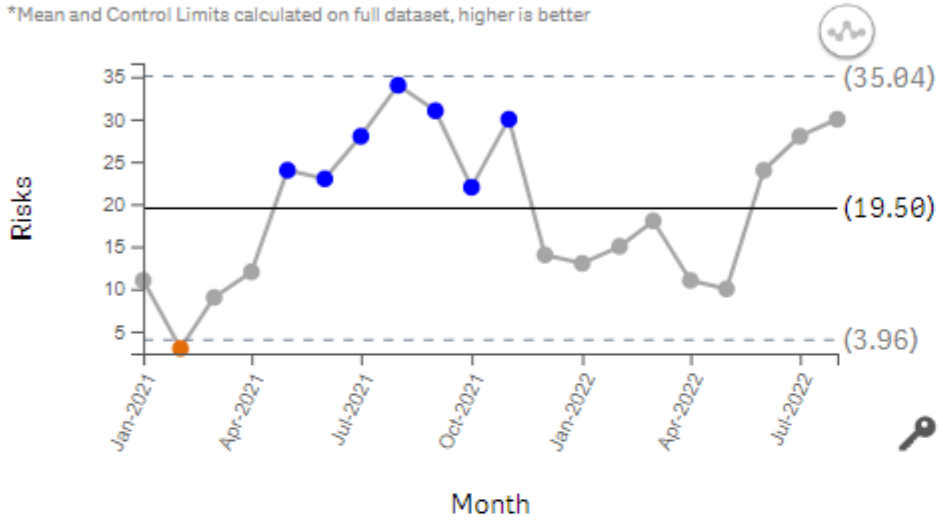
Latest
89.7%
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Risk - 3

University Hospitals of Morecambe Bay NHS Foundation Trust

Volume Of New Risks By Month

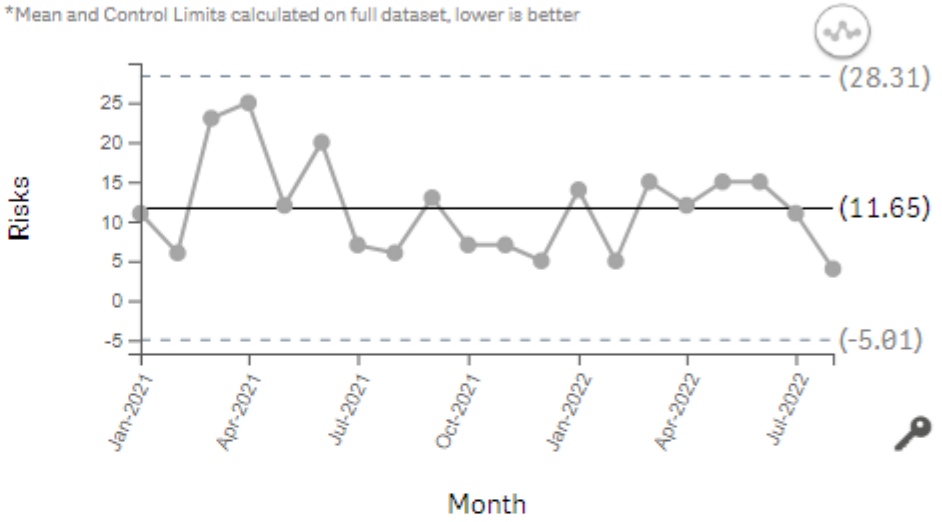
*Mean and Control Limits calculated on full dataset, higher is better



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

Volume Of Closed Risks By Month

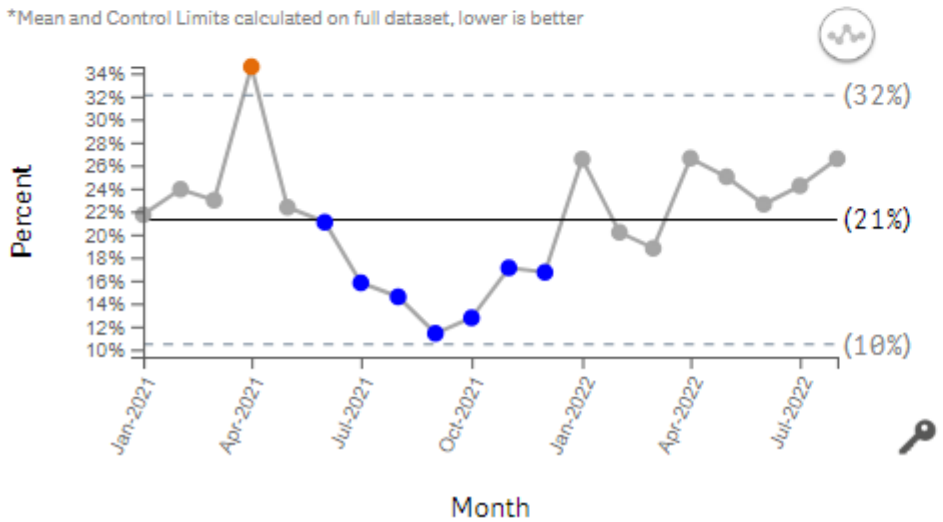
*Mean and Control Limits calculated on full dataset, lower is better



Latest
4
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Risks Beyond Target Completion Date

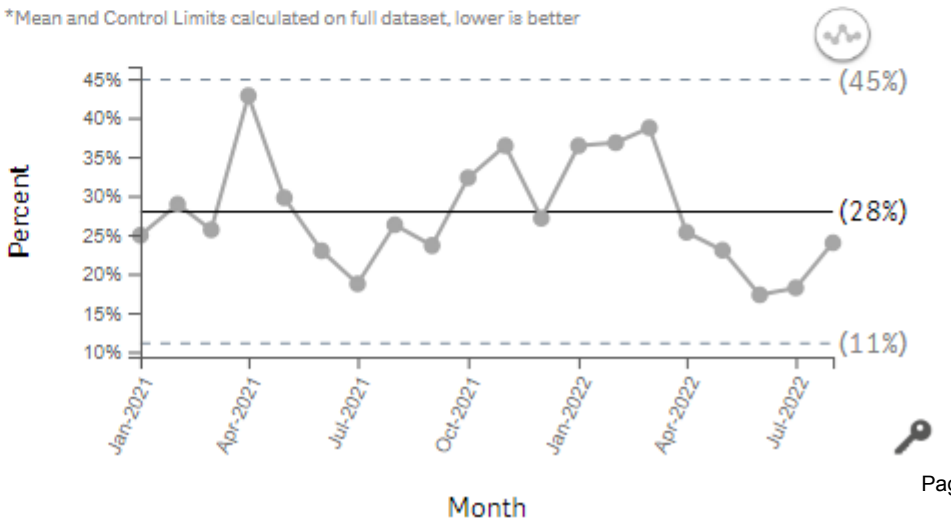
*Mean and Control Limits calculated on full dataset, lower is better



Latest
26.6%
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Risk Actions Beyond Target Completion Date

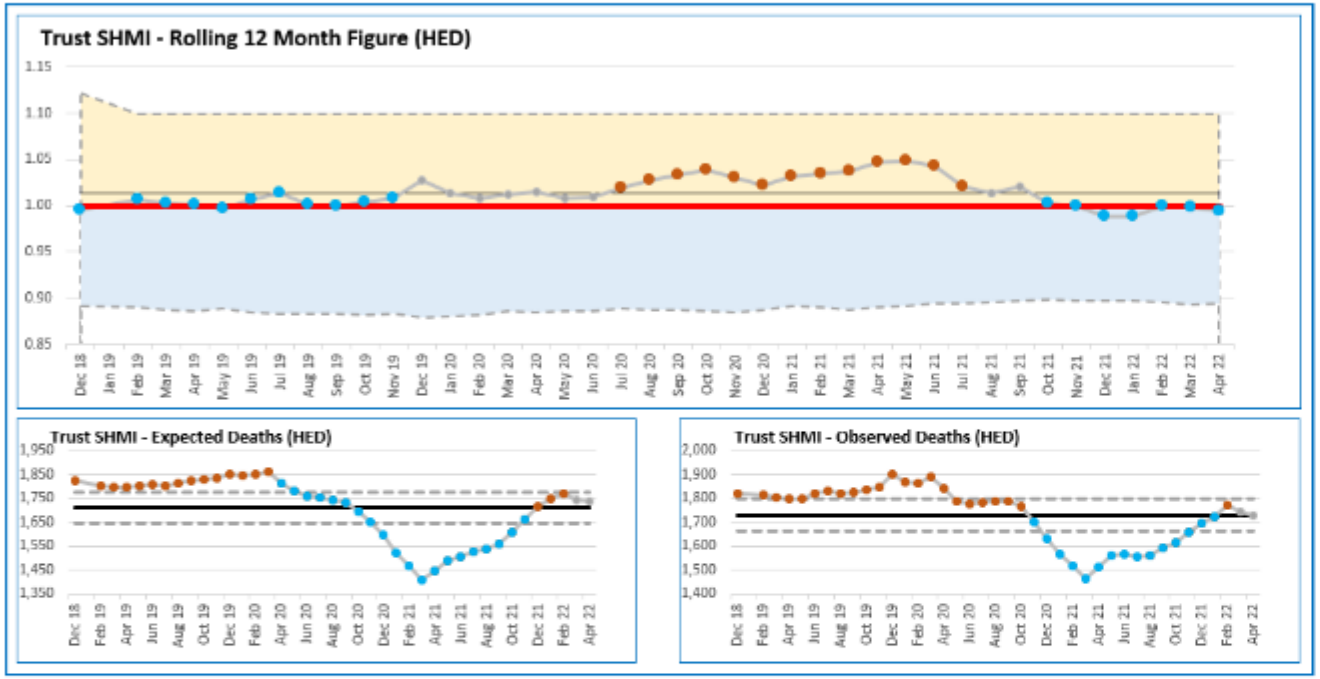
*Mean and Control Limits calculated on full dataset, lower is better



Latest
24.0%
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

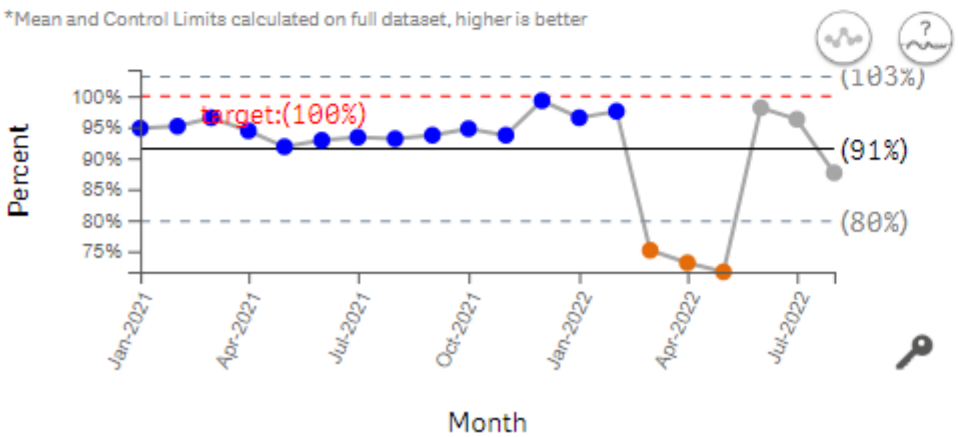
Mortality - 1

University Hospitals of Morecambe Bay NHS Foundation Trust



Hospital Deaths Scrutinised by Medical Examiner

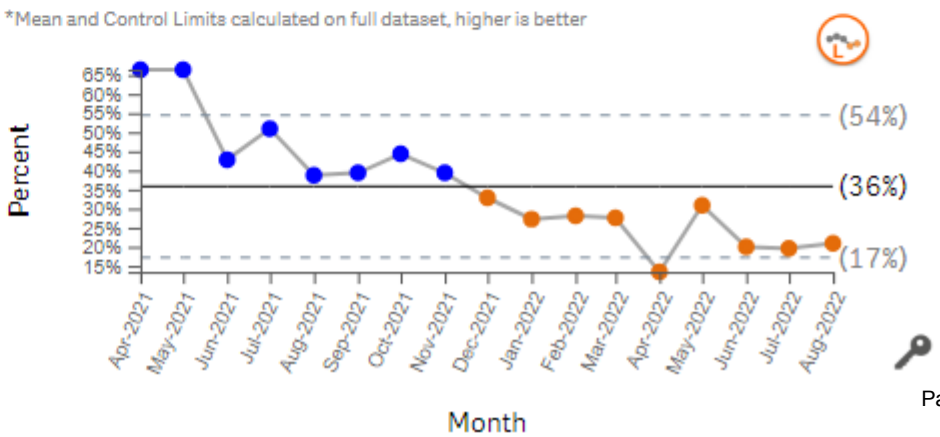
*Mean and Control Limits calculated on full dataset, higher is better



Latest
88%
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



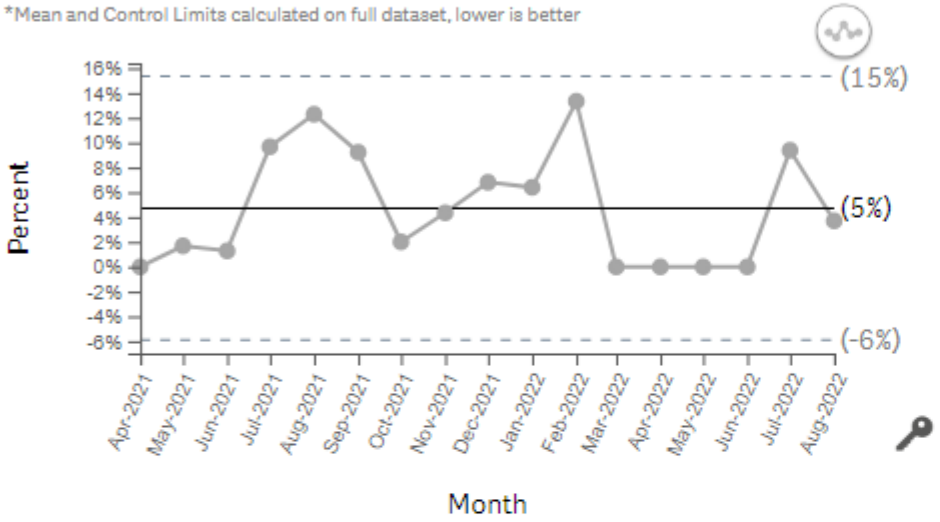
Latest
21%
Variance Type
Special cause variation - cause for concern (indicator where low is a concern)
Target
N/A
Target Achievement

Mortality - 2

University Hospitals of Morecambe Bay NHS Foundation Trust

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

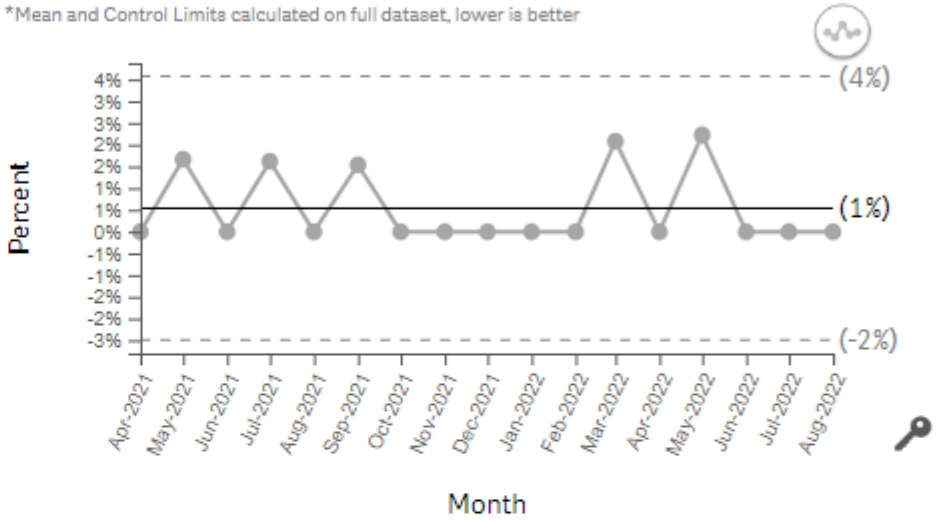
*Mean and Control Limits calculated on full dataset, lower is better



Latest
4%
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

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

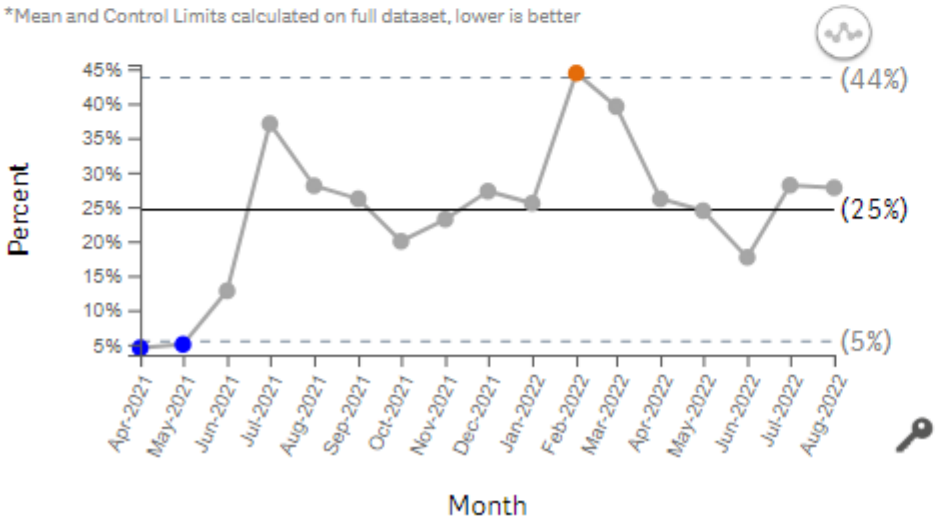
*Mean and Control Limits calculated on full dataset, lower is better



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

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

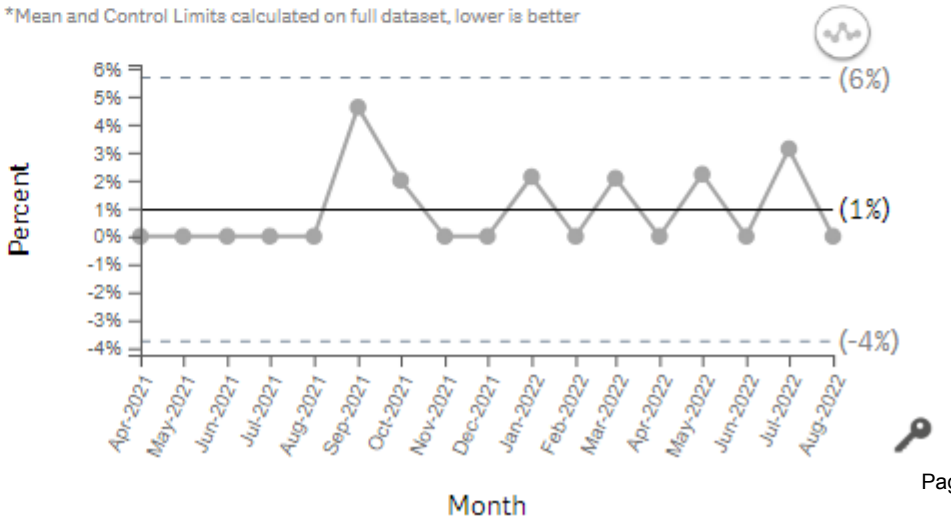
*Mean and Control Limits calculated on full dataset, lower is better



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



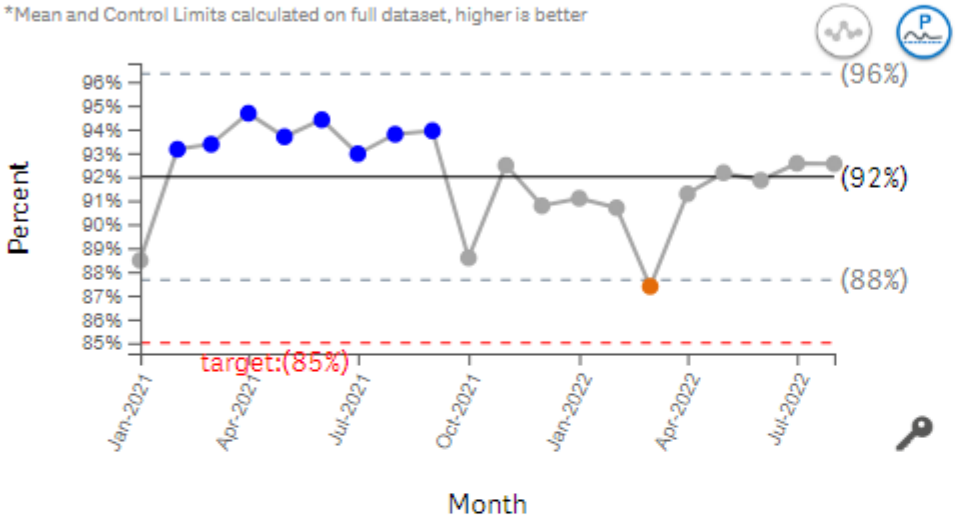
Latest
0%
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Safer Staffing

University Hospitals of Morecambe Bay NHS Foundation Trust

Registered Nurse Fill Rate

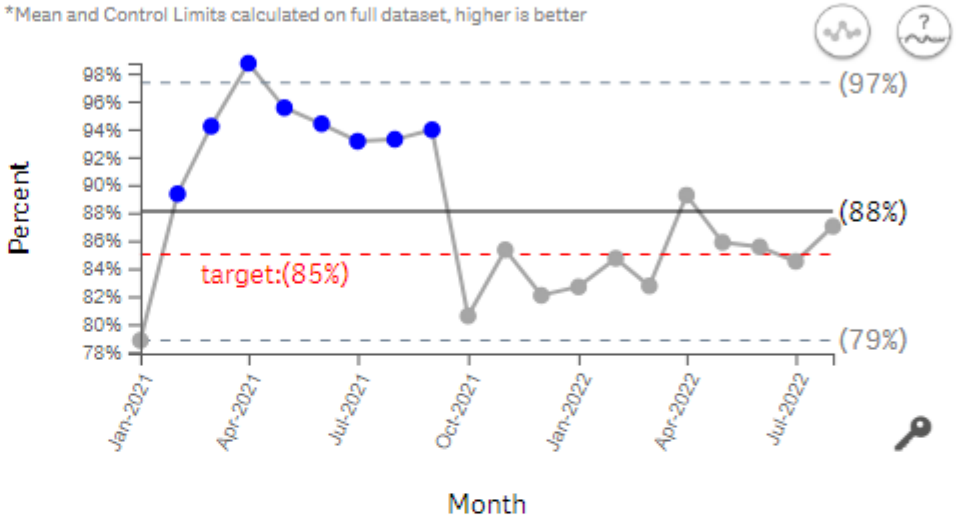
*Mean and Control Limits calculated on full dataset, higher is better



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



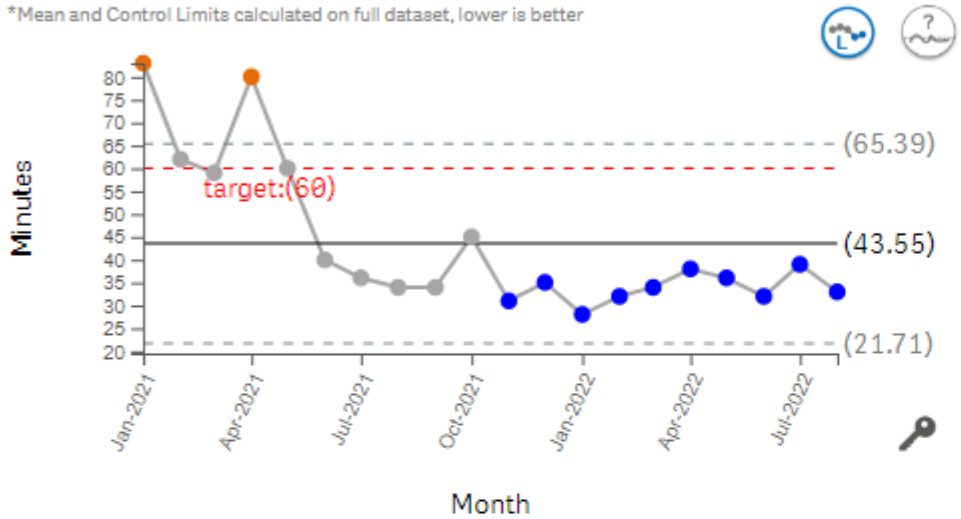
Latest
87.0%
Variance Type
Common cause variation
Target
85%
Target Achievement
The system may achieve or fail the target subject to random variation

Stroke - 1

University Hospitals of Morecambe Bay NHS Foundation Trust

Median Arrival Time to Scan (mins)

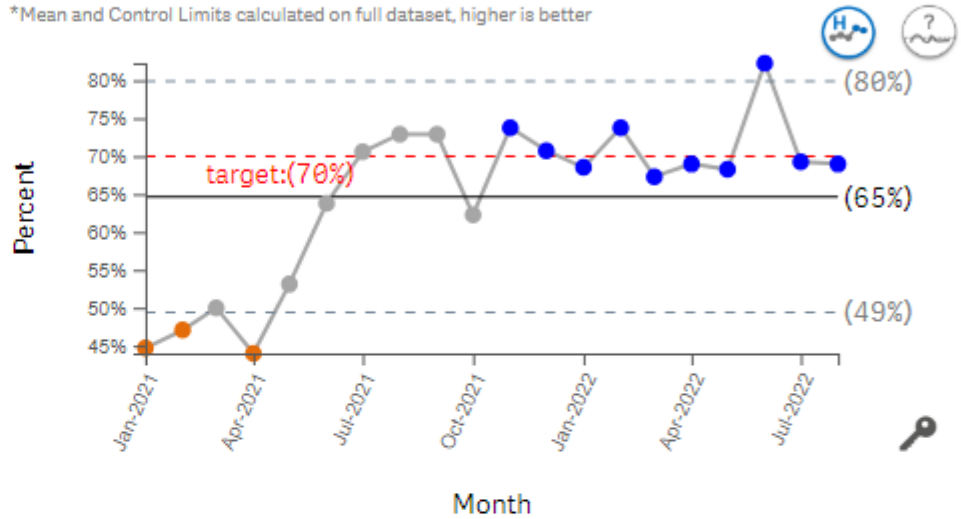
*Mean and Control Limits calculated on full dataset, lower is better



Latest
33
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

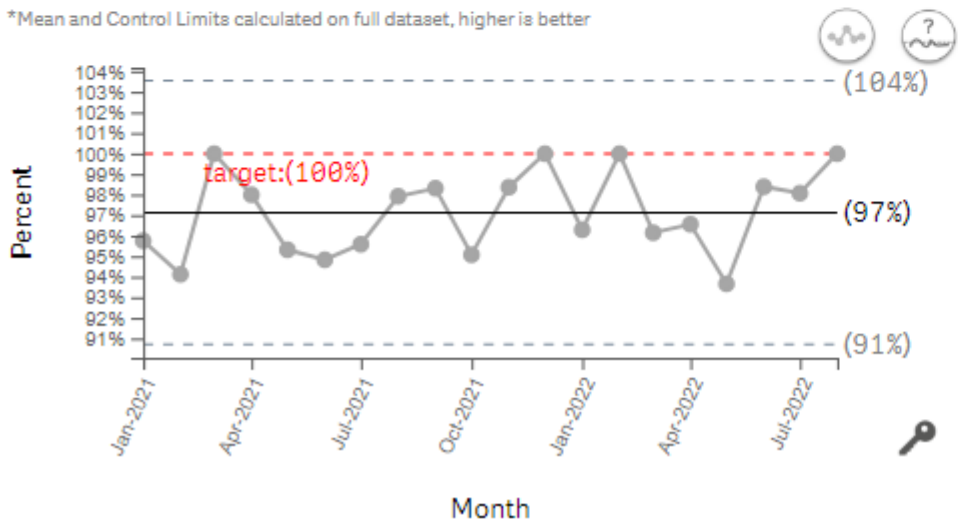
*Mean and Control Limits calculated on full dataset, higher is better



Latest
69.0%
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

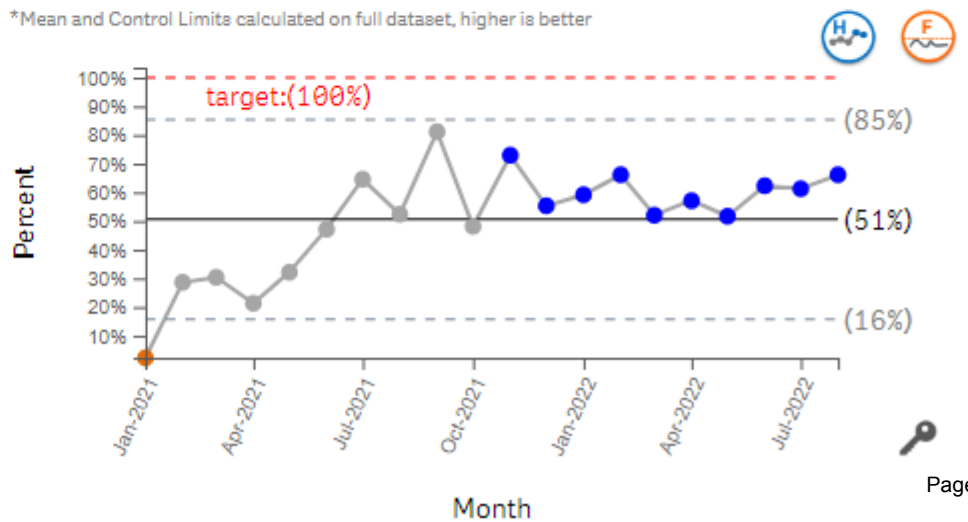
*Mean and Control Limits calculated on full dataset, higher is better



Latest
100.0%
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



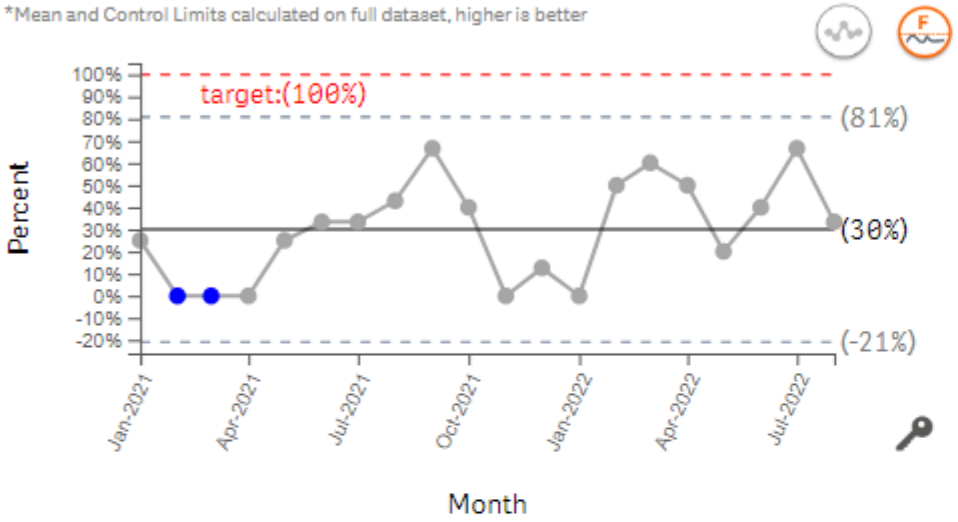
Latest
66.1%
Variance Type
Special cause variation - improvement (indicator where high is good)
Target
100%
Target Achievement
The system is expected to consistently fail the

Stroke - 2

University Hospitals of Morecambe Bay NHS Foundation Trust

Thrombolysed within 1hr

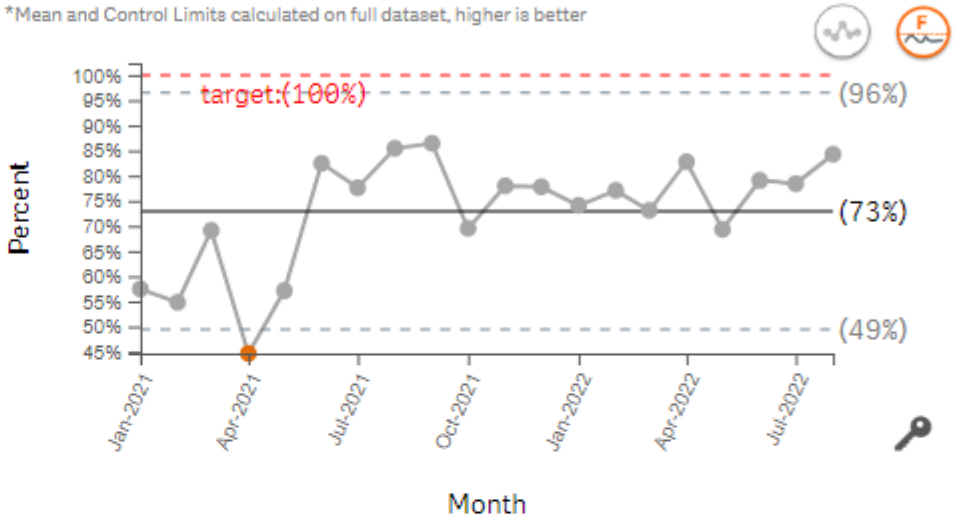
*Mean and Control Limits calculated on full dataset, higher is better



Latest
33.3%
Variance Type
Common cause variation
Target
100%
Target Achievement
The system is expected to consistently fail the target

Swallow Screened within 4hrs

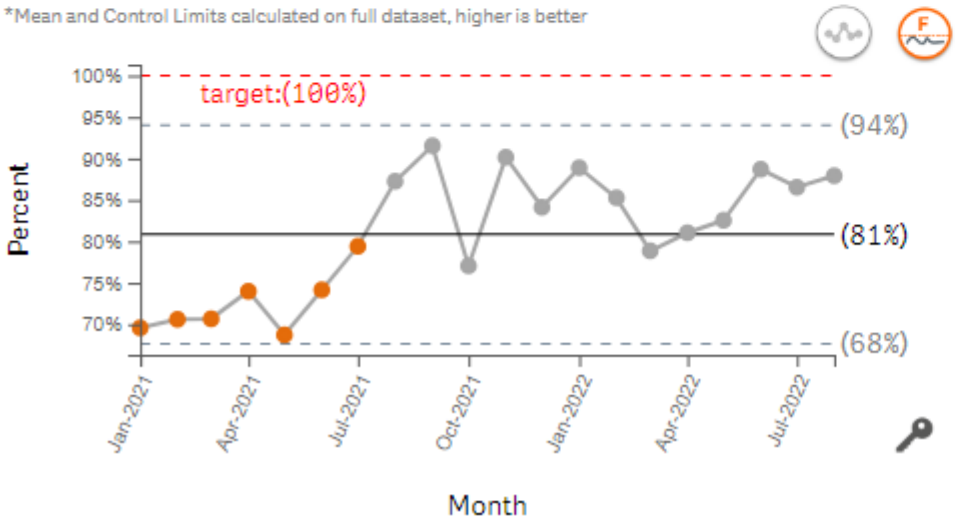
*Mean and Control Limits calculated on full dataset, higher is better



Latest
84.2%
Variance Type
Common cause variation
Target
100%
Target Achievement
The system is expected to consistently fail the target

Assessed by Stroke Consultant within 24h

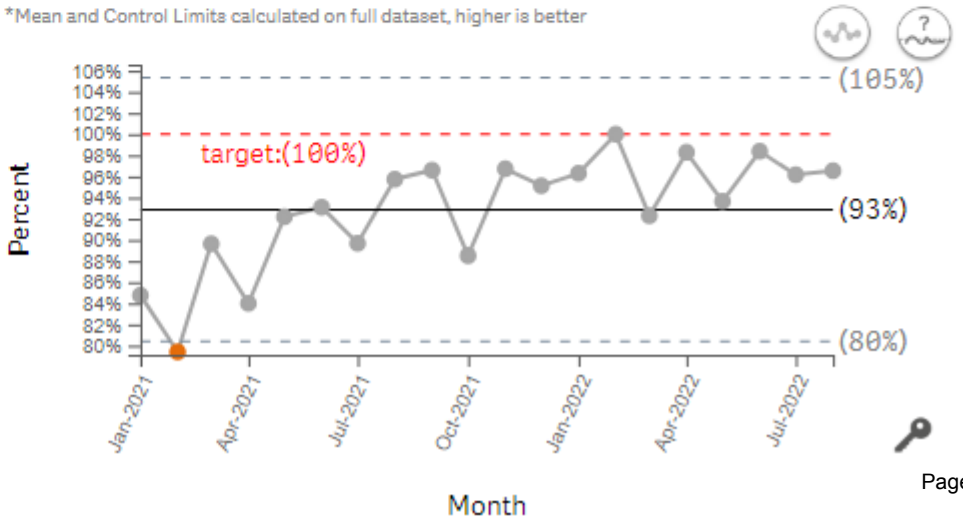
*Mean and Control Limits calculated on full dataset, higher is better



Latest
87.9%
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



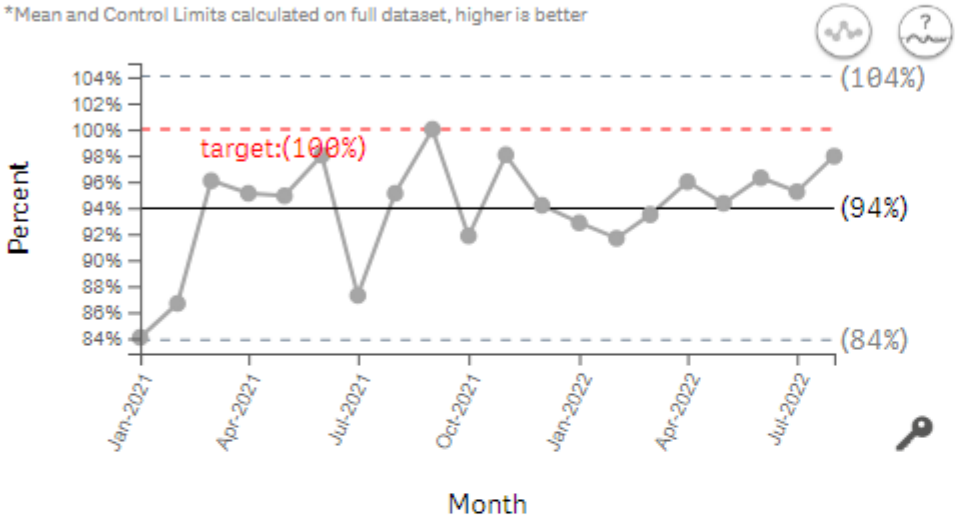
Latest
96.6%
Variance Type
Common cause variation
Target
100%
Target Achievement
The system may achieve or fail the target subject to random variation

Stroke - 3

University Hospitals of Morecambe Bay NHS Foundation Trust

Occupational Therapy Assessment within 72h

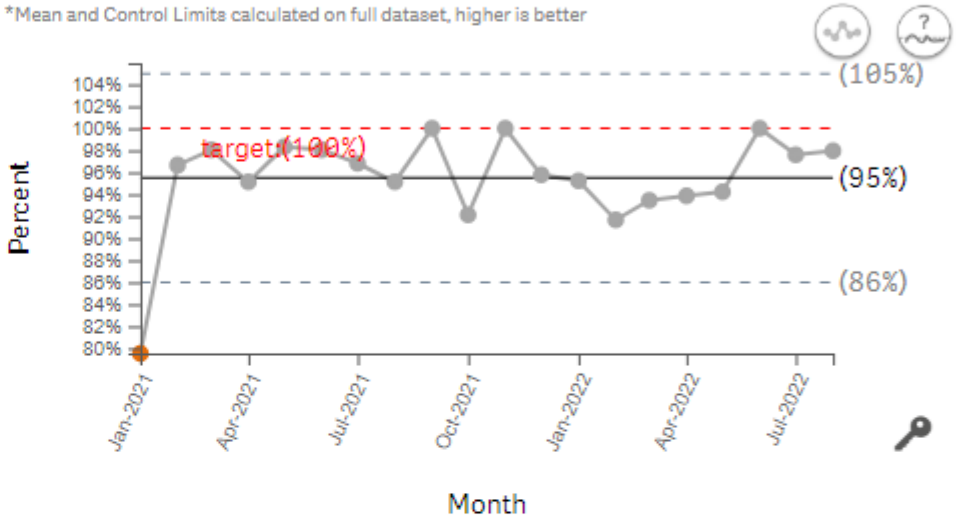
*Mean and Control Limits calculated on full dataset, higher is better



Latest
98.0%
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

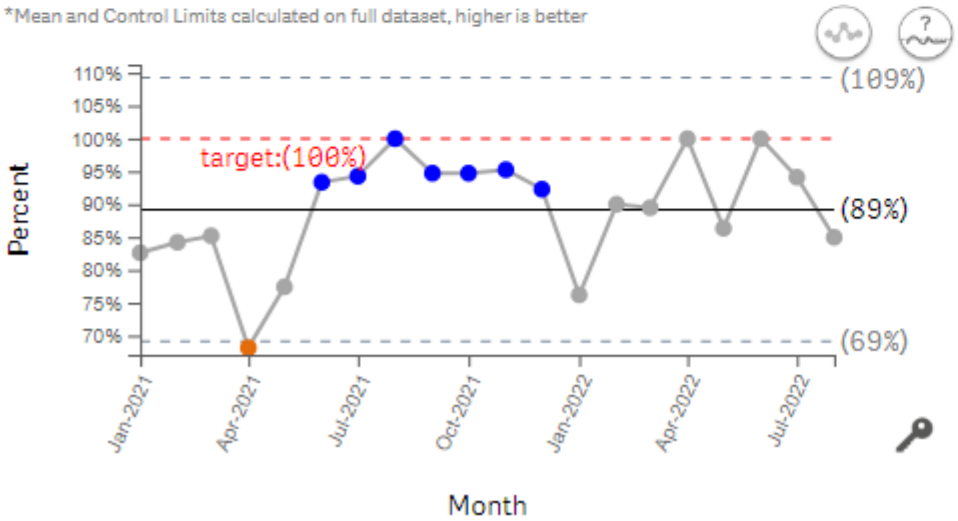
*Mean and Control Limits calculated on full dataset, higher is better



Latest
98.0%
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



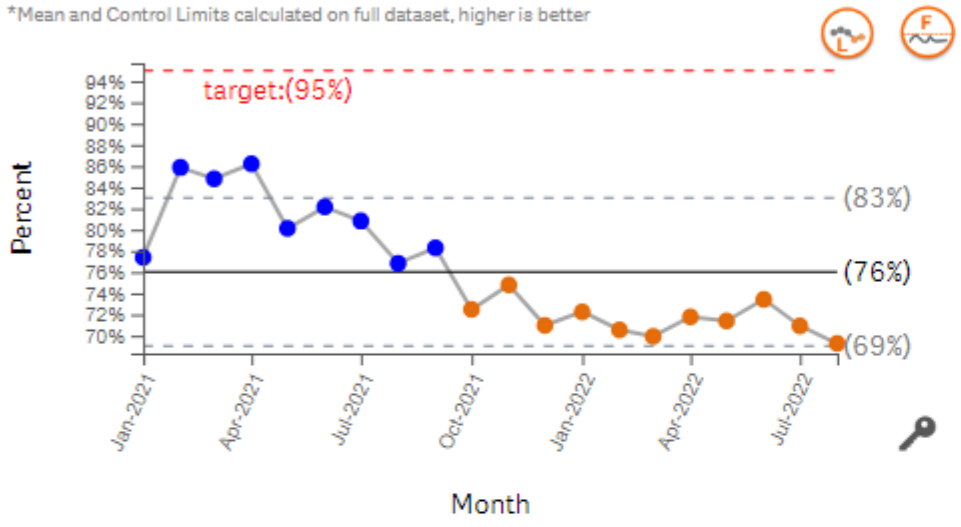
Latest
85.0%
Variance Type
Common cause variation
Target
100%
Target Achievement
The system may achieve or fail the target subject to random variation

Urgent & Emergency Care - 1

University Hospitals of Morecambe Bay NHS Foundation Trust

ED 4 hrs (%)

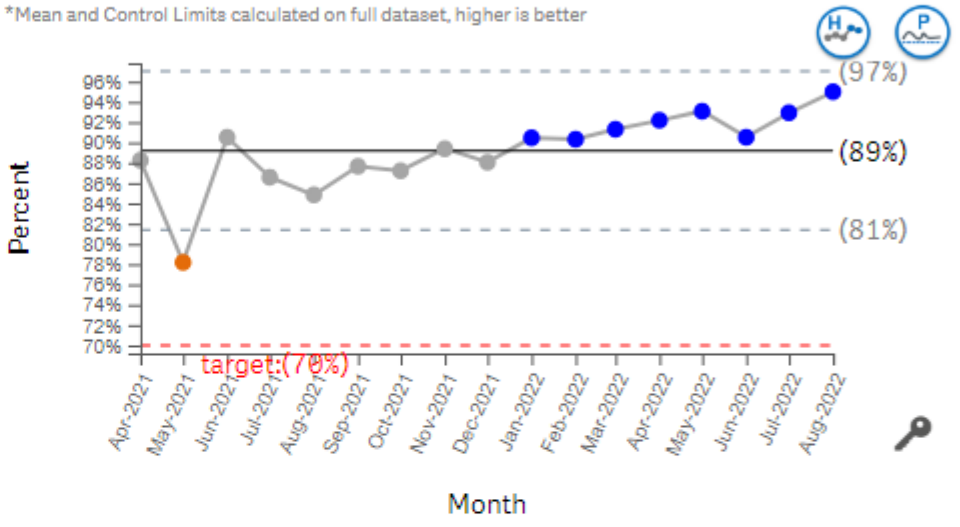
*Mean and Control Limits calculated on full dataset, higher is better



Latest
69.3%
Variance Type
Special cause variation - cause for concern (indicator where low is a concern)
Target
95%
Target Achievement
The system is expected to consistently fail the

2 hour Urgent Community Response

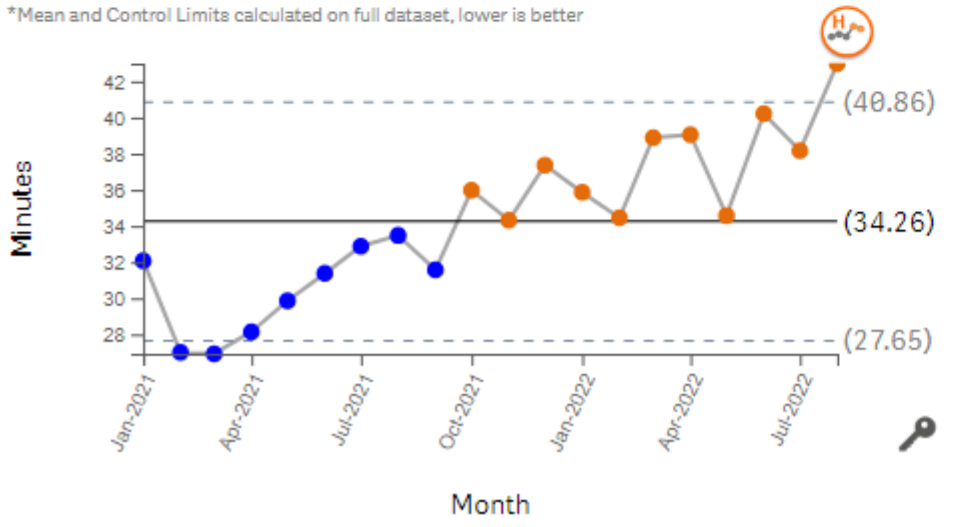
*Mean and Control Limits calculated on full dataset, higher is better



Latest
95.0%
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)

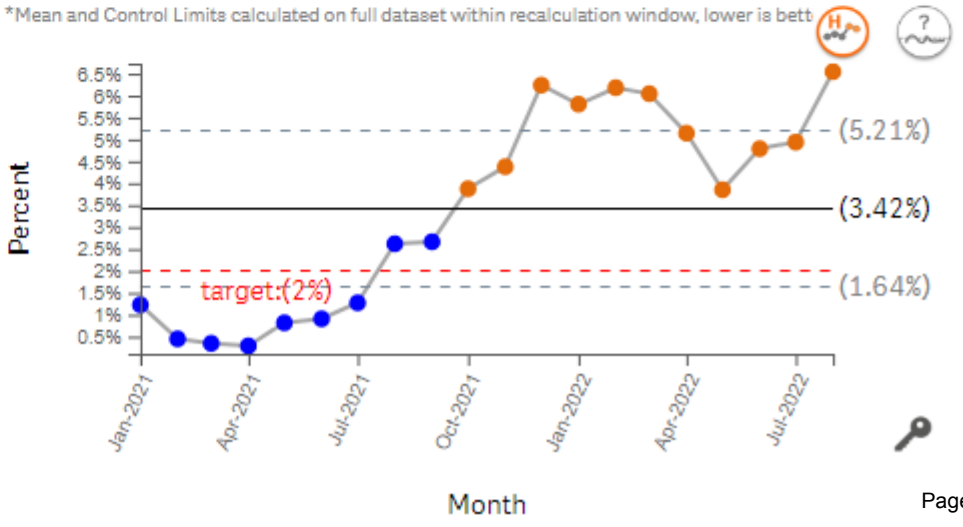
*Mean and Control Limits calculated on full dataset, lower is better



Latest
43.0
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



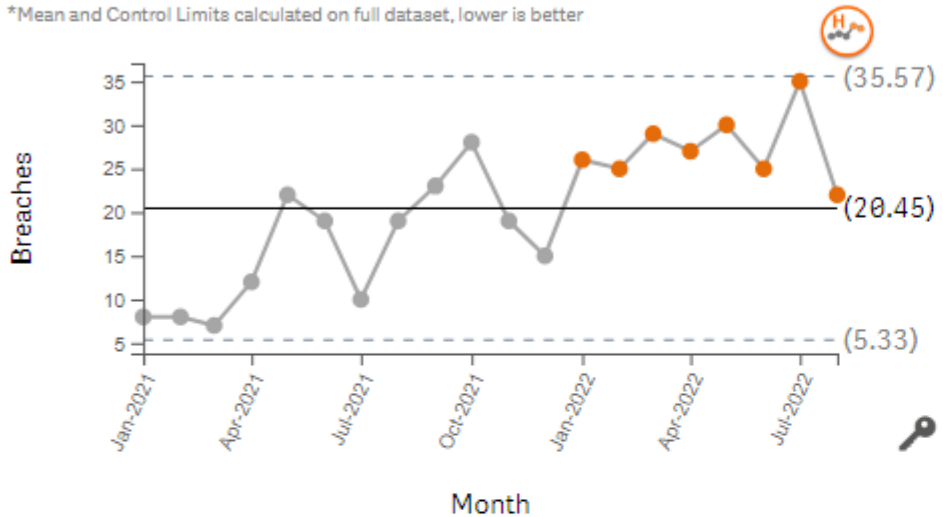
Latest
6.6%
Variance Type
Special cause variation - cause for concern (indicator where high is a concern)
Target
2%
Target Achievement
The system may achieve or fail the target subject to

Urgent & Emergency Care - 2

NHS
University Hospitals of Morecambe Bay
NHS Foundation Trust

Patients Spending over 12 hours in ED: Mental Health Reasons

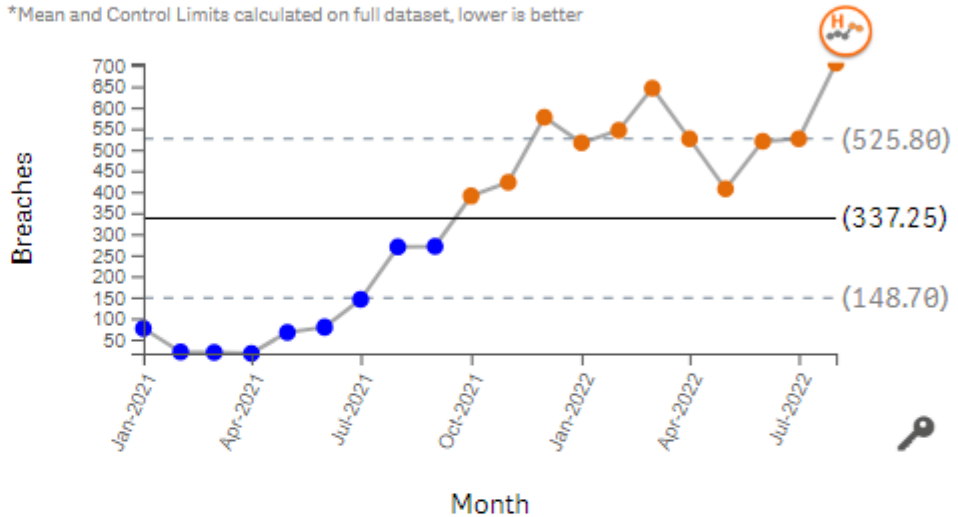
*Mean and Control Limits calculated on full dataset, lower is better



Latest
22
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

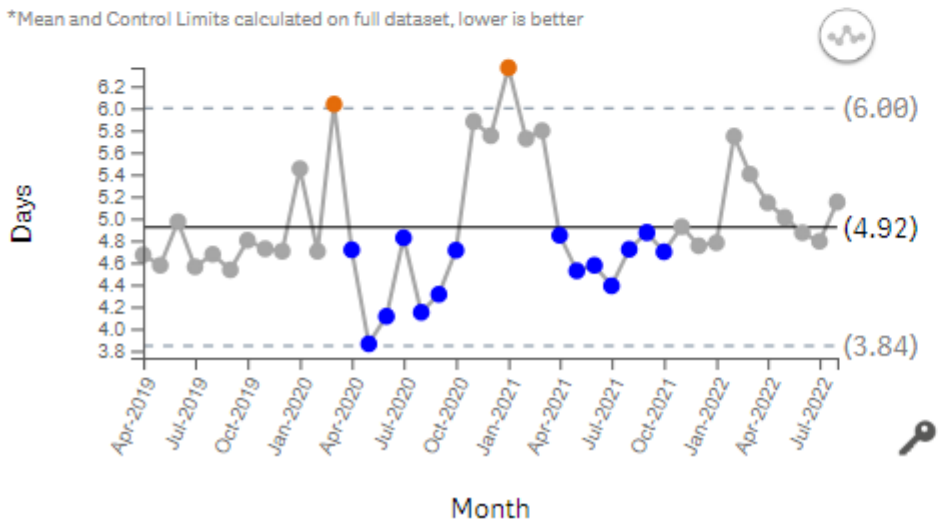
*Mean and Control Limits calculated on full dataset, lower is better



Latest
705
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

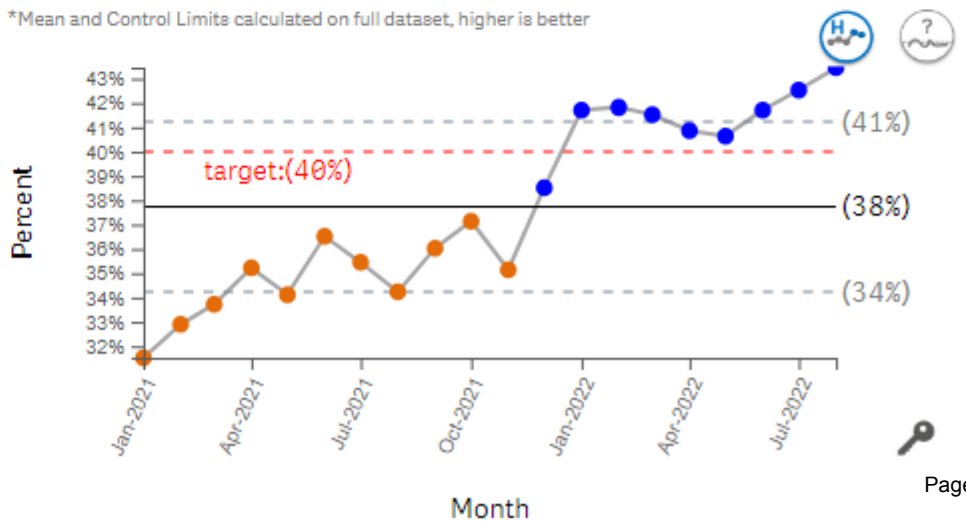
*Mean and Control Limits calculated on full dataset, lower is better



Latest
5.1
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



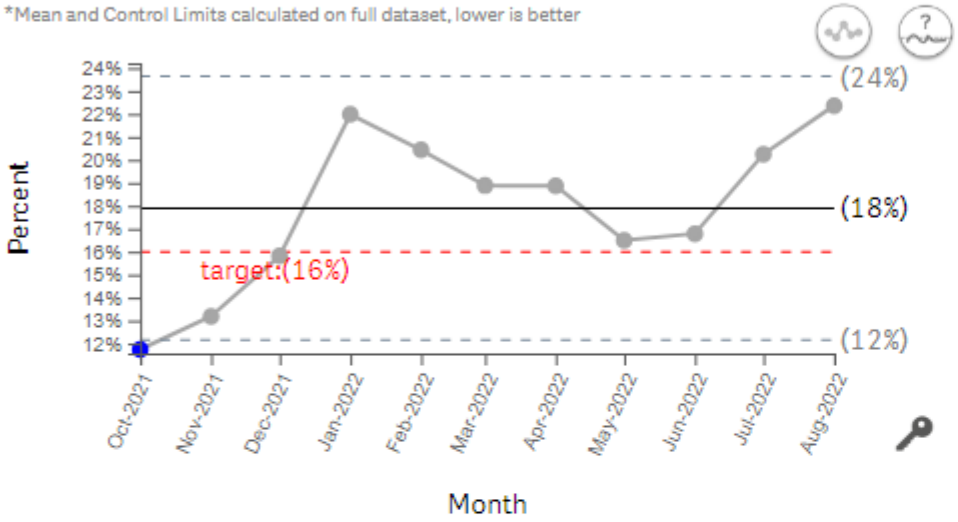
Latest
43.5%
Variance Type
Special cause variation - improvement (indicator where high is good)
Target
40%
Target Achievement
The system may achieve or fail the target subject to

Urgent & Emergency Care - 3

University Hospitals of Morecambe Bay NHS Foundation Trust

NMC2R - Percent of G&A Beds

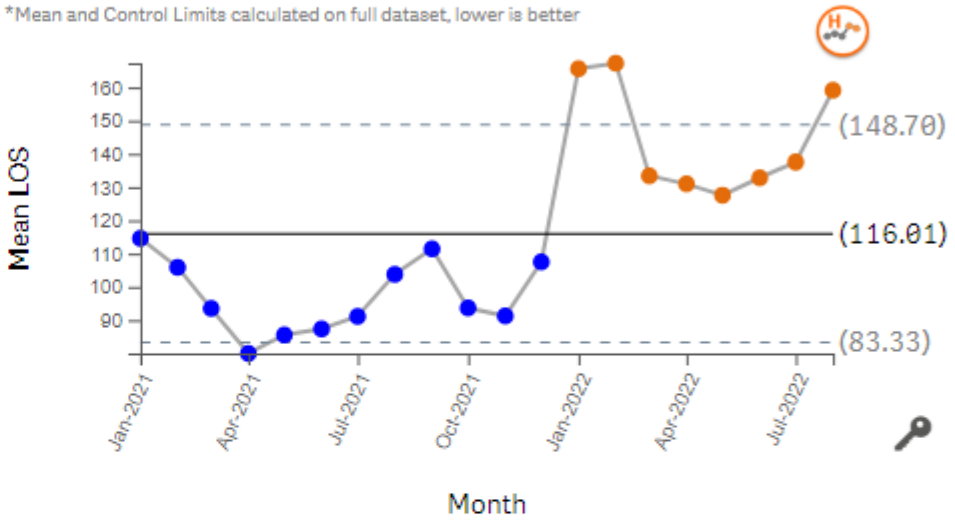
*Mean and Control Limits calculated on full dataset, lower is better



Latest
22.4%
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
159
Variance Type
Special cause variation - cause for concern (indicator where high is a concern)
Target
N/A
Target Achievement
N/A

Minutes of the People Committee Meeting held on Monday 18 July 2022 via M/S Teams

PRESENT:

Adrian Leather	Chair, Non-Executive Director
David Wilkinson	Director of People & OD
Lyn Hadwin	Deputy Director of People & OD
Ray Olive	Assistant Director of People & OD
Scott McLean	Chief Operating Officer
Richard Matthews	Governance Business Partner
Bridget Lees	Executive Chief Nurse
Lorna Pritt	Associate Chief Nurse
Matt France	Assistant Director of Organisational Development & Learning
Mike Wilson	Public Governor
Paul Jones	Company Secretary
Lee Tarren	Assistant Director of People & OD – Workforce Transformation
Peta Heron	Head of Learning & Development
Hannah Chandisingh	Head of Inclusion & Engagement
Clare Hill	Occupational Health & Wellbeing Matron/Clinical Lead
Karmini McCann	Head of Culture Transformation
Ben Maden	USS Chair
Rebekah Coombes	Deputy Improvement Director (NHSIE) (observing)
Caroline Chubb	Minute Taker

24. WELCOME & APOLOGIES FOR ABSENCE

Apologies were received from Richard Sachs, Leanne Cooper, Lynne Wyre and Jane McNicholas. The Committee welcomed Scott McLean, Mike Thomas and Rebekah Coombes to the meeting.

25. DECLARATIONS OF INTEREST

No conflicts of interest were noted.

26. MINUTES OF THE MEETING HELD ON MONDAY 16 MAY 2022

The minutes were accepted as a true and accurate record.

27. MATTERS ARISING AND ACTION LOG

Discussions took place regarding overdue actions in the Action Log with the following agreed:

- Item 119 (15.03.21) - to be closed and open a new action relating to the ER report to include the high-level data and dashboard from the new Case Management System. Report to be presented at September PC and refine it from that point.
- Item 100 (17.01.22) – due date to be changed to October.
- Item 111 (21.02.22) – to be combined with Item 100.
- Item 116 (21.02.22) – date for Lyn to report back to the PC to be September. Lyn Hadwin to ensure this action is also on the Moving Forward Action Tracker and link with Ben to ensure actions are recorded.
- Item 139 (21.03.22) – to be closed. Matt France assured the Committee that work is ongoing within E&F to support colleagues. The Committee was assured that a new Director of Estates & Facilities will be appointed this week and a review of the E&F people programme plan will take place, alongside discussions with USS to co-produce the work. Matt to commission a report from Picker for national comparison purposes to determine the insight and outcomes we are seeking reassurance on and how they may be delivered via PNCC.
- Item 142 (21.03.22) – to be closed.

UPDATE ON ACHIEVING EXCELLENCE IN CORE SKILLS FRAMEWORK TRAINING

Consideration was given to the report submitted by Matt France.

Matt highlighted that the report provides assurance of very high levels of CSTF compliance within the organisation but with some gaps in safeguarding and basic life support. In comparison with other Trusts, UHMB are in very good position. The Committee noted paragraph 16 of Matt's report regarding particular areas the CQC focussed on – these are subject to an internal audit report to examine more details on the requirements with the results providing assurance or highlighting gaps specifically for safeguarding and paediatric life support. The Chair was assured by Matt that these two particular training requirements will be reported within the IPR going forward to enable monitoring by the Committee and will feature from the next meeting.

AGREED: The Committee:

- was assured of the generally high levels of CSTF compliance
- noted the request to monitor training gaps for safeguarding level 3 and paediatric life support and accepted the recommendation to apply interim targets to these in future reporting
- will check at the next meeting that a technical solution to removing CSFT extension periods has been found

28. PEOPLE & OD RISK REPORT

(a) RISK REPORT

Consideration was given to the report submitted by Ray Olive.

Ray confirmed that as planned, the old BAF risks have closed with new risks, 3090 (BAF1 - staffing levels) and 3091 (BAF2 - health & wellbeing of colleagues) now opened which require scoring to be agreed. Paul Jones accepted BAF1 and suggested it's scored at 20, and proposed BAF2 is given a medium score due to the number of controls and assurances in place.

The Committee noted there are currently 6 overdue risks, (5 in Surgery & Critical Care & 1 in Core Clinical Services), and that risk 2850 (Critical Care) has been reduced due to recruitment activity and will be closed by the Care Group. The Committee noted that risk 2872 is reduced but there are still concerns in WAC's, particularly Midwifery. The Committee were assured by the reduction of risks to 53 in the People & OD domain with 8 indirectly linked.
The Committee discussed the approval of creating two new risks to recognise (1) the ability to achieve the P&OD CIP target of 18.5% within the current financial year and (2) the high impact upon delivery of services whilst attempting to meet the CIP, particularly given the additional work associated with the Cultural and Recovery Support Programmes. The Committee acknowledged the 18.5% target is achievable, however it means some services will not be delivered with risks and mitigations around these currently being explored. The Committee agreed to accept the new risks with the scores being agreed upon the development of further evidence and information which will be assured by operational colleagues and proposed to the Committee in September.

Ray provided the Committee with examples of the standard matrix for scoring risks and highlighted that the organisation does not have unsafe staffing levels for more than a day or two. Discussion took place with Scott McLean raising concerns regarding a number of the workforce risks and the significant risk of major harm to patients as a result of the organisation's staffing provision. Ben Maden highlighted that Community colleagues are facing pressures around fuel costs and are seeking support with morale being low which may lead to staff being absent. Ben confirmed these issues are being addressed this week as requested by Aaron Cummins.

The Chair requested to see a proactive element for BAF1 to understand the forecasted pressures the Trust will face and requested assurance that BAF2 regarding staff wellbeing re fuel prices and pay awards are to be included or dealt with elsewhere. Lyn explained that the Financial Wellbeing Strategy will come back to PC and confirmed there are a number of short, medium and long term actions in place with Community colleagues with mileage being priority this this week. Lyn suggested the wording of the risks are reviewed in liaison with Scott and amended to accurately reflect the actions being taken. The Committee agreed it expects to see a revised set of measures and level of risk based upon Scott's feedback.

ACTION:

- Scott to meet urgently with Bridget & Jane regarding the workforce risks and feedback to the next Committee
- Scott to contact the Chair to ensure escalation of these issues to the Board and liaise with Ray regarding the re-scoring
- Bridget to review the risk ratings process to ensure that ratings are agreed prior to reaching People Committee meetings and to report back to the next Committee in September

(b) BOARD ASSURANCE FRAMEWORK

Consideration was given to the report submitted by Paul Jones which was circulated separately to the rest of the papers. It was noted that some changes and revisions may be required ahead of the Board, as such Paul will discuss with Ray and Lyn to ensure a comprehensive position around controls and mitigating actions.

AGREED: The Committee:

- Accepted the BAF as proposed with the amendments discussed for presentation at the Board

ACTION:

- Paul to review the wording of the risks with Ray and Lyn
- Paul, Ray & Lyn to discuss changes and revisions required prior to the Board

29. PROGRESS REPORT ON CARE QUALITY COMMISSION (CQC), NICHE AND ROYAL COLLEGE OF SURGEONS (RCS) IMPROVEMENT PLANS

Consideration was given to the report submitted by Richard Matthews who presented the paper on behalf of Richard Sachs.

Richard confirmed that the programme of Support & Review Panels is now in place with one taking place this week attended by David Wilkinson to explore progress against the recommendations around Culture. The panels are the main method by which the organisation can establish whether there is evidence that a recommendation or an action is completed for subsequent closure.

Richard confirmed the CQC report following the Emergency & Urgent Care inspection in March is expected to be received in July with any recommendations which the Committee need to be sighted on, being brought to the next meeting. Richard advised the Committee that following the publication of the Ockenden Review, work is in progress in the WACs Care Group around the recommendations and actions required and more details may be included in the next report for the Committee.

Richard updated the Committee regarding the recommendations and actions applicable to the Committee and highlighted there is particular challenge around Appraisal levels in Surgery at RLI with work ongoing to resolve. The main Trust-wide key risk applicable to the Committee is around Culture with a number of actions now in place to support the recommendations and these will be reviewed at a Support & Review Panel in July.

The Committee noted that an update on the Deep Dive will be reported to the Committee at the November 2022 meeting.

The Committee noted that the mitigations on Recommendation MD5/3 to MD5/6 will be updated to reflect the accurate position.

AGREED: The Committee noted:

- current positive progress of the recommendations from the CQC Inspection Report, NICHE Investigation Report and RCS Review:
    - 23 Recommendation were closed in May
    - 6 Recommendations were completed in May
    - 5 further Recommendations are now Behind Schedule
    - 65 Actions were reviewed at the Support and Review Panel Meetings
- evidence to support completion of all actions/recommendations continues to be populated within AMaT to allow for tolerance testing
- schedule of Support and Review Panel Meetings with Care Groups is in progress
- the aim to achieve level three compliance with the Bruce standards of assurance

ACTION:

- Richard Matthews to circulate a summary extract to show the recommendations and actions which are applicable to the Committee

30. CULTURE, LEADERSHIP & OD – PROGRAMME REPORT

Consideration was given to the report submitted by Karmini McCann.
Karmini reported that an additional action will be led by Matt France to ensure the organisation maximises the opportunity with the leadership programme around the learning on restorative practice and just and learning. Karmini confirmed that the BSF will be retired and the Trust will transition to focus on developing and embedding the new values and behaviours which already feature in the BSF – Rachel Hunt, P&OD Business Partner, will lead this piece of work.

The Committee noted that the Culture, Leadership & OD programme is a long-term project and will take years to embed Just & Learning Restorative practises into all aspects of the organisation. David highlighted the risk of Karmini leaving the Trust and reported that work is taking place to develop mitigations. The Chair acknowledged and thanked Karmini for the work she has carried out for the Trust.

Karmini updated the Committee on the 3A's element of the report, highlighting that the EDI will be completed subject to the Committee's approval of the year 1 plan today and that 123 colleagues have completed the face to face delivery of the leadership programme Focus 2, with 383 booked on, meaning 32% of leaders have either completed or booked a place. Ray Olive is working on the Reward & Recognition with Phil Woodford and linking with the Culture Change Team. The Culture Programme Board leads are meeting on a fortnightly basis to work on a deep dive approach. The Committee noted the risk that David as the SRO is also leaving the Trust and that work is taking place to ensure the transition from David and Karmini to others. Karmini advised on the risk in connection with the CIP and highlighted that long-term sustainable plans need to be considered to expand the number of People & OD colleagues who can deliver the leadership programme training.

As today is David's final attendance at the People Committee, the Chair expressed thanks on behalf of the Committee for his professional and personal commitment to the Trust and his work with the Committee and the Board.

AGREED: The Committee:

- were assured on the engagement of colleagues and noted that 474 people have booked onto the programme
- noted the consultation work taking place around the new Disciplinary and MHPS policies
- were assured that the work being undertaken will have a positive impact on the risk
- were assured regarding the transition plans in respect of David & Karmini's roles

31. COLLEAGUE HEALTH & WELLBEING – 2022/23 PLAN

Consideration was given to the presentation given by Ray Olive and Clare Hill.

Ray confirmed that the final reviewed Flourish Strategy will be circulated when Aaron Cummins has approved the Foreword. Clare outlined that from feedback from the Pulse Survey, the National Staff Survey, the Moving Forward feedback and the RSP plan, it is clear that work is still required to ensure the organisation meets the basic needs of colleagues.

The Committee noted the contents of the presentation and acknowledged the work which has taken place to significantly reduce waiting times for psychological support and safety.

Hannah Chandisingh raised that reports in 2020 highlighted 2 in 5 nurses were missing meals and NHS Employers have since suggested this will increase in 2022 – as such, it would be good to see the mitigations on the nutrition and cost of living aspects of the plan.

Bridget confirmed her position as the SRO for this work and assured the Committee that meaningful actions are taking place and are planned and these will be included in the report presented at the next Committee.

ACTION:

- full plan to be presented at the September Committee, to include action plans, impact and engagement figures

32. NURSING, MIDWIFERY AND ALLIED HEALTH PROFESSIONAL UPDATE STAFFING REPORT

Consideration was given to the report submitted by Bridget Lees which was presented by Lorna Pritt.

Lorna assured the Committee that processes are established to ensure accurate data collection for staffing reviews and highlighted the Trust's positive position in respect of the modelling set out in the report for the next two years. However, there is still a potential risk in terms of the ageing workforce which may leave significant gaps. Recruitment work for registered nurses continues through international sources and the apprenticeships with the plan to adopt the "Grow Your Own" philosophy which will also address the gap in Clinical Support Worker modelling.

Lorna assured the Committee that an Apprenticeship Business Case is being developed to support the national imperative target of 5% vacancies by 2028, building nursing associate, registered degree nurse, midwifery, ODP and AHP apprenticeship roles into a 4-year model to allow the organisation to become self-sustaining with the case being presented at the Investment Priorities Group in July. The Committee noted that this is based on the current assumptions of need as set out in the report and given the modelling across various areas in conjunction with the Clinical Strategy, this is expected to change in line with requirements going forward. The Committee noted the key requirement to have local educational partnerships in place to provide the relevant academic support and work is ongoing to secure this.

The Committee noted the Workforce Plan covering the next 5 years is required to be signed off by March 2023 with the draft plan being presented to the People Committee in January 2023, and the final document for sign off at the Committee at the March 2023 meeting.

AGREED: The Committee:

- accepted the recommendations and assurance as set out in the report

33. POSITIVE DIFFERENCE ACTION PLAN 2022

Consideration was given to the report and action plan submitted by Hannah Chandisingh.

The Committee noted that the Positive Difference Annual Report will be presented at the People Committee in September 2022. Hannah confirmed that feedback was given by the Equality & Diversity Steering Group to ensure the action plan was streamlined, clear and

measurable. The Committee noted that the action plan is for all of People & OD to be proactive and involved in ensuring the plan is met.

AGREED: The Committee:

- noted the action plan and agreed to support to deliver this as an enabling programme

ACTION:

- Hannah to come back to the PC if there are any further recommendations for oversight of any actions

34. PEOPLE & OD INTEGRATED PERFORMANCE REPORT

Consideration was given to the report submitted by Ray Olive.

Recruit & Retain – Consultant recruitment remains concern for the Trust; the current vacancy rate is 17.4% and has increased in month. This picture is in line with the risk profile highlighted by the Care Groups, but should improve as several successful consultants have been appointed, with 16 Consultants in the current recruitment process which will reduce the figure to 11.6% (32 vacancies). All other Medics (SAA/Higher & Junior) positions saw an improved picture due to several successful Doctors starting in post. Midwifery vacancies are at 15.99% with 8.9% in the recruitment pipeline. Agency Spend Medical & Dental showed another small increase in month by £24k (to a total of £866k) and Nursing Agency Spend increased significantly by £54k (to a total of £201k), this is a 33% increase on previous month and the highest since significant pressure in March. This is a result of increased absence and a higher agency cost for agency staff. Colleague turnover decreased to 9.6% in June 2022 (8.7% in June 2021), this is above the Trust's target for turnover. The biggest reason for leaving was retirement, which accounted for 18.9% of the 713 leavers, closely followed by Voluntary Resignation – Relocation at 15.1%.

The Committee noted Ray's confirmation that the medical and dental high turnover rate is due to Junior Doctors rotation. The Committee also noted that the Finance Committee owns the Agency Spend risk and that the People Committee provide support in terms of reducing expenditure by ensuring the best value for money with the organisation's partnership with Retinue.

Grow & Develop – Departmental fire training has remained above target for four consecutive months. Basic Life Support training has declined for three months in a row. Whilst within statistical variation tolerances, contact made with the BLS delivery team to understand whether current levels of provision are adequate. Leadership programme launched – pilot workshops in June ahead of open programme commencing in July. 474 places booked to date.

Engage & Involve – Behavioural Standards Framework (BSF) refresh commenced in June: conversations have been opened with colleagues via multiple routes: a digital survey, culture and leadership roadshows, BSF face to face pop ups around Trust sites and Microsoft Teams engagement sessions. Culture and leadership roadshow took place through June, connecting with colleagues across UHMB. WRES data shows some positive signs for UHMB and improvements in several areas.

Health & Wellbeing – Attendance has been a concern this month with attendance dropping to 92.2% daily rate. Covid related absence is the biggest driver for this after almost doubling in month from 0.9% to 1.7%. Non-Covid has seen a slight rise due to a number of short-term illnesses that have been reported. From 07 July 2022 the COVID terms and conditions will

be withdrawn and there will be no special leave arrangements for isolation with pay reverting to normal contractual provisions. Any colleague who remains absent as of 07 July will be transitioned back to normal arrangements by 01 September. Demand for psychological support remains high with a total number of 266 consultations carried out. Planning has continued for the roll out of EASE service, which will give early access to sickness absence support, service to commence from 04 July. This service is a measure to assist with the reduction of absence by referring colleagues on Day 1 of absence to OH for either MSK or Psychological support services.

AGREED: The Committee:

- noted the contents of the report

ACTION:

- Bridget to link with Lorna regarding Basic Life Support, Paediatric and Advanced Life Support training and report back to the PC in September

35. LONG COVID ABSENCE REVIEW

Consideration was given to the report presented by Lyn Hadwin.

The Committee noted the number of colleagues still absent due to Long Covid, in particular concern regarding 14 who do not have a return plan in place. It was also noted that the Covid terms and conditions have now been withdrawn so colleagues absent with Covid from 07 July 2022, will be classed as sickness absence and those currently absent with Covid will have a phased transition approach from September. Concerns have been raised by Union colleagues regarding the removal of the terms and conditions and what this will mean for colleagues who do not have a return to work plan. Ben outlined the risk of asymptomatic positive-testing colleagues who may choose to work to avoid sickness absence, therefore causing a wider impact on patients in addition to colleagues. Hannah requested that the ethnicity of the affected colleagues is determined to check if there are any BAME colleagues who are being disproportionately affected and suggested that an Equality Impact Assessment is carried out.

The Committee noted that the Trust will continue to work empathetically and compassionately with colleagues affected with support for them to return to work.

AGREED: The Committee:

- noted the number of colleagues absent due to Long Covid
- noted the support in place for these colleagues
- noted the return to normal contractual arrangements

ACTION

- Lyn Hadwin to carry out an Equality Impact Assessment

36. EMPLOYEE RELATIONS UPDATE

Consideration was given to the report by Lyn Hadwin.

The Committee noted that future ER reports will be produced from the new Case Management system which will include an equality lens. It is anticipated the first of these new reports will be generated for the September Committee and Board. Lyn highlighted to the Committee that there is one additional employment tribunal. The Committee were

assured by the positive position in respect of Urology. It was noted that future reports should include teams which would benefit from on-going, long-term support but consideration would need to be given to the capacity of the team who are delivering the support.

AGREED: The Committee:

- Noted that hotspot areas continue to progress and where there is formal action underway, this is closely overseen by the Deputy Director of People & OD to ensure that cases are progressing as timely as possible

ACTION:

- Lyn, Hannah & Ben to develop a brief report for the Board and Governors highlighting the learning and progress which the team have made to increase the profile and recognition of the work which has taken place, with the focus being on learning. Ben suggested a review on how impactful the support was offered to the Stroke Services & Maternity teams following the CQC and Ockenden reports. To be developed with a view to presenting at the September Committee.

37. PEOPLE & OD STRATEGY GROUP

3A key issues report and actions received and noted.

38. CULTURAL TRANSFORMATION PROGRAMME BOARD

Minutes and 3A key issues report not available at the time of papers being circulated for the People Committee.

39. JOINT LOCAL NEGOTIATING COMMITTEE (JLNC)

No meeting was held in May 2022 therefore no 3A key issues report or minutes were available.

40. PARTNERSHIP NEGOTIATING CONSULTATIVE COMMITTEE

Draft minutes were received and noted.

41. INCLUSION AND DIVERSITY STEERING GROUP

3A key issues report was not available.

42. CYCLE OF BUSINESS

The Chair noted the proposal of two items: (a) the Guardian of Safe Working Hours quarterly report is added to the Cycle of Business and (b) the P&OD Senior Team are able to submit further items for consideration on the Cycle of Business and we will receive any further items in future meetings.

43. ATTENDANCE MONITORING REGISTER

The Committee noted that the meeting was well attended with core members of the Committee.

44. ANY OTHER BUSINESS

- **3A'S REPORT** – The Chair to discuss with Caroline Chubb.

AGREED: The Committee agreed that the level of Assurance at today's Committee was Moderate.

DATE AND TIME OF NEXT MEETING:

People Committee Meeting: Monday 26 September 2022, 09:30–11.30 via M/S Teams

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Minutes of the Audit Committee held on Thursday 25 August 2022 in the Board Room, Westmorland General Hospital, Kendal LA9 7RG

The meeting also took place via Microsoft Teams.

Present:	Liz Sedgley (LS-NED)	Non-Executive Director (Chair)
	Adrian Leather (AL-NED)	Non-Executive Director
	Sarah Rees (SR-NED)	Non-Executive Director
In Attendance:	Chris Adcock (CA)	Chief Financial Officer / Deputy Chief Executive
		Mersey Internal Audit Agency
	Richard Anderson (RA)	Engagement Manager
	Nicola Barnes	Grant Thornton
	Louise Cobain (LC)	Trust Board Administrator
		Executive Director – Assurance
	Paul Jones (PJ)	Mersey Internal Audit Agency
	Michael McCarthy (MM)	Company Secretary
	Sarah Nicholls (SN)	Finance Manager
	Damian Price (DP)	Head of Medical Devices (for 22/45 only)
	Richard Sachs (RS)	Director of Governance
	Jane Stanley (JS)	Head of Financial Services
	Lisa Warner (LW)	Internal Audit Manager

22/42 Welcome and Introductions

Apologies

Apologies were received from Karen Deeny, Gareth Kelly, Neil McQueen, Tim Povall, Hugh Reeve, Jill Stannard and Steve Ward.

Declarations of Conflicts of Interest

None.

22/43 Minutes of the Audit Committee held on 21 June 2022

22/35e – Audit Finding Report
CA clarified his comments in relation to point 17 regarding stroke care provision.

Decision: That, subject to the above amendment, the Minutes of the meetings held on 21 June 2022 be agreed as an accurate record.

22/44 Action Sheet and Matters Arising from the Minutes of the Audit Committee held on 14 April 2022

Decision: The Committee considered the action sheet and noted the actions taken.

22/45 Internal Audit Reports

Internal Audit Progress Report

Consideration was given to a report presented by LW.

The following points were made in discussion:

1. LW advised she had invited MM to present the IT and medical devices audit reports.
2. MM presented the medical devices audit report advising the opinion was *Limited Assurance*. Areas of good practice had been identified with areas for improvement. There were two high risks in relation to medical device management which had identified gaps in the medical devices register with no regular risk assessments undertaken across the Trust. The second high risk recommendation related to security and software as some devices did not meet the requirement of the Trust's password policy.
3. MM provided a briefing on the data toolkit audit report. The Trust's self-assessment was fair as the opinion was *Substantial Assurance*. There were a few areas for improvement but nothing significant to alert the Committee.
4. LW advised the payroll / ESR report had provided an overall opinion of *Moderate Assurance*. LW outlined the recommendations of the report and explained that as all the recommendations had been completed, MIAA had closed them.
5. LW advised that in relation to the risk management report all but one of the recommendations had been addressed. MIAA would continue to attend the Risk Management Committee as this provided MIAA an opportunity to engage with the Trust regarding risk management. A follow up review would be carried out.
6. LW advised on status of the follow up reviews and explained there had been improved engagement on responses to the follow up requests. Fortnightly meetings with Sarah Nicholls had been established and this had helped to address any outstanding follow up recommendations.
7. LW advised the Director of People and OD had requested a review of the additional activity payments made to one consultant who had been identified as the highest earner. This formed part of the highest earners report which would be presented to the Remuneration Committee later on today. A number of actions were underway to address this.
8. LW advised there were two proposed changes to the audit plan: Since the audit plan was approved, NHSE had requested nationally that all NHS organisations undertake a self-assessment by 30 September 2022 against the HFMA checklist, *Improving Financial Sustainability in the NHS, are you getting the basics right?* The Director of Governance requested that a review of Incident Reporting is included in the audit plan for 2022/23 to provide assurances on the improvements that had been made to the processes.
9. Progress against the audit plan was outlined. A number of reviews were underway and on track to enable the Head of Internal Audit Opinion to be delivered by 31 March 2023.

During deliberation of this item the following points were considered:

10. In relation to the medical devices report, LS-NED sought assurance on actions taken to mitigate the risks and address the recommendations. MM advised there were mitigations in place.

11. SR-NED sought assurance on how the Committee would be assured that the recommendations of the medical devices report had been completed.
12. DP advised that most of the actions linked to the medical devices report were contained in the risk register with an action plan within medical engineering. DP advised a lot of the actions were around data holding. Mechanisms were in place to improve the recording of data but acknowledged there were risks. In terms of password complexity, there were a number of issues; a lot of medical devices were not domain-controlled and therefore the Trust enforced password complexity was not enforced on those devices, as this was the way medical devices were designed. Security on medical devices was not as advanced due to the nature of how medical devices were developed. DP would share the action plan with the Audit Committee for information to demonstrate how the recommendations were being addressed. SR-NED sought assurance on the reporting mechanism of the action plan. DP advised initial reporting would be to the Medical Devices Management Group which reported to the Health and Safety Committee.
13. MM advised a follow up review would be undertaken to ensure the actions were completed.
14. CA commented on the importance of ensuring the risk register captured the nature of the risks and this would be monitored through that process. As SIRO, CA would seek additional assurance from the Information Governance Manager and Chief Information Officer to ensure any risk reporting and actions plans regarding information governance were connected to I3. CA agreed to follow this up.
15. To reassure the Committee of the reporting mechanism to ensure the actions had been completed, RS advised DP attended Health and Safety Committee which reported to the Risk Management Committee of which MIAA attended.
16. CA sought assurance on the risk articulated by DP regarding medical devices lagging behind in terms of passwords and whether this was consistent with other organisations. MM advised that DP point regarding medical devices was accurate as they did not have the same level of security. It was an NHS wide issue which was becoming more prominent.
17. SR-NED was assured by the monitoring mechanism.
18. LS-NED recognised that there were risks and DP would review the medical devices across the Trust. DP advised on the actions taking place to mitigate the risk of cyber-attacks. Need to ensure moving forward we have them patched. Working with Lee Coward in I3 re cirlera. One of the main issues with medical devices – the roadmap for Microsoft and medical devices do not run on the same path, we do have a number of medical devices running on previous iterations of Microsoft without investing in new equipment.
19. LS-NED requested a follow up report in six months' time.
20. LS-NED acknowledged the work done to address the outstanding follow up actions and thanked those involved.
21. LS-NED invited the Committee's view on the request to review of the additional activity payments made to one consultant who had been identified as the highest earner.
22. RA advised that within the Niche recommendations, it was recommended that audit reviews were carried out as part of a group rather than individual consultant[*please see footnote].
23. CA advised that the response to this issue also included the establishment of a Pay Control Board. The Financial Improvement Group reviewed the brief and remit of this. CA suggested LW met with SN to discuss this further. CA reminded the Committee of the process in terms of decisions regarding the internal audit plan.

24. PJ advised that this request was very specific to an outlier in terms of the typical range of high earners. The schedule of business of the Remuneration Committee included annual submission of a highest earner report and the review was commissioned by the fact that this was a particular outlier. On the basis of evidence reviewed, this was the only outlier that had been identified. The Committee considered the benefit of a wider report and as this was the only outlier that had been identified, the Committee agreed a wider report was not required at this stage.
25. CA suggested the controls be reviewed to understand how the outlier occurred. If there was a singular review, it would be sensible to describe it as a prelude to the process work which would avoid contradicting the Niche recommendation.
26. LW noted the Committee's comments and suggested a review of the processes in place to approve additional activity payments with a focused review of the particular clinician.
27. SR-NED supported PJ comment that this referred to a significant outlier and in view of the Niche recommendation, the Committee should consider widening out the review with discussions at the Remuneration Committee to understand how the outlier arose.
28. RS advised he would review the specific recommendation from Niche said in this regard and share with the relevant colleagues to apply to this circumstance.
29. LW advised she would be required to review the internal audit plan if the remit of this particular review was widened.

Decision: That the Committee approved the changes to the audit plan.

**footnote: Following the meeting RS advised the Chair of the Committee that in relation to an individual's practice requiring scrutiny and whether it should be contextualised against peers, RS advised the origin of the idea stemmed from the commissioning of the Royal College of Surgeons trauma and orthopaedic review, which sought to examine the practice of a single clinician and was undertaken without benchmark against suitable peers.*

Terms of Reference for the Improving NHS Financial Sustainability Internal Audit Review

30. Consideration was given to a report presented by LW.

Decision: That the report be noted.

Insight Progress Update Report

31. Consideration was given to a report presented by LW.

Decision: That the report be noted.

Anti-Fraud Update Report

Consideration was given to a report presented by LW.

The following points were made in discussion:
32. There were no issues to alert the Committee.
33. The key messages were outlined in the report.

During deliberation of this item the following points were considered:

34. AL-NED sought assurance on the process for pre-employment checking.
35. LW advised that the workforce team undertook the appropriate checks which were recorded on the Trust's TRAC system.
36. PJ advised the TRAC system and the pre-employment checks were prescribed on the system. There was a risk of individuals providing false information. The purpose of the review was to mitigate the gaps identified. It was agreed the anti-fraud specialist would share the Terms of Reference of the locum use / pre-employment checks review with the People Committee to share the scope of the review and provide assurance to the Committee that the gaps identified had been addressed.

Decision:

1. That the report be noted; and
2. The Anti-Fraud Specialist would share the Terms of Reference of the locum use / pre-employment checks review with the People Committee.

22/46 Annual Report and Accounts 2021/22: Auditor's Annual Report on University Hospitals of Morecambe Bay NHS Foundation Trust

Consideration was given to a report presented by RA.

The following points were made in discussion:

1. RA presented the draft report which included the findings on the financial standards and value for money conclusion. There were areas in the report which had been reviewed by the relevant executives to respond to the recommendations, particularly in response to the IT control weakness, New Hospital Programme, payroll leavers and context around the Recovery Support Programme. The report would be finalised once all the management responses had been collated to enable the Trust to publish its annual report in line with the requirements of the Annual Reporting Manual.
2. RA highlighted the key messages of the report which included the 4 areas of significant weakness. At the meeting of the Audit Committee in June 2022, there were 3 areas of significant weakness. Since that time, RA and team had completed their work on governance in response to the findings of Care Quality Committee (CQC) , Niche and Royal College of Surgeons (RCS) reports and had concluded there was a significant weakness in that regard.
3. RA advised that 4 significant weaknesses in one report was large and consideration had been undertaken as whether to apply any statutory recommendations. This has been the challenge from Grant Thornton's internal panel. Following deliberation, it was agreed implementation of statutory recommendations was not appropriate in view of the progress the Trust was making to strengthen arrangements of the significant weaknesses identified and the fact that the Trust had been transparent on this. RA advised that although this assessment would be kept under review, the external auditors were satisfied at the moment not to execute their statutory powers.
4. Regarding financial sustainability, the external auditors acknowledged the work in year to develop and strengthen arrangements and develop a medium to long term plan setting out what would be required to return the Trust to a financially sustainable organisations in the medium term. The improvements had been noted recognising the 2022/23 plan was a stretching plan with risks to its delivery and in terms of the medium to longer term, these were still to be developed.

5. RA advised that overall the external auditors recognised the improvements made and the trajectory was positive, but the significant weaknesses remained.
6. In relation to the provision of stroke care, Grant Thornton secured the support of a clinical governance specialist to review this and the Trust's response to the CQC Section 31 Notice. The external auditors recognised the improvements, particularly the SSNAP data which had been referenced in the report. In terms of reaching a conclusion, it had been agreed that this significant weakness could not be removed as the Section 31 Notice had not been removed formally.
7. RA advised that in relation to governance, the clinical governance specialist reviewed the CQC improvement plan and responses to the Niche and RSP recommendations. The work done to ensure connectivity with the recovery support programme had been recognised. The process for monitoring, however, had not been standardised with no formal process embedded to ensure the actions and improvements implemented were sustained. It was for this reason the significant weakness remained.
8. Regard the IT control environment significant weakness, weaknesses had been identified within the main accounting system and the risk it exposed the Trust to. RA advised that this finding referred to the risk as opposed to anything witnessed through the year. The next agenda item would outline the Trust's response to this.

During deliberation of this item the following points were considered:

9. AL-NED sought assurance on the rationale for the significant weakness of financial sustainability recognising the lack of a plan covering all 5 years. RA acknowledged that the Trust had put in arrangements to deliver a medium-term financial plan through the sustainable financial improvement plan and the workstreams, and that financial sustainability was a key priority of the Trust. The significant weakness was due to the fact that this had not translated into detailed delivery plans to make the necessary savings.
10. RS advised that the Board of Directors received monthly update reports in relation to progress against the recommendations of the CQC, Niche and RCS reports. The governance structures had been reinforced by the PDSA cycle through the Good Governance Institute review to embed structures along with robust project management arrangements for Niche and CQC *must do* and *should do* actions.
11. CA noted a 5 year financial plan at that level of detail would be challenging at years 3 and 4. The report did reference the Trust's placement of System Oversight (SOF) Level 4 and the actions against the recovery support programme.
12. RA advised that they undertook audits of a number of NHS providers and when a significant weakness was reported, this was discussed by an internal panel. Looking at UHMB, key considerations were the size of the underlying deficit, the level of savings required to deliver the 2022/23 financial plan and the level of savings over the medium term.
13. RA advised that in relation to the IT control environment, the audit code of practice highlighted a range of different areas for comment which may be indicative of weaknesses and arrangements. A specialist team with an understanding of the system the Trust was using carried out the review and it was their view that it did expose the Trust to a significant risk and before the mitigations were put in place, they reached an opinion of significant weakness.
14. RA agreed to work with CA on how to better articulate the work of the recovery support programme before the report was finalised.

15. CA acknowledged the scale of deficit and the underlying deficit warranted the concern raised. Regarding the recovery support programme, the view of the Intensive Support Director would be sought to ensure the work of the Trust had been reflected in the report.
16. SR-NED sought assurance on the governance section as the management response did not address the AMAT issue.
17. RS advised that in terms of AMAT, work had been undertaken to strengthen the processes around the placement of information on AMAT. Critical to this work was the quality assurance of the information placed on AMAT. It was agreed the management commentary would be updated to reflect this.
18. SR-NED encouraged a review of the commentary to demonstrate improvements made. The Trust had submitted evidence to NHSIE on this matter and suggested the report reflected the evidence tested with external partners as well as the work done internally.
19. RS advised that it was an unfortunate timing mismatch as Grant Thornton were looking to seek evidence of sustainability and it was too early to be able to demonstrate this robustly.
20. RA advised Grant Thornton took into consideration other external assurance arrangements. Grant Thornton sought the support of a clinical governance specialist of this particular area.
21. CA acknowledged SR-NED comment and suggested reviewing the exit criteria of SOF level 4 to avoid an external audit report which contradicted the Trust's progress to SOF level 3.
22. LS-NED acknowledged CA comments regarding financial sustainability and noted the scale of the underlying deficit. It was important to show the Trust were addressing the underlying deficit.
23. CA advised he was not disputing the scale and challenge of addressing the underlying financial deficit.
24. LS-NED suggested that at the meeting of the Audit Committee in January 2023, a discussion around the potential significant weaknesses for 2022/23 and the progress made in responding this was undertaken.
25. PJ outlined the timetable to lay the Annual Report and Accounts 2022/23. PJ proposed further amendments to the report was made to reflect discussions at today's meeting and suggested reconvening a meeting on 31 August 2022 approve the final report in order send the Annual Report and Accounts for checking to the Parliamentary team by 2 September 2022 so the report could be laid w/c 12 September 2022.

Decision:

1. That the report be noted; and
2. That the Committee agreed to meet on 31 August 2022 to consider the final auditor's report.

22/47 Trust Response to the Recommendations set out in the Audit Findings Report

Consideration was given to a report presented by JS.

The following points were made in discussion:

1. The report set out the Trust's response to the recommendations made in the Audit Findings Report for the year 2021/22.
2. The risks identified in relation to the IT control environment and payroll control staff leaving the organisation were set out in the report. The report set out the actions to address the risks identified in the report.

During deliberation of this item the following points were considered:

3. CA advised that in relation to payroll control of staff leaving the organisation, this had been raised with the Care Groups at their performance meetings in July 2022 with follow up discussions at the meetings in September 2022.
4. In relation to the oracle system weakness, LS-NED sought assurance that the issues would be addressed. JS outlined the actions that had been done to date in terms of addressing the immediate issues. There were underlying risks and there was no evidence that the controls had been compromised. JS advised the Trust was looking to explore the expertise of an external organisation in the short term to provide support. Work was ongoing to address the longer-term actions.
5. LS-NED requested an update in January 2023.

Decision:

1. That the report be noted;
2. That a further update on the work undertaken to address the recommendations of the audit findings report be presented at the Audit Committee on 19 January 2023.

22/48 Head of Financial Services Update

Consideration was given to a report presented by JS.
The following points were made in discussion:

1. JS advised the reports set out the key messages.
2. There had been a breach of a single quote waiver which had been outlined in the report.

During deliberation of this item the following points were considered:

3. In relation to overpayment of salaries, AL-NED sought assurance the Trust's payroll provider was fit for purpose. JS advised that 70% of overpayment of salaries was due to the fact that managers did not update the system once a member of staff had left the Trust. There were no issues of accuracy from the payroll provider.
4. LS-NED noted that this had been raised amongst the Care Groups in terms of financial accountability responsibilities.
5. The Committee approved the new format of the report.

Decision: That the report be noted.

22/49 Clinical Audit Forward Plan 2022/23

Consideration was given to a report presented by HP.

The following points were made in discussion:

1. HP presented the clinical audit forward plan for 2022/23. The audit included must-do audits required by NHS Trusts. The Trust conneded with the national database to review all national audits the Trust was eligible to participate in; these were then discussed and included in the plan.
2. There were 152 audits of which 95% were prioritised. The plan outlined the different speciality levels.
3. HP advised the Care Groups had reviewed the plan.
4. The Quality Committee had approved the plan in April 2022.

During deliberation of this item the following points were considered:

5. SR-NED sought assurance on the process for monitoring the audits as many of them were due to report in March 2023.
6. HP advised that the audits identified on the plan were monitored regularly. Exceptions were reported to the Clinical Audit Standards Groups and the Care Group Assurance Group meetings.

Decision: That the report be noted.

22/50 Personal Data Related Incidents

Consideration was given to a report presented by PJ.

The following points were made in discussion:

1. PJ advised that during presentation of the Annual Governance Statement (AGS) at a previous meeting of the Committee, the high number of personal data incidents reports were noted and the Committee sought assurance on the learning of the personal data related incidents information contained within the AGS.
2. The report outlined the actions taken and set out the governance framework in relation to personal data related incidents.
3. There were no risks to alert the Committee.

Decision: That the report be noted.

22/51 Conflicts of Interest Update

Consideration was given to a report presented by PJ.

The following points were made in discussion:

1. This report provided assurance on the Trust's arrangements for managing conflicts of interest. PJ advised improvements had been made to systems and processes to ensure that more robust arrangements were in place to identify any breaches and improve management awareness.
2. MIAA would undertake a review of processes.
3. The report included data around the levels of declarations made, which showed an upward trajectory.

Decision:

1. That the report be noted;
2. The Committee noted the progress made and actions being taken in relation to breaches; and
3. The Committee approved the amendments to the Managing Conflicts of Interest Policy.

22/52 Update on Revisions to NHS Code of Governance

Consideration was given to a report presented by PJ.

The following points were made in discussion:

1. PJ advised the report set out the proposed revisions to the NHS Code of Governance. This aligned with changes to the Financial Standards Conduct arrangements and reflected the new legislation in terms of system working.

During deliberation of this item the following points were considered:
2. LS-NED sought assurance on the implications of recruiting Non-Executive Directors.
3. PJ advised that Foundation Trusts could appoint Non-Executive Directors with governors and the appointment process for NHS Trusts included the involvement of NHSI/E.

Decision: That the report be noted.

22/53i Board Assurance Framework Update Report

Consideration was given to a report presented by PJ.

The following points were made in discussion:
1. PJ advised the report provided an update on the operation of the Board Assurance Framework (BAF) and alignment of the internal audit plan.
2. The report set out improvements suggested by MIAA following their review of the BAF. Data was more specific in terms the assurances that had been received by the Board and its Committees. Mitigating actions had been assigned to a Senior Responsible Officer with time frames for delivery. These actions would be tracked through the Assurance Committees.
3. The form and content of the BAF would be kept under review and bench marking with other Trust's was planned for quarter 2 of 2022/23 which would be targeted at another North West Trust in System Oversight Framework (SOF) level 4.
4. PJ advised the internal audit activity would form part of the Assurance Framework for 2022/23.

During deliberation of this item the following points were considered:
5. SR-NED sought assurance on Committee reporting in relation to BAF. PJ advised the form and content of the BAF had been reviewed with greater assurance on actions. A review of the BAF was undertaken by the Good Governance Institute and a benchmark exercise would be undertaken with a further report to the next Committee in October 2022.
6. LS-NED suggested the bench marking exercise included an organisation in SOF level 2. PJ advised this would be included.
7. SR-NED supported LS-NED suggestion and given the ambition to progress to SOF levels 3 and 2, agreed this would be helpful.

Decision:
1. The Committee noted the report, and that further work would continue to review the form and content of the Board Assurance Framework; and
2. That a further report presenting the outcome of the benchmarking review would be presented to the Audit Committee on 20 October 2022.

22/53ii Risk Management Group Annual Report 2021/22

Consideration was given to a report presented by PJ.

The following points were made in discussion:
1. The report set out the risk management processes. The report included the annual report of the Risk Management Group which demonstrated the

improvements made over the last 12 months.

During deliberation of this item the following points were considered:

2. LS-NED sought assurance on feedback from the Care Groups regarding the processes for risk management.
3. PJ advised that Becky Southall had been supporting the Chief Nursing Officer and Director of Governance to review this. The Board of Directors would receive a revised quality governance and accountability framework for consideration which would demonstrate the amendments to the structures. PJ suggested inviting the Care Groups to the Committee in few months' time which would allow time for the new structure to be embedded.
4. SR-NED sought assurance on whether the risk management group be included on the Committee's schedule.
5. PJ advised the Terms of Reference of the Committee state that the Committee review the Board Assurance Framework. It was felt the annual report of the Risk Management Group would be helpful to share with the Committee to demonstrate triangulation of information received by MIAA regarding risk management.
6. LS-NED suggested that given governance had been identified as a significant weakness by the external auditors, a quarterly update on risk management was included in the schedule along with an annual report from the Risk Management Group.

Decision:

1. That the report be noted; and
2. The Committee's Schedule of Business be updated to include quarterly updates on risk management, including an annual report from the Risk Management Group.

22/53iii Update on Fraud Risk Exercise

Consideration was given to a report presented by Paul Jones (PJ).

The following points were made in discussion:

1. PJ advised that MIAA has had a robust fraud risk assessment methodology in place with its Trust clients which met the requirements of the NHS Counter Fraud Authority (NHSCFA) Standards for Providers. However, a new Government Functional Counter Fraud Standard, adapted for the NHS, required health bodies to undertake a baseline assessment against that standard.
2. Since the new Functional Standard was identified as a requirement, the NHSCFA, via their 'fraud risk knowledge hub', had shared template documents, held online seminars and provided general guidance to the AFS community as to how to undertake the risk assessment process to met the new national requirement. Based on that guidance, MIAA's Anti-Fraud Service had completed updating its fraud risk assessment toolkit for Trust providers.
3. In total, of the 120+ fraud risks which had been identified across the NHS, 57 of these had been determined as being applicable to Trusts. Due to similarities in those risks and their associated countermeasures, some of those 57 risks had been further condensed and grouped, resulting in around 40 key risks to be considered in the risk assessment. The 40 risks had been further categorised under 7 thematic / strategic, fraud risk headings.
4. PJ advised that it was not the intention to include all 40 risks on risk registers, rather that the 7 thematic areas (including the NHS staff sub-categories) be

recommended for inclusion on the Trust's risk register.

5. PJ explained the Trust had a single generic fraud risk and proposed that this be closed and replaced with the 7 thematic risks. A further report would be presented to the Audit Committee on those fraud risks.

Decision:

1. That the report be noted; and
2. That a further report on the 7 thematic fraud risks be presented to a future Audit Committee.

22/54 Items to be recommended for decision or discussion by the Board or other Committees

Decision:

1. The Auditor's Annual Report identified significant weaknesses in financial sustainability and governance; and
2. It was agreed that the final version of the Auditor's Annual Report would be presented for approval to the Audit Committee on 31 August 2022.

22/55 Schedule of Business

Noted.

22/56 Attendance Monitoring Register

Noted.

22/57 Urgent business

None.

22/58 Date and time of next meeting:

It was noted that the next meeting of the Audit Committee would be held on Thursday 20 October 2022 in the Board Room, Westmorland General Hospital, Kendal LA9 7RG and also via Microsoft Teams.

Minutes of the Audit Committee held on Wednesday 31 August 2022 in the Board Room, Westmorland General Hospital, Kendal LA9 7RG

The meeting also took place via Microsoft Teams.

Present:	Liz Sedgley (LS-NED)	Non-Executive Director (Chair)
	Sarah Rees (SR-NED)	Non-Executive Director
	Jill Stannard (JS-NED)	Non-Executive Director
	Stephen Ward (SW-NED)	Non-Executive Director
In Attendance:	Richard Anderson (RA)	Engagement Manager Grant Thornton
	Nicola Barnes	Trust Board Administrator
	Paul Jones (PJ)	Company Secretary
	Gareth Kelly (GK)	Engagement Lead Grant Thornton
	Tim Povall (TP)	Operational Director of Finance
	Jane Stanley (JS)	Head of Financial Services

22/59 Welcome and Introductions

Apologies

Apologies were received from Karen Deeny, Adrian Leather and Hugh Reeve.

Declarations of Conflicts of Interest

None.

22/60 Annual Report and Accounts 2021/22: Auditor's Annual Report on University Hospitals of Morecambe Bay NHS Foundation Trust

Consideration was given to a report.

The following points were made in discussion:

1. PJ advised that at the Audit Committee on 25 August 2022, the Committee received a draft version of the auditor's annual report and noted external audit work had progressed to the point that the Value for Money work had been completed and a draft report had been shared for a management response. Management responses had been received in respect of financial sustainability and governance and were supported by the Committee. Further responses were required in relation to the New Hospitals Programme and overpayments to staff. Various revisions had been made to the report which were presented for the Committee's consideration.
2. RA outlined the changes that had been made to the report and advised there were no significant changes. The first section of the report had been updated in relation to the significant weakness of financial sustainability to reflect discussions by the Committee on 25 August 2022. RA explained the key factor

driving the significant weakness of financial sustainability was the underlying scale of the financial deficit and the fact that the Trust did not have a detailed plan to address that

3. In relation to the IT control environment, no management response had been included in the draft version of the report presented to the Audit Committee on 25 August 2022. The report had, however, been updated to include the detailed report presented by the Head of Financial Services at the Audit Committee on 25 August 2022.
4. RA advised comments from the Trust's Intensive Support Director regarding the recovery support programme and maternity improvements had been included in the revised version of the report.
5. RA explained the report had been updated to reflect the relationship between development of the clinical strategy and the inter-dependency with the medium-term financial plan to ensure that the link was explicit in the report.
6. TP suggested that in terms of workforce and capital, reference to estates and IT be included for completeness.
7. TP and PJ explained that the Board of Directors had approved the quality governance and accountability framework at their meeting on 31 August 2022. RA agreed to update the report to reflect this.
8. RA advised that the report had been updated to reflect the changes to clinical leadership.

During deliberation of this item the following points were considered:

9. SR-NED outlined the typo error on page 38 of the report.
10. PJ shared the Intensive Support Director's comments with the Committee and explained that the Chief Financial Officer had requested the improvement team review the draft report to ensure the management responses had been accurately reflected in respect of the significant weaknesses identified by the external auditors.
11. TP thanked all colleagues for their contribution to the management response.
12. LS-NED thanked all colleagues involved in preparing the annual report and accounts.

Decision: That the Committee approved the auditor's report.

22/61 Items to be recommended for decision or discussion by the Board or other Committees

None.

22/62 Date and time of next meeting:

It was noted that the next meeting of the Audit Committee would be held on 20 October 2022 at 9am in the Board Room, Westmorland General Hospital, Kendal LA9 7RG and also via Microsoft Teams.

Minutes of the Finance Committee held on Monday 26 September 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:	Joanne Myers Suzanne Hargreaves Juliet Wearing Jim Collins (Item 22/62) Jane Stanley (Item 22/67) Angela Parfitt (Item 22/69) Nicola Crossman	Interim Head of Financial Management Associate Director of Strategy & Transformation Finance Manager, Income & Costing Head of Integrated Procurement & Supplies Head of Financial Services Deputy Director of Clinical Governance Minute Secretary
22/59	**Welcome and Introductions** **Apologies for Absence** Apologies were noted from Bridget Lees, Richard Sachs, Andy Wicks, Jane McNicholas, Tim Povall and Ian Lacey. Although the meeting was quorate, it was noted that neither the Chief Medical Officer nor the Executive Chief Nurse were present. **Declarations of Conflicts of Interest** None.	
22/60	**Minutes of the Finance Committee held on 8 August 2022** **Decision:** The minutes of the meeting held on 8 August 2022 were agreed as an accurate record.	
22/61	**Action Sheet and Matters Arising from the Finance Committee held on 8 August 2022** The action to facilitate a Cyber deep dive and identify how the Trust's Digital Strategy supports System and National NHS objectives will be carried forward to October 2022. **Decision:** The Committee noted the progress against the actions.	
22/62	**Chief Financial Officer's Report** CA provided a brief overview of the report provided in the pack which was accepted as read.	

	A set of formalised agreements relating to the system roadmap was anticipated ahead of consideration by the Provider Collaborative Board in October 2022 and would be documented formally, for the Committee at its next meeting, as part of the Month 6 review of the first half of the year, and as a documented risk-based review of the forecast. The Head of Procurement & Supplies (JC) joined the meeting to provide an update on the electricity contract following a previous update to the Board of Directors. Recent government intervention to introduce a cap, currently for 6 months only, and energy providers no longer offering contracts exceeding 12 months, meant a subsequent recommendation for Executive colleagues to authorise a 12-month contract which would see the expected cost-pressure reduce from £2m to circa. £800k dependent on market fluctuation. The Committee noted the update and recommendation for progression of the electricity contract with executive colleagues. **Decision:** The Committee noted the content of the Chief Financial Officer's report.
22/63	**Month 5 Financial Performance Report** JM outlined the Financial Performance Report that detailed the Trust's financial performance to the end of August 2022. Key items brought to the attention of the Committee: • Year to date deficit of £4.4m, was £127k worse than plan. This included projected slippage against the ICS stretch income. • Although the year to date position was positive actual Care Group performance had worsened by £1.3m, with pay and agency pay the maim pressure areas. • The Pay Control Board was not yet active. • For Q1 and Q2, there will be no clawback of accrued ERF income equating to approximately £3m, however there had been no indication for the second half of the financial year. • Since the time of writing, the BMA had issued a new increased rate card for consultants and SAS doctors. The Trust did not intend to support the rate card and several colleagues had indicated they would no longer undertake additional activity as a result. The main impact would be in Surgery & Critical Care and was a risk to the achievement of 104% activity target. Care Group and Finance colleagues were working on modelling and scenario planning which would be brought back to the Committee next month. • Some slippages in forecast savings and overall now forecast to achieve £2m less than forecast at month 4. An escalation process has been implemented where movement against key schemes were evidenced and reported to the Chief Financial Officer weekly. Further work required to identify slippage in year and whether recurrent savings will still be achieved. The following points were raised in consideration of the report:

	1. SW requested further information on the cause of delays in Retinue recruitment reported in Care Group reports. JM noted some delays in correct roles being put to market, but also national shortages for some roles. 2. SW queried the consistency of approach to the BMA rate card across ICS provider organisations. SM confirmed consistency between Workforce and Medical Directors which Chief Executives have sponsored and validated. UHMB will be impacted more severely than other providers. 3. For future reports, SW asked if it would be possible to isolate the financial cost of patients not meeting criteria to reside exceeding the planned assumptions. 4. CA noted slippage around savings had currently been offset by releasing provisions and some technical items. There was also a pipeline of savings that would offset that position within Care Groups. Through performance meetings, Care Groups had been tasked with documenting their plans to achieve savings, which CA would be reviewing along with best and realistic case projections with support from the Finance Director once in post. 5. In terms of the Pay Control Board, CA would establish with the workforce lead, what actions need to be in place to remobilise the controls to address agency rate of spend, which was currently projected to exceed the capped level as well as the planned level. 6. The issue to raise in the forecast is that the pressures get bigger, and the mitigations reduce, so it would be important to improve performance and escalate actions associated with that. 7. With reference to emerging risks described with not meeting criteria to reside and BMA rate card, etc, LS suggested the Board Assurance Framework risk for finance should be updated. CA agreed to review the Board Assurance Framework risk and in addition, noted that scenario modelling was being undertaken with regard to the BMA rate card which will be consistent with the modelling operational teams are doing in relation to not meeting criteria to reside. In terms of not meeting criteria to reside, recently re-calculated that the total cost is around £13m and the excess over planned levels would be around £10m for the full year. 8. KD asked where the challenges being described would be translated into patient level impact, experiences, and outcomes. SM outlined that the IPR and Winter Plan papers going to public board will reference risks around not meeting criteria to reside. Risks relating to the BMA rate card and not meeting criteria to reside, will need to be formally sighted by both the Finance and Performance and Quality Assurance Committees as well as the Board. KD emphasised the importance of extrapolating the implication for people and patients more explicitly through the Committees.

	9. SW requested comment on the results of the performance accountability framework meetings with Care Groups. CA updated the Committee that the third cycle of these meetings took place last week. Although it hadn't been possible to produce the output report for this meeting, that would be done in October. Review of process and feedback on key themes and messages post September reviews. Members of NHSE/I intensive support team joined the recent round of performance review meetings to look at how the process was conducted in support of well-led self-assessment. The output report in October will illustrate an evolution of input from Care Groups with different progress in different areas. There were key themes around workforce risks and particular focus on job planning and BMA rate cards. From October, the report would also advise on implementation of Care Group level metrics. 10. LS sought comment regarding inflation rate and dollar rate fall exposure. A detailed inflation rate tracker was now in place and as part of the Month 6 review, there would be an assessment of the excess cost of inflation incurred in the year to date. The forecast will include factors such as electricity impact, but in addition, an assessment of excess inflationary impact of other things like exchange rate risk would also be included. **Action: Review the Board Assurance Framework with reference to emerging risks described with not meeting criteria to reside and BMA rate card. – Lead CA** **Decision:** The Committee noted the content of the report.
22/64	**Operational Performance Report** SM outlined the Operational Performance report which set out key performance indicators and associated actions and assurance. The report was accepted as read. The following key points were drawn to the attention of the Committee: In relation to unscheduled care, deterioration in performance could be seen by any metric which continued into September where OPEL4 had been declared twice. The main issue noted was due to hospital occupancy driven by the rise of patients not meeting criteria to reside which currently stood at 153. The Winter Planning paper going to the Board this week would provide further detail on evolving plans to mitigate over the winter period. In cancer, a deterioration had been seen in several parameters, recognising an increase in referral demand, requiring 30-40 additional clinics per month to process. Detailed work completed in the three big pathways, colorectal, breast and urology, but the BMA rate card will affect the totality of RTT, so the focus would continue on cancer. RTT remained steady, hitting trajectory performance of 104 weeks, 78 weeks and 52 weeks and the waiting list size was reducing. Two-hour crisis response continues to perform at a reasonable and improving level. The following points were raised in consideration of the report:

	1. SW requested an update on discussions with the social care sector and wider ICS, specifically any feeling of improvement or movement in response. An improvement had been seen in senior level involvement in conversations across the system and region, but not enough traction in terms of a plan at this point. SM intended to bring a plan to Board that could unilaterally bring in additional domiciliary care over winter, although noted the significant risk that caried in the business-as-usual domiciliary care market. 2. KD queried if the Trust had looked at providers outside of the ICS with similar demographic and provider as well as social care challenges to identify potential solutions or mitigations we may not be sighted on. SM outlined an example from the Southwest, particularly focussing on attracting key workers and an emerging conversation here around a similar model. More information would be shared as the conversation matures. 3. LS raised a query regarding understanding the bed base in the community and numbers that should be aspired to. Providing domiciliary care packages in the system to provide care closer to or at home was key which goes back to the same point of workforce challenges. 4. SW asked to what extent is regular contact with MPs being sought to unlock some of the issues. At local elected member level, SM attending the health overview and scrutiny committee for Cumbria County Council. **Decision:** The Committee noted the report.
22/65	**Capital Schedule Update** The Committee received the Capital schedule update which was accepted as read. 1. KD sought clarity on how activity reflected in the report interfaced with organisational change and the processes that need to happen to deliver against projects. The capital programme was made up of different elements and this was more of an issue around developmental aspects of the programme. SM had already started conversations around the governance and oversight of the New Hospitals Programme, and CA had asked for a review and update of a series of things relating to the oversight of the capital programme and there would be opportunity to pick those issues up within that. Some good news stories relating to the Community Diagnostic Centres would get into the practicalities of how that is mobilised as it progresses, which is outside of the scope of this report currently but would enhance it going forward.

	In addition, SH outlined that IPG review all capital business cases and once cases are approved, they're subject to monitoring of benefits realisation. The IPG reports through the Committee and monitoring reports have begun to be reported to the TMG as well as featuring in performance reviews. As part of improved reporting and oversight arrangements, CA intended to provide better information about how things vary post approval from a capital perspective and possible implications, and that insight would be received by the Committee. 2. LS requested feedback from a recent update provided to the Committee on capital funds that had been made available nationally and the outcome of any bids submitted against that. Trying to improve coordination arrangements at a PCB level on that currently to include a clear feedback route. **Decision:** The Committee approved the Capital schedule update
22/66	**Investment and Priorities Group 3As Report** The Investment and Priorities summary reports for August and September 2022 were included for information and accepted as read. SH signalled a business case expected to come to the Committee for approval in October regarding the Outreach Acute Care Team, which had been subject to several iterations through IPG and TMG and would require some investment. **Decision:** The Committee noted the content of the report
22/67	**Insurance Renewals** JS provided an overview of the report to inform the Committee of the renewal of the Trust's insurance policies with effect from 1 October 2022. It was brought to the attention of the Committee that the property & business interruptions policy cover for additional costs of working in the event of catastrophic damage to buildings in the final policy terms stated in paragraph 15 of the report had been reduced from £5m to £1.5m . The recommendation that the Trust do not have cyber insurance at this time due to cost remained and a process to ascertain whether the Trust would be eligible for cyber insurance was underway. It was noted that consideration as part of the wider cyber security deep-dive in this regard would be beneficial. It was also noted that increases in insurance costs were likely going forward and were being seen across the board. The Committee were asked to approve the insurance costs as set out in the paper. The following points were raised in consideration of the report: 1. KD asked if there were any insight into how other Trusts are managing challenges around cyber insurance.

	Not many Trusts had taken cyber insurance due to the cost and the complexities in deciding the level of cover required. The I3 service keep the Trust up to date in terms of cyber security and insurance was under continuous review. 2. In terms of mitigation for cyber risk, SW noted that protection such as penetration testing was a more effective mitigation than gaining money back from insurance. 3. LS queried whether there was merit in escalating nationally with NHSI/E to cover cyber concerns. CA recommended that reference to cyber insurance concerns should be escalated to the SIRO at the ICB in the first instance which was currently the Chief Finance Officer, and the recently appointed Chief Information Officer. 4. Favourable developments overall in the clinical negligence premium were recognised. **Decision:** The Committee Approved the insurance costs as set out in the report.
22/68	**National Cost Collection Return** JW provided an overview of the report to update the Committee on the submission of the National Cost Collection for 2021/22 costs and activity, and to highlight the summary outputs regarding the costs and productivity of the Trust. The National cost collection return was submitted on 8 August 2022 and this was the first year the that community costing at patient level was submitted. The paper outlined the checks and reviews carried out throughout the year to support the accuracy of costing to ensure it's within NHS guidelines and it was also noted that work had already commenced towards next year's return. The information is used in national benchmarking and helps to compare to other Trusts and understand how our costs and case mix compare. The report includes information from 2020/21 and shows costs for the year were 19% higher than the national average and the model health system gives indicative figures of the opportunities for improvement based on average costs. The comparative information for 2021/22 was not yet available. The costing team were currently analysing the results of the 2021/22 information and a further paper was planned for next month to show where the potential benefits could be to support financial improvement and how the costing information would be taken forward. In consideration of the report the following points were raised: 1. SW asked whether there was a sense that the impact of COVID had settled to allow meaningful comparison. It was expected that 2021/22 will be better than 2020/21 although some COVID effect would remain particularly in the first part of the year when activity was taken down.

	2. CA noted that an extended version of the paper had been discussed as this was a massive exercise and rich source of data and therefore would like to explore how to use this within the planning round next year and align with opportunities identified within financial sustainability plans. In the context of the ICS, this is valuable information to share with other providers and should be a key factor in influencing new hospitals programme and clinical strategy across the region. 3. Is there a longer-term plan as more mature and granular detail emerges for interface with the performance accountability framework and where more effective savings could be? CA confirmed that this is what would be hoped to achieve by incorporating the data into the planning process. **Decision:** The Committee noted the content of the report
22/69	**CQC Update** AP provided an overview of a report to summarise the current position and progress of the Improvement plans in relation to this Committee. The report was accepted as read. Part of the exit criteria for SOF4 to ensure CQC actions were completed and for this Committee there were six must do and 10 should do actions or recommendations outstanding which were detailed within the report. Outstanding actions were allocated to Care Groups and reviewed on a cyclical basis with varied frequency ranging from weekly to monthly dependent of Care Group and the number of actions and recommendations outstanding. In terms of this Committee, 4 of 16 recommendations were complete, 1 awaiting approval but essentially complete, 6 were on track in progress, and 5 were overdue in terms of progress update and AP provided some further information on work underway to address overdue actions. In consideration of the report the following points were raised: 1. In relation to completed actions, KD asked what embedding assurance is in place. AP confirmed that for an action to be signed off as complete, there must be sufficient assurance that there has been a system change to enable governance processes within the organisation to pick up and monitor that process going forward. Part of that will be to ensure there is an oversight process in place or something else that gives assurance of on-going monitoring and escalation to ensure a more robust space to be able to articulate to the CQC and a lot of work has been done to link across to governance systems and processes. **Decision:** The Committee noted the content of the report
22/70	**New Hospitals Programme Flash Report** **Decision:** The Committee received and noted the content of the report.
22/71	**Schedule Of Business**

	The Chair encouraged Committee members to review and update the schedule of business. **Decision:** The Committee noted the Schedule of business
22/72	**Attendance Monitoring Register** **Decision:** The Committee noted the Attendance Monitoring Register.
22/73	**3As Report and Meeting Effectiveness**
22/74	**Any Urgent Business** None.
	Date, Time and Venue of Next Meeting It was noted that the next meeting of the Committee would be held on 24 October 2022 via Microsoft Teams.

Minutes of the Quality Assurance Committee Meeting held on Monday 26th September 2022

Present:	Hugh Reeve (HR) Bridget Lees (BL) Ameeta Joshi (AJ) Richard Sachs (RS)	Chair & Non-Executive Director Chief Nursing Officer Deputy Chief Medical Officer (deputising for CMO) Director of Governance
In attendance:	Simon Bradley (SBr) Lorraine Crossley-Close (LCC) Gregg Peers (GP) Barry Rigg (BR) Scott McLean (SMc) Emily Sidebottom (ES) Donna Southam (DS) Sarah Maguire (SM) Daniel Bakey (DB) Cathy Hay (CH) Vera Gotz (VG) Amy Mbuli (AM) Glyn Davies (GD) Gary Baker (SB) Lynne Wyre (LW) Ameeta Joshi (AJ) Dan West (DW) Heather Pratt (HP) Karen Deeney (KD) Emma Fitton (EF) Georgina Barber (GB)	Quality Improvement Lead, Morecambe Bay ICB Governor Governance Business Partner, S&CC Head of Patient Experience Chief Operating Officer Clinical Site Manager, T&O (Trauma & Orthopaedics) Quality, Safety & Assurance Lead Midwife Associate Chief Nurse Deputy Associate Director of Operations, SCC Deputy Chief Medical Officer Consultant Physician, Acute Medicine Clinical Lead, Head of Infection Prevention Estates Divisional Manager Assistant Manager, Sterile Services Deputy Chief Nursing Officer Deputy Chief Medical Officer Deputy Chief Nursing Officer Head of Compliance, Assurance and Clinical Audit Non-Executive Director, Board Maternity Safety Champion Associate Chief Nurse Executive Assistant to the Chief Nursing Officer
104	**Welcome and Introductions** Hugh Reeve opened the meeting at 13.00 and performed introductions. Karen Deeney was welcomed to the Committee by HR in her role as Maternity Safety Champion to the Board and Non-Executive Director. All report presenters were asked to accept reports as read and highlight salient points only due to the length of the agenda. **Apologies for Absence** Apologies were noted from Sarah Lees, Jane McNicholas, and Janet Pitman **Declarations of Conflicts of Interest** No Declarations of Interest were declared.	
105	**Minutes of the Quality Assurance Committee Meeting held on 26.09.2022** The minutes of the meeting held on 26.09.2022 were accepted as a true and accurate reflection following the amendments listed below. 1. Agenda item 72 Integrated Performance Report. Action to be amended to read ' Further information related to an increase in moderate and above incidents to be provided to HR prior to the Board meeting of 27.07.2022' 2. Agenda item 81 VTE (Venous Thromboembolism) Update Report. Bullet points 1 & 2 to be amended to read	

	'The 12 month annual combined VTE assessment currently sat at 86%' 'The day case compliance was currently sat at 17.7% and required more work to understand' 3. Agenda item 83 Review of the BAF (Board Assurance Framework). Amendment to HR comment 'HR (NED) praised the work of the Hive Group' **Decision:** 1. That the Minutes of the held on 26.09.2022 be agreed as an accurate record. **Action:** 1. The listed amendments be made to the minutes of 26.09.2022
106	**Action Sheet and Matters Arising from the Minutes of the Quality Assurance Committee on 26.09.2022** The Committee reviewed the action tracker and noted the updates. All actions were confirmed to be included on the agenda or scheduled beyond the date of the meeting. Action 74. RS agreed to provide an update at the October meeting. Action 80. GB agreed to remind IC Care Group of the required additions to their next quarterly update. **Decision:** 1. That the Quality Assurance Committee had considered the tracker sheet.
107	**Integrated Performance Report** The Committee considered the monthly IPR (Integrated Performance 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: - The organisation was in the process of changing to a new IPR and with SPC (Statistical Process Control) charts but work on the report for some of the Committees and Sub-Committees had not yet been completed, this meant that despite substantial amounts of narrative against the performance, the report did not specifically answer the "So What" question. Contributors to the report would be asked to focus on answering the question in their narrative to better indicate where and when improvements would be seen, what further opportunities there were to improve and where the Trust sat among peers and against national standards - The amount of work being undertaken but not reflected in the IPR was highlighted - The agenda pack for the System Improvement Board would be brought to the Committee in October to demonstrate the work being undertaken in Fundamentals of Care - Within VTE and mortality there had been some movement on data but it was not statistically significant. Further information on both would be covered later in the agenda by Ameeta Joshi During deliberation of the item the following points were made in discussion: KD (NED) discussed the current IPR, noting that there was a lack of reporting to show the impact of the data provided and the themes being scrutinised. BL advised that two functions of IPR were in use currently and once ongoing work on the report had been completed there would be a greater focus on the outcomes. HR (NED) noted several points:

	- Acronyms to be clarified in future reports - A 20% reduction in hospital acquired pressure ulcers was required from the Hive work, when would the impact be seen in the data? LW advised the data was currently available but it was too soon to see an impact. AM noted that wards had completed driver diagrams to show risks for pressure ulcers in their units. It was highlighted that there were currently no unstageable ulcers in the Trust - In relation to falls resulting in moderate or above harm, HR requested the harm occurred to be detailed. LW would action and confirmed that there was a 20% reduction in falls that cause harm and a further 20% reduction in general falls required - In relation to the incidents data it was highlighted that each month the graph indicated one Never Event with the text confirming none; RS would review and action - Improved performance in response times and complaints revisited were noted and the accompanying data in the appendix of the CQC report detailing how the improvement had been achieved was noted to have been useful KD (NED) requested further clarification for community onset (acquired by people in the community or those in the community under Trust care). BL discussed the need for a data dictionary to clarify, the data would be split in the new IPR. **Decision:** 1. That the report be noted. 2. That the report be approved for submission to the Board of Directors **Action:** 1. RS to review and amend the data related to Never Events.
108	**Monthly CQC (Care Quality Commission) & RCS (Royal College of Surgeons) Update** The Committee considered the monthly regulatory update which was presented by Richard Sachs (RS). The report summarised the Trust's current position and progress across the various improvement plans to address CQC must and should do recommendations and the Royal College of Surgeons recommendations. During a summary of the report the following key points were highlighted: - The report title on the agenda referenced Niche but it was clarified that a Niche update had been included in a separate report - Key details in the report provided assurance on the current position - Helen Kelly was supporting the Medicine Care Group to review and test their CQC Must and Should Do Actions - The Review and Support Panels were being held regularly and were reported to be working well. An ICB (Integrated Care Board) representative had been invited to attend the panels on a permanent basis - A Non-Executive Director had attended a recent panel and had provided useful feedback - A challenging winter was anticipated and it was acknowledged that this would impact on the time available for the team to progress on the CQC actions During deliberation of the item the following points were made in discussion: KD (NED) discussed concerns that in the current challenging climate there was a risk that improved ways of working and embedded actions could slip. RS confirmed that a

	new Deputy Director of Governance was in post and had brought with her considerable CQC experience; this had been applied to the Trust's actions, highlighting that some had been over complicated and would be reviewed in a more pragmatic way. The new governance structure in place would ensure actions and improvements were embedded into everyday business, with checks and triggers put in place to highlight any slippage. The Trust's diligence in addressing problems was discussed and it was acknowledged that the same energy now needed to be directed to ensuring a more proactive way of working, identifying, and addressing concerns before they affected patients. BL highlighted that the new governance process, the improved IPR, the richness of agendas across the new Committees and Sub-Committees, the performance reviews, and the ward to board dashboard, noting they would all play an integral part in enhancing current safeguards and ensuring the correct triggers were in place. The work was confirmed to be underway. SB updated that the ICB had welcomed the opportunity to review the CQC actions with the Trust and were supportive of the new approach. A new richness and robustness to evidence submitted had been noted and he confirmed that the ICB were happy to support the Trust with quality visits. HR (NED) noted that the August position showed 45 actions behind schedule and queried if this was a cause for concern. RS confirmed that they would be reviewed to ensure they were on track; it was highlighted that a number of actions required fundamental changes such as estate requirements. It was noted that a lag in movement in some actions could be attributed to a lack of evidence being available to close. **Decision:** 1. That the report be noted.
109	**Maternity Monthly Updates** The Committee considered the monthly update which were presented by Donna Southam. A suite of maternity updates were provided which included: **Maternity Monthly Assurance Report** - Collaborative work with Richard Sachs and his team had been undertaken to review the WACS actions and significant improvements had already seen - An increase in moderate and above harm had continued to be seen but this was noted to be harm that had occurred rather than caused, reported in line with CQC regulation guidance - A CQC request had been received following concerns raised by an employee around staffing levels - August fill rates had dipped below 80%, this had been attributed to planned annual leave in addition to sickness. Safety continued to be maintained and daily safety huddles were held to review and monitor - Anaesthetics continued to be challenging due to workforce issues - Progress was being seen in relation to the MSSP (Maternity Safety Support Programme) exit criteria KD (NED) discussed the moderate and above harms that had been reported, querying if there were wider implications or learning from these and how the Care Group were working with other system partners to share information. DS confirmed that work was ongoing with the governance team to ensure shared learning across the Trust and wider partners.

HR (NED) queried the August drop in midwifery fill rates, questioning if this were anticipated to be a one-off situation or if there was a concern that the Trust could not maintain appropriate staffing, acknowledging that maintaining fill rates was a national challenge. DS explained that August was renowned for being difficult in terms of staffing with planned annual leave, she confirmed that daily huddles to review staffing levels were held, that specialist midwives were picking up two clinical shifts a month to support, that nine international midwives were anticipated to start with the Trust in November and that rolling recruitment continued to ensure short and long term safe care.

Maternity Incentive Scheme Years 1 – 4 CNST (Clinical Negligence Scheme for Trusts)

- Progress to date for Year 4 CNST had been detailed within the report
- The date for submission had been pushed back from January 2023 to February 2023 to allow Trust's more time for mandatory training
- A change in guidance relating to Continuity of Carer had been received, with further information due in the next week; focus would be levelled at recruitment and retention

KD (NED) discussed the challenge related to mandatory training for obstetrics and anaesthetics, asking if there was any support that the QAC (Quality Assurance Committee) or the Board of Directors could provide. DS confirmed that obstetrics was being progressed with a trajectory in place but that further support with Anaesthetics would be appreciated, noting that progress remained static.

Ockenden Feedback and Action Plan

- The Trust had received a visit in July as part of ongoing assurance of compliance and sustainability; the Trust was found to be partially compliant with all seven EIA's
- A report had since been received which detailed recommendations and in response a robust action plan had been developed
- A multidisciplinary group had been formed
- The Insight Team planned to return to the Trust in October 2022 to support the improvement journey

KD (NED) noted that, following recommendation from the MSSP, a Safety Champions Quarterly Report would be submitted to the Quality Assurance Committee and the Board of Directors to ensure sufficient oversight of the work of the Safety Champions, the first of which was scheduled for submission in October.

NHSR (NHS Resolution) Action Plan

- The finding of an NHS Resolution Thematic Review were presented to the Trust in March 2022, in response an action plan had been developed to address the themes identified
- The Care Group Governance Assurance Group (CGGAG) would monitor progress against actions and regular updates would be shared with the Trust Board Safety Champions; NHS Resolutions would be kept up to date with progress

HR (NED) discussed the substantial number of actions from different reviews that sat with the WACS Care Group and the challenge and risks that they posed, suggesting that it would be useful to have a sense of how they were being integrated and pulled together in the next report.

	Decision: 1. That the report be noted. 2. That the Monthly Maternity Update be approved for submission to the Board of Directors **Action:** 1. A Quarterly Safety Champions Report be added to the QAC Cycle of Business
110	**Fractured Neck of Femur Pathway** The Committee considered the report which was presented by Daniel Bakey. The report provided an update on the work of the Fractured Neck of Femur Steering Group. The report provided oversight and assurance of the actions being undertaken to improve the pathway and associated mortality rates at the Trust. During a summary of the report the following points were highlighted: - Training had been delivered at the Emergency Departments at both RLI (Royal Lancaster Infirmary) and FGH (Furness General Hospital) to complete Fascia Iliac blocks, which would improve pain management and therefore analgesia requirements - A SOP (Standard Operating Procedure) had been developed on the peri-operative management of anti-coagulant agents in emergency use, which would help minimise unnecessary delays to theatre and would standardise practise - Hip precautions had been reviewed and revised - The #NOF Pathway and Management SOP had been updated and now provided clear protocols for delivery of the pathway - Incident reporting for #NOF surgery breaches had been reviewed with the Patient Safety Team - Ring fenced beds for #NOF patients were in place at RLI and FGH - Numerous next steps were planned which included a workstream on delirium, the commencement in post of a new trauma co-ordinator at FGH, and the development of an E-Whiteboard for trauma During deliberation of the item the following points were made in discussion: KD (NED) noted the key actions detailed in the report but asked how the Committee could be assured that completed actions would remain embedded; DB acknowledged that the pathway was complex and that there were a number of ways that problems could arise so there would be continued engagement with workforce, the #NOF Steering Group would remain active and ongoing audit would be implemented where possible. HR (NED) discussed the planned trauma dashboard, commenting that it would be useful as an early warning sign and asking when it would be live. ES confirmed that the dashboard was ready now although there was some issues with the FGH data, this should be rectified when the Trauma Co-ordinator commenced in post. HR (NED) thanked the team for an informative report and requested a further update be brought to the Committee in two months (November 2022). **Decision:** 1. That the report be noted. **Action:** 1. That a further report be submitted to the QAC in November 2022.
111	**Theatre Never Events Six Month Update** The Committee considered the report which was presented by Danny Bakey.

	The report offered an update on patient safety incidents and actions from previous Never Events, WHO Safer Surgery processes, performance, transformation, theatre timetables, scan updates, patient experience, H&S, claims, litigation, training, celebrations, actions, and risks. The report was accepted as being read and questions were taken. During deliberation of the item the following points were made in discussion: HR (NED) highlighted the 10,000 feet initiative, noting issues when last launched and querying how the current launch had gone. SB confirmed that the initiative was well established in theatres and in addition to it the Stop Moment had been implemented, one of GIRFT best practice requirements. HR (NED) discussed the importance of human factor training, noting that training had been carried out in 2021 and had been considered particularly useful. SM confirmed that there was ongoing civility work being carried out in addition to simulation training, which would be embedded into routine practise. KD (NED) queried the enhanced safeguarding knowledge in theatres that had been referenced in the paper and asked how it related to the Trust's mandatory safeguard training. It was confirmed that the Trust's safeguarding training was not specific around consent forms and greater understanding was required due to issues with patients who came to theatre under various sections of the Mental Health Act. KD requested that safeguarding compliance within theatre and any additional knowledge, insights or learning required be detailed in the next report to the Committee. **Decision:** 1. That the report be noted.
112	**Furness General Hospital ICU (Intensive Care Unit) Concerns** The Committee considered the report which was presented by Cathy Hay. The report provided an update on actions taken following the receipt of anonymous letters raising concerns regarding the care of five patients at the FGH ICU. During a summary of the report the following key points were highlighted: - Areas of good practice had been identified throughout the review and there had been no evidence of patient harm - The review was clear that care had been provided within local and national guidelines - The timing of withdrawal of treatment had been questioned in two cases, in response the End of Life SOP, forms and procedures had been reviewed - Documentation for Renal Replacement Therapy had been flagged as not easy to identify and therefore the critical care teams were reviewing current systems - Implications for learning spread beyond the ICU and in response the Clinical Systems Group were reviewing all relevant EPR (Electronic Patient Record) related processes During deliberation of the item the following points were made in discussion: HR (NED) remarked that from concerns being raised and a potentially worrying situation, excellent learning had been accomplished from the external views, much of it with wider applicability.

	RS highlighted the effects on the teams involved and reiterated the Trust's commitment to ensuring their stories and experiences were heard and learnt from; dates had been set to allow conversations to happen in the near future. CH offered thanks to Greg Peers and the Surgical and Critical Care triumvirate for their support. **Decision:** 1. That the report be noted. 2. That the concern and associated actions be closed from QAC.
113	**Testicular Implant Recall Update** The Committee considered the report which was presented by Gregg Peers. The report provided an update on the revisit of the 2016 recall process for patients who underwent the insertion of a testicular implant. During a summary of the report the following key points were highlighted: - A total of 36 patients were identified - 22 of the patients identified attended a One Stop Clinic; 20 patients were discharged with no issues identified, 2 patients were identified to have issues on ultrasound and were referred on a 2WW (2 Week Wait) pathway, 0 patients were found to have a needle guard in situ (the issue that had raised the original concern) - 4 patients failed to attend clinics despite two appointments being offered; their GPs were notified - 4 patients needed no follow up appointment following initial identification via Lorenzo - 4 patients had moved out of area and their GPs had been contacted and asked to review locally - 2 patients had been identified with needle guards in situ before the repeat recall, both had had litigation claims resolved and closed - Lessons learnt included the procedure for introducing new prosthetics into the Trust; ownership, identification, and inclusion of an accountable item; governance around defining a Never Event; expectations of clinicians; clinical coding errors and field notices During deliberation of the item the following points were made in discussion: KD (NED) highlighted the importance of lessons learnt and embedment of actions and improvements, questioning if they would be systematically revisited to ensure they remained in place. GP confirmed that they would be the subject of ongoing audit which would monitor compliance, issues were discussed at weekly ERG meetings and regular forums. HR (NED) discussed the closing of the review and where the ongoing actions and learning would be monitored, with RS confirming there were various meetings including Care Group Governance and Patient Safety meetings that would take this on. **Decision:** 1. The update be noted. Closed.
114	**Niche Report** The Committee considered the report which was presented by Richard Sachs.

	The report provided an update and assurance on the process to check and test evidence to support recommendations to a level 3 or above (NIAF) with gaps identified and actions taken. The Niche framework (NIAF) was shared by RS with Committee members during the discussion. During a summary of the report the following key points were highlighted: - Phase 1 to 4 had now been completed - Phase 5 comprised of an assurance review commencing 6 to 12 months after the publication of the report (24th November 2021) - Twice weekly Support and Review (S&R) meetings were in place within the Care Group and speciality - An external compliance and assurance specialist had been working with the Trust since July and was assisting in the checking and testing of evidence based on the NIAF - Following this testing process a decision had been taken to reopen some recommendations previously thought to be complete - A dashboard had been included in the report which described the current position on the quality of evidence provided During deliberation of the item the following points were made in discussion: HR (NED) suggested clinician input on how the situation felt to them and how changes were working and benefitting the service would be useful, RS would speak with them to arrange but flagged that the current combination of aspiring to Niche level 3 and the implementation of the new governance structure may mean that feedback would be best given further into quarter 3. RS to provide a date for the action tracker outside of the meeting. KD (NED) voiced agreement with HR's request, when appropriate, to have clinician input at a future meeting, feeling it offered an opportunity to clearly see how changes translated into work on the ground. The re-opening of closed recommendations was discussed further, with RS acknowledging disappointment. but it was concluded that it was positive that improvements could be implemented at the current stage rather than further into the journey. **Decision:** 1. That the update be noted. **Action:** 1. RS to discuss with clinicians' possible attendance at a future QAC meeting and to advice a suitable date to GB.
115	**External Review into Deaths and Peer Review of SJR's** The Committee considered the report which was presented by Ameeta Joshi. The report provided an update on the 2022 Better Tomorrow External Peer Review. During a summary of the report the following key points were highlighted: - The review had looked at 62 deaths and a comparative review of 39 cases, many of which had demonstrated good practice with room to improve in some cases

	- The quality of the SJR's was noted in terms of their depth, comprehensiveness, learning identified and escalation - Regarding the SJR (Structured Judgement Reviews) and avoidable death, a meeting had been organised and further engagement with AMaT (Audit Management and Tracking) to support better data collection - The report had suggested there was opportunity to learn and follow best practice for care of patients with a learning disability at the end of their lives; further training would be provided by the LD Matron to ward nurses and via the CNO (Chief Nursing Officer) team - The skills and consistency of the clinical reviewers was noted in the report, meetings had been arranged and a masterclass was planned in addition to video training - Arrangements had been made for the BT team to meet and engage with care groups to understand lessons learnt - The names of six nurses had been put forward by the CNO along with 3 AHP's to help ensure a multidisciplinary team of reviewers - Work had been undertaken with Richard Sachs to discuss tracking of learning from cases and a new proforma had been rolled out - A further report would be submitted to the QAC in January 2023 to demonstrate change and sustainability - A follow up visit had been arranged for January 2023 to review the improved process and a closure report would be provided During deliberation of the report the following key points were highlighted: KD (NED) discussed the improvement action related to the care of patients with a learning disability and questioned if a regular report to the QAC would be useful. LW confirmed that a mortality review of such patients had been carried out during the Covid-19 pandemic and no concerns had been identified. It was confirmed that an overarching report was prepared monthly and submitted to the Patient Experience Group on a regular basis. HR (NED) welcomed further updates and requested that AJ incorporate them into the quarterly mortality reports. **Decision:** 1. The update was noted. **Action:** 1. That an update be brought to the Committee (November 2022).
116	**Organ Donation Annual Report** The Committee considered the report which was presented by Vera Gotz. The report provided an update on organ donation across the Trust. During a summary of the report the following key points were highlighted: - The annual report had been submitted to provide assurance - Everything was progressing well During deliberation of the report the following points were considered: HR (NED) queried if there were any concerns that the Committee needed to be aware of with VG explaining that any improvements were reviewed on a case-by-case basis and there were no current concerns or actions.

	Decision 1. The update was noted.
117	**Mortality Quarterly Report** The Committee considered the report which was presented by Ameeta Joshi. The report provided an update position on the Trust's latest HED data for HSMR (Hospital Standardised Mortality Ratio) and SHMI (Summary Hospital Level Mortality Indictor) data including an update on mortality indicators. During a summary of the report the following key points were highlighted: - The Mortality Steering Group continued to meet with a focus on learning from mortality along with improvement of priorities following the receipt of the Better Together report - The Trust had scored green for both HSMR and SHMI - Work was still required but progress was promising - Measure were being put in place related to #NOF and would reduce length of stay and mortality for patients - The Trust had been notified that there was an expectation for mortality data to be shared at a regional level between Trust's and L&SC ICB. A data dashboard compiled by NHSEI would be updated weekly for wider sharing and identification of area of improvement. The CMO would be the named lead for the Trust During deliberation of the report the following key points were highlighted: RS surmised that if mortality within 30 days of discharge was seen to be reducing then it would be reasonable to assume that you may see an increase in mortality 31 -60 days post discharge. AJ agreed and confirmed that the data would be available on the dashboards for GPs to access and review. HR (NED) noted the positive improvements in relation to the SHMI and HSMR data (both green) and looked forward to seeing this continue. **Decision:** 1. The report was noted.
118	**Infection Prevention Report** The Committee considered the reports which were presented by Amy Mbuli. A suite of IPC reports was submitted which included a quarterly IPCC (Infection Prevention and Control Committee) update and an update following the NHSEI visit and subsequent report. During a summary of the report the following key points were highlighted: - The report included information on the first quarterly report for gram negative blood stream infections and the associated actions that had been identified - There had been no previous gram negative threshold nationally. Consideration was being given to how to share the learning to a wider audience and include in Care Group reporting; it was anticipated that the data would be available in the Care Group smart board data - Work around pressure ulcers continued; there had been no national benchmarking historically but work was being undertaken with the national wound team and model hospital which would allow data to be evidenced against peers During deliberation of the report the following key points were highlighted:

	HR (NED) noted the good work on gram negative infections. HR (NED) discussed the NHSEI visit and the actions from it, voicing concern around the number of actions flagging red with no narrative available. AM confirmed that narrative was now available and would be added for the next report. It was confirmed that the actions were being picked up Trust wide to ensure the fulfilment of the requirements; progress meant some had now been updated to amber. KD (NED) questioned if the metrics would be included on the early warning screen dashboard and, if so, what the timescale was. AM confirmed that they would be included but was not sure yet of timescales. **Decision:** 1. That the report be noted.
119	**Safer Staffing RSP (Recovery Support Programme) Exit Report** The Committee considered the report which was presented by Dan West. The report provided an update on the safe staffing process and compliance with the exit criteria for the Recovery Support Programme. The paper was accepted as being read and no concerns were highlighted to the Committee. KD (NED) queried if there was an intention that safer staffing metrics would form part of the dashboard with BL advising that it was a mandatory requirement for the report to be submitted to the QAC, The People Committee and finally to Board of Directors. The data would be broken down to ward levels for fill rate. Assurance would be provided by dashboard data and six-monthly reports. **Decision:** 1. The report was noted.
120	**Care Group Quarterly Report – Estates and Facilities** The Committee considered the report which was presented by Glyn Davies. The report provided an update on the control measures employed within the Care group to retain high levels of effectiveness and quality of service. The report was accepted as read and it was noted that there was nothing to report by exception. During deliberation of the report the following key points were highlighted: HR (NED) asked about the appointment of the new Director of Estates, it was confirmed he would commence in post at the end of November. HR (NED) queried if there were any concerns that needed to the brought to the attention of the Committee within the report, with GD confirming there were no current concerns. It was noted that this was the first report by the Estates and Facilities group and that a meeting would be arranged with RS once the new director was in post to discuss the make-up of future reports. **Decision:** 1. That the report be noted. **Actions:** 1. That a meeting be arranged between RS and the Director of Estates to discuss the QAC report going forwards. Action RS.

121	**Patient Experience Report** The Committee considered the report which was presented by Barry Rigg. The report provided an update on the results of the UHMBT (University Hospital Morecambe Bay Trust) Inpatient Survey 2021. During a summary of the report the following key points were highlighted: - The 2021 National Adults Inpatient Survey was part of a national survey run by the CQC to collect feedback on the experiences of patients using inpatient care services nationally - The results of the survey contribute toward the CQC's assessment of NHS performance in addition to ongoing monitoring and inspections - A total of 1250 UHMBT patients were invited to take part in the survey with 511 responding (43%) - There were 62 questions in the survey, of which 41 could be compared with previous reports - There were five developmental areas which were detailed in the report During deliberation of the report the following key points were highlighted: KD (NED) discussed a recurrent theme of improvements being made but not always sustained; she queried what had been put in place to ensure sustainability of improvements. BR confirmed that sustainability was the role of the Patient Experience Group which was Chaired by the Deputy Chief Nursing Officer. The meeting met bi-monthly and reviewed all national surveys, identifying key themes. BL highlighted the need to quantify in the reports what improvements have been made and this should be considered and reviewed outside of the meeting. HR (NED) discussed themes identified which related to a lack of feedback being received from patients during their hospital stay and asked that alternative ways to encourage real time feedback to be considered. **Decision:** 1. That the report be noted.
122	**Risk Management Group Annual Report** The Committee considered the report which was presented by Richard Sachs. The report demonstrated assurance that the Risk Management Group had met the requirements of its Terms of Reference. It was noted that the report had been submitted to the Board of Directors in July, out of sync of the usual governance route. It had subsequently been submitted to the TMG meeting before the QAC Committee. During deliberation of the report the following key points were highlighted: HR (NED) queried the Training Needs Analysis in terms of staffing and queried how many staff had been trained to date and if the number was sufficient, it was also queried how many more staff were expected to receive the training. HR would require the information prior to the Board meeting on the 28/09/22, RS to action and provide. *RS confirmed after the meeting via email that 35 staff had currently completed the training, a further 40 were booked to attend before Christmas and another 14 were*

	awaiting course dates for January 2023. The figure of 100 would be reviewed in the context of the size of the organisation and the risks being carried. KD (NED) asked for an explanation around the relationship of the report and the Board Assurance Framework and what further work was required to calibrate it. RS acknowledged that further work was required and more information would be available for the Board of Directors meeting on the 28th of September 2022. The matter had been discussed at the Management Committee by Paul Jones, Company Secretary, and had been recognised as an area for development. Further consideration and discussions would take be arranged. **Decision:** 1. That the report be noted. **Actions:** 1. That RS provide updates to HR and KD in readiness for the Board of Director's meeting on the 28th of September 2022. The updates were emailed to both as requested on the 27.09.22 and added to the minutes above retrospectively on the 29.09.22 by GB.
123	**Quality Governance Accountability Framework** **Safer Staffing RSP Exit Report:** The Committee considered the report which was presented by Richard Sachs. The report provided an update on the refreshed quality governance and accountability framework following a review by NHSEI. It was noted that the report had been submitted to the Board of Directors in August for consideration and had subsequently been submitted to the QAC following approval. During a summary of the report the following key points were highlighted: - The framework was built on the original work of the GGI (Good Governance Institute) which had been followed by a PDSA cycle - The document had been taken to, and approved at, Board of Directors in August During deliberation of the report the following key points were highlighted: HR (NED) noted that the document clearly identified the groups that reported to the Quality Assurance Committee and the Quality Governance and Patient Safety Group and that a review meeting should be undertaken to ensure that the reporting schedule was in line with the new structure. **Decision:** 1. That the report be noted. **Action:** 1. That a review of the Cycle of Business for the QAC be undertaken to ensure reporting groups were in line with the new governance structure.
124	**Emergency Preparedness, Resilience and Response (EPRR) Annual Assurance Return** The Committee considered the report which was presented by Scott Mclean. The report provided an update on the EPRR annual assurance process which assesses the preparedness of NHS organisations including Commissioners. During a summary of the report the following key points were highlighted:

	- The report had been submitted to the Board of Directors for discussion on 28th September 2022 During deliberation of the report the following key points were highlighted: Due to technical errors SMc was unable to present the paper. RS would email the following questions on behalf of the Committee: HR (NED) Are we confident that the two partial compliance matters are resolvable and not critical functions? *SMc confirmed confidence, noting that neither were critical functions and the compliance plan had been reviewed and noted to have SMART objectives against it.* KD (NED) How does the return link to the wider system responsibilities in respect of EPRR asks and requirements? *SMc confirmed that there was no link, noting the ICN EPRR arrangements were emergent and would be a key part of these. A plethora of work was confirmed to be ongoing between the Trust's EPRR team and the wider system. In the immediate term the self-assessment would be for the Trust's sovereign responsibility.* Following the meeting, SMc responded to both questions via email and these were added retrospectively above. **Decision:** 1. The report be noted. **Actions:** 1. RS to email the questions from HR and KD to SMc. Email response was received from SMc on 26.09.22 and the update was retrospectively added to the minutes above on 29.09.22 by GB.
125	**SI (SERIOUS INCIDENT) 3A Report** The Committee noted the report. **Decision:** 1. The report was noted.
126	**QGPS 3A Report** The Committee noted the report. **Decision:** 1. The report was noted.
127	**Executive Review Group 3A Report** Reports from the ERG had not been received. Further thought would be given to the 3A reports as the meetings had now been increased to three per week. **Action:** 1. RS to consider the reporting schedule for the ERG to the QAC.
128	**Patient Safety 3A Report** The Committee noted the report. KD (NED) queried where assurance from risks and alerts were processed, with RS confirming that the information was taken to a number of groups and Committees and that all were discussed in the Patient Safety and Clinical Effectiveness meetings which reported to TMG (Trust Management Group). **Decision:**

	1. The report was noted.
129	**RSP 3 A Report** The Committee noted the report. Alerts around NOF were discussed and the Committee were assured that the concerns were being managed. The alert concerning patients Not Meeting Criteria to Reside was highlighted, RS confirmed that the concerns were managed through the operational groups and Committees. The Committee discussed the ongoing work related to Stroke and requested an update be brought to the October meeting. SM to be alerted to the ask. **Decision:** 1. The report was noted. **Action:** 1. An update on Stroke be brought to the QAC in October. Action SMc.
130	**Quality Assurance Cycle of Business** Noted.
131	**Attendance Monitoring Register** Noted. The monitor would be updated to show the new members.
132	**Any Other Business** The Organ Donation Annual Report was discussed and RS would meet with VG to clarify requirements going forwards.
133	**Chair Report for Board** Alert - Fractured Neck of Femur (#NOF) rates were still flagging red in both HSMR and SHMI data. In-depth reports indicated some early signs showed this may be improving Assure - The Committee had received closure reports for both ICU Concerns at FGH and Testicular Recall and had been assured that the concerns had been reviewed with appropriate actions taken and could be closed from the Committee. Advise - The importance of assurance around ongoing sustainability was highlighted throughout the meeting. The Committee would like to see embedment and sustainability highlighted in reports going forwards. - A quarterly Maternity Safety Champions report would be added to the QAC Cycle of Business. The report would be approved at the QAC for submission to the Board of Directors to highlight the work of the Champions and the first paper would be received in October 2022.
134	**Date, Time, and Venue of Next Meeting** It was noted that the next meeting of the Quality Assurance Committee would be held on Monday 17th October 2022, 13.00 – 15.00 via Teams.