MEETING OF THE BOARD OF DIRECTORS IN PUBLIC

Gateshead Health NHS Foundation Trust

Date: Tuesday 29th September 2020
Time: 9.30 am
Venue: (via teleconference)

AGENDA

	TIME	ITEM	STATUS	PAPER
1.	9:30 am	**Welcome and Chair's Business**		
2.	9:35 am	**Declarations of Interest** To declare any pecuniary or non-pecuniary interests *Check – Attendees to declare any potential conflict of items listed on the agenda to the Trust Secretary on receipt of agenda, prior to the meeting*	Declaration	Verbal
3.		**Apologies for Absence** *Quoracy check: (s3.3.31 SOs: No business shall be transacted at a meeting unless a minimum of **4** members of the Board (including at least **one** Non-Executive and **one** Executive Member of the Board) are present)*	Agree	Verbal
4.	9:40 am	**Minutes of the meeting held on 29th July 2020** To be agreed as an accurate record	Agree	Enclosure 4
5.		**Matters Arising/Action Log**	Update	Enclosure 5
6.	9:45 am	**Patient Story** To receive a patient story from the Community Services Business Unit	Assurance	Presentation
		ITEMS FOR DECISION		
7.	10.00 am	**BME Actions** To approve the collective promise, presented by the Chief Executive	Approval	Enclosure 7
8.	10:10 am	**Calendar of Board Meetings** To approve the calendar of Board meeting dates for 2021, presented by the Chair	Approval	Enclosure 8
9.	10:15 am	**Winter Plan** To approve the plan, presented by the Chief Operating Officer	Approval	Enclosure 9
		ITEMS FOR ASSURANCE		
10.	10:25 am	**Performance Update** To receive the report, presented by the Interim Associate Director of Planning and Performance	Assurance	Enclosure 10

11.	10:35 am	**COVID Update** To receive the report, presented by the Director of Nursing, Midwifery and Quality	Assurance	Verbal
12.	10:45 am	**Finance Update** To receive the report, presented by the Group Director of Finance	Assurance	Enclosure 12
13.	10:55 am	**Audit Results Report 2020** To receive the Audit Results Report from the Group Director of Finance	Assurance	Enclosure 13
14.	11:00 am	**Healthcare Associated Infections** To receive the report, presented by the Director of Nursing, Midwifery and Quality	Assurance	Enclosure 14
15.	11:05 am	**Nurse Staffing Exception Report** To receive the routine report presented by the Director of Nursing, Midwifery and Quality	Assurance	Enclosure 15
16.	11:10 am	**Integrated Quality and Learning Report** To receive the report, presented by the Director of Nursing, Midwifery and Quality	Assurance	Enclosure 16
17.	11:15 am	**SIRO Report and Digital Update** To receive the report including Digital Committee Terms of Reference, presented by the Chief Digital Information Officer	Assurance	Enclosure 17
18.	11:25 am	**PLACE Report** To receive the report presented by the QEF Managing Director/Commercial Director	Assurance	Enclosure 18
19.	11:35 am	**EPRR Core Standards Self-Assessment** To receive the report presented by the Chief Operating Officer (Accountable Emergency Officer)	Assurance	Enclosure 19
20.	11:45 pm	**Assurance from Board Committees** To receive the assurance reports from the following committees: (i) Quality Governance Committee held on 15/09/2020 (ii) Finance and Performance Committee held on 28/09/2020 (iii) HR Committee held on 11/08/2020 (iv) Audit Committee held on 03/09/2020	Assurance	Enclosure 20
		ITEMS FOR INFORMATION		
21.	11:55 pm	**Questions from Governors in Attendance** To receive any questions from governors in attendance		Verbal
22.	12:05 pm	**Date and Time of the next Meeting** The next scheduled meeting of the Board of Directors to be held in public will be Wednesday 25th November 2020 at 9:30 am		Verbal
23.		**Chair Declares the Meeting Closed**		Verbal
24.		**Exclusion of the Press and Public** To resolve to exclude the press and public from the remainder of the meeting, due to the confidential nature of the business to be discussed		Verbal

Trust Board

Minutes of a meeting of the Board of Directors held at 9.30 am on Wednesday 29th July 2020, via Microsoft Teams

Gateshead Health NHS Foundation Trust

Present:	
Mrs A Marshall	Chair
Mrs J Baxter	Chief Operating Officer
Mrs J Bilcliff	Group Director of Finance
Dr R Bonnington	Non-Executive Director
Mr S Bowron	Non-Executive Director
Cllr M Gannon	Non-Executive Director
Mr P Harding	Commercial Director and Managing Director, QE Facilities
Mr N Halford	Deputy Medical Director
Dr H Lloyd	Director of Nursing, Midwifery and Quality
Mr A Moffat	Associate Non-Executive Director
Mrs Y Ormston	Chief Executive
Mrs H Parker	Associate Non-Executive Director
Mr J Robinson	Non-Executive Director
Mr M Robson	Non-Executive Director
Mr D Shilton	Non-Executive Director
In Attendance:	
Mrs D Renwick	Interim Associate Director Planning & Performance (20/90)
Ms D Waites	PMO/KPO Co-ordinator
Mrs J Williamson	Membership Co-ordinator
Ms A Wiseman	Director of Public Health Gateshead (20/89)
Governors and Members of the Public:	
Mrs E Adams	Public Governor – Central
Mr L Brown	Public Governor – Western
Mrs J Coleman	Staff Governor
Mr D Costello	Public Governor – Eastern
Reverend J Gill	Public Governor – Western
Mrs G Henderson	Public Governor – Western
Mrs J Todd	Public Governor – Western
	4 x members of the public
Apologies:	
Mrs D Atkinson	Trust Secretary
Mr A Beeby	Medical Director
Mr P Hopkinson	Non-Executive Director

Agenda Item	Discussion and Action Points	Action By
20/83	**CHAIR'S BUSINESS:** The meeting being quorate, Mrs A Marshall, Chair, declared the meeting open at 9.30 am and confirmed that the meeting had been convened in accordance with the Trust's Constitution and Standing Orders.	

<table>
<tr><th>Agenda Item</th><th>Discussion and Action Points</th><th>Action By</th></tr>
<tr><td></td><td>She welcomed Mr Andrew Moffat and Mrs Hilary Parker, new Associate Non-Executive Directors to the meeting, along with Trust Governors, staff members and members of the public.</td><td></td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td>20/84</td><td>DECLARATIONS OF INTEREST:

Mrs A Marshall, Chair, requested that Board members present report any revisions to their declared interests or any declaration of interest in any of the items on the agenda.</td><td></td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td>20/85</td><td>APOLOGIES FOR ABSENCE:

Apologies were received from Mrs D Atkinson, Mr A Beeby and Mr P Hopkinson.</td><td></td></tr>
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<tr><td>20/86</td><td>MINUTES OF THE PREVIOUS MEETING:

The minutes of the meeting of the Board of Directors held on Wednesday 3rd June 2020 were approved as a correct record with no amendments.</td><td></td></tr>
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<tr><td>20/87</td><td>MATTERS ARISING FROM THE MINUTES:

The Board Action Plan was updated accordingly to reflect matters arising from the minutes.</td><td></td></tr>
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<tr><td>20/88</td><td>DECLARATIONS OF INTEREST:

Mrs A Marshall, Chair, presented the Declaration of Board Members' Interests and the Fit and Proper Persons Declaration.

Mr A Moffat and Mrs H Parker, Associate Non-Executive Directors, have satisfactorily completed the Fit and Proper Persons Declaration and the declared interests are shown below:

<table>
<tr><th>Name</th><th>Position</th><th>Interest</th><th>Interest of Spouse</th><th>Category</th></tr>
<tr><td>Mr Andrew Moffat</td><td>Associate Non-Executive Director (from 01/07/2020 to 30/09/2020)</td><td>None</td><td>None</td><td>-</td></tr>
</table>
</td><td></td></tr>
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Agenda Item	Discussion and Action Points	Action By

	Non-Executive Director (from 1st October)			
Mrs Hilary Parker	Associate Non-Executive Director (from 01/07/2020 to 30/09/2020) Non-Executive Director (from 1st October)	Kingston Properties Limited Consultant with Sintons LLP Trustee Newcastle University Development Trust	None	A B D

It was noted that Mr Moffat is a confirmed Board member of the North East Local Enterprise Partnership (NELEP) and Chair of the NELEP Investment Board however is not included in the categorisation.

Mrs Marshall confirmed that Mr Moffat and Mrs Parker have signed the declaration and a search of insolvency, bankruptcy and disqualified directors' registers has also taken place.

Following discussion, it was:

RESOLVED: i) to approve the declared interests and Fit and Proper Persons Declaration

ii) to note the next full routine review of the declaration of Board members interests will take place in April 2021

20/89 **LOCAL OUTBREAK CONTROL PLAN:**

Ms A Wiseman, Director of Public Health Gateshead, provided a presentation of the Local Outbreak Control Plan and partnership working.

She started by thanking all staff associated with the Trust and community in their response in Gateshead to the pandemic and by working together to deliver one system. She drew attention to the proactive testing work of the Microbiologists and Community Nursing Team work within the care home settings.

Agenda Item	Discussion and Action Points	Action By
	The presentation highlighted that Gateshead currently has a low number of cases and a reduction in the average number of deaths. By National comparison (from 22nd July 2020) in the last 7 days there have been only 3 confirmed cases in Gateshead. The team has also developed geographical mapping capability which helps to look for clusters and issues in specific settings and enables a better understanding of overall cases within Gateshead. The Local Outbreak Control Plan was developed in line with partners in Newcastle and includes 7 areas: 1. Care Homes and Schools – to identify outbreaks early enabling prevention and appropriate response 2. High risk places, locations and communities 3. Local Testing Capacity – robust capacity within QE team 4. Contact Tracing in Complex Settings 5. Data Integration – currently some limitations but improving 6. Vulnerable People – support for isolation 7. Local Boards – Local Engagement Board chaired by Counsellor Donovan. Focuses on stakeholder representation from different communities within Gateshead (eg. Jewish community, learning disabilities, local businesses including representation from the Federation of Small Businesses) Ms Wiseman assured the Board that processes are in place to identify local increases and local relationships have been effective. A dedicated email inbox has been set up and local businesses have been contacted. She highlighted that it is essential that community testing rates are maintained, if not increased, and a better understanding of asymptomatic test results in care settings is required. Public Health has recently contacted care homes to invite the return of visitors and Dr H Lloyd reported that the Infection Prevention and Control team are working closely with care homes and robust systems are in place. Mrs Y Ormston reported that testing continues to be a challenging area and care homes are high on agenda. Antibody testing for care home staff is currently being undertaken. She explained that it is essential that a clear national strategy is in place for testing going forward to ensure preparedness for winter and possible second spike. Discussions are ongoing with the lab and ICS in relation to further capacity and additional resilience and it is important that the transformation ways of working are continued going forward. Cllr M Gannon took the opportunity to congratulate the team on the seamlessness working being undertaken and Mr J Robinson was assured by the service based approach and established working relationships. Further discussion took place around the measures in place to identify a rise in cases and Ms Wiseman explained that there has been good communications and cooperation within the community including schools and local businesses. She highlighted	

Agenda Item	Discussion and Action Points	Action By
	that additional funding has been approved to provide further investment in community nursing and a new Communications Officer has been appointed with the Council to ensure clear communication, marketing and PR. Mrs Marshall thanked Ms Wiseman for providing the Board with her presentation. After consideration, it was: **RESOLVED:** to receive the presentation on the local outbreak control plan and partnership working Ms Wiseman left the meeting.	
20/90	**PERFORMANCE UPDATE:** Mrs D Renwick, Interim Associate Director of Planning and Performance, provided an overview of recovery and restart in the hospital identifying current restrictions, current activity levels and summary impact on operational performance, ensuring the Board receives assurance about the Trust's recovery restart, return to new normal and impact on performance. The Board reviewed the summary dashboard and Mrs Renwick highlighted reduced capacity due to infection prevention and control measures and consequent workforce risks. She reported that outpatient referrals are predominantly back to normal due to new ways of working including digital consultations and telephone triaging although activity is less in terms of face to face appointments. Activity is significantly less for elective patients and day cases due to reduced capacity for theatre space, endoscopy capacity and patient choice in that some patients are deferring coming in although this has impacted on longer lengths for RTT and waiting lists. There is currently an over-performance for new patients as this includes serology testing however how this is recorded will be looked at going forward. Emergency Department attendance is less than usual and has resulted in a better performance against the A&E target. Cancer performance has deteriorated due to capacity restrictions and a report will be presented in September which will include a detailed improvement plan against workforce, capacity and trajectories. The dashboard also includes indicators relating to flow and the impact of less patients on occupancy levels however this has shown less delayed transfers of care. Mrs Renwick highlighted the current risks and reported that she will be working with Mrs J Baxter, Chief Operating Officer, to ensure plans are in place. These include new normal capacity deficits, growing	

Agenda Item	Discussion and Action Points	Action By
	waiting lists, imposed 14 day isolation guidance prior to diagnostic and surgical procedures, winter and possible second wave, data challenges and how data is collected virtually, endoscopy and new planning guidance/SOF measures. Next steps will include learning from digital improvements and reviewing new ways of working as services are reset to new normal. The Board acknowledged the difficulties surrounding the lack of capacity in relation to demand and following a query from Mr Robinson in relation to the main factors, Mrs Renwick explained the impact of the implementation of social distancing rules within waiting areas and the transfer of some overnight cases to day cases however emphasised the need to keep staff and patients safe. Mrs Marshall felt that it would be beneficial to discuss further with external partners and Mr Robinson reminded the Board of previous discussions in relation to the use of Blaydon and Bensham. Cllr Gannon also highlighted that additional space could be sought from leisure centres and Mrs Ormston agreed that this could be looked at. Mrs Baxter confirmed that clinic sites and available estate would be reviewed as part of the future planning work. Following further discussion, it was: **RESOLVED:** to note the current significant challenges facing the Trust: i) in our requirement to follow rigorous infection prevention and control arrangements to ensure we offer a safe environment to care for patients whilst keeping our staff safe we have significantly reduced our available capacity to see patients in all care settings. Activity volumes for June are below the comparative period in 2019. ii) As referrals return to pre-covid levels patients are already waiting significantly longer for elective outpatient, diagnostic and inpatient elective care and have been reluctant to attend hospital appointments. iii) An analysis of the activity gap and back-log of patients waiting will be presented in September's report. iv) New ways of working have presented data capture & data completeness issues which are impacting on patient pathway management, progress on recovery to be presented at September's Board.	YO

Agenda Item	Discussion and Action Points	Action By
20/91	**COVID UPDATE:** Dr H Lloyd, Director of Nursing, Midwifery and Quality, provided a verbal update to the Board on the work being carried out due to new Covid requirements. She reported that a detailed report will be presented in Part 2 however highlighted that work is continuing and an Infection Prevention and Control report and integrated learning report are being completed which will be presented to the Board in the near future. Main points to note include: • No staff infections via track and trace • Patients continue to be tested on admission • No PPE shortages • Reduced capacity within services • Clear plans for recovery in place and Phase 3 planning guidance awaited • Winter preparedness • Key digital enablers • Health & Wellbeing - continue to support staff Mr S Bowron raised a query on visitor guidance and Dr Lloyd reported that a new plan has been put in place for ward manager discretion. Visiting can therefore be arranged for longer term patients; one person at a time for one hour ensuring social distancing. This will be reviewed on an ongoing basis. After further discussion, it was: **RESOLVED:** to receive the update for assurance	
20/92	**FINANCE UPDATE:** Mrs J Bilcliff, Group Director of Finance, provided the Board with a summary performance against plan for activity, income and expenditure as at 30th June 2020 (Month 3) for the Group (inclusive of Trust and QE Facilities, excluding Charitable Funds). Mrs Bilcliff reported that In response to the Covid-19 outbreak, guidance was issued in March 2020 that suspended the 2020/21 national operational planning process. An interim financial framework was established intended initially to cover the period 1 April to 31 July 2020. During this time, the Trust will receive a guaranteed level of income that is intended to reflect the actual cost base. Therefore, it is a national expectation that sufficient funds will	

Agenda Item	Discussion and Action Points	Action By
	be provided to enable the Trust to return an overall income and expenditure break even position for these four months. The cash payment profile has been amended so that the Trust will receive cash payments in advance, delivering a positive cash flow for this period. Expenditure incurred as at June 2020 in response to the Covid-19 outbreak totals £9.163m which includes additional staffing costs incurred including bank and agency across all staffing groups has cost £2.386m and the non-staff element of £6.777m includes expenditure on behalf of Newcastle Gateshead CCG and costs of laboratory reagents and equipment, computer hardware, decontamination and clinical supplies. Mrs Bilcliff highlighted that planning guidance is due out this week and indicates that the current framework will continue throughout August, September and October therefore the block contract will end in October 2020. Therefore a lot of work around plans will be completed when the guidance is received. Following further discussion, it was: **RESOLVED:** to receive the report for assurance	
20/93	**HEALTHCARE ASSOCIATED INFECTIONS** Dr H Lloyd, Director of Nursing, Midwifery and Quality & Joint Director of Infection Prevention and Control (DIPC), provided an update to the Board on the current performance of HCAI mandatory performance for the Trust throughout the 2019/20 period. As the Trust returns to business as usual, Dr Lloyd highlighted the proposed changes to the NHS standard contract outlined in December 2019 to remove MRSA and CDI. However due to the onset of the COVID-19 pandemic, the mandatory reporting infection objectives for 2020/21 have not yet been set, therefore the Trust has taken the decision to continue to adopt the national aspiration of a zero tolerance approach to all avoidable infections. To the end of June 2020, the Trust has reported the following infection objectives: • MRSA cases – zero • CDI cases – 8 hospital and 1 community. This is being investigated due to the cluster of cases • MSSA – 4 hospital and 9 community • E-Coli – 9 hospital and 55 community. This is believed to be related to the high elderly population and partnership working will take place with the CCG and Primary Care	

Agenda Item	Discussion and Action Points	Action By
	• Pseudomonas – 1 hospital and 4 community • Klebsiella – 1 hospital and 12 community From 14th May 2020, the Trust was required to report COVID-19 positive results against four categories: • Community-Onset – first positive specimen date <=2 days after admission • Hospital-Onset Indeterminate Healthcare-Associated (HOIHA) – first positive specimen date 3-7 days after admission • Hospital-Onset Probable Healthcare-Associated (HOPHA) – first positive specimen date 8-14 days after admission • Hospital-Onset Definite Healthcare-Associated (HODHA) – first positive specimen date 15 or more days after admission From May 2020 to the end of Q1 the Trust has reported one HOIHA (3-7 days after admission), zero HOPHA and zero HODHA cases. The Board were reassured that there were no hospital related Covid positive cases. Mr N Halford explained that it is difficult to control E-coli infection transmission rates due to the ageing population and deprivation. Dr R Bonnington reported that urine infections were more prominent in elderly females and care homes encourage regular hydration. After further consideration, it was: **RESOLVED:** to receive the report for assurance	
20/94	**INTEGRATED QUALITY AND LEARNING REPORT:** Dr H Lloyd, Director of Nursing, Midwifery & Quality provided an update to the Board on the Trust's quality and safety performance for the last 18 months to May 2020. The report has been received and discussed at the Quality Governance Committee on 15th July 2020. She highlighted some of the key messages including: • Falls have gone down however the rate has gone up. This is due to the difference in data – lower patient numbers in hospital but with higher dependency • All Serious Incident Panels were suspended as part of the Trust's response to Covid-19 however clear plans are in place to reinstate the SUI panels and the Falls Serious Incident Panel was reinstated in June 2020 • Pressure damage has increased however this demonstrates special cause variation due to the number of poorly patients requiring critical care in the organisation and community. • Never events – Human Factors training focussed on theatres	

Agenda Item	Discussion and Action Points	Action By
	• Mortality rates – HSMR and SHMI are reported as expected and a high number of deaths related to Covid. Learning Disability mortality reviewed and assessed as non-preventable • Reduction in complaints and increase in compliments. The complaints service has now been fully reinstated • CQUIN "holiday" implemented and will remain suspended for the remainder of year Following a query from Mr J Robinson regarding whether the mortality statistics will be adjusted in relation to Covid deaths, Dr Lloyd explained that there is a time delay in quarterly reporting figures. After consideration, it was: **RESOLVED:** to receive the report for assurance	
20/95	**NHS INPATIENT SURVEY 2019:** Dr H Lloyd, Director of Nursing, Midwifery & Quality, provided a summary of the NHS Inpatient Survey for 2019. She reported that the NHS Inpatient Survey is carried out by Picker, on behalf of the Trust, along with 74 other trusts. The report presents the organisation's results in comparison to the average for these trusts. 48% of patients responded to the survey and the Trust is placed 15th in the League Table for overall positive score. Dr Lloyd drew attention to some of the good story highlights including a positive score of 88% overall rated their experience as 7/10 or more, 98% felt treated with respect or dignity and 98% felt that doctors had confidence and trust. A review of the low scoring questions will take place and focus areas for improvement will be developed into action plans for the Business Units to be reported back to the Quality Governance Committee in 6 months' time. Following further discussion, it was: **RESOLVED:** to receive the report for assurance.	HL
20/96	**ASSURANCE REPORTS FROM BOARD COMMITTEES** Mrs A Marshall requested a verbal update on the assurance reports from the Committees that have been reinstated and the assurance reports for all Board Committees will be presented at the September Board.	AM

Agenda Item	Discussion and Action Points	Action By
	i) Quality Governance Committee Mr D Shilton provided a verbal update from the Committee meeting held on 15th July 2020. He reported that updates were provided on the Board Assurance Framework and Risk Register, Quality & Safety report and IPC Framework. Discussion took place in relation to the Medical Examiner roles and cancer services, diagnostics and treatments. Concerns were raised regarding the safeguarding of adults and children due to an increase in neglect cases primarily due to Covid isolation and domestic abuse. An overall green rating was provided. The CQC Insights Report was reviewed which included a wide range of metrics however performance is similar to other organisations. An overall amber rating was provided due to work still to be done. A verbal update was provided on the Maternity review which is making good progress and a full report will be presented to the Board in September. Amber rating **ii) Finance & Performance Committee** Mr S Bowron provided a verbal update from the Committee meeting held on Tuesday 28th July 2020. The Trust's financial performance report was discussed earlier in the meeting and Mr Bowron reminded the Board that the Trust is in a breakeven position. Planning guidance is currently awaited and an action plan is expected to be presented in September. This will be jointly reviewed with the Quality Governance Committee to take into discussions around risk. Strategic objectives will be discussed further in Part 2 however further development work is ongoing to ensure these are completed in line with SMART guidance.	HL JB/HL
20/97	**QUESTIONS FROM GOVERNORS IN ATTENDANCE:** Reverend J Gill wished to thank Alice Wiseman for her comprehensive presentation and was reassuring to be made aware of the collaboration between the Trust and Council and will pass this on. Mrs A Marshall also felt that it would be beneficial for the rest of the Governors to ensure that this is shared.	

Agenda Item	Discussion and Action Points	Action By
	Mr J Stephens requested further assurance around staff well-being and Dr H Lloyd emphasised that staff have worked tremendously well and have been encouraged to take annual leave to ensure sufficient rest and recuperation periods. Some staff have been working from home and staff morale is good recognising the benefits from the national response. There is a level of uncertainty in relation to the long term effects however there has been a large focus on health and well-being and psychological support has been ensured. Mrs Y Ormston highlighted that staff risk assessments have been undertaken in relation to evidence of health inequalities particularly around BAME staff and these assessments are due to be completed by the end of this week. Mrs J Baxter reported that Mr J Emerson, Interim Deputy Director of Workforce, is looking at undertaking regular snapshot surveys which will be monitored closely and feedback will be presented to the Board.	JMB
20/98	**DATE AND TIME OF THE NEXT MEETING:** **RESOLVED:** that the next meeting of the Board of Directors will be held at 9:30 am on Tuesday 29th September 2020 via Microsoft Teams	
20/99	**EXCLUSION OF THE PRESS AND PUBLIC:** **RESOLVED:** to exclude the press and public from the remainder of the meeting due to the confidential nature of the business to be discussed	

PUBLIC BOARD ACTION TRACKER

Gateshead Health NHS Foundation Trust

Item Number	Date	Action	Deadline	Executive Lead	Progress
20/90	29/07/2020	Outpatient capacity – to look at possible additional space from leisure/community centres. To be reviewed as part of future planning work.	30/09/2020	YO/JMB	Being considered as part of the Phase 3 action plan, all eventualities being considered. Request to close
20/95	29/07/2020	NHS Inpatient Survey 2019 – Business Unit action plans to be developed to be reported back to Quality Governance Committee in 6 months' time	31/01/2021	HL	
20/96	29/07/2020	Board Committee Assurance Reports – to be reinstated and presented at the September Board	29/09/2020	AM	
20/96	29/07/2020	Quality Governance Committee Assurance Report – Maternity Review Report to be presented at the September Board	29/09/2020	HL	
20/96	29/07/2020	Finance & Performance Committee Assurance Report – Planning guidance action plan to be jointly reviewed with Quality Governance Committee to discuss risks	30/09/2020	JB/HL	
20/97	29/07/2020	Staff Health & Well-Being – to undertake regular snapshot surveys to feedback and present to the Board	30/11/2020	JMB/LCJ	JMB to discuss ongoing considerations with LCJ – request to close

Trust Board

Gateshead Health NHS Foundation Trust

Report Cover Sheet

Agenda Item: 7

Date of Meeting:	Tuesday 29 September 2020			
Report Title:	Work to Support our Black Asian and Minority Ethnic Staff			
Purpose of Report:	To endorse the contents of the ICS Collective Promise as attached at Appendix 1 and support the next steps			
	Decision: ☒	**Discussion:** ☐	**Assurance:** ☐	**Information:** ☐
Trust Goals that the report relates to: (Including reference to any specific risk)	**Goal 1** Working with partners, we will manage and improve the health of the population of Gateshead, promoting wellbeing and preventing the occurrence and progression of ill-health wherever possible. **Goal 2** All the services we deliver will be good or outstanding when assessed against being safe, effective, caring, responsive, and well-led. **Goal 4** All our services will have a high safety culture in which openness, fairness, accountability and learning from high levels of incident reporting and mortality reviews is the norm. **Goal 5** All our services will be effective: we will reduce unwarranted variation, ensure our practice is consistent with recognised best practice 7 days a week, and improve outcomes for patients. **Goal 6** We will have an engaged and motivated workforce living the values and behaviours of the organisation, and who are responsive and adaptive to the changing needs of our environment. **Goal 7** We will deliver value for money and help ensure the local health and care system is sustainable and well led.			

Recommendations: (Action required by Board of Directors)	The Board is asked to 1 Endorse the contents of the ICS Collective Promise as attached at Appendix 1 and support the next steps 2 Note the further Trust actions required as part of the delivery of Phase 3 Covid and the Peoples Plan which will be reported to the Board 3 Note the further actions agreed on 21 August 2020 as part of the Board Development Session
Financial Implications:	
Risk Management Implications:	Failure to comply with NHS and Statutory requirements
Human Resource Implications:	
Trust Diversity & Inclusion Objective that the report relates to: (including reference to any specific implications and actions)	**Objective 2** The Trust promotes a culture of inclusion where employees have the opportunity to work in a supportive and positive environment and find a healthy balance between working life and personal commitments. **Objective 3** Leaders within the Trust are informed and knowledgeable about the impact of business decisions on a diverse workforce and the differing needs of the communities we serve.
Author:	Mrs Y Ormston MBE, Chief Executive
Presented by:	Mrs Y Ormston MBE, Chief Executive

EQUALITY, DIVERSITY AND INCLUSION

WORK TO SUPPORT OUR BLACK, ASIAN AND MINORITY ETHNIC STAFF (BAME)

INTRODUCTION

We want all our staff to feel valued and supported at work and to be themselves. The EDI work within our Trust aims to influence policy within the organisation, improve staff experience and generally work to ensure we have greater diversity and a more culturally inclusive organisation. This in turn will help us to better meet the need of our patient population.

The Board as part of its Development Programme recently spent some time focusing on listening to the experiences of some of our BAME staff and what it feels like to work in the Trust and received an update on the work that the BAME Staff Network has been involved in and plans going forward.

BACKGROUND

Last year as part of our EDI work and in response to staff feedback from both the Staff Survey results and the Time to Talk sessions, three staff networks were established.

- The Black, Asian and Minority Ethnic Network (BAME)
- The Disability Network (D-Ability)
- The Lesbian, Gay, Bisexual, Transgender + Network (LGBT+)

The Networks have made a fantastic start and have been invaluable to us through Covid. Whilst the pandemic has taught us new ways of working, it has also served to draw attention to the injustices and inequalities in our society, communities and workplaces, in particular inequalities experienced by people from BAME backgrounds.

1. The Health Foundation report on Covid-19 identified that it has been apparent from the early stages of the pandemic that some groups are at much higher risk of catching and dying from the virus than others. Factors such as age, gender, ethnicity and socioeconomic deprivation are all known to be important. Critically these factors combine in complex ways to put some people at much greater risk.

2. The Public Health England's recent report tells us that the research suggests that people of Bangladeshi ethnicity are twice as likely to die as those who are white British. People of Chinese, Indian, Pakistani, other Asian, Caribbean and other black ethnicities have a 10-50% higher risk of death than those of white British ethnicity.

3. Tackling inequalities has been identified as a priority going forward in both the planning for the Phase 3 Recovery and the Peoples Plan with some very specific actions in relation to BAME staff.

TRUST WORK

Some of the recent work and initiatives that we have put in place recently include:

1. The appointment of Equality, Diversity and Engagement Manager, Mr Kuldip Sohanpal. Kuldip joins us from Pennine Care NHS Foundation Trust where he has been working as an EDI Manager and brings with him a wealth of experience in this area.
2. A WRES action plan has been approved by the HR Committee. This will be reviewed when Kuldip and the Director of People and OD come into post.
3. The BAME Network has been successfully established and the Chair has been given protected time. The group has been establishing its membership, work priorities, resource directory, giving advice to HR eg. risk assessments, webinars, planning events for Black History month in October. The Board heard the detailed results of a survey of BAME staff, their work experience and how they felt the Trust could better support them.
4. Requirement for risk assessments for BAME staff. This was extended to all staff and good progress has been made.
5. A personal letter from the CEO to all staff was sent out in June 2020 requesting everyone to think about what more they could do to make a positive difference to inequality and discrimination.
6. The Board development session held on 21 August.

ICS WORK

As WRES lead for the ICS, the CEO has additionally led discussions regarding the collective actions we need to be taking and these have also fed into a broader meeting with LA, Healthwatch and voluntary sector representatives. This work then fed into North East and Yorkshire Regional discussions with the national Director for Workforce Race Equality and the formulation of a Collective Promise to our BAME Staff. All NHS organisations have been asked to formally sign up to the content and support the next steps, recognising that as conversations continue with our BAME communities, the promise may be further shaped and refined. The Promise is attached at Appendix 1 and the Board is requested to formally endorse this.

Next steps include:

- All BAME Network Chairs to be invited to a collective ICS meeting to share the Promise and start a conversation as to what the Promise means for us locally and next steps, notably relating to actions needed.
- Work with the group of Network Chairs to provide them with leadership support with the potential in time to use the group as a reference point for ICS decision-making.
- Explore whether other ICS partners would like to adopt the Promise as a Public Sector promise adapted for their own use.
- A self-assessment audit is being undertaken of the various Staff Networks across the ICS to determine further development/support needs.

FURTHER TRUST ACTIONS

Both the Phase 3 Covid response and the Peoples Plan contained a number of themes and actions relating to health inequalities, Equality, Diversity and Inclusion and looking after our BAME staff and local populations. In particular the following:

Phase 3 Covid Actions

- Protecting the most vulnerable from Covid with enhanced analysis and community engagement to mitigate risk.
- Accelerate preventative programmes which pro-actively engage those at greatest risk of poor health outcomes including BAME.
- Strengthening leadership and accountability by having a named Board Executive for tackling inequalities.
- Publish an Action Plan showing how over the next five years Board and senior staffing will in percentage terms match the overall BAME composition of its overall workforce, or its local community whichever is the higher.
- Review and ensure completeness of patient ethnicity data.

Peoples Plan

- Overhaul recruitment and promotion practices to ensure that staffing reflects the diversity of the community, and regional and national labour markets.
- Discuss Equality and Diversity and Inclusion with every member of staff as part of the Health and Wellbeing conversation.
- Publish progress on leadership reflecting BAME workforce.
- 51% of organisations to have eliminated the ethnicity gap on numbers entering the formal disciplinary process.
- Review governance arrangements to ensure staff networks are able to contribute and inform decision making processes.

As part of the Board Development a number of points were raised in discussion:

- The CEO and Chair will look at the potential of creating a shadow board which could include the Network Chairs and other staff. In other organisations these have been used as part of a talent management approach and succession planning but also to hear the voices of those staff who find it difficult to be heard.
- The CEO and Chair will also develop a proposal for a NED apprentice scheme specifically encouraging BAME and other protected characteristic applicants.
- A number of Boards have committed to reverse mentorship schemes. This allows Board members to gain exposure to the diverse insights of staff with different lived experiences.
- Many initiatives throughout NHS organisations have endeavoured to increase inclusivity but this is extremely challenging if it is not led and role modelled from the Board. The Board is requested to maintain a focus on EDI as part of its development work and hold similar conversations with other protected characteristic groups.

- We have received a request from all the Staff Networks to assign a named Executive Director to support them. Jo Baxter has agreed to support the BAME Staff Network.

RECOMMEDNDATIONS

The Board is asked to

1 Endorse the contents of the ICS Collective Promise as attached at Appendix 1 and support the next steps
2 Note the further Trust actions required as part of the delivery of Phase 3 Covid and the Peoples Plan which will be reported to the Board
3 Note the further actions agreed on 21 August 2020 as part of the Board Development Session

Mrs Yvonne Ormston MBE
Chief Executive

APPENDIX 1

Our collective promise to our
Black, Asian and minority ethnic colleagues and communities

Healthcare leaders across the North East and Yorkshire are committed to better supporting people from Black, Asian and minority ethnic (BAME) communities. This includes ensuring fairness for all and embedding a culture where, no matter your race and/or background, your personal experience, either as a staff member or as someone who accesses health and care services, is one that is not influenced by racism or any bias, be it unconscious or not.

Our collective promise includes:

- Increasing diversity across all levels of workforce, boards and governing bodies (including leadership), underpinned by transparent and fair recruitment processes
- Introducing yearly learning and development activities for all staff on the subject of unconscious bias and/or cultural intelligence
- Ensuring through commissioning and encouragement that all leadership boards have a programme of reporting, training and development which focuses on workforce race equality standards, such as WRES metrics or other locally determined measures.
- Ensuring feedback mechanisms are firmly in place for all protected groups and can demonstrate specific feedback from BAME colleagues and communities creating psychological safety
- Supporting zero tolerance for bullying and abuse as a result of racism
- A programme which recognises the talent and leadership potential of our BAME colleagues
- Ensuring our work place environments support people from all backgrounds
- Ensuring all organisations have established staff networks to support listening into real, tangible action, where not already in place
- A commitment to continue to understand and develop strong allyship to our BAME communities and colleagues
- Ensure promotional or communications activity actively reflects the communities we service and our workforce
- Engaging BAME service users and carers in patient and carer involvement activities

Signed: Signed: Signed:

Date: Date: Date:

Trust Board

Gateshead Health NHS Foundation Trust

Report Cover Sheet

Agenda Item: 8

Date of Meeting:	Tuesday 29th September 2020			
Report Title:	Board Meetings 2021			
Purpose of Report:	To inform the Board of the planned Board meeting dates for 2021.			
	Decision: ☒	**Discussion:** ☐	**Assurance:** ☐	**Information:** ☐
Trust Goals that the report relates to: (including reference to any specific risk)	Not applicable			
Recommendations: (Action required by Board of Directors)	The Board is asked to: • Receive for approval the dates of the Board of Directors' meetings to be held in 2021			
Financial Implications:	None			
Risk Management Implications:	None			
Human Resource Implications:	None			
Trust Diversity & Inclusion Objective that the report relates to: (including reference to any specific implications and actions)	None			
Author:	Kirsty Roberton, Strategic Transformation Programme Lead Transformation			
Presented by:	Alison Marshall, Chair			

Gateshead Health NHS Foundation Trust

Board of Directors' Meetings 2021

During 2021 the Board of Directors will hold 7 public meetings including the Annual General Meeting.

Date	Time	Venue
27 January 2021	9.30am	Room 3 Trust HQ
31 March 2021	9.30am	Room 3 Trust HQ
26 May 2021	9.30am	Room 3 Trust HQ
28 July 2021	9.30am	Room 3 Trust HQ
28 September 2021 (Tuesday)	9.30am	Room 3 Trust HQ
29 September 2021 Annual General Meeting	9.30am	Lecture Theatre
24 November 2021	9.30am	Room 3 Trust HQ

Trust Board

Gateshead Health NHS Foundation Trust

Report Cover Sheet

Agenda Item: 9

Date of Meeting:	Monday 28th September			
Report Title:	Winter Plan			
Purpose of Report:	For approval			
	Decision: ☒	**Discussion:** ☒	**Assurance:** ☒	**Information:** ☐
Trust Goals that the report relates to: (Including reference to any specific risk)	**Goal 1** Working with partners, we will manage and improve the health of the population of Gateshead, promoting wellbeing and preventing the occurrence and progression of ill-health wherever possible. **Goal 3** In all locations and settings of delivery, our patients will experience excellent, timely and seamless care that meets their individual needs. **Goal 5** All our services will be effective: we will reduce unwarranted variation, ensure our practice is consistent with recognised best practice 7 days a week, and improve outcomes for patients. **Goal 7** We will deliver value for money and help ensure the local health and care system is sustainable and well led.			
Recommendations: (Action required by Board of Directors)	The Board is asked to agree the winter plan and note the robust planning that has taken place to ensure our services are sustainable during winter. The board are however asked to note the risks in relation to bed availability to delivery of key performance targets and Phase 3 recovery requirements. However as described in the plan those risks will be mitigated wherever possible by implementing the transformation programmes to reduce admissions, reduce length of stay and improve discharge arrangements.			
Financial Implications:	The financial implications are set out in section 20 of the plan.			

Risk Management Implications:	All risks will be documented in the Trusts risk management system and will be managed in line with the actions set out in the plan
Human Resource Implications:	Workforce Implications are set out in section 11
Trust Diversity & Inclusion Objective that the report relates to: (including reference to any specific implications and actions)	Those highlighted in the Phase 3 recovery and people plan have been considered.
Author:	Operational Directors Mrs Joanne Baxter, Chief Operating Officer
Presented by:	Mrs Joanne Baxter, Chief Operating Officer

Gateshead Health
NHS Foundation Trust

Gateshead Health NHS Foundation Trust Winter Plan 2020/21

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APPENDICES

1. Introduction

1.1 Although there is no long-term weather forecast available for winter 2020/21, the likely effects of winter on the population served by the Trust as well as the wider population and NHS are well known, for example, increased fractures due to slips trips and falls, and increased emergency admissions as a result of the deterioration of chronic health problems. In addition, increased staff sickness absences and potential transport difficulties are likely to have an impact on the Trust's ability to deliver a high quality service over the winter months. Robust planning and forecasting is therefore required in order to reduce the likely impact as much as possible to ensure our patients continue to receive safe, effective care and a good patient experience.

1.2 This year, winter 2020/21 is likely to be an unusual year made more complex due to Covid-19 but also taking into the account the changing patterns of demand shown in 2019/20, (discussed below in review of last year) along with the likelihood of a challenging flu season.

1.3 The Trust provides a range of services including Acute Medical and Surgical specialties, Urgent and Emergency care provision, Diagnostic and Screening services, Older Persons Mental Health services consisting of inpatient beds, community and day care services, along with a wide range of Community Services. It is important therefore that our Winter Plan is robust and provides resilience in all services to ensure the pressures that winter brings are managed appropriately

1.4 Since last winter the Trust has taken a number of steps to improve resilience these include:

- Revised its senior management structure to strengthen its operational capacity and co-ordination
- Appointed a new Chief Operating Officer and four Director of Operations roles
- Created a new Head of Emergency Planning, Preparedness and Resilience role and strengthened supporting arrangements for resilience, patient flow and escalation
- Clarified the roles of senior medical, nursing and service managers in managing winter pressures to be more in line with best practice
- Reviewed and updated the related policies and procedures relating to bed and site management along with ensuring on-call requirements meet the needs set out within the NHS England EPRR (Emergency Preparedness Resilience and Response) core standards
- Revised operational policies and procedures for patient flow, discharge, length of stay, bed management, escalation, and capacity in the hospital out of hours and at weekends.
- Is working to ensure the proactive use of IT and live performance dashboards in real time to support bed and site management and decision making, ensuring forecasting drives planning assumptions
- Improved management of surges in demand with NEAS and other partners through working more collaboratively at the point of call.
- The use of revised and clear concise action cards to inform decision making at Operational, Tactical and Strategic levels related to OPEL escalation
- Invested in the estate to facilitate better patient flow and escalation

1.5 The Trust has co-operated and collaborated with system partners via the Regional Chief Operating Officer Group (COO Group) and Urgent and Emergency Care Network with the ICS and ICP in planning for winter across a wider footprint than Gateshead. We have submitted information in response to requests from:

- The North East and North Cumbria Emergency Care Network modelling 2 scenarios
- The Local Area A&E Delivery Board setting out our winter intentions
- To the COO Group for use by the Integrated Care System, this winter plan is consistent with those submissions

1.6 To manage winter pressures the Trust works with health and care partners in Gateshead through the Gateshead System Group (all partners) and Gateshead Care Partnership (Providers). This partnership working emphasises the importance of:

- Accessible and responsive primary care to avoid admissions
- An adequate provision of social care including care homes, accommodation for patients to "step down" into from hospital or "step up" into to avoid admission, and trusted assessor and discharge to assess arrangements are in place
- Effective patient transport to enable timely discharge
- Community Services especially rehabilitation and rapid response to avoid admissions.
- Embedding early supported discharge processes commenced during Covid 19
- System wide working- reducing perceived or actual barriers to safe timely care provision

1.7 This plan has included the use of best practice such as those described in:

- Transforming Urgent and Emergency Care Services, Safe, Faster, Better (2015)
- Good Practice Guide, focus on patient flow (2017)
- Safer Patient Flow Bundle
- Hospital Discharge Service Requirements (NHS England 2020)

1.8 It also relates to other associated documents such as:

- The Trust's Outbreak Plan
- OPEL escalation Plan
- Bed management policy
- MAJAX plan/Major Incident Plan
- Flu Pandemic Plan
- Flu Plan
- Adverse Weather Plan
- Discharge Policy
- Opening a ward procedure
- Business continuity plans

2. Covid-19

2.1 The Covid-19 pandemic has fundamentally impacted on our winter planning. We are now operating in a totally different way including:

- Reallocation of wards to support Covid, query Covid and non-Covid patients this is particularly in relation to front of house services namely EAU and Wards 1 & 2
- Increased infection control measures ranging from wearing PPE, donning and doffing requirements, to socially distancing requirements in waiting areas
- Enhanced cleaning regimes and therefore turnaround times of clinical estate
- Having a robust Covid outbreak policy that can be instituted quickly to minimise spread of potential Covid cases
- Linking our winter, Covid escalation and Phase 3 recovery work with triggers and thresholds determining operational delivery
- Risk assessing staff and in particular our BAME staff to reduce the risk of their exposure to Covid
- Supporting staff shielding or self-isolating which impacts on staffing numbers
- Patient Testing requirements on admission and discharge
- Testing and tracing staff potentially exposed to Covid in line with national guidance. The impact of this on staffing numbers is significant
- Having 2 metres between beds which has reduced bed capacity on our estate
- Increased disruption to social care, therefore a need to continue to support social care especially care homes
- Promoting Independence Centres have not reinstated intermediate care bed provision
- Discharge to assess model
- Continuing health care funding has completely changed
- The implementation of shielding requirements for patients
- A focus on managing care which was delayed by Covid-19 and has had an impact on waiting times and referrals to treatment

2.2 The Trust first admitted patients with suspected Covid-19 on 20th March 2020. We reached a peak of 124 patients on 9th April 2020 and stayed at a consistently high level of occupancy until mid-May 2020. Gateshead was identified as one of the five local authority areas with the highest rates of infection and was placed back on the national watch list on 10th September 2020 with local lockdown restrictions from 18th September 2020.

2.3 Staffing availability was also affected as in line with national guidance staff shielded. At the highest point on 9th April 2020 459 staff, approximately 15% was absent due to Covid-19.

2.4 The Trust initiated its Command and Control Emergency arrangements on 16 March 2020 and implemented strategic, tactical and operational command structures. A Covid escalation plan was developed to support this.

2.5 In line with national guidance the Trust:

- Increased critical care capacity to 41 beds and redeployed staff
- Suspended elective surgery
- Created Covid and non Covid areas
- Suspended routine Community Services
- Carried out estates work to increase capacity for oxygen supply and therapy
- Implemented revised discharge arrangements

- Revised to whole estate to ensure services were safe, this involved moving a number of services within the Trust acute and community sites.

2.6 The Trust also joined local created “cells” covering:

- Testing and because of our Pathology expertise, took a lead role in Covid detection
- Care Home Support
- Discharge
- Primary Care including supporting GP ‘hot sites’
- Outbreak Control led by the Director of Public Health. Standard Operating Procedures have been agreed for outbreak management

2.7 These cells have now been disbanded and routine governance arrangements are now slowly moving back in place

2.8 Some of the key lessons from our experience of Covid-19 to date include:

- The need to be able to respond quickly to increasing numbers of Covid presentations including the reallocation of wards and rapid discharge of patients
- The need to deploy staff and resources quickly in response to evolving situations
- Keeping staff safe, healthy and well both physically and psychologically
- Supporting flexible working
- Risk assessing staff and particularly our BAME staff
- Adopting new ways of working including remote consultations via Attend Anywhere as an example
- Growing our workforce including via training for specific areas such as critical care
- Working collaboratively across our locality of Gateshead but also more broadly in our Integrated Care Partnership (ICP) and Integrated Care System (ICS)
- Protecting the most vulnerable people in our community from Covid
- Restoring our NHS services by accelerating transformation programmes
- Strengthening our leadership
- The need, with the CCG, Primary Care and Gateshead Council to support care homes with nursing capacity. At the CCG’s request in Phase 1 and 2 we intervened to keep a number of care homes open. There is a need to commission a Rapid Response Team to support care homes with Covid-19 outbreaks or staff shortages in the winter period and beyond, this is currently being developed with GCP partners. This has been funded for 12 months.
- To adapt national guidance to local circumstances especially on testing regimes
- Increasing the frequency and detail of communications to staff
- With partners to ensure primary care continues to operate an accessible service
  We are working through these lessons with partners. Plans are in place and are being progressed for implementation.
- Ensure a whole system approach is utilised linking key professionals
- Daily pattern calls to support real time information and unified planning
- Mutual understanding of service or delivery pressures across all partners and the impact on others
- Mutual understanding and co-ordination of key messages going to staff- trying to pre-empt Q+A's across all partners
- Secondary, Primary and Social care to work in collaboration to provide resilience and support
- Co-location of rapid response services during critical times to share information and reduce duplication of effort

- The ability to be flexible in service delivery very quickly i.e. within hours
- The willingness of staff to help wherever they could to ensure patient care was not negatively affected
- Mutual aid and response when one are of service delivery at a system level was unable to deliver
- Co-ordination at a central level for direction and communication
- Resilience in many workforces was not enough at peak outbreak which did affect the quality of care delivered
- We are an integrated provider and community services were being asked to support in all directions so tough decisions had to be made
- Palliative and EOL care was a particular challenge as staff felt they did not the time to get to know their patients well enough prior to death
- Procurement/facilities and estates colleagues need to be an integral part of any planning processes going forward

2.9 We have learned the lessons of the earlier phases and have well tested Covid-19 systems and processes. This includes the use of testing for patients likely to be admitted for 24 hours or more. For winter 20/21 we have developed pathways for Covid-19 positive and Query Covid patients as part of our approach to bed management. Thresholds and trigger points to support escalation and de-escalation are detailed in our Covid escalation plan.

2.10 The Winter Plan 2020/21 assumes manageable levels of Covid-19 admissions. Caveats to the Winter Plan linked to Covid-19 include:

- Infection and admission rates are maintained at predicted levels
- The social care sector being able to maintain residents at home and accept discharges
- No major changes in IPC which would reduce our bed base or staff availability
- No major staffing difficulties as a result of track and trace

3. Review of Winter 2019/20

3.1 Winter 2019/20 was one of the most challenging ever faced by the NHS. The key features were:

- The continuation of demand pressures from Winter 2018/19 into Spring and Summer
- An earlier onset of winter pressures from September 2019 linked to a strain of ‘flu’ first identified in Australia
- The continuation of winter pressures at an intense level over into early Spring 2020.
- The COVID 19 Pandemic from early March 2020

3.2 For the Trust this meant:

- Sustained increase in demand of 7% on average above usual winter pressures
- An average bed occupancy of 96.5% and on some weeks 98% which inhibited patient flow which affected ED performance
- Staffing and budget pressures caused by the need to open beds over and above the winter plan. The Trust opened additional beds, especially on Ward 12 for a longer period than planned.
- Levels of performance below the nationally mandated targets and the exceptional situation of 2 breaches of 12 hour waiting times
- Poor patient experience
- Sustained stress on staff

- Requests to other Trusts for mutual help on more occasions
- Increased scrutiny by regulators and reporting to Trust Board

3.3 These additional pressures were experienced across the North East but particularly in some neighbouring Trusts. Consequently there was an unknown and therefore unplanned impact on increased activity in Gateshead which led to patients in ambulances being diverted to us therefore affecting our ability to respond.

3.4 Our experience of Winter 2019/20 highlighted:

- The need to work more closely at a senior level with ICP and ICS partners to plan for winter and in the day to day management of pressures –
    - As a result there is now a regional Chief Operating Officer network and this is strengthened by the regional Urgent and Emergency Care Network which reports directly to the ICS. LADB's have also been aligned to the ICP footprints.
- The need to strengthen our operational management of winter aligned with business continuity planning and emergency response and resilience (EPRR) –
    - Appointment of a Chief Operating Officer (Accountable Emergency Officer) and Head of EPRR, aligning the winter response through on-call, escalation and resilience planning
- The need to revise our structures and investing in operational capacity –
    - the appointment of the new Operational Directors
- Severe staffing pressures in the nursing and medical workforce need to be addressed –
    - recruitment to nursing posts has been successful and refinement of services and the estate to make best use of medical teams and ensuring processes are lean. We have introduced new rota management systems and are working on strengthening our senior decision maker presence overnight and at weekends.
- Our planning and forecasting needed to be more accurate to enable appropriate bed management and staffing is planned for and managed proactively –
    - this plan therefore includes modelling from a number of scenarios taken from previous actual activity and that seen through Phase 1 of the Pandemic to ensure our staffing and bed capacity can flux to meet that demand as best possible.
- The opening of extra beds needs to be managed safely and effectively and the need for same managed through improved bed occupancy, reduced length of stay and better discharge processes –
    - best practice relating to the above is being incorporated into our transformation programme and winter planning requirements

4. National Guidance and Good Practice

4.1 Good practice is available from a number of sources including:

- NHSE's Emergency Care Intensive Support Team (ECIST).
- The Royal College of Emergency Medicine.
- The Kings Fund.
- NHS England/Improvement
- Provider organisations such as NHS Providers.

4.2 The good practice that we will implement is:

- Working collaboratively with partners in Social Care, Ambulance Services, Primary Care, the Voluntary Sector and Community Services to reduce avoidable presentations to A&E, admissions and re-admissions.
- Implement the Same Day Emergency Care requirements to safely avoid admissions for those with ambulatory conditions
- Implement 'Talk before you Walk' to manage urgent activity more effectively
- Reducing length of stay by setting an expected date of discharge on the day of admission utilising model hospital benchmarked LOS data and one that the whole of the MDT work together on to realise
- Create discharge processes which aim to discharge 33% of patients before 12 noon using criteria led discharge, discharge to assess and regular senior review
- Ensuring robust discharge transport arrangements are in place
- Closely and proactively monitoring and reviewing stranded, super stranded and DTOC
- Implement Red and Green Days approach
- Implement SAFER Care Bundle
- As part of discharge and caring for people at home, have Rapid Response health and care services available
- Implement new discharge requirements published August 2020

4.3 Through the Trust's Transformation Portfolio we are also working towards good practice with an emphasis on:

- Ensuring real time bed management is in place and develop the 'command' centre approach utilising the technology available
- Proactively managing capacity through forecasting, modelling and improved preparation and planning through live dashboards
- Ensuring real time workforce management information is available to better manage workforce requirements

5. Purpose of the Winter Plan

5.1 Taking into consideration the learning from previous winters and the COVID pandemic, this Winter plan for 20/21 sets out the framework within which the operational processes will be implemented, and any surge in activity managed effectively. It does not however contain the detailed contingency plans (e.g. MAJAX) or the related procedures that will be implemented over the winter period e.g. the Operational Pressures Escalation Plan (OPEL) and associated action cards and bed capacity management procedure as these plans are already in existence and fit for purpose.

If the surge in activity is a result of seasonal flu, then the plan will work alongside the Trust's Flu escalation levels. If a result of pandemic flu then the winter plan will work in conjunction with the agreed Trust wide pandemic flu plan and outbreak plan.

5.2 The key aims of the winter plan are therefore to:

- Ensure the Trust has the ability to respond effectively and quickly to increased seasonal and Covid-19 demand whilst also maintaining Phase 3 recovery work
- Maintain the highest standards of patient safety, quality of care and patient experience
- Most efficient use of resources available
- Ensure staff feel supported
- Ensure key performance standards are met
- Effective management of Covid and non Covid-19 beds and infection prevention and control

5.3 This document applies to the whole of Gateshead Health NHS Foundation Trust and will form part of the regional whole health economy winter plan. It will be submitted to Trust Board, the Local A&E Delivery Board and will be scrutinised by the ICP and ICS, NHSE/I.

6. Roles and Responsibilities

6.1 To enable the winter plan to work effectively staff must be clear about their roles and responsibilities in delivery of the plan. Outlined below are the roles and responsibilities of the key people in terms of delivering the winter plan. Where the key person below is unavailable eg. due to annual leave, they are required to ensure clear and appropriate arrangements are in place to ensure continuity of their responsibilities/tasks for example nomination of a deputy. The following section outlines the known responsibilities for these people, as plans are developed additional responsibilities may be added to reflect the planned approach.

6.2 Trust Board

The role of the Trust Board is to ensure that the winter plan is produced and is fit for purpose to meet expected patient demand.

6.3 Chief Executive

The role of the Chief Executive is to ensure that there are robust winter planning arrangements in place, that there is delegated responsibility to an Executive Director for the delivery and monitoring of the plan and to ensure adequate resources are made available to implement it.

6.4 Chief Operating Officer

The Chief Operating Officer has delegated responsibility from the Chief Executive for the development, implementation and monitoring the effectiveness of the plan alongside being the Accountable Emergency Officer (AEO). In addition, the Chief Operating Officer has the responsibility to alert the Chief Executive and other Executive Directors if the plan is not working and advise what remedial action has been taken and its impact.

The Chief Operating Officer has shared responsibility, along with the Medical Director and the Director of Nursing, through the triumvirate to ensure that the quality of care and patient safety is maintained during times of increased patient activity and acuity throughout the winter period. The Chief Operating Officer is also responsible for leading the development of communication mechanisms with external bodies.

6.5 Heads of Clinical Service

The Heads of Service will work with the Directors of Operations and Chief Matrons through the triumvirate to ensure best practice guidance and the trusts transformation plan is implemented and adhered to in relation to maintaining flow to support the delivery of the winter plan and provide visible clinical leadership during winter. They will ensure clear communication strategies are in place with clinical leads and ensure the best practice for patient review, criteria led discharge and the safety of patients is maintained

They will also ensure that any risks to patient safety are identified and mitigated appropriately. Where this cannot be achieved ensure issues are escalated appropriately.

6.6 Directors of Operations

The Directors of operations are responsible for ensuring the development and operational management and delivery of the winter plan and its related arrangements, including ensuring there are robust processes in place for SITREP reporting. They will:

- Ensure teams are fully aware of their roles and responsibilities in relation to winter.
- Ensure those that are identified as requiring it attend the training in relation to winter and surge management e.g. those on call.
- Provide Tactical level support to ensure the site is managed appropriately
- Take a key role in Tactical on call rota
- Ensure that, wherever possible patient flow occurs in a way to benefit patients who are on an acute pathway and also support the teams who are delivering the pathways of care across the health and social care economy so they are joined up to ensure that there is a seamless transition of care into and out of hospital to and from different care settings.
- Escalate any concerns which cannot be resolved by them to the Chief Operating Officer

6.7 Director of Nursing

The Director of Nursing has shared responsibility with the Medical Director and Chief Operating Officer to ensure that the quality of care and patient safety is maintained at times of increased patient activity and acuity during the winter period. The Director of Nursing must ensure that quality and safety risks are quantified and escalated appropriately and ensure that mitigating actions are identified, implemented and monitored.

The Director of Nursing will continue to provide visible professional leadership to Nursing, Midwifery and AHP colleagues, most specifically at times of increased pressure, and provide leadership and support as DIPC during the planned staff flu vaccination programme.

6.8 Medical Director

The Medical Director has shared responsibility with the Director of Nursing and Chief Operating Officer to ensure that the quality of care and patient safety is maintained during times of increased patient activity and acuity during the winter period.

The Medical Director will ensure that in the event that quality and safety risks occur, they are quantified and escalated appropriately, and that mitigating actions are identified, implemented and monitored.

The Medical Director will continue to provide visible professional leadership to medical colleagues, most specifically at times of increased pressure. The Medical Director as DIPC will provide leadership and support during the planned staff flu vaccination programme.

The Medical Director will play a major role in liaising with the CCG's, Social Services and GPs and will provide leadership and support during the planned staff flu vaccination programme.

6.9 Clinical Leads

Clinical Leads will work closely with the SLMs and Matrons and their clinical teams to ensure that patients are reviewed and discharged in a timely manner. This should ensure that patient flow in their respective areas does not adversely impact on patient safety. Where appropriate, they will instigate additional ward rounds to ensure patients move quickly and safely through their pathways of care. In addition, they will ensure, as far as practicable, that there are sufficient medical cover to meet the increased demand and complexity of patients. They will ensure that internal professional standards remain in place over the winter period.

In Clinical Support the Clinical Director will ensure services are running effectively to meet the service demands and where necessary expedite tests/procedures to facilitate early diagnosis and possible discharge.

In Community Services the Clinical Lead will work with operational leads and partners within the Gateshead system and GCP to facilitate timely discharge back to the patient's normal place of residence with an objective of "home first" principles. The clinical lead will work with the operational managers to support the integrated discharge liaison team to deliver the national requirements in terms of discharge to assess working with the MDT and LA partners

6.10 Consultants

Consultants will work with their clinical teams to ensure that patients are seen in a timely manner and that they are discharged appropriately in line with their proposed EDD wherever possible. They must co-operate with any changes made to deal with an increased influx of patients. It is expected that on-call physicians will ensure that triage and escalation is delivered during times of increased activity and, where possible, will work to support the colleagues to ensure every patient is reviewed.

6.11 Service Line Managers (SLMs)

The SLMs will work with their teams, clinical leads, matrons and ward managers through the triumvirate, to ensure that best practice and transformation plans are implemented and the flow of patients, patient safety and patient experience is maintained at all times and other services within their areas are managed effectively.

They will ensure that, wherever possible, flow from ED to AAU and flow from AAU to base wards occurs in a way to benefit patients who are on an acute pathway and also support the teams who are delivering the pathways of care across the health and social economy so they are joined up to ensure that there is a seamless transition of care into and out of hospital to and from different care settings.

6.12 Chief Matrons

Chief Matrons for medicine and Surgery will ensure a daily assessment of the bed state, including community beds is made at 9.00am and made available to the site management meeting.

Under the instruction of the Operations Director or Senior Manager on call the Chief Matrons are responsible for the opening and closing of beds to meet fluctuation in demand and monitor the quality of care and safety of patients in line with the opening of beds procedure. One / both Chief Matrons will escalate to relevant managers any issues relating to the implementation of the plan and dial into the daily site management meetings (Mon-Fri), as well as providing leadership for the matrons. They will ensure that any risks to patient safety as a result of winter are identified and escalated appropriately and that minimum safe staffing levels are met.

The Matrons for Medicine and Surgery will review all patients with a length of stay over 7 days and both Chief Matrons will review all patients whose length of stay exceeds 10 days

6.13 **Matrons/Community Team Leaders**

Matrons/Community Team Leaders will ensure sufficient staff is available to meet the fluctuations of patient activity and to monitor the flow of patients. Where demand exceeds available staff they will prioritise workload appropriately and utilise additional assistance technologies where necessary.

The Matron on-call will be present at site management meetings and monitor the quality of care and patient safety at ward and community level as reported in the daily shift reports. They will provide leadership to ward managers.

The Community Clinical lead and Clinical operation managers will work in partnership with Primary care to prevent avoidable admissions and support timely discharge. The discharge liaison team will support delivery of pathways 1-3 with attendance at the board rounds and links to the social work and placement teams following a trusted assessor and discharge to assess models.

6.14 **Ward Managers**

Ward Managers will be responsible for ensuring their areas are staffed appropriately and escalate to the Matron whey they have exhausted all possibilities within their remit or when forecasted staffing difficulties can be foreseen and remain unmitigated. Proactively managing staff in relation to demand and acuity. They will be responsible for ensuring all patients have an EDD and ensure the MDT work towards that date. They will also ensure the new discharge requirements are adhered to. They will ensure that real time bed management information is actioned in Medway.

6.15 **Patient Flow Manager and Team**

The Patient Flow Team are the single point of contact for decisions regarding the allocation of beds in collaboration with Ward Managers and Matrons for all acute and elective admissions. The Team is responsible for maintaining a current bed state ensuring the use of available electronic systems and will attend the daily site management meetings. They are also responsible for liaising with the ECC to ascertain their activity throughout the day, and to plan the bed base for anticipated admissions. They will arrange the transfer of patients (in accordance with the Transfer Policy) between wards and receive transfer requests from external organisations.

6.16 **Head of EPRR**

- To receive the cold weather alerts on behalf of the Trust and circulate as appropriate (1 November – 31 March).
- Manage the on-call rota ensuring appropriate cover is available at all levels and any gaps in the rota are filled.
- Ensure sitrep reporting is communicated externally on behalf of the Chief Operating Officer
- Be the point of contact for NHSE/I winter command room and communications including surge
- Be the key contact for overall site resilience and surge management overseeing and monitoring of the winter and associated plans and report to the Chief Operating Officer
- Be responsible for ensuring robust resilience is managed daily in relation to surges in activity along with daily management of the patient flow team

6.17 **Managing Director QEF**

Will ensure that:

- Arrangements are in place to monitor the temperature of clinical areas and take action to ensure safe temperatures are maintained.
- Timely repairs are made and contingency plans put in place to address winter issues
- Access to the hospital is clear and safe in the event of snow and ice and the site is adequately gritted.
- QEF support the actions to manage winter pressures and surges in activity.

6.18 **IPC and Microbiology**

The IPC Team and Microbiology will provide expert advice and support to wards and departments in line with national guidance. Further detail is contained within section 27.

7 Approach to Winter 2020/21

7.1 The 2020/21 winter plan has been compiled following a number of winter debriefs and winter planning sessions.

7.2 This year the plan has been developed during the COVID-19 pandemic. This means we have factored Covid-19 with:

- Our capacity and demand assumptions
- Our bed model and clinical model
- Our staffing plans

7.3 Covid-19 has added a higher degree of uncertainty into our planning and that of our partners in primary and social care

8 Capacity and demand modelling

8.1 In preparation for Winter 2020/21 the Trust has refreshed its bed modelling to inform capacity requirements for the winter period including a Covid-19 projection. Models based on 9 different scenarios were considered.

8.2 For the purposes of bed modelling for winter 2020-21 an assumed model of a return to 'normal' winter demand + Covid-19 demand being at 50% of the phase 1 peak is assumed. This is in-line with regional planning parameters. This combines:

- A return to 'normal' winter demand based on previous years
- Covid-19 demand being at 50% of the Phase 1 peak
- Bed occupancy at 92% in line with national guidelines rising to 100% when capacity is exceeded

Appendix 1 contains a copy of the detailed modelling used with above scenario highlighted. This shows the Trust will need a maximum of 576 beds (473 medical, 81 non elective surgical and 22 elective surgery).

Modelling assumptions include:

- Identical shape/pattern of winter demand to 2019/20 uplifted by the growth %s in the modelling. This cannot account for fluctuating daily demand or surge activity which can adversely impact on flow.
- No change to length of stay – though this may be revisited should the initial success of the Trust's reducing long length of stay work be felt to be sustainable through winter
- Surgical bed number forecasts have been adjusted for the transfer of Vascular activity by the Trust.

This results in projected levels of Medicine bed requirements for each period under each demand scenario are as follows based on previous years modelling of step up and step down levels. Covid level A = 33% peak, B = 50% peak and C = 66% peak

Table 1 : Projected medicine beds required

Projected medicine beds required	**Normal**								
	Low			**Mid**			**High**		
Covid Level	**A**	**B**	**C**	**A**	**B**	**C**	**A**	**B**	**C**
October-Christmas, March	330	349	368	403	422	441	440	459	477
First half January	370	391	412	452	**473**	494	493	514	535
Second half January, February	336	356	375	410	430	449	448	467	486

Surgical bed demand does not vary with broadly predictable seasonality of Medicine bed demand. However, for the period in which Surgery cancels non-urgent elective surgery, demand is modelled based on previous scenarios of levels of surgical non-elective demand. The high demand scenario is most likely to occur during a period of prolonged freezing weather (such as that experienced during the February/March 2018 'Beast from the East'). Covid level A = 33% peak, B = 50% peak and C = 66% peak

Table 2 : Projected non elective surgical beds required

Projected non elective surgical beds required	Normal								
	Low			Mid			High		
Covid Level	**A**	**B**	**C**	**A**	**B**	**C**	**A**	**B**	**C**
October-Christmas, March	57	58	59	71	72	73	79	80	80
First half January	64	65	66	80	**81**	82	88	89	90
Second half January, February	58	59	60	73	74	75	80	81	82

Total bed requirements (excluding elective work)

Covid level A = 33% peak, B = 50% peak and C = 66% peak

Table 3 : Projected total non-elective beds required

Projected total non elective beds required	Normal								
	Low			Mid			High		
Covid Level	**A**	**B**	**C**	**A**	**B**	**C**	**A**	**B**	**C**
October-Christmas, March	387	407	427	474	494	514	519	539	557
First half January	434	456	478	532	**554***	576	581	603	625
Second half January, February	394	415	435	483	504	524	528	548	568

* Excluding 22 elective surgical beds counted in the modelling

For the purposes of bed modelling for winter 2020-21 an assumed model of a return to 'normal' winter demand + Covid-19 demand being at 50% of the phase 1 peak. Two bed occupancy scenarios were applied namely 92% and 100% across the winter period as below:

Table 4 : Projected non-elective beds required (applying bed occupancy)

Projected non-elective beds required	Medicine		Surgery		Total	
Bed Occupancy Rate	92%	100%	92%	100%	92%	100%
October-Christmas, March	422	389	72	67	494	455
First half January	473	436	81	75	554	510
Second half January, February	430	396	74	69	504	464

Elective surgical beds need to be accommodated in the total bed numbers. If an attempt is made to **preserve 35 elective beds** [except during the first half of January*] (an assumption made on previous elective bed use during these periods), the overall Trust bed requirement is as show

Table 5 : Projected beds required (inc 35 protected elective surgical beds*)

Projected beds required	Medicine		Surgery		Total	
Bed Occupancy Rate	92%	100%	92%	100%	92%	100%
October-Christmas, March	422	389	107	99	529	487
First half January	473	436	81	75	554	509
Second half January, February	430	396	109	101	539	496

In an attempt to achieve the required bed capacity the Trust plans to open additional beds across the Trust as detailed in Table 7 below. Note that Table 6 shows the number of actual winter beds in 2019/20 for comparison.

Table 7 : Bed Escalation Plan - Winter 2020/21

Comparing the bed modelling and the planned bed escalation plan throughout winter as detailed above this will still result in a significant shortfall in beds to meet demand across all periods as illustrated below.

Table 8 : Projected beds shortfall (inc bed occupancy rates)

Projected beds shortfall	**Medicine**		**Surgery**		**Total**	
Bed Occupancy Rate	92%	100%	92%	100%	92%	100%
October-Christmas, March	-66 to -100	-33 to -57	+1	+9	-65 to -91	-22 to -48
First half January	-62	-25	-8	-1	-70	-26
Second half January, February	-74	-48	+1	+7	-73	-41

It can therefore be predicted that if the demand remains true to the modelling as described, elective activity including Phase 3 recovery will be impacted upon for the whole period. The implications of this on patients are well understood and plans to mitigate this are being explored. This includes use of the independent sector.

8.3 Table 6 – Bed Configuration Winter 2019/20 (for comparison)

General and Acute Wards - Core Bed Stock	Core Bed Total	Business Unit	Specialties	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
EAU	24	Medical	General Medicine	24	24	24	24	24	24	24	24	24	24	24	24
Ward 1	24	Medical	General Medicine	24	24	24	24	24	24	24	24	24	24	24	24
Ward 2	24	Medical	Short Stay Unit	24	24	24	24	24	24	24	24	24	24	24	24
Ward 4	30	Medical	Stroke	30	30	30	30	34	34	34	34	34	36	34	34
Ward 6	16	Medical/Surgical	Hospital to home	25	25	25	25	16	19	24	24	27	27	32	32
Ward 8	21	Medical	Cardiology	21	21	21	21	21	21	21	24	21	21	21	21
Ward 9	36	Medical	Respiratory	37	37	37	37	38	37	24	39	39	39	39	39
Ward 11	29	Medical	Gastroenterology	29	29	29	29	29	29	29	29	29	29	29	29
Ward 12 (Winter Ward)	0	Medical	General Medicine	27	27	27	27	0	0	12	24	24	29	20	20
Ward 14	16	Surgical	General Surgery	0	0	0	0	16	16	16	21	21	21	21	21
Ward 14A	26	Surgical	Trauma & Orthopaedics	32	32	32	32	32	32	26	26	30	30	32	28
Ward 21	18	Surgical	Gynae/Oncol	18	18	18	18	18	18	18	18	18	18	18	18
Ward 22	29	Medical	Geriatric Medicine	29	29	29	29	29	29	29	29	29	29	29	29
Ward 23	24	Medical	Geriatric Medicine	24	24	24	24	24	24	24	24	24	24	24	24
Ward 24	29	Medical	Geriatric Medicine	29	29	29	29	29	29	29	29	29	29	29	29
Ward 25	30	Medical	Geriatric Medicine	30	30	30	30	30	30	30	30	30	30	30	30
TCL1 Ward 26	24	Surgical	Trauma & Orthopaedics	30	30	30	30	24	26	29	24	25	30	27	27
TCL2 Ward 27	30	Surgical	General Surgery	30	30	30	30	30	30	30	30	30	30	30	30
St Bedes	10	Medical	Palliative Medicine	10	10	10	10	10	10	10	10	10	10	10	10
Total	440														
Bed Stock Over night stay Total				**473**	**473**	**473**	**473**	**452**	**456**	**457**	**487**	**492**	**504**	**497**	**493**

Table 7 Bed Escalation Plan - Winter 2020/21

General and Acute Wards - Core Bed Stock	Core Bed Total	Business Unit	Specialties	Notes on winter plan	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
EAU	24	Medical	General Medicine	No change	24	24	24	24	24	24	24	24
Ward 1	24	Medical	General Medicine	No change	24	24	24	24	24	24	24	24
Ward 2	24	Medical	Short Stay Unit	No change	24	24	24	24	24	24	24	24
Ward 4	20	Medical	Stroke	Increases from 20 to 30 beds for 1st half of January	20	20	20	20	30	20	20	20
Ward 6	0	Medical/Surgical	Hospital to home	Decommissioned	0	0	0	0	0	0	0	0
Ward 8	21	Medical	Cardiology	No change	21	21	21	21	21	21	21	21
Ward 9	36	Medical	Respiratory	No change	36	36	36	36	36	36	36	36
Ward 10	12	Medical	Respiratory	12 beds to open from October onwards	0	12	12	12	12	12	12	12
Ward 11	25	Medical	Gastroenterology	No change	25	25	25	25	25	25	25	25
Ward 12 (Winter Ward)	0	Medical	General Medicine	16 beds to open October, 24 beds Nov-March, reduce to 16 beds for Easter period. Close 14th April	0	0	16	24	24	24	24	16
Ward 14	25	Medical	General Medicine	No change	25	25	25	25	25	25	25	25
Ward 14A	26	Surgical	Trauma & Orthopaedics	Reassign up to 16 beds to medicine for January & February	26	26	26	26	10	10	26	26
Ward 14A reassigned beds		Medical	General Medicine		0	0	0	0	16	16	0	0
Ward 21	28	Surgical	Gynae/Oncol	Reassign up to 18 beds to medicine for January & February	28	28	28	28	10	10	28	28
Ward 21 reassigned beds		Medical	General medicine		0	0	0	0	18	18	0	0
Ward 22	29	Medical	Geriatric Medicine	No change	29	29	29	29	29	29	29	29
Ward 23	24	Medical	Geriatric Medicine	No change	24	24	24	24	24	24	24	24
Ward 24	29	Medical	Geriatric Medicine	No change	29	29	29	29	29	29	29	29
Ward 25	30	Medical	Geriatric Medicine	No change	30	30	30	30	30	30	30	30
TCL1 Ward 26	24	Surgical	Trauma & Orthopaedics	No change	24	24	24	24	24	24	24	24
TCL2 Ward 27	30	Surgical	General Surgery	No change	30	30	30	30	30	30	30	30
St Bedes	10	Medical	Palliative Medicine	No change	10	10	10	10	10	10	10	10
Total	441											
Bed Stock Over night stay Total					**429**	**441**	**457**	**465**	**475**	**465**	**465**	**457**

9 Elective phasing to increase capacity

9.1 The suspension of elective surgery during the peak of the pandemic has resulted in the Trust accumulating a significant backlog of elective cases with associated risk to patient safety due to lengthening delay to surgery. The Phase Three recovery plan developed by the surgical team aims not only to maximise elective activity prior to the full onset of winter but also to focus on the flexible management of activity during peak periods in order to sustain and deliver full recovery.

The protection of the reserved elective beds (35 beds) during the 'October-Christmas, March' and 'Second half January, February' periods as described within the above model would significantly improve the Trust position in terms of delivery of the elective plan. The model will still however require high levels of "boarding" of medical patients into surgical wards.

It is important to note that capacity on Ward 26 (elective orthopaedic ward) is pivotal to delivery of the Phase 3 elective plan. The schedule plans for an average of 24 elective orthopaedic patients per week to be accommodated on this ward. The ward comprises 30 individual en-suite rooms and it is due to this configuration that it is identified as the escalation ward for 'pending admissions' should Covid positive / query activity exceed capacity of wards 1and 2 and as such represents a significant risk to delivery of the Phase 3 recovery plan.

9.2 Elective Theatre Programme

The elective recovery plan accommodates an increase in elective surgery in the run up to peak activity period. This is followed by a planned shift to day-case activity as pressure on beds increases during the peak winter period.. However all cancer and urgent operations will be continued throughout the period . The elective Theatre schedule is as follows:

- QEH elective theatre lists will be scheduled as normal up to, and including, Thursday 24th December 2020.

- From Friday 25th December 2020 to Friday 1st January 2021, inclusive normal elective theatre lists will automatically be cancelled – with the exception of the following lists:

    - Tuesday 29th December – (1) all day Gynae Oncology (2) 'urgent' elective list
    - Wednesday 30th December – (1) all day Gynae Oncology (2) 'urgent' elective list
    - Thursday 31st December – (1) all day Gynae Oncology (2) 'urgent' elective list
    - Gynaecology RAC/TOP list – flexible to available list on dates above.
    - Pain procedural list –dependent on demand and flexible to available list on dates above.

Normal elective theatre lists will restart on Monday 4th January 2021.

9.2.1 Day case and Inpatient period split

All inpatient cancer and urgent cases requiring scheduling during the daycase period should be discussed with the Speciality SLM who will consider the Trust bed status and other

influencing factors impacting on in-patient surgery to facilitate appropriate scheduling of cases.

9.2.2 **Trauma Theatre List**

No dedicated Trauma lists will be scheduled on Friday 25th December 2020 and Friday 1st January 2021. On all other dates the Trauma theatre list will run as normal.

9.2.3 **Use of the Independent Sector**

A national contract has been agreed to facilitate access to independent sector facilities. Within the ICS the Trust has been granted access to Washington Spire and Nuffield Hospital in Newcastle and Ramsay Cobalt Hospital at Silverlink. QEH has been working in collaboration with other ICS partners to enable access to theatre, Endoscopy and diagnostic capacity on these sites. It is anticipated that this resource will enable the Trust to continue with both day-case and inpatient elective work throughout periods of significant escalation.

9.3 **Diagnostics**

All 7 modalities prioritise inpatients throughout the winter period to minimise the length of hospital stays and to ensure effective use of bed capacity. Ultrasound (US), CT and MRI do this by allocating capacity throughout the day to inpatient scans which would be allocated to outpatients at other times of the year. The modalities also reflect the position and needs of EAU to support patient flow.

CT, XRay and MRI services run 8-8 7 days a week, US 8-4. To maintain turnaround times for reporting capacity with outsourcing companies increases. Consultant on-call and duty-rotas support urgent needs. Mobile vans have been booked for MRI and CT. CT arrangements are being established within the NHSEI contracts, along with IS capacity, for MRI, CT and Ultrasound. 4 mobile X-Rays and 2 mobile ultrasound scanners (currently on loan from NHSEI) can be deployed as needed on the wards and also to reduce patient movement around the hospital.

9.4 **Endoscopy Capacity**

Review of endoscopy lists to front load activity in December carving out capacity in January for cancer and urgent patient appointments only. Non-medical Endoscopists will be able to free up limited capacity for senior Medical staff to support patient flow during the pressured post-Christmas period.

10 Flu planning

10.1 The Trust has plans in place to achieve the flu uptake target.

- The campaign commences on 28th September 2020 until 31st January 2021
- Sufficient quadrivalent vaccinations have been ordered and will be monitored to ensure no impact due to Brexit etc.
- The Flu Planning Group including a wide-range of representatives from across the Trust has met from June 2020 to review last year's campaign and develop the following 2020/21 plan.
- The robust plan in place covers all key recommendations from NHS Employers Flu Fighter Guide
- A blended approach to offering staff the vaccination has been arranged. This includes:
  - utilisation of a small cohort of trained bank nurses to work early shifts, twilight shifts, night shifts, weekends, visiting every ward/department on multiple occasions from Sept-Nov (to be reviewed in light of the current Covid situation)

- Occupational Health Team following the same methodology visiting clinical departments at the QE, Bensham, Blaydon, Eastwood
- The SCIL Team will support the campaign and have a plan to visit Pathology department every day for the first two weeks this complements the drop-in clinics held in the Occupational Health Departments at both Bensham Hospital and the QE from 8.30am – 4pm each day (for first two weeks) and at various times thereafter
- Peer vaccinators have been trained to vaccinate staff at venues or larger departments including Woodside, Urgent Care Team
- Peer vaccinators for the Community have been trained who are based at Bensham hospital
- Staff can inform the Trust they've received the vaccine at a pharmacy/GP surgery/ supermarket etc
- Specific events/meetings/gatherings of larger groups of staff will be attended by the Occupational Health team in person

- A full communications plan has been developed and will be implemented by the Communications Team, commencing 2 weeks preceding the campaign
- To say thank you to staff for having the vaccination, a range of incentives will be used (i.e., free hot drinks voucher, a "Jab for a Jab" donation to UNICEF, "Flu Friday Treats" for teams achieving over 80%).
- Level of uptake will be shared with all staff via QE Weekly/Screensavers/Flu page
- Business Units/Service Lines will be informed of their current level of uptake, and senior teams asked to engage/encourage/communicate with their teams.

11 Workforce Plan

Winter planning is a collaborative Trust wide effort to ensure staff with the right skills and experience are redeployed throughout the winter period to care for patients.

Nurse staffing has been carefully monitored in 2020 to meet forecasted predictions recognising the additional pressures in the system this year due to the Covid pandemic. Mindful of the Covid-19 recovery period the nurse workforce plan reflects the "new normal" including post Covid nurse staffing establishments, bed modelling reconfiguration and key considerations such as the No-Ward Based Nursing (NWBN) plan.

To support safe and sustainable staffing the following is in place:

- The existing process of continuous recruitment,
- A Trust wide nurse retention programme continuing into winter 20/21.
- Alignment of Aspirant nurses into vacant positions
- Registered Nursing Associates practising on wards
- Utilisation of Health roster in relation to requesting bank shifts
- Flexible working initiatives.
- Visible and clinical leadership to support teams.

The governance and delivery of the safe and sustainable staffing plan will be led and monitored by the Chief Matrons in the acute setting and the Clinical Lead for community services.

Non- Ward Based Nurses (NWBN*) Supporting Winter Pressures 2020

Over the winter period non-ward based nurses are required to support ward teams to ensure staffing levels can meet the nursing care needs of patients. The following plan has been

developed to ensure a standardised approach to the utilisation of non-ward based nurses (NWBN) across the Trust.

From October 2020, non-clinical and nurse practitioners will be required to spend time with their teams within the clinical area to familiarise themselves with ward routine and fundamental aspects of care they will undertake.

NWBN and non-clinical nurses contribute to maintain safe staffing levels and patient safety under the supervision of a registered nurse from that clinical area. These Registered staff however have specialist knowledge skills and experience and are deployed to facilitate discharge and prevent re admissions, share their expertise to enhance patient experience, expedite early discharge, as well as offer pastoral support to newly qualified and existing staff.

Listening to staff feedback and learning from previous winters of extreme pressure there have been some further key considerations, risks identified and mitigated in this year's plan. Any contribution will be carefully considered alongside in and out patient activity to balance post Covid-19 Phase 3 recovery objectives.

* The NWBN teams provide their availability to the business unit lead 6 weeks in advance of mobilising support, this year the release commences from Nov 2nd.

The fundamental areas of practice they can also contribute to are :

All NWBN registered staff	Tasks undertaken as part of the registrants daily practice	Practitioners who work regular bank shift
Personal care Assisting with nutritional needs Undertaking observations 2nd checker for medications Record keeping Escorting patients Communication skills	Tasks such as Phlebotomy, Cannulation, Point of care testing Catheterisation Use of e- systems	Undertake the role of the nurse in charge of a team of patients

Each practitioner needs to ensure they are up to date with core skills, basic life support, managing deteriorating patient skills and patient moving and handling.

Non ward based nurses will be aligned to an identified ward or department which would be most appropriate for them, using a fair and equitable approach within the size of teams. For example x1 shift every 2/52 for a team that consists of less than x 3 WTE further agreed between themselves and their line manager.

The business unit lead should communicate the allocations information via e-mail to the medical business unit secretaries who will forward to the matrons in each business unit.

The identified matron or for each business unit should familiarise themselves with the NWBN staffing allocations on a daily basis, monitoring planned release and actual attendance. The NWBN and matrons will need to work closely with the service line manager to ensure the phase 3 recovery objectives are met. For example – meeting cancer targets.

NWBN's nurses should commence their shift at the standard start time (unless alternative start time has been previously agreed with their matron).

If the nurse in-charge of the ward feels that their staffing is optimal **without** the additional support of the non-ward based nurse the senior nurse should be contacted to determine if another member of the ward team should be re-deployed to another area of need. The non-ward based nurse should remain within their agreed ward area.

The identified Senior nurse should inform the business unit lead for NWBN staffing of any DNA's or issues via e-mail, on a daily basis and through escalation to the chief matrons.

The Chief Matrons attend the weekly resilience meeting and report any issues, DNA's regarding NWBN allocations and actions taken.

Business unit Leads for NWB Nurse Staffing :

Business Unit	Lead	Ext	Bleep	e-mail
Medicine	Janet Thompson	3676	3124	janet.thompson9@nhs.net
Surgery	Caroline Lane	3535	2677	caroline.lane@nhs.net
Clinical Support	Peter Savage	8420	2772	peter.savage3@nhs.net
Nursing Directorate	Yvonne Tamburro Karen Roberts		-	yvonne.tamburro@nhs.net Karen.roberts@nhs.net
Medical or surgical matrons can be contacted via VOCERA on 6391				

In line with chronological order of the timeline of the winter plan:

- Ward 10 opens 1st October – additional 12 beds
- Ward 12 part opens 4th November – 16 beds
- Ward 12 fully opens 2nd December – another 8 beds to create 24 bedded ward
- Ward 14a & Ward 21 beds are flipped from surgery to medicine between 25th December and 28th February
- Ward 12 part closes 31st March – reduces to 16 beds
- Ward 12 closes 14th April 2021 (covering the BH Easter period)

Ward 9 and 10

Phase 1 of the winter plan:

Twelve additional beds will open on Ward 10 on 1st October 2020. These will be additional to the 36 beds currently on Ward 9.

Ward 9's existing nurse staffing establishment beyond 24 beds will be reassigned to ward 10 and the floor will be managed in partnership. There is an already experienced senior leadership team on ward 9 that will lead on the management and opening of ward 10 however the ward will require an uplift in the senior nurse team to provide senior nurse cover over a 7 day period.

Due to the ward layout medical gases reconfiguration requirements have been scoped and deemed ward 9 to run as an existing 36 bed area with ward 10 as plus 12 beds, to l create a 48 bed respiratory floor . the nurse staffing plan is considerate of the risks associated with IPC prevention and management and will need to be dynamic and responsive to any presenting IPC risk.

The respiratory ward receives "step down" patients from CCD as well as patients requiring NIV scoring high acuity. The ward has had an increase in establishment (uplift of qualified and HCA) to meet the planned staffing requirements of plus 12 beds on ward 10.

The staffing plan for Ward 10 is on predicted track to support the opening of the ward on October 1st.

Ward 12

Phase 2

Ward 12 is scheduled to open to open to 16 beds on 1st November 2020 increasing to 24 beds on Dec 1st 2020. The staffing establishment is made up of Registered nurses and Health Care Assistants, a ward clerk and housekeeper. The safe staffing plan is facilitated by matrons working with their teams to identify the release of staff from across the Trust, with the right skills and experience. The HCA recruitment event on 19th September will afford temporary backfill support to the areas that support the staffing release.

Future State - Proposed Model 20/21							
FUTURE BED NUMBERS	**BASED ON FUTURE SHIFT PATTERNS:**		**GRADE**	**Establishment 2020**	**New Model WTE**	**NEW MODEL COST £**	**comments supporting establishment review**
24		WEEKDAY	7	No Current establishment or budget	1.00	£53,400	
	EARLY	4Q & 3HCA	6		2.00	£101,570	
	LATE	4Q & 3HCA	5		14.62	£597,140	
	NIGHT	2Q & 2HCA	4				
			2		13.99	£420,740	
			NON PAY				

Ward 12

The table below describes the staffing required at 16 and 24 beds. Any further increase beyond 24 beds would require Director of Nursing sign off.

	Early		Late		Nights	
Ward 12 @	Qualified	HCA	Qualified	HCA	Qualified	HCA
16 beds	2	2	2	2	2	2
24	4	3	4	3	2	2
>24 beds*	4	3	4	3	2	2

*Sign off by Director of Nursing

Ward 12 - Leadership plan

As tabled, includes a Matron, ward manager and Deputy ward manager team. The Matron is assigned as "winter lead" and is responsible for Quality and Safety with operational and performance oversight". The matron is supported by the Service Line Manager and both Chief Matrons. Recruitment of the ward manager is underway alongside the appointments of deputy ward managers. Ward 12 senior nurse team will provide operational leadership over a 7 day period.

Quality impact Assessment: Ward 12

The nurse staffing plan faces increased significant pressure this winter, with the dynamic management of staff absence through test and trace/ self isolation rules and Covid activity. The matrons have worked together and with their NWBN teams to coordinate the release of skilled staff to support the nurse staffing plan, identifying staff with the right skills to be deployed appropriately to the right place. The NWBN teams form the support that frontline teams need through winter pressures and the focus this year is on supporting, assisting discharge and preventing admissions/ readmissions.

Staff support

Nominated staff must have a minimum of 6 months experience beyond their preceptorship. Staff moved for the winter period will be offered bespoke support from teams such as Practice Development /Education, Health Roster and Vocera systems management.

Winter Plan 2020/21

Ward 12 Nursing plan

BED NUMBERS	BASED ON FUTURE SHIFT PATTERNS:		GRADE	New Model WTE	NEW MODEL COST £
24		WEEKDAY	7	1.00	£53,400
	EARLY	4Q & 3HCA	6	2.00	£101,570
	LATE	4Q & 3HCA	5	14.62	£597,140
	NIGHT	2Q & 2HCA	4		
			2	13.99	£420,740
			NON PAY		

Appendix 2 contains a detailed breakdown of the staffing plan.

Ward 14 a

This element of the plan will not require any increased resource, the ward is staffed with an experienced team managing acute orthogeriatric patients and previous medical patients.

Ward 21

This ward which normally functions as an elective surgical ward has recently been remodelled to provide up to 31 beds. The plan is to convert a minimum of 10 beds to accommodate female elderly care patients. The plan is to blend surgical and medical nursing staff, however this team throughout the Covid-19 period have gained experience in caring for medical patients.

Summary (base wards)

There are 27.8 WTE Registered Nurse vacancies mapped against the winter plan.
Within existing establishments this includes x13 WTE vacancies across the medical Business Unit.
This is exclusive of ECC that is currently undergoing a service review across ECC level 3 and level 4.

There are 18 candidates in September's interviews, a mix of experienced and newly qualified external applicants. However these cannot be included against the winter plan due to the unknown forecasted dates of their commenced posts or registration.

Area	WTE vacancies		
Surgery	0		
Gen med	8		
Ward 12	14	Gaps with an identified plan	
COTE	5.8		

Health Roster and management of bank and Agency

Ward teams are expected to work within their establishments to manage effective safer staffing. Where there are any acute sudden shortfalls, the matrons will support the ward managers with their

planned rosters to facilitate safe staffing. There is functionality within the health roster system to send shifts directly to bank rather than via the bank team.

Community Staffing

The clinical lead working with the operational managers will ensure there are safe levels of appropriately skilled staff to manage the complexity of the caseload. Community locality teams have devised a system of prioritisation of "complex care interventions" that enable safer scheduling and therefore safer caseloads for community based teams and rapid response will utilise mobile working technologies.

The transformation work has enabled community to embed the right skills right time right place principles into all the community teams however ongoing monitoring and review is needed as the discharge to assess model and changes to CHC funding and packages of care have impact on the demand for community intervention. This needs to be done in parallel with the acute staffing rota's and in conjunction with local partners eg LA and Primary Care. There will need to be investment to deliver the expectations of primary care in terms of flu vaccination, for the over 50's this year in addition to being prepared for any further Covid outbreaks.

In order to fully implement the discharge to assess model there will need to be transition of hospital-based resource to community, and additional training to increase the number of trusted assessors available. The DLN team will continue to work 8am until 8pm 7 days a week to continue to early supported discharge model implemented during Covid.

12 Medical cover

- In determining levels of medical cover for patients on medical base wards, consideration has been given to the ward configuration outlined above and the previous years' experience of likely recruitment.

Senior medical consultant cover

- The ward arrangement seeks to reduce the level of ad hoc boarding which has been seen in previous years. Patients will be co-locate wherever possible to wards adjacent to the medical team most suited to their needs. The "boarding" policy will be refreshed to ensure that this is delivered.
- Additional senior medical cover will also be provided over known periods of peak demand in ECC. These dates are typically the weekends immediately after Christmas and following the New Year.
- Other periods of high demand are known to fluctuate, therefore operational teams will seek additional senior medical cover as and when necessary to ensure the safety of patients and quality of care provided.
- Ward 10 – to be covered by Ward 9 consultant team (respiratory)
- Ward 12 – to be covered by Ward 11 consultant team (gastroenterology) with additional consultant cover (preferably 9 – 5 M – F) (short-term contract / locum depending on availability)
- Ward 14a borders - to be covered by Ward 14 (Diabetes / Endocrine / Rheumatology)
- Ward 21 borders – to be covered by Care of the Elderly consultant teams

Junior medical cover

- Ward 10 – an additional junior clinical fellow / F3 post to be added to the Ward 9 respiratory team to spread cover across the whole floor.

- Ward 12 – 3 or 4 additional junior clinical fellow / F3 posts required to provide day-time ward cover.
- Ward 21 – 2 or 3 additional junior clinical fellow / F3 posts required to provide day-time ward cover.
- The uplift in junior medical cover for patients on medical base wards has been determined by an assessment the new base ward configurations and may require additional cover (ward 10 and 12), and where the degree of medical input may change due to the reassignment of surgical beds to medical patients (ward 21).
- The assessment of junior cover required has been considered for the in hours period only. Allowance will also need to be made for support into the weekend, evening and OOH periods.
- Additional ad hoc shifts are likely to be required for annual leave and sickness absence.

13. Therapy cover

13.1 The current Physiotherapy and Occupational Therapy workforce will continue to deliver a service over 7 days to manage referrals from across the Trust. The services continue to work with the Business Units to deliver transformational change, which may provide additional opportunities to support new workforce models and patient pathways to reduce length of stay.

13.2 Physiotherapy has extended its twilight service until 8pm across all specialties. This service provides an opportunity to support the assessment and discharge of patients up to 8.00pm both Front and Back of House

Two advance practitioner posts work front of house to support rapid assessment/ management and discharge of patients. One post supports Medicine and Elderly pathways and the second post works in ED supporting the management of patients presenting with MSK conditions.

13.3 The Occupational Therapy Service has realigned its workforce to manage the needs of patients in those areas demonstrating high clinical demand in areas which have not historically had dedicated support. Service delivery supports both Back and Front of House delivery.
Work is ongoing with the Community Rapid Repose Team to ensure timely transfers of care for those patients who can receive ongoing assessment and rehabilitation in the community, and form part of the integrated team who will embed the discharge to assess principles.

14. Pharmacy Cover

14.1 The Pharmacy department will be building on the experience of winter plans over the last few years to deliver a comprehensive suite of strategies to support clinical care across the site.

14.2 Many of the successful pilot schemes we have trialled over the last 3 winters have now been developed into ‘business as usual’ services, and this year we hope to offer extended Pharmacy services at weekends in time for the key winter period.

Scheme	Dates	Actions	Implications	Resource
Extended 7 day Pharmacy Services	Permanent, from Summer 2020 onwards [currently in consultation with staff]	• Significant extension to In-Patient Pharmacy Weekend Opening Times: Saturday: 09:00 – 17:00 *(currently 09:00 – 14:30)* Sunday: 09:00 – 17:00 *(currently 13:00 – 16:00)* • Significant extension to Weekend Clinical Pharmacy Ward presence • Extended Weekend Omnicell® Automated Drug Cabinet refills	• Access to medicines from Pharmacy, and the availability of dispensing of discharges over a longer timescale at weekends. • Quick and accurate medicines reconciliation and support with prescribing. Clinical Pharmacy support beyond EAU. • The ability to refill Omnicell® Automated Drug Cabinets in high use areas across the weekend, where appropriate.	• Within current budget • Within current budget • Within current budget
Clinical Pharmacy Technician Weekend Support	January and February 2021 Only 09:00 – 17:00 (30 min Lunch)	Support Pharmacist Independent Prescribers at Weekends with Medicines Reconciliation – Sat and Sun.	Maximise Medicines Reconciliation Rate GIRFT NB: This will be to undertake Med Rec on EAU Only.	Within current budget
QEF Dispensary Saturday am opening Formal request has been made to QEF	Permanent [If approved]	Extend Opening Hours of QEF Dispensary to Saturday am 08:30 – 13:00	OP Dispensary available for dispensing IVF scripts to relieve pressure on IP Pharmacy; Sell OTC medicines direct to patients (A & E workstream?), dispense A & E prescriptions and support any OP clinics flexed into Sat am.	Requires extra funding circa. £15,000 per annum
Weekday Late Shift Flexibility	January and February 2021	Increase dispensary staff capacity to manage peaks in activity	To help manage surges in discharge prescriptions	Within current budget

Extra Clinical Pharmacy Technician Support to Anticoagulant Service and Meds Rec	1 Nov 2020 – 31 Mar 2021	Extend hours of part-time Clinical Pharmacy Technicians	Clinical Pharmacist resource released from Anticoagulant Service/Meds Rec to support extra medical in-patient workload	Within current budget
Pharmacist support to Dispensary	1 Nov 2020 – 31 Mar 2021	Extend hours of locum Pharmacist to release Clinical Pharmacist resources.	Clinical Pharmacist resource released to support extra medical in-patient workload	Requires extra funding 0.4 wte Band 6 Pharmacist

14.3 Community Services have access to a Macmillan pharmacist Monday to Thursday to support palliative and EOL patients in the community and on St Bedes, they are available for advice and support or face to face consultations.

15 Facilities Team

15.1 Facilities team plans for winter will be responsive to the increased level of activity and the additional risks during this period. Facilities will look to provide additional front line staffing specifically within the response team for winter period within Domestic services. However, at very severe pressure it may be necessary for the Trust to support the deployment of staff with domestic skills and knowledge e.g. housekeepers to support domestic response teams. In addition domestics will redeploy staff from lower risk areas to high risk areas to maintain quality, standards and support patient flow decisions. Requests to escalate will be made via existing escalation routes. Communication of the impact of redeploying resources will be actioned by the Trust Communication Team. It is essential that clear routes of communication are followed and domestic resources are used effectively.

15.2 The pre-existing escalation plan will continue to link with existing Trust command and control structure. Learning from last year's plans identified the advantages for deploying additional Vocera units to ensure timely and accurate communication to front line supervision to integrated between the Trust and QEF.

15.3 Additional support within porters will be required with a review of the need to reintroduce a twilight shift to support activity late evening. Portering manager/senior charge hands to attend the bed meetings each day to understand Trust pressures and add extra resource at those times. Requests for additional work to be Porter tracked to identify the demand and react. Out of hours charge hand to liaise with Senior Nurse to assist in making a decision on prioritising urgent tasks in event extremely high demands on Portering services. Pre-existing escalation plan will be evoked if necessary.

15.4 Contingency stocks for linen and laundry will be increased to provide a level of resilience for adverse weather.

15.5 Medical engineering and medical devices will need to be guided with clear details on expected patient numbers and requirements to ascertain additional demand for medical devices. Medical Engineering will be available 24/7 with an On Call engineer available out of hours, contactable via the switchboard. Medical Engineering will attend bed management meetings when requested to support patient flow decisions and manage the deployment and retraction of assets (medical devices and beds) across the estate. Planned and unplanned requests for medical device assets should be made directly to the department on Ext 2116.

15.6 Depending on the prevailing weather conditions the Estates team will implement the Winter Maintenance Plan/Adverse Weather Plan to deploy resources in accordance with the agreed Plan priorities.

16 Community

16.1 The following are the initiatives and service changes that will be in place to support system pressures during winter 2020/21. Some of these changes will be implemented as part of the ongoing transformation programme within the Community Business Unit.

- Use of mobile devices by teams will be extended to the majority of community staff by winter. The use of such devices and access to live clinical records in the patient home will as has been shown enhance patient safety and team efficiency and responsiveness.
- Community services have developed and set up a Hospice at Home service operational 24/7. This is to support timely discharge and /or step up support for palliative patients. The impact over winter should be specifically the support this service can provide in timely discharge for patients at the end of life which has been problematic in past winters.
- Rapid Response service has been working more closely with GP OOH service during COVID-19 response and this is planned to continue with the aim to enhance clinical decision making and expand out of hospital care and treatment to avoid more efficiently hospital attendances and admissions. In addition rapid response will implement mobile working in September 20 to support accurate and timely patient treatment/communication.
- Frailty Nurses through COVID changed working remit to cover back of house non COTE wards as well as FoH role this to remain going into winter.
- 7 day a week therapy cover in community to continue into winter post COVID changes
- Community service staff input and support increased to cover across all PICs to support LA staff.
- Discharge team extended working hours, 8am-8pm, 7 days; as per government guidance through COVID. This is to be mirrored by LA colleagues; which is currently under negotiation.
- Community services are in the process of currently (June 2020) rolling out a Monday to Friday wound clinic for ambulatory patients, previously seen by primary care. By winter 2020/21 the service will be available over 3 sites. We are currently also working on developing a weekend clinic. This will ensure no patents unnecessarily attend ED for routine dressing changes.
- Immunisation programme of house bound and care home patients against Influenza to be carried as per plan in negotiation with CCG and primary care once the vaccine is available.
- Community services are currently working to develop an extension of health care provision across elderly care homes in Gateshead to include all such facilities. The aim would be to have a Community Nurse Practitioner linked to the remaining 4 care homes without such link currently. Through the COVID crisis CNPs have been key to supporting the care homes and providing daily contact to help problem solve as well as clinically supporting residents care plans and the GP link on ward rounds.
- Locality MDTs working in the main virtually will be implemented across all 5 locality areas by winter. These MDTs include health and care staff from the trust and LA as well as primary care colleagues. The aim is to reduce admissions and LoS with better coordinated support within the community.
- Adult Speech and Language Team will prioritise patients due to their clinical need with the potential of flexing the team to support prompt discharge where appropriate in line with SLT clinical standards

17 The Trust will work towards a home first principle and in line with national guidance (from 1st Sept20) discharge to assess across all disciplines - therefore supporting timely discharge, which will be monitored and reportable.

- Working with patients and their families discharge planning will start on admission.

- Discharges will continue to be categorised 0-3 with (0 being non-complex ward based co-ordinated discharges (estimated 50%) pathways 1-3 need to be referred to the DLN team (estimated 45% will be pathway 1, <4% pathway 2 ,<3% pathway residential or nursing care)
- The acute service should not be deciding which pathway the patient will follow they need referral to the DLN team as part of the integrated system support if the patient has any ongoing needs/support or intervention- this service will be available 8am-8pm 7 days a week throughout winter
- A DLN team member will attend board rounds to support and identify any patients with complex needs post discharge
- All palliative ad EOL care patients (requiring care up to 12 weeks) will be referred to the Hospice at Home service via the DLN team
- The principle of discharge to assess model is embedded in the new hospital Discharge Service Policy and will operate to ensure no delays to those patients requiring on going health requirements via the trusted assessor model.
- Community services will work with partners to embed the new continuing health care guidance (from 1st Sept 20)
- There is a need to continue the follow up phone calls to all discharged patients as has been established and continued throughout Covid- this will have a resource implication.
- Reablement and rehabilitation will be provided in the community but will need resourcing appropriately with the right time right pace right skills principles.

18 Collaborative Operational Planning

18.1 There will be Multi-Agency Surge meetings which will increase in frequency chaired by Community Services Clinical Business Manager, these will include CCG, Medicine and Surgical BU representation, to ensure system wide response to challenges that arise in admission/discharges or transfers of care.

19 Transformation

19.1 The Trust launched a major Transformation Portfolio in 2019 covering improvements in managing demand and improving patient flow. This was temporarily delayed as part of our response to Covid-19. However, we aim to keep improvements we have made as part of our Covid-19 response including:

- Clinical Model for flow (Covid v non Covid)
- Criteria led discharge
- Length of stay reductions
- Enhanced Discharge Team
- Same day emergency care measures
- Availability of senior decision makers
- Capacity overnight and at weekends
- Digital first

19.2 The trust needs to continue to manage the response to covid – 19 as well as returning services and activity to a new normal. The Trust has therefore identified the key programmes and projects to prioritise for the remainder of 2020/21.

The key priorities will support the organisation through the winter period aiming to implement sustainable changes to achieve longer term benefits.

1. **Modernising Workforce** – to include Health Roster, Job Planning, Medical Staff Solutions for rostering and advanced roles
2. **Digital Transformation** – to support new ways of working
3. **Elective Care** – Capacity and Demand, Productive Theatres and Performance Improvement
4. **Flow** – SDEC, integrated approach to discharge, ward ways of working, ward rounds and board rounds to facilitate decision making for timely and safe discharge
5. **Culture and Leadership** - building on the corporate Vision, values and behaviours, Goals & Performance.

20 Financial plan

20.1 The total estimated cost of the winter plan as outlined in this document is £2.214m (full costing Appendix 3). The comparable costs for last year were £1.723m. Therefore, the anticipated costs for this years plan represent an increase in runrate of £0.491m in comparison. The main driver for this increase is the opening of additional bed capacity. Compounding this increase in costs are the changes made in response to the Covid 19 outbreak. The cost of some of this is inherent in the winter costing and cannot be easily extracted to identify separately. Offsetting some of the increase is the costs that were associated with the use of ward 6 during the previous winter period.

20.2 The Trust is receiving its funding via a nationally determined block for this financial year, and as such will receive no additional funding to cover the increased costs expected with the winter plan. However, all of the modelling around the financial outturn for the organisation continues to include a predicted outturn for winter, and is therefore inherent in the ongoing financial analysis.

21 Operational Management and Escalation arrangements

21.1 To ensure all operational staff work consistently and in accordance with agreed policy the OPEL checklist and Action Cards have been updated to include clearer roles and responsibilities and attendance at site management calls.

21.2 To proactively manage Capacity and Demand a daily timetable is in place which is referenced in the revised Capacity Management and Patient Flow Policy which includes escalation triggers and actions in line with the OPEL levels.

21.3 An EPRR work plan is in place with mandatory requirements to hold 2 communication exercises per year and the update of the major incident action cards every 6 months. A test of the outbreak plan is planned and training of all operational, tactical and strategic staff is planned as part of winter preparedness.

21.4 A single email and telephone contact point is in place:
Email:england.cne-winter@nhs.net
Phone: 01138251405

22 Organisational on-call arrangements

22.1 Out of hours on-call arrangements have been reviewed in line with the EPRR Core standards. This will involve a command and control structure featuring an Operational, Tactical and Strategic on call rota. Involvement of each level of the on call structure in day to day site management will be linked to the escalation plans and OPEL levels and appropriate actions cards specific to role. Awareness raising/training sessions have been arranged for the on-call management teams for early October 2020 and a review of the frequency of on-call periods has been undertaken to improve consistency and communication. Conference call facilities are available for those responsible for delivery of the winter plan to proactively manage the site this is to prevent the command centre from becoming overwhelmed and also to ensure community services are involved to support the whole patient pathway from admission avoidance through to discharge. Calls will include wider system partners when required.

23 Adverse weather plan

Gritting and snow ploughing

Please note:

- Contractor and Council gritting will generally be carried out outside of normal working hours, ie during the night or early hours of the morning. Gritting during normal hours (6.30am – 4.00pm, Monday to Friday) will be carried out using QEF's own resources.

- Under very heavy snow fall, QEF may need to mobilise all maintenance staff to help keep all sites clear of snow and safe. Local decision may need to be made at very short notice and will be dependent upon staff availability, prevailing weather conditions and competing priorities.

For Winter 2021/21, the following arrangements have been put in place; please refer to Adverse Weather Plan.

Winter Team

A Winter Team is being made available this year to enable a quicker reaction to adverse weather conditions and ensure all Trust sites (Queen Elizabeth Hospital, Bensham Hospital, Dunston Hill Hospital and Moss Heaps Car Park) are well gritted and snow cover is kept to a minimum:

Winter teams will be called in by the on call estates officer or may be asked to attend in advance as weather forecasts dictate.

Grounds workers will also commence there shift at 6.30am during the winter period so that an early response can be taken to any gritting requirements.

Queen Elizabeth Hospital

Main Circulation Roads & Car Parks

When the Met Office predicts frost, overnight gritting will be carried out by Gateshead Council. The work will be undertaken automatically, with no request required by QEF. The Hospital is on the council's red priority list, which is the same priority as the main public roads outside the hospital.

As the Council cannot commit to undertake snow ploughing, this work will be undertaken by QEF Winter/Grounds Teams.

It is to be noted that Gateshead Council will snow plough upon request, but only if they have spare capacity.

Footpaths
When the Met Office predicts frost, footpaths will be gritted by both Coatsworth Landscapes and QEF's Winter/Grounds Teams. Coatsworth Landscapes will undertake the work automatically without with no request required by QEF to instigate the work, QEF will supplement the service provided by the Contractor when necessary.

Outside of normal working hours, when necessary and with no request required by QEF, Coatsworth Landscapes will also snow plough footpaths. Under heavy snowfall QEF will mobilise their own staff to supplement the service provided by the Contractor.

Car Parks
When necessary QEF's Winter/Grounds Teams will snow plough all of the Queen Elizabeth Hospital's car parks. During prolonged or very heavy snowfall arrangements are in place for QEF's service to be supplemented by Coatsworth Landscapes.

Bensham & Dunston Hill Hospitals
The main circulation roads will be gritted by Gateshead Council and, when necessary, Coatsworth Landscapes will undertake snow ploughing.

Footpaths will be gritted and, when necessary, snow ploughed by Coatsworth Landscapes. QEF will supplement the service provided by the Contractor when necessary.

Moss Heaps Car Park
Moss Heaps will be gritted and snow ploughed by Coatsworth Landscapes. The work will be undertaken automatically, with no request required by QEF when the Met Office predicts frost or snow. The Contractor will be provided with a gate key to enable access at all times.
QEF will supplement the service provided by the Contractor when necessary.

CONTACT NUMBERS

Coatsworth Landscapes	Mobile: 07710 804752 (Priority 1) Mobile: 07710 804280 (Priority 2) Office: 01670 825335
Gateshead Council	
During daytime hours 0700-2130 Mon – Fri	Tel. 0191 433 7411 Matty Lindsay Tel. 0191 433 7415/7965 Brian Drummand
After 21.30pm the nighshift is the POC.	Require on call list from Council
Duty Highways Manager	Mobile: 07849 304 528
Brian Drummond, Highways Manager	Mobile: 07771 972999
QEF On-Call Estates Officer	Contact via Switchboard
Require Estates winter on call rota	

24 Transport/Estates

24.1 QEF Transport fleet 4x4 capability, increased to 5 vehicles with 4x4 volunteer responders on call.

24.2 24/7 on call rota established and communicated to all team members.

25 Management of Outpatient Clinics

25.1 Action cards in place for the cancellation (and reinstatement) of outpatient clinics.

26 Pathology demand from increasing winter illness

26.1 In Pathology we take the following steps:

- The laboratory has procured a stock of flu consumables for the rapid flu test in preparation for the winter season. The turnaround time on this test is 60 minutes and will be available 24/7.
- Point of care services are available in acute locations to provide blood gas analysis including in A/E and EAU, there is a laboratory back up service in place.
- A point of care device for Full Blood Count has been installed in A/E and will be commissioned by the end of November 2019.
- The main laboratory equipment has sufficient capacity to service the additional demand from increasing winter illness.

27 IPC

27.1 2020 has been dominated by the rapidly evolving COVID-19 pandemic. The IPC team and Microbiologists are involved in the interpretation and dissemination of the guidance issued from national bodies, including Public Health England and NHS England/Improvement. This supports operational effectiveness within this organisation and the wider healthcare community.

This includes supporting risk assessments during the organisations return of services, aiming to minimise the impact on operational services whilst maintaining the highest level of quality and safety for all our patients, visitors and staff.

27.2 IPC advice support and guidance is provided throughout the organisation to: clinical and non-clinical areas, clinical and non-clinical staff, visitors to the organisation, the fabric of the estate, QE site and all other buildings utilised for service delivery.

27.3 The IPC team and Microbiologists to work with colleagues within GHNFT and others involved in providing care to the wider Gateshead population, including; Community Services, Primary Care, Mental Health Providers, Care Homes and Community groups. The Consultant Microbiologist supports wider Public Health requirements for the locality via the Gateshead Outbreak Control Board at Gateshead Council.

27.4 The IPC team and Microbiologist support the requirements of 'Test and Trace'.

27.5 During the winter months there is an increase in the seasonally related infections conditions of influenza and Norovirus. In addition the COVID-19 pandemic remains a priority. Therefore winter 2020/21 will potentially create a unique combination of infectious conditions that will require the ability to respond adopting a cohesive and collaborative approach.

National COVID-19 IPC guidance is updated as knowledge of the virus increases, and can be found at:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/910885/COVID-19_Infection_prevention_and_control_guidance_FINAL_PDF_20082020.pdf

27.6 During winter and beyond the IPC team will continue to review new national guidance and provide expert advice.

Operational IPC advice is supported by the suite of IPC policies, available on the intranet, which includes outbreak management, guidance on standard and enhanced IPC precautions, environmental decontamination and specific organism management.

27.7 The escalation plan to manage increased numbers of COVID-19 cases is available

27.8 Throughout winter the Microbiologists will continue a 24 hour on call service and can be contacted via Vocera during working hours or by switchboard out of hours.

27.9 The IPC team providing QEH on-site advice, attend bed meetings and support during the winter period:

- 08:00 – 18:00 Monday – Friday
- 08:00 – 16:00 Saturday – Sunday

27.10 Community services have trained 73 “super trainers” across the Gateshead system in IPC fundamentals and some specific Covid 19 related guidance . Each care home has an identified IPC lead to support and rationalise IPC guidance. All community CNP’s who access care homes (elderly care homes) are IPC trained and can support in outbreak control and management.

GHNT as part of the Gateshead system response to outbreak control and management that has been established during Covid, works collaboratively to understand the prevalence, share information, support PHE guidance working closely with microbiology consultants, DIPsI’s and the CCG.

GCP are working with the Director of Public Health to establish and outbreak response team that will support a Gateshead system wide response.

28 Communications strategy

28.1 Internal and external communications

- The final winter plan will be cascaded through internal communication channels and an on-line resource pack will updated.
- The key components of the plan to be shared at UECN/LADB

29 Risk Assessment

29.1 There are a number of key risks to this plan and the current mitigations are set out below.

Area of Risk	Objective Affected	Mitigating Action Taken
Potential that patient numbers exceed the levels of demand planned including Covid-19 admissions	• Patient safety • Meeting demand • Performance targets not met • Staff overwhelmed	All available physical bed capacity has been identified and every effort made to recruit staff to support these. In the event that demand exceeds identified the escalation process requires the on-call service line manager and director to take decisions based on staffed bed capacity and the planned programme. Where necessary this may include decisions to reduce the elective programme or to seek mutual aid, as per OPEL checklists
Risk that insufficient qualified staff are recruited and retained to meet the anticipated need or that during the winter period seasonal viruses take their toll on staff affecting numbers	• Patient safety • Meeting demand • Performance targets not met • Staff overwhelmed	Every effort has been made through the year as part of a rolling recruitment programme to attract as many qualified staff as are needed. More use is being made of AHPs where recruitment is not as challenged as qualified nursing. Non ward based nursing plan to support ward areas All wards will be assessed for safe staffing levels on a daily basis. Staffing plans are updated at site huddles and reported to the site management meeting. All staff are encouraged to have their flu vaccination to reduce the risk of illness.
Risk that the national access targets will not be met	• Contractual obligations • Patient Safety, quality of care and experience adversely affected	Every effort has been made to ensure that the trust has the physical and staffing resources to allow it to meet the national 4hour standards and local ambulance handover targets. This is tracked through the site huddles. Investment in the patient flow team and discharge capacity is specifically targeted at ensuring patients are moved through the system to support the front of house teams. Performance escalation meetings will be held as required to ensure organisational effort is targeted at delivery of the targets.
Risk to the elective programme (increased medical outliers and reduced elective activity) and impact on RTT.	• Patient access • Patient safety • Patient experience • Performance targets	In planning the winter capacity every effort has been made to ensure sufficient medical capacity to support anticipated demand but there remains the potential for periods of peak demand to impact on the elective programme.
Increased costs of providing capacity and associated financial risk	• Delivering financial balance • Organisational sustainability	All proposals have been scrutinised by Executive Team and agreed to be critical to the delivery of the winter programme.
Risk that to cover any increased	• Delivering financial	All staff are encouraged to have their flu

level of staff sickness additional costs will be incurred through bank or agency costs	balance and quality • Organisational sustainability	vaccination. Policies are in place to minimise risk of spreading infection among staff but beyond this there is little pre-emptive action that can be taken. Process for use of agency and monitored?
System pressure not managed, leading to increased diverts to QEH, leading to increased risk of overcrowding in ED and ambulance handover delays, A&E 4 hour wait breaches	• Patient safety • Quality of carte • Patient experience • Performance targets	Regional surge management team in place to support with regional pressures. Winter 2019/20 showed exceptional pressures in the Central ICP and increased demand on other NHS Services Use of flight deck, build relationships across ICP and NEAS, accurate and timely use of OPEL, communication is effective and timely

Appendix 1

Demand and Capacity Modelling

Demand has been modelled based on 9 different scenarios combining:

- A return to 'normal' winter demand based on previous years
- 20% reduction in demand compared to our 'normal' winter
- A 10% increase in demand compared to a 'normal' winter
- Covid-19 demand being at 33%, 50% and 66% of the Phase 1 peak
- Bed occupancy at 92% in line with national guidelines

Demand assumptions for each of these scenarios have been developed for A&E attendances, medical bed demand and surgical bed demand. These assumptions are outlined as follows:

Medicine

Medicine beds modelled on delivering 92% occupancy levels based on average

	D: Maintain at 50% of peak			E: Reduce to 33% of peak			F: Spike back to 66% of peak		
A: Return to normal	**473**			**452**			**494**		
	52	*360*	*61*	*35*	*360*	*57*	*69*	*360*	*65*
B: 20% below normal	**391**			**370**			**412**		
	52	*287*	*52*	*35*	*287*	*48*	*69*	*287*	*56*
C: 10% above normal	**514**			**493**			**535**		
	52	*396*	*66*	*35*	*396*	*62*	*69*	*396*	*70*

Surgery non-elective

Surgery beds modelled on delivering 92% occupancy levels based on average

	D: Maintain at 50% of peak			E: Reduce to 33% of peak			F: Spike back to 66% of peak		
A: Return to normal	**81**			**80**			**82**		
	3	*59*	*19*	*2*	*59*	*19*	*4*	*59*	*19*
B: 20% below normal	**65**			**64**			**66**		
	3	*47*	*15*	*2*	*47*	*15*	*4*	*47*	*15*
C: 10% above normal	**89**			**88**			**90**		
	3	*66*	*20*	*2*	*66*	*20*	*4*	*66*	*20*

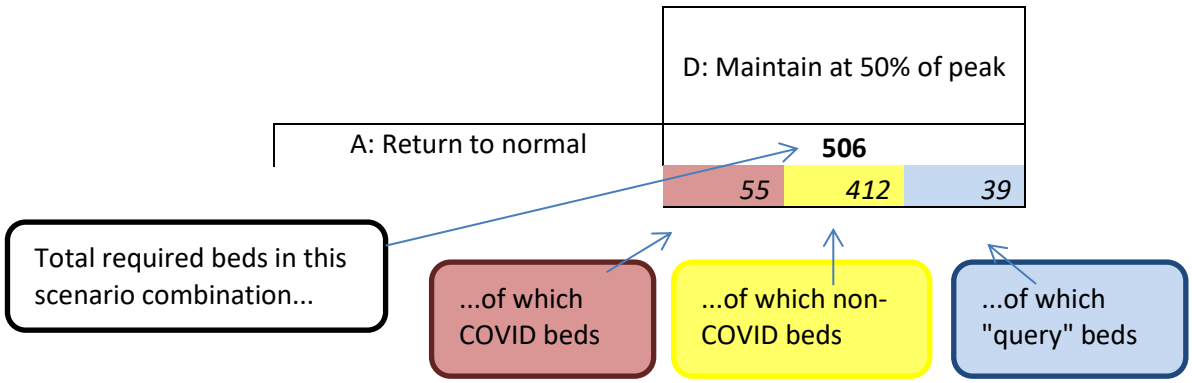
Winter Plan 2020/21

Surgery elective	
A: Return to normal	22
B: 20% below norma	18
C: 10% above normal	24

HOSPITAL LEVEL TOTAL

	D: Maintain at 50% of peak			E: Reduce to 33% of peak			F: Spike back to 66% of peak		
A: Return to normal	**576**			**554**			**598**		
	55	*441*	*80*	*37*	*441*	*76*	*73*	*441*	*84*
B: 20% below norma	**474**			**452**			**496**		
	55	*352*	*67*	*37*	*352*	*63*	*73*	*352*	*71*
C: 10% above normal	**627**			**605**			**649**		
	55	*486*	*86*	*37*	*486*	*82*	*73*	*486*	*90*

Key:



Appendix 2

Detailed Nurse Staffing Plan

RN Planned	Position	From :	Ward 12 winter Staffing Names	RN Actual	Notes: Move from	Backfill of NWBN
Band 8a	Matron	Gen Medicine Winter Lead	TBC	1.0	MED	
Band 7	Ward Manager	TBC	TBC	1.0	MED	
Band 6	Deputy Sister x2	TBC	Interviews 18.09.20	1.0	MED	
		TBC		1.0	SURG	
Band 5 14.62	RN5/6	TBC	18.09.20	1.0	MED	
	RN5	4*	confirmed	1.0	MED	
	RN5	4*	confirmed	1.0	MED	
	RN5	4*	confirmed	0.64	MED	
	RN5	8	confirmed	1.0	MED	
	RN5	9	TBC	1.0	MED	
	RN5	14a	TBC	1.0	SURG	
	RN5	26	TBC	1.0	SURG	
	RN5	27	confirmed	1.0	SURG	
	RN5	C support	TBC – ward 10	1.0	C support	
	RN5	C support	TBC	1.0	C support	
	RN5	NWBN	TBC	To call each shift	Discharge Team	
	RN5	NWBN	TBC	To call each shift	Dietetics / C support	
Total						

17.62WTE				**14.64 WTE**		
HCA	**Position**		**Ward 11/12 winter** **Staffing Names**	**From :**		**HCA backfill:**
	HCA			**1.0**		**X1**
	HCA			**1.0**		**X1**
	HCA			**1.0**		**X1**
	HCA			**1.0**		**X1**
	HCA			**1.0**		**X1**
	HCA			**1.0**		**X1**
	HCA			**1.0**		**X1**
	HCA			**1.0**		**X1**
	HCA			**1.0**		**X1**
	HCA		**TBC**	**1.0**	**No name identified**	**X1**
	HCA			**1.0**		
	HCA			**1.0**		
	HCA			**1.0**		
	HCA			**1.0**		
	HCA			**1.0**		
Support Staff						
Ward clerk	**Band 2**					
House K	**Band 2**			**1.0/0.5**		
Volunteer			**TBC**		**Via** **Jane Douthwaite/Judith Curry**	

Winter Plan 2020/21

Appendix 3

Business Unit	Resource Requirement	Supporting Infornation	WTE	Cost (£)
Medicine	Junior Doctor Cover - In hours WTE estimated per additional beds in accordance with each phase of plan	Junior Clinical fellow + OOHs	WTE requirement varies per month in accordance with plan (2.58 WTE at lowest peak; 11.79 WTE at peak)	216,738
	Junior Doctor cover - OOHs	Junior Clinical fellow + OOHs	3.84 WTE per week (Oct-Mar)	171,792
		Medical Registrar	0.81 WTE per week (Oct-Mar)	
	Consultant WLI		-	200,275
	Ward Costs	Ward 10 - 12 beds for 6 months	22.60 WTE	367,020
		Ward 10 Non Pay	-	45,434
		Ward 12 - 24 beds for 6 months	31.60 WTE	516,261
		Ward 12 Non Pay	-	90,868
	Matron	6 Month Role	1.00 WTE	28,716
	Transfer Team		1.00 WTE	11,786
	Housekeeper		1.00 WTE	11,786
	Ward Clerk		1.00 WTE	11,786
	Discharge Co-ordinator		1.00 WTE	12,944
	Additional support for front of house and triaging		9.5 WTE	137,243
	Additional Bank Spend (increased winter rate)		-	
Surgery	Ward 14A Non Pay		-	13,671
	Ward 21 Non Pay		-	14,723
	Additional Bank Spend (increased winter rate)		-	36,761
Clinical Support & Screening	Physiotherapy Support		1.50 WTE	23,667
	Pharmacy - Dispensary Support		0.40 WTE	6,338
Community	Discharge Liaison Team		10.80 WTE	207,401
	Flu Vaccine Delivery		-	24,070
	Community Therapies Support	7 Day Support	0.20 WTE	9,699
	Call Back Service		3.00 WTE	55,225
Total Cost				**£2,214,205**

Trust Board

Gateshead Health NHS Foundation Trust

Report Cover Sheet

Agenda Item: 8

Date of Meeting:	Tuesday 29th September 2020			
Report Title:	Phase 3 Activity Planning & Performance			
Purpose of Report:	To provide an update on phase 3 activity planning, revised metrics and performance challenges.			
	Decision: ☐	**Discussion:** ☒	**Assurance:** ☐	**Information:** ☒
Trust Goals that the report relates to: (Including reference to any specific risk)	**Goal 3** In all locations and settings of delivery, our patients will experience excellent, timely and seamless care that meets their individual needs. **Goal 7** We will deliver value for money and help ensure the local health and care system is sustainable and well led.			
Recommendations: (Action required by Board of Directors)	The Committee is asked to note the changes in compliance measures and performance reporting from the Phase 3 Planning Guidance. Acknowledge the detailed planning work (in progress – as per timetable) to deliver maximised capacity plans & increase activity levels in support of Phase 3 activity trajectories. Note the challenges ahead in recovery modelling to reduce backlog waiters, particularly in relation to a potential further increase in COVID cases. Actions required - To seek further information and test robustness of plans as it feels is required, to allow a judgement regarding levels of assurance for future levels of operational performance.			
Financial Implications:	There are financial implications to delivering the plans; increased activity includes WLI's & weekend working to deliver additional capacity. Financial plans are indicative/not fully worked up at the time of writing this report; however the Committee may wish to discuss the balance of financial and operational performance risk of patients currently waiting for treatment. Across all indicators, potential future actions to improve operational performance are likely to incur additional spend.			
Risk Management Implications:	Financial Framework is unpublished at the time of producing this report; draft activity plans require financial investment. There are constraints in current estate to maximise capacity. A second wave C-19 pandemic will significantly reduce activity plans			

	and reduce chances of recovery. Test and trace is having an adverse impact on admin teams as well as clinical teams. Currently there are 3308 patients breaching 18 weeks on Trust PTL's with 41 of these being over 52 weeks. Activity plans and participation in the national diagnostic programme to reduce patients waiting over 52 weeks by March 2021 & reduce long waiting backlog. Acknowledging current constraints on Upper/Lower GI pathways re: endoscopy capacity. There are 635 patients waiting on all cancer treatment pathways, 48 of these patients are waiting more than 104 days. Patient pathways are being reviewed weekly to reduce waits. Robust data quality plans need to be aligned to patient tracking and validation to ensure all patients are seen according to clinical need and in turn.
Human Resource Implications:	Several areas of reduced activity are assessed as being linked to unavailability of key clinical staff. There may be an impact on staff wellbeing as a result of working in an increasingly pressurised operational environment.
Diversity and Inclusion Implications:	Delivery of national and local access targets should ensure D&I requirements are met.
Author:	Debbie Renwick/Elizabeth Graham
Presented by:	Debbie Renwick

1. Introduction & Summary

Detailed guidance, issued 7th August 2020, has been released to support the implementation of Phase 3 of the NHS Response to the COVID-19 Pandemic (reference: letter from Amanda Pritchard and Sir Simon Stevens dated 31st July 2020). NHSE/I have clear expectations for managing through winter whilst restoring elective capacity.

This paper provides the Committee Leads with an overview of our revised Phase 3 Activity Submission (2) and detail of how our activity plans compare with national activity and waiting list expectations, noting the risks to delivery.

At the time of writing this report the Trust has not received the financial envelope to consider the cost of delivery; therefore risks remain around sanctioning further additional work to recover waiting lists. Indications from the ICP/ICS call place the North ICP at risk because of the North's financial starting position.

The Committee Leads are asked to note the activity plan and performance implications alongside the on-going and emerging risks to delivery.

2. Background & Expectations

On 31 July 2020 NHS England confirmed the national expectations regarding the third phase of the NHS response to the COVID-19 pandemic. The ask is for organisations to return to near-normal levels of activity between now and winter including;

- In September, delivering at least 80% of last year's activity for both overnight electives and for outpatient/day-case procedures, rising to 90% in October (while aiming for 70% in August);
- This means that systems need to very swiftly return to at least 90% of their last year's levels of MRI/CT and endoscopy procedures, with the goal to reach 100% by October; and
- 100% of last year's activity for first outpatient attendances and follow-ups (face to face or virtually) from September through the balance of the year (and aiming for 90% in August).
- The letter alluded to a change in the financial framework which had been in existence for the initial response to COVID-19 and suggested a framework whereby there are 'system' funding envelopes issued to support delivery of the above targets.
- GHNFT have submitted a draft plan in August with a final activity and workforce plan, including supportive narrative following on 15th September.

3. Operational Processes & Current Activity

The Trust undertakes a process of clinically reviewing patients at all stages of their pathway:

(i) At referral;
(ii) Following outpatient & or diagnostic review, and
(iii) Inpatient waiting-list /decision to admit.

Appointments and attendances are offered and booked on the basis of (i) 2week waits, (ii) Urgent and (iii) Routine slots across outpatients and diagnostics. For elective day case and inpatient stays patients are added to the waiting list and are seen according to clinical urgency i.e. cancers/urgent clinical conditions and then following triage - longest waiters first.

The above process is in-line with phase 3 expectations.

Current Activity

During phase 2 and the restart of activity the Trust has prioritised patients in line with phase 3 expectations.

The activity below demonstrates current total activity levels as a % of last year's activity which is the baseline for the Phase 3 expectations. All activity lines are making progress towards the September plan percentages.

		Apr-20	May-20	Jun-20	Jul-20	Aug-20
Daycase	Actual	734	882	1336	1830	1705
	% of 19/20 activity	29%	34%	58%	65%	69%
Elective	Actual	37	59	102	206	268
	% of 19/20 activity	10%	14%	25%	49%	79%
Outpatients	Actual (New)	1135	1470	2369	3099	2687
	% of 19/20 activity	29%	37%	63%	74%	79%
	Actual (FU)	3133	3514	5288	5625	4884
	% of 19/20 activity	46%	48%	78%	76%	76%

		Apr-20	May-20	Jun-20	Jul-20	Aug-20
All Diagnostics	Actual	2050	3440	4560	5504	5475
	% of 19/20 activity	27%	44%	63%	68%	73%

		Apr-20	May-20	Jun-20	Jul-20	Aug-20
MRI	Actual	279	459	550	550	730
	% of 19/20 activity	34%	53%	74%	69%	96%
CT	Actual	997	1471	1695	1811	1756
	% of 19/20 activity	56%	76%	98%	95%	95%
Colonoscopy	Actual	14	42	89	124	135
	% of 19/20 activity	5%	17%	33%	42%	56%
Non Obs Ultrasound	Actual	535	1163	1373	1930	1848
	% of 19/20 activity	20%	43%	53%	69%	69%
Flexi Sig	Actual	5	13	29	63	46
	% of 19/20 activity	5%	18%	27%	82%	61%
Gastroscopy	Actual	19	25	185	219	266
	% of 19/20 activity	6%	8%	59%	59%	108%

Figure 1 – Current activity

4. GHNFT Submitted plan against Phase 3 Elective Targets

The table below identifies the submitted activity plans; actions to achieve these include use of the independent sector, amendments to patient pathways and premium activity rates.

Activity monitoring against the submission will start in September and will be reported in October's meeting.

		Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Daycase	**Plan**	81%	88%	91%	89%	88%	89%	89%
	Phase 3 target	80%	90%	90%	90%	90%-100%	90%-100%	90%-100%
Elective	**Plan**	99%	101%	101%	102%	101%	101%	103%
	Phase 3 target	80%	90%	90%	90%	90%-100%	90%-100%	90%-100%
Outpatients	**Plan (New)**	90%	93%	94%	97%	97%	98%	98%
	Phase 3 target	100%	100%	100%	100%	100%	100%	100%
	Plan (FU)	85%	88%	89%	88%	88%	88%	90%
	Phase 3 target	100%	100%	100%	100%	100%	100%	100%

		Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
All Diagnostics	**Plan**	83%	82%	88%	89%	91%	91%	91%
	Phase 3 target	90%	100%	100%	100%	100%	100%	100%

		Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
MRI	**Plan**	80%	90%	90%	90%	90%	90%	90%
	Phase 3 target	90%	100%	100%	100%	100%	100%	100%
CT	**Plan**	95%	90%	95%	95%	95%	95%	95%
	Phase 3 target	90%	100%	100%	100%	100%	100%	100%
Colonoscopy	**Plan**	65%	65%	65%	65%	65%	65%	65%
	Phase 3 target	90%	100%	100%	100%	100%	100%	100%
Non Obs Ultrasound	**Plan**	80%	90%	95%	100%	100%	100%	100%
	Phase 3 target	90%	100%	100%	100%	100%	100%	100%
Flexi Sig	**Plan**	65%	65%	65%	65%	65%	65%	65%
	Phase 3 target	90%	100%	100%	100%	100%	100%	100%
Gastroscopy	**Plan**	65%	65%	65%	65%	65%	65%	65%
	Phase 3 target	90%	100%	100%	100%	100%	100%	100%

Figure 2 – Planned activity against phase 3 Targets

5. Performance Impact

Referral to treatment

During Phase 1 and into Phase 2 C-19, RTT performance reporting and validation ceased within the Trust. This, along with the Trust's legacy referral issues has caused numerous data quality issues, which are documented on the Trust's Risk Register. The plan to rectify will take considerable time to implement fully and will impact on the ability to analyse the waiting-list and produce robust projections of backlog.

The long waiters will be targeted at patient level through weekly operational PTL meetings with Business Units, however it is known that

- Pressures exist in all surgical Lower GI (part of surgical) pathways where endoscopy capacity is limited.

- There are also pressures in our Urology pathways – (5 month Newcastle backlog for UES's) due to current waits in Newcastle.
- Gastroscopy patients at greatest risk; based on limited endoscopy capacity and service knowledge regarding availability to see 52 week backlog.
- Cardiology patient breaches are predicted to increase due to current workforce restrictions, & limited workforce options to carry out TOE's in the diagnostic element of the pathway.
- Patients are choosing to delay treatments
- Booking processes do not provide confirmed TCI's into future months
- The Trust is currently awaiting the outcome of the 'Bulk referral closure'
- All pathways will be affected if the Trust is required to restrict elective capacity over winter or in the event of further C-19 disruption

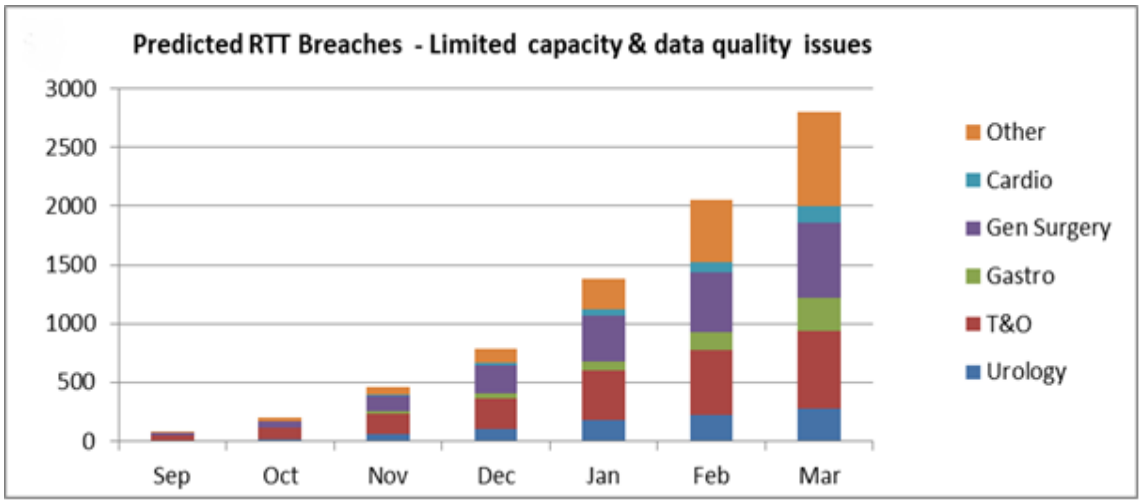


Figure 3 - Predicted 52 week breaches in RTT

Cancer

Phase 3 identifies 3 areas of activity monitoring for cancer pathways:

- All patients urgently referred with suspected cancer by their GP who received a first outpatient appointment in the given month;
- Number of patients receiving first definitive treatment following a diagnosis within the month, for all cancers;
- Cancer 62 day pathways waiting 63 days or more after an urgent suspected cancer referral at the end of the reporting period, and patients waiting over 104 days to have an immediate action plan.

The table in figure 4 summarises the cancer Phase 3 Submission in line with the 3 performance areas, the 2ww activity plan has increased to 100% of the previous year's activity from the previous submission as the patients who would normally go direct to endoscopy are being 'seen' in OP.

	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
2 week waits (seen)	944	1025	989	924	920	945	937
31 day Definitive diagnosis (seen)	98	111	100	96	104	66	127
Cancer patients >62 days (waiters)	127	122	117	117	112	107	102

Figure 4 – Cancer Phase 3 submission

2 week wait pathways

Patients with a high suspicion of cancer are referred via their GP under the two week wait rule which requires the patient to be seen in a face to face clinic within 14 days (this has been adapted to include telephone clinics during COVID). A reduction in the number of 2 week wait (2ww) referrals was initially noted during the height of the pandemic. Current numbers of referrals are returning to normal levels. Activity has been slow to restart, however the chart below depicts a positive variance of 10% in August 2020 in comparison to last year.

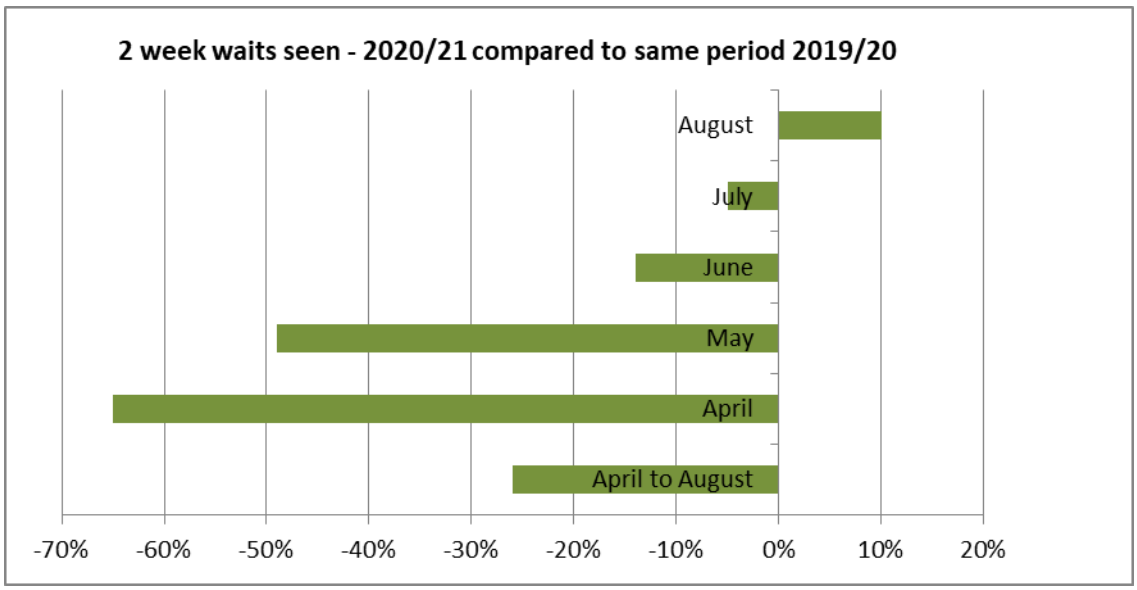


Figure 5 – Two week wait activity comparison of 2019/20 - 2020

Risks in Relation to 2 Week Wait pathways

The chart below shows the percentage of 2 week wait referrals seen within 2 weeks. Breast services are under pressure - all patients are being seen albeit not within the traditional 2 week standard, patients are waiting circa 3-4 weeks. Whilst the initial wait is longer Gateshead breast services offer a 'gold standard' service via a one stop clinic, undertaking diagnostic procedures at the same time as the initial outpatient discussion, thereby eradicating delays further down the pathway.

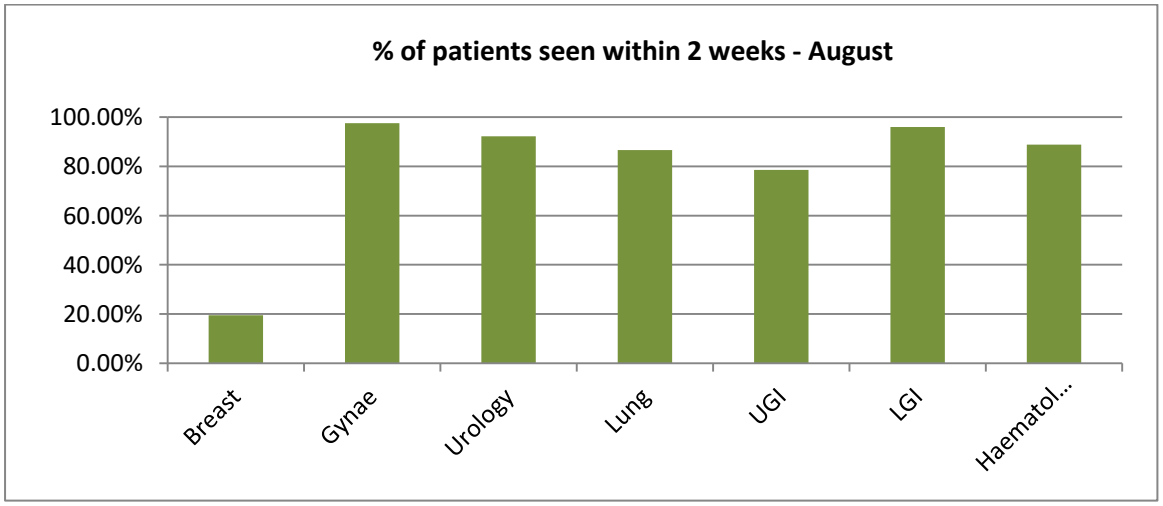


Figure 6 – Urgent cancer referrals % seen within 2 weeks

ICP/ICS issues are emerging south of the patch in both Teesside and Durham, whereby breast service provision issues could potentially result in patients choosing Gateshead for breast care and/or where screening hubs are the first port of call to offer mutual aid. A return has been requested from all provider trusts in the area identifying recent waiting patterns and activity data.

Diagnostics

Diagnostics provide a crucial element of any cancer pathway and the majority flow through radiology and endoscopy units.

Radiology services have continued on site and have also made use of access to the independent sector for CT and MRI services alongside the use of an onsite mobile scanning unit.

Endoscopy capacity within Gateshead was a pre-existing weakness prior to the pandemic. Reduced capacity has been challenging and is impacting upon cancer pathways**.** All procedures which were undertaken within endoscopy have now been restarted with the necessary infection control practices in place. Cancer diagnostic tests are prioritised within the endoscopy unit with appropriate triage by clinical teams.

The endoscopy clinical team are continually reviewing their internal processes to maximise capacity, ensuring appropriate infection control procedures and patient flow through the department is maintained. Capacity modelling is continually being undertaken with the unit. The unit is currently running at 65% capacity. It is anticipated that it will take 7 weeks of day, evening and weekend working to reduce the current backlog.

Access to the independent sector continues to be utilised but there has been reluctance from patients to travel to the independent site for endoscopic procedures. The clinical team are continuing to promote the use of the independent sector for more routine surveillance procedures but uptake remains poor.

A pilot of the use of nasal endoscopy is currently being undertaken within the department. This has advantages as it takes less time to recover the patient from the procedure and potentially will increase capacity within the department

The current endoscopy estate does not allow for environmental improvement without a substantial capital investment. Bids for capital funding and equipment have been submitted and responses are awaited.

The development of regional diagnostic hubs may provide a positive solution but this will require substantial organisation in the initial set up phase.

62 Day pathways waiting over 63 days

Cancer services have maintained comprehensive Patient Time Line (PTL) data to ensure robust timelines with documented evidence of decisions made, COVID-19 delays and safety netting in place to ensure patient delays are kept to a minimum and to ensure that patients are not “lost” within the cancer system.

Weekly cancer MDT’s have utilised video conferencing via remote access to ensure timely discussion and agreement on treatment pathways.

The Phase 3 plan modelling identified **102 patients** waiting **63 days or over** for cancer treatments. The chart below shows the predicted number of patients waiting by tumour site.

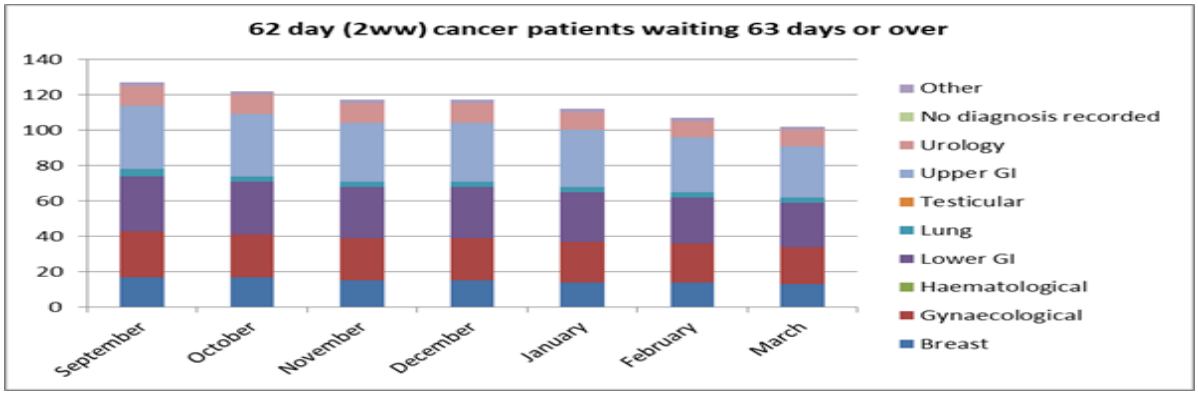


Figure 7 – Projected number of patients waiting more than 63 days at the end of March 2021

Immediate Plans for Patients Waiting Over 104 Days

Patients are stratified into treatment and tumour time bands, those waiting >104 are an immediate focus for the weekly operational delivery group. Progress to date has shown a 51% reduction in the total number of patients waiting over 104 days and a 65% reduction in 62 day patients waiting over 104 days.

Dates	Numbers on 62 day classic (2ww) pathway waiting over 104 days	Total numbers on cancer pathways waiting over 104 days
2/8/20	92	135
9/8/20	67	115
16/8/20	58	100
23/8/20	54	82
30/8/20	52	75
6/9/20	31	66

Figure 8 – Over 104 day waiters on cancer pathways

Risks in Relation to Cancer Treatments

The continued use of the independent sector is required to support our surgical treatments. From the 7th September access to the independent sector for our planned breast surgery has been reduced. Further reduction or withdrawal of this capacity will have a negative impact on our breast surgery capacity and our ability to treat patients within a 62 day target.

Some of our tumour pathways are shared pathways with Newcastle Centre for Cancer Care (NCCC) and patient flow to NCCC is dependent on their capacity. Surgical interventions for lung, urology and upper GI cancers are all dependent on NCCC. This patient flow is actively monitored via cancer tracking reviews and delays are highlighted and expedited if NCCC capacity allows.

Our urology shared pathway is of particular concern for a number of reasons related to our diagnostic pathway for prostate cancer. Current information suggests insufficient capacity from the available service model to meet the service demands especially in terms of consultant led activity. However, there are a number of data quality issues which are currently being reviewed. Once this data cleansing work is complete there will be an opportunity to better quantify the perceived gap in capacity. In order to minimise the impact for cancer services, the nursing team regularly look to

convert routine appointments to create short notice cancer referral capacity. A service review is planned to provide recommendations on the future direction of the service to address these issues.

Risks – Activity & Performance

Outpatients

Referrals into the Trust are planned to return to back to near pre-COVID referrals (between 90-100%)

Patients and GP's continue to access our systems via e- referral system into (i) directly bookable appointments (ii) Referral Assessment Service (RAS) and (iii) Advice and guidance. The RAS service and Advice and guidance are effectively triage facilities, which enable a Consultant review and then are either converted into an appointment or returned back to GP. T&O triage patients using Windip (referrals are received from TIMS).

The activity plan does not (as per national coding and counting definitions) include Advice & Guidance. In comparison to the same period last year activity for August has increased by 65% from 252 contacts in 2019 to 418 contacts in 2020. This has significant financial implications as is out-with the current activity contract. Areas most affected by the increase are GI & Liver, Gastroenterology, Respiratory medicine, Paediatrics, Rheumatology and general gynaecology. The recognition of enhanced A&G is being actively pursued via ICP/ICS.

Access to face to face outpatient appointment services are clinically triaged to minimise footfall in the hospital, protecting patients and staff. Telephone and video conferencing contacts equate to 37% of all new activity and 57% of all follow-up. The Booking centre continues to work closely with Business Units to flex available capacity when clinical need requires.

Clinic space in main OPD (QEH site) has been reviewed and updated each month since services were reinstated in June via the Outpatient Cell, to ensure available space is maximised appropriately and according to IPC regulations. All clinic space has now been allocated and operational monitoring arrangements are in place to closely manage utilisation of the clinics.

The Trust has, in line with revised IPC measures, reviewed and updated the number of patients per clinic whilst still maintaining safe social distancing guidance. Based on the revised clinic formats and discussion with the BU's – the following table indicates our predicted OP activity (including digital technology).

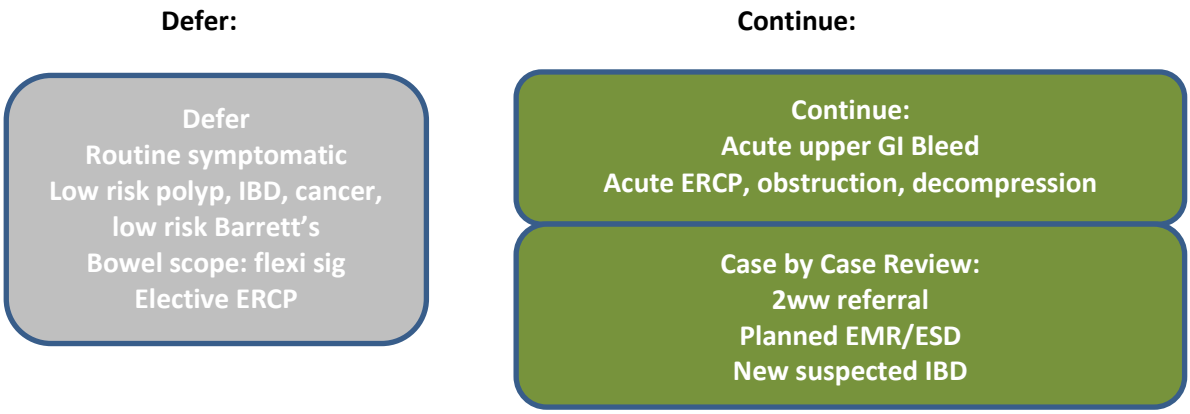
Number	Sep	Oct	Nov	Dec	Jan	Feb	Mar
New 1920	3,915	4,389	3,810	3,478	3,668	3,499	3,068
New 2021	3,524	4,082	3,581	3,373	3,558	3,429	3,481
FU 1920	7,119	7,576	6,759	6,174	7,118	6,394	6,134
FU 2021	6,051	6,667	6,015	5,433	6,264	5,626	6,342
Total 1920	11,034	11,965	10,569	9,652	10,786	9,893	9,202
Total 2021	9,575	10,749	9,596	8,806	9,822	9,055	10,183
Delivery	87%	90%	91%	92%	91%	92%	93%

Figure 9 – Outpatient projections

Outpatient clinics have been re-instated at Blaydon PCC since July and a plan to commence services at Washington is currently being developed. The Jubilee Day Hospital (JDH) is currently still occupied by the Urgent Treatment Centre which was re-located from the Emergency Care Centre to the JDH during COVID to release additional capacity in ED, thereby limiting OP capacity.
Numerous estates decisions are aligned to the capital spending plan which may involve re-locating OP clinics previously held in JDH elsewhere on site. Given the challenge in meeting NHSE Phase 3 expectations, this is a priority to find and establish alternative estate.

Diagnostics – Endoscopy

During the early COVID period, advice from BSG / JAG / NHSEI was to suspend endoscopy services except emergencies and clinically urgent referrals (as per criteria below).



This has been reviewed regularly throughout the pandemic phase and sessions have been introduced at Cobalt (Monday and Wednesday all day) for predominantly LGI tests, the utilisation of the lists has been variable due to patient choice.

During Phase 3: Lists at QEH have increased and the current maximum capacity is between 27 and 29 lists for UGI/LGI and flexi sig per week depending upon consultant availability. This is estimated to be 65% of pre-COVID capacity.

Estate constraints and IPC measures are the rate limiting factor in returning to pre-COVID levels. Draft plans (which require costing & workup and are therefore not included in this activity submission) include:

- Recruitment of a fully qualified nurse endoscopist
- Late evenings (Tuesday and Thursday) and Saturday sessions
- Train a further two non-medical endoscopists in LGI (will take 18 months minimum)
- Scoping a proposal for insourcing to assist with current backlogs
- Business Case for Nasal Endoscopy

The service and service support members hold weekly capacity meetings and fortnightly endoscopy cell meetings to focus the team on flexing current capacity to ensure patients are seen based on clinical need whilst meeting the wider demands on the service.

Elective Capacity

The principles guiding elective care recovery are to prioritise patients with the greatest clinical need, then treat waiters in chronological order. The clinical model includes defaulting to day-case where possible to minimise hospital stays and maximise capacity within IPC guidelines.

Physical theatre capacity is now back at pre-COVID levels, staffing is also at full complement, noting the nursing workforce has circa 40% new staff to theatres. Staff in theatre are willing to provide additional WLI sessions via evening and weekend working to see more patients to support clinical needs, long waiting times and back-log reduction.

Revised numbers include implementing the theatre utilisation plan to increase the number of cases on lists in line with regional benchmarking and reviewing current pre-assessment processes, oversight via Elective Care Board.

Elective usable bed capacity is back to pre-COVID levels; elective activity modelled in the Phase 3 plan is in line with the patch-wide assumption of (R=1). A second spike of C-19 places the greatest risk to the proposed elective plan.

The current clinical model to manage C-19 outbreaks places elective surgery; orthopaedic and gynaecology and gynaeoncology patients at greatest risk.

Non Elective Activity

Non Elective activity is in-line with the winter plan; and is modelled on winter at last year's activity. Elective activity plans are at risk if the operational plan escalates into wards identified for elective care as per Phase 1.

Key Overarching Risks

COVID
- Second Surge
- Single site hospital / Estate restrictions
- IPC restrictions / flow
- IPC restrictions / downtime
- IPC kit availability
- Patient choice not to attend hospital / IS provision
- Demand predictions & winter?
- Track & Trace – workforce pressures

DATA VALIDATION & PT. TRACKING
Historic legacy data issues – (Bulk Closure)
New ways of working – capturing patient outcomes

WINTER
Flu and seasonal winter pressures are risks to protected WINTER
Flu and seasonal winter pressures are risks to protected elective activity

TESTING
Availability of testing / and reporting downtime.

PPE
Increased down time in between procedures - limitations with available capacity

FINANCIAL
Risk delivering activity – EL/DC work

PATIENT CONFIDENCE
There remains an unwillingness to attend hospital. Public reassurance is key to deliver the required activity levels.

WORKFORCE
- Shielding staff
- Track & Trace
- Medical Rotas
- Health & Well Being

Operational Risks

The areas below summarise the operational risk register themes:

Workforce

Admin Review & JD issues
Admin: RTT validation capacity
Gynaeoncology Admin staff
Surgical capacity (C-19 modifications)
Theatre skill mix
Medical Staffing Rota
COTE/Stroke/Audiology/ENT

Estate / Capital Restrictions

Reduced POD capacity: (Pre-assessment CPEX)
2 Theatres require essential maintenance work (8 weeks down time)
Audiology / ENT
Endoscopy

Activity & Performance

COTE/Stroke/Audiology Assessments/ENT/Endoscopy/Respiratory/ Cardiology/Gastroenterology
Urology pathways
Lower GI pathways
Cancer 2 week waits referral – Breast services

Patients & pathways

Patient initiated delays – choosing to wait, fear of C-19
Compliance with IPC measures
Pathway validation
Legacy data quality issues (referrals/outcomes)

Winter / Flu / 2nd spike

Impact on recovery trajectories

Trust Board

Gateshead Health NHS Foundation Trust

Report Cover Sheet

Agenda Item: 12

Date of Meeting:	Tuesday 29th September 2020			
Report Title:	Consolidated Finance Report			
Purpose of Report:	To provide a summary of performance as at 31st August 2020 (Month 5) for the Group (inclusive of Trust and QE Facilities, excluding Charitable Funds).			
	Decision: ☐	**Discussion:** ☒	**Assurance:** ☒	**Information:** ☐
Corporate Objectives report relates to: (Including reference to any specific risk)	9. Meet the Trust's financial requirements, hitting our control total by reducing costs and improving efficiency 10. Ensure the Trust continues to be well-led and has a clear strategy for the future			
Recommendations: (Action required by Board of Directors)	The Committee is asked to note the reported financial performance for Month 5 2020/21.			
Financial Implications:	As included in the report			
Risk Management Implications:	As included in the report			
Human Resource Implications:	None			
Equality and Diversity Implications:	**Objective 3** Leaders within the Trust are informed and knowledgeable about the impact of business decisions on a diverse workforce and the differing needs of the communities we serve.			
Author:	Mrs Kris Mackenzie, Deputy Director of Finance			
Presented by:	Mrs Jacqueline Bilcliff, Group Director of Finance			

NHS
Gateshead Health
NHS Foundation Trust

Executive Summary

The purpose of this report is to inform the Board of Directors of the financial position of the Group for the period to 31st August 2020.

Summary

In response to the Covid 19 outbreak, guidance was issued in March 2020 that suspended the 2020/21 national operational planning process. An interim financial framework was established intended initially to cover the period 1 April to 31 July 2020, this has been extended to September.

During the period 1 April to 30 September, the Trust will receive a guaranteed level of income that is intended to reflect the actual cost base. Therefore, it is a national expectation that sufficient funds will be provided to enable the Trust to return an overall income and expenditure break even position for these four months.

The cash payment profile has been amended so that the Trust will receive cash payments in advance, delivering a positive cash flow for this period.

In response, the Trust has suspended its internal financial control framework and in this paper reports against the projected break even position for the period of the national interim financial framework. A national formula has re-set the planned income and expenditure levels for this period, and so when this paper reports performance against plan, it is in reference to the revised plan issued by NHSI/E.

Recommendation

The Board are asked to note the financial position and financial performance for month 5 of 2020/21 and the key assumptions made

Key financial performance indicators

Finance KPIs	Plan	Actual	Difference
Performance against control total (including Top up funding)	**0**	**0**	**0**
Performance against control total (excluding Top up funding)	**(13,498)**	**(16,407)**	**(2,909)**
Capital spend	**1,337**	**1,284**	**(53)**
Cash position	**3,544**	**27,318**	**23,774**
Liquidity days	**(18.53)**	**(7.63)**	**10.90**

Key financial metrics

Not reported under the interim financial framework.

Key risks

Risk	CRR	Progress / Mitigation
Risk that the level of efficiency savings required in year cannot be achieved	16	The financial framework has been suspended for the first part of the year. Business units are now once again engaged in detailed financial forecasting and identification of cost control. The 'ask' however is still unknown for 20/21.
Unable to agree a reasonable financial plan or envelope for 2020/21 given current timescales	16	The financial envelope / detailed planning guidance for the current year were received on 16/9/20. The Trust is currently working through the implications of this in partnership with the ICP; it is too early to determine whether the Trust will be in a position to agree a plan for the remainder of the year. The Trust response will be part of a collective ICP response.
Robustness of the financial forecast given the uncertainty surrounding COVID and the effect on capacity and demand	12	DFBMs working closely with the business units to ensure implications of potential second wave are identified but also the costs of 'catch up' included within the planning/forecast requirements.
Unmanaged escalation in costs leading to deterioration in underlying financial position and cost base of the Trust	15	Budgetary control framework remains in place, separate identification of COVID costs, continued focus on VFM and cost control to organisation.

Section 1 - Summary Income and Expenditure Position (see Appendix 1)

As at 31st August the Group is reporting a deficit position (excluding Top-Up funding) of £16.407m for the period. This is against a revised planned deficit of £13.498m, an adverse variance of £2.909m. Once Top-Up funding is incorporated, the Group reports a breakeven position, as projected by the NHSE/I covid regime.

Within this total operating income (including Top-Up funding) is more than the revised plan by £1.473m, total operating expenses are more than the revised plan by £1.147m and other non-operating expenses are more than the revised plan by £0.420m. Adjusting for the impact of donated assets totalling £0.094m gives a breakeven position.

An expanded Income & Expenditure performance is presented at **Tables 1 and 2**.

Section 2 - Income Analysis (see Appendix 1 Table 2)

The reported income position as at August is an over recovery against NHSI plan of £1.473m. This comprises an over recovery of £0.009m for operating income from patient care activities and £1.464m against other operating income.

As part of the interim financial framework, activity based billing has been postponed with the exception of inter-trust invoicing, and has been replaced by a block value for NHS income.

The block values were calculated centrally based on the income the Trust received during December 2019; with an inflation uplift of 2.8% applied. Using the average expenditure of the months November 2019, December 2019 and January 2020 to derive anticipated costs, it was recognised nationally that this initial block funding would not bring the Trust back to break-even (a requirement of the interim financial framework), therefore a further payment of non-recurrent income known as 'Top-Up' was allocated. Furthermore, there is an avenue to apply for additional retrospective 'Top-Up' funding where necessary if there are reasonable costs incurred in response to the Covid-19 outbreak.

Operating income from patient care activities is an over recovery of £0.009m. This comprises of an under achievement from CCG Commissioners totalling £0.018m, an over performance against control total against NHS England Commissioners of £0.102m both relating to final 19-20 activity reconciliations. Performance against Foundation Trust's is an over performance of £0.299m which mainly relates to the pathology service line agreement with South Tyneside & Sunderland Foundation Trust. These over-performing income streams are offset by an adverse variance of £0.374m on other income lines including private patients and the NHS Injury Cost Recovery Scheme.

Other operating income is an over recovery of £1.464m, with an adverse £1.445m relating to reduced non-patient care income that sits outside of the block values identified as part of the interim financial framework. The favourable balance is £2.909m of additional income that relates to further retrospective top up funding required to enable the Trust to achieve a breakeven position in accordance with the interim financial framework. This additional payment is due to additional expenditure relating to Covid-19.

Section 3 - Expenditure Analysis (see Appendix 1 and 2)

As at August total operating expenses are higher than plan by £1.147m, comprising of a pay underspend of £2.217m and a non-pay overspend of £0.935m with depreciation and revaluation overspends of £0.212m. See **Tables 1 and 2.**

Tables 3, 4, 5, and 6 highlight the different variances within the employee position and the run rate for the component parts of the employee budgets; substantive staff, waiting list payments, agency and contract staff and bank. **Tables 7 and 8** present the same for non-pay.

As part of the interim financial framework, the Trust is required to diligently record all expenditure incurred in response to the Covid 19 outbreak. As at August 2020 the Trust has incurred cost of £12.824m, with further detail provided in **Table 9**. Additional staffing costs incurred including bank and agency across all staffing groups has cost £3.761m and the non-staff element of £9.063m includes expenditure on behalf of Newcastle Gateshead CCG, the costs of laboratory reagents and equipment, computer hardware, decontamination and clinical supplies.

Section 4 - CRP performance

The interim financial framework has set allocated funding on the assumption that no efficiencies will be delivered for the period 1 April to 30 September. The Trust is pursuing its internal financial framework for the remainder of the financial year which will be influenced by the post September financial framework. It is expected efficiencies are a key part of its delivery. Therefore, there is ongoing work within the organisation in response to this.

Section 5 - Cash and working balances (see Appendix 3)

Cash at the beginning of the 2020/2021 financial year was £5.800m above initial plan, at £14.4m, due in the main to scheduled creditor payments in respect of the 2019/2020 financial year end. The cash position was further strengthened by the receipt of an additional £4.700m of PSF/FRF monies in respect of 2019/2020. The cash position presented has been adjusted for payments in advance, with August's Statement of Financial Position inclusive of September's block income. Current contract arrangements and reduced elective activity in the hospital have also had a positive impact upon cash levels; however this is not expected to be maintained for the remainder of the financial year as revised arrangements are anticipated.

The adjusted cash position of £27.318m as at 31st August is equivalent to 33.86 days operating costs (30.98 days in July) and represents a £2.320m increase from July. Cash is £23.800m above initial plan.

The liquidity metric has improved by 0.07 days against July to -7.63 days and is 10.9 days better than initial plan driven by a £8.9m improvement in the working capital balance.

Debtors have reduced by £8.100m in the year due in the main to the receipt of PSF/FRF monies and are £1.400m below initial plan.

Trade and other payables have increased by £3.99m since 31st March 2020 and are cumulatively £13m above initial plan. Trade creditors have increased by £0.15m in the year, at £2.848m as at 31st August, however this is a reduction of £0.801m against July. Of the trade creditor balance there are no creditors currently authorised for payment and outstanding over 30 days.

Section 6 – Capital spend (see Appendix 4)

The 2019/2020 capital programme was initially set at £7.090m at the planning stage; this CDEL limit has increased to £7.116m to reflect additional capital funding received of £0.026m in respect of Breast Screening Trailers.

Out with the Trusts CDEL limit, capital expenditure is being incurred in response to the Covid 19 outbreak. Building works have been commissioned on two major schemes, the Tranwell Unit £0.450m and Ward 21 £0.480m. Alongside this, equipment costs of £0.495m have been incurred. Funding in respect of all Covid 19 related capital expenditure has been sought, and approval is now anticipated by the end of September depending on when claims were submitted. No reimbursement has been received to date, and therefore, the Trust has a risk of over commitment against its CDEL.

The outline of the programme (excluding Covid 19 related expenditure) is included at Table 11 together with spend to date.

Section 7 – Summary

The Trusts financial position is break even in line with the revised plan introduced as part of the national interim financial framework.

Jacqueline Bilcliff, Group Director of Finance

Appendix 1 – Summary Income and Expenditure Position

Table 1 – summary financial position Statement of Comprehensive Income

August 2020/21	GROUP POSITION NHSI/E Covid Plan			VARIANCE		
Red >100k over Amber <> (£50k) - £99.99k Green <(£50.1k)	Apr- Sept Covid Plan Total	Covid Plan to Date	Actual to Date	Variance (Actual - Budget)		Previous Month Variance
	£000's	£000's	£000's	£000's		£000's
Operating						
Operating Income from Patient Care activities						
Income From NHS Care Contracts	(127,548.0)	(106,290.0)	(106,672.9)	(382.9)		(317.0)
Income From Local Authority Care Contracts	(54.0)	(45.0)	(37.5)	7.5		6.0
Private Patient Revenue	(366.0)	(305.0)	(111.7)	193.3		163.4
Injury Cost Recovery	(462.0)	(385.0)	(76.0)	309.0		219.4
Other non-NHS clinical revenue	(6.0)	(5.0)	(141.3)	(136.3)		(108.3)
Total Operating Income From Patient Care activities	**(128,436.0)**	**(107,030.0)**	**(107,039.4)**	**(9.4)**		**(36.6)**
Other Operating Income						
Education and Training Income	(3,462.0)	(2,885.0)	(2,685.6)	199.4		(13.9)
R&D Income	(486.0)	(405.0)	(263.3)	141.7		117.3
Top Up Funding	(16,198.0)	(13,498.0)	(16,406.7)	(2,908.7)		(3,106.2)
Other Income	(6,732.0)	(5,610.0)	(4,505.9)	1,104.1		949.5
Donations & Grants Received	-	-	-	-		-
Total Other Operating Income	**(26,878.0)**	**(22,398.0)**	**(23,861.5)**	**(1,463.5)**		**(2,053.3)**
Total Operating Income	**(155,314.0)**	**(129,428.0)**	**(130,900.9)**	**(1,472.9)**		**(2,089.9)**
Operating Expenses						
Total Employee Expenses	**101,832.0**	**84,860.0**	**82,643.0**	**(2,217.0)**		**(1,679.5)**
Operating Expenses included in EBITDA	**150,544.0**	**125,453.0**	**126,387.6**	**934.6**		**1,678.2**
Operating Expenses excluded from EBITDA	**3,024.0**	**2,520.0**	**2,732.1**	**212.1**		**189.7**
Total Operating Expenses	**153,568.0**	**127,973.0**	**129,119.8**	**1,146.8**		**1,867.9**
(Profit)/Loss from Operations	**(1,746.0)**	**(1,455.0)**	**(1,781.1)**	**(326.1)**		**(222.0)**
Non Operating						
Non-Operating Income						
Finance Income	(84.0)	(70.0)	(22.5)	47.5		39.7
Total Non-Operating Income	**(84.0)**	**(70.0)**	**(22.5)**	**47.5**		**39.7**
Non-Operating Expenses						
Finance Costs	318.0	265.0	362.4	97.4		51.7
Gains / (Losses) on Disposal of Assests	-	-	(0.3)	(0.3)		(0.3)
PDC dividend expense	1,236.0	1,030.0	1,200.3	170.3		136.2
Total Finance Costs (for non-financial activities)	**1,554.0**	**1,295.0**	**1,562.4**	**267.4**		**187.6**
Total Non-Operating Expenses	**1,554.0**	**1,295.0**	**1,562.4**	**267.4**		**187.6**
(Surplus) / Deficit Before Tax	**(276.0)**	**(230.0)**	**(241.2)**	**(11.2)**		**5.3**
Corporation Tax	276.0	230.0	334.8	104.8		69.7
(Surplus) / Deficit After Tax	**-**	**-**	**93.6**	**93.6**		**75.0**
(Surplus) / Deficit After Tax from Continuing Operations	**-**	**-**	**93.6**	**93.6**		**75.0**
Remove capital donations / grants I&E impact	-	-	(93.6)	(93.6)		(74.9)
Adjusted Financial Performance (Surplus) / Deficit	**-**	**-**	**(0.0)**	**(0.0)**		**0.1**
						-
Adjusted Financial Performance (Surplus) / Deficit	**-**	**-**	**(0.0)**	**(0.0)**		**0.1**
Top Up Adjustment	16,198.0	13,498.0	16,406.7	2,908.7		3,106.0
Adjusted Financial Performance (Surplus) / Deficit excluding Top Up	**16,198.0**	**13,498.0**	**16,406.7**	**2,908.7**		**3,106.1**

Table 2 – Detailed financial position Statement of Comprehensive Income

August 2020/21	GROUP POSITION NHSI/E Covid Plan			VARIANCE		
Red >100k over Amber <> (£50k) - £99.99k Green <(£50.1k)	Apr- Sept Covid Plan Total	Covid Plan to Date	Actual to Date		Variance (Actual - Budget)	Previous Month Variance
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Operating Income from Patient Care activities						
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Income From Local Authority Care Contracts	(54.0)	(45.0)	(37.5)	→	7.5	6.0
Private Patient Revenue	(366.0)	(305.0)	(111.7)	↓	193.3	163.4
Injury Cost Recovery	(462.0)	(385.0)	(76.0)	↓	309.0	219.4
Other non-NHS clinical revenue	(6.0)	(5.0)	(141.3)	↑	(136.3)	(108.3)
Total Operating Income From Patient Care activities	**(128,436.0)**	**(107,030.0)**	**(107,039.4)**		**(9.4)**	**(36.6)**
Other Operating Income						
Education and Training Income	(3,462.0)	(2,885.0)	(2,685.6)	↓	199.4	(13.9)
R&D Income	(486.0)	(405.0)	(263.3)	↓	141.7	117.3
Top Up Funding	(16,198.0)	(13,498.0)	(16,406.7)	↑	(2,908.7)	(3,106.2)
Other Income	(6,732.0)	(5,610.0)	(4,505.9)	↓	1,104.1	949.5
Donations & Grants Received	-	-	-	→	-	-
Total Other Operating Income	**(26,878.0)**	**(22,398.0)**	**(23,861.5)**		**(1,463.5)**	**(2,053.3)**
Total Operating Income	**(155,314.0)**	**(129,428.0)**	**(130,900.9)**		**(1,472.9)**	**(2,089.9)**
Operating Expenses						
Total Employee Expenses	**101,832.0**	**84,860.0**	**82,643.0**		**(2,217.0)**	**(1,679.5)**
Operating Expenses included in EBITDA	**150,544.0**	**125,453.0**	**126,387.6**		**934.6**	**1,678.2**
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Total Operating Expenses	**153,568.0**	**127,973.0**	**129,119.8**		**1,146.8**	**1,867.9**
(Profit)/Loss from Operations	**(1,746.0)**	**(1,455.0)**	**(1,781.1)**	↑	**(326.1)**	**(222.0)**
Non Operating						
Non-Operating Income						
Finance Income	(84.0)	(70.0)	(22.5)	→	47.5	39.7
Total Non-Operating Income	**(84.0)**	**(70.0)**	**(22.5)**		**47.5**	**39.7**
Non-Operating Expenses						
Finance Costs	318.0	265.0	362.4	→	97.4	51.7
Gains / (Losses) on Disposal of Assests	-	-	(0.3)	→	(0.3)	(0.3)
PDC dividend expense	1,236.0	1,030.0	1,200.3	↓	170.3	136.2
Total Finance Costs (for non-financial activities)	**1,554.0**	**1,295.0**	**1,562.4**		**267.4**	**187.6**
Total Non-Operating Expenses	**1,554.0**	**1,295.0**	**1,562.4**		**267.4**	**187.6**
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Corporation Tax	276.0	230.0	334.8	↓	104.8	69.7
(Surplus) / Deficit After Tax	**-**	**-**	**93.6**		**93.6**	**75.0**
(Surplus) / Deficit After Tax from Continuing Operations	**-**	**-**	**93.6**	→	**93.6**	**75.0**
Remove capital donations / grants I&E impact	-	-	(93.6)	↑	(93.6)	(74.9)
Adjusted Financial Performance (Surplus) / Deficit	**-**	**-**	**(0.0)**		**(0.0)**	**0.1**
Adjusted Financial Performance (Surplus) / Deficit	**-**	**-**	**(0.0)**	→	**(0.0)**	**0.1**
Top Up Adjustment	16,198.0	13,498.0	16,406.7		2,908.7	3,106.0
Adjusted Financial Performance (Surplus) / Deficit excluding Top Up	**16,198.0**	**13,498.0**	**16,406.7**	↓	**2,908.7**	**3,106.1**

Appendix 2 – Expenditure analysis

Table 3 – Budgeted & actual pay expenditure including COVID expenditure

August 2020/21		GROUP POSITION NHSI/E Covid Plan			VARIANCE		
Red	>100k over	Apr- Sept Covid Plan Total	Covid Plan to Date	Actual to Date	Variance (Actual - Budget)		Previous Month Variance
Amber	<> (£50k) - £99.99k						
Green	<(£50.1k)						
		£000's	£000's	£000's	£000's		£000's
	Operating Expenses						
	Employee Expenses - Substantive	96,060.0	80,050.0	77,922.6	(2,127.4)		(1,642.2)
	Employee Expenses - Bank	3,378.0	2,815.0	3,196.0	381.0		349.0
	Employee Expenses - Agency	2,040.0	1,700.0	1,165.4	(534.6)		(437.9)
	Employee Expenses - Other	354.0	295.0	359.0	64.0		51.6
Total Employee Expenses		**101,832.0**	**84,860.0**	**82,643.0**	**(2,217.0)**		**(1,679.5)**

Table 4 – Substantive pay run rate including COVID Expenditure and Waiting List Initiatives

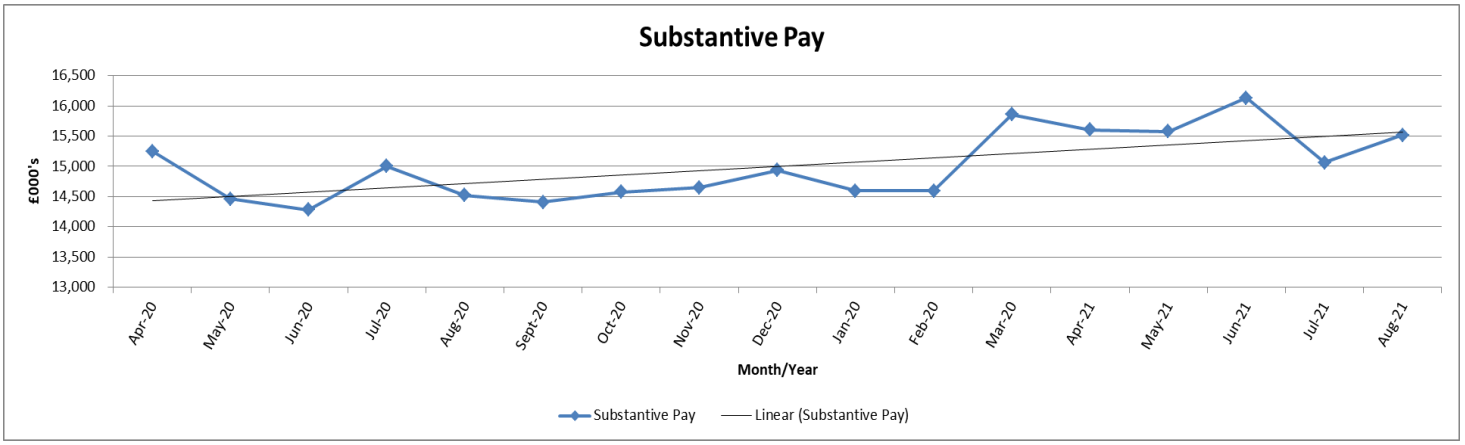


Table 5 – Non substantive pay run rate including COVID Expenditure

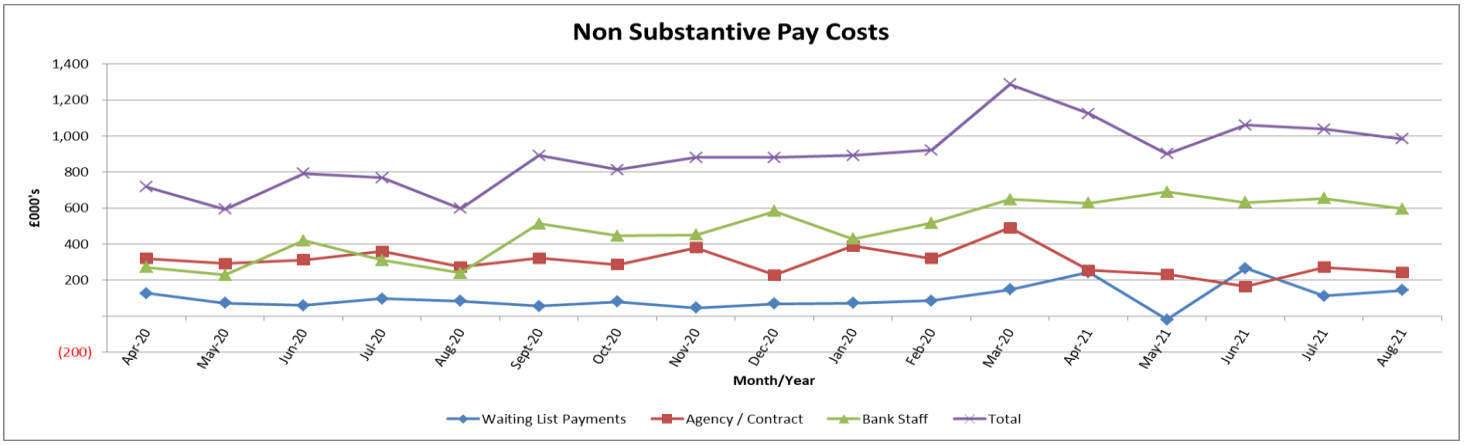


Table 6 – Whole Time Equivalent run rate

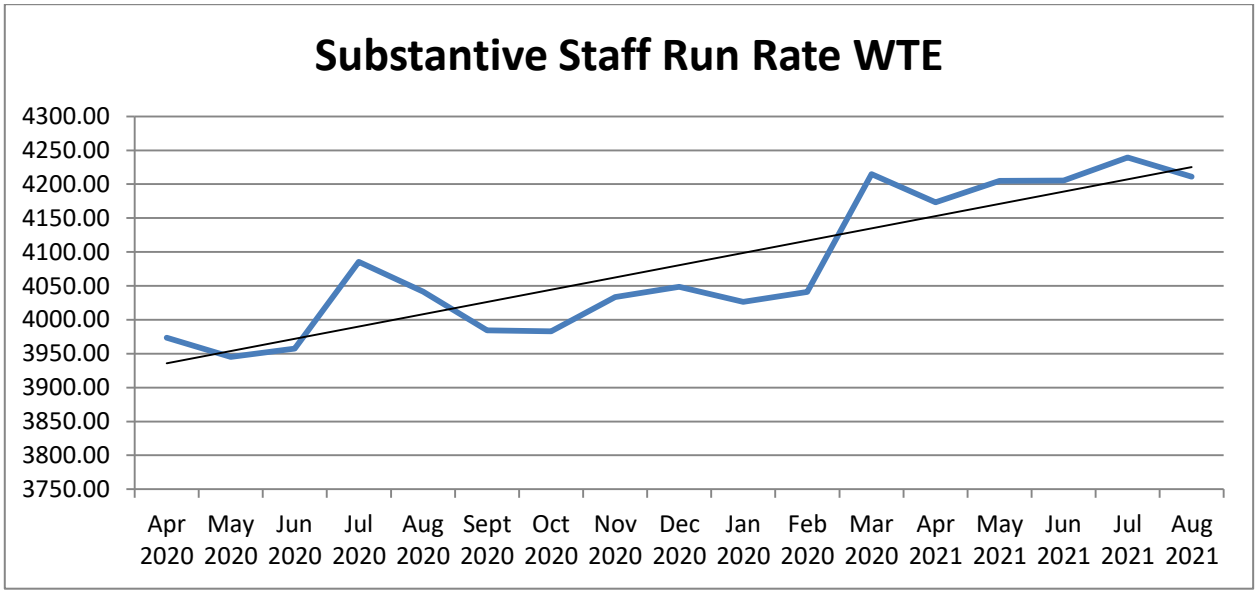


Table 7 – Budgeted & actual non pay expenditure including COVID expenditure

August 2020/21	GROUP POSITION NHSI/E Covid Plan			VARIANCE		
Red >100k over Amber <> (£50k) - £99.99k Green <(£50.1k)	Apr- Sept Covid Plan Total	Covid Plan to Date	Actual to Date	Variance (Actual - Budget)		Previous Month Variance
	£000's	£000's	£000's	£000's		£000's
Purchase of Healthcare - NHS bodeis	2,628.0	2,190.0	2,282.7	92.7		69.3
Purchase of Healthcare - Non NHS bodies	714.0	595.0	421.3	(173.7)		(113.8)
NED's	90.0	75.0	79.9	4.9		2.5
Supplies & Services - Clinical	16,948.0	14,123.0	10,159.2	(3,963.8)		(3,544.0)
Supplies & Services - General	1,104.0	920.0	874.1	(45.9)		(13.4)
Drugs	8,748.0	7,290.0	6,349.5	(940.5)		(836.2)
Research & Development expenses	72.0	60.0	2.0	(58.0)		(46.0)
Education & Training expenses	372.0	310.0	1,028.4	718.4		584.4
Consultancy costs	12.0	10.0	16.0	6.0		5.0
Establishment expenses	1,866.0	1,555.0	1,126.3	(428.7)		(347.0)
Premises	7,902.0	6,585.0	6,740.0	155.0		186.0
Transport	750.0	625.0	349.2	(275.8)		(236.0)
Clinical Negligence	3,354.0	2,795.0	3,079.9	284.9		227.9
Operating Leases	-	-	-	-		-
Other Operating expenses	4,152.0	3,460.0	11,236.2	7,776.2		7,418.9
Cost Improvement Programme	-	-	-	-		-
Reserves	-	-	-	-		-
Non Pay Operating Expenses included in EBITDA	**48,712.0**	**40,593.0**	**43,744.6**	**3,151.6**		**3,357.7**

Table 8 – Non Pay Run rate including COVID expenditure

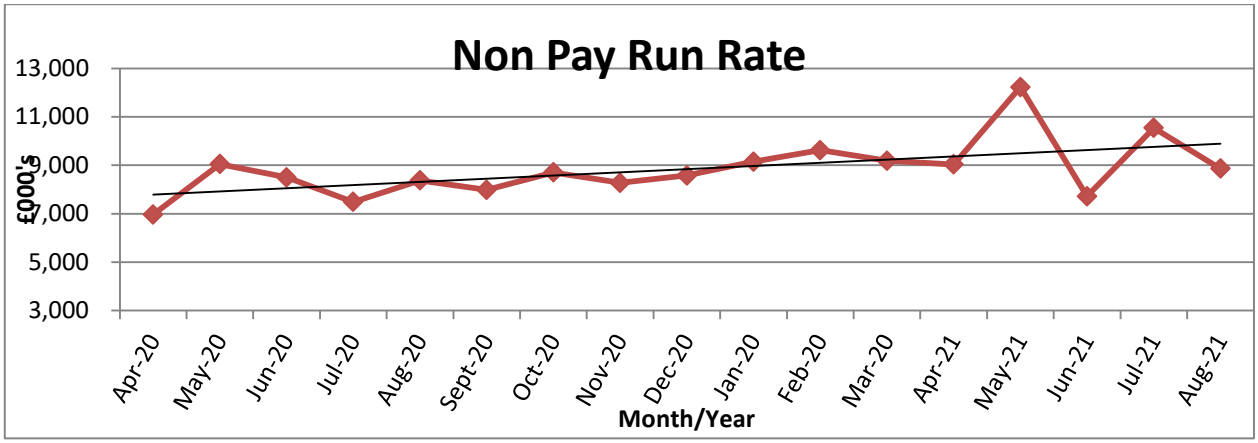


Table 9 – COVID 19 expenditure

Covid Spend Group position		
Type	**Subjective Heading**	**Total £'000's**
Staff	Substantive Staff	2,488.7
	Bank Staff	1,002.0
	Substantive Staff (Termination Benefit)	0.4
	Agency / Contract	269.6
Staff Total		**3,760.6**
Non Staff	Drugs Costs (Drug Inventory Consumed and Purchase Of Non-Inventory Drugs)	11.6
	Education and Training - Non-Staff	0.1
	Establishment	120.6
	Other	7,270.2
	Premises - Other	693.0
	Purchase Of Healthcare From NHS Bodies	8.3
	Purchase Of Healthcare From Non-NHS Bodies	10.9
	Premises - Business Rates Payable To Local Authorities	28.5
	Supplies and Services – Clinical (Excluding Drugs Costs)	805.1
	Supplies and Services - General	115.0
	Transport	0.0
Non Staff Total		**9,063.3**
Grand Total		**12,824.0**

Appendix 3 – Cash and working balances

Table 10 – statement of financial position

Statement of Position - August 2020

	2020/2021 July 2020 Group	2020/2021 August 2020 Group	Variance - Prior Month	2020/2021 August 2020 QEF	2020/2021 July 2020 FT
	£000's	£000's	£000's	£000's	£000's
Assets					
Non-Current Assets					
Investments	80	80	0	80	16,824
Property, Plant and Equipment, Net	115,825	115,718	(107)	403	115,315
Trade and Other Receivables, Net	2,332	2,303	(29)	889	1,414
Finance Lease - Intragroup				43,416	0
Trade and Other Receivables - Intragroup Loan	0	0	0		19,771
Total Non Current Assets	118,237	118,101	(136)	44,789	153,324
Current Assets					
Inventories	4,202	4,178	(24)	2,193	1,984
Trade and Other Receivables - NHS	3,049	2,650	(399)	503	2,147
Trade and Other Receivables - Non NHS	3,932	3,593	(339)	651	2,941
Trade and Other Receivables - Intragroup	7,753	7,469	(284)	6,896	574
Trade and Other Receivables - Other	0	0	0		0
Prepayments	5,938	5,404	(534)	369	5,035
Cash and Cash Equivalents	47,922	50,158	2,235	7,946	42,212
Other Financial Assets - PDC Dividend	1,395	1,412	16	467	945
Accrued Income	283	313	29		313
Finance Lease - Intragroup				793	0
Trade and Other Receivables - Intragroup Loan					2,260
Total Current Assets	74,475	75,176	701	19,817	58,411
Liabilities					
Current Liabilites					
Deferred Income	25,755	25,670	(86)	187	25,483
Provisions	318	781	463	0	781
Current Tax Payables	3,740	3,696	(44)	310	3,386
Trade and Other Payables -Intragroup	7,753	7,469	(284)	574	6,896
Trade and Other Payables - NHS	1,656	1,073	(583)	681	392
Trade and Other Payables - Other	8,695	8,220	(475)	2,655	5,565
Trade and Other Payables - Capital	17	(46)	(63)	0	(46)
Other Financial Liabilities - Accruals	26,642	28,057	1,415	5,127	22,930
Other Financial Liabilities - Borrowings FTFF	1,177	13,413	12,236	0	13,413
Other Financial Liabilities - PDC Dividend	960	1,200	240	0	1,200
Other Financial Liabilities - Intragroup Borrowings	0	0		2,260	0
Finance Lease - Intragroup	0	0		0	793
Total Current Liabilities	76,714	89,533	12,819	11,794	80,792
NET CURRENT ASSETS (LIABILITIES)	(2,239)	(14,357)	(12,119)	8,023	(22,381)
Non-Current Liabilities					
Deferred Income	2,649	2,648	(0)	1,869	780
Provisions	2,748	2,748	0	0	2,748
Trade and Other Payables - Other	0	0	0	0	0
Other Financial Liabilities - Accruals	0	0	0	0	0
Other Financial Liabilities - Intragroup Borrowings	0	0	0	19,771	0
Other Financial Liabilities - Borrowings FTFF	27,423	15,187	(12,236)	0	15,187
Finance Lease - Intragroup				0	43,416
Total Non-Current Liabilities	32,820	20,584	(12,236)	21,640	62,131
TOTAL ASSETS EMPLOYED	**83,178**	**83,160**	**(19)**	**31,172**	**68,812**
Tax Payers' and Others' Equity					
PDC	118,208	118,208	0	0	118,208
Taxpayers Equity	0	0	0	0	0
Share Capital	0	0	0	16,824	0
Retained Earnings (Accumulated Losses)	(44,151)	(44,169)	(18)	14,348	(58,516)
Other Reserves	0	0	0	0	0
Revaluation Reserve	9,022	9,022	0	0	9,022
Misc Reserve	99	99	0	0	99
TOTAL TAXPAYERS EQUITY	83,178	83,160	(18)	31,172	68,812
TOTAL ASSETS EMPLOYED	**83,178**	**83,160**	**(18)**	**31,172**	**68,812**

Appendix 4 – Capital programme delivery

Table 11 – detailed capital schemes

Scheme description	2020/21 Plan £000	Plan to month 5 £000	Actual to month 5 £000
IT GDE	2,350	460	508
IT Radiology	181	181	181
IT Breast Screening	250	0	7
IT Community Mobile Working	50	50	0
ECC Cladding	360	0	0
Equipment Replacement	1,189	380	227
Maternity Scheme	1,100	50	36
Paediatric Scheme	600	0	0
Backlog Maintenance	396	111	236
H&S Disabled Access	100	30	15
Simulation Training Equipment	80	40	35
Salix Energy Conservation	50	0	6
Dementia Environmental	47	0	0
HPV	30	0	3
Woodside	27	9	6
CQC Ambulance Works	24	0	0
Gynea. Equipment	15	15	11
Workforce Dept. Refurbishment	11	11	0
Donated Assets	230	0	13
Breast Screening Trailers	26	26	26
	7,116	**1,363**	**1,310**

Trust Board

Gateshead Health NHS Foundation Trust

Report Cover Sheet

Agenda Item: 13

Date of Meeting:	29 September 2020			
Report Title:	Audit Results Report 2020			
Purpose of Report:	The Trust receives an Annual Audit Letter each year from our External Auditors which summarises the main issues resulting from the audit.			
	Decision: ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
Trust Goals that the report relates to: (Including reference to any specific risk)	**Goal 7** We will deliver value for money and help ensure the local health and care system is sustainable and well led.			
Recommendations: (Action required by Board of Directors)	The Board is asked to receive the report for assurance.			
Financial Implications:	None			
Risk Management Implications:	None			
Human Resource Implications:	None			
Trust Diversity & Inclusion Objective that the report relates to: (including reference to any specific implications and actions)	None			
Author:	Helen Henshaw, Associate Partner, Ernst and Young LLP			
Presented by:	Mrs Jacqueline Bilcliff, Group Director of Finance			

Gateshead Health NHS Foundation Trust

Audit results report

Year ended 31 March 2020

Building a better working world

Private and Confidential

12 June 2020

Dear Audit Committee Members,

We have substantially completed our audit of Gateshead Health NHS Foundation Trust ("the Trust") for the year ended 31 March 2020.

Subject to the adequate resolution of the outstanding matters listed in our report, we confirm that we anticipate being in a position to issue an unqualified audit opinion on the financial statements before the statutory deadline on 25 June 2020.

Our audit report will include going concern as a key audit matter, which we have not previously done, due to the lack of certainty over NHS funding arrangements beyond 31 July 2020. Our audit report will also include additional narrative to highlight financial statement disclosures of a material valuation uncertainty over land and buildings. These matters do not constitute a qualification of our audit opinion. Further details of the content of our report are provided in Section 3.

We have no matters to report about your arrangements to secure economy, efficiency and effectiveness in your use of resources and we will issue an unmodified (unqualified) value for money conclusion.

This report is intended solely for the use of the Council of Governors, Audit Committee, other members of the Board of Directors and senior management, and should not be used for any other purpose nor given to any other party without our prior written consent.

We would like to thank your staff for the assistance provided to us during the engagement.

We look forward to the opportunity of discussing with you any aspects of this report or any other issues arising from our work.

Yours faithfully,

Helen Henshaw
Associate Partner

For and on behalf of Ernst & Young LLP

United Kingdom

Contents

01 Executive Summary

Executive Summary

Update to our risk assessment and the scope of our audit

In our audit planning report tabled at the 5 March 2020 Audit Committee meeting, we provided you with an overview of our audit scope and approach for the audit of the financial statements. Since that meeting, we have provided Audit Committee members with an update setting out how Covid-19 has impacted upon our audit scope and our audit plan. We carried out our audit in accordance with this updated plan, with the following exceptions:

Changes to reporting timescales

On 23 March 2020, NHSE/I wrote to all commissioners and providers setting out changes to the 2019/20 accounts reporting timescales as a result of Covid-19. The deadline for submission of audited accounts was changed from 29 May 2020 to 25 June 2020. We have worked with the Trust to deliver our audit in line with the revised reporting timescale.

Changes in Materiality

In our Audit Planning Report, we communicated that our audit procedures would be performed using a materiality of £5.5m. We have considered whether any change to our materiality is required in light of Covid-19. Following this consideration we remain satisfied that the basis for planning materiality, performance materiality and our audit threshold for reporting differences to you remain appropriate. We have however updated our materiality assessment using the draft financial statements. Based on our materiality measure of Group operating expenses we have updated our overall materiality assessment to £5.9m (Audit Planning Report – £5.5m). This results in updated performance materiality, at 75% of overall materiality, of £4.4m (Audit Planning Report – £4.1m). We have revised component performance materialities to £4.4m for the Trust (Audit Planning Report - £4.0m), £2.0m for QE Facilities Limited (Audit Planning Report - £1.8m) and £0.9m for the Charitable Fund (Audit Planning Report - £0.8m). We have not revised our audit threshold for reporting differences.

Impacts of Covid-19 – Operational planning processes for the 2020/21 financial year were suspended across the NHS in March 2020. At the same time, it was announced that commissioners would agree funding arrangements with providers for the period 1 April 2020 to 31 July 2020 on a block basis. Providers were also informed that they would be reimbursed for additional expenditure incurred responding to Covid-19. The financial framework which will apply beyond 31 July 2020 has not yet been announced, therefore management's going concern assessment has had to include assumptions about future funding arrangements which would not normally be required. Note 1 to the financial statements includes disclosure of these assumptions. Our opinion will include going concern as a key audit matter and will draw the attention of the users of the financial statement to these disclosures. See also page 11.

Status of the audit

Our audit work in respect of the Trust audit opinion is substantially complete. The following items relating to the completion of our audit procedures are the most significant outstanding matters at the date of this report:

- Completion of our review of the Annual Governance Statement;
- Completion of our internal review and consultation processes.

Details of all outstanding items, actions required to resolve and responsibility is included in Appendix B.

On the basis of our work performed to date, we anticipate issuing an unqualified auditor's report in respect of the Trust accounts. However, until we have completed our outstanding procedures, it is possible that further matters requiring amendment may arise.

Executive Summary

Audit differences

There are no unadjusted misstatements of a factual nature arising from our audit, however we highlight on page 16 several management judgements and other matters to bring to your attention. Management have corrected misstatements amounting to £823k.

We also identified a number of amendments to disclosures as part of our audit procedures and these are set out in more detail in Section 4.

Value for money

We have considered your arrangements to take informed decisions; deploy resources in a sustainable manner; and work with partners and other third parties. In our Audit Planning Report we identified a significant risk in respect of arrangements for managing the Trust's financial resources.

We have no matters to report about your arrangements to secure economy, efficiency and effectiveness in your use of resources.

Other reporting issues

We have reviewed the information presented in the Annual Report for consistency with our knowledge of the Trust. We have audited the parts of the remuneration and staff report disclosures that are required to be audited. We have no matters to report.

We are still to review the Annual Governance Statement and perform the procedures requested by the National Audit Office with respect to the Trust's Whole of Government Accounts (WGA) submission. We will provide a verbal update on this work, including any matters to be reported, at the meeting of the Audit Committee on 16 June 2020.

As notified in our Covid-19 update, NHS Improvement have removed the requirement for Trusts to seek assurance from their external auditor over their 2019/20 Quality Report. We therefore offer no assurance in respect of the Quality Report

We have no other matters we wish to report.

Control observations

During the audit we identified two observations and make improvement recommendations in relation to management's financial processes and controls. We identified findings in relation to:

- Management's recognition of expected credit losses;
- The Trust's staff induction policy.

Further details of our observations, along with updates to our prior year observations, are set out in Section 7.

We also considered whether circumstances arising from COVID-19 resulted in a change to the overall control environment or effectiveness of internal controls, for example due to significant staff absence or limitations as a result of working remotely. We identified no issues which we wish to bring to your attention.

Executive Summary

Areas of audit focus

In our Audit Planning Report and subsequent Covid-19 update we identified a number of key areas of focus for our audit of the Trust's financial statements. This report sets out our observations and conclusions in relation to these areas, including our views on areas which might be conservative and areas where there is potential risk and exposure. Our consideration of these matters and others identified during the period is summarised within the "Areas of Audit Focus" section of this report.

Where applicable we have identified those matters that we consider to be key audit matters. Key audit matters are selected from the matters we communicate to you that in our opinion are of most significance to the current period audit and required significant attention in performing the audit. In accordance with ISA (UK) 701 key audit matters are included in our auditor's report.

Audit findings and conclusions

Significant risk – Risk of fraud in revenue and expenditure recognition

- Our audit procedures did not identify any material misstatements arising from the recognition, or non-recognition, of revenue and expenditure.

Significant risk – Misstatements due to fraud and error

- Our audit procedures did not identify any material misstatements or other matters which would indicate potential management override of controls.

Inherent risk – Valuation of land and buildings

- Our audit procedures did not identify any material misstatements arising from the valuation of land and buildings.

Inherent risk – Going concern

- We are satisfied that preparing the financial statements on a going concern basis is appropriate, however our audit opinion will include going concern as a key audit matter highlighting management's disclosures around the uncertainty of future funding arrangements.

We request that you review these and other matters set out in this report to ensure:

- There are no residual further considerations or matters that could impact these issues;
- You concur with the resolution of the issue;
- There are no further significant issues you are aware of to be considered before the audit report is finalised.

There are no matters, other than those reported by management or disclosed in this report, which we believe should be brought to the attention of the Council of Governors, Audit Committee or Board of Directors.

Independence

We confirm that we have remained independent from the Trust.

Please refer to Section 9 for our update on Independence.

02 Areas of Audit Focus

Areas of Audit Focus

Significant risk: Risk of fraud in revenue and expenditure recognition

Risk of fraud in revenue and expenditure recognition

What is the risk?

Under ISA 240, there is a presumed risk that revenue may be misstated due to improper revenue recognition. In the public sector, this requirement is modified by Practice Note 10 issued by the Financial Reporting Council, which states that auditors should also consider the risk that material misstatements may occur by the manipulation of expenditure recognition.

Given the anticipated deficit position of the Trust and challenging financial environment, we consider the significant risk to lie in the overstatement of revenue and understatement of expenditure.

What judgements are we focused on?

The risk is most focused around those items of income and expenditure which are non-routine and involve greater estimation and judgment by management, such as income accruals for year end settlements with the CCGs, significant releases of deferred income, criteria for capitalisation of expenditure and omission of expenditure from the accounts.

What did we do?

We performed the following procedures to address this risk:

- Reviewed the intra-NHS agreement of balances outputs and investigated any significant variances between parties to gain assurance over the transactions and balances recognised by the Trust;
- Reconciled income with the Trust's main commissioners back to contracts and agreed a sample of contract variations and other adjustments made during the year to underlying documentation, including signed agreements and bank statements;
- Tested significant releases of deferred income with reference to the original agreements to ensure amounts released were appropriate;
- Tested a sample of property, plant and equipment additions to ensure they were correctly capitalised under the reporting framework;
- Reviewed a sample of transactions recorded in the ledger and payments made from the bank after year-end to confirm expenditure had been recorded in the correct period; and
- Considered the completeness of provisions recognised in the financial statements in light of our knowledge of the Trust.

What are our conclusions?

- In response to Covid-19, the thresholds for the agreement of balances exercise were increased to £500k for balance sheet items (previously £100k) and £5m for income and expenditure (previously £1m). There were two balance sheet variances above this threshold which we have investigated, in both cases the amounts reported by the counter-party are reflected in the financial statements but not the Trust's agreement of balances submission (1 disputed balance, 1 omission). No variances relating to income and expenditure exceeded the agreement threshold;
- We have reviewed the impact of variances below these thresholds and note they would have net impacts on income and expenditure of £183k and £346k, respectively. The net impacts on receivables and payables would be (£98k) and £361k, respectively. The absolute value of all variances on income and expenditure was £3.5m and on receivables and payables was £2.4m. Positive impacts represent counter-party positions which would be more advantageous to the Trust than those included within the financial statements, negative impacts the opposite;
- Our audit procedures over contract income, releases from deferred income, additions to property, plant and equipment and ledger transactions and bank payments after the year end did not identify any audit findings;
- We have not identified any omitted provisions which would impact on expenditure. We do however note that management have opted not to recognise a provision for clinicians' pension obligations, which would not impact on expenditure. Further details are provided on page 16.

Overall, we are satisfied that the financial statements are not materially misstated as a result of fraud in revenue or expenditure recognition.

Areas of Audit Focus

Significant risk: Misstatements due to fraud or error

Misstatements due to fraud or error

What is the risk?

The financial statements as a whole are not free of material misstatements whether caused by fraud or error.

As identified in ISA (UK) 240, management is in a unique position to perpetrate fraud because of its ability to manipulate accounting records directly or indirectly and prepare fraudulent financial statements by overriding controls that otherwise appear to be operating effectively. We identify and respond to this fraud risk on every audit engagement.

What did we do?

We performed the following procedures to address this risk:

- We identified risks of fraud during the planning stage of our audit;
- We inquired of management as to their assessment of fraud risks, and the controls put in place to address those risks;
- We inquired as to the oversight given by those charged with governance to management's processes to respond to fraud risks;
- We considered the effectiveness of management's controls designed to address the risks of fraud;
- We developed an audit strategy which addressed the identified risks of fraud; and
- We performed testing of the manual journals and other adjustments made in the preparation of the financial statements.

What are our conclusions?

- Our assessment of fraud risks, including after enquiry of management as to their assessment of fraud risks, consideration of the controls put in place to respond to those risks and the effectiveness of those controls, did not identify any additional fraud risks to bring to your attention.
- Our testing of manual journals and other adjustments made in the preparation of the financial statements did not identify any findings.

Overall, we are satisfied that the financial statements are not materially misstated as a result of fraud or error.

Areas of Audit Focus

Inherent risk: Valuation of land and buildings

Valuation of land and buildings

What is the risk?

Land and buildings are the most significant assets on the Trust's Statement of Financial Position. The valuation of land and buildings is dependent upon a number of judgements and assumptions, small changes in which can have a significant impact upon the financial statements.

We have reduced the level of risk from a significant risk in the prior year to an inherent risk as we did not identify any issues during the prior year's audit and are expecting management to follow a similar approach to the valuation of land and buildings for the current period.

What did we do?

We performed the following procedures to address this risk:

- We have considered the work performed by the Trust's external property valuers, Cushman and Wakefield, including adequacy of the scope of their work, their professional capabilities and the results of their work;
- We have considered the basis on which the valuations have been undertaken and the appropriateness of the assumptions used;
- We have sample tested key asset information used by the valuer in preparing their valuation (such as floor plans for properties valued using a £/sq. foot methodology);
- We have considered the appropriateness of any changes to the useful economic lives of assets;
- We have reviewed the accounting entries for consistency with the valuations provided by the external valuer, including the treatment of revaluation movements;
- We have reviewed management's disclosures in respect of the uncertainty of valuations*;
- We have consulted with EY Real Estates, our internal specialists on property asset valuations, to inform our assessment of the implications of the material uncertainty clause in the external valuers' report and the level of uncertainty inherent to the Trust's assets*.

* Procedures marked with an asterisk are a response to Covid-19 and were not part of our original plan. The extent of work performed as part of planned procedures was also increased.

What are our conclusions?

- The Trust's external valuer has include a material uncertainty clause within their valuation report, highlighting additional uncertainty over the valuation of land and buildings arising from the Covid-19 pandemic;
- We also note that in all materials regards the Trust's property is valued on a depreciated replacement cost basis, which should contain less uncertainty than a valuation dependent upon future sale value or rental incomes;
- We have reviewed management's disclosures in respect of this uncertainty and are content that the uncertainty is appropriately disclosed;
- Given the significance of these and other disclosures relating to the impacts of Covid-19, we consider it appropriate to include narrative in our opinion to highlight these disclosures. See section 3 for further details;
- Other than the considerations above in respect of the material uncertainty, our audit procedures over the work of management's external valuer, the basis of valuations, the input data used and the accounting entries did not give rise to any audit findings. We would however highlight the key judgements we have previously highlighted around the exclusion of VAT and adoption of different useful lives for valuations than for accounting as remaining relevant.

Areas of Audit Focus

Inherent risk: Going concern

Going concern

What is the risk?

Details of the funding arrangements which will be in place after 31 July 2020 have not yet been announced. In the absence of known funding arrangements beyond 31 July 2020, management will need to carefully consider the assumptions and information upon which they assess whether the Trust is a going concern.

The financial statement disclosures will need to adequately reflect the key considerations and judgements made in reaching a conclusion on going concern.

What did we do?

We performed the following procedures to address this risk:

- We have obtained management's going concern assessment and reviewed it for evidence of bias or inconsistency with the financial statements;
- We have reviewed the financial forecasts prepared by management, including consideration of the key assumptions, any stress testing applied to those assumptions and potential risks to future cashflows;
- We have reviewed the going concern disclosures within the financial statements to ensure they appropriately disclose management's key assumptions and judgements, along with the basis for the overall conclusion;
- Considered the impact of our observations for our audit opinion. This has involved additional internal consultations.

What are our conclusions?

- Our review of the cashflow forecasts prepared by management to support the assessment of the Trust as a going concern, including assumptions used therein, has not identified any evidence of bias or inconsistency with the financial statements;
- Whilst management have prepared forecasts for several scenarios we note that management's forecast for a return to pre-Covid 19 funding levels, which management consider the pessimistic scenario, produces a cash position at 30 June 2021 of just £2.5m, leaving little headroom within the Trust's available funding should this scenario play out;
- We have reviewed management's updated disclosures relating to going concern and are satisfied that they appropriately disclose both the uncertainty and the assumptions made by management, including due to the absence of an agreed NHS funding framework;
- We are proposing, subject to our internal consultation procedures, for our audit report to include going concern as a key audit matter, including narrative stating we consider management's disclosures in respect of going concern to be fundamental to the users understanding of this matter.

Overall, we are content with the adoption of a going concern basis for the preparation of the financial statements.

Areas of Audit Focus

Other areas of focus

In our Audit Planning Report and our Covid-19 update we identified an additional area of focus which we did not consider to represent a significant or inherent risk, but which was still important when considering the risk of material misstatement of the financial statements or disclosures.

What is the risk?	What are our conclusions?
IFRS 16 – Leases IFRS 16 Leases was issued by the IASB in 2016. Its main impact is to remove (for lessees) the traditional distinction between finance leases and operating leases. Finance leases have effectively been accounted for as acquisitions (with the asset on the balance sheet, together with a liability to pay for the asset acquired). In contrast, operating leases have been treated as "pay as you go" arrangements, with rentals expensed in the year they are paid. IFRS 16 requires all substantial leases to be accounted for using the acquisition approach, recognising the rights acquired to use an asset. IFRS 16 Leases was being applied by HM Treasury in the Government Financial Reporting Manual (FReM) from 1 April 2020, however adoption of IFRS 16 across the public sector, including by the Trust, has been deferred by an additional year to 2021/22 to reduce the burden on finance teams during preparation of 2019/20 accounts. QE Facilities Limited (QEF) will still be required to adopt IFRS 16 in their statutory accounts for 2019/20. As a result of the deferral, disclosures within the 2019/20 financial statements are no longer expected to disclose quantitative information on the impact of the new standard. Disclosure of this information should however be considered where the underlying analysis has already been performed.	▸ The financial information prepared by QEF for the purposes of preparing the Group financial statements was prepared on the basis of pre-IFRS 16 accounting. Accordingly, no adjustments were required at Group level to strip out the effect of the new standard on the financial information of QEF to be consolidated. ▸ Management have opted not to include information on the anticipated impact of the new standard on the Trust and the Group within the 2019/20 financial statements. Disclosure is made of the new accounting standard and the change in treatment it will entail, without providing quantitative analysis. ▸ As there are no disclosures relating to IFRS 16, other than a factual description of the requirements of the new standard, within the 2019/20 financial statements, we have not performed detail work in respect of IFRS 16. We have however reviewed management's disclosure of the requirements of the new standard for accuracy. We are content that management's disclosure of the requirements of the new standard within the financial statements is factually correct. The impact of the new standard on the 2019/20 financial statements of QEF will be considered separately and further details will be provided in our Audit Planning Report for the QEF audit.

03 Audit Report

Audit Report

Considerations for our audit report

Our opinion on the financial statements

We have identified several matters during the course of our audit which impact upon the form and wording of our audit opinion, including:

- A lower level of certainty than would normally exist over the Trust's future funding levels. The current block funding arrangements which have been in place since 1 April 2020 are advantageous to the Trust as they provide sufficient funding to break-even, however they expire on 31 July 2020 and no announcement has been made as to the funding arrangements for NHS providers beyond this date. NHS England and NHS Improvement have however issued a joint statement advising providers that they can "continue to expect NHS funding to flow at similar levels to that previously provided where services are reasonably still expected to be commissioned"; and

- The valuation report provided by Cushman and Wakefield and used to inform the valuation of land and buildings within the Trust's financial statements was prepared on the basis of a material valuation uncertainty.

Following audit challenge, additional disclosures have been included within the financial statements in respect of these matters.

Our audit opinion will include additional text to make reference to these disclosures and bring them to the attention of users of the financial statements. This will not constitute a modification of our audit opinion, and we are still proposing an unmodified opinion.

Given these additional elements to our opinion, the wording of our opinion is being subjected to additional internal consultation. This consultation is ongoing as of the point of submitting this report therefore we are unable to provide the final form in this report. We will provide a verbal update to the Committee on the format of our report.

04 Audit Differences

Audit Differences

In the normal course of any audit, we identify misstatements between amounts we believe should be recorded in the financial statements and the disclosures and amounts actually recorded. These differences are classified as 'known' or 'judgemental'. Known differences represent items that can be accurately quantified and relate to a definite set of facts or circumstances. Judgemental differences generally involve estimation and relate to facts or circumstances that are uncertain or open to interpretation.

Summary of adjusted differences

During our audit we identified two misstatements which have been adjusted by management:

- **NHSE Pension Income** – We identified that £413k of notional income from NHSE in respect of employee pension contributions for QEF employees had been incorrectly recognised by the Trust rather than QEF. As the error related to which group entity recognised the income, this impacted the Trust's individual statements but had nil net impact on the Group statements.

- **Income Consolidation Error** – We identified that £411k of income to the Trust from QEF had been incorrectly removed from the Trust's financial statements, as well as the Group's, as part of the consolidation process thereby understating the Trust's income.

Summary of unadjusted differences

We have not identified any unadjusted misstatements of a factual nature, however there are several management judgements and other matters we would bring to your attention:

- **Expenditure Cut-Off** – our testing of expenditure recorded by QEF identified two transactions totalling £160k which related to 2018-19 but had not been accounted for in the prior year. As these transactions were recorded in July and September 2019, we are unable to consider the issue to be isolated to transactions around the year-end and have extrapolated our findings over the whole population. This gives an extrapolated error of £2.7m, though the true error may be higher or lower. As the issue relates to omission of expenditure from the prior period and is immaterial in value, the correct accounting treatment is to recognise as expenditure in the current period. We do not therefore consider this amount as a misstatement, though it is technically recorded in the wrong period.

- **Expected Credit Losses** – our review of management's bad debt policy has identified that expected credit losses are not recognised until a debt is 90 days past due. This is a later recognition point than required by IFRS 9, which requires recognition of expected credit losses from the point a debt is recognised (though often at a very small proportion of the overall value). We have performed analysis of the Group receivables balance and estimate expected credit losses equal to c. 66% of the balances not captured by management's policy, excluding balances with other NHS bodies assumed under DHSC's Group Accounting Manual to have zero credit risk, would be required for a material impact on the financial statements. We do not consider it plausible that a reasonable estimate would be this high, therefore we are content there is not a material understatement of expected credit losses. There is however likely to be a degree of understatement which, as we have assured ourselves it will not be material, we have not quantified. See also our recommendation on page 25.

- **Provisions for Clinician Pension Liabilities** – NHS England wrote to all Trusts and Foundation Trusts in April 2020 expressing an expectation that providers recognise provisions within their 2019-20 financial statements where they employ clinicians likely to have a tax liability and take advantage of the NHS scheme to be reimbursed for that tax liability upon retirement. Management have not recognised a provision on the basis that they will have no reliable information as to how many of the Trust's clinicians have opted to participate in the scheme until July 2020. The Trust has 187 clinicians eligible for the scheme and NHS England have set a provision amount of £3,345 per clinician, therefore the maximum provision the Trust could recognise would be £625k. Note that recognition of a provision would have no impact on expenditure as a corresponding reimbursement asset from NHS England would also be recognised.

Audit Differences

Comments on disclosure notes

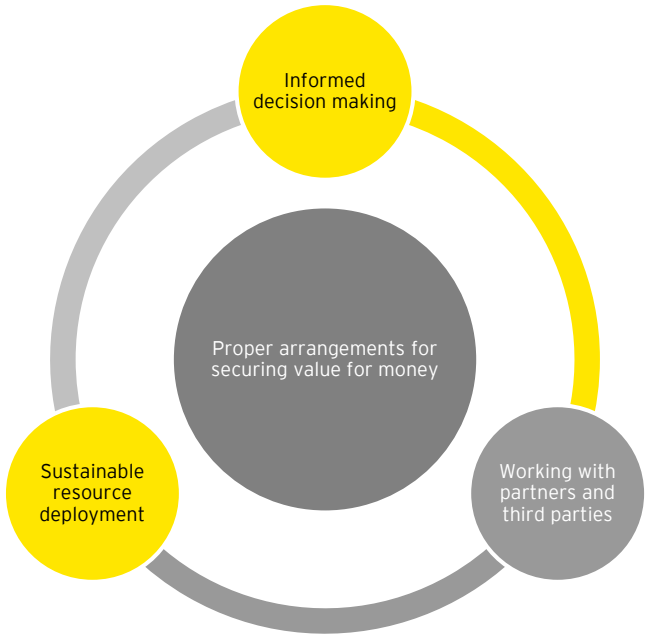
We raised a recommendation last year that an extra layer of review should be built in to the accounts production process due to the number of casting and internal consistency errors we identified. Our review of the draft accounts presented for audit this year found a lower number of such errors.

The more significant disclosure errors identified as part of our audit included:

- The going concern disclosures required additional narrative to disclose the impact of Covid-19 on NHS funding arrangements and how this has impacted management's going concern assessment. This included adding a reference to the joint statement from NHS England and NHS Improvement which was issued after the draft financial statements had been provided for audit;
- There was no disclosure in the financial statements of the material valuation uncertainty applicable to the valuation of the Trust's land and buildings;
- The accounting policies had not been updated to reflect the change in useful economic lives applied to medical and surgical equipment, as communicated to the Audit Committee in September 2019;
- Misclassification within the Trust's Statement of Cash Flows of movements relating to intra-Group finance leases;
- Mispresentation of the revaluation reserve balance for assets disposed of during the year as expenditure, where the correct treatment is a direct transfer from the revaluation reserve to the income and expenditure reserve on the face of the Statement of Changes in Taxpayers' Equity. Note this remains uncorrected but the description of the relevant line, which contains a clearly trivial amount, was amended to a more general description;
- Omission of £12.2m of Revenue Support Working Capital Loans from the fair value of financial liabilities note;
- Misclassifications within the payables note of a £270k VAT payable as Corporation Tax, and the true Corporation Tax payable of £372k as 'other payables'; and
- Overstatement of the audit fee.

05 Value for Money

Value for Money



Economy, efficiency and effectiveness

We are required to consider whether the Trust has put in place 'proper arrangements' to secure economy, efficiency and effectiveness on its use of resources. This known as our value for money conclusion.

Proper arrangements are defined by statutory guidance issued by the National Audit Office. They comprise your arrangements to:

- Take informed decisions;
- Deploy resources in a sustainable manner; and
- Work with partners and other third parties.

In considering your proper arrangements, we draw on the requirements of the guidance issued by NHS England and NHS Improvement to ensure that our assessment is made against a framework that you are already required to have in place and to report on through documents such as your annual governance statement.

Impact of Covid-19 on our Value for Money assessment

On 16 April 2020 the National Audit Office published an update to auditor guidance in relation to the 2019/20 Value for Money assessment in the light of Covid-19.

This clarified that in undertaking the 2019/20 Value for Money assessment auditors should consider NHS bodies' response to Covid-19 only as far as it relates to the 2019-20 financial year; only where clear evidence comes to the auditor's attention of a significant failure in arrangements as a result of Covid-19 during the financial year, would it be appropriate to recognise a significant risk in relation to the 2019-20 VFM arrangements conclusion.

Overall conclusion

We identified one significant risk in relation to these arrangements. The table below presents the findings of our work in response to the risk identified in our Audit Planning Report.

To date we have identified no matters to report about your arrangements to secure economy, efficiency and effectiveness in your use of resources.

Value for Money

VFM risks

We are only required to determine whether there are any risks that we consider significant within the Code of Audit Practice which defines as:

'A matter is significant if, in the auditor's professional view, it is reasonable to conclude that the matter would be of interest to the audited body or the wider public'

Our risk assessment supports the planning of sufficient work to enable us to deliver a safe conclusion on arrangements to secure value for money and enables us to determine the nature and extent of further work that may be required. If we do not identify any significant risk there is no requirement to carry out further work.

The table below presents the findings of our work in response to the risk identified in our Audit Planning Report.

What is the significant VFM risk?	What arrangements did this impact?	What are our findings?
Our planning meetings with management have indicated that the Trust is highly likely to be in deficit for 2019/20 and management are working within a budgeted deficit of £9.5m. In addition, the Trust has been provided with annual financial targets for the medium term by NHS Improvement which management considers challenging to achieve. There is therefore a risk that the Trust does not have appropriate arrangements in place to effectively manage its resources.	Deploying resources in a sustainable manner	The Trust successfully managed its financial resources during 2019/20, such that it achieved the financial control total set by NHS Improvement and improved its cash position. The Trust was originally set a control total of breaking even, after PSF, FRF and MRET funding, for 2019-20 but was granted an additional £3m headroom by NHSI during the year. We have reviewed the correspondence from NHSI to confirm this revision. We have also reviewed the minutes of Board meetings throughout the year, and note that for much of the year management were transparently reporting that they expected to breach this control total. As late as January management were reporting a likely breach by over £1m. We have enquired with management as to how this was recovered by year end, and are satisfied with the explanations provided. We also note that there was a significant restructuring of the senior management team during the year. We have reviewed correspondence with the Board and Remuneration Committee and confirmed the costs of these changes of c. £0.5m were transparently reported and the changes appropriately authorised prior to implementation. We have also considered the Trust's future financial plans, including the draft proposals for the sharing of control totals and Financial Recovery Fund (FRF) funding across the North East and North Cumbria Integrated Care System (ICS) and the North of Tyne and Gateshead Integrated Care Partnership (ICP) from 2020-21 and the Trust's 5-year plan. We have no findings to raise, however we would highlight that elements of future FRF funding which may be required to achieve the Trust's control total in future years may be dependent upon the financial performance of other members of the ICP and ICS, not just the Trust's own financial performance, under these proposals.

06 Other reporting issues

Other reporting issues

Annual Report including Annual Governance Statement

We are required to give an opinion on the consistency of the Annual Report and other information published with the financial statements and the parts of the remuneration report that are required to be audited. We are also required to review the Annual Governance Statement for completeness of disclosures, consistency with other information we are aware of from our work and whether it complies with relevant guidance. In reviewing the Annual Report and other information published with the financial statements we took account of updated guidance issued to bodies in the light of Covid-19.

Financial information within the Annual Report and published with the financial statements is consistent with the Annual Accounts.

We reported that the remuneration and staff report was not prepared properly with regards to the pay multiple disclosures, where the banded remuneration of the highest-paid director was incorrect. Other than this point, the Remuneration and Staff report was properly prepared and within the rules set.

We have performed a preliminary review of the Annual Governance Statement and have a small number of queries to work through with management before we can conclude it is consistent with our knowledge gained during the course of the audit.

We will provide a verbal update on outstanding matters to the Audit Committee at the meeting on the 16 June 2020.

Whole of Government Accounts

Alongside our work on the financial statements, we also report to the Trust on differences, within a tolerance of £300,000, between the Trust's consolidation schedules and the audited financial statements. We report to the NAO under Whole of Government Accounts group audit instructions.

As at the point of submitting this report, we have only recently received the Trust's final consolidation schedules therefore our review of these schedules for consistency with the financial statements is still to be completed. We will provide a verbal update on these procedures to the Audit Committee at the meeting on the 16 June 2020.

Other powers and duties

We also have a duty under the Local Audit and Accountability Act 2014 to consider whether, in the public interest, to report on any matter that comes to our attention in the course of the audit in order for it to be considered by the Trust or brought to the attention of the public. We did not identify any issues which required us to issue a report in the public interest.

07 Assessment of Control Environment

Assessment of Control Environment

Financial controls

It is the responsibility of the Trust to develop and implement systems of internal financial control and to put in place proper arrangements to monitor their adequacy and effectiveness in practice. Our responsibility as your auditor is to consider whether the Trust has put adequate arrangements in place to satisfy itself that the systems of internal financial control are both adequate and effective in practice.

As part of our audit of the financial statements, we obtained an understanding of internal control sufficient to plan our audit and determine the nature, timing and extent of testing performed. As we have adopted a fully substantive approach, we have therefore not tested the operation of controls.

Although our audit was not designed to express an opinion on the effectiveness of internal control we are required to communicate to you significant deficiencies in internal control.

We have not identified any significant deficiencies in the design or operation of an internal control that might result in a material misstatement in your financial statements of which you are not aware.

We considered whether circumstances arising from Covid-19 resulted in a change to the overall control environment of effectiveness of internal controls, for example due to significant staff absence or limitations as a result of working remotely. We identified no issues which we wish to bring to your attention.

The matters reported here are limited to those deficiencies that we identified during the audit and that we concluded are of sufficient importance to merit being reported to you.

Assessment of Control Environment

Area	Expected credit losses	Rating

Observation

In 2018-19 the Trust adopted IFRS 9: Financial Instruments, which introduced a new more forward-looking requirement for entities to provide for expected credit losses (ECLs. As a minimum, IFRS 9 requires that ECLs are based on a probability weighted scenario of at least two potential outcomes – usually applied in practice as a loss scenario and a no-loss scenario.

The expected credit loss requirements of IFRS 9 also apply to financial assets other than trade receivables, such as the loan between the Trust and QEF, finance lease receivables and contract assets recognised under IFRS 15.

Our review of the Trust's bad debt policy identified that the Trust only considers providing against trade receivable debts which are at least 90 days past due. Furthermore, the policy does not consider assets other than trade receivables which are within the scope of IFRS 9's ECL requirements.

The Trust's bad debt policy is therefore inconsistent with the requirements of IFRS 9.

We recommend management review the bad debt policy to ensure it supports accounting which is consistent with the current reporting framework.

Management comment

Current Year Recommendations

Area	Staff induction policy	Rating

Observation

Our review of the Trust's policies and procedures, which are publicly available on the Trust's website, identified that the Trust's staff induction policy is stated as most recently reviewed in August 2017.

The expiry date is stated as August 2015, though given this comes before the last review date this is likely to be an error. Nevertheless, given the Trust's other policies are generally reviewed on an annual or two yearly cycle, the policy has likely expired.

Management have informed us that a more current version is available to Trust staff via the Trust's intranet, however we have not been able to confirm this prior to submitting this report.

We therefore recommend management either review the staff induction policy to ensure it is current, or ensure the publicly available policies are also updated when policies are updated.

Management comment

Assessment of Control Environment

Area	**Segregation of duties at QEF**
Observation	As part of our walkthrough procedures, we identified some instances where segregation of duties in QEF could be improved. We acknowledge that the team at QEF is relatively small and recommend that management consider whether any support is required at Group level to ensure appropriate controls remain in place.
Update	As part of our walkthrough procedures in the current year, we have continued to identify instances where the segregation of duties in QEF could be improved.

Area	**Quality of accounts presented for audit**
Observation	We noted that the draft accounts submitted to NHSI and presented for audit contained a number of casting and consistency errors and incorrect references. We recommend that management implement additional controls within the quality review procedures over the accounts production process to eliminate these items in accounts presented to external partners.
Update	Our review of the draft accounts presented for audit this year found a lower number of such errors, though some were still observed.

Update on prior-year recommendations

Area	**Monitoring of compliance with terms and conditions in the funding agreements with the Department of Health and Social Care (DHSC)**
Observation	We note that section 8 of the revenue funding agreements with the Department of Health and Social Care contains a number of terms and conditions with which the Trust must comply to be eligible for funding. Management do not currently monitor compliance with these terms and conditions as they are linked to the requirements of the license of the Trust or other statutory duties. We accept that it is unlikely that this funding would be clawed back by the DHSC; however we recommend that management monitor compliance with the agreement so that prompt action can be taken should a breach occur.
Update	Management have informed us that, as in the prior year, conditions are monitored in the context of the Trust's license but no additional monitoring is undertaken with regards to compliance with funding eligibility criteria.

08 Independence

Independence

We confirm there are no changes in our assessment of independence since our confirmation in our Audit Planning Report issued in March 2020.

We complied with the FRC Ethical Standards. In our professional judgement the firm is independent and the objectivity of the audit engagement partner and audit staff has not been compromised within the meaning of regulatory and professional requirements.

We consider that our independence in this context is a matter that should be reviewed by both you and ourselves. It is therefore important that you and your Audit Committee consider the facts of which you are aware and come to a view. If you wish to discuss any matters concerning our independence, we will be pleased to do so at the forthcoming meeting of the Audit Committee on 16 June 2020.

As part of our reporting on our independence, we set out below a summary of the fees you have paid us in the year ended 31 March 2020.

We confirm that we have not undertaken non-audit work.

	2019/20	2018/19
	£	£
Audit of Group and Trust financial statements (1)	TBC*	32,800
Audit of Charitable Funds financial statements	3,250	3,250
Audit of QE Facilities Limited financial statements	7,000	7,000
Total audit	**TBC**	**43,050**
Other assurance services – Quality Report (2)	TBC**	6,375
Total assurance services	**TBC**	**49,425**
Total fees	**TBC**	**49,425**

* Engagement fee is £42,800, as communicated in our Covid-19 Update.

** Engagement fee is £6,375, as communicated in our Audit Planning Report.

(1) We have had to perform additional procedures, over what we planned at the start of our audit, to respond to the impacts on Covid-19 on the financial statements. This has included:

- Consulting with our EY Real Estate property valuation specialists to inform our evaluation of the material valuation uncertainty in the valuation of land and buildings;
- Additional procedures to review how management have addressed the lack of certainty over future funding arrangements within their going concern assessment;
- Additional internal consultations to consider the impact of these matters on our audit report.

We also performed additional procedures to support remote observation of year-end stock counts, including the involvement of more senior staff than would be required for a standard stock count. We do however note that inventory is immaterial to the Trust and Group, therefore this work will be used to support our opinion on the separate financial statements of QEF rather than the Group.

These additional procedures will impact upon our final fee, which we will discuss with management following completion of our audit.

(2) As reported in our Covid-19 update, NHS Improvement have removed the requirement for Trusts to seek assurance from their external auditor over the Quality Report, however given the late stage at which this requirement was removed we have incurred some costs in preparing for this work and designing our procedures.

We invoiced £3,188, half of the planned fee, prior to the requirement for us to perform this work being removed. We will agree with management the amount which should be retained by us to cover the costs incurred prior to cancellation following completion of our audit.

Independence

New UK Independence Standards

The Financial Reporting Council (FRC) published the Revised Ethical Standard 2019 in December and it will apply to accounting periods starting on or after 15 March 2020. A key change in the new Ethical Standard will be a general prohibition on the provision of non-audit services by the auditor (and its network) which will apply to UK Public Interest Entities (PIEs). A narrow list of permitted services will continue to be allowed.

Summary of key changes

- Extraterritorial application of the FRC Ethical Standard to UK PIE and its worldwide affiliates;
- A general prohibition on the provision of non-audit services by the auditor (or its network) to a UK PIE, its UK parent and worldwide subsidiaries;
- A narrow list of permitted services where closely related to the audit and/or required by law or regulation;
- Absolute prohibition on the following relationships applicable to UK PIE and its affiliates including material significant investees/investors:
    - Tax advocacy services
    - Remuneration advisory services
    - Internal audit services
    - Secondment/loan staff arrangements
- An absolute prohibition on contingent fees;
- Requirement to meet the higher standard for business relationships i.e. business relationships between the audit firm and the audit client will only be permitted if it is inconsequential;
- Permitted services required by law or regulation will not be subject to the 70% fee cap;
- Grandfathering will apply for otherwise prohibited non-audit services that are open at 15 March 2020 such that the engagement may continue until completed in accordance with the original engagement terms;
- A requirement for the auditor to notify the Audit Committee where the audit fee might compromise perceived independence and the appropriate safeguards; and
- A requirement to report to the audit committee details of any breaches of the Ethical Standard and any actions taken by the firm to address any threats to independence. A requirement for non-network component firm whose work is used in the group audit engagement to comply with the same independence standard as the group auditor. Our current understanding is that the requirement to follow UK independence rules is limited to the component firm issuing the audit report and not to its network. This is subject to clarification with the FRC.

Next Steps

We will continue to monitor and assess all ongoing and proposed non-audit services and relationships to ensure they are permitted under FRC Revised Ethical Standard 2019, which came into effect from 1 April 2020.

We do not currently provide any non-audit services which would be prohibited under the new standard.

Independence

Other communications

EY Transparency Report 2019

Ernst & Young (EY) has policies and procedures that instil professional values as part of firm culture and ensure that the highest standards of objectivity, independence and integrity are maintained.

Details of the key policies and processes in place within EY for maintaining objectivity and independence can be found in our annual Transparency Report which the firm is required to publish by law. The most recent version of this Report is for the period ended 28 June 2019 (published September 2019):

https://assets.ey.com/content/dam/ey-sites/ey-com/en_uk/about-us/transparency-report-2019/ey-uk-2019-transparency-report.pdf

09 Appendices

Appendix A

Required communications with the Audit Committee

We have detailed below the communications that we must provide to the Audit Committee**.**

		Our Reporting to you
Required communications	**What is reported?**	**When and where**
Terms of engagement	Confirmation by the Audit Committee of acceptance of terms of engagement as written in the engagement letter signed by both parties.	Engagement Letter dated 20 February 2018
Our responsibilities	Reminder of our responsibilities as set out in the engagement letter	Audit Planning Report (March 2020)
Planning and audit approach	Communication of the planned scope and timing of the audit, any limitations and the significant risks identified.	Audit Planning Report (March 2020)
Significant findings from the audit	▸ Our view about the significant qualitative aspects of accounting practices including accounting policies, accounting estimates and financial statement disclosures; ▸ Significant difficulties, if any, encountered during the audit; ▸ Significant matters, if any, arising from the audit that were discussed with management; ▸ Written representations that we are seeking; ▸ Expected modifications to the audit report; and ▸ Other matters if any, significant to the oversight of the financial reporting process	Audit Results Report (March 2020)

Appendix A

Required communications with the Audit Committee (continued)

		Our Reporting to you
Required communications	**What is reported?**	**When and where**
Going concern	Events or conditions identified that may cast significant doubt on the entity's ability to continue as a going concern, including: ▸ Whether the events or conditions constitute a material uncertainty; ▸ Whether the use of the going concern assumption is appropriate in the preparation and presentation of the financial statements; and ▸ The adequacy of related disclosures in the financial statements	Audit Results Report (This report)
Misstatements	▸ Uncorrected misstatements and their effect on our audit opinion, unless prohibited by law or regulation; ▸ The effect of uncorrected misstatements related to prior periods; ▸ A request that any uncorrected misstatement be corrected; ▸ Corrected misstatements that are significant; and ▸ Material misstatements corrected by management	Audit Results Report (This report)
Fraud	▸ Enquiries of the Audit Committee to determine whether they have knowledge of any actual, suspected or alleged fraud affecting the entity; ▸ Any fraud that we have identified or information we have obtained that indicates that a fraud may exist; and ▸ A discussion of any other matters related to fraud	Audit Results Report (This report)
Related parties	▸ Significant matters arising during the audit in connection with the entity's related parties including, when applicable: ▸ Non-disclosure by management; ▸ Inappropriate authorisation and approval of transactions; ▸ Disagreement over disclosures; ▸ Non-compliance with laws and regulations; and ▸ Difficulty in identifying the party that ultimately controls the entity	Audit Results Report (This report)

Appendix A

Required communications with the Audit Committee (continued)

		Our Reporting to you
Required communications	**What is reported?**	**When and where**
Independence	Communication of all significant facts and matters that bear on EY's, and all individuals involved in the audit, objectivity and independence. Communication of key elements of the audit engagement partner's consideration of independence and objectivity such as: ▸ The principal threats; ▸ Safeguards adopted and their effectiveness; ▸ An overall assessment of threats and safeguards; and ▸ Information about the general policies and process within the firm to maintain objectivity and independence	Audit Planning Report (March 2020); and Audit Results Report (This report)
External confirmations	▸ Management's refusal for us to request confirmations; and ▸ Inability to obtain relevant and reliable audit evidence from other procedures	Audit Results Report (This report)
Consideration of laws and regulations	▸ Audit findings regarding non-compliance where the non-compliance is material and believed to be intentional. This communication is subject to compliance with legislation on tipping off; and ▸ Enquiry of the Audit Committee into possible instances of non-compliance with laws and regulations that may have a material effect on the financial statements and that the Audit Committee may be aware of.	Audit Results Report (This report)
Internal controls	▸ Significant deficiencies in internal controls identified during the audit	Audit Results Report (This report)

Appendix A

Required communications with the Audit Committee (continued)

		Our Reporting to you
Required communications	**What is reported?**	**When and where**
Group audits	▸ An overview of the type of work to be performed on the financial information of the components; ▸ An overview of the nature of the group audit team's planned involvement in the work to be performed by the component auditors on the financial information of significant components; ▸ Instances where the group audit team's evaluation of the work of a component auditor gave rise to a concern about the quality of that auditor's work; ▸ Any limitations on the group audit, for example, where the group engagement team's access to information may have been restricted; and ▸ Fraud or suspected fraud involving group management, component management, employees who have significant roles in group-wide controls or others where the fraud resulted in a material misstatement of the group financial statements.	Audit Planning Report (March 2020); and Audit Results Report (This report)
Representations	Written representations we are requesting from management and/or those charged with governance	Audit Results Report (This report)
Material inconsistencies and misstatements	Material inconsistencies or misstatements of fact identified in other information which management has refused to revise.	Audit Results Report (This report)
Auditors report	Any circumstances identified that affect the form and content of our auditor's report.	Audit Results Report (This report)

Appendix B

Outstanding matters

The following items relating to the completion of our audit procedures are outstanding at the date of the release of this report:

Item	Actions to resolve	Responsibility
Substantive testing of staff costs	We have a small number of outstanding evidence requests / queries with regards to staff costs and associated disclosures which we are working with management to resolve.	Management / Audit Team
Other substantive testing	We have a couple of outstanding evidence requests / queries with regards to operating leases and PPE which we are working with management to resolve.	Management / Audit Team
Review of the Governance Statement	We have performed a preliminary review and have a small number of queries to resolve with management.	Management / Audit Team
Review of the WGA consolidation schedules for consistency with the financial statements.	The final schedules to be reviewed and any comments arising notified to management.	Audit Team
Internal review procedures	We are still completing our internal review procedures to ensure the quality of our work.	Audit Team / Management (if further enquiries arise from review)
Internal consultation on the final wording of our audit opinion	Given the exceptional circumstances this year, we have introduced additional internal consultation processes in respect of our audit opinion which we need to conclude.	Audit Team
Events after the reporting period	Both management and the audit team will need to continue to consider events after the reporting period up to the date of signing.	Management / Audit Team

Appendix C

Regulatory update

Since the date of our last report to the Audit Committee, there have been a number of regulatory developments. The following table provides a high level summary of that which has the potential to have the most significant impact on you:

Name	Summary of key measures	Impact on Gateshead Health NHS Foundation Trust
ISA (UK) 570 (Revised September 2019) – Going concern	▸ The standard is effective for audits of financial statements for periods commencing on or after 15 December 2019, however EY expects to early-adopt the revised standard for all of our audits of periods ending on or after 30 June 2020; ▸ This auditing standard has been revised in response to enforcement cases and well-publicised corporate failures where the auditor's report failed to highlight concerns about the prospects of entities which collapsed shortly after; ▸ The revised standard increases the work we are required to perform when assessing whether Gateshead Health NHS Foundation Trust is a going concern and means UK auditors will follow significantly stronger requirements than those required by current international standards; ▸ The revised standard requires: ▸ greater work for us to challenge management's assessment of going concern, thoroughly test the adequacy of the supporting evidence we obtained and evaluate the risk of management bias. Our challenge will be made based on our knowledge of Gateshead Health NHS Foundation Trust obtained through our audit, which will include additional specific risk assessment considerations which go beyond the current requirements; ▸ improved transparency with a new reporting requirement for public interest entities, listed and large private companies to provide a clear, positive conclusion on whether management's assessment is appropriate, and to set out the work we have done in this respect; ▸ a stand back requirement to consider all of the evidence obtained, whether corroborative or contradictory, when we draw our conclusions on going concern; and ▸ Necessary consideration regarding the *appropriateness* of financial statement disclosures around going concern. ▸ The revised standard extends requirements to report to regulators where we have concerns about going concern.	▸ Whilst the revised standard is for EY as auditors, it will have an impact on the management of Gateshead Health NHS Foundation Trust as additional going concern forecasts might need to be prepared in response to our identified risks. However, it does not change the responsibilities of management or those charged with governance; ▸ We are anticipating the audit effort required to obtain sufficient and appropriate audit evidence to conclude on the appropriateness of management's use of the going concern basis of accounting in the preparation of the financial statements of Gateshead Health NHS Foundation Trust, including related disclosures and auditor reporting, will increase; ▸ There will be additional disclosures in our auditor's report on the financial statements of Gateshead Health NHS Foundation Trust; and ▸ For Gateshead Health NHS Foundation Trust the revised standard is effective for the audit of the financial statements for the period ended 31 March 2021.

Appendix D

Management representation letter

We include below a copy the management representation letter which we request is printed on Trust letterheaded paper, signed and provided to us prior to us signing our audit report.

Management Representation Letter

XX June 2020

Mrs Helen Henshaw
Ernst & Young
Citygate
St James' Boulevard
Newcastle-upon-Tyne
NE1 4JD

Dear Helen,

This letter of representations is provided in connection with your audit of the consolidated and Trust financial statements of Gateshead Health NHS Foundation Trust ("the Group and Trust") for the year ended 31 March 2020.

We recognise that obtaining representations from us concerning the information contained in this letter is a significant procedure in enabling you to form an opinion as to whether the consolidated and Trust financial statements give a true and fair view of (or 'present fairly, in all material respects,') the Group and Trust financial position of Gateshead Health NHS Foundation Trust as of 31 March 2020 and of its financial performance (or operations) and its cash flows for the year then ended in accordance with, applicable law and the accounting policies directed by Monitor (operating as NHS Improvement) with the consent of the Secretary of State as relevant to the National Health Service in England.

We understand that the purpose of your audit of our consolidated and Trust financial statements is to express an opinion thereon and that your audit was conducted in accordance with International Standards on Auditing, which involves an examination of the accounting system, internal control and related data to the extent you considered necessary in the circumstances, and is not designed to identify - nor necessarily be expected to disclose - all fraud, shortages, errors and other irregularities, should any exist.

Accordingly, we make the following representations, which are true to the best of our knowledge and belief, having made such inquiries as we considered necessary for the purpose of appropriately informing ourselves:

A. Financial Statements and Financial Records

1.We have fulfilled our responsibilities, as set out in the terms of the audit engagement letter dated 20 February 2018, for the preparation of the financial statements in accordance with International Financial Reporting Standards (IFRSs), and as adapted by the Government Financial Reporting Manual as contained in the relevant Department of Health and Social Care Group Accounting Manual for the year under audit and the Accounts Direction issued by Monitor (operating as NHS Improvement) with the consent of the Secretary of State as relevant to the National Health Service in England (the Accounts Direction).

2. We acknowledge, as members of management of the Group and Trust, our responsibility for the fair presentation of the consolidated and Trust financial statements. We believe the consolidated and Trust financial statements referred to above give a true and fair view of the financial position, financial performance and cash flows of the Group in accordance with the NHS Foundation Trust Annual Reporting Manual issued by the Independent Regulator of NHS Foundation Trusts ("Monitor") and are free of material misstatements, including omissions. We have approved the financial statements.

3. The significant accounting policies adopted in the preparation of the Group and Trust financial statements are appropriately described in the Group and Trust financial statements.

Appendix D

Management representation letter (continued)

Management Representation Letter

4. As members of management of the Group and Trust, we believe that the Group and Trust have a system of internal controls adequate to enable the preparation of accurate financial statements in accordance with applicable law and the accounting policies directed by Monitor (operating as NHS Improvement) with the consent of the Secretary of State as relevant to the National Health Service in England and the Department of Health and Social Care (DHSC) Group Accounting Manual (GAM) that are free from material misstatement, whether due to fraud or error. We have disclosed to you any significant changes in our processes, controls, policies and procedures that we have made to address the effects of the Covid-19 pandemic on our system of internal controls.

5. We believe that the effects of any unadjusted audit differences, summarised in the accompanying schedule, accumulated by you during the current audit and pertaining to the latest period presented are immaterial, both individually and in aggregate, to the consolidated and Trust financial statements taken as a whole. We have not corrected these differences identified and brought to our attention by the auditor because [*management to provide rationale*].

B. Non-compliance with law and regulations, including fraud

1. We acknowledge that we are responsible for determining that the Group and Trust's activities are conducted in accordance with laws and regulations and that we are responsible to identify and address any non-compliance with applicable laws and regulations, including fraud.

2. We acknowledge that we are responsible for the design, implementation and maintenance of internal controls to prevent and detect fraud.

3. We have disclosed to you the results of our assessment of the risk that the consolidated and Trust financial statements may be materially misstated as a result of fraud.

4. We have no knowledge of any identified or suspected non-compliance with laws or regulations, including fraud that may have affected the Group or Trust (regardless of the source or form and including without limitation, any allegations by "whistleblowers"), including non-compliance matters:

- involving financial statements;
- related to laws and regulations that have a direct effect on the determination of material amounts and disclosures in the consolidated or Trust's financial statements;
- related to laws and regulations that have an indirect effect on amounts and disclosures in the financial statements, but compliance with which may be fundamental to the operations of the Group or Trust's activities, its ability to continue to operate, or to avoid material penalties;
- Involving management, or employees who have significant roles in internal controls, or others; or in relation to any allegations of fraud, suspected fraud or other non-compliance with laws and regulations communicated by employees, former employees, analysts, regulators or others.

C. Information Provided and Completeness of Information and Transactions

1. We have provided you with:

- Access to all information of which we are aware that is relevant to the preparation of the financial statements such as records, documentation and other matters;
- Additional information that you have requested from us for the purpose of the audit; and
- Unrestricted access to persons within the entity from whom you determined it necessary to obtain audit evidence.

Appendix D

Management representation letter (continued)

Management Representation Letter

2. All material transactions have been recorded in the accounting records and all material transactions, events and conditions are reflected in the consolidated and Trust financial statements, including those related to the Covid-19 pandemic.

3. We have made available to you all minutes of the Group and committees of directors, including the Trust Board and Remuneration Committee and the QE Facilities Limited Board and Remuneration Committee (or summaries of actions of recent meetings for which minutes have not yet been prepared) held through the year to the most recent meeting on the following date: [*to reflect latest meeting minutes provided as at point of signing letter*]

4. We confirm the completeness of information provided regarding the identification of related parties. We have disclosed to you the identity of the Group and Trust's related parties and all related party relationships and transactions of which we are aware, including sales, purchases, loans, transfers of assets, liabilities and services, leasing arrangements, guarantees, non-monetary transactions and transactions for no consideration for the period ended, as well as related balances due to or from such parties at the year end. These transactions have been appropriately accounted for and disclosed in the consolidated and Trust financial statements.

5. We believe that the significant assumptions we used in making accounting estimates, including those measured at fair value, are reasonable.

6. We have disclosed to you, and the Group and Trust has complied with, all aspects of contractual agreements that could have a material effect on the consolidated and Trust financial statements in the event of non-compliance, including all covenants, conditions or other requirements of all outstanding debt.

7. We have disclosed to you any cybersecurity breach that either occurred or that third parties (including regulatory agencies, law enforcement agencies and security consultants) had brought to our attention during the period under audit that could potentially be material to the financial statements.

D. Liabilities and Contingencies

1.All liabilities and contingencies, including those associated with guarantees, whether written or oral, have been disclosed to you and are appropriately reflected in the consolidated and Trust financial statements.

2. We have informed you of all outstanding and possible litigation and claims, whether or not they have been discussed with legal counsel.

3. We have recorded and/or disclosed, as appropriate, all liabilities related to litigation and claims, both actual and contingent, and have disclosed in the consolidated and Trust financial statements all guarantees that we have given to third parties.

E. Subsequent Events

1. Other than the replacement of the existing Department and Health and Social Care interim revenue and capital loans totalling £12.253m with the issue of Public Dividend Capital as described in Note 16.2 to the consolidated and Trust financial statements, there have been no events, including events related to the Covid-19 pandemic, subsequent to period end which require adjustment of or disclosure in the consolidated and Trust financial statements or notes thereto.

F. Group audits

1. We recognise the restrictions on the use of charitable fund balances and reserves in accordance with the wishes of the donors and the general principles and purpose of the charity. We confirm that the charitable funds have only been used for appropriate purposes in line with these restrictions and have not been used for any improper purpose. There are no other significant restrictions on the use of charitable funds other than those indicated in the accounts.

Appendix D

Management representation letter (continued)

Management Representation Letter

2. There are no significant restrictions on our ability to distribute the retained profits of the Group because of statutory, contractual, exchange control or other restrictions other than those indicated in the Group financial statements.

3. Necessary adjustments have been made to eliminate all material intra-group unrealised profits on transactions amongst parent, subsidiary undertakings and associated undertakings.

G. Other information

1. We acknowledge our responsibility for the preparation of the other information. The other information comprises The Annual Report.

2. We confirm that the content contained within the other information is consistent with the financial statements.

H. Agreement of Balances and key judgments

1. We have disclosed to you details of all transactions and judgments we have made on income and expenditure, payable and receivable balances with counter-parties irrespective of whether or not they have been included in the 2019/20 Agreement of Balances exercise

2. We have agreed balances, disputes and claims with all NHS bodies via the Agreement of Balances process and where not agreed, we have reported the matter to you.

3. We have disclosed to you all of the risks and judgments we have made in arriving at the Trust's reported financial outturn for financial year ended 31 March 2020.

I. Going Concern

1.Note 1 to the consolidated and Trust financial statements discloses all the matters of which we are aware that are relevant to the Group and Trust's ability to continue as a going concern, including significant conditions and events, our plans for future action, and the feasibility of those plans.

J. Income and Indirect Taxes

1. We acknowledge our responsibility for the tax accounting methods adopted by the Group and Trust, which have been consistently applied in the current period, and for the current year income tax provision calculation.

K. Use of the Work of a Specialist

1.We agree with the findings of the specialists that we engaged to evaluate the valuation of land and buildings and have adequately considered the qualifications of the specialists in determining the amounts and disclosures included in the consolidated and Trust financial statements and the underlying accounting records. We did not give or cause any instructions to be given to the specialists with respect to the values or amounts derived in an attempt to bias their work, and we are not otherwise aware of any matters that have had an effect on the independence or objectivity of the specialists.

Yours faithfully,

_____

Group Finance Director

_____

Chair of the Audit Committee

Appendix D

Management representation letter (continued)

Management Representation Letter

Schedule of unadjusted audit difference

Expenditure Cut-Off – audit testing of expenditure recorded by QEF identified two transactions totalling £160k which related to 2018-19 but had not been accounted for in the prior year. As these transactions were recorded in July and September 2019, you were unable to consider the issue to be isolated to transactions around the year-end and have extrapolated your findings over the whole population. This gives an extrapolated error of £2.7m, though the true error may be higher or lower. As the issue relates to omission of expenditure from the prior period and is immaterial in value, the correct accounting treatment is to recognise as expenditure in the current period.

Expected Credit Losses – your review of the Trust's bad debt policy has identified that expected credit losses are not recognised until a debt is 90 days past due. This is a later recognition point than required by IFRS 9, which requires recognition of expected credit losses from the point a debt is recognised (though often at a very small proportion of the overall value). You have performed analysis of the Group receivables balance and estimate expected credit losses equal to c. 66% of the balances not captured by the Trust's policy, excluding balances with other NHS bodies assumed under DHSC's Group Accounting Manual to have zero credit risk, would be required for a material impact on the financial statements. We do not consider it plausible that a reasonable estimate would be this high. There is however likely to be a degree of understatement which we consider to be immaterial.

Provisions for Clinician Pension Liabilities – NHS England wrote to all Trusts and Foundation Trusts in April 2020 expressing an expectation that providers recognise provisions within their 2019-20 financial statements where they employ clinicians likely to have a tax liability and take advantage of the NHS scheme to be reimbursed for that tax liability upon retirement. The Trust has not recognised a provision on the basis that we will have no reliable information as to how many of the Trust's clinicians have opted to participate in the scheme until July 2020. The Trust has 187 clinicians eligible for the scheme and NHS England have set a provision amount of £3,345 per clinician, therefore the maximum provision the Trust could recognise would be £625k. Recognition of a provision would have no impact on expenditure as a corresponding reimbursement asset from NHS England would also be recognised.

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Trust Board

Gateshead Health NHS Foundation Trust

Report Cover Sheet

Agenda Item: 14

Date of Meeting:	**September 2020**			
Report Title:	**Healthcare Associated Infection (HCAI) Performance Report**			
Purpose of Report:	To update and advise the Trust Board on the current performance of HCAI mandatory reporting for Gateshead Health NHS Foundation Trust throughout the 2020-21 period.			
	Decision: ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
Trust Goals that the report relates to: (Including reference to any specific risk)	**Goal 1** Working with partners, we will manage and improve the health of the population of Gateshead, promoting wellbeing and preventing the occurrence and progression of ill-health wherever possible. **Goal 2** All the services we deliver will be good or outstanding when assessed against being safe, effective, caring, responsive, and well-led. **Goal 3** In all locations and settings of delivery, our patients will experience excellent, timely and seamless care that meets their individual needs.			
Recommendations: (Action required by Board of Directors)	To note the Trust performance on mandatory HCAI reporting and other infection prevention activity as required.			
Financial Implications:	**Yes** - HCAI and treatment is costly across the whole healthcare economy, delays discharge and increases length of hospital stay. Financial sanctions may also be applied by NHS England and Commissioners.			
Risk Management Implications:	**Yes** - HCAI has implications for the whole healthcare economy. The expertise, advice and support of the IPC team are crucial in ensuring that the risk and spread of infection is minimised.			
Human Resource Implications:	**Yes** – organisational culture and behaviours, engagement, responsibility and ownership required across the whole healthcare economy.			
Trust Diversity & Inclusion Objective that the report relates to: (*including reference to any specific implications and actions*)	**Objective 1** All patients receive high quality care through streamlined accessible services with a focus on improving knowledge and capacity to support communication barriers.			
Author:	**Louise Caisley** - Head of Infection Prevention and Control			
Presented by:	**Dr Hilary Lloyd** - Director of Nursing, Midwifery, AHPs & Quality Joint Director of Infection Prevention and Control (DIPC)			

1.0 EXECUTIVE SUMMARY

The Trust continues to adopt the national aspiration of attaining a zero tolerance approach to all avoidable infections. The mandatory reporting infection objectives for CDI and blood stream infections (BSI) for 2020/21 have not been published by NHS England/NHS Improvement for 2020/21.

COVID-19 continues to be the prominent organism of focus in 2020, and is dominating the healthcare horizon.

From April 2020 the financial sanctions and associated appeals process for CDI cases were discontinued. To the end of August 2020 the Trust has reported twenty two (**22**) CDI healthcare associated samples - *compared to thirteen (**13**) for the same period last year*. Seventeen (**17**) hospital onset healthcare associated (HOHA) and five (**5**) community onset healthcare associated (COHA). The increase in incidence of HOHA cases has been experienced by neighbouring organisations.

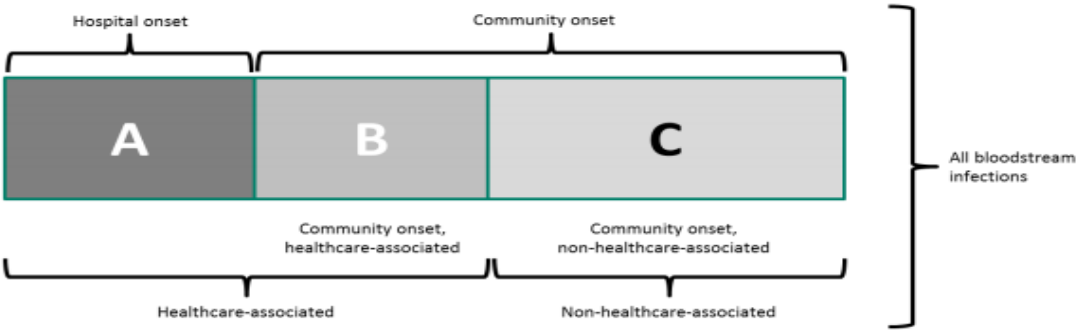
From August 2020 the reporting process for BSI changed to reflect the categories against which the anticipated objectives will be set. Therefore, from the end of July 2020, BSI are no longer reported as hospital onset/community onset but rather as healthcare associated and community associated (non-healthcare associated) and it is anticipated the Trust objective will be set against the healthcare associated category.

The Healthcare associated category comprises:

- Hospital Onset – Healthcare Associated (HOHA) – when the sample is taken 48 hours following admission (equivalent to the previous Hospital onset category)

and

- Community Onset – Healthcare Associated (COHA) – when the sample is taken within the first 48 hours following admission **and** the patient has undergone an healthcare intervention in the preceding 28 days prior to the sample collection



As a result of the changes to the categorisation of BSI, it is not currently possible to extrapolate the 'rate per 100k bed days', which is usually, used a comparator in this report. Therefore in this report the comparative Healthcare Associated rates will not be presented.

To the end of August 2020 the Trust reported zero (**0**) Hospital-onset Meticillin resistant *Staphylococcus aureus* (MRSA) blood stream infections (BSI) with a **0.00** rate per 100k bed days and zero (**0**) Community-onset Meticillin resistant *Staphylococcus aureus* (MRSA) blood stream infections (BSI).

From April 2020 to the end of July 2020 the Trust reported seven (**7**) Hospital-onset Meticillin sensitive *Staphylococcus aureus* (MSSA) blood stream infections (BSI) with a **2.86** rate per 100k bed days and fifteen (**15**) Community-onset Meticillin sensitive *Staphylococcus aureus* (MSSA) blood stream infections (BSI). During August 2020 the Trust reported three (**3**) Healthcare-associated Meticillin sensitive *Staphylococcus aureus* (MSSA) blood stream infections (BSI) and three (**3**) Community Associated Meticillin sensitive *Staphylococcus aureus* (MSSA) blood stream infections (BSI).

From April 2020 to the end of July 2020

- *Escherichia coli* (*E.coli*): The Trust reported ten (**10)** Hospital-onset BSI with a rate of **4.57** per 100k bed days and seventy four (**74**) Community-onset samples.
- *Pseudomonas aeruginosa*: The Trust reports one (**1**) Hospital-onset BSI with a rate of **0.6** per 100k bed days and five (**5**) Community-onset samples.
- *Klebsiella spp*: The Trust reports two (**2**) Hospital-onset BSI with a rate of **1.1** per 100k bed days and fifteen (**15**) Community-onset samples.

During August 2020

- *Escherichia coli* (*E.coli*): The Trust reported four (**4**) Healthcare-associated BSI and eleven (**11**) Community-associated samples.
- *Pseudomonas aeruginosa*: The Trust reported zero (**0**) Hospital-associated BSI and zero (**0**) Community-associated samples.
- *Klebsiella spp*: The Trust reports zero (**0**) Hospital-associated BSI and five (**5**) Community-associated samples.

From May 2020 the Trust was required to report COVID -19 positive results against four categories:

- Community-Onset – First positive specimen date <=2 days after admission to Trust; Hospital-Onset Indeterminate Healthcare-Associated (HOIHA)– First positive specimen date 3-7 days after admission to trust;
- Hospital-Onset Probable Healthcare-Associated (HOPHA) - First positive specimen date 8-14 days after admission to trust;
- Hospital-Onset Definite Healthcare-Associated (HODHA) – First positive specimen date 15 or more days after admission to trust.

The Trust reports the number of COVID-19 positive in-patients via SitRep and investigates and reports all identified nosocomial COVID-19 cases and COVID-19 outbreaks. Nosocomial COVID-19 cases are considered against the three categories and from May 2020 to end of August the Trust has reported one (**1**) indeterminate, zero (**0**) probable and zero (**0**) definite hospital onset healthcare associated cases .

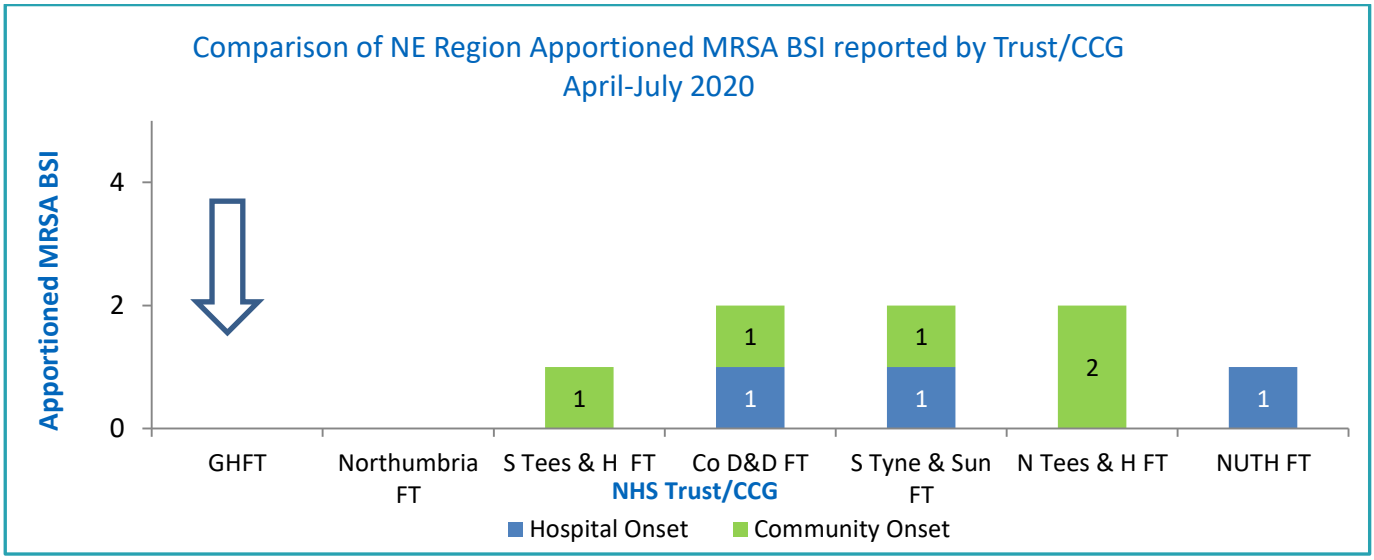
2.0 MANDATORY HCAI SURVEILLANCE

2.1 Meticillin Resistant *Staphylococcus aureus* (MRSA) Blood Stream Infections (BSI)

The Trust reported zero (**0**) Hospital-onset samples of MRSA BSI to end of August 2020 with a rate of **0** per 100k bed days and zero (**0**) Community-onset MRSA BSI identified in *table 1*.

Table 1 **– Hospital onset**	**Q1**			**Q2**			**Q3**			**Q4**		
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Healthcare Associated **MRSA BSI**	**0**	**0**	**0**	**0**	**0**							
Cumulative YTD	**0**											
2019/20 data = **1/0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**

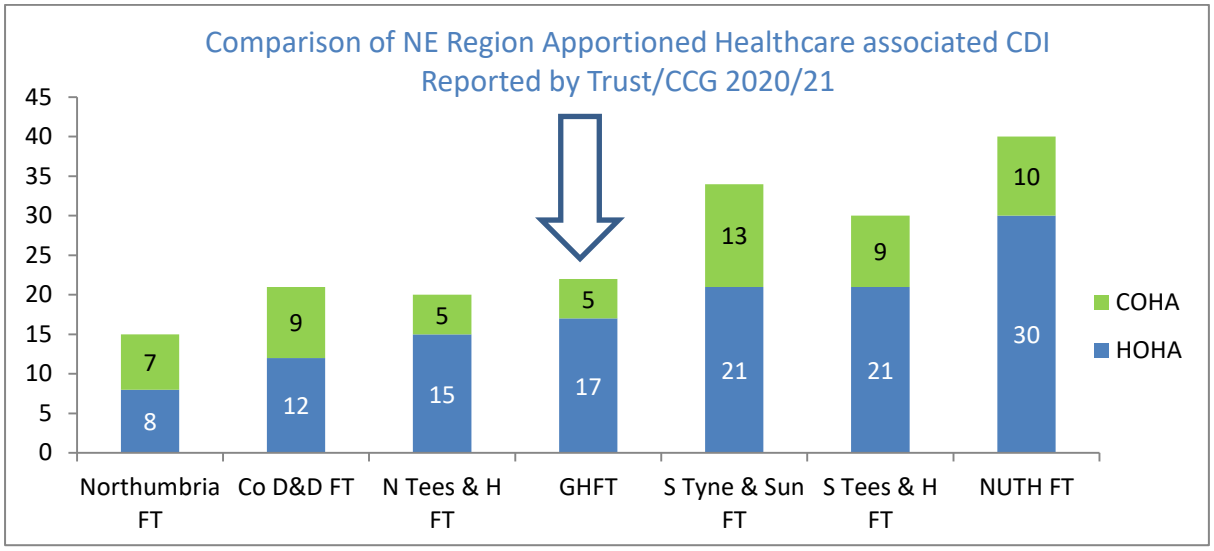
Table 1 **– Community onset**	**Q1**			**Q2**			**Q3**			**Q4**		
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Healthcare/Indeterminate/Community Associated **MRSA BSI**	**0**	**0**	**0**	**0**	**0**							
Cumulative YTD	**0**											
2019/20 data = **2/0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**1**	**0**	**0**	**0**



2.2 *Clostridium difficile* Infection (CDI)

Clostridium difficile infection (CDI) is an unpleasant, and potentially severe or fatal infection that occurs mainly in elderly and other vulnerable patient groups, especially those who have been exposed to antibiotic treatment. Reduction of CDI continues to present a key challenge to patient safety across the Trust. The CDI reporting objective for 2020/21 has not yet been published.

From April 2020 the financial sanctions and the associated appeals process for CDI cases were discontinued. From April 2020 to the end of August 2020 the Trust has reported twenty two (**22**) CDI healthcare associated samples - *compared to thirteen (**13**) for the same period last year*. Seventeen (**17**) hospital onset healthcare associated (HOHA) and five (**5**) community onset healthcare associated (COHA). The increase in incidence of CDI cases has also been experienced by neighbouring organisations.

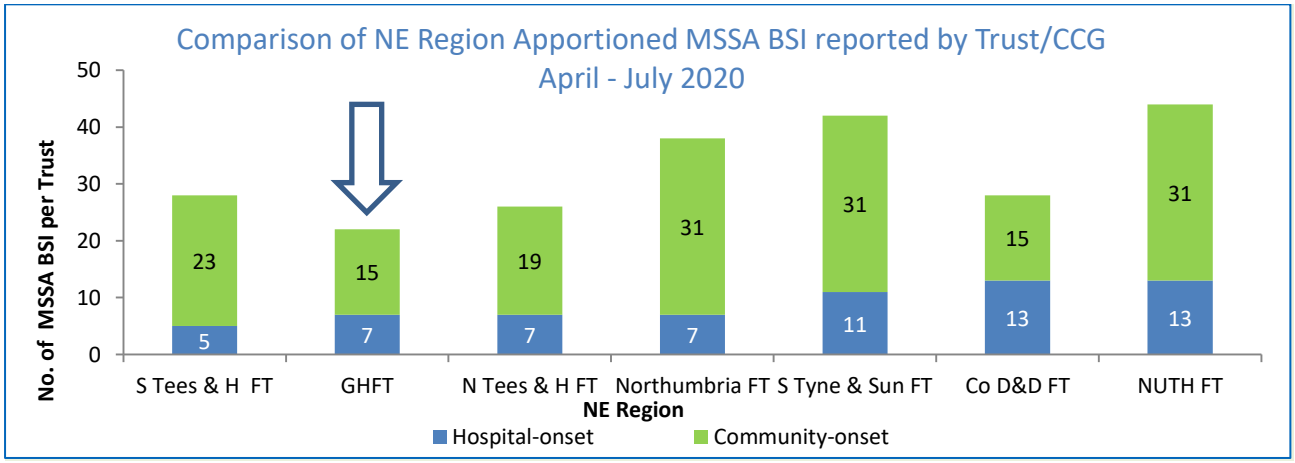


2.3 Meticillin Sensitive *Staphylococcus aureus* (MSSA) Blood Stream Infections (BSI)

The Trust reported seven (**7**) Hospital-onset samples of MSSA BSI to end of July 2020 with a rate of **2.86** per 100k bed days and fifteen (**15**) Community-onset MSSA BSI as identified in *table 3*.

***Table 3* - Acute Trust Data**	**Q1**			**Q2**			**Q3**			**Q4**		
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Hospital-onset MSSA BSI	**0**	**1**	**3**	**3**								
Cumulative YTD	**7**											
2019/20 Actual = 7	**0**	**0**	**2**	**1**	**0**	**0**	**2**	**0**	**0**	**1**	**1**	**0**

***Table 3* - Community Data**	**Q1**			**Q2**			**Q3**			**Q4**		
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Community-onset MSSA BSI	**4**	**2**	**3**	**6**								
Cumulative YTD	**15**											
2019/20 Actual = 52	**7**	**3**	**4**	**2**	**5**	**3**	**3**	**4**	**12**	**2**	**4**	**3**

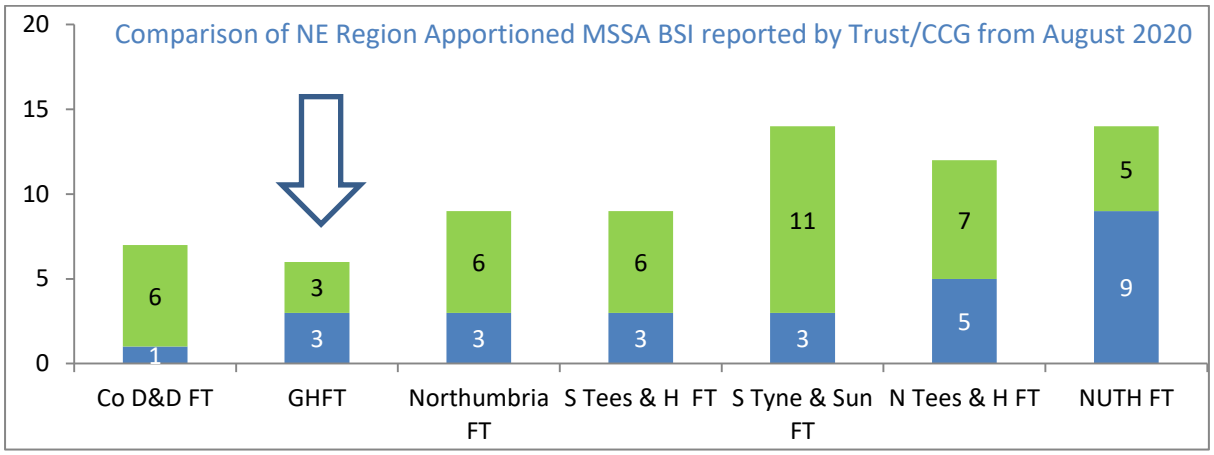


Review of Data adopting the revised PHE classifications (applied 17/07/2020)

The Trust reported three (**3**) Healthcare associated samples of MSSA BSI for August 2020 and three (**3**) Community associated MSSA BSI as identified in *table 3a*.

Table 3a – Healthcare associated	Q1			Q2			Q3			Q4		
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Hospital onset/Community onset **MSSA BSI**					3							
Cumulative YTD	3											

Table 3a – Community associated	Q1			Q2			Q3			Q4		
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Indeterminate/Community onset **MSSA BSI**					3							
Cumulative YTD	3											



3.0 GRAM-NEGATIVE BLOOD STREAM INFECTIONS (GNBSI) - ENGLAND ONLY

The anticipated Gram-negative BSI reporting objectives for 2020/21 have not yet been published.

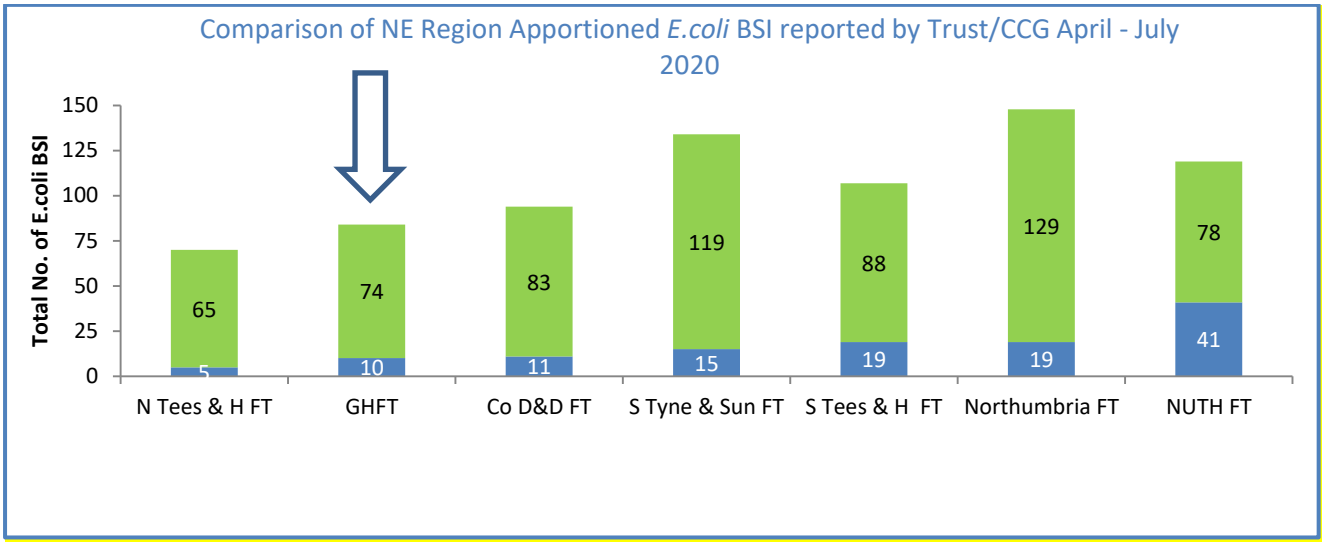
The following data representing *E. coli, Klebsiella* species and *Pseudomonas aeruginosa* blood stream infections (BSI) and demonstrate that the main proportion of BSI occur within the primary and social care environment.

3.1 Escherichia coli BSI (*E. coli*)

The Trust reported ten (**10**) Hospital-onset samples of *E. coli* BSI to end of July 2020 with a rate of **4.57**per 100k bed days and seventy four (**74**) Community-onset *E. coli* BSI identified in *table 4*.

Table 4 - Acute Trust Data	Q1			Q2			Q3			Q4		
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Hospital-onset (HO) *E-coli* BSI	2	3	4	2								
YTD	10											
HO *E-coli* BSI 2019/2020 = 41	2	5	4	3	2	5	4	3	2	6	3	2

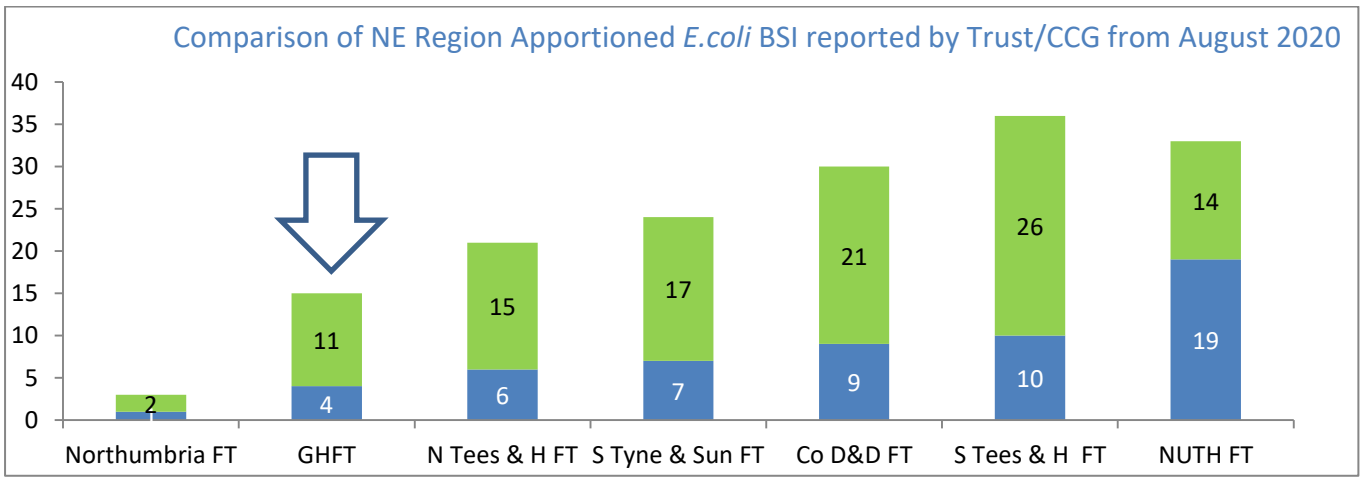
Table 4 - Community Data	Q1			Q2			Q3			Q4		
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Community-onset (CO) *E-coli* BSI	13	26	16	19								
YTD	74											
CO *E-coli BSI* 2019/2020 = 186	14	10	16	23	16	13	13	12	13	21	17	18



Review of Data adopting the revised PHE classifications (applied 17/07/2020)

The Trust reported four (**4**) Healthcare associated samples of *E. coli* BSI for August 2020 and eleven (**11**) Community-onset *E. coli* BSI identified in *table 4a*.

***Table 4a* – Healthcare associated**	**Q1**			**Q2**			**Q3**			**Q4**		
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Hospital onset/Community onset **MSSA BSI**					**4**							
Cumulative YTD	**4**											
***Table 4a* – Community associated**	**Q1**			**Q2**			**Q3**			**Q4**		
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Indeterminate/Community onset **MSSA BSI**					**11**							
Cumulative YTD	**11**											



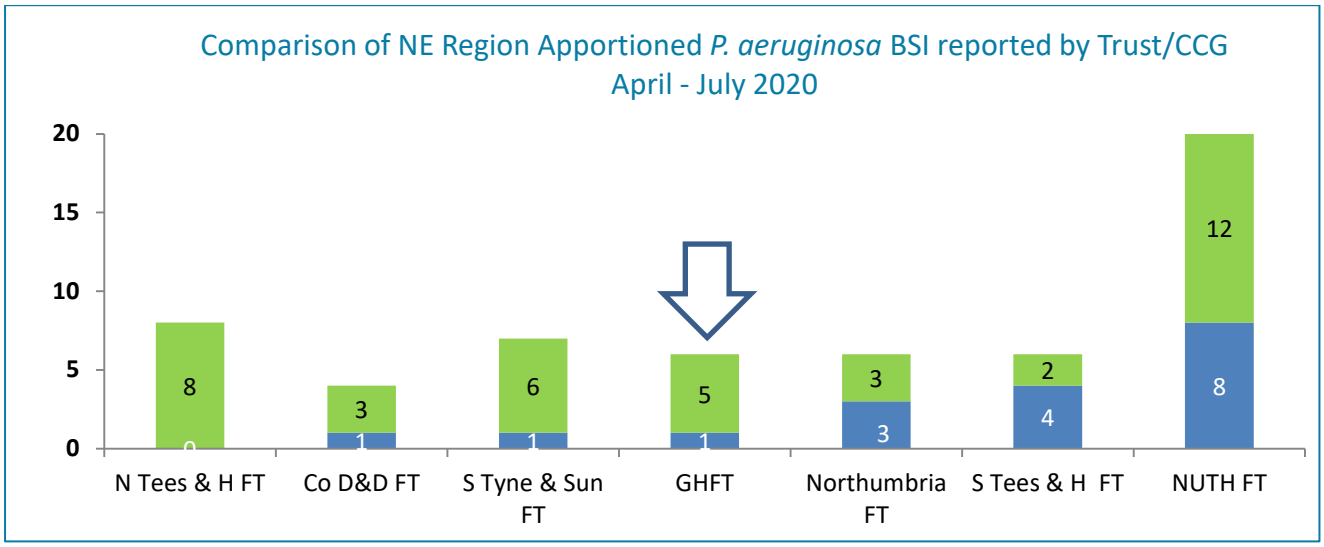
3.2 Pseudomonas aeruginosa BSI

Pseudomonas aeruginosa is a common opportunistic Gram-negative pathogen often found in soil and ground water. It rarely affects healthy individuals however can cause a wide range of infections, particularly in those with a weakened immune system. In hospitals, the organism can contaminate devices that are left inside the body, such as respiratory equipment and urinary catheters. P. aeruginosa is also resistant to many commonly-used antibiotics

The Trust has reported one (**1**) Hospital-onset *P. aeruginosa* BSI to the end of July 2020 with a rate of 0.6 per 100k bed days and five (**5**) Community-onset identified in *table 5*.

***Table 5* - Acute Trust Data**	**Q1**			**Q2**			**Q3**			**Q4**		
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Hospital-onset (HO) *P. aeruginosa BSI*	**1**	**0**	**0**	**0**								
Cumulative YTD	**1**											
HO *P. aeruginosa BSI* 2019/2020 = 8	**2**	**0**	**2**	**1**	**1**	**0**	**1**	**1**	**0**	**0**	**0**	**0**

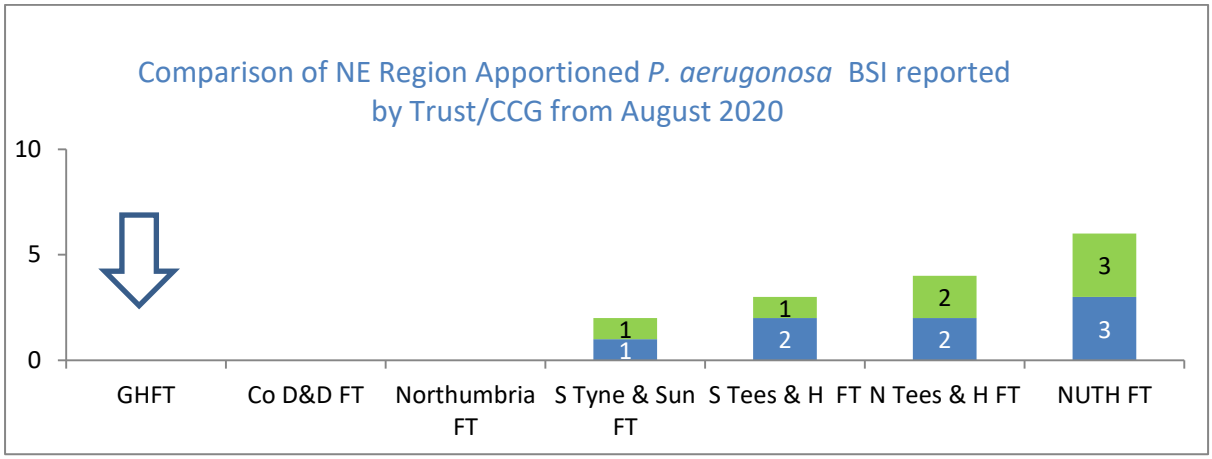
***Table 5* - Community Data**	**Q1**			**Q2**			**Q3**			**Q4**		
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Community-onset (CO) *P. aeruginosa* BSI	**0**	**3**	**1**	**1**								
Cumulative YTD	**5**											
CO *P. aeruginosa* BSI 2019/2020 = 16	**4**	**1**	**0**	**1**	**1**	**0**	**1**	**2**	**1**	**4**	**0**	**1**



Review of Data adopting the revised PHE classifications (applied 17/07/2020)

The Trust has reported zero (**0**) Healthcare associated *P. aeruginosa* BSI for August 2020 and zero (**0**) Community associated identified in *table 5a*.

***Table 5a* – Healthcare associated**	**Q1**			**Q2**			**Q3**			**Q4**		
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Hospital onset/Community onset ***P. aeruginosa* BSI**					**0**							
Cumulative YTD	**0**											
***Table 5a* – Community associated**	**Q1**			**Q2**			**Q3**			**Q4**		
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Indeterminate/Community onset ***P. aeruginosa* BSI**					**0**							
Cumulative YTD	**0**											



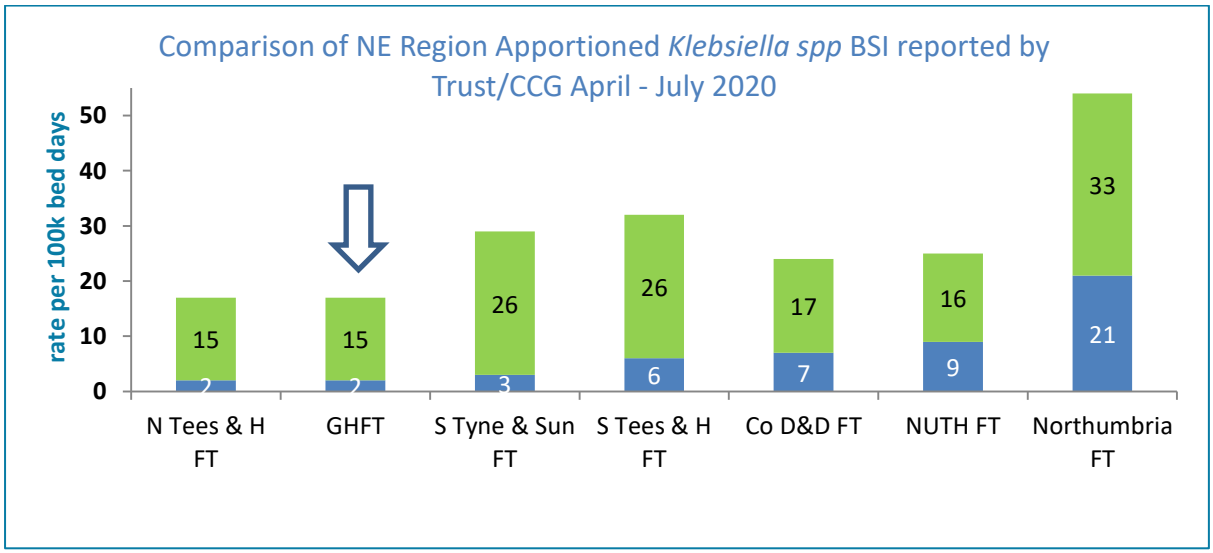
3.3 *Klebsiella species* BSI

Klebsiella species are a type of bacteria that are found ubiquitously in the environment and also in the human intestinal tract and are commonly associated with a range of HCAI. In healthcare settings, Klebsiella infections are seen in vulnerable, immunocompromised and unwell patients who have other co-morbidities and who are receiving treatment for other conditions.

The Trust has reported two (**2**) Hospital-onset *Klebsiella sp* BSI to the end of July 2020 with a **1.1** rate per 100k bed days and fifteen (**15**) Community-onset BSI identified in *table 6*.

***Table 6* - Acute Trust Data**	**Q1**			**Q2**			**Q3**			**Q4**		
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Hospital-onset (HO) *Klebsiella spp. BSI*	**0**	**0**	**1**	**1**								
Cumulative YTD	**2**											
HO *Klebsiella spp. BSI 2019/20 = 10*	**0**	**0**	**0**	**0**	**1**	**2**	**1**	**2**	**1**	**1**	**1**	**1**

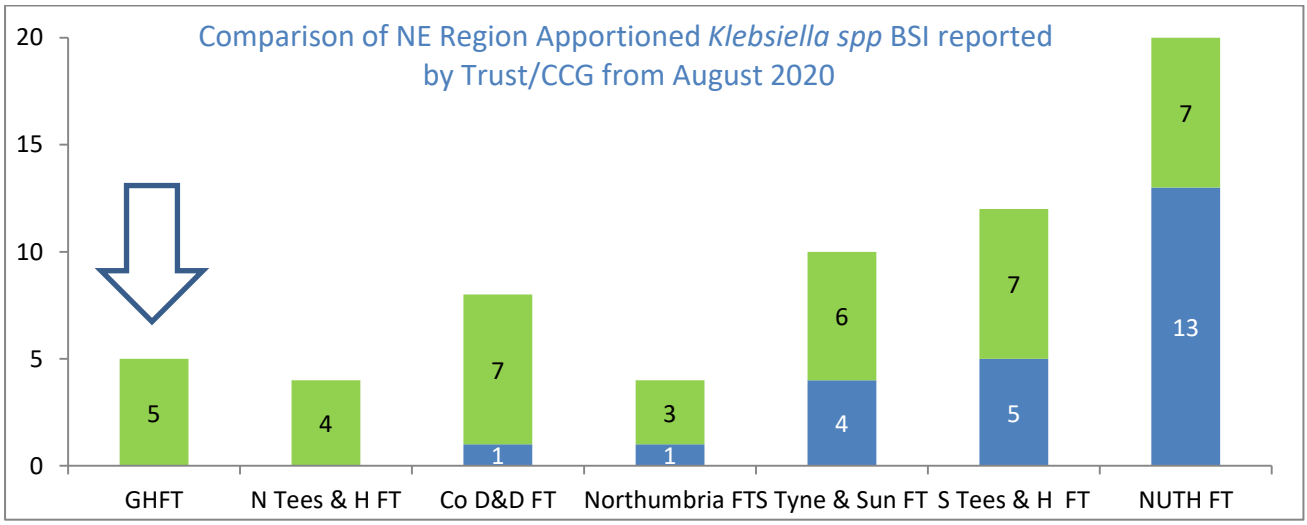
***Table 6* - Community Data**	**Q1**			**Q2**			**Q3**			**Q4**		
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Community-onset (CO) *Klebsiella spp.* BSI	**6**	**1**	**5**	**3**								
Cumulative YTD	**15**											
CO *Klebsiella spp.* BSI 2019/2020 = 47	**5**	**2**	**6**	**3**	**1**	**5**	**6**	**5**	**4**	**4**	**2**	**4**



Review of Data adopting the revised PHE classifications (applied 17/07/2020)

The Trust has reported zero (**0**) Healthcare associated *Klebsiella sp* BSI for August 2020 with a **0** rate per 100k bed days and five (**5**) Community associated BSI identified in *table 6a*.

***Table 6a* – Healthcare associated**	**Q1**			**Q2**			**Q3**			**Q4**		
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Hospital onset/Community onset ***Klebsiella sp*. BSI**					**0**							
Cumulative YTD	**0**											
***Table 6a* – Community associated**	**Q1**			**Q2**			**Q3**			**Q4**		
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Indeterminate/Community onset ***Klebsiella sp*. BSI**					**5**							
Cumulative YTD	**5**											



4.0 PERIODS OF INCREASED INCIDENCE (PII) AND OUTBREAKS

An outbreak is the occurrence of two or more actual or potentially related infections within a ward/department/area of practice within the Trust. This is also referred to as a 'Period of Increased Incidence' (PII) for clusters of known/unknown infections.
COVID-19 outbreak definition is outlined in section 5.0

The Trust has experienced zero (**0**) PII due to confirmed Norovirus infections from April 2020 the end of August 2020

All PII are managed consistently with the outbreak policy to minimise disruption to bed occupancy and patient flow.

Table 7 indicates the number of PII by month against 2019/20.

***Table 7* - Outbreaks & Periods of Increased Incidence (PII)**	**Q1**			**Q2**			**Q3**			**Q4**		
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
2020/21	**0**	**0**	**0**	**0**	**0**							
YTD	**0**											
2019/20 Actual = 12	**0**	**0**	**0**	**0**	**0**	**1**	**1**	**2**	**0**	**2**	**6**	**0**

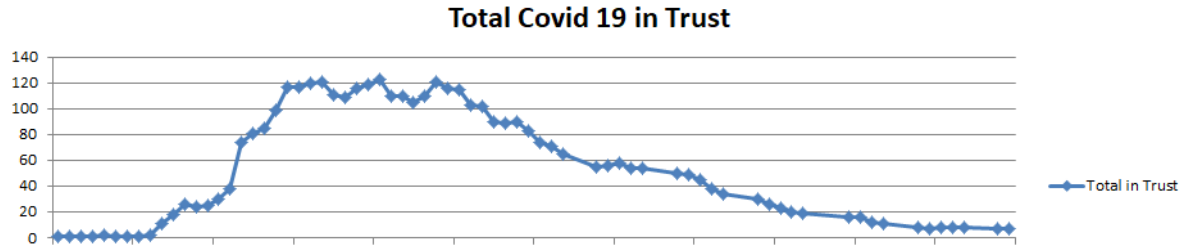
5.0 COVID - 19

COVID-19 is a novel coronavirus identified in 2019 which has resulted in a pandemic.
The emerging evidence base on COVID-19 is rapidly evolving but at the time of writing transmission of COVID-19 is thought to occur mainly through respiratory droplets generated by coughing and sneezing, and through contact with contaminated surfaces. The predominant modes of transmission are assumed to be droplet and contact and require the use of standard infection control precautions and transmission based precautions when managing patients with suspected or confirmed COVID-19.

The latter part of 2019/20 and all of 2020/21 has been dominated by the rapidly evolving COVID-19 pandemic.

Following the initial surge, the number of COVID positive inpatients steadily reduced. The IPC team and Microbiologists have provided advice and support to the 'phase 3' response to increase non-COVID health services.

To note: Due to an increase in the level of the virus circulating in the community, Gateshead was added to the Government's watch list on the 10/09/2020. It is anticipated that this will result in an increase in the numbers of COVID-19 positive patients requiring admission to the hospital and the number of staff affected.



The Trust reports instance of Healthcare associated COVID-19 cases against 3 categories

- Hospital-Onset Definite Healthcare-Associated – First positive specimen date 15 or more days after admission to trust.
- Hospital-Onset Probable Healthcare-Associated - First positive specimen date 8-14 days after admission to trust
- Hospital-Onset Indeterminate Healthcare-Associated – First positive specimen date 3-7 days after admission to trust.

Table 8 indicates the number of cases reported by the organisation from April 2020.

Table 8	Q1			Q2			Q3			Q4		
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Hospital-Onset Definite Healthcare-Associated	n/a	0	0	0	0							
Hospital-Onset Probable Healthcare-Associated	n/a	0	0	0	0							
Hospital-Onset Indeterminate Healthcare-Associated	n/a	1	0	0	0							

COVID-19 outbreaks

An outbreak of COVID-19 is defined using the criteria detailed below and are required to be declared by NHS England/improvement and PHE.

	Criteria to declare	Criteria to end
Outbreak in an inpatient setting	Two or more confirmed cases of COVID-19 OR clinically suspected cases of COVDI-19 among individuals associated with a specific setting. For linked patients this will be onset dates 8-14 days after admissions within the same ward or wing of a hospital. NB. If there is a single laboratory confirmed case, this would initiate further investigation and risk assessment.	No confirmed cases with onset dates in the last 28 days in that setting.
Outbreak in an outpatient setting	Two or more confirmed cases of COVID-19 among individuals associated with a specific setting with onset dates within 14 days AND: Identified direct exposure between at least two of the confirmed cases in that setting (e.g. within 2 metres for >15 minutes) during the infectious period of the putative index case	No confirmed cases with onset dates in the last 28 days in that setting
Outbreak in a non-clinical workplace	Two or more confirmed cases of COVID-19 among individuals associated with a specific setting with onset dates within 14 days AND: Identified direct exposure between at least two of the confirmed cases in that setting (e.g. within 2 metres for >15 minutes) during the infectious period of the putative index case	No confirmed cases with onset dates in the last 28 days in that setting.

Table 9 identifies that the Trust has reported zero (**0**) COVID-19 related outbreak up to August 2020.

The Microbiologist and IPC team support any investigation, management, and reporting of an outbreak. The trust would be involved with the contact tracing required for all patients and staff that have a positive swab in line with the National Test and Trace service.

Table 9 **COVID 19 outbreaks 2020/21**	**Q1**			**Q2**			**Q3**			**Q4**		
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Inpatient setting	**0**	**0**	**0**	**0**	**0**							
Outpatient setting	**0**	**0**	**0**	**0**	**0**							
Non-clinical workplace	**0**	**0**	**0**	**0**	**0**							

A COVID-19 outbreak policy has been created to reflect the updated NHS England/Improvement & PHE guidance.

Louise Caisley
Head of Infection Prevention and Control

Trust Board

Gateshead Health NHS Foundation Trust

Report Cover Sheet

Agenda Item: 15

Date of Meeting:	Tuesday 29th September 2020			
Report Title:	Nursing Staffing Exception Report			
Purpose of Report:	Provide assurance to the Board that staffing establishments are being met month by month			
	Decision: ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
Trust Goals that the report relates to: (Including reference to any specific risk)	**Goal 2** All the services we deliver will be good or outstanding when assessed against being safe, effective, caring, responsive, and well-led **Goal 3** In all locations and settings of delivery, our patients will experience excellent, timely and seamless care that meets their individual needs **Goal 5** All our services will be effective: we will reduce unwarranted variation, ensure our practice is consistent with recognised best practice 7 days a week, and improve outcomes for patients			
Recommendations: (Action required by Board of Directors)	The Board are asked to receive the report for assurance			
Financial Implications:	Costs associated with nurse bank to provide cover for maternity and sickness			
Risk Management Implications:	Areas of potential risk have been mitigated against through the implementation of robust staffing plans and ongoing monitoring of staffing levels across the organisation			
Human Resource Implications:	Nurse recruitment continues to be a challenge; however the Trust is being proactive and innovative in terms of recruitment solutions			
Diversity and Inclusion Implications:	**Objective 3** Leaders within the Trust are informed and knowledgeable about the impact of business decisions on a diverse workforce and the differing needs of the communities we serve			
Author:	Dr Karen Roberts, Deputy Director of Nursing, Midwifery & Quality Michael Shaw, Acting Clinical Lead HealthRoster			
Presented by:	Dr Hilary Lloyd, Direct of Nursing, Midwifery & Quality			

Gateshead Health NHS Foundation Trust

Nursing and Midwifery Staffing Exception Report

July – August 2020

1. Introduction

This report is to provide assurance to the Board that staffing establishments are being met on a shift-to-shift basis. The Board will receive monthly updates on workforce information, including the number of actual staff on duty during the previous month, compared to the planned staffing level, the reasons for any gaps and the actions being taken to address these. Following the Lord Carter Cole report, it was recommended that all trusts start to report on care hours per patient per day (CHPPD) this is to provide a single consistent way of recording and reporting deployment of staff working on inpatient wards/units. It is calculated by adding the hours of registered nurses to the hours of support workers and dividing the total by every 24 hours of inpatient admissions. This report provides information for July and August 2020.

2. Staffing

The actual ward staffing against the budgeted establishments for July and August are presented in Tables 1a and 1b: Ward by ward staffing is included in Appendix 1. In addition the Trust has published this information on our website for the public, and provided a link from NHS Choices to this information.

Table 1a: Whole Trust wards staffing July 2020

Day	Day	Night	Night
Average fill rate - registered nurses/midwives (%)	**Average fill rate - care staff (%)**	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate - care staff (%)**
96%	160.0%	105.0%	144.0%

Table 1b: Whole Trust wards staffing August 2020

Day	Day	Night	Night
Average fill rate - registered nurses/midwives (%)	**Average fill rate - care staff (%)**	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate - care staff (%)**
90%	134%	103.0%	139.0%

The Trust is required to present information on funded establishments (planned) against actual nurses on duty.

3. Exceptions:

The Board will be advised of those wards where staffing capacity and capability frequently falls short of what is planned, the reasons why, any impact on quality and the actions taken to address

gaps in staffing. In terms of exception reporting, we will report to the Board if the safe planned staffing drops below 75%.

The exceptions to report are as below:

July 2020			August 2020	
Qualified Nurse Days	**%**		**Qualified Nurse Days**	**%**
Ward 21	73.6%		Ward 21	70.2%
Ward 27	67.0%		Ward 27	66.9%

Qualified Nurses

During the month of July and August the ward 21 and ward 27 areas had lower fill rates on day shift. This was largely due to operational ward changes where by ward 21 was working to a reduced bed capacity (16 beds for 18). Ward 27 had lower acuity / dependency and was not taking critical care step down patients thus purposefully not rostering an additional qualified nurse on late shifts. Both Areas were supplemented by additional student support as part of the COVID 19 response (Aspirant Nurses Band 4 and second year Student nurses Band 3). These nurses supported the wards deficit with their enhanced skills although this support is counted in the unqualified fill rates.

There are no reportable night Shift exceptions for qualified staff.

Nursing Assistants

Fill rates for Nursing Assistant days and nights are exceptionally high across all areas. This is due largely to two fundamental reasons:

- COVID-19 Student support in the form of band 4 Aspirant nurses and Band 3 Year 2 student nurses who are counted in the Nursing Assistant fill rates.
- EAU, Ward 1 and SSU have had additional nursing assistants rostered to support increased COVID 19 “Donning and doffing” requirements.

It is anticipated that the Nursing Assistant high fill rates will normalise as the currently employed band 4 Aspirant Nurses progress to their registered status and the Band 3 student support will return to normal student status. We have successfully recruited 47 of the 52 Aspirant Nurses into Band 5 RN posts which is an excellent conversion rate.

4. Care Hours Per Patient Day (CHPPD)

Following the Lord Carter Cole report, it was recommended that all trusts start to report on care hours per patient per day (CHPPD) this is to provide a single consistent way of recording and reporting deployment of staff working on inpatient wards/units. It is calculated by adding the hours of registered nurses to the hours of support workers and dividing the total by every 24 hours of inpatient admissions. CHPPD is relatively stable month on month but they can show variation due to a number of factors including:

- Patient acuity and dependency
- Patients required enhanced care and support

- Bed occupancy (activity)

Work is ongoing to use the CHPPD metric to monitor and provide assurance in relation to the safe staffing of our ward areas. In line with this review more information will be provided in future board papers.

5. Monitoring Nurse Staffing via Datix

The Trust has in place a process for reporting and monitoring any concerns regarding nurse staffing levels. This is via the Datix incident reporting system. A report is generated on a monthly basis and helps identify areas where nurse staffing may have fallen below planned levels and what actions were taken to manage the situation. It is also helpful in identifying trends and organisational learning. There were 2 incidents reported in August 2020 due to gaps in shift primarily due to enhanced care requirements in CCD.

6. Governance

Actual staff on duty on a shift to shift basis compared to planned staffing is clearly displayed on the ward 'time to care' boards alongside key quality and outcome metrics i.e. safety thermometer; infection measures. These 'time to care' boards are all located in an area clearly visible to the public.

7. Recommendations

The Board is asked to receive this report for assurance.

Dr Karen Roberts , Deputy Director of Nursing, Midwifery and Quality

Michael Shaw Acting Clinical Lead HealthRoster

Appendix 1 - Ward by Ward staffing July 2020

	Day		Night		Care Hours Per Patient Per Day (CHPPD)			
Ward	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative patient count over the month	Registered midwives / nurses	Care Staff	Overall
Cragside Court	89.0%	177.0%	101.9%	228.7%	305	6.3	12.1	18.3
CCD	92.2%	153.8%	90.3%	139.1%	170	46.2	11.5	57.7
EAU/SSU	103.9%	274.0%	93.3%	156.7%	819	7.8	7.6	15.4
Maternity	139.4%	157.0%	134.2%	164.0%	395	22.1	9.9	32.1
Paediatrics	118.9%	147.7%	130.5%	-	25	101.8	41.5	143.4
SCBU	96.1%	91.4%	126.5%	90.0%	182	10.7	3.1	13.8
St Bede's	96.1%	138.2%	99.6%	117.1%	250	6.2	7.0	13.2
Sunniside	114.9%	114.6%	101.6%	105.2%	359	5.0	4.9	10.0
Ward 1	93.1%	147.9%	122.7%	112.2%	295	7.1	8.4	15.5
Ward 11	88.1%	160.7%	102.1%	135.3%	653	3.4	4.7	8.2
Ward 14 Surgery	125.1%	128.0%	100.3%	227.6%	537	4.0	4.5	8.5

	Day		Night		Care Hours Per Patient Per Day (CHPPD)			
Ward	**Average fill rate - nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Average fill rate - nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Cumulative patient count over the month**	**Registered midwives / nurses**	**Care Staff**	**Overall**
Ward 14A Trauma	76.3%	130.1%	99.9%	163.4%	567	3.7	6.0	9.7
Ward 21	73.6%	123.5%	97.9%	84.7%	298	5.2	5.7	10.9
Ward 22	85.7%	167.0%	100.4%	156.4%	793	2.8	4.2	6.9
Ward 23	80.8%	193.7%	102.6%	215.5%	601	3.0	7.4	10.4
Ward 24	76.8%	167.9%	103.7%	142.5%	795	2.6	4.1	6.6
Ward 25	86.0%	179.1%	101.7%	164.7%	753	2.9	4.7	7.6
Ward 26	80.2%	123.8%	95.9%	78.6%	294	6.2	8.9	15.1
Ward 27	67.0%	129.8%	103.6%	137.0%	786	2.8	4.2	7.0
Ward 4	98.8%	284.5%	103.8%	115.8%	535	3.8	6.6	10.5
Ward 8	110.1%	156.1%	106.6%	145.2%	537	4.1	5.2	9.3
Ward 9	75.5%	150.0%	125.6%	107.2%	895	3.6	3.8	7.3

Ward by Ward staffing August 2020

	Day		Night		Care Hours Per Patient Per Day (CHPPD)			
Ward	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative patient count over the month	Registered midwives / nurses	Care Staff	Overall
Cragside Court	78.5%	146.6%	102.1%	141.7%	295	6.0	9.3	15.3
CCD	80.7%	117.2%	88.6%	155.5%	245	29.3	6.8	36.1
EAU/SSU	109.4%	207.8%	82.2%	152.7%	1002	6.3	5.2	11.4
Maternity	105.1%	99.3%	132.4%	119.5%	357	20.0	7.2	27.3
Paediatrics	107.2%	120.0%	126.6%	-	26	90.5	32.3	122.8
SCBU	85.7%	81.2%	117.5%	96.8%	143	12.4	3.9	16.2
St Bede's	93.6%	123.9%	98.4%	99.0%	239	6.3	6.5	12.8
Sunniside	113.0%	99.1%	101.7%	196.2%	338	5.3	5.5	10.9
Ward 1	92.6%	122.0%	114.6%	122.2%	329	6.2	6.8	12.9
Ward 11	97.3%	126.1%	102.1%	127.0%	646	3.7	4.0	7.7
Ward 14 Surgery	120.5%	141.3%	100.2%	241.7%	652	3.2	4.0	7.2

	Day		Night		Care Hours Per Patient Per Day (CHPPD)			
Ward	Average fill rate - nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative patient count over the month	Registered midwives / nurses	Care Staff	Overall
Ward 14A Trauma	80.5%	107.8%	101.9%	170.7%	634	3.5	4.8	8.3
Ward 21	70.2%	118.2%	101.8%	98.6%	388	3.9	4.3	8.3
Ward 22	88.7%	146.7%	102.0%	151.8%	803	2.8	3.7	6.5
Ward 23	76.8%	161.8%	101.0%	199.6%	653	2.6	5.9	8.5
Ward 24	82.1%	158.8%	101.5%	159.6%	799	2.7	4.0	6.7
Ward 25	76.6%	147.6%	101.5%	146.3%	811	2.5	3.7	6.2
Ward 26	80.9%	96.7%	107.3%	82.1%	431	4.4	5.0	9.5
Ward 27	66.9%	114.6%	92.1%	133.3%	777	2.8	3.8	6.6
Ward 4	100.3%	235.1%	103.5%	111.2%	467	4.4	6.6	11.0
Ward 8	115.0%	124.3%	101.7%	125.4%	589	3.8	3.9	7.7
Ward 9	76.7%	152.0%	130.1%	113.0%	1011	3.2	3.4	6.7

Trust Board

Gateshead Health NHS Foundation Trust

Report Cover Sheet

Agenda Item: 16

Date of Meeting:	Tuesday 29th September 2020			
Report Title:	Integrated Quality and Learning Report			
Purpose of Report:	To provide assurance to the Board on the Trust's quality and safety performance.			
	Decision: ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☒
Trust Goals that the report relates to: (Including reference to any specific risk)	**Goal 3** In all locations and settings of delivery, our patients will experience excellent, timely and seamless care that meets their individual needs. **Goal 4** All our services will have a high safety culture in which openness, fairness, accountability and learning from high levels of incident reporting and mortality reviews is the norm.			
Recommendations: (Action required by Board of Directors)	To receive for information on the Trusts key quality and safety indicators.			
Financial Implications:	Financial sanctions may be applied by NHS England and commissioners in relation to Health Care Associated Infection (HCAI)			
Risk Management Implications:	The indicators contained relate to the quality of patient care. Risks are associated with any areas of poor performance of these indicators.			
Human Resource Implications:	None.			
Trust Diversity & Inclusion Objective that the report relates to: (including reference to any specific implications and actions)	**Objective 1** All patients receive high quality care through streamlined accessible services with a focus on improving knowledge and capacity to support communication barriers.			
Author:	Mr A Ward – Senior Information Analyst Mrs W McFadden – Safecare Lead for Clinical Effectiveness Mrs A Tweddell - Strategic Lead for Patient Safety			
Presented by:	Dr H Lloyd – Director of Nursing, Midwifery and Quality			

Integrated Quality and Learning Report
August 2020

Gateshead Health NHS Foundation Trust

Overall Good		
	Safe	Good ●
	Effective	Good ●
	Caring	Outstanding ☆
	Responsive	Good ●
	Well-led	Good ●

Integrated Quality and Learning Report

Introduction and about SPC

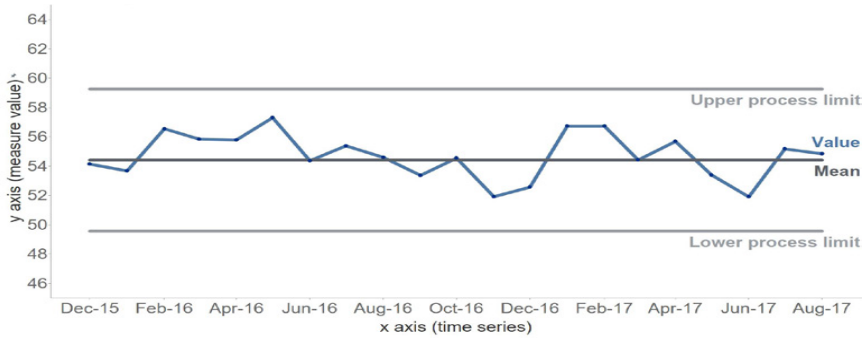
Gateshead Health NHS Foundation Trust

This report details quality indicators monitored by the Trust and also provides trust learning from these indicators. It is designed as an enhancement to replace the previous Trust Quality and Safety Dashboard and CLIP (Complaints, Litigation, Incidents, PALS).

Statistical process Control (SPC) has been used where appropriate to identify where situations may be improving or deteriorating.

Statistical process control (SPC) chart

This is an SPC chart. It's a time series line chart with three reference lines that help you appreciate variation in the data.



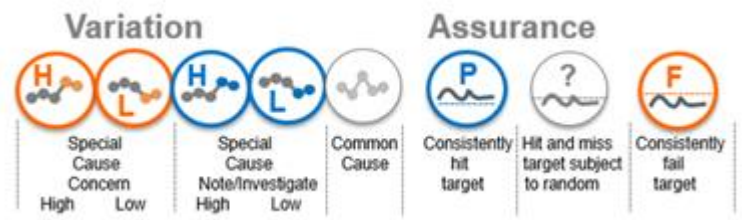
The reference lines are:

- centre reference line: the average line (often represented by the mean, sometimes the median)
- upper and lower reference lines: the process limits, also known as control limits.

You can expect approximately 99% of data points to fall within the process limits.

Key

The following symbols are used in this report to identify areas of special cause variation ,or where targets are consistently achieved, failed, or may be achieved / fail as a result of normal variation.



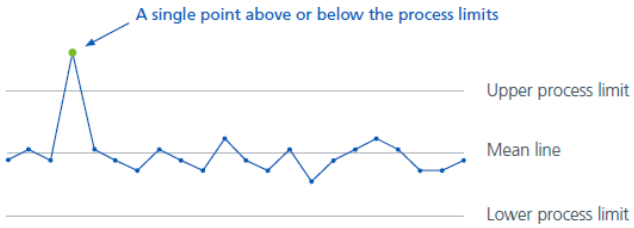
Integrated Quality and Learning Report

more about SPC

Gateshead Health NHS Foundation Trust

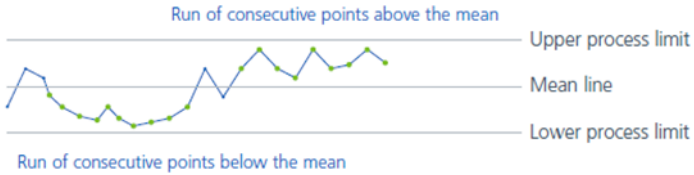
A single point outside the control limits

Whenever a data point falls outside a process limit (upper or lower) something unexpected has happened because we know that 99% of data should fall within the process limits.



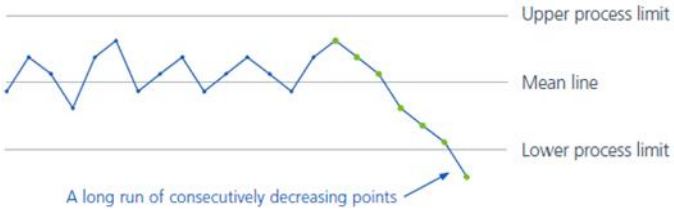
Consecutive points above or below the mean line

A run of values above or below the average (mean) line represents a trend that should not result from natural variation in the system.



Six consecutive points increasing or decreasing

A run of six or more values showing continuous increase or decrease is a sign that something unusual is happening in the system.



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Included this month

Gateshead Health NHS Foundation Trust

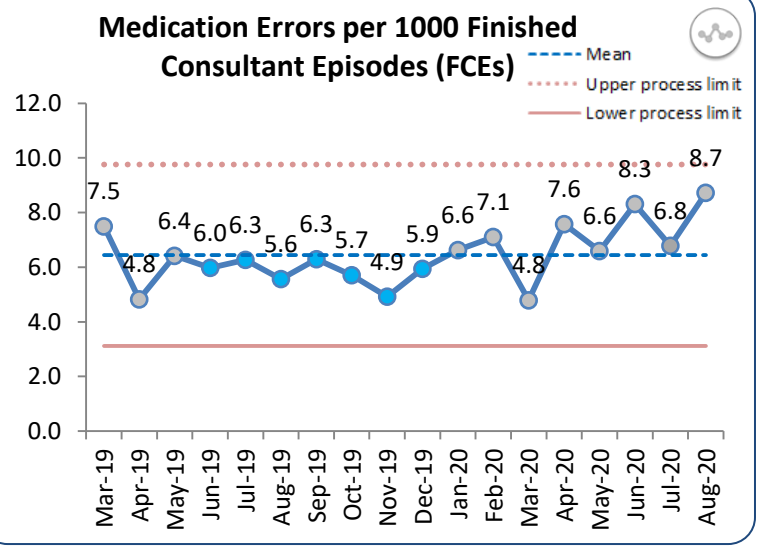
Please note that data in this report is accurate at the time of production. The severity and number of incidents may change due to additional information being available following investigation, meaning the severity may be re-categorised.

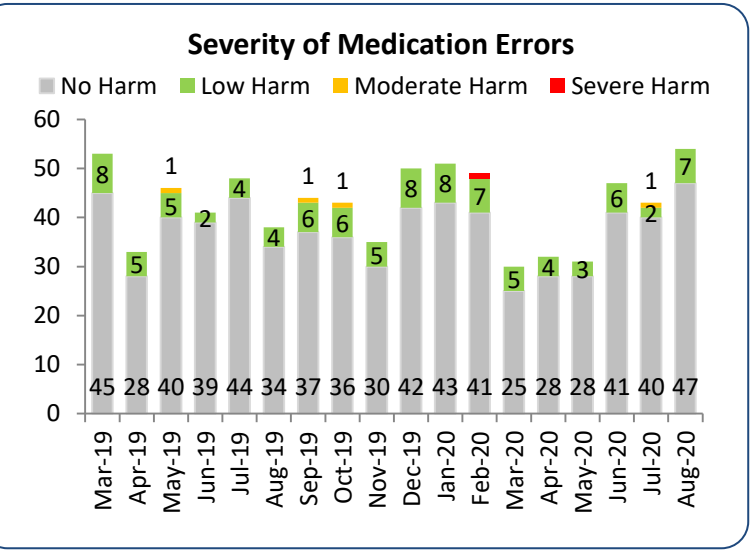
Safe	**5-17**	• Medication Errors • Health-Care Associated Infections • Falls • Pressure damage	• Never Events • Serious Incidents (SIs) • Patient Safety Incidents
Effective	**18-19**	• Mortality • HSMR • SHMI	• Learning from mortality council
Caring	**-**	• Friends and Family Test (Currently Suspended)	
Responsive	**20-21**	• Compliments • Informal Complaints • Formal Complaints	
Well-led	**22**	• CQUIN	

Integrated Quality and Learning Report

Medication Reporting

Safe





Medication Errors

July
- A total of 43 medication errors were reported in July 2020
- There was 1 moderate harm and 0 severe harm errors.

August
- A total of 54 medication errors were reported in August 2020.
- There were 0 moderate harm or severe harm errors.

- There have been an increase in reports relating to Insulin equating to 22% of the medication incidents reported in August 2020.
- Following recent initiatives to increase awareness of insulin errors and the importance of reporting, we suspect this is a reflection of increased reporting.
- A large proportion of the incidents relate to the clerking and prescribing process and the following actions have been taken:

    - All insulin related Datix reports are now reviewed by the MSO (medicines safety officer) and our specialist diabetes pharmacist, in conjunction with the diabetes team to identify themes and learning.
    - New resources are being distributed across the wards to support safer insulin prescribing and administration.
    - Individual feedback is given to our prescribers to raise awareness and discuss human factors to inform our going safety initiatives.
    - Additional medicines safety training has been arranged for our F1 and F2 medical colleagues delivered by the pharmacy team tailored to the groups needs.
    - Standardisation of insulin descriptions across our EPMA system.

Duodopa is a specialist treatment used for the management of complex Parkinson's disease (PD) for which there has been an increase in incidents.

- Work is underway with the PD and Pharmacy teams to produce a guideline on the safe management of patients prescribed this treatment.

Integrated Quality and Learning Report

Healthcare Associated Infections

August 2020

Safe

NHS
Gateshead Health
NHS Foundation Trust

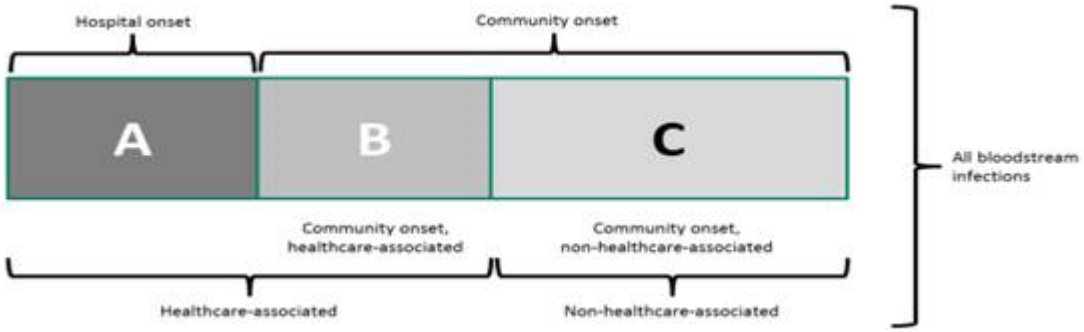
From August 2020 the reporting process for blood stream infections (BSI) changed to reflect the categories against which the anticipated objectives will be set. Therefore, from the end of July 2020, BSI are no longer reported as Hospital onset/Community onset but rather as Healthcare associated and Community Associated (non-healthcare associated) and it is anticipated the Trust objective will be set against the Healthcare associated category.

The Healthcare associated category comprises

- Hospital onset – Healthcare Associated (HOHA) – when the sample is taken 48 hours following admission (equivalent to the previous Hospital onset category)

and

- Community onset – Healthcare Associated (COHA) – when the sample is taken within the first 48 hours following admission and the patient has undergone an healthcare intervention in the preceding 28 days prior to the sample collection



Due to these changes, from August 2020 it is not possible to draw a direct comparison between the previously reported Hospital onset/Community onset BSI and new Healthcare associated categories, therefore subsequent IQLR will be against the updated categories

Integrated Quality and Learning Report

Safe

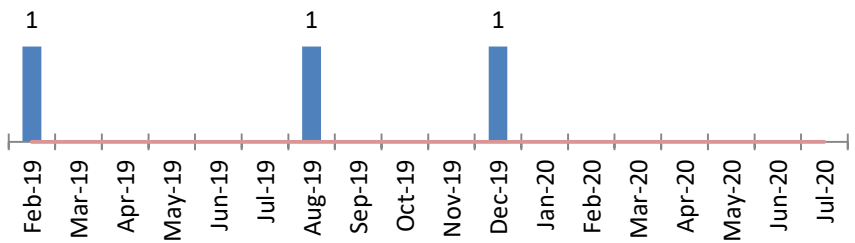
Healthcare Associated Infections
MRSA & nosocomial COVID-19

Gateshead Health NHS Foundation Trust

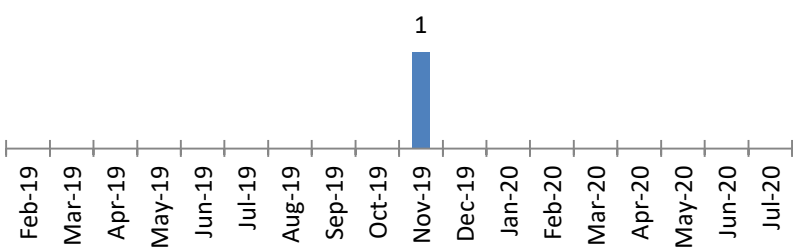
The Trust adopts the national aspiration of a zero tolerance to all avoidable infections including MRSA blood stream infections (BSI).

The trust has had zero incidence of hospital onset or Community onset MRSA BSI in 2020-21.

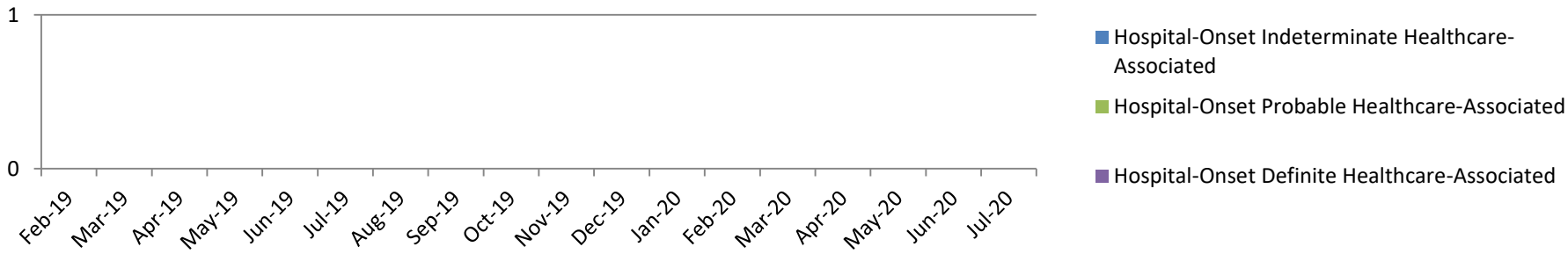
MRSA BSI Community Onset



MRSA Acute BSI – Hospital Onset



nosocomial COVID-19



Nosocomial COVID 19 cases
The Trust has had zero incidence of nosocomial COVID-19

Integrated Quality and Learning Report

Safe

Healthcare Associated Infections

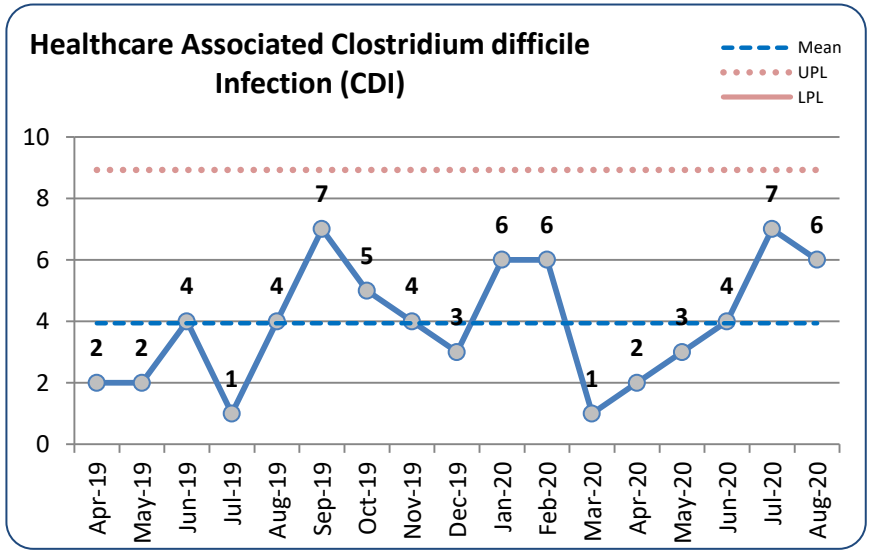
Clostridium Difficile

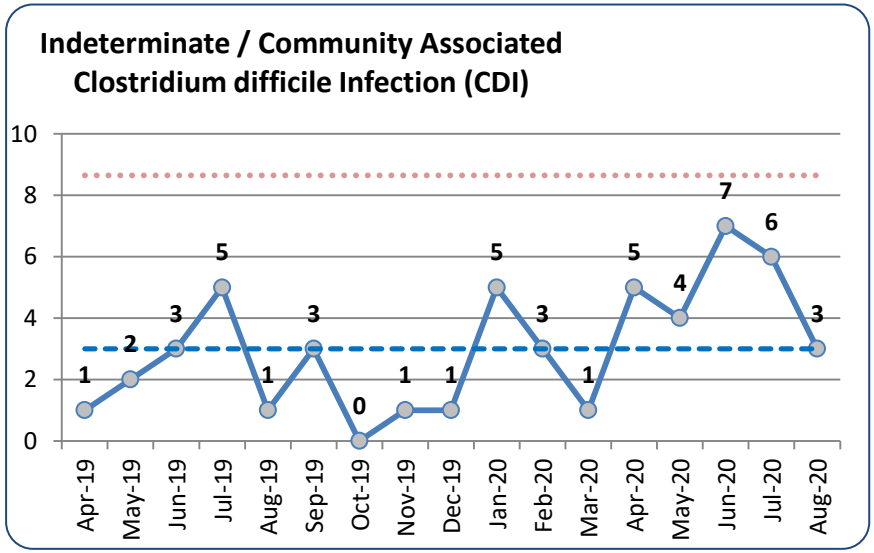
Gateshead Health NHS Foundation Trust

For the period 01/04/2020 to 31/08/2020 the Trust has reported 22 healthcare associated CDI.
Review of the cases identified there was learning around timely stool submissions, poor communication and incomplete documentation.
The findings have been fed back to the relevant teams.

The increase in incidence of CDI is also reported by other trusts in the region .

NHS England/NHS Improvement has not yet published the CDI objectives for 2020/21





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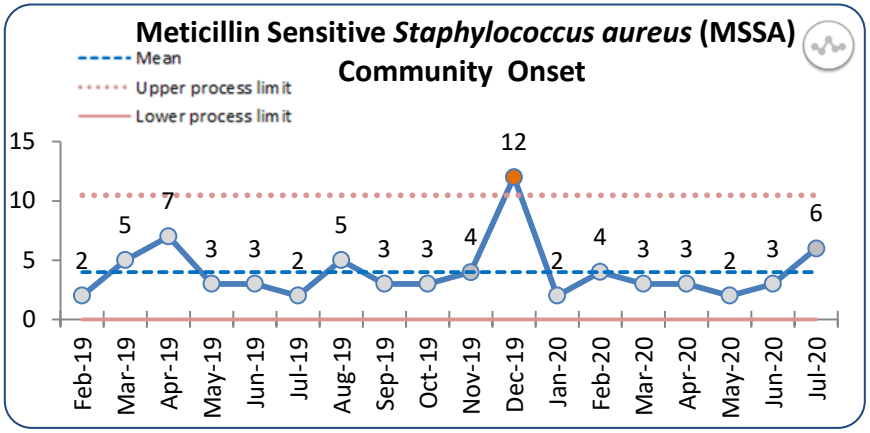
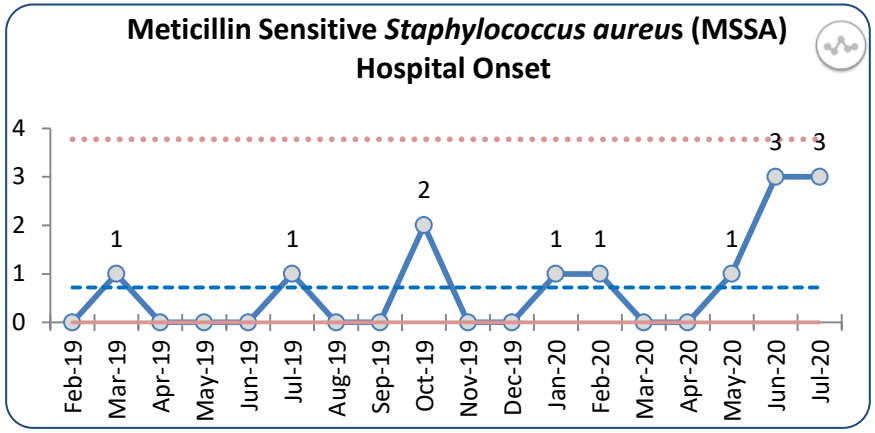
Healthcare Associated Infections

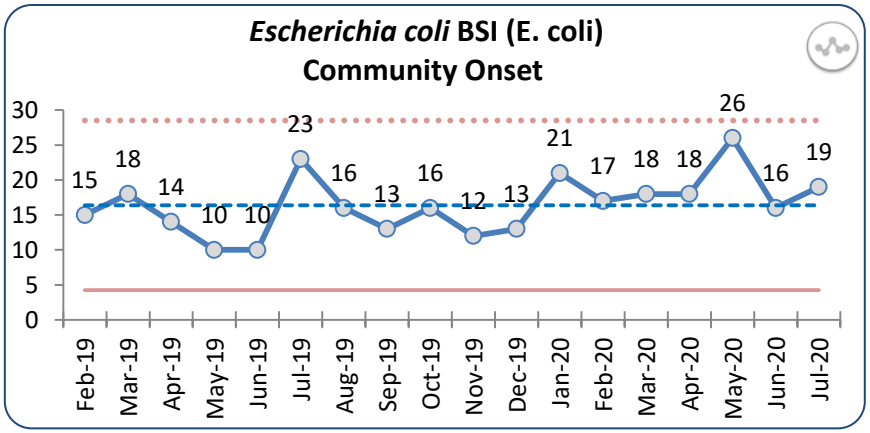
MSSA & E Coli

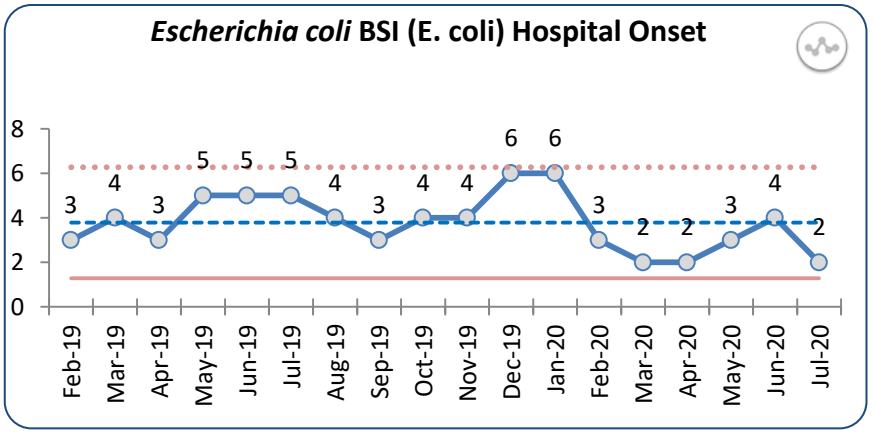
Safe

Gateshead Health NHS Foundation Trust







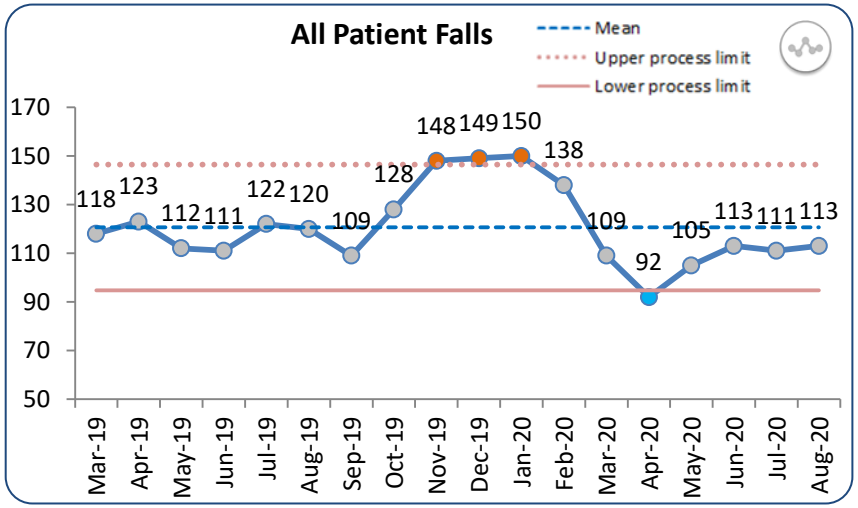


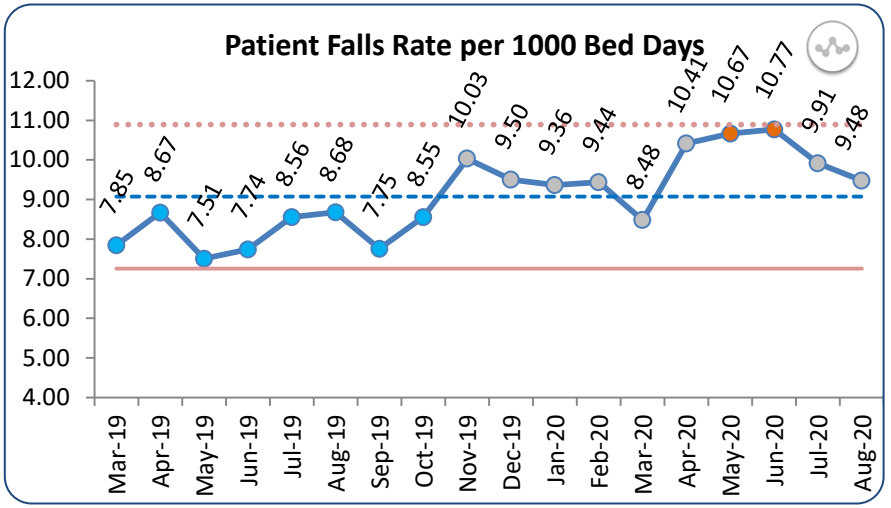
Normal variation observed for MSSA BSI and E.coli BSI.
Data here is provided against the classification of Hospital-onset and Community-onset, however subsequent reports will provide the data against the revised classifications of Healthcare associated.

Integrated Quality and Learning Report

Falls

Safe





Patient Falls – statistics and learning

- August 2020 – 113 falls reported; 88 no harm, 23 low harm; 1 moderate harm; 1 death. The moderate harm fall resulted in a fractured pubic rami, not requiring any surgical intervention; the fall which resulted in death involved a patient who was admitted following a fall in the community setting and had an unwitnessed fall whilst an inpatient. A traumatic subdural haematoma was identified on CT scan and the patient died later that day. Investigations are ongoing in both of these incidents which occurred on Care of the Elderly wards.

- July 2020 – 111 falls reported; 88 no harm, 20 low harm; 2 moderate harm; 1 severe harm. The injuries caused by the falls which resulted in moderate harm included a fracture of the humerus and a head injury. The fall resulting in severe harm resulted in the patient suffering from a fragmented intertrochanteric fracture of the femur.

- Analysis of the Trust's performance against the CQUIN target '3 high impact actions to reduce hospital falls' has demonstrated that the Trust is performing poorly nationally in relation to taking the lying and standing blood pressure on admission and therefore actions to address this are essential. The Falls Team are looking to develop an electronic falls risk assessment within Nerve Centre which will make the recording of a lying and standing BP mandatory however until this is developed, all staff need to remember to perform this.

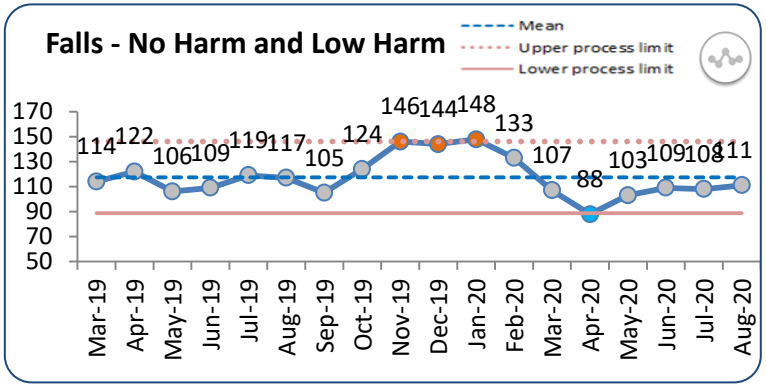
Integrated Quality and Learning Report

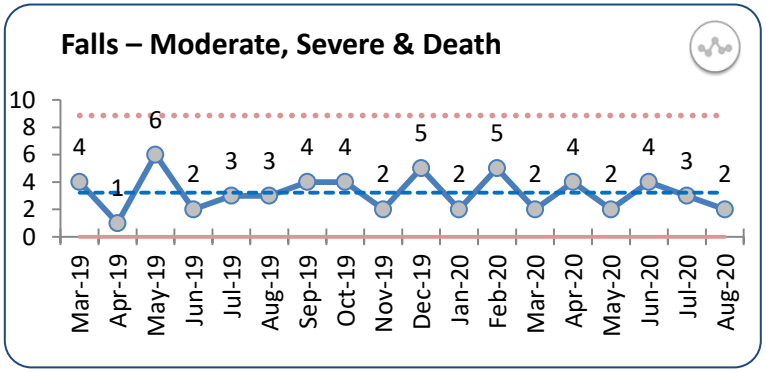
Gateshead Health NHS Foundation Trust

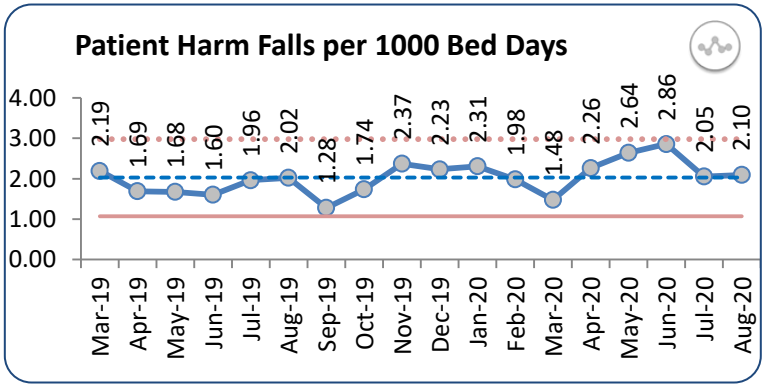
Datix Software for Patient Safety

Falls

Safe







Further learning from Inpatient Patient Falls

Due to the suspension of a number of elective activities and also the reduced bed occupancy, the total number of inpatient falls reported has decreased.

The actual inpatient falls rate remains within normal variation.

The Inpatient Falls panel was reinstated in June 2020 following its suspension during Covid-19. To address the backlog in cases which arose from the pausing of routine incident investigations, an additional panel was held at the end of July.

One of the key findings from investigating severe harm falls involves the omission of performing a lying and standing blood pressure on admission and ensuring that this information is shared when patients are transferred between wards.

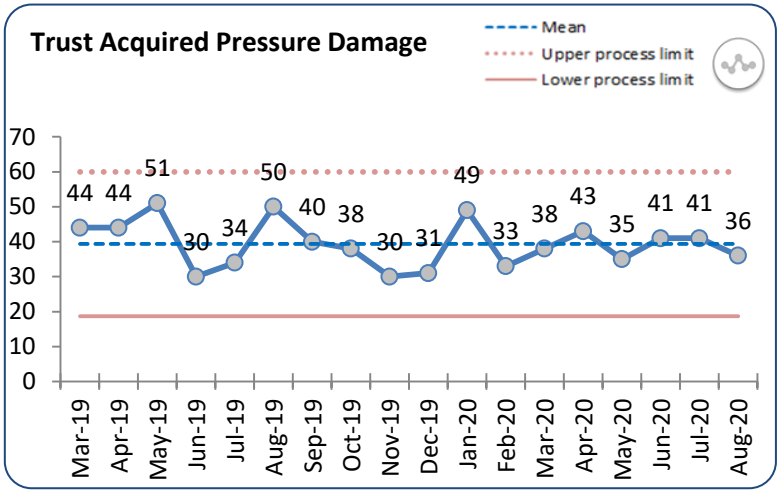
Another key finding is the transferring of patients from the floor to their bed without using the hoverjack equipment.

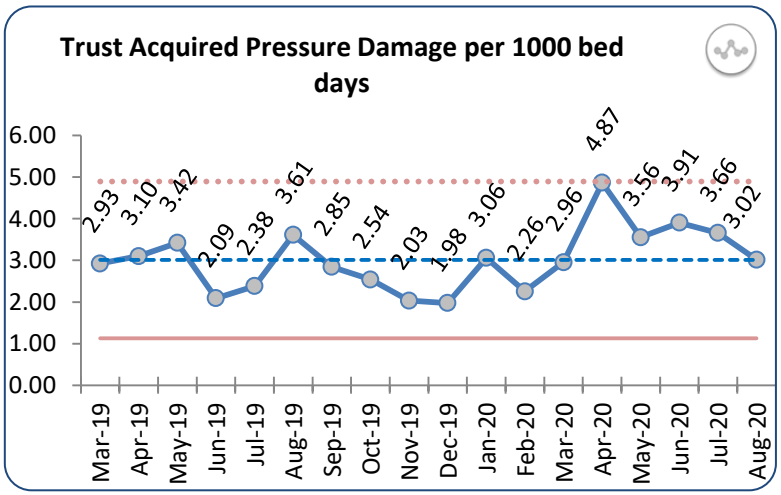
The Trust Falls Group is exploring a number of communication strategies which can be adopted to raise awareness of these issues such as screen savers and QE Weekly. In addition to these, the falls team hope to identify Falls Champions within the acute setting to support staff in training needs related to falls prevention including the care of a patient immediately following a fall and performing lying and standing blood pressure.

Integrated Quality and Learning Report

Trust & Hospital Acquired Pressure Damage

Safe





Trust Acquired Pressure Damage
(Category 2 and above including deterioration, unstageable and deep tissue injuries)

Please note that these figures include pressure damage acquired in both acute and community settings whilst under the care of the Trust.

- Common cause variation is currently displayed in the rate of Trust Acquired pressure damage per 1000 bed days
- 41 incidents of Trust acquired pressure damage were reported in July 2020, and 36 incidents reported in August.
- The breakdown of August pressure damage is provided below:
- 6 incidents observed in an acute setting
    - 3 x category 2
    - 1 x device related category 2 during Trust care
    - 2 x unstageable
- 30 incidents observed in a community setting during Trust care
    - 25 x category 2
    - 2 x unstageable
    - 2 x deep tissue injuries
    - 1 x deterioration to category 2 during Trust care

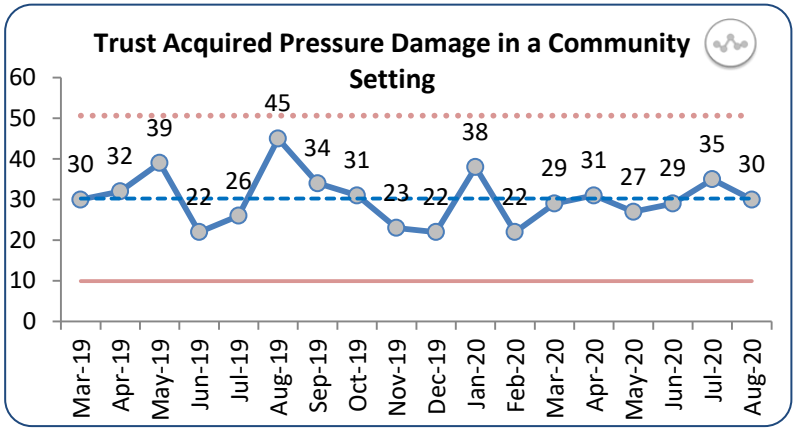
Integrated Quality and Learning Report

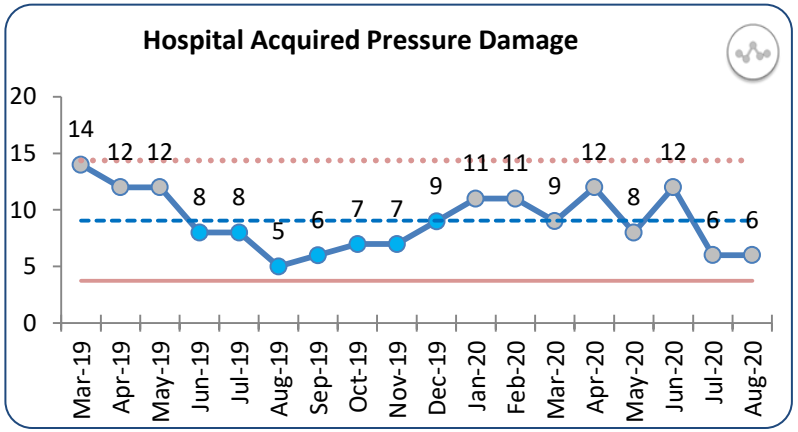
Gateshead Health NHS Foundation Trust

Datix Software for Patient Safety

Safe

Trust & Hospital Acquired Pressure Damage





The monthly reporting of pressure damage has not changed significantly and demonstrates common cause variation in both the community and hospital setting. Reviews undertaken by the Tissue Viability Nursing Team have demonstrated a training need in relation to the identification and grading of moisture lesions and grade 2 damage occurring within the community: the team will provide sector-based sessions to support staff with recognising the differences between the two types of damage.

The Pressure Damage panel was reinstated in June 2020 and has been held monthly. Key learning from these investigations includes the requirement to evaluate the training and uptake of training available to staff and to consider alternative ways of offering training such as a blend of face-to-face and e-learning. The TVN Nursing team will continue to support training by providing formal sessions and also facilitate bedside training during joint visits with community colleagues.

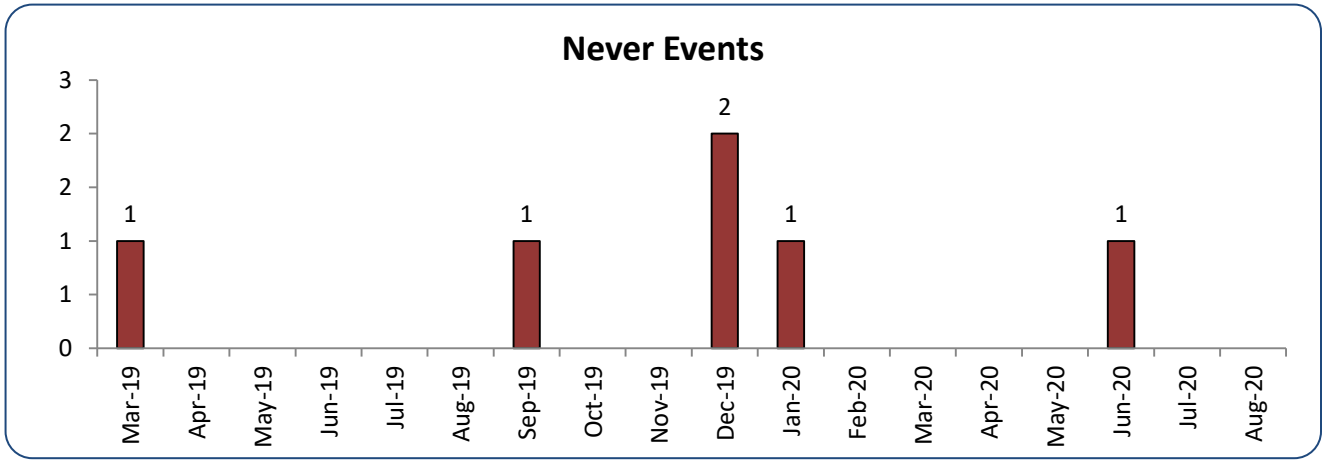
Documentation issues around the use of the Wound Care booklet and SSKIN bundle and supporting staff to care for patients with pressure damage who are not working in their usual work environment have also been identified as requiring action; these will be addressed by partnership working between the TVN Nursing team and ward/community staff.

Integrated Quality and Learning Report

Never Events

Safe

Never Events are defined as Serious Incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
The Trust operates a zero tolerance approach to Never Events. When Never Events occur a comprehensive investigation is undertaken to identify learning and implement appropriate actions.



Never Events

- June 2020 - Incorrect equipment / medical device used – Severity None/Negligible
- January 2020 – Wrong site surgery carried out.
- December 2019 – 2 x Wrong implant/prosthesis identified from procedures undertaken in August and October 2015
- September 2019 – Overdose of methotrexate for non-cancer treatment (moderate harm)
- March 2019 - Wrong Patient for treatment/procedure (Low Harm)

Integrated Quality and Learning Report

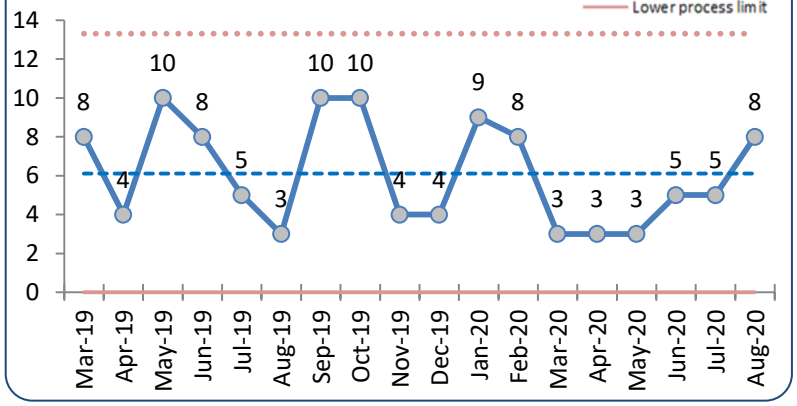
Serious Incidents

Gateshead Health NHS Foundation Trust

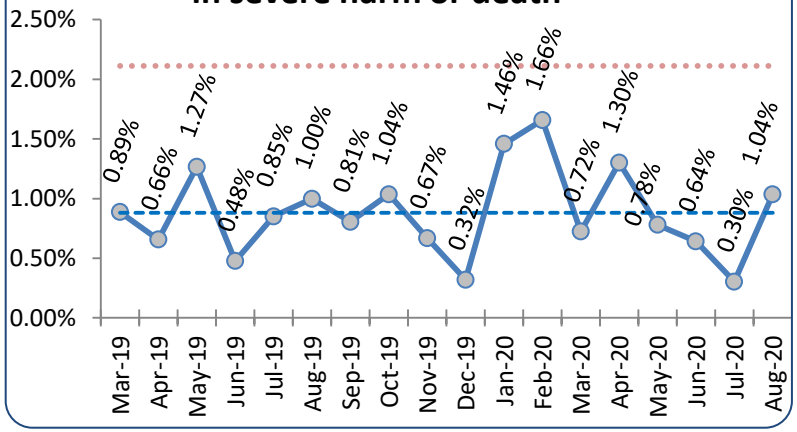
Datix Software for Patient Safety

Safe

Serious Incidents Reported to StEIS



% of Patient Safety Incidents that result in severe harm or death



Serious Incidents Reported to StEIS

July 2020 5 serious incidents reported

- 2 x Deterioration to Category 3 during trust care (community setting) (Moderate harm)
- 1 x Unnecessary exposure to radiation
- 1 x Apgar score <7 at 5 minutes
- 1 x Fall from height – bed

August 2020 8 serious incidents reported

- 2 x Fall from height – bed
- 1 x Fall on same level - cause unknown
- 1 x Tests - failure / delay in requesting
- 1 x Diagnosis - delay / failure
- 1 x Trust acquired (community setting) - Category 3 (Moderate harm)
- 1 x Trust acquired (community setting) - Category 4 (Severe harm)
- 1 x Deterioration to Category 3 during trust care (community setting) (Moderate harm)

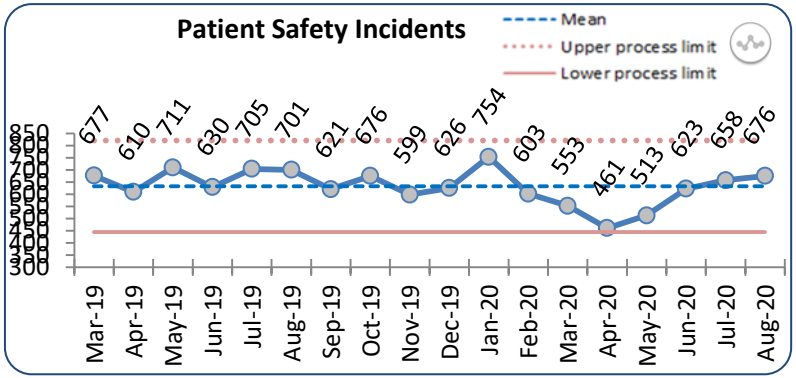
Learning from Serious Incidents Review

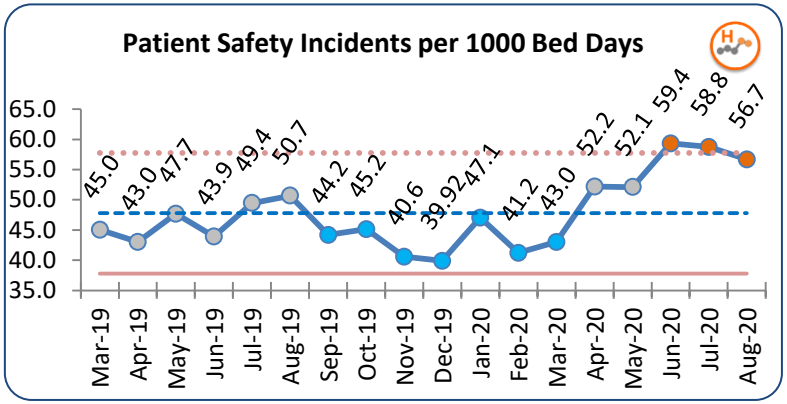
The Serious Incident Review Panel was reinstated in June and has occurred each fortnight; 26 incidents have been presented, either for discussion around the severity of the incident or for final presentation.
An extraordinary panel was convened to receive the final reports for two maternity cases reported to and reviewed by HSIB; a third report currently in draft was discussed however a number of amendments were requested by the Maternity team before agreeing the report as complete.
Following the death of a patient who had taken an overdose; the investigating team identified that input from senior staff and PLT needed is essential in decision-making around capacity assessment and treatment.
The findings also recommended that training was required for staff around increasing awareness of MCA1 & 2 supported by both PLT and the safeguarding teams.

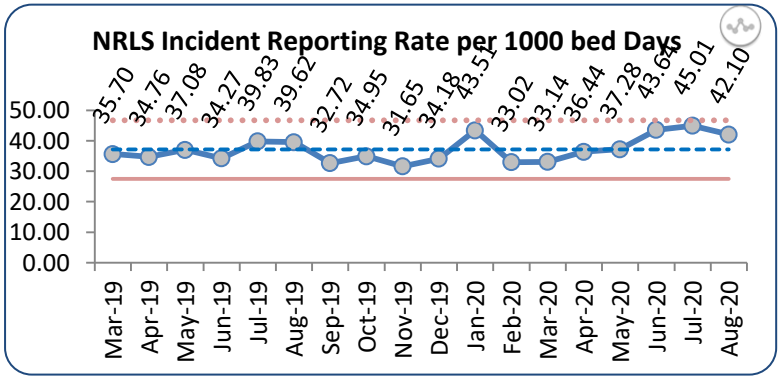
Integrated Quality and Learning Report

Patient Safety Incidents

Safe







Patient Safety Culture

The NRLS (National Reporting & Learning System) incident reported rate was 42.10 incidents per 1000 bed days in August 2020.

Patient Safety Incidents

- 658 patient safety incidents reported in July 2020
- 676 patient safety incidents were reported in August 2020

- The top 5 incident types for August 2020 are listed below:
  - Pressure damage
  - Patient falls
  - Medication
  - Delay / failure to treat / monitor
  - Discharge or transfer issue

Learning from Patient Safety Incidents

Analysis of the data demonstrates that the incident reporting rate has started to return to pre-Covid-19 levels; however there has been fewer patient contacts within the organisation demonstrating special cause variation in patient safety incidents per 1000 bed days.

The range of incident category is very general, with no variation observed regarding trends.

This may be explained by staff having more time to report patient safety incidents as patient contact is reduced however this requires close monitoring by Business Units and the Patient Safety Team.

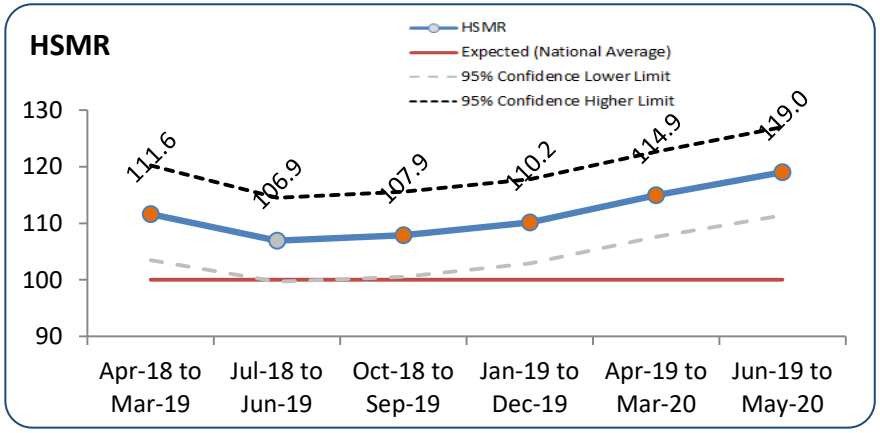
The Trust also saw a decrease in the number of incidents sent for investigation by Primary Care between April and June as priorities were focused on pandemic response activity however thematic analysis of incidents which were forwarded for information and awareness has continued. Key trends identified included an increase in the number of patients breaching the 2 week waiting appointments particularly for lower GI referrals and duplication of information n being sent to Primary Care has also been identified including discharge summaries and clinic c letters being sent out more than once. Issues will be shared with the departments involved to determine action taken in response to these themes.

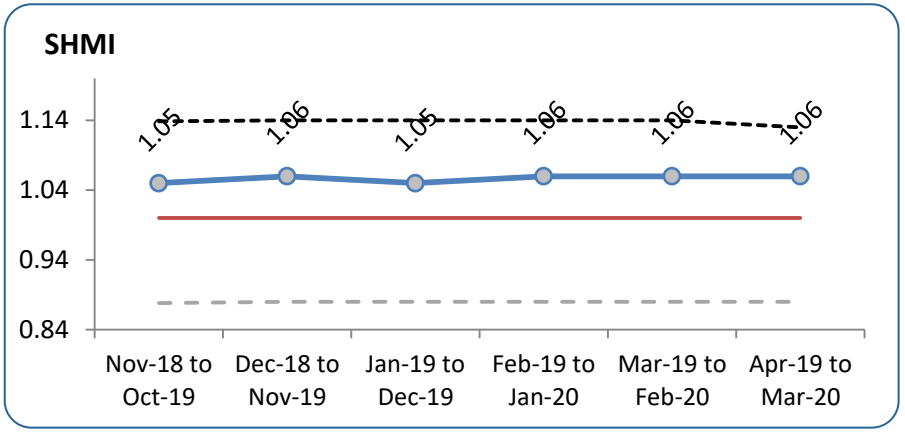
Integrated Quality and Learning Report

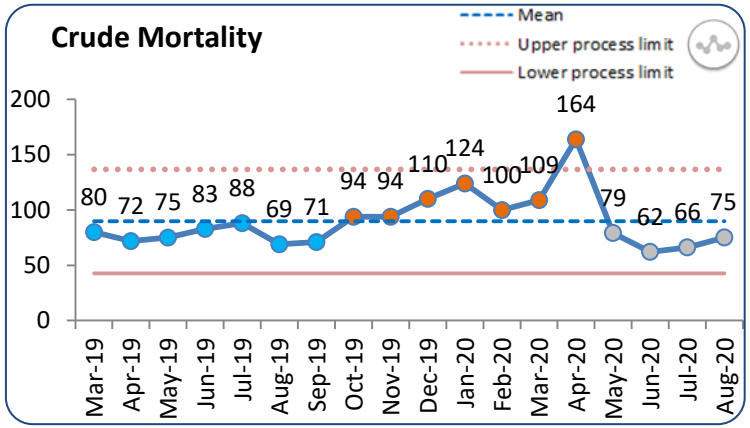
Gateshead Health NHS Foundation Trust

Effective

Mortality







Mortality Review

Period: August 2019 to July 2020

	Deaths in period	Deaths reviewed	%	Hogan 1	Hogan 2	Hogan 3	Hogan 4	Hogan 5	Hogan 6	Potentially Avoidable Deaths
All Deaths	1236	829	67.1%	97.8%	1.6%	0.5%	0.1%	0.0%	0.0%	0.1% (1)
Learning Disability Deaths	7	5	71.4%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

- HSMR – For the most recent 12 months the Trust is demonstrating more deaths than expected. A meeting was held with the Head of Cancer, where it was agreed that all alerts relating to cancer would be shared with them for review. To ensure appropriate level of scrutiny in relation to mortality alerts, deaths that have been highlighted via mortality alerts (both HSMR or SHMI) identifying where they have been more deaths than expected in particular diagnosis groups will be reviewed by the Mortality Council as well as the Level 1 review on the ward area. This may be all deaths or a sample depending on volume.
- SHMI – The Trust has consecutive scores of over the England Average (1) and has a banding of 'As Expected'.
- The number of inpatient deaths is showing special cause variation trend between October 2019 and April 2020. The April figure includes 100 COVID-19 Deaths.

Integrated Quality and Learning Report

Gateshead Health NHS Foundation Trust

Effective

Mortality

Learning from Mortality Council

The Mortality Council in July was dedicated to reviewing a sample of Covid-19 deaths. 13 deaths were reviewed, the scores of which were;

Hogan 1	Hogan 2	NCEPOD 1
10	3	13

One of the cases originated as a formal complaint, the Council found that there was lots of discussions documented with the family in this very complex case and no issues were identified with the care given.

Good practice identified:
Documentation of discussions with family
Appropriate use of palliative care team and pathways
Appropriate use of swabbing, PPE and restriction of visitors
Patients isolated appropriately when became symptomatic
Rapid release of body was not affected

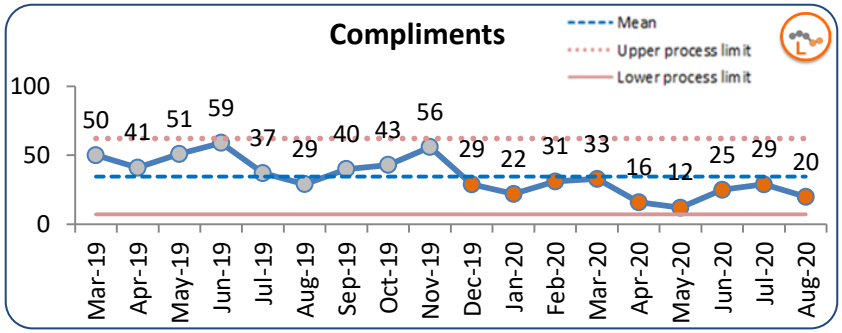
Learning:
In 3 cases, it was unclear whether Covid-19 was contracted in hospital, investigations have been begun in these cases and will be reported back once completed.

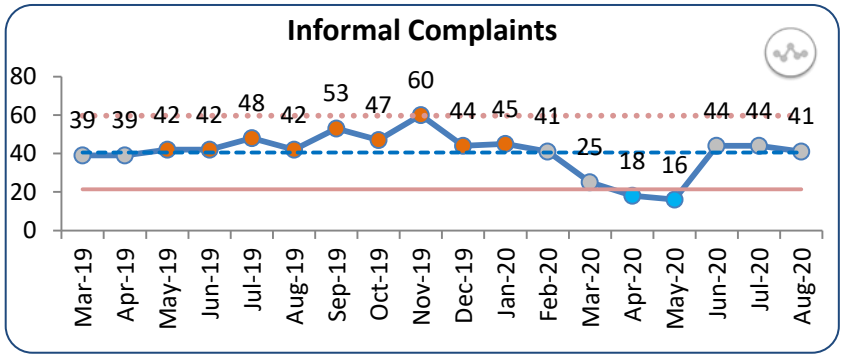
LeDeR Reviews:
Six members of staff have volunteered and been allocated to assist the CCG with the backlog of LeDeR reviews. They are required to complete an e-learning package and will then be allocated to review cases. This knowledge will benefit the Trust by enhancing the current mortality review process particularly in relation to learning disabilities.

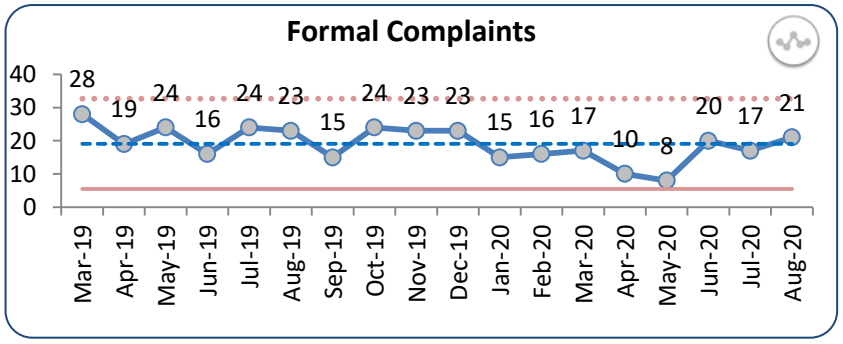
Integrated Quality and Learning Report

Learning From Compliments and Complaints

Responsive







The Top 5 themes identified in complaints were:

- Clinical Treatment (3 complaints including actions not carried out, inappropriate treatment)
- Values and behaviours of staff (3 complaints including poor attitude)
- Admissions, discharge and transfers (2 complaints about inappropriate discharge)
- Clinical Treatment (2 complaints in Obstetrics & Gynaecology and surgical Group)
- Communication

Breakdown of Formal Complaints by clinical area:

Emergency Care (4)
Trauma & Orthopaedics (3)
General Surgery (2)
Theatres & Anaesthetics (1)
Acute Medicine (1)
Respiratory (1)
Care of the Elderly (3)
Obstetrics (2)
Mental Health (2)
Facilities (1)
Paediatrics (1)

Learning from Complaints

A patient was having ongoing issues with urination however staff did not have easy access to a bladder scanner device for use on their ward despite urinary retention being suspected.

The ward plan to order a bladder scanner and have received quotes for a it to be kept exclusively on their ward and hope to proceed with the purchase soon. The Ward Manager has engaged in further education with the nursing team on the ward around urinary retention, and the importance of closely monitoring and documenting urine output.

Integrated Quality and Learning Report

Learning From Compliments and Complaints

Responsive

Gateshead Health NHS Foundation Trust

Datix Software for Patient Safety

Planned work

Patient Experience Feedback on virtual clinic appointments with the Outpatients Department

A body of work is planned between the Patient Experience Team and the Outpatients Transformation team to undertake an impact assessment of the recent service developments in the Outpatients Department, who during COVID-19 began to offer virtual clinic appointments via Attend Anywhere. This body of work aligns with the Phase 3 letter that the Trust received and the feedback from patients will influence Trust decisions regarding future service delivery.

It is anticipated that this will involve a multi layered approach to patient experience feedback data collection which will use both a text message questionnaire and in-depth qualitative interviews with a smaller cohort of patients to explore a range of topics including satisfaction with the service as well as accessibility.

Review of the internal complaints policy

An internal review is being undertaken of the Trust's complaints policy and process to ensure the allocation, investigation and subsequent development of a complaint response is appropriate and escalation is undertaken as required. The Trust have approached Northumbria NHS Trust to undertake an external review of the Trust's handling of one complaint , demonstrating transparency and a willingness to learn and improve. The learning and recommendations from both reviews will influence the development of the new complaints policy.

Integrated Quality and Learning Report

Gateshead Health NHS Foundation Trust

Well-led

National Acute & Community CQUIN 2020/21

Following advice from the CCG stating that a CQUIN 'holiday' had been implemented for Q3 and4 of 2019/20 and Q1 2020/21, further guidance has been published to confirm that the CQUIN scheme will remain suspended for all providers for the remainder of the year.

Gateshead Health NHS
NHS Foundation Trust

Trust Board

Report Cover Sheet

Agenda Item 17

Date of Meeting:	28 September 2020		
Report Title:	SIRO Report 2019-2020 SIRO Update – September 2020		
Purpose of Report:	To provide the Finance and Performance Committee with a statement of assurance on Information Governance issues across the Trust including the submission of the Data Security and Protection Toolkit		
Decision:	**Discussion:**	**Assurance: X**	**Information:**
Corporate Objectives report relates to: (Including reference to any specific risk)	Data Security and Protection Toolkit (DSPT) Compliance with Data Protection and General Data Protection Regulation Information and Cyber Security requirements		
Recommendations: (Action required by Board of Directors)	The Finance and Performance Committee is requested to receive this report and agree to the DSPT compliance submission as required by NHS Digital.		
Financial Implications:	None		
Risk Management Implications:	Compliance with confidentiality, data protection, information security, freedom of information, records management and data quality standards.		
Human Resource Implications:	None		
Equality and Diversity Implications:	None		
Author:	Nick Black, Chief Digital Information Officer and Senior Information Risk Officer.		
Presented to:	Finance & Performance Committee		

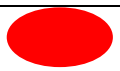
Senior Information Risk Owner (SIRO)
Information Governance Assurance Statement – September 2020

The Information Governance Assurance Group has fulfilled its role and functions as defined within its terms of reference. The national deadline for achieving DSP Toolkit requirements for 2019-20 was extended to 30 September 2020, this report therefore closes 2019/20 and updates to the end of September 2020. The focus of the IG Team remains on improving the effectiveness and raising awareness of Information Governance and Information Risk, throughout the Trust.

The 2019-20 SIRO Report is attached below; the current assurance levels are shown below.

Assurance to F&P	Assurance level	Committee update	Next action	Timescale
DSPT Compliance		Information Governance Training There is a national requirement that 95% of all staff will have completed training annually. The Trust is just failing to achieve this target which currently stands at 94.1% (need 38 more people)	Individual emails, and escalation to CMT	30/09/2020
		Annual Pen Test – Completed	Schedule next Test	Annual
BCP Exercise		BCP Completed on 01/09/2020	Implement mitigation and schedule follow up	Ongoing
Cyber Security.		Cyber Essentials Plus is a standard which has to be achieved by all Trusts by June 2021. (77% complete as of 18/09/2020)	Submission to NHS Digital.	Ongoing
Information Asset Register/Data Flow Maps.		Reviewed for 2019-20	Annual continuous reviewing process implemented	Ongoing
IG Incidents		3 incidents reported to ICO – All investigated and no further action taken	Annual continuous reviewing process implemented	Ongoing
FoI Requests		FoIs are being answered on average in 7-9 days from receipt	Annual continuous reviewing process implemented	Ongoing

Assurance Key

	Level of Assurance
	Assured – there are no gaps in assurance and no issues of concern
	Partially assured – there are gaps in assurance but we are assured appropriate action plans are in place to address these
	Not assured – there are significant gaps in assurance and we are not assured as to the adequacy of current action plans

REPORT – FOR INFORMATION

SIRO Report 2019-20

Prepared for the Information Governance Assurance Group (IGAG)

Purpose of Document:	This report is to inform of progress against the Information Governance (IG) work programme, in 2019-20, and to outline the key priorities and associated work programmes.
Actions required:	IGAG is also requested to note the report recommendations and the key areas of work for the coming year.
Author:	Dianne Ridsdale, Information Governance Officer
Date of IGAG Meeting	19/05/2020

Contents

1. Data Security and Protection Toolkit (DSPT)

The DSPT is an online self-assessment tool that allows the Trust to measure its performance.

The toolkit was audited by AuditOne in January 2020 and the final report highlighted one action regarding IG training compliance figures. As a result of the COVID-19 pandemic, the following standards as at 31/3/20 were non-compliant:

3.3.1'At least 95% of all staff has completed their annual data security awareness training in the period 1 April to 31 March.'

- The Trust training figure is currently 85.70%.[1] The Information Governance team has been fully focussed on achieving this figure by devising two action plans, targeted emails to SLMs, managers and individuals; compilation and distribution of a workbook as an extra option for those staff finding it difficult to complete the training online; communications through QE Weekly, Staff Bulletin, Screen savers and IGAG/CMT reporting.

7.1 *'A continuity plan is in place to respond to threats to data security, including significant data breaches or near misses, and it is tested once a year as a minimum, with a report to senior management.' and* 7.2 *'There is an effective test of the continuity plan and disaster recovery plan for data security incidents.*

- Planned BCP exercise 10/03/2020 cancelled and not yet re-arranged due to COVID-19.

NHS Digital has extended the compliance period to 30/09/20.

2. Data Protection and Security Governance Assurances

The IG Team manages and maintains a register of data protection and sharing documents within the Trust.

The following table is a summary of the position in 2019-20:

Governance area	**Total number**	**Number approved/ reviewed/ updated**	**Number in draft/ in review**		
Information Sharing Agreements (ISA)[2]	27	18	9		
Data Processing Agreements (DPA)[3]	24	20	2	**Number outside the EU/EEA**	**Countries outside EU/EEA**
Data Protection Impact Assessments (DPIA)[4]	28	16	12		
Caldicott[5]	50	45	5	2	USA (age and sex) and Canada (anonymised)

[1] As of 01/04/2020

[2] ISAs are reciprocal agreements for the exchange of information between the Trust and other organisations.

[3] DPAs are legal agreements for the processing of personal information on behalf of the Trust by other organisations which stipulate how Trust information is processed in line with GDPR.

[4] DPIAs are a process which assists the Trust in identifying and minimising data protection risks that are likely to result in a high risk to individuals.

[5] Caldicott approvals are required when third parties require access to the Trust's patient data for non-care purposes e.g. research or conducting national surveys etc.

3. IG Spot Checks

General spot checks for both clinical and non-clinical areas for this period have taken place for 2019-20. There are no significant findings of concern to report.

4. Data Protection and Security Incidents

All Information Governance incidents are reported through the Trust's incident reporting system, DATIX and after evaluation may be reported to the ICO:

IG Reported Incidents 2019-20		
Datix		
Total	Closed	Under Investigation
111	96	15
ICO		
Total	Closed	ICO Outcome
3	2	No further action required

Datix Incident ID	ICO Ref	Service	Summary of Incident	ICO Outcome
71305	IC-37350-L5S8	Paediatrics	Paediatric handover sheet found in Mothercare Team Valley	Further information requested
59518	IC-14114-J9V7	Endoscopy	Incorrect discharge documents given out	No further action
38812	IC-32348-R5N2	West Locality Team	Worksheet misplaced – outside of the Trust	No further action

5. Information Requests

The Trust has a statutory responsibility to comply with requests under the Freedom of Information Act 2000 and the subject access provisions of the Data Protection Act and the General Data Protection Regulation (GDPR).

SARs for the period 01/01/2019 to 31/12/2019		
Received	Late	Compliance %
1137	48	96
FoIs for the period 01/02/2019 to 31/01/2020		
Received	Late	Compliance %
595	32	94.62

6. System access management audit

This audit has highlighted through returns and communications with IAOs they are not monitoring or auditing systems where access controls are linked to Active Directory such as E-learning and ESR and it has been advised and is recommended this is corrected as soon as possible as this does not provide assurance on relevant and appropriate access levels for those systems.

Gateshead Health NHS
NHS Foundation Trust

The below table is a summary of the findings within the last 6 months of the system access audits. Responses were not received for all the questions asked for those systems.
The incident in Carestream PACs occurred in the US where Sonographers were reporting on US studies in PACS using the account that was already logged in instead of their own. Gateshead Sonographers highlighted the practice to the system administrator who then logged a Datix and passed the incident through to the US manager to investigate.

Information System (Full Name)	**# of approved users[6]**	**# of privileged user**	**# of normal users**	**# of generic user accounts[7]**	**# of external user accounts[8]**	**# of un approved users[9]**	**# of inactive accounts [10]**	**# of accounts disabled/ deleted**	**# of generic user account disabled/ deleted**	**# of external user accounts disabled/ deleted**	**# of login sharing incidents**
BadgerNet	458	8	409	0	41	0	0	0	0	0	0
BlueSpier	710	3	702	3	2	0	95	252	0	0	0
Carestream PACS	1196	12	1162	15	7	0	0	1155	0	0	1
Carestream RIS	588	39	549	0	5	0	0	234	0	0	0
Cherwell	147	18	129	0	5	0	0	10	0	4	0
Click Travel	1012	11	1001	0	0	581	N/A	431	N/A	N/A	0
CLW Rota	64	8	56	1	1	0	4	0	7	0	0
COHORT	20	4	16	20	0	0	41	41	41	0	0
Dendrite Intellect	264	7	210	264	47	0	0	64	54	10	0
Directory Manager	17	1	16	0	0	0	0	0	0	0	0

[6] An 'Approved User' is an individual that has received authorisation to access data/systems.
[7] A 'Generic Account' **is an account which allows multiple users in a department or team to use one login to access the system with a designated owner managing access to this account.**
[8] An 'External User' is an individual outside the Trust and accesses systems/information to provide support, maintenance, contractual obligations etc.
[9] An 'Unapproved User' is an individual with an account and there is no approval evident
[10] An 'Inactive User' is an individual that has not accessed their account for the specified period within their user agreement/system policy i.e. 30 days

Information System (Full Name)	# of approved users[6]	# of privileged user	# of normal users	# of generic user accounts[7]	# of external user accounts[8]	# of un approved users[9]	# of inactive accounts [10]	# of accounts disabled/ deleted	# of generic user account disabled/ deleted	# of external user accounts disabled/ deleted	# of login sharing incidents
DSR3	2	2	0	0	0	0	0	0	0	0	0
DSR4	275	5	270	0	0	0	218	69	0	0	0
Email	4899	36	4863	334	0	0	1149	3377	0	0	0
Emis	708	22	686	0	1	0	480	480	0	5	0
Epix	3	3	Epix is a legacy system that only has minimal users and no reporting on old accounts								
Filefast	1695	11	1684	0	1	0	1233(462 active in last 30 days)	197	0	0	0
HED	12	1	11	0	0	0	9	8	0	0	0
ICE Desktop	5922	31	5890	29	1	0	7349	0	0	0	0
ICE Desktop HPV	5498	17	5480	2	1	0	8200	0	0	0	0
MARS	53	3	50	0	0	0	0	0	0	0	0
Membra	1	1	0	0	0	0	0	0	0	0	0
NHS Jobs	488	9	479	0	0	0	391	8	0	0	0
Olib Library	557	3	557	1	0	0	0	114 (removed by automatic process)	0	0	0
Ovid Library	891	3	891	891	0	0	0	Expired records manually deleted			

Information System (Full Name)	# of approved users[6]	# of privileged user	# of normal users	# of generic user accounts[7]	# of external user accounts[8]	# of un approved users[9]	# of inactive accounts [10]	# of accounts disabled/ deleted	# of generic user account disabled/ deleted	# of external user accounts disabled/ deleted	# of login sharing incidents
								after 28 days			
Practice Navigator	13	2	11	0	0	0	0	25	0	0	0
Premier IT	223	3	220	0	5	0	73	73	1	0	0
Radiology IEP	164	5	159	0	26	0	0	69	0	5	0
Roche cITM	212	15	198	14	1	0	55	0	0	0	0
SmartCard	2069	8	2061	0	0	N/A	N/A	N/A	N/A	N/A	0
SMOT	1	1	8	0	0	0	0	8	0	0	0
WardWatcher	109	26	83	0	0	109	48	48	0	0	0
WinCHILL	4	1	3	0	0	0	0	0	0	0	0

Gateshead Health NHS
NHS Foundation Trust

7. Top three risks

The top 3 risks on the Trust risk register are discussed at IGAG to give assurance to the Board that they being managed and reviewed:

Datix ref	Risk
1650	Contracts implemented without appropriate IG/IT requirements
2413	Training - general IG training plus specialist roles
Various	Cyber vulnerabilities

8. Key areas for the 2020-21 Data Protection and Security Programme

The below are the five key areas within the 20-21 IG work programme and areas 1, 2, 3 and 4 has a review paper attached as an appendix.

1. **Appendix 1: Standardised central process for all contracts, service level agreements, framework agreements etc. regardless of price**
   Any new processes, services, information systems need to be developed and implemented in a structured manner, to enable the Trust to comply with data protection and security requirements.

2. **Appendix 2: Training - reinforce staff ownership and responsibility**
   The requirement to have adequate Information Governance Training throughout the Trust is essential and this is something that must be maintained. Emphasis is required on staff responsibility and contractual obligations to ensure they are compliant each year and needs managing in line with Trust policy.

3. **Appendix 3: Embedding Information Asset Owners (IAO) leadership and ownership throughout the Trust**
   Work must continue to embed local data protection and security management structures across the organisation. Reviewing the current structure to implement a senior IAO level may encourage ownership and responsibility while also providing greater assurances in areas such as asset management, information flows, and encouraging regular audit reporting in all areas where information is processed for the Trust.

4. **Appendix 4: Embedding System Level Security Policies (SLSP)**
   SLSPs have replaced the system specific security policies within the Trust and are currently being tested before roll out.
   Roll out will require training and awareness of the new process and what it's purpose is as well as an understanding of responsibilities with IAO, IAAs and System Administrators.
5. **Cyber Essential Plus accreditation completion**
   The attainment of the cyber essentials plus accreditation will greatly improve the compliance with the national data guardian's 10 data security requirements.

9. Summary

This report highlights the work of the Information Governance Team within the Trust in 2019-20.
IG staff throughout the financial year has worked hard to ensure that the National Information Governance agenda has been adhered to including facilitating the completion of the DSP Toolkit.

The general public and media's awareness of data breaches is high and therefore there is a heightened awareness of the requirement for robust data protection and security processes. The Trust's standard of IG support remains high and includes effective support and facilitation of IG throughout the Trust by providing guidance, support and advice via various methods.

The key areas for the Trust and the SIRO are to continue to ensure compliance with the DSPT, obtain Cyber Essentials Plus accreditation, achieve full support of all IAOs and achieve IG training compliance to provide assurance to the Trust board.

10. Recommendations

1. Standardised central process for all contracts, service level agreements, framework agreements etc. regardless of price	• Central process for all contracts, service level agreements, framework services etc. regardless of price. • Sign off and agreements at Director level, by the SIRO and/or DPO. • Contract, agreements etc. are to be issued by the Trust as the controller.
2. Training - reinforce staff ownership and responsibility	• IG training risk currently sits under the IG team this is a corporate risk and should be moved and managed by L&D. • IAOs to review and implement managing staff training compliance practices in their areas. • L&D communicating that IAOs and their managers are responsible for staff training compliance in their areas.
3. Embedding Information Asset Owners (IAO) leadership and ownership throughout the Trust	• Introduction of SIAO role to provide greater IAO support and ownership for divisions in information risk management. • SIAO responsible for reporting assurance and issues to SIRO through IGAG attendances.
4. Embedding System Level Security Policies (SLSP)	• IAO and IAA SLSP completions and reviews. • Cooperation between IAOs, IT Security Officer and IG with regards to.
5. Cyber Essential Plus	• Accreditation completion.

Appendix 1	Contract review paper  2019-20 SIRO Report Contracts Review Pap
Appendix 2	Training review paper  19-20 SIRO Report Training Review Pape
Appendix 3	IAO review paper  2019-20 SIRO Report IAO Review P
Appendix 4	SLSP review paper  2019-20 SIRO Report SLSP Review F

REPORT – FOR DISCUSSION and ASSURANCE

SIRO Report 2019-20
Data Security Standard 10 Accountable Suppliers

Prepared for the Information Governance Assurance Group (IGAG)

Purpose of Document:	To highlight the findings of the review of supplier and 3rd party processor agreements.
Actions required:	The IGAG is required to receive and acknowledge the report.
Author:	Rahima Oliver, Information Governance Manager
Date of IGAG Meeting	19th May 2020

Appendix 1: SIRO Report 2019-20 Data Security Standard 10 Accountable Suppliers

Contents

Introduction

The IG Team holds a record of IT systems and 3rd parties that process personal information - this is a statutory requirement under GDPR. The record details:

- Name of 3rd party
- The type of contract in place
- The personal information that is processed and why
- The contract duration
- IG due diligence undertaken

Contracts have been reviewed to ensure GDPR compliance as stated in Article 28 – we must only appoint processors who can provide "sufficient guarantees" to meet the requirements of the GDPR. Under the GDPR, data controllers (Gateshead Health NHS Foundation Trust) are responsible for their own compliance as well as that of processors. Due diligence includes:

- Data Protection Impact Assessment (DPIA)
- Third Party Supplier Security Questionnaire
- IT System Checklist
- Data Processing Agreement (DPA)

Background

The DPA, which is legally binding regulates the particularities of data processing – such as its scope and purpose – as well as the relationship between the controller and the processor. Depending on the type of 3rd party and service/system being procured, the DPA may form part of an SLA or Standard NHS Terms and Conditions contract.

The table below details below the types of agreements held by the IG Team and the current status of those:

Type of Agreement	Final	Unsigned	Draft	Not started	Grand Total
Data Processing Agreement	23	2	2	1	28
SLA	4		2	2	8
Standard NHS T&Cs	6	1	4	2	13
Grand Total	**33**	**3**	**8**	**5**	**49**

Where the agreement status is 'draft' or 'unsigned', they are being followed up to identify whether they are still required.

Where the agreement status is 'final', they are being reviewed to ensure they are relevant, adequate in terms of GDPR clauses and in date. Where there are discrepencies, appropriate due dillgence is being undertaken with contract variations being issued.

Where the agreement is 'not started' they are going through a procurement exercise.

Findings and issues

The key findings from the review of the agreements are discussed below:

Findings	Issues
1. Some agreements were issued by the 3rd party rather than by the Trust as data controller.	Contract protects us from our point of view and is not simply for the benefit of the data processor. Doing this could leave us vulnerable in certain situations. We as data controller issue the contract and due diligence documents. However, it may not always be possible to use our contract. Examples might include Microsoft and Salesforce, two processors where you are mandated to use their standard contractual terms. In this situation the proposed contracts should be reviewed and terms which are inconsistent with our organisational standards should be identified and the risks evaluated – and signed off by the SIRO and DPO.
2. When standard NHS T&Cs were issued there was no associated DPA completed.	If we don't specifiy what data is to be processed by the 3rd party, then we haven't fulfilled our responsibilities under the GDPR and can be punished in the event of a data breach regardless of how the breach occurred. The standard contract (whether that is a PO or framework agreement) is a lengthly document. There is a section that requires a DPA to be completed if the 3rd party is processing personal information as part of the agreement.
3. Lack of due dillegence undertaken on 3rd party systems and processes.	When reviewing whether a contract should be put in place with a 3rd party it is recommended that we: • Don't assume 3rd parties take security and compliance seriously, let alone are GDPR compliant. • Clearly define all of the areas and activities in which GDPR is in scope, and tha we have 3rd parties agree and provide signed contractual assurances. • Agree that 3rd parties will not outsource any GDPR-relevant scoped services without written approval. • Do our due diligence and regularly audit 3rd party processes.
4. Contracts/agreements are not managed centrally.	• They are signed off by various people across the organisation. • No corporate oversight/governance of what data is being processed by whom and for what purpose. • Inconsistent T&Cs as some agreements written locally which may not be legally binding.

Recommendations

1) Central point for all contracts, service level agreements, framework services etc. regardless of price and whether they go out to tender.
    a. There should be a single register of all contract types.
2) All agreements to be signed off at Director level, by the SIRO and/or DPO if data is processed.
3) Contract, agreements etc. are to be issued by the Trust as the controller.

Training Review Paper

Introduction

The following paper provides a review of Information Governance Training strategies adopted during 2019/20 and highlights the risks and proposed training strategy for 2020/21.

Background

It is a requirement of the NHS that 95% of staff have completed Information Governance (IG) training annually. The 95% training target was missed by the Trust in both 2017/18 and 2018/19. The information Governance Team therefore implemented several strategies throughout the year to achieve 95%.

IG Training during 2019/20

There were regular communications through QE Weekly, Screen Savers, Intranet and emails to managers which reminded staff to attend face-to-face training or complete ESR online training. This had little or no impact in improving the compliance rates, however provided evidence of accountability and ownership issues within departments which contradicts Trust Policy.

Throughout the first half of the year, face-to-face training sessions were delivered for both Induction and Core skills days. In autumn 2019 face-to-face training was removed requiring training to be completed online only.

During November and December the IG team emailed individual members of staff whose training had expired and those who had not yet completed in the financial year asking for training to be completed through ESR.

In February 2020 the alternative option of a workbook by email was offered to staff who were still non-compliant with training. This had minimal impact on the compliance figures.

In March 2020 staff remaining non-compliant were offered a short (5-10min) face to face presentation to complement the workbook. This however had to be suspended due to COVID-19.

Despite the different strategies implemented throughout the year, training compliance of 95% was not met.

Compliance rates during 2019/20		
	Year-to-Date	**Rolling**
17th October 2019	49%	79%
6th January 2020	68%	76%
31 March 2020	80%	80%

However, NHS Digital have extended the compliance period to 30/09/20. Therefore the 95% figure will be calculated over an 18 month period.

Ongoing Risks

At least 95% of staff must be trained in Information Governance in the financial year. The Trust's compliance remains significantly lower than the requirement.

A lack of knowledge increases the risk of data breaches and poor practice concerning data handling.

If training compliance remains under 95% the Trust risks not meeting the standards required by the DSPT and once again having to put in place an action plan.

If DSPT standards are not met this could affect the services provided by the Trust, its reputation as well as new contract and funding in some areas as:

- this will have to be declared in the Quality Account
- compliance is referenced in various other Trust publications
- unsatisfactory toolkit compliance will have to be declared to Commissioners/ Auditors/ Research Partners
- NHS Digital look at our toolkit compliance for the provisions of IT services including our N3 connection
- all the GDE documentation references the toolkit and that we are satisfactory
- if/when there is a data breach the Information Commissioners Office look at IG training compliance for an organisation

Recommendations

1) Learning and Development (L&D) to fully implement their training policy.
    a) Training non-compliance risk is to be assigned to L&D and managed at a corporate risk level.
    b) L&D to manage new starters compliance rates directly with line manager.
    c) L&D to manage a central communication programme and drive compliance with those areas consistently non-compliant.
    d) L&D are the central point for compliance queries for all staff.
    e) L&D supply accurate and up to date compliance rates from ESR to all staff.

2) IG team will assist the L&D team to implement their plan to achieve training compliance.
    a) The IG team will advise L&D of training options, content and resources available.
    b) Removal of year to date training figures external to the IG Team and the SIRO.
    c) RAG reported figures submitted to CMT uses the 85% as the Trust compliance target which needs to be changed to 95%.

3) Non-compliance with training to be reflected in staff annual review and pay progression.

4) Access request forms to systems which process staff or patient information to include a question on whether IG training is up to date. If this is not then access denied or revoked.

Appendix 3 - 2019-20 SIRO Report IAO review paper

Introduction

Data Protection and security awareness has increased throughout the UK since the introduction of the EU General Data Protection Regulation in 2018. The Trust has embraced the NHS information risk model which outlines and addresses responsibilities. However the current model does not support the practices within the Trust and requires essential development to strengthen ownership and accountability. This review paper recommends a new role of Senior Information Asset Owner (SIAO) to support the Senior Information Risk Officer (SIRO) with manging information risk management programme for the Trust.

Background

The information risk model adopted by the Trust is aimed at those responsible for managing information risk within the Trust and reflects Government guidelines which were adopted by the NHS. It introduced the roles of SIRO, Information Asset Owners (IAOs) and Information Asset Administrators (IAAs) for NHS organisations and understood that information risk should be managed in a robust way within work areas and not be seen as something that is the sole responsibility of IT or IG staff.

This structured approach relies on the identification of information assets and assigning 'ownership' of assets to senior accountable staff to allow for regular and consistent management and reporting. To date the IG team has been able to approximately identify 46 IAOs, 120 IAAs, 30 System Administrators (SAs).

The image below is the current information risk model:

Findings and Issues

This current model assumes the IG team are responsible for managing and facilitating the information risk programme. The IG team are responsible for providing support to IAOs as an advisory, guiding and support function.

The issues with this model are summarised below:

- Changes in senior roles in the organisation has meant that the right individuals may not have been identified as IAO/IAAs
    - Training as a result is out of date or not been delivered to the right individuals.
    - Lack of understanding of the responsibilities and accountabilities of the roles due to training.
    - Some IAAs stating they're "unaware" or "unsure" of who their IAO
- Little or no communication within divisions leading to:
    - IAO/IAA perception of the programme is incorrect
    - IAO/IAA ownership struggles and rejections of responsibility

  - Staff comments have been “I do not have time for any of this” “this has nothing to do with me” “I am not an IAO/IAA”
- The Trust is unable to provide full assurance across all areas of the Trust due to:
  - Staff engagement at IAO level is poor or none existent
  - IAO and IAA role fluidity impedes programme progression

Proposed model expectations

The image below is the proposed information risk model. Appendix 1 outlines the responsibilities.

- Removes the perception of IG team ownership of the programme and clearly places it within departments
  - The IG team will support the model when required
- Improved ownership, auditing, reporting and attendance to relevant meetings
- IAO and IAA role fluidity no longer an issue as additional support layer focused on supporting and driving the programme resulting in:
  - Clearly defined role structure improving ownership and management responsibility.
- Improved and clearly defined communication/support routes

Recommendations

1) IGAG to identify the SIAOs and agree implementation of the new model.
   a) SIRO to update SIAO staff of their role responsibilities
   b) Roles to be formalised into Job Descriptions
   c) IGAG to determine regularity of the SIAO group/forum chaired by the SIRO
   d) IGAG to determine the attendance requirements of SIAO/IAO to IGAG meetings to update on group/forum discussions and provide assurances
   e) SIRO to communicate out to approximately 46 IAOs, 120 IAAs, 30 SAs changes
      i) To the model
      ii) To their job description
      iii) Their SIAO contact
2) IGAG to determine and agree effectiveness measures and review period for the new model
3) IG team to devise a training package for SIAOs and update current training for the other roles to incorporate SIAOs

Appendix 1

New model role responsibilities outline

- The CEO is the 'Accounting Officer' and has overall responsibility for ensuring that information risks are assessed and mitigated to an acceptable level.
- The SIRO must provide the Accounting Officer with assurance that information risk is being managed appropriately and effectively across the Trust and for any services contracted by the Trust via the SIAO and IG Team.
- The SIAO understands, embeds and assists the SIRO and IAOs addressing risks to the information assets effectively through leading the programme.
- The IAO is responsible for all information assets under their management and must understand what information is held, what systems they manage, what is shared, how information flows, who has access etc. while ensuring all risks are identified and managed with support via their SIAO.
- The IAA ensures that policies and procedures are followed, recognises actual or potential security incidents, consults with their IAO on incident management, and ensures that information asset registers and data flow maps are accurate and up to date for all their assets with support from their IAO.
- The SA ensures the management and maintenance of the information systems they manage through auditing and reporting with support from their IAO.
- The IG team support the model by collating and reporting assurance to the SIRO through IGAG and provide training and support to staff within these roles.

Appendix 4 - 2019-20 SIRO Report SLSP Review Paper

Introduction
All NHS organisations should be proactively assessing, monitoring and managing the risks associated with their information systems. NHS information assets/IT systems are considered key components of the UKs NHS infrastructure and the Information Asset Owner (IAO) responsible for each information system must ensure that all risks are identified and all reasonable measures are taken.

Background
System Specific Security Policies (SSSPs) have been used within the Trust to support the Information Risk Management Programme and OP06 IT and Information Security Policy. IAAs have highlighted lack of support and understanding of the document; it's cumbersome to review and is often left to last minute as it's not a task they want to complete.

Findings and Issues
The main issues identified from discussions with IAAs:

- The Trust does not have a comprehensive list of systems in use
    - Incapable of identifying all systems used
    - Unable to understand vulnerabilities of the systems used
    - Ineffective management of systems and the information they contain
    - Comprehensive assurances on risk unattainable
- The Trust does not have a comprehensive contact list of IAOs, IAAs and SAs
    - Responsibility and ownership of systems is not clear and defined
    - Difficulties understanding which staff will require specialised training and understanding of their responsibilities to the systems they own/manage
    - Inappropriate management of systems and the information they contain
    - Unmanageable risk to the Trust and the information it holds
- Staff finding the SSSP document difficult to use, review and understand
    - Comments such as "we quickly scan and re-date", "we update what we know has changed and don't review the rest of the document", "It's a dreaded task"

The SSSP was revised with a new System Level Security Policy (SLSP) inclusive of a Procedure, Template and Risk Assessment.

Recommendations

- Redesign the information risk management model to include an extra layer of support to IAOs to encourage accountability and responsibility at IAO level to allow for:
    - Clearly defined reporting and responsibilities
    - Centralisation of system management making the SLSP the 'master document' for that system
    - IAOs acquire greater understanding and ownership to support IAAs and SAs with the management of SLSPs

- SIAO to embed accountability regarding data protection and security management of systems with IAOS, IAAs and SAs through support and management.
- Rollout of new documentation
    - Communication plan for staff awareness of new documents and training opportunities
- IG and IT Directory and Security Manager to devise training and awareness to include:
    - Records management
    - Risk Assessment completion
    - Auditing expectations
    - Reporting expectations
    - Meeting attendances etc.
- IG team with SIAO assistance will coordinate training for identified staff
- SIAOs will report regularly to IGAG on progress
- IGAG to determine effectiveness measures of the training and SLSP implementation:
    - All SSPS replaced
    - Full comprehensive log of all systems managed in the Trust

Committee Terms of Reference	NHS Gateshead Health NHS Foundation Trust

Digital Committee

Constitution and Purpose

The Digital Committee is a sub-committee of Gateshead Health NHS Foundation Trust's Board of Directors.

The purpose of the Committee is to oversee the development and implementation of the Trust's Digital strategy and associated transformation programme, thereby maximising the contribution of digital solutions and services in the delivery of the Trust's Strategic Plan and objectives.

The Committee will report bi-monthly to the Trust Board and provide assurance on all aspects of strategic and operational digital services.

Date Adopted	September 2020
Review Frequency	Annually

Core Accountabilities	
Terms of reference drafting	Chief Digital Information Officer
Review and approval	Digital Committee
Adoption and ratification	Trust Board

1. Membership and attendance at meetings

Membership

The Committee shall be appointed by the Trust Board and the voting membership shall consist of:

- Two Non-Executive Directors (identified by the Trust Board)
- Group Director of Finance
- Chief Operating Officer
- Chief Digital Information Officer
- Chief Clinical Information Officer
- Chief Nursing Information Officer

Invited as required

- QE Facilities representative
- Head of Pharmacy
- Pathology Services Manager

- HR and Workforce Lead
- Digital Transformation Programme Lead
- Other officers as required

Attendance

The Non-Executive Directors will be appointed Chair and Vice-Chair.

Attendance will be recorded at each meeting.

Quorum

To be quorate there should be a minimum of four voting members, which includes the Chair or Vice-Chair.

Members are responsible for cascading information in a timely way from the meetings to inform colleagues who they are representing.

2. Roles and responsibilities

The key responsibilities of the Committee are:

Assurance:

- To provide assurance to the Trust Board that the Digital Strategy roadmap and transformation initiatives are progressing against agreed measures;
- To oversee the development of digital key performance indicators (KPIs) and provide assurance to the Trust Board that these KPIs are being achieved within Business Units/teams, identifying appropriate actions where necessary;
- To provide assurance to the Trust Board that the Trust is compliant with the relevant Data Security and Protection toolkit standards and national requirements;
- To provide assurance to the Trust Board that the clinical safety of all digital services has been reviewed and approved;
- To oversee the development, approval and review of all digital policies and procedures, ensuring they are in line with legislation and the Trust's objectives;
- To provide assurance to the Trust Board that digital services are managed and operate appropriately through the use of internal audit.

Strategy:

- To shape the Trust's Digital Strategy and associated plans (across all domains and in line with organisational/service strategies and objectives), across a short, medium and long-term planning range;
- To ensure the Trust's Digital Strategy and associated plans have regard to productivity and efficiency;
- To ensure the Trust's workforce development plan supports the full adoption of digital technology.

Risks:

- To have oversight of all digital risks identified through strategic planning, operational

plans and as recorded in the Corporate Risk Register, escalating matters of concern to the Trust Board;

- To escalate key strategic digital risks for inclusion in the Trust's Board Assurance Framework (BAF), and ensure delivery against any associated action plans;

Organisational Awareness:

- To receive assurance from groups which report to the Committee, that specific strands of the Digital Strategy are being progressed in accord with agreed plans and timeframes

3. Conduct of business

The Committee shall be supported administratively by the Corporate Management Team secretarial body.

The Committee will meet on a bi-monthly basis, although additional meetings may be convened as necessary in order to deal with urgent business.

The Committee will be scheduled to occur in advance of the Trust Board in order to provide assurance in a timely manner.

An assurance report from the Committee after every meeting will be submitted to the Board of Directors.

Annually, the Committee will undertake a self-assessment of its performance and report this to the Trust Board.

The Committee will produce an annual timetable of items to be covered at each meeting.

Papers for the meeting will be distributed no less than 5 working days prior to the meeting date.

4. Groups reporting to the Committee

The Committee will have the authority to set up and disband steering groups, sub-committees or working groups in order to effectively discharge its function. All groups are to be evaluated by the Committee annually to ensure their effectiveness.

The Committee will keep under review the number of groups reporting to it and, where possible, ensure that these are time limited.

In establishing steering/working groups there should be clear Terms of Reference, appropriate membership, reporting arrangements and, where appropriate, Governor and patient representation should be encouraged.

Each group will be required to submit a copy of the minutes to the Committee on a regular

basis to provide assurance it is operating effectively and addressing appropriate issues.

The groups that report to the Committee are:

- Digital Transformation Programme Board
- Digital Assurance Group

Trust Board

Gateshead Health NHS Foundation Trust

Report Cover Sheet

Agenda Item: 18

Date of Meeting:	Tuesday 29 September 2020			
Report Title:	Patient Led Assessment of the Care Environment			
Purpose of Report:	This paper aims to update the Board on the outcome of the annual Patient Led Assessment of the Care Environment			
	Decision: ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
Trust Goals that the report relates to: (Including reference to any specific risk)	**Goal 1** Working with partners, we will manage and improve the health of the population of Gateshead, promoting wellbeing and preventing the occurrence and progression of ill-health wherever possible. **Goal 2** All the services we deliver will be good or outstanding when assessed against being safe, effective, caring, responsive, and well-led. **Goal 3** In all locations and settings of delivery, our patients will experience excellent, timely and seamless care that meets their individual needs. **Goal 5** All our services will be effective: we will reduce unwarranted variation, ensure our practice is consistent with recognised best practice 7 days a week, and improve outcomes for patients. **Goal 7** We will deliver value for money and help ensure the local health and care system is sustainable and well led.			
Recommendations: (Action required by Board of Directors)	To note PLACE assessment scores			
Financial Implications:	Yes, continue funding of PLACE assessment scores			
Risk Management	Yes			

Implications:	
Human Resource Implications:	No
Trust Diversity & Inclusion Objective that the report relates to: (including reference to any specific implications and actions)	**Objective 1** All patients receive high quality care through streamlined accessible services with a focus on improving knowledge and capacity to support communication barriers. **Objective 2** The Trust promotes a culture of inclusion where employees have the opportunity to work in a supportive and positive environment and find a healthy balance between working life and personal commitments. **Objective 3** Leaders within the Trust are informed and knowledgeable about the impact of business decisions on a diverse workforce and the differing needs of the communities we serve.
Author:	Andy Colwell, Head of Facilities
Presented by:	Peter Harding, Commercial Director/Managing Director, QEF

Patient Led Assessment of the Care Environment (PLACE)

1. INTRODUCTION

This paper aims to update the Board on the outcome of the annual Patient Led Assessment of the Care Environment (PLACE) undertaken in 2019.

The 2019 assessments adopted a different methodology and scoring design so scores are not comparable to earlier historical results.

Our approach to PLACE is somewhat unique in that we do not approach the assessment as a one off exercise but rather undertake weekly PLACE inspections with the same team members who will undertake the annual assessment. This team is made up of Facilities, Estates, Infections Control, Nursing, and our voluntary external assessors. This collaborative approach relies heavily on the commitment of our PLACE assessors and adds significant value to our commitment to the patient environment. When issues are noted they are formally recorded and action taken to resolve. This provides a high degree of assurance to the patient assessors that their contribution is valued, acted upon and provides them with the confidence that we are proactive. The Gateshead Health Group has continued to invest in the environment with rolling programs for improvements in wayfinding, painting programs, maintenance activities, dementia and disability improvement works which are all undertaken on an ongoing basis.

2. BACKGROUND

The Annual PLACE (Patient Lead Assessment of the Care Environment) Inspection is an annual self-assessment of non-clinical services which contribute to good quality patient care.

The assessment process encourages the involvement of patients, patient representatives and staff providing an opportunity to measure current performance whilst also identifying areas for improvement/development. The audit team comprised of a 50/50 ratio Patient Representatives/Trust Staff including external verifiers from across the region.

Areas the assessments were focused on included:

- Wards acute/community;
- Emergency departments/minor injuries unit;
- Out-patients department;
- External areas; Car Parks, Entrances, Grounds and Gardens
- Internal areas; Public circulation areas, refreshment areas, public toilets
- Food – including the availability of food and drink

Assessment of these areas included the following domains;

- Cleanliness
- Food and Hydration
- Privacy, Dignity and Wellbeing (how the environment supports the delivery of care with regards to the patient's privacy dignity and wellbeing)
- Condition, Appearance and Maintenance of healthcare premises
- Dementia (whether the premises are equipped to meet the needs of people with dementia against a specified range of criteria)

- Disability (the extent to which premises are able to meet the needs of people with disability against a specified range of criteria)

On completion patient representatives are required to complete their own review of the assessment process.

3. ASSESSMENT PROCES/ PLACE DOMAINS

The assessment of ***Cleanliness*** covers all items commonly found in the healthcare Premises including patient equipment; baths, toilets and showers, furniture, floors and other fixtures and fittings.

The assessment of ***Food and Hydration*** includes a range of organisational questions relating to the catering service, for example, the choice of food, 24-hour availability, meal times and access to menus. An assessment of food services at ward level and the taste and temperature of food are also completed.

The assessment of ***Privacy, Dignity and Wellbeing*** includes infrastructural/ organisational aspects such as provision of outdoor/ recreation areas, changing and waiting facilities, access to television, radio, computers and telephones. It also includes the practicality of male and female services such as sleeping and bathroom/ toilet facilities, bedside curtains sufficient in size to create a private space around beds and ensuring patients are appropriately dressed to protect their dignity.

The assessment of ***Condition, Appearance and Maintenance*** includes various aspects of the general environment including décor, the condition of fixtures and fittings, tidiness, signage, lighting (including access to natural light), linen, access to car parking, waste management, and the external appearance of buildings and maintenance of grounds.

The ***Dementia*** assessment focusses on flooring, decor and signage, but also includes such things as availability of handrails and appropriate seating and, to a lesser extent, food. The items included in the assessment do not constitute the full range of issues requiring assessment which, in total, are too numerous to include in these assessments. However they do include a number of key issues, and organisations are encouraged to undertake more comprehensive assessments using one of the recognised environmental assessment tools available.

The ***Disability*** assessment focusses on issues of access including wheelchair, mobility (e.g. handrails), signage and provision of such things as visual/ audible appointment alert systems, hearing loops, and aspects relating to food and food service. It shares many facets with the dementia assessment, and with very few exceptions draws on existing aspects of the assessment rather than introducing new additional questions. This ‘double’ counting allows better use of data and avoids imposing additional burdens on data providers. The items included in the assessment do not constitute the full range of issues, rather focussing on a limited range with strong buildings/environment related aspects.

The aim of PLACE assessment is to provide a snapshot of how an organisation is performing against the range of non-clinical activities highlighted which impact on the patient experience of care. PLACE aims to promote the principles established by the NHS Constitution that focus on areas that matter to patients, families and carers:

- Putting patients first;
- Active feedback from the public. patients and staff;
- Adhering to basics of quality care;
- Ensuring services are provided in a clean and safe environment that is fit for purpose.

The inspection process was completed over 2 days in November 2019; audits were completed at agreed dates and times enabling assessment throughout the working day.

The decisions on where to visit were agreed with the patient representatives, consideration was given to the areas assessed in previous years, to ensure over time all areas of the Trust are included in annual audit. The Trust is required to include all units/sites with 10 in-patient beds or more. Assessment to included 10 In-Patient Wards (or 25% whichever is the greater) and a similar number of Out Patient Facilities all covering a range of specialties and buildings of different age and conditions. The Team are also required to sample and complete food assessments which were completed at the lunch and evening meal service at the QE.

Queen Elizabeth Hospital

In-patient areas (Wards)	**Non-Ward Patient Areas**
Sunniside	Accident and Emergency
Ward 1	Ambulatory Care
Ward 4	Fracture Clinic
Ward 8	Breast Screening
Ward 12	Urology
Ward 21	PIU
Ward 23	ECG
Ward 24	Radiology
Lvl2 Peter Smith	MRI
St Bedes	Jubilee Day unit
	Internal And External Public Area
	Emergency Care Circulation

It was felt that the above included fair representation of Trust accommodation with a mix of services.

4. SCORING METHODOLOGY

The outcome of the assessment is based on scores achieved to 'Yes/ No' answers and assessments against standards which can be scored as a Pass/Qualified Pass/Fail.

At the end of the process, each hospital/ unit which has undertaken an assessment is provided with a result against each of the six domains namely Cleanliness, Food and Hydration, Privacy/Dignity and Wellbeing, Condition/Appearance and Maintenance, Dementia and Disability. Results are calculated by reference to the score (points) achieved expressed as a percentage of the maximum score which could have been achieved had every aspect of the assessment they undertook achieved the maximum score.

The food assessment is split into two components: Organisational relating to the catering service e.g. choice of food, 24 hour availability, meal times and access to menus. It also includes an

assessment of food at Ward level including taste, texture and appropriateness of serving and temperature.

For the purposes of comparison, a national average of scores from all participating hospitals/ units has been calculated. This average is weighted to take account of the fact that hospitals vary in size and that in larger hospitals not all areas are assessed. The weighting factor used in this calculation is bed numbers. Bed numbers are used since they are common to all organisations, whereas some premises in which assessments are undertaken do not have wards e.g. certain mental health/learning disabilities units and Treatment Centres.

$$\frac{\text{The sum of (Each site's score [points] multiplied by the number of beds in that site)}}{\text{The total number of beds in all assessed sites}}$$

A total of 1,144 assessments were undertaken by 261 organisations. Of this 214 (82%) were NHS trusts and 47 (18%) were voluntary, independent or private healthcare providers.

Appendix 1. - Our scores achieved, this also includes national/regional, comparison scores. It can be seen that the Trust's overall score in all categories achieved higher than the national average score.

PLACE assessment and scoring will be used by a range of public bodies such as the Care Quality Commissions Intelligent Monitoring (IM) process, the Department of Health and NHS England. The data being used to support ongoing quality programs encompassing nutrition, compassion and privacy and dignity.

In overview it was considered by all involved that the assessments went very well. Constructive comments were received from the patient representatives who commented on the value of the weekly PLACE audits which they feel very strongly supports the annual process and sustained improvements.

5. KEY FINDINGS

Scorings

Gateshead has consistently scored well in all areas as detailed below.

National Average	Our Scores
Cleanliness National Average 98.62%	Gateshead 99.96% ↑
Food National Average 92.51%	Gateshead 99.61% ↑
Organisation Food National Average 91.37%	Gateshead 98.37% ↑
Ward Food national Average 93.67%	Gateshead 100% ↑
Privacy & Dignity National Average 87.52	Gateshead 98.39% ↑
Condition and Maintenance National Average 96.38%	Gateshead 99.71% ↑
Dementia National Average 83.47%	Gateshead 97.59% ↑
Disability National Average 83.92%	Gateshead 96.79% ↑

(↑ higher than the national average)

Further analysis indicates that as a Trust we have done remarkably well on a regional and national basis for 2019. Our scores in comparison to other Trusts are as follows,

- 2nd overall Nationally of 209 Trusts
- 1st overall regionally of 31 Trusts in the North East and Yorkshire Commissioning Region
- 1st overall nationally in terms of Small Acute of 31 Trusts

Statistically as an overall average across all domains;

- 8.19% better than the overall national average score
- 7.80% points better than the overall regional average
- 9.01% points above the small acute overall national average

Our 'lowest' % score we achieved across the domains was for Disability (96.79%) which exceeded the average national, regional and small acute scores of 83.64%, 83.68% and 83.48% respectively.

Please see **Appendix 1** for detailed local and national level comparison in site scores

Condition/Appearance –

- Attention required to minor damage in terms of decoration
- Attention required to impact damage to internal doors and some internal fixtures and fittings
- Attention required to flooring in terms of repairs creating a patchy effect
- Attention required to some soft furnishing , very slight wear and tear damage

Privacy, Dignity and Wellbeing –

- Facilities for family to stay overnight is limited to bedside only
- No outdoor facility for outdoor physical activities
- Not all wards designed so that no patient needs to pass through or near to a ward for the opposite sex to access bathrooms, toilets or lave the ward.
- Some patients may pass through general waiting area in A &E after consultation.

Dementia friendly environment –

- Noise reducing flooring fitted in some areas
- Most seats / flush handles compliant following a program to replace throughout all patient areas
- Dementia friendly colours almost completed

Actions

- Doors painted out – standard adopted as part of planned redecoration programme. Dementia friendly colours agreed.

Food Organisational Questions

The acute team work closely with the catering department including working collaboratively to assess the patient menus to ensure the patient's nutritional needs are met. The hospital adheres to

the protected mealtimes and this is audited by the Collaborative Walkabout which takes place across all wards – all of which contribute towards PLACE compliance.

Areas that could improve the overall organisation score also include, practice which allows patients to choose their meal at the point of service:

- choice, providing a choice of 2 starters at lunch time, a hot and cold desert with the evening meal
- providing hot meals to the discharge area currently patients in this area receive a substantial snack such as soup and sandwiches.

Whilst all of these changes could be made a balance needs to be considered regarding the consequential increase in the length of service time at ward level which would place a higher demand on nursing, domestic and housekeeper staff time as well as increasing provisions costs.

- **Food Service**
  Lunch and Dinner services were assessed over a two day period. The food was found to be excellent in taste, appearance and temperature. Service seemed to vary dependent on ward staff available with Domestics staff supporting service and clear down and conducting beverage services.

6 NEXT STEPS

The positive impact from PLACE on our environmental standards has improved steadily over the years. Our approach is to continue with improvements on a progressive basis supported with an action plan which is reviewed by the assessors regularly. Recorded findings from the weekly audits are shared with assessors and regular improvements works which are undertaken as part of larger schemes (capital) or as part of minor refurbishments or under maintenance. Previous investment in staffing for maintenance staff (painters) has continued to see high standards of decoration achieved and maintained across the Estate. Dementia and disability improvements continue to be made which is dependent on continuing funding (£50k). As an illustration to our progressive approach we have identified from April 2019-Feb 2020, 588 environmental tasks for rectification under PLACE. This is then distributed by Trade group for rectification with feedback provided to the PLACE team. Actions are tabled as part of the regular quarterly PLACE meetings with assurance on an annual basis to the respective Boards and internal quality governance committees.

7 RECOMMENDATION

The Board is requested to endorse this report.

Peter Harding
Commercial Director Gateshead Health NHS FT/
Managing Director, QEF

Source: NHS Patient-Led Assessments of the Care Environment Collection, NHS Digital

Organisation Code	Organisation Name	Commissioning Region	Organisation Type	NHS	CLN Score %	Food Score %	Org Food Score %	Ward Food %	PDW Score %	CAM Score %	DEM Score %	DIS Score %	Overall average %
RBN	ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST	NORTH WEST COMMISSIONING REGION	ACUTE - MEDIUM	NHS	100.00%	99.45%	98.36%	99.88%	98.81%	100.00%	96.73%	99.42%	99.08%
RR7	GATESHEAD HEALTH NHS FOUNDATION TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	ACUTE - SMALL	NHS	99.96%	99.61%	98.37%	100.00%	98.39%	99.71%	97.59%	96.79%	98.80%
RTF	NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	ACUTE - LARGE	NHS	99.97%	99.13%	98.15%	99.67%	95.39%	99.61%	97.14%	97.11%	98.27%
RXT	BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST	MIDLANDS COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	NHS	100.00%	97.97%	95.68%	100.00%	97.43%	99.96%	98.48%	95.96%	98.19%
RBS	ALDER HEY CHILDRENS NHS FOUNDATION TRUST	NORTH WEST COMMISSIONING REGION	ACUTE - SPECIALIST	NHS	96.88%	99.04%	93.18%	100.00%	98.76%	99.17%	-	100.00%	98.15%
R1D	SHROPSHIRE COMMUNITY HEALTH NHS TRUST	MIDLANDS COMMISSIONING REGION	COMMUNITY	NHS	99.84%	98.57%	97.08%	100.00%	95.44%	98.29%	96.36%	95.48%	97.63%
RY9	HOUNSLOW AND RICHMOND COMMUNITY HEALTHCARE NHS TRUST	LONDON COMMISSIONING REGION	COMMUNITY	NHS	100.00%	96.74%	94.81%	98.81%	91.23%	99.01%	99.17%	100.00%	97.47%
RTX	UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	NORTH WEST COMMISSIONING REGION	ACUTE - MEDIUM	NHS	98.98%	99.42%	97.68%	100.00%	97.69%	95.55%	94.82%	94.52%	97.33%
RWX	BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST	SOUTH EAST COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	NHS	99.76%	95.29%	95.71%	94.67%	96.65%	99.20%	98.86%	97.66%	97.23%
RP1	NORTHAMPTONSHIRE HEALTHCARE NHS FOUNDATION TRUST	MIDLANDS COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	NHS	99.79%	96.64%	96.06%	96.04%	96.76%	97.83%	97.25%	95.47%	96.98%
RT1	CAMBRIDGESHIRE AND PETERBOROUGH NHS FOUNDATION TRUST	EAST OF ENGLAND COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	NHS	99.85%	96.22%	94.02%	98.23%	94.30%	99.07%	98.18%	95.87%	96.97%
RQM	CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST	LONDON COMMISSIONING REGION	ACUTE - TEACHING	NHS	99.75%	97.98%	96.87%	98.29%	93.76%	99.65%	94.14%	94.13%	96.82%
RRF	WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	NORTH WEST COMMISSIONING REGION	ACUTE - MEDIUM	NHS	100.00%	95.79%	90.74%	97.28%	92.98%	100.00%	98.22%	99.05%	96.76%
RNU	OXFORD HEALTH NHS FOUNDATION TRUST	SOUTH EAST COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	NHS	99.31%	95.90%	94.35%	97.71%	93.90%	98.47%	97.66%	96.41%	96.71%
RRE	MIDLANDS PARTNERSHIP NHS FOUNDATION TRUST	MIDLANDS COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	NHS	98.26%	97.08%	96.69%	97.89%	96.47%	96.88%	97.39%	92.74%	96.68%
RBQ	LIVERPOOL HEART AND CHEST NHS FOUNDATION TRUST	NORTH WEST COMMISSIONING REGION	ACUTE - SPECIALIST	NHS	98.91%	99.29%	100.00%	98.95%	93.98%	98.26%	91.72%	91.96%	96.63%
RLY	NORTH STAFFORDSHIRE COMBINED HEALTHCARE NHS TRUST	MIDLANDS COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	NHS	99.33%	98.26%	95.74%	99.67%	94.69%	96.80%	96.23%	91.35%	96.51%
RA2	ROYAL SURREY COUNTY HOSPITAL NHS FOUNDATION TRUST	SOUTH EAST COMMISSIONING REGION	ACUTE - MEDIUM	NHS	99.44%	97.33%	97.14%	97.42%	89.07%	98.58%	95.66%	96.76%	96.43%
RBV	THE CHRISTIE NHS FOUNDATION TRUST	NORTH WEST COMMISSIONING REGION	ACUTE - SPECIALIST	NHS	99.38%	97.67%	100.00%	96.43%	95.71%	98.44%	93.55%	89.89%	96.38%
RJ6	CROYDON HEALTH SERVICES NHS TRUST	LONDON COMMISSIONING REGION	ACUTE - MEDIUM	NHS	99.30%	98.60%	97.78%	98.82%	90.92%	96.32%	93.22%	95.54%	96.31%
RX3	TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	NHS	99.04%	95.80%	93.15%	98.71%	95.77%	97.68%	95.73%	93.66%	96.19%
TAD	BRADFORD DISTRICT CARE NHS FOUNDATION TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	CARE TRUST	NHS	98.53%	98.22%	96.20%	99.29%	98.63%	98.08%	89.78%	90.40%	96.14%
RBA	TAUNTON AND SOMERSET NHS FOUNDATION TRUST	SOUTH WEST COMMISSIONING REGION	ACUTE - MEDIUM	NHS	98.24%	98.87%	98.33%	98.99%	90.14%	97.34%	93.97%	92.40%	96.04%
RWR	HERTFORDSHIRE PARTNERSHIP NHS FOUNDATION TRUST	EAST OF ENGLAND COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	NHS	99.42%	96.74%	96.33%	96.80%	93.83%	98.99%	93.57%	91.15%	95.85%
RRP	BARNET, ENFIELD AND HARINGEY MENTAL HEALTH NHS TRUST	LONDON COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	NHS	98.99%	97.00%	98.97%	96.22%	93.17%	98.43%	93.92%	89.91%	95.83%
RXG	SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	NHS	99.40%	93.70%	94.79%	92.40%	96.20%	98.61%	96.50%	94.25%	95.73%
RA4	YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST	SOUTH WEST COMMISSIONING REGION	ACUTE - SMALL	NHS	99.12%	98.46%	98.15%	98.56%	84.96%	98.59%	91.43%	96.23%	95.69%
RPY	THE ROYAL MARSDEN NHS FOUNDATION TRUST	LONDON COMMISSIONING REGION	ACUTE - SPECIALIST	NHS	98.52%	94.93%	90.39%	98.63%	94.15%	97.21%	95.29%	94.80%	95.49%
RET	WALTON CENTRE NHS FOUNDATION TRUST	NORTH WEST COMMISSIONING REGION	ACUTE - SPECIALIST	NHS	100.00%	96.30%	99.26%	94.44%	95.72%	99.43%	89.33%	89.33%	95.48%
RYR	WESTERN SUSSEX HOSPITALS NHS FOUNDATION TRUST	SOUTH EAST COMMISSIONING REGION	ACUTE - LARGE	NHS	99.79%	94.08%	95.43%	93.66%	89.23%	98.01%	95.41%	98.14%	95.47%
TAJ	BLACK COUNTRY PARTNERSHIP NHS FOUNDATION TRUST	MIDLANDS COMMISSIONING REGION	CARE TRUST	NHS	99.69%	95.06%	92.39%	97.87%	93.27%	98.56%	94.77%	91.63%	95.41%
RV3	CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST	LONDON COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	NHS	99.71%	94.42%	89.37%	97.70%	95.88%	98.06%	94.08%	93.07%	95.29%
TAH	SHEFFIELD HEALTH AND SOCIAL CARE NHS FOUNDATION TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	CARE TRUST	NHS	99.30%	96.20%	92.48%	98.36%	92.02%	97.00%	96.20%	90.43%	95.25%
RMY	NORFOLK AND SUFFOLK NHS FOUNDATION TRUST	EAST OF ENGLAND COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	NHS	99.45%	93.53%	94.40%	92.77%	95.05%	99.07%	92.24%	94.05%	95.07%
RNS	NORTHAMPTON GENERAL HOSPITAL NHS TRUST	MIDLANDS COMMISSIONING REGION	ACUTE - MEDIUM	NHS	99.02%	97.56%	95.19%	98.08%	88.17%	98.11%	90.41%	93.54%	95.01%
RXA	CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST	NORTH WEST COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	NHS	99.92%	97.63%	95.70%	100.00%	92.97%	91.06%	91.51%	90.07%	94.86%
RMP	TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	NORTH WEST COMMISSIONING REGION	ACUTE - SMALL	NHS	99.32%	94.20%	90.19%	96.20%	91.35%	99.73%	93.17%	93.74%	94.74%
RL1	ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST	MIDLANDS COMMISSIONING REGION	ACUTE - SPECIALIST	NHS	99.91%	96.15%	90.00%	100.00%	94.66%	98.31%	89.43%	89.33%	94.72%
REM	AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	NORTH WEST COMMISSIONING REGION	ACUTE - TEACHING	NHS	99.61%	96.66%	91.67%	97.45%	92.53%	98.53%	91.90%	89.28%	94.70%
RJ1	GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	LONDON COMMISSIONING REGION	ACUTE - TEACHING	NHS	99.56%	97.09%	95.93%	97.43%	91.06%	98.88%	88.63%	88.76%	94.67%
RJE	UNIVERSITY HOSPITAL OF NORTH MIDLANDS NHS TRUST	MIDLANDS COMMISSIONING REGION	ACUTE - TEACHING	NHS	99.95%	95.03%	90.47%	96.30%	91.49%	99.56%	91.21%	92.97%	94.62%
RV5	SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST	LONDON COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	NHS	99.57%	89.74%	95.33%	87.85%	95.65%	98.81%	94.44%	93.80%	94.40%
RQY	SOUTH WEST LONDON AND ST GEORGE'S MENTAL HEALTH NHS TRUST	LONDON COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	NHS	95.70%	95.84%	95.43%	95.98%	94.90%	84.45%	96.46%	95.94%	94.34%
RX2	SUSSEX PARTNERSHIP NHS FOUNDATION TRUST	SOUTH EAST COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	NHS	96.68%	95.12%	95.43%	94.85%	93.08%	96.96%	91.68%	89.66%	94.18%
RP4	GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST	LONDON COMMISSIONING REGION	ACUTE - SPECIALIST	NHS	98.46%	92.57%	90.93%	92.81%	93.09%	96.71%	-	93.42%	94.00%
RXL	BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	NORTH WEST COMMISSIONING REGION	ACUTE - TEACHING	NHS	98.24%	97.18%	97.27%	97.27%	91.90%	97.14%	83.71%	89.17%	93.99%
RWV	DEVON PARTNERSHIP NHS TRUST	SOUTH WEST COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	NHS	98.09%	93.39%	88.74%	96.00%	95.95%	94.60%	91.74%	92.83%	93.92%
RJC	SOUTH WARWICKSHIRE NHS FOUNDATION TRUST	MIDLANDS COMMISSIONING REGION	ACUTE - SMALL	NHS	99.69%	94.78%	96.06%	94.60%	91.57%	98.67%	86.20%	89.40%	93.87%
R1A	WORCESTERSHIRE HEALTH AND CARE NHS TRUST	MIDLANDS COMMISSIONING REGION	COMMUNITY	NHS	99.93%	96.70%	96.71%	96.76%	92.42%	98.43%	83.51%	86.51%	93.87%
RHW	ROYAL BERKSHIRE NHS FOUNDATION TRUST	SOUTH EAST COMMISSIONING REGION	ACUTE - LARGE	NHS	99.53%	97.61%	96.48%	97.84%	87.50%	97.49%	86.77%	87.61%	93.85%
RGP	JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	EAST OF ENGLAND COMMISSIONING REGION	ACUTE - SMALL	NHS	99.68%	96.89%	96.30%	97.14%	87.01%	97.91%	85.37%	89.84%	93.77%
RXX	SURREY AND BORDERS PARTNERSHIP NHS FOUNDATION TRUST	SOUTH EAST COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	NHS	99.53%	90.70%	93.68%	88.73%	90.89%	98.86%	93.47%	92.87%	93.59%
RL4	THE ROYAL WOLVERHAMPTON NHS TRUST	MIDLANDS COMMISSIONING REGION	ACUTE - LARGE	NHS	99.62%	96.43%	97.26%	96.27%	89.25%	98.67%	83.08%	86.37%	93.37%
RJN	EAST CHESHIRE NHS TRUST	NORTH WEST COMMISSIONING REGION	ACUTE - SMALL	NHS	99.34%	96.43%	93.42%	98.23%	86.36%	95.37%	87.97%	89.26%	93.30%
RT2	PENNINE CARE NHS FOUNDATION TRUST	NORTH WEST COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	NHS	98.49%	92.82%	88.64%	97.24%	91.66%	96.17%	92.91%	87.87%	93.23%
R0B	SOUTH TYNESIDE AND SUNDERLAND NHS FOUNDATION TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	ACUTE - LARGE	NHS	99.73%	93.79%	96.41%	93.57%	88.01%	98.60%	86.04%	89.63%	93.22%
RVW	NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	ACUTE - MEDIUM	NHS	99.89%	95.93%	95.70%	96.01%	88.16%	99.72%	85.57%	84.73%	93.21%
RY8	DERBYSHIRE COMMUNITY HEALTH SERVICES NHS TRUST	MIDLANDS COMMISSIONING REGION	COMMUNITY	NHS	98.79%	89.79%	81.96%	98.01%	93.90%	98.47%	93.24%	89.85%	93.00%
RTV	NORTH WEST BOROUGHS HEALTHCARE NHS FOUNDATION TRUST	NORTH WEST COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	NHS	98.65%	98.63%	96.90%	100.00%	90.02%	93.20%	84.40%	81.80%	92.95%
RTQ	GLOUCESTERSHIRE HEALTH AND CARE NHS FOUNDATION TRUST	SOUTH WEST COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	NHS	99.98%	90.62%	84.84%	98.03%	94.98%	98.96%	91.76%	83.28%	92.81%
RR8	LEEDS TEACHING HOSPITALS NHS TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	ACUTE - TEACHING	NHS	99.82%	97.09%	94.53%	97.68%	89.94%	98.52%	81.92%	82.91%	92.80%
RQX	HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	LONDON COMMISSIONING REGION	ACUTE - MEDIUM	NHS	99.81%	93.67%	96.41%	93.21%	84.71%	97.47%	86.58%	88.42%	92.54%
R1C	SOLENT NHS TRUST	SOUTH EAST COMMISSIONING REGION	COMMUNITY	NHS	96.36%	94.98%	99.22%	92.02%	89.50%	92.74%	88.04%	87.13%	92.50%
RM3	SALFORD ROYAL NHS FOUNDATION TRUST	NORTH WEST COMMISSIONING REGION	ACUTE - TEACHING	NHS	99.53%	93.64%	88.89%	94.76%	91.20%	98.47%	86.20%	86.75%	92.43%
RT3	ROYAL BROMPTON AND HAREFIELD NHS FOUNDATION TRUST	LONDON COMMISSIONING REGION	ACUTE - SPECIALIST	NHS	99.43%	93.88%	92.51%	94.49%	90.37%	99.00%	86.20%	82.93%	92.35%
RF4	BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST	LONDON COMMISSIONING REGION	ACUTE - LARGE	NHS	99.93%	98.16%	93.70%	99.10%	84.80%	98.94%	81.37%	82.75%	92.34%
RGR	WEST SUFFOLK NHS FOUNDATION TRUST	EAST OF ENGLAND COMMISSIONING REGION	ACUTE - SMALL	NHS	100.00%	92.40%	88.90%	93.79%	88.37%	98.49%	86.39%	90.16%	92.31%
RK5	SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	MIDLANDS COMMISSIONING REGION	ACUTE - MEDIUM	NHS	99.92%	92.26%	97.44%	91.18%	87.99%	99.48%	84.14%	85.14%	92.19%
RTR	SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	ACUTE - TEACHING	NHS	96.16%	94.37%	99.14%	93.30%	86.04%	93.26%	85.64%	89.22%	92.14%
RFS	CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST	MIDLANDS COMMISSIONING REGION	ACUTE - SMALL	NHS	99.25%	91.87%	98.89%	89.94%	87.97%	97.69%	84.47%	87.00%	92.14%
RA9	TORBAY AND SOUTH DEVON HEALTH CARE NHS FOUNDATION TRUST	SOUTH WEST COMMISSIONING REGION	ACUTE - MEDIUM	NHS	99.18%	92.38%	95.88%	92.19%	92.45%	94.77%	83.26%	86.75%	92.11%
RY4	HERTFORDSHIRE COMMUNITY NHS TRUST	EAST OF ENGLAND COMMISSIONING REGION	COMMUNITY	NHS	98.72%	93.80%	95.00%	92.76%	87.37%	99.22%	83.63%	86.30%	92.10%
RA7	UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST	SOUTH WEST COMMISSIONING REGION	ACUTE - TEACHING	NHS	99.41%	96.35%	98.94%	95.03%	87.73%	95.44%	82.17%	81.48%	92.07%
RGM	ROYAL PAPWORTH HOSPITAL NHS FOUNDATION TRUST	EAST OF ENGLAND COMMISSIONING REGION	ACUTE - SPECIALIST	NHS	98.96%	95.87%	94.81%	96.13%	85.47%	98.36%	82.51%	84.35%	92.06%
RWY	CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	ACUTE - LARGE	NHS	99.08%	91.34%	95.50%	90.40%	92.68%	98.78%	82.40%	85.94%	92.02%
RYX	CENTRAL LONDON COMMUNITY HEALTHCARE NHS TRUST	LONDON COMMISSIONING REGION	COMMUNITY	NHS	99.74%	94.86%	93.30%	95.75%	86.45%	95.60%	85.43%	84.71%	91.98%
RQ3	BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST	MIDLANDS COMMISSIONING REGION	ACUTE - SPECIALIST	NHS	99.97%	92.89%	85.45%	96.71%	90.15%	99.39%	85.06%	86.16%	91.97%
RFF	BARNSLEY HOSPITAL NHS FOUNDATION TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	ACUTE - SMALL	NHS	99.79%	91.58%	93.70%	90.97%	88.58%	97.15%	85.39%	88.04%	91.90%
RXP	COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	ACUTE - MULTI-SERVICE	NHS	99.45%	97.45%	97.09%	97.74%	85.32%	98.54%	78.56%	80.66%	91.85%
RK9	UNIVERSITY HOSPITALS PLYMOUTH NHS TRUST	SOUTH WEST COMMISSIONING REGION	ACUTE - TEACHING	NHS	99.09%	94.61%	91.48%	94.84%	86.61%	94.86%	86.50%	86.46%	91.81%
RV9	HUMBER TEACHING NHS FOUNDATION TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	NHS	99.25%	94.99%	90.01%	99.75%	88.54%	94.41%	84.29%	83.21%	91.81%
RH5	SOMERSET PARTNERSHIP NHS FOUNDATION TRUST	SOUTH WEST COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	NHS	99.99%	89.94%	82.12%	98.50%	86.31%	99.30%	90.83%	87.43%	91.80%
RYJ	IMPERIAL COLLEGE HEALTHCARE NHS TRUST	LONDON COMMISSIONING REGION	ACUTE - TEACHING	NHS	99.64%	93.03%	98.20%	91.44%	83.11%	98.77%	84.79%	85.28%	91.78%
RCU	SHEFFIELD CHILDRENS NHS FOUNDATION TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	ACUTE - SPECIALIST	NHS	99.70%	92.65%	89.50%	94.87%	82.80%	97.64%	-	85.30%	91.78%
RAX	KINGSTON HOSPITAL NHS FOUNDATION TRUST	LONDON COMMISSIONING REGION	ACUTE - SMALL	NHS	98.60%	90.95%	96.21%	89.96%	85.71%	98.65%	85.34%	88.70%	91.77%
R1L	ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST	EAST OF ENGLAND COMMISSIONING REGION	ACUTE - MULTI-SERVICE	NHS	99.50%	90.46%	84.70%	97.36%	84.89%	97.16%	95.09%	84.71%	91.73%
RRK	UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	MIDLANDS COMMISSIONING REGION	ACUTE - TEACHING	NHS	98.17%	95.92%	98.11%	95.41%	82.98%	96.58%	81.64%	85.02%	91.73%
RGN	NORTH WEST ANGLIA NHS FOUNDATION TRUST	EAST OF ENGLAND COMMISSIONING REGION	ACUTE - LARGE	NHS	99.04%	92.82%	90.57%	93.48%	89.05%	98.03%	85.59%	85.19%	91.72%
RPG	OXLEAS NHS FOUNDATION TRUST	LONDON COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	NHS	98.93%	89.82%	90.79%	88.25%	89.92%	96.07%	91.66%	88.17%	91.70%
RDZ	THE ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPITALS NHS FOUNDATION TRUST	SOUTH WEST COMMISSIONING REGION	ACUTE - MEDIUM	NHS	96.90%	95.72%	93.87%	96.24%	84.75%	94.73%	85.45%	85.10%	91.60%
R0A	MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	NORTH WEST COMMISSIONING REGION	ACUTE - TEACHING	NHS	98.63%	93.97%	95.50%	93.66%	87.88%	97.44%	83.20%	82.30%	91.57%
RBD	DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST	SOUTH WEST COMMISSIONING REGION	ACUTE - SMALL	NHS	99.76%	94.29%	97.04%	93.38%	86.39%	99.69%	79.56%	81.91%	91.50%
RAP	NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST	LONDON COMMISSIONING REGION	ACUTE - SMALL	NHS	97.49%	86.05%	98.33%	82.96%	90.83%	94.93%	89.99%	90.56%	91.39%
RYY	KENT COMMUNITY HEALTH NHS FOUNDATION TRUST	SOUTH EAST COMMISSIONING REGION	COMMUNITY	NHS	99.18%	92.03%	86.39%	98.54%	86.34%	95.26%	86.95%	86.30%	91.37%
R1J	GLOUCESTERSHIRE CARE SERVICES NHS TRUST	SOUTH WEST COMMISSIONING REGION	CARE TRUST	NHS	99.96%	93.59%	88.47%	98.87%	87.31%	99.31%	82.56%	80.19%	91.28%
RXF	MID YORKSHIRE HOSPITALS NHS TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	ACUTE - LARGE	NHS	99.77%	93.22%	85.56%	94.92%	86.69%	99.45%	85.63%	84.98%	91.28%
RA3	WESTON AREA HEALTH NHS TRUST	SOUTH WEST COMMISSIONING REGION	ACUTE - SMALL	NHS	98.76%	92.37%	85.37%	96.62%	84.96%	95.87%	87.13%	89.04%	91.27%
TAF	CAMDEN AND ISLINGTON NHS FOUNDATION TRUST	LONDON COMMISSIONING REGION	CARE TRUST	NHS	98.29%	91.09%	89.46%	91.99%	91.73%	95.03%	86.14%	86.38%	91.26%
RYG	COVENTRY AND WARWICKSHIRE PARTNERSHIP NHS TRUST	MIDLANDS COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	NHS	98.30%	92.27%	80.75%	97.09%	92.73%	94.12%	90.81%	82.90%	91.12%
RYW	BIRMINGHAM COMMUNITY HEALTHCARE NHS FOUNDATION TRUST	MIDLANDS COMMISSIONING REGION	COMMUNITY	NHS	98.29%	91.63%	92.83%	90.56%	83.98%	97.35%	89.56%	84.22%	91.05%
RDR	SUSSEX COMMUNITY NHS FOUNDATION TRUST	SOUTH EAST COMMISSIONING REGION	COMMUNITY	NHS	98.70%	95.58%	94.02%	96.98%	84.76%	94.78%	81.31%	82.18%	91.04%
RDY	DORSET HEALTHCARE NHS FOUNDATION TRUST	SOUTH WEST COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	NHS	97.60%	91.39%	84.21%	96.37%	87.67%	95.50%	89.70%	85.77%	91.03%
RWK	EAST LONDON NHS FOUNDATION TRUST	LONDON COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	NHS	97.02%	86.91%	90.85%	82.22%	93.18%	90.93%	97.40%	89.66%	91.02%
RW5	LANCASHIRE CARE NHS FOUNDATION TRUST	NORTH WEST COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	NHS	99.20%	83.92%	83.38%	84.58%	94.48%	98.37%	91.42%	92.36%	90.96%
RLT	GEORGE ELIOT HOSPITAL NHS TRUST	MIDLANDS COMMISSIONING REGION	ACUTE - SMALL	NHS	98.97%	92.39%	81.48%	96.58%	81.17%	97.42%	89.34%	90.13%	90.94%
RX4	CUMBRIA, NORTHUMBERLAND, TYNE AND WEAR NHS FOUNDATION TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	NHS	98.90%	91.59%	89.34%	94.41%	89.50%	97.92%	85.58%	79.97%	90.90%
RVN	AVON AND WILTSHIRE MENTAL HEALTH PARTNERSHIP NHS TRUST	SOUTH WEST COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	NHS	99.41%	93.65%	90.38%	95.67%	90.13%	96.66%	76.78%	83.58%	90.78%
RAT	NORTH EAST LONDON NHS FOUNDATION TRUST	LONDON COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	NHS	99.76%	94.14%	88.28%	99.93%	88.96%	90.40%	84.53%	80.25%	90.78%

R1H	BARTS HEALTH NHS TRUST	LONDON COMMISSIONING REGION	ACUTE - TEACHING	NHS	99.96%	92.45%	98.20%	91.12%	87.44%	98.48%	76.77%	81.63%	90.76%
RY3	NORFOLK COMMUNITY HEALTH AND CARE NHS TRUST	EAST OF ENGLAND COMMISSIONING REGION	COMMUNITY	NHS	99.30%	90.63%	84.49%	96.46%	90.04%	95.61%	86.51%	81.79%	90.60%
REP	LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	NORTH WEST COMMISSIONING REGION	ACUTE - SPECIALIST	NHS	99.89%	96.27%	96.02%	96.43%	86.52%	96.97%	77.50%	75.00%	90.58%
RXK	SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	MIDLANDS COMMISSIONING REGION	ACUTE - LARGE	NHS	99.55%	97.33%	97.19%	97.38%	82.79%	98.89%	73.62%	77.77%	90.57%
RAL	ROYAL FREE LONDON NHS FOUNDATION TRUST	LONDON COMMISSIONING REGION	ACUTE - TEACHING	NHS	99.50%	93.27%	91.49%	93.77%	88.52%	98.53%	77.93%	81.36%	90.55%
RTK	ASHFORD AND ST. PETER'S HOSPITALS NHS FOUNDATION TRUST	SOUTH EAST COMMISSIONING REGION	ACUTE - MEDIUM	NHS	99.80%	97.66%	92.02%	99.82%	80.97%	92.19%	77.68%	84.02%	90.52%
RW6	PENNINE ACUTE HOSPITALS NHS TRUST	NORTH WEST COMMISSIONING REGION	ACUTE - LARGE	NHS	99.53%	95.03%	94.12%	95.53%	76.43%	97.80%	81.95%	83.74%	90.52%
RW4	MERSEY CARE NHS FOUNDATION TRUST	NORTH WEST COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	NHS	98.32%	91.56%	85.50%	95.70%	89.76%	95.24%	88.11%	79.55%	90.47%
RY6	LEEDS COMMUNITY HEALTHCARE NHS TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	COMMUNITY	NHS	95.24%	95.60%	94.04%	97.24%	86.62%	95.00%	72.22%	86.92%	90.36%
RWA	HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	ACUTE - TEACHING	NHS	97.33%	93.72%	88.89%	94.84%	86.36%	94.99%	78.83%	87.54%	90.31%
REN	CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	NORTH WEST COMMISSIONING REGION	ACUTE - SPECIALIST	NHS	100.00%	79.84%	62.88%	97.62%	97.27%	100.00%	94.30%	90.58%	90.31%
RXV	GREATER MANCHESTER MENTAL HEALTH NHS FOUNDATION TRUST	NORTH WEST COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	NHS	99.40%	86.84%	88.64%	86.19%	93.23%	97.59%	85.49%	84.99%	90.30%
RHA	NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST	MIDLANDS COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	NHS	96.46%	94.01%	88.57%	97.19%	87.58%	94.52%	76.83%	84.22%	89.92%
RC1	BEDFORD HOSPITAL NHS TRUST	EAST OF ENGLAND COMMISSIONING REGION	ACUTE - SMALL	NHS	99.54%	94.89%	89.07%	95.95%	79.90%	97.15%	77.06%	85.73%	89.91%
RXM	DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST	MIDLANDS COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	NHS	95.81%	87.20%	83.66%	90.95%	91.12%	95.59%	92.93%	81.75%	89.88%
RRJ	ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST	MIDLANDS COMMISSIONING REGION	ACUTE - SPECIALIST	NHS	99.40%	92.03%	93.70%	91.49%	84.35%	93.55%	82.44%	81.94%	89.86%
RJL	NORTHERN LINCOLNSHIRE AND GOOLE NHS FOUNDATION TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	ACUTE - LARGE	NHS	99.28%	90.05%	86.74%	90.96%	85.89%	97.53%	82.69%	85.70%	89.86%
RQ6	ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	NORTH WEST COMMISSIONING REGION	ACUTE - TEACHING	NHS	98.99%	96.52%	94.81%	97.16%	86.05%	94.34%	71.86%	79.01%	89.84%
RBT	THE MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	NORTH WEST COMMISSIONING REGION	ACUTE - SMALL	NHS	97.27%	96.58%	92.11%	97.33%	86.21%	93.17%	77.67%	77.95%	89.79%
RVV	EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST	SOUTH EAST COMMISSIONING REGION	ACUTE - TEACHING	NHS	98.67%	92.31%	92.64%	92.29%	78.00%	96.77%	81.59%	85.71%	89.75%
RXC	EAST SUSSEX HEALTHCARE NHS TRUST	SOUTH EAST COMMISSIONING REGION	ACUTE - LARGE	NHS	98.68%	94.46%	91.53%	95.37%	83.86%	99.38%	74.70%	79.37%	89.67%
RJ2	THE LEWISHAM AND GREENWICH NHS TRUST	LONDON COMMISSIONING REGION	ACUTE - LARGE	NHS	97.74%	87.89%	95.28%	86.45%	81.75%	99.44%	82.46%	85.91%	89.62%
RWF	MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST	SOUTH EAST COMMISSIONING REGION	ACUTE - LARGE	NHS	99.41%	88.65%	78.85%	91.38%	85.57%	98.70%	86.71%	86.18%	89.43%
RWH	EAST AND NORTH HERTFORDSHIRE NHS TRUST	EAST OF ENGLAND COMMISSIONING REGION	ACUTE - LARGE	NHS	99.63%	91.85%	96.58%	90.73%	82.50%	98.57%	75.56%	79.32%	89.34%
RHQ	SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	ACUTE - TEACHING	NHS	99.87%	91.71%	95.07%	90.99%	84.01%	98.37%	77.10%	77.29%	89.30%
RGT	CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	EAST OF ENGLAND COMMISSIONING REGION	ACUTE - TEACHING	NHS	98.31%	92.16%	94.81%	91.73%	81.75%	95.85%	80.62%	78.84%	89.26%
RTG	UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST	MIDLANDS COMMISSIONING REGION	ACUTE - TEACHING	NHS	99.56%	93.12%	87.32%	94.44%	88.94%	96.69%	75.27%	78.69%	89.25%
RJR	COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	NORTH WEST COMMISSIONING REGION	ACUTE - SMALL	NHS	99.73%	91.77%	96.69%	90.58%	80.01%	98.44%	76.13%	80.23%	89.20%
RHU	PORTSMOUTH HOSPITALS NHS TRUST	SOUTH EAST COMMISSIONING REGION	ACUTE - LARGE	NHS	98.83%	90.79%	80.37%	92.83%	86.43%	97.16%	82.64%	83.62%	89.08%
RVJ	NORTH BRISTOL NHS TRUST	SOUTH WEST COMMISSIONING REGION	ACUTE - LARGE	NHS	96.06%	94.61%	85.56%	96.23%	89.26%	96.82%	76.35%	77.76%	89.08%
RNZ	SALISBURY NHS FOUNDATION TRUST	SOUTH WEST COMMISSIONING REGION	ACUTE - SMALL	NHS	96.72%	91.37%	96.67%	89.80%	85.80%	97.41%	79.26%	75.48%	89.06%
R1K	LONDON NORTH WEST HEALTHCARE NHS TRUST	LONDON COMMISSIONING REGION	ACUTE - LARGE	NHS	98.88%	89.81%	97.42%	87.91%	86.14%	96.36%	78.15%	76.83%	88.94%
RDE	EAST SUFFOLK AND NORTH ESSEX NHS FOUNDATION TRUST	EAST OF ENGLAND COMMISSIONING REGION	ACUTE - MEDIUM	NHS	99.38%	92.93%	90.68%	93.72%	82.99%	96.94%	75.14%	79.68%	88.93%
RP5	DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	ACUTE - TEACHING	NHS	98.64%	90.70%	93.52%	90.14%	86.92%	98.67%	75.15%	77.58%	88.92%
RXR	EAST LANCASHIRE HOSPITALS NHS TRUST	NORTH WEST COMMISSIONING REGION	ACUTE - LARGE	NHS	97.78%	85.07%	93.87%	82.57%	86.67%	92.95%	86.91%	85.16%	88.87%
RN7	DARTFORD AND GRAVESHAM NHS TRUST	SOUTH EAST COMMISSIONING REGION	ACUTE - SMALL	NHS	99.58%	90.90%	92.96%	90.38%	81.03%	97.14%	76.77%	82.03%	88.85%
RMC	BOLTON NHS FOUNDATION TRUST	NORTH WEST COMMISSIONING REGION	ACUTE - MEDIUM	NHS	97.99%	91.16%	86.40%	92.26%	86.17%	96.11%	76.38%	83.95%	88.80%
RC9	LUTON AND DUNSTABLE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	EAST OF ENGLAND COMMISSIONING REGION	ACUTE - MEDIUM	NHS	96.02%	92.73%	94.70%	92.33%	78.20%	93.39%	78.56%	84.01%	88.74%
RFR	THE ROTHERHAM NHS FOUNDATION TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	ACUTE - MEDIUM	NHS	97.73%	94.04%	96.59%	93.39%	85.66%	92.89%	71.49%	77.38%	88.65%
RAS	THE HILLINGDON HOSPITALS NHS FOUNDATION TRUST	LONDON COMMISSIONING REGION	ACUTE - SMALL	NHS	98.32%	95.09%	99.26%	93.65%	83.59%	90.40%	73.38%	75.09%	88.60%
RBL	WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	NORTH WEST COMMISSIONING REGION	ACUTE - TEACHING	NHS	99.01%	84.52%	87.10%	83.65%	81.89%	98.34%	80.81%	91.10%	88.30%
RAJ	SOUTHEND UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	EAST OF ENGLAND COMMISSIONING REGION	ACUTE - MEDIUM	NHS	99.46%	90.81%	93.70%	90.37%	79.95%	95.61%	77.82%	77.62%	88.17%
RXE	ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	NHS	95.66%	92.46%	83.76%	99.19%	89.40%	94.13%	75.59%	74.13%	88.04%
RGD	LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	NHS	96.02%	83.00%	77.33%	87.96%	89.34%	95.39%	91.18%	84.08%	88.04%
RXQ	BUCKINGHAMSHIRE HEALTHCARE NHS TRUST	SOUTH EAST COMMISSIONING REGION	ACUTE - MULTI-SERVICE	NHS	99.52%	93.78%	93.08%	93.84%	85.21%	96.25%	70.56%	71.91%	88.02%
RQW	THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	EAST OF ENGLAND COMMISSIONING REGION	ACUTE - SMALL	NHS	98.12%	93.15%	93.89%	92.99%	81.70%	93.75%	75.00%	74.67%	87.91%
REF	ROYAL CORNWALL HOSPITALS NHS TRUST	SOUTH WEST COMMISSIONING REGION	ACUTE - LARGE	NHS	96.18%	89.16%	90.73%	89.15%	73.45%	93.17%	83.99%	86.84%	87.83%
RKE	WHITTINGTON HEALTH NHS TRUST	LONDON COMMISSIONING REGION	ACUTE - MEDIUM	NHS	98.78%	91.01%	89.63%	91.44%	84.17%	96.35%	73.71%	77.46%	87.82%
RNQ	KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST	MIDLANDS COMMISSIONING REGION	ACUTE - SMALL	NHS	98.58%	88.66%	80.56%	90.38%	81.67%	97.01%	80.79%	82.90%	87.57%
RAE	BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	ACUTE - TEACHING	NHS	98.21%	92.91%	93.90%	92.82%	81.18%	97.42%	70.82%	72.29%	87.44%
RCF	AIREDALE NHS FOUNDATION TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	ACUTE - SMALL	NHS	96.47%	82.85%	85.56%	82.22%	88.14%	95.01%	86.12%	82.30%	87.33%
RYK	DUDLEY AND WALSALL MENTAL HEALTH PARTNERSHIP NHS TRUST	MIDLANDS COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	NHS	97.61%	87.03%	75.18%	98.08%	86.50%	91.90%	81.61%	80.56%	87.31%
RKB	UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	MIDLANDS COMMISSIONING REGION	ACUTE - TEACHING	NHS	99.31%	93.44%	97.39%	92.37%	79.68%	98.95%	64.41%	72.90%	87.31%
RXY	KENT AND MEDWAY NHS AND SOCIAL CARE PARTNERSHIP TRUST	SOUTH EAST COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	NHS	99.03%	82.29%	89.49%	75.70%	94.04%	95.23%	81.69%	80.45%	87.24%
RKL	WEST LONDON NHS TRUST	LONDON COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	NHS	94.57%	85.04%	77.03%	90.80%	89.74%	90.32%	84.14%	86.18%	87.23%
RD3	POOLE HOSPITAL NHS FOUNDATION TRUST	SOUTH WEST COMMISSIONING REGION	ACUTE - SMALL	NHS	98.31%	94.06%	85.23%	95.73%	81.47%	94.47%	73.74%	74.42%	87.18%
RTP	SURREY AND SUSSEX HEALTHCARE NHS TRUST	SOUTH EAST COMMISSIONING REGION	ACUTE - MEDIUM	NHS	99.26%	85.04%	83.33%	85.43%	85.15%	98.34%	77.55%	82.42%	87.07%
RBZ	NORTHERN DEVON HEALTHCARE NHS TRUST	SOUTH WEST COMMISSIONING REGION	ACUTE - SMALL	NHS	97.94%	83.44%	79.26%	85.85%	86.44%	97.57%	82.02%	82.96%	86.94%
RCX	THE QUEEN ELIZABETH HOSPITAL KING'S LYNN NHS FOUNDATION TRUST	EAST OF ENGLAND COMMISSIONING REGION	ACUTE - SMALL	NHS	99.95%	90.07%	79.81%	93.56%	80.36%	98.78%	75.87%	75.90%	86.79%
RHM	UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST	SOUTH EAST COMMISSIONING REGION	ACUTE - TEACHING	NHS	97.02%	88.33%	98.36%	87.25%	76.76%	95.98%	73.21%	77.23%	86.77%
RT5	LEICESTERSHIRE PARTNERSHIP NHS TRUST	MIDLANDS COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	NHS	98.57%	90.52%	88.71%	91.90%	86.03%	86.02%	73.86%	78.17%	86.72%
RX1	NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	MIDLANDS COMMISSIONING REGION	ACUTE - TEACHING	NHS	97.51%	91.03%	100.00%	89.80%	82.30%	94.64%	65.98%	71.41%	86.58%
RRV	UNIVERSITY COLLEGE LONDON NHS FOUNDATION TRUST	LONDON COMMISSIONING REGION	ACUTE - TEACHING	NHS	98.73%	90.77%	88.00%	90.84%	74.21%	94.12%	75.31%	80.53%	86.56%
RTD	THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	ACUTE - TEACHING	NHS	99.66%	91.70%	83.95%	93.36%	87.39%	98.68%	66.23%	71.52%	86.56%
R1F	ISLE OF WIGHT NHS TRUST	SOUTH EAST COMMISSIONING REGION	ACUTE - MULTI-SERVICE	NHS	93.11%	92.40%	89.44%	93.38%	82.17%	92.82%	76.02%	72.41%	86.47%
RW1	SOUTHERN HEALTH NHS FOUNDATION TRUST	SOUTH EAST COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	NHS	96.93%	90.61%	87.77%	92.37%	86.50%	87.55%	77.11%	72.39%	86.40%
RWW	WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	NORTH WEST COMMISSIONING REGION	ACUTE - TEACHING	NHS	99.61%	87.85%	84.79%	88.83%	80.85%	96.58%	75.83%	75.86%	86.28%
RNA	THE DUDLEY GROUP NHS FOUNDATION TRUST	MIDLANDS COMMISSIONING REGION	ACUTE - MEDIUM	NHS	97.39%	81.49%	87.59%	79.94%	89.41%	93.43%	77.72%	82.27%	86.16%
RBK	WALSALL HEALTHCARE NHS TRUST	MIDLANDS COMMISSIONING REGION	ACUTE - MEDIUM	NHS	97.41%	87.50%	93.89%	86.04%	83.78%	95.58%	71.04%	73.70%	86.12%
RD1	ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRUST	SOUTH WEST COMMISSIONING REGION	ACUTE - MEDIUM	NHS	99.69%	92.87%	84.47%	94.35%	79.24%	96.34%	69.83%	71.36%	86.02%
RP7	LINCOLNSHIRE PARTNERSHIP NHS FOUNDATION TRUST	MIDLANDS COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	NHS	98.20%	87.91%	83.48%	92.89%	84.11%	93.36%	74.86%	72.96%	85.97%
RWE	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	MIDLANDS COMMISSIONING REGION	ACUTE - TEACHING	NHS	97.76%	88.56%	90.37%	88.16%	83.56%	87.48%	73.18%	76.16%	85.65%
RJ8	CORNWALL PARTNERSHIP NHS FOUNDATION TRUST	SOUTH WEST COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	NHS	97.91%	90.39%	86.06%	94.79%	79.19%	90.28%	72.97%	73.18%	85.60%
RJ7	ST GEORGE'S UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	LONDON COMMISSIONING REGION	ACUTE - TEACHING	NHS	92.73%	89.11%	91.25%	89.04%	80.54%	90.61%	77.64%	73.36%	85.54%
RM1	NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	EAST OF ENGLAND COMMISSIONING REGION	ACUTE - TEACHING	NHS	99.23%	86.38%	88.33%	86.07%	82.90%	97.87%	71.64%	71.59%	85.50%
RD8	MILTON KEYNES HOSPITAL NHS FOUNDATION TRUST	EAST OF ENGLAND COMMISSIONING REGION	ACUTE - SMALL	NHS	95.28%	82.07%	94.07%	79.27%	82.55%	93.89%	77.30%	79.45%	85.49%
RN3	GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST	SOUTH WEST COMMISSIONING REGION	ACUTE - MEDIUM	NHS	94.09%	89.16%	92.50%	88.46%	76.94%	92.30%	74.92%	75.39%	85.47%
RQ8	MID ESSEX HOSPITAL SERVICES NHS TRUST	EAST OF ENGLAND COMMISSIONING REGION	ACUTE - MEDIUM	NHS	99.44%	82.53%	91.77%	80.84%	79.18%	97.79%	77.35%	74.49%	85.42%
RAN	ROYAL NATIONAL ORTHOPAEDIC HOSPITAL NHS TRUST	LONDON COMMISSIONING REGION	ACUTE - SPECIALIST	NHS	96.99%	92.17%	99.26%	88.51%	78.11%	92.89%	67.29%	67.79%	85.38%
RDD	BASILDON AND THURROCK UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	EAST OF ENGLAND COMMISSIONING REGION	ACUTE - MEDIUM	NHS	98.92%	84.95%	96.67%	82.95%	79.45%	97.38%	70.42%	71.03%	85.22%
RCD	HARROGATE AND DISTRICT NHS FOUNDATION TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	ACUTE - SMALL	NHS	99.27%	88.57%	90.12%	87.63%	72.69%	97.56%	70.76%	75.01%	85.20%
RTH	OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	SOUTH EAST COMMISSIONING REGION	ACUTE - TEACHING	NHS	96.31%	89.21%	86.67%	89.87%	74.68%	93.02%	73.15%	75.36%	84.78%
RY5	LINCOLNSHIRE COMMUNITY HEALTH SERVICES NHS TRUST	MIDLANDS COMMISSIONING REGION	COMMUNITY	NHS	98.19%	84.27%	81.67%	87.05%	84.05%	93.37%	74.72%	74.82%	84.77%
RWJ	STOCKPORT NHS FOUNDATION TRUST	NORTH WEST COMMISSIONING REGION	ACUTE - MEDIUM	NHS	97.45%	88.43%	89.44%	88.13%	81.47%	97.28%	65.95%	67.37%	84.44%
RJZ	KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	LONDON COMMISSIONING REGION	ACUTE - TEACHING	NHS	97.65%	87.17%	91.63%	86.19%	78.24%	95.64%	69.64%	68.41%	84.32%
RWP	WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	MIDLANDS COMMISSIONING REGION	ACUTE - LARGE	NHS	98.51%	81.81%	88.01%	80.75%	78.95%	96.63%	73.50%	75.59%	84.22%
RH8	ROYAL DEVON AND EXETER NHS FOUNDATION TRUST	SOUTH WEST COMMISSIONING REGION	ACUTE - LARGE	NHS	98.61%	88.88%	85.66%	89.64%	78.66%	96.85%	66.63%	68.37%	84.16%
RCB	YORK TEACHING HOSPITAL NHS FOUNDATION TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	ACUTE - TEACHING	NHS	97.42%	85.01%	87.98%	83.95%	81.11%	95.76%	71.35%	69.55%	84.02%
RVY	SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	NORTH WEST COMMISSIONING REGION	ACUTE - SMALL	NHS	97.56%	88.06%	70.77%	94.60%	74.62%	92.03%	76.63%	77.31%	83.95%
RPC	QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST	SOUTH EAST COMMISSIONING REGION	ACUTE - SPECIALIST	NHS	99.74%	79.03%	92.41%	71.60%	85.51%	96.26%	70.47%	75.78%	83.85%
RXN	LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	NORTH WEST COMMISSIONING REGION	ACUTE - TEACHING	NHS	99.88%	81.68%	82.78%	81.44%	87.57%	97.65%	69.90%	69.45%	83.79%
RNN	NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	ACUTE - SMALL	NHS	92.46%	87.93%	83.03%	89.27%	77.30%	92.11%	72.24%	75.48%	83.73%
RWD	UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	MIDLANDS COMMISSIONING REGION	ACUTE - LARGE	NHS	95.16%	89.68%	93.15%	89.00%	76.03%	92.29%	65.79%	68.21%	83.66%
RN5	HAMPSHIRE HOSPITALS NHS FOUNDATION TRUST	SOUTH EAST COMMISSIONING REGION	ACUTE - LARGE	NHS	98.29%	85.58%	85.56%	85.58%	81.39%	94.57%	65.65%	69.75%	83.30%
RXW	SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	MIDLANDS COMMISSIONING REGION	ACUTE - LARGE	NHS	99.60%	82.34%	86.26%	81.22%	76.58%	94.66%	70.11%	73.98%	83.09%
RPA	MEDWAY NHS FOUNDATION TRUST	SOUTH EAST COMMISSIONING REGION	ACUTE - MEDIUM	NHS	96.13%	84.71%	95.93%	83.46%	82.96%	92.00%	63.63%	64.10%	82.87%
RLQ	WYE VALLEY NHS TRUST	MIDLANDS COMMISSIONING REGION	ACUTE - SMALL	NHS	94.01%	84.71%	92.38%	80.53%	74.69%	91.87%	72.47%	70.30%	82.62%
RWG	WEST HERTFORDSHIRE HOSPITALS NHS TRUST	EAST OF ENGLAND COMMISSIONING REGION	ACUTE - MEDIUM	NHS	98.99%	87.31%	88.89%	86.77%	73.96%	91.03%	66.04%	66.83%	82.48%
RXH	BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS NHS TRUST	SOUTH EAST COMMISSIONING REGION	ACUTE - TEACHING	NHS	98.44%	87.03%	89.80%	86.25%	70.44%	89.94%	63.20%	70.76%	81.98%
RVR	EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST	LONDON COMMISSIONING REGION	ACUTE - LARGE	NHS	97.34%	82.74%	82.68%	82.88%	74.13%	91.48%	68.69%	70.43%	81.30%
RTE	GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST	SOUTH WEST COMMISSIONING REGION	ACUTE - LARGE	NHS	94.29%	83.99%	77.51%	85.68%	74.15%	93.75%	68.35%	68.80%	80.82%
			National average		98.57%	92.12%	91.34%	92.94%	86.92%	96.33%	82.84%	83.64%	90.61%

Source: NHS Patient-Led Assessments of the Care Environment Collection, NHS Digital

Organisation Code	Organisation Name	Commissioning Region	Organisation Type	NHS	CLN Score %	Food Score %	Org Food Score %	Ward Food %	PDW Score %	CAM Score %	DEM Score %	DIS Score %	Overall average %
RR7	GATESHEAD HEALTH NHS FOUNDATION TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	ACUTE - SMALL	NHS	99.96%	99.61%	98.37%	100.00%	98.39%	99.71%	97.59%	96.79%	98.80%
RA4	YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST	SOUTH WEST COMMISSIONING REGION	ACUTE - SMALL	NHS	99.12%	98.46%	98.15%	98.56%	84.96%	98.59%	91.43%	96.23%	95.69%
RMP	TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	NORTH WEST COMMISSIONING REGION	ACUTE - SMALL	NHS	99.32%	94.20%	90.19%	96.20%	91.35%	99.73%	93.17%	93.74%	94.74%
RJC	SOUTH WARWICKSHIRE NHS FOUNDATION TRUST	MIDLANDS COMMISSIONING REGION	ACUTE - SMALL	NHS	99.69%	94.78%	96.06%	94.60%	91.57%	98.67%	86.20%	89.40%	93.87%
RGP	JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	EAST OF ENGLAND COMMISSIONING REGION	ACUTE - SMALL	NHS	99.68%	96.89%	96.30%	97.14%	87.01%	97.91%	85.37%	89.84%	93.77%
RJN	EAST CHESHIRE NHS TRUST	NORTH WEST COMMISSIONING REGION	ACUTE - SMALL	NHS	99.34%	96.43%	93.42%	98.23%	86.36%	95.37%	87.97%	89.26%	93.30%
RGR	WEST SUFFOLK NHS FOUNDATION TRUST	EAST OF ENGLAND COMMISSIONING REGION	ACUTE - SMALL	NHS	100.00%	92.40%	88.90%	93.79%	88.37%	98.49%	86.39%	90.16%	92.31%
RFS	CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST	MIDLANDS COMMISSIONING REGION	ACUTE - SMALL	NHS	99.25%	91.87%	98.89%	89.94%	87.97%	97.69%	84.47%	87.00%	92.14%
RFF	BARNSLEY HOSPITAL NHS FOUNDATION TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	ACUTE - SMALL	NHS	99.79%	91.58%	93.70%	90.97%	88.58%	97.15%	85.39%	88.04%	91.90%
RAX	KINGSTON HOSPITAL NHS FOUNDATION TRUST	LONDON COMMISSIONING REGION	ACUTE - SMALL	NHS	98.60%	90.95%	96.21%	89.96%	85.71%	98.65%	85.34%	88.70%	91.77%
RBD	DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST	SOUTH WEST COMMISSIONING REGION	ACUTE - SMALL	NHS	99.76%	94.29%	97.04%	93.38%	86.39%	99.69%	79.56%	81.91%	91.50%
RAP	NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST	LONDON COMMISSIONING REGION	ACUTE - SMALL	NHS	97.49%	86.05%	98.33%	82.96%	90.83%	94.93%	89.99%	90.56%	91.39%
RA3	WESTON AREA HEALTH NHS TRUST	SOUTH WEST COMMISSIONING REGION	ACUTE - SMALL	NHS	98.76%	92.37%	85.37%	96.62%	84.96%	95.87%	87.13%	89.04%	91.27%
RLT	GEORGE ELIOT HOSPITAL NHS TRUST	MIDLANDS COMMISSIONING REGION	ACUTE - SMALL	NHS	98.97%	92.39%	81.48%	96.58%	81.17%	97.42%	89.34%	90.13%	90.94%
RC1	BEDFORD HOSPITAL NHS TRUST	EAST OF ENGLAND COMMISSIONING REGION	ACUTE - SMALL	NHS	99.54%	94.89%	89.07%	95.95%	79.90%	97.15%	77.06%	85.73%	89.91%
RBT	THE MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	NORTH WEST COMMISSIONING REGION	ACUTE - SMALL	NHS	97.27%	96.58%	92.11%	97.33%	86.21%	93.17%	77.67%	77.95%	89.79%
RJR	COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	NORTH WEST COMMISSIONING REGION	ACUTE - SMALL	NHS	99.73%	91.77%	96.69%	90.58%	80.01%	98.44%	76.13%	80.23%	89.20%
RNZ	SALISBURY NHS FOUNDATION TRUST	SOUTH WEST COMMISSIONING REGION	ACUTE - SMALL	NHS	96.72%	91.37%	96.67%	89.80%	85.80%	97.41%	79.26%	75.48%	89.06%
RN7	DARTFORD AND GRAVESHAM NHS TRUST	SOUTH EAST COMMISSIONING REGION	ACUTE - SMALL	NHS	99.58%	90.90%	92.96%	90.38%	81.03%	97.14%	76.77%	82.03%	88.85%
RAS	THE HILLINGDON HOSPITALS NHS FOUNDATION TRUST	LONDON COMMISSIONING REGION	ACUTE - SMALL	NHS	98.32%	95.09%	99.26%	93.65%	83.59%	90.40%	73.38%	75.09%	88.60%
RQW	THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	EAST OF ENGLAND COMMISSIONING REGION	ACUTE - SMALL	NHS	98.12%	93.15%	93.89%	92.99%	81.70%	93.75%	75.00%	74.67%	87.91%
RNQ	KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST	MIDLANDS COMMISSIONING REGION	ACUTE - SMALL	NHS	98.58%	88.66%	80.56%	90.38%	81.67%	97.01%	80.79%	82.90%	87.57%
RCF	AIREDALE NHS FOUNDATION TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	ACUTE - SMALL	NHS	96.47%	82.85%	85.56%	82.22%	88.14%	95.01%	86.12%	82.30%	87.33%
RD3	POOLE HOSPITAL NHS FOUNDATION TRUST	SOUTH WEST COMMISSIONING REGION	ACUTE - SMALL	NHS	98.31%	94.06%	85.23%	95.73%	81.47%	94.47%	73.74%	74.42%	87.18%
RBZ	NORTHERN DEVON HEALTHCARE NHS TRUST	SOUTH WEST COMMISSIONING REGION	ACUTE - SMALL	NHS	97.94%	83.44%	79.26%	85.85%	86.44%	97.57%	82.02%	82.96%	86.94%
RCX	THE QUEEN ELIZABETH HOSPITAL KING'S LYNN NHS FOUNDATION TRUST	EAST OF ENGLAND COMMISSIONING REGION	ACUTE - SMALL	NHS	99.95%	90.07%	79.81%	93.56%	80.36%	98.78%	75.87%	75.90%	86.79%
RD8	MILTON KEYNES HOSPITAL NHS FOUNDATION TRUST	EAST OF ENGLAND COMMISSIONING REGION	ACUTE - SMALL	NHS	95.28%	82.07%	94.07%	79.27%	82.55%	93.89%	77.30%	79.45%	85.49%
RCD	HARROGATE AND DISTRICT NHS FOUNDATION TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	ACUTE - SMALL	NHS	99.27%	88.57%	90.12%	87.63%	72.69%	97.56%	70.76%	75.01%	85.20%
RVY	SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	NORTH WEST COMMISSIONING REGION	ACUTE - SMALL	NHS	97.56%	88.06%	70.77%	94.60%	74.62%	92.03%	76.63%	77.31%	83.95%
RNN	NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	ACUTE - SMALL	NHS	92.46%	87.93%	83.03%	89.27%	77.30%	92.11%	72.24%	75.48%	83.73%
RLQ	WYE VALLEY NHS TRUST	MIDLANDS COMMISSIONING REGION	ACUTE - SMALL	NHS	94.01%	84.71%	92.38%	80.53%	74.69%	91.87%	72.47%	70.30%	82.62%
			Acute Small Average		98.35%	91.50%	90.77%	91.89%	84.25%	96.38%	81.70%	83.48%	89.79%

Source: NHS Patient-Led Assessments of the Care Environment Collection, NHS Digital

Organisation Code	Organisation Name	Commissioning Region	Organisation Type	NHS	CLN Score %	Food Score %	Org Food Score %	Ward Food %	PDW Score %	CAM Score %	DEM Score %	DIS Score %	Overall average %
RR7	GATESHEAD HEALTH NHS FOUNDATION TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	ACUTE - SMALL	NHS	99.96%	99.61%	98.37%	100.00%	98.39%	99.71%	97.59%	96.79%	98.80%
RTF	NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	ACUTE - LARGE	NHS	99.97%	99.13%	98.15%	99.67%	95.39%	99.61%	97.14%	97.11%	98.27%
RX3	TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	NHS	99.04%	95.80%	93.15%	98.71%	95.77%	97.68%	95.73%	93.66%	96.19%
TAD	BRADFORD DISTRICT CARE NHS FOUNDATION TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	CARE TRUST	NHS	98.53%	98.22%	96.20%	99.29%	98.63%	98.08%	89.78%	90.40%	96.14%
RXG	SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	NHS	99.40%	93.70%	94.79%	92.40%	96.20%	98.61%	96.50%	94.25%	95.73%
TAH	SHEFFIELD HEALTH AND SOCIAL CARE NHS FOUNDATION TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	CARE TRUST	NHS	99.30%	96.20%	92.48%	98.36%	92.02%	97.00%	96.20%	90.43%	95.25%
R0B	SOUTH TYNESIDE AND SUNDERLAND NHS FOUNDATION TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	ACUTE - LARGE	NHS	99.73%	93.79%	96.41%	93.57%	88.01%	98.60%	86.04%	89.63%	93.22%
RVW	NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	ACUTE - MEDIUM	NHS	99.89%	95.93%	95.70%	96.01%	88.16%	99.72%	85.57%	84.73%	93.21%
RR8	LEEDS TEACHING HOSPITALS NHS TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	ACUTE - TEACHING	NHS	99.82%	97.09%	94.53%	97.68%	89.94%	98.52%	81.92%	82.91%	92.80%
RTR	SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	ACUTE - TEACHING	NHS	96.16%	94.37%	99.14%	93.30%	86.04%	93.26%	85.64%	89.22%	92.14%
RWY	CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	ACUTE - LARGE	NHS	99.08%	91.34%	95.50%	90.40%	92.68%	98.78%	82.40%	85.94%	92.02%
RFF	BARNSLEY HOSPITAL NHS FOUNDATION TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	ACUTE - SMALL	NHS	99.79%	91.58%	93.70%	90.97%	88.58%	97.15%	85.39%	88.04%	91.90%
RXP	COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	ACUTE - MULTI-SERVICE	NHS	99.45%	97.45%	97.09%	97.74%	85.32%	98.54%	78.56%	80.66%	91.85%
RV9	HUMBER TEACHING NHS FOUNDATION TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	NHS	99.25%	94.99%	90.01%	99.75%	88.54%	94.41%	84.29%	83.21%	91.81%
RCU	SHEFFIELD CHILDRENS NHS FOUNDATION TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	ACUTE - SPECIALIST	NHS	99.70%	92.65%	89.50%	94.87%	82.80%	97.64%	-	85.30%	91.78%
RXF	MID YORKSHIRE HOSPITALS NHS TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	ACUTE - LARGE	NHS	99.77%	93.22%	85.56%	94.92%	86.69%	99.45%	85.63%	84.98%	91.28%
RX4	CUMBRIA, NORTHUMBERLAND, TYNE AND WEAR NHS FOUNDATION TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	NHS	98.90%	91.59%	89.34%	94.41%	89.50%	97.92%	85.58%	79.97%	90.90%
RY6	LEEDS COMMUNITY HEALTHCARE NHS TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	COMMUNITY	NHS	95.24%	95.60%	94.04%	97.24%	86.62%	95.00%	72.22%	86.92%	90.36%
RWA	HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	ACUTE - TEACHING	NHS	97.33%	93.72%	88.89%	94.84%	86.36%	94.99%	78.83%	87.54%	90.31%
RJL	NORTHERN LINCOLNSHIRE AND GOOLE NHS FOUNDATION TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	ACUTE - LARGE	NHS	99.28%	90.05%	86.74%	90.96%	85.89%	97.53%	82.69%	85.70%	89.86%
RHQ	SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	ACUTE - TEACHING	NHS	99.87%	91.71%	95.07%	90.99%	84.01%	98.37%	77.10%	77.29%	89.30%
RP5	DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	ACUTE - TEACHING	NHS	98.64%	90.70%	93.52%	90.14%	86.92%	98.67%	75.15%	77.58%	88.92%
RFR	THE ROTHERHAM NHS FOUNDATION TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	ACUTE - MEDIUM	NHS	97.73%	94.04%	96.59%	93.39%	85.66%	92.89%	71.49%	77.38%	88.65%
RXE	ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	NHS	95.66%	92.46%	83.76%	99.19%	89.40%	94.13%	75.59%	74.13%	88.04%
RGD	LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	NHS	96.02%	83.00%	77.33%	87.96%	89.34%	95.39%	91.18%	84.08%	88.04%
RAE	BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	ACUTE - TEACHING	NHS	98.21%	92.91%	93.90%	92.82%	81.18%	97.42%	70.82%	72.29%	87.44%
RCF	AIREDALE NHS FOUNDATION TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	ACUTE - SMALL	NHS	96.47%	82.85%	85.56%	82.22%	88.14%	95.01%	86.12%	82.30%	87.33%
RTD	THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	ACUTE - TEACHING	NHS	99.66%	91.70%	83.95%	93.36%	87.39%	98.68%	66.23%	71.52%	86.56%
RCD	HARROGATE AND DISTRICT NHS FOUNDATION TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	ACUTE - SMALL	NHS	99.27%	88.57%	90.12%	87.63%	72.69%	97.56%	70.76%	75.01%	85.20%
RCB	YORK TEACHING HOSPITAL NHS FOUNDATION TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	ACUTE - TEACHING	NHS	97.42%	85.01%	87.98%	83.95%	81.11%	95.76%	71.35%	69.55%	84.02%
RNN	NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TRUST	NORTH EAST AND YORKSHIRE COMMISSIONING REGION	ACUTE - SMALL	NHS	92.46%	87.93%	83.03%	89.27%	77.30%	92.11%	72.24%	75.48%	83.73%
			Regional average		98.42%	92.80%	91.62%	93.74%	87.89%	97.04%	82.52%	83.68%	91.00%

Notes and Definitions - Organisation Scores[1]

Field	Definition
Organisation Code	Code of healthcare provider
Organisation Name	Name of healthcare provider
Commissioning Region	Commissioning Region for healthcare provider
NHS or Independent Organisation	Whether the organisation is NHS or Independent
Organisation Type	Type of service(s) provided by the Organisation: (Acute - Large; Acute - Medium; Acute - Multi-Service; Acute - Small; Acute - Specialist; Acute - Teaching; Care Trust; Independent Sector; Mental Health and Learning Disability; Small Community)
CLN Score %	Cleanliness domain marks achieved by the organisation's sites that completed a PLACE return as a percentage of the maximum possible Cleanliness domain marks for those sites
Food Score %	Food domain marks achieved by the organisation's sites that completed a PLACE return as a percentage of the maximum possible Food domain marks for those sites
Org Food Score %	Organisation Food domain marks achieved by the organisation's sites that completed a PLACE return as a percentage of the maximum possible Organisation Food domain marks for those sites
Ward Food Score %	Ward Food domain marks achieved by the organisation's sites that completed a PLACE return as a percentage of the maximum possible Ward Food domain marks for those sites
PDW Score %	Privacy, Dignity and Wellbeing domain marks achieved by the organisation's sites that completed a PLACE return as a percentage of the maximum possible Privacy, Dignity and Wellbeing domain marks for those sites
CAM Score %	Condition, Appearance and Maintenance domain marks achieved by the organisation's sites that completed a PLACE return as a percentage of the maximum possible Condition, Appearance and Maintenance domain marks for those sites
DEM Score %	Dementia domain marks achieved by the organisation's sites that completed a PLACE return as a percentage of the maximum possible Dementia domain marks for those sites
DIS Score %	Disability domain marks achieved by the organisation's sites that completed a PLACE return as a percentage of the maximum possible Disability domain marks for those sites

Note:
1 Organisation score calculations now exclude sites with zero beds (previously they were given a default value of 1 bed for use in 'average' calculations such as these).

Appendix 2

Weekly Place Inspections – QEF Actions Logged by Trade Group

Total Place Audit Jobs By Tradesman - 3rd Apr19 - 13th Feb20

Joiner = 67	Plumber = 32	Estates Off = 10
Electrician = 18	Maint Assist = 221	Gardener = 8
Fitter = 7	Bricklayer = 4	Decorator = 221

TOTAL JOBS = 588

Trust Board

Gateshead Health NHS Foundation Trust

Report Cover Sheet

Agenda Item: 19

Date of Meeting:	Tuesday 29th September 2020			
Report Title:	EPRR Assurance Report			
Purpose of Report:	Provide assurance on EPRR Core standards compliance and that we have undertaken a comprehensive and thorough review of learning to date of the COVID-19 pandemic embedding associated EPRR actions into the work programme.			
	Decision: ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
Trust Goals that the report relates to: (Including reference to any specific risk)	**Goal 1** Working with partners, we will manage and improve the health of the population of Gateshead, promoting wellbeing and preventing the occurrence and progression of ill-health wherever possible. **Goal 2** All the services we deliver will be good or outstanding when assessed against being safe, effective, caring, responsive, and well-led. **Goal 4** All our services will have a high safety culture in which openness, fairness, accountability and learning from high levels of incident reporting and mortality reviews is the norm. **Goal 5** All our services will be effective: we will reduce unwarranted variation, ensure our practice is consistent with recognised best practice 7 days a week, and improve outcomes for patients. **Goal 6** We will have an engaged and motivated workforce living the values and behaviours of the organisation, and who are responsive and adaptive to the changing needs of our environment. **Goal 7** We will deliver value for money and help ensure the local health and care system is sustainable and well led.			
Recommendations: (Action required by Board of Directors)	To receive the report for assurance and to note the ongoing EPRR action plan.			

Financial Implications:	
Risk Management Implications:	Failure to comply with NHS and Statutory requirements
Human Resource Implications:	
Trust Diversity & Inclusion Objective that the report relates to: (including reference to any specific implications and actions)	**Objective 2** The Trust promotes a culture of inclusion where employees have the opportunity to work in a supportive and positive environment and find a healthy balance between working life and personal commitments. **Objective 3** Leaders within the Trust are informed and knowledgeable about the impact of business decisions on a diverse workforce and the differing needs of the communities we serve.
Author:	Andy Colwell - Head of Facilities, QEF
Presented by:	Jo Baxter - Chief Operating Officer/ Peter Harding - Managing Director QEF

Gateshead Health NHS Foundation Trust

EPRR Assurance Statement 2020-2021

1) Introduction and context

It is a requirement that NHS Providers submit for approval by their boards their current self-assessment statement of assurance against the Emergency Planning Core Standards.

In recognition of the current situation with COVID-19 a revised amended approach to the annual assessment has been issued by the Director of EPRR (National) on 20th August 2020.

The following EPRR assurance statement therefore provides an updated position on the following amended requirements,

1) EPRR assurance action plans have been reviewed in order to improve your level of compliance against the 2019/2020 EPRR Assurance Core Standards, and where you have previously reported partial or non-compliance as your overall assurance rating that you provide an updated assurance level following review and delivery of your ongoing action plans.

2) That you have undertaken, or plan to undertake, a formal review process on your response to the COVID-19 pandemic to date, and have associated plans to ensure that the lessons and recommendations from that review are embedded as part of your ongoing EPRR work programme, and

3) That you have reviewed your response to the COVID-19 pandemic and taken steps to embed key lessons and actions in your planning for winter and associated system response arrangements.

The attached Action Plan details the core standards requiring additional work at the time of submission these were all rated partially or non-compliant.

2. Assurance Elements

2.1 EPRR Core Standards and Action Plan review

A review of the EPRR core standards and the associated plan has been undertaken and the overall level of compliance has been assessed as **Partially Compliant**. It is evident that a key number of standards have lapsed and some of the evidence submitted for previous standards compliance cannot be used as it does not describe the current position. It should be noted that a number of key individuals responsible for delivery of EPRR within the Trust have previously left the organisation. The Trust has been without a designated Accountable Emergency Officer (AEO) since March 2020 and an EPRR Lead since December 2019.

In addition, a number of policy decisions are needed to ensure compliance with a number of standards which require corporate approval and a change in the way the organisation approaches EPRR.

A summary of the standards submission assessment scores against the respective core standards is provided below,

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	14	10	0	4
Command and control	2	1	1	0
Training and exercising	3	0	3	0
Response	7	5	2	0
Warning and informing	3	3	0	0
Cooperation	4	4	0	0
Business Continuity	9	6	2	1
CBRN	14	14	0	0
Total	64	51	8	5

Deep Dive	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Severe Weather response	15	14	1	0
Long Term adaptation planning	5	1	4	0
Total	20	15	5	0

A number of standards are awaiting sign off at the next EPRR committee and with the appointment of a dedicated Head of EPRR and a resourced team it is expected that the level of compliance will improve as actions are progressed. The associated action plan is provided at Appendix A.

2.2 Assurance that the review process on our response to the COVID-19 pandemic to date, and have associated plans to ensure that the lessons and recommendations from that review are embedded as part of your ongoing EPRR work programme.

The Trust responded to the Covid-19 pandemic in line with the guidance set out from NHSE/I and put actions in place to redirect staff and resources which freed-up the maximum possible inpatient and critical care capacity.

A Command Structure was introduced alongside an Incident Control Centre which was a central hub managing flow of information and supported the command structures by supplying loggists and action logs were maintained.

Support was available to staff to stay well and at work where possible as well as providing equipment for staff to work safely from home, where appropriate, and an enhanced health and wellbeing support programme was available for all staff.

The Trust held a Strategic Recovery Planning Workshop on the 29th April 2020 which identified the key priorities and approach to recovery which was in line with the NHS Chief Executive Simon Stevens letter outlining how the NHS was entering the second phase of the NHS Response to COVID-19.

A phased plan was implemented which considered recovery of services and adaptions to return to business as usual utilising the following principles.

- Adhere to Government guidelines: social distancing etc.
- Review new ways of working:.
- What do we need to Stop doing
- Digital First – using technology to support best practice
- Treatment opportunities: using treatments available to reduce face to face contacts & footfall

In addition to the internal review, lessons learnt from the regional NE Yorkshire Phase 1 Covid 19 initial response identified specific EPRR actions which will support the progression of our plans and principles of working in the future. These include the following elements,

Training and exercising

- Trust to have staff (leaders) who are trained and competent decision makers/ commanders. This should be sustained and embedded.
- Embed internal decision making frameworks within EPRR command and control frameworks.
- Consider EPRR to be part of annual mandatory training.
- Maximise partnership working
- Consideration of a digital solution for loggists role which complies with legislative requirements

EPRR Governance

- Identified clinical lead for EPRR to support work programme
- Implement command and control arrangements which can stand up to any incident
- Implement rota arrangements to support incident command and control
- Ensure command resilience for Winter

Duty to maintain plans

- Plans should be adaptable and flexible and tested against a range of differing scenarios

Business Continuity

- Undertake a revised Business Impact Assessment (BIA) in light of new ways of working including review of digital integrity and infrastructure, procurement and supply chain resilience.
- Review of BCP to support care homes and their contingency arrangements in advance of winter.
- Continuity of PPE supplies and supply chain coinciding with impact of Brexit

2.3 That you have reviewed your response to the COVID-19 pandemic and taken steps to embed key lessons and actions in your planning for winter and associated system response arrangements.

Our winter plan has changed fundamentally as a consequence of COVID-19. We are now operating in a totally different way including:-

- Infection control measures in place ranging from wearing PPE to socially distancing requirements in waiting areas
- Having 2 metres between beds which has reduced bed capacity
- Regular testing of patients and staff
- Some staff shielding or self-isolating therefore reducing staffing numbers
- Increased disruption to social care
- A need to continue to support social care especially care homes
- The implementation of shielding requirements for patients
- A focus on managing care which was delayed by Covid-19 and has had an impact on waiting times and referrals to treatment

The Trust initiated its Command and Control Emergency arrangements on 16 March 2020 and implemented strategic, tactical and operational command structures. In line with national guidance the Trust:

- Increased critical care capacity to 41 beds and redeployed staff
- Suspended elective surgery
- Created Covid and non Covid areas
- Suspended Community Services
- Carried out estates work to increase capacity for oxygen supply and therapy

- Implemented revised discharge arrangements

The Trust also joined locally created “cells” covering:

- Testing and because of our Pathology expertise, took a lead role in Covid detection
- Care Home Support
- Discharge
- Primary Care including supporting GP ‘hot sites’
- Outbreak Control led by the Director of Public Health. Standard Operating Procedures have been agreed for outbreak management

Some of the key lessons from our experience of Covid-19 to date also include:-

- The need, with the CCG, Primary Care and Gateshead Council to support care homes with nursing capacity. At the CCG’s request in Phase 1 and 2 we intervened to keep a number of care homes open. There is a need to commission a Rapid Response Team to support care homes with Covid-19 outbreaks or staff shortages.
- To adapt national guidance to local circumstances especially on testing regimes
- To continue with our additional wellbeing initiatives for staff
- To train more staff in critical care skills
- Increasing the frequency and detail of communications to staff
- With partners to ensure primary care continues to operate an accessible service

For winter 20/21 we have developed pathways for Covid-19 positive patients as part of our approach to bed management. We have learned the lessons of the earlier phases and have well tested Covid-19 systems and processes. This includes the use of testing for patients likely to be admitted for 24hours or more.

The Winter Plan 2020/21 assumes manageable levels of Covid-19 admissions. Caveats to the Winter Plan linked to Covid-19 include:

- Infection and admission rates at predicted levels
- The social care sector being able to maintain residents at home and accept discharges
- No major changes in IPC which would reduce our bed base or staff availability

3. Conclusion

Assurance can be provided that the Trust has responded well to COVID-19 and has undertaken a comprehensive and thorough review of learning to date of the COVID-19 pandemic. This has included converting the learning into practice and ensuring that actions are embedded within our EPRR Action plan for progressing.

Andy Colwell
Head of Facilities
QEF

Appendix A

EPRR Core Standards Action Plan

Ref	Domain	Standard	Expected Detail	Organisation Evidence	RAG	Action to be taken	Lead	Timescale
9	Duty to maintain plans	Collaborative planning	Plans have been developed in collaboration with partners and service providers to ensure the whole patient pathway is considered.	No recent evidence of plans been shared.	Non compliant	Need to formally record the submission on plans to partners and evidence collaborative approach. Update EPRR policy and associated plans to evidence this standard	Head of EPRR	Mar-21
11	Duty to maintain plans	Critical incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as defined within the EPRR Framework).	Over reliance on Majax Plan which is a casualty plan does not cover adequately a critical incident	Non compliant	Produce a critical incident plan to manage local (Level 1) critical incident	Head of EPRR	Mar-21
15	Duty to maintain plans	Pandemic influenza	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to pandemic influenza.	The Trust has a pandemic influenza plan which has not been reviewed and updated. There are regular IPCC meetings held as well as Flu planning meetings to discuss issues and promotion of the vaccination programme there	Non compliant	Update the Plan, include lessons learnt from CV-19 response. Should consider adding to IPC committee TOR to review and contribute to formal review the plan and ownership of the content needs explicitly detailed as it is an organisational plan with various leads.	Trust IPC Lead/ Head of EPRR	Dec-20

Ref	Domain	Standard	Expected Detail	Organisation Evidence	RAG	Action to be taken	Lead	Timescale
17	**Duty to maintain plans**	**Mass countermeasures**	In line with current guidance and legislation, the organisation has effective arrangements in place to distribute Mass Countermeasures - including arrangement for administration, reception and distribution of mass prophylaxis and mass vaccination. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements.	No evidence of up to date mass counter measure procedures in place currently.	Non-compliant	Current plans need updated and tested urgently. Pharmacy and Community teams would be expected to support. Dovetail with COVID vaccination mobilisation plans	Trust IPC Lead/ Head of EPRR / Chief Pharmacist	Oct-20

Ref	Domain	Standard	Expected Detail	Organisation Evidence	RAG	Action to be taken	Lead	Timescale
25	**Command and control**	**Trained on-call staff**	On-call staff are trained and competent to perform their role, and are in a position of delegated authority on behalf of the Chief Executive Officer / Clinical Commissioning Group Accountable Officer. The identified individual: • Should be trained according to the NHS England EPRR competencies (National Occupational Standards) • Can determine whether a critical, major or business continuity incident has occurred • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout.	Previous on-call training has lapsed Limited number of staff trained to required standards	Partially compliant	on call arrangement have been redefined - work progressing to train to required standards, currently not complaint to standards for command levels	Trust COO/ Head of EPRR	Oct-20
26	**Training and exercising**	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are competent in their role; training records are kept to demonstrate this.	The previously completed TNA has not been translated into a formal training strategy/ will need revised given the changes in the approach for EPRR/ On call arrangements	Partially compliant	Produce an EPRR training strategy and implement measure to ensure compliance	Trust COO/ Head of EPRR	Dec-20

Ref	Domain	Standard	Expected Detail	Organisation Evidence	RAG	Action to be taken	Lead	Timescale
27	**Training and exercising**	**EPRR exercising and testing programme**	The organisation has an exercising and testing programme to safely test major incident, critical incident and business continuity response arrangements. Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement.	The Trust has recently taken part in regional communication test as organised through NEAS. Annual table top exercises take place, with the Trust being part of Pelican Exercises (1, 2 & 3) as organised by NHSE and PHE. Hot debriefs take place after each exercise and questionnaires are sent out to all participants on what went well, what didn't go so well and areas that could be improved, COVID and a lack of EPRR resource has impacted on capacity to exercise in 2021 Overreliance on live events to evidence compliance. Picked up by internal audit 2019	Partially compliant	Exercise programme to be approved for 2020-21 Implement a formal process to record lessons learns and follow up actions via governance arrangements. Comms exercise Nov 20 to test revised EPRR MI Action Cards. Diary Live test 2020 Address issues with Internal Audit recommendations	Head of EPRR Action Card leads (DNS/ MED/ DEF)	01/11/2020 01/12/21

Ref	Domain	Standard	Expected Detail	Organisation Evidence	RAG	Action to be taken	Lead	Timescale
28	**Training and exercising**	**Strategic and tactical responder training**	Strategic and tactical responders must maintain a continuous personal development portfolio demonstrating training in accordance with the National Occupational Standards, and / or incident / exercise participation	Previous records of training and attendees of Incident Management training courses are kept but is not part of a continuous development programme	Partially compliant	Previous training has lapsed and the PDP process is not inclusive of responder training. Portfolio of evidence not maintained centrally via ESR competency. Process to be defined and actioned. EPRR training strategy/ policy needs defined and approved	Head of EPRR	Mar-21
32	**Response**	**Management of business continuity incidents**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Business continuity (BC) plans are in place to respond to any BC incident whether planned or unplanned, these are reviewed and updated as necessary and are based on ISO 22301.	Partially compliant	Plans exist but need reviewed – review plans	All BCP owners/ Head of EPRR	Dec-20
33	**Response**	**Loggist**	The organisation has 24 hour access to a trained loggist(s) to ensure decisions are recorded during business continuity incidents, critical incidents and major incidents. Key response staff are aware of the need for keeping their own personal records and logs to the required standards.	22 loggists trained by NEAS to support COVID response, but formal arrangements needed to ensure that when an incident occurs loggist staff are mandated to attend the incident command cell.	Partially compliant	Formalise and recognise the Loggist role in job descriptions and mandate attendance at incidents as part of on call arrangements	Head of EPRR	
49	**Business Continuity**	**Business Impact Assessment**	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(s).	Business continuity plans are reviewed bi annually or when there has been a change to processes or an incident where improvement is necessary, any risks will be put onto the Datix system and reviewed at the EPRR committee depending on their severity.	Partially compliant	Review outdated BCP's and review risks including review BIA Update BCP policy to detail annual review of BCP	Head of EPRR	Dec-20

Ref	Domain	Standard	Expected Detail	Organisation Evidence	RAG	Action to be taken	Lead	Timescale
51	**Business Continuity**	**Business Continuity Plans**	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure These plans will be reviewed regularly (at a minimum annually), or following organisational change, or incidents and exercises.	A business impact analysis is carried out in the various wards, areas and departments to gather information on who or what they rely on and who or what relies on them using this information the business continuity plans are developed.	Partially compliant	Trust Business continuity plans exist for incidents they are reviewed bi annually (should be annual) there is no arrangements / system to manage or effectively evidence compliance or escalation of non-compliance. BCMS process has lapsed.		
53	**Business Continuity**	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board.	BCMS states there is an audit process but no evidence exists of auditing of plans IA did audit BC policy and actions identified need followed through	Non-compliant	Conduct internal audit of BCMS Close out existing audit recommendations.	Head of EPRR	Mar 21 Dec 20

Ref	Domain	Standard	Expected Detail	Organisation Evidence	RAG	Action to be taken	Lead	Timescale
15	**Severe Weather response**	**ICT BC**	The organisations ICT Services have been thoroughly exercised and equipment tested which allows for remote access and remote services are able to provide resilience in extreme weather e.g. are cooling systems sized appropriately to cope with heatwave conditions, is the data centre positioned away from areas of flood risk.	Covid response and numbers of homeworkers accessing systems remotely - not identified as Critical but the system appears to work	Partially compliant	Assessment of needs has not been formalised to identify number of "critical" users. Approach has been tested with COVID but not formally agreed/ approved with any risks identified.	Head of IT/ Head of EPRR	Dec-20
17	**Long term adaptation planning**	**Overheating risk**	The organisation has identified and recorded those parts of their buildings that regularly overheat (exceed 27 degrees Celsius) on their risk register. The register identifies the long term mitigation required to address this taking into account the sustainable development commitments in the long term plan. Such as avoiding mechanical cooling and use of cooling higherachy.	BMS (building Management System) records ward temperatures	Partially compliant	Review of BMS records and updating of risk register with ward areas	QEF/ Head of EPRR	Oct-20
18	**Long term adaptation planning**	**Building adaptations**	The organisation has in place an adaptation plan which includes necessary modifications to buildings and infrastructure to maintain normal business during extreme temperatures or other extreme weather events.	Adaption plan has been completed - DATIX action 2532	Partially compliant	Approval of plan needed at next EPRR committee	Sustainability/ Head of EPRR	Oct-20

Ref	Domain	Standard	Expected Detail	Organisation Evidence	RAG	Action to be taken	Lead	Timescale
19	**Long term adaptation planning**	**Flooding**	The organisations adaptation plans include modifications to reduce their buildings and estates impact on the surrounding environment for example Sustainable Urban Drainage Systems to reduce flood risks.	Flood risk assessment completed with Blaydon only site with flood risk Datix action 2532	Partially compliant	flood risk assessment and plans to be presented to next EPRR committee	QEF / Head of EPRR	Oct-20
20	**Long term adaptation planning**	**New build**	The organisation considers for all its new facilities relevant adaptation requirements for long term climate change	Adaption plan has been completed - DATIX action 2532	Partially compliant	Approval of plan needed at next EPRR committee	QEF/ Head of EPRR	Oct-20

Trust Board

Gateshead Health NHS Foundation Trust

Report Cover Sheet

Agenda Item: 20

Date of Meeting:	Tuesday 29th September 2020			
Report Title:	Summary of Assurances and Items for Escalation from Board Committees			
Purpose of Report:	To receive the assurance reports from the following meetings: • Quality Governance Committee held on 15th September 2020 • Finance and Performance Committee held on 28th September 2020 • Human Resources Committee held on 11th August 2020 • Audit Committee held on 3rd September 2020			
	Decision: ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
Trust Goals that the report relates to: (Including reference to any specific risk)				
Recommendations: (Action required by Board of Directors)	To receive the reports for assurance.			
Financial Implications:				
Risk Management Implications:				
Human Resource Implications:				
Equality and Diversity Implications:				
Author:				
Presented by:				

Quality Governance Committee – 15 September 2020

The Quality Governance Committee has fulfilled its role and functions as defined within its terms of reference. The reports received by the Quality Governance Committee and level of assurance are set out below.				
ISSUES TO BE RAISED TO BOARD	**ASSURANCE LEVEL**	**COMMITTEE UPDATE**	**NEXT ACTION**	**TIMESCALE**
Board Assurance Framework		The Committee noted the three strategic objectives within Aim 1 and agreed it would be positive to include an objective aligned to mental health.	Update BAF for Trust Board	September 2020
IPC Board Assurance Framework		The Committee received a comprehensive update and agreed this report would be received quarterly for assurance.		
Integrated Quality and Learning Report		The Committee received good assurance from this report.		
Draft Quality Account		The committee received a draft copy of the 2019/20 Quality Accounts for assurance.	Action plan to be received in a future Committee	January 2021
Maternity Review		The Committee received this update for assurance and noted the recommendations made.	Action plan to be brought to next meeting	October 2020
Mental Health Integrated Report		The Committee received good assurance from this report.		
Sunniside Mitigation Plan		The Committee received good assurance in relation to the Sunniside plan and noted further work was required.	Progress to be reported to QGC on a 2 monthly basis	November 2020
Risk Management Annual Report		The Committee received good assurance and noted that a Pressure Damage and Mortality Deep Dive would be arranged.	Pressure damage deep dive to be completed	November 2020
Learning from Historical Surgical Never Events		The Committee received good assurance from this update and noted that robust safety measures are in place to prevent Never Events.		
NICE Annual Report		The Committee noted the significant work done and improvements made from the previous report.	This will be monitored through SafeCare Council	

Finance and Performance Committee – 28th August 2020

The Finance and Performance Committee has fulfilled its role and functions as defined within its terms of reference.

The reports received by the Finance and Performance Committee and level of assurance are set out below.

ISSUES TO BE RAISED TO BOARD	ASSURANCE LEVEL	COMMITTEE UPDATE	NEXT ACTION	TIMESCALE
Financial Performance – Finance & Activity Report		Year to Date: The Committee received revenue monitoring. Still under national framework, now until September, therefore, break even. Capital approval outstanding hence amber assurance.		Monthly review of progress through the Committee
		Forecast: Planning guidance issued but significant risks remain due to uncertainty of financial framework.	Update and plan to be completed by end of September.	Monthly review of progress through the Committee
Financial Performance – Finance & Sustainability Programme		Year to Date: The report was not received due to suspension of internal control framework.	Report due at the September Committee.	Monthly review of progress through the Committee
		Forecast: As above.	As above.	Monthly review of progress through the Committee
Performance Report – NHSI Governance Rating Impact		Year to Date: The Committee received an update on Recovery and targets now that the national guidance for planning and performance has been received.	Ongoing work with the Business Units to maximise capacity and increase activity to resume service delivery & improve performance. Further update in September.	Monthly review of progress through the Committee
Board Assurance Framework (BAF)		The Committee noted that work is ongoing to update the BAF with the new objectives now in place. Strategic aim 3 and strategic aim 5 will be presented at this Committee.	Developments will continue in line with the revised Corporate Objectives for 20/21. QEF to be refined further.	Monthly through the committee

Human Resources Committee – 11 August 2020

The Human Resources Committee has fulfilled its role and functions as defined within its terms of reference.

The reports received by the Human Resources Committee and level of assurance are set out below.

Draft minutes of the Human Resources Committee are included within Board papers for information.

ISSUES TO BE RAISED TO BOARD	ASSURANCE LEVEL	COMMITTEE UPDATE	NEXT ACTION	TIMESCALE
HR Policies: • Home Working Policy & Home working Guidance		The Committee approved the policy which has also been approved by the Staff Side. The Home Working guidance was approved subject to grammatical amendments.	Policy and Guidance document to be launched within the organisation.	Oct 2020
Update on Covid-19 & Staffing		The Committee received a positive update and a great deal had been learnt during the Covid-19 pandemic. A Health and Well Being programme has been produced to support staff with any help or assistance that is required.		
QEF Gender Pay Gap Report		The Committee received the report for information which did not highlight any concerns. This was approved by the QEF Board in March 2020.		
Committee Risk Report		The Committee received the report and agreed that future reports would highlight risks that are monitored as part of the governance review for discussion.		Oct 2020
Workforce Race Equality Standard & Disability Equality Standard		The Committee received an update and the narrative reports are currently progressing and these will be circulated to the relevant Committees for approval.		Sept 2020
People Plan 2020 – 2021		The Committee received the report for information. Work is ongoing and an update will be presented at a future meeting.		Oct 2020 – Dec 2020
Health & Well Being Proposal		The Committee received the report which highlights and sets out suggested measures and investments required to improve provisions for the health and wellbeing of staff.		

Audit Committee held on 3 September 2020

The Audit Committee has fulfilled its role and functions as defined within its terms of reference. The issues to be raised to the Board are set out below

ISSUES TO BE RAISED TO BOARD	ASSURANCE LEVEL	COMMITTEE UPDATE	NEXT ACTION	TIMESCALE
Losses and Special Payments Register		The Committee received and approved the Losses and Special Payments Register.		
Counter Fraud Progress Report		The Committee received a detailed and comprehensive report from Counter Fraud.		
Internal Audit Gateshead Health Group Progress Report		The Committee received the progress report for assurance. The Committee agreed that this would remain amber due to the number of outstanding recommendation in relation to HR and IT issues.		
Audit Plans		The Committee reviewed the revised plans for 2020/21 and agreed this was a realistic plan.		
External Audit Gateshead Health Trust External Audit Result		The Committee received a comprehensive update on the QE Facilities Audit Plan.		

Assurance Key

	Level of Assurance
	Assured – there are no gaps in assurance
	Partially assured – there are gaps in assurance but we are assured appropriate action plans are in place to address these
	Not assured – there are significant gaps in assurance and we are not assured as to the adequacy of current action plans