MEETING OF THE BOARD OF DIRECTORS IN PUBLIC

Gateshead Health NHS Foundation Trust

Date: Wednesday 30th March 2022
Time: 9:30 am
Venue: Gateshead Marriott

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 Company Secretary on receipt of agenda, prior to the meeting*	Declaration	Verbal
3.	9:35 am	**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 26 January 2022** To be agreed as an accurate record	Agree	Enclosure 4
5.	9:42 am	**Matters Arising / Action Log**	Update	Enclosure 5
6.	9:45 am	**Director of Public Health Annual Report 2020/21** To receive a presentation from Alice Wiseman	Assurance	Presentation
		ITEMS FOR DECISION		
7.	10:05 am	**Board Assurance Framework 2021/22** To approve the closing position presented By the Company Secretary	Approval	Enclosure 7
8.	10:13 am	**Quality Governance Committee Terms of Reference** To ratify the revised terms of reference presented By the Company Secretary	Approval	Enclosure 8
9.	10:15 am	**Trust Green Plan (2022-2025)** To approve the 3 year plan/strategy presented By the QEF Managing Director	Approval	Enclosure 9
		ITEMS FOR ASSURANCE		
10.	10:25 am	**Assurance from Board Committees** i. Finance and Performance Committee – 25th January 2022 & 22 February 2022 ii. Quality Governance Committee– 19th January 2022 and 16th February 2022 (including **Ockenden – One Year On**) iii. Digital Committee – 14th February 2022 iv. POD Committee – 8th March 2022 v. Audit Committee – 3rd March 2022	Assurance	Enclosure 10
11.	10:55 am	**Chief Executive's Update Report** To receive a briefing report from the Chief Executive	Assurance	Presentation

12.	11:05 am	**Governance Reports** i. **Corporate Objective Delivery** ii. **Organisational Risk Register** To receive the reports presented by the Company Secretary (BAF) and Chief Nurse (ORR)	Assurance	Enclosure 12
13.	11:15 am	**Annual Staff Survey Results** To receive a presentation from the Executive Director of People & OD	Assurance	Enclosure 13
14.	11:35 pm	**Finance Update** To receive the report, presented by the Group Director of Finance and Digital	Assurance	Enclosure 14
15.	11:45 am	**Integrated Oversight Report** To receive the report, presented by the Chief Operating Officer, Chief Nurse, Medical Director and Executive Director of People and Organisational Development	Assurance	Enclosure 15
16.	12:00 pm	**Nurse Staffing Exception Report** To receive the report, presented by the Chief Nurse	Assurance	Enclosure 16
		ITEMS FOR INFORMATION		
17.	12:10 pm	**Cycle of Business** To receive the cycle of business outlining forthcoming items for consideration by the Board, presented by the Company Secretary	Information	Enclosure 17
18.	12:15 pm	**Questions from Governors in Attendance** To receive any questions from governors in attendance		Verbal
19.	12:30 pm	**Date and Time of the next Meeting** The next scheduled meeting of the Board of Directors to be held in public will be 25th May 2022 at 9:30 am at a location to be confirmed		Verbal
20.	12:30 pm	**Chair Declares the Meeting Closed**		Verbal
21.	12:30 pm	**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 26th January 2022, via Microsoft Teams

Gateshead Health NHS Foundation Trust

Present:	
Mrs A Marshall	Chair
Mrs J Baxter	Chief Operating Officer
Mr A Beeby	Medical Director
Mrs J Bilcliff	Group Director of Finance & Digital
Dr R Bonnington	Non-Executive Director
Mrs L Crichton-Jones	Director of People & OD
Mrs G Findley	Chief Nurse
Cllr M Gannon	Non-Executive Director
Mr A Moffat	Non-Executive Director
Mrs Y Ormston	Chief Executive
Mrs H Parker	Non-Executive Director
Mrs M Pavlou	Non-Executive Director
Mr A Robson	Managing Director QEF
Mr M Robson	Vice Chair/Non-Executive Director
Dr M Sani	Associate Non-Executive Director (NExT Placement)
Mrs A Stabler	Non-Executive Director
In Attendance:	
Miss J Boyle	Company Secretary
Mr N Gammack	Chief Pharmacist (22/06)
Ms V Lamb	Communications Manager
Mrs K Mackenzie	Deputy Director of Finance
Ms M Newton	Children's Bladder and Bowel Specialist Nurse (22/06)
Ms D Waites	Corporate Services Assistant
Governors and Members of the Public:	
Mrs E Adams	Public Governor – Central
Mrs H Adams	Staff Governor
Mr J Bedlington	Public Governor – Central
Mr L Brown	Public Governor – Western
Mr A Dougall	Public Governor – Eastern
Dr A Lowes	Staff Governor
Mr R Morrell	Staff Governor
Mr G Riddell	Public Governor – Western
	Member of the public
Apologies:	
	None

Agenda Item	Discussion and Action Points	Action By
22/01	**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	

Agenda Item	Discussion and Action Points	Action By
	convened in accordance with the Trust's Constitution and Standing Orders. Mrs Marshall welcomed the Trust's Governors and members of the public. She drew attention to the recent letter received from NHS England and Improvement in relation to reducing the burden to free up capacity guidance. In light of this, the agenda has been streamlined to highlight key themes including operational pressures, staffing and the work around mandated vaccines.	
22/02	**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.	
22/03	**APOLOGIES FOR ABSENCE:** There were no apologies received from members of the Board.	
22/04	**MINUTES OF THE PREVIOUS MEETING:** The minutes of the meeting of the Board of Directors held on Tuesday 24th November 2021 were approved as a correct record.	
22/05	**MATTERS ARISING FROM THE MINUTES:** The Board Action Plan was updated accordingly to reflect matters arising from the minutes.	
22/06	**PATIENT & STAFF STORY:** **Neurodiversity:** The Board welcomed Michelle Newton, Children's Bladder and Bowel Specialist Nurse, who provided a presentation on neurodiversity after being diagnosed with dyslexia and autism. She described some of the social stigma around hidden disabilities and how despite this, she was successful in becoming a nurse. She highlighted the support she received within the Trust from the D-Ability Network and Coleen Knox, HR Business Partner/D-Ability Network Chair, as well as receiving Insight Coaching from Jo Coleman, Strategic Safeguarding Lead, which helped her to embrace her	

Agenda Item	Discussion and Action Points	Action By
	disabilities and also helped others to understand them. She highlighted the need for neurodiverse individuals to have access to supportive information as well as Health and Well-Being and drew attention to further work that could be introduced via organisational policies and procedures. Mrs Marshall thanked Ms Newton for sharing her story with the Board and Dr R Bonningon, Non-Executive Director, felt that it was helpful insight and demonstrated the valued service received from the Staff Networks and Coaching services. Mrs G Findley, Chief Nurse, also wished to highlight the excellent service provided by the Children's Bladder and Bowel Service which is recognised throughout the Region. Mrs L Crichton-Jones, Executive Director for People and Organisational Development, felt that it would be useful to meet with Ms Newton outside of the meeting to further discuss improvements which could be made around supporting colleagues with neurodiversity. Mr A Robson, QE Facilities Managing Director, recognised the need to include neurodiversity within staff programmes and felt that it would be beneficial to further share Ms Newton's story. **Pharmacy Service:** Mrs Marshall introduced Mr N Gammack, Chief Pharmacist, and informed the Board that he was retiring from the Trust following 33 years within the NHS and 28 years at the Queen Elizabeth Hospital. She highlighted some of his achievements whilst at the Trust including the introduction of the Pharmacy Robot, Omnicell and E-prescribing initiatives. She thanked him for his incredible service and the Board acknowledged that he will be a huge miss to his team and the Trust. Mr Gammack gave a presentation on the Medicines Optimisation work which included the introduction of integrated digital systems and explained that the department was an early adopter of the Trust's Lean Programme into reducing waste. He highlighted that the department has created 38 Key Performance Indicators and are reviewed on a monthly basis. He also demonstrated that the department produces a Health and Well-Being newsletter which is welcomed by the team and includes competitions and prizes. He concluded by informing the Board that the department has experience of delivering robust clinical services safely and there is significant potential to develop more advanced pharmacy services in the future. Mrs Marshall thanked Mr Gammack for his final presentation and the Board wished him a happy retirement. Mrs Y Ormston, Chief Executive, thanked him for his years of service and felt that he should be extremely proud of the legacy he is leaving. This includes his approach to Lean working and Mrs Ormston reported that work	LCJ / GF

Agenda Item	Discussion and Action Points	Action By
	around a refresh is being explored.	
22/07	**BOARD COMMITTEE TERMS OF REFERENCE:** Miss J Boyle, Company Secretary, presented the terms of reference for the Audit Committee and the Digital Committee which have been fully reviewed and updated. She reported that the updates take into account the adjusted remits of the Committees and includes a new standardised template following recommendations from the recent Well-Led Peer Review to ensure consistency of format for the terms of reference. Detailed reviews and discussions on the content of the terms of reference have also taken place at each Board committee prior to approval. After consideration, it was: **RESOLVED:** to ratify the terms of reference of the Audit Committee and the Digital Committee, taking assurance that they have been subject to detailed review by each respective Board committee prior to approval.	
22/08	**BOARD GOVERNANCE DURING THE LATEST WAVE OF COVID-19:** Miss J Boyle, Company Secretary, presented the paper which sets out the Trust's response to Board governance as a consequence of the latest NHS England and Improvement (NHSE/I) reissued letter to NHS organisations entitled Reducing the burden of reporting and releasing capacity to manage the COVID-19 pandemic. She highlighted that the Board, Board Committees and Council of Governors meetings will continue as planned with focussed agendas directly linked to Covid and only items which are not business-critical will be deferred. She explained that items which pose or identify a material risk for the Trust, its staff or patients will not be deferred and will continue to be in the form of written updates where practical. Mrs Marshall reported that this has discussed this with Mr A Rabin, Acting Lead Governor, and will be under continual review. Following consideration, it was: **RESOLVED:** to expressly endorse and approve the proposed approach to Board governance outlined within this paper and take assurance that the Trust will move back to normal governance arrangements when pressures ease.	

Agenda Item	Discussion and Action Points	Action By
22/09	**ASSURANCE REPORTS FROM BOARD COMMITTEES** The Board Committee Chairs provided updates from the assurance reports as follows: **Finance & Performance Committee** Mr M Robson provided the assurance report for the Committee meetings held on 23rd November 2021 and 14th December 2021 and also provided a verbal update on the meeting held yesterday (25th January 2022). There was one item for escalation which related to the submission of the financial plan for 2022/23. He explained that details were received on 24th December 2021 and included the timetable for the submission of the draft plan by 3rd March 2022. As there is no formal Board meeting prior to this, it was agreed that delegated authority be given to Committee to sign off the plan prior to submission and formal ratification would then be given by the Board at its March meeting or at the February Board Strategy Session. Mr Robson also highlighted the following key points: • Supply Procurement Summary Table – partial assurance was given as further details around some of the decisions was required. Mrs K Mackenzie, Deputy Director of Finance, will review this and link this with the review of the Standing Orders. • Integrated Oversight Report – partial assurance was provided due to the significant challenges to maintain targets although it was recognised that clear and robust plans are in plan. An issue was raised in relation to echo-cardiology breaches and an updated report will be provided to highlight plans and progress. Full recovery of this is expected by August 2022 and the Committee congratulated the team for their work around this and accepted robust plans were in place. • Month 9 Finance Report – partial assurance was provided. It was recognised that the Trust is over-achieving, the plan however does not reflect the submitted plan. The Committee received details on the actions being taken to deliver targets in line with planning requirements. • Capital Programme – partial assurance was provided which reflects significant increases in allocations throughout the year. This includes £2m slippage due to the difficulties in obtaining materials however mitigation plans are in place. Mr Robson highlighted that further scheme approvals may need to be undertaken as a Chair's action if timescales for year-end prove challenging. • Emergency Care Intensive Support Team (ECIST) update was	MR/JB

Agenda Item	Discussion and Action Points	Action By
	given on the work being undertaken following the review in relation to patient flow within Urgent and Emergency Care. The Committee acknowledged that excellent progress was being made and bi-monthly progress reports will be presented to the Committee moving forward. • Review of Corporate Objectives – the governance report is on today's agenda however Mr Robson highlighted that full assurance had been given by the Committee due to improved reporting. • The Board Assurance Framework was updated following the Committee based on the actions discussed. **Quality Governance Committee** Mrs A Stabler provided the assurance report for the Committee meeting held on 17th November 2021 and provided a verbal update on the meeting held on 19th January 2022. There was item for escalation which related to mandated vaccines and the Committee acknowledged the huge scope of this work and the clear risks associated with the implementation of the legislation. It was agreed that oversight of this work would be reported to the Quality Governance Committee as well as the People and OD Committee to identify which clinical services are likely to be affected as well as what mitigation will be put in place to ensure continuity of patient care. Partial assurance was therefore provided due to the ongoing work required. Mrs Stabler also highlighted the following key points: • Maternity (Mind the Gap) – full assurance was provided following the submission of the return template to NHS Resolutions which confirmed compliance against year three training. This work will be updated via the maternity report and Maternity Champion meetings going forward. • Fluid balance and electrolyte chart audit – the Committee noted that a Task and Finish Group had been established and will also be monitored via the Mortality & Morbidity Council. • Integrated Oversight Report (IOR) – full assurance was provided due to the significant work being undertaken to reduce patient numbers between the Trust and Local Authority. • Quality Report Proposal for 2022/23 – full assurance was provided and the Committee noted that a virtual stakeholder event will take place to look at the Quality Priorities for 2022/23 in February 2022. • Corporate Objective Delivery - partial assurance due to continued pressures which present future risk to delivery of the outstanding objectives. • Safeguarding Group Report – full assurance reflecting that all	

Agenda Item	Discussion and Action Points	Action By
	statutory posts are filled and the Committee welcomed the appointment of the designated safeguarding doctor for children (Dr Neelmanee Ramphul). • SafeCare, Risk & Patient Safety Council Assurance Report – the Committee received the first report from above and partial assurance was provided due to further work required around identifying learning within the report. • Quarterly Learning Report – full assurance given and the Committee noted the common themes identified which have been triangulated through patient safety investigations, mortality reviews, formal complaints and PALS processes, which highlight areas of learning and good practice as well as actions taken. • Health & Safety Quarterly Report – partial assurance reflecting that a further update required on Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) reportable incidents and Control of Substances Hazardous to Health (COSHH) compliance. • The Board Assurance Framework was updated following the Committee based on the actions discussed. **Digital Committee** Mr A Moffat provided the assurance report for the Committee meeting held on 13th December 2021. There were no items for escalation however the following key points were discussed: • Strategic Aims and Objectives/Strategy Transformation Road Map – partial assurance due to some slippage. Mr Moffat highlighted that the Trust has achieved certification as being a Digital Leader from NHSX. • Key Performance Indicators – partial assurance reflecting the continued evolution of the report. • Policy Updates – partial assurance. A review of IT & Digital policies has taken place and good progress is being made. It was identified that the Telecoms Policy had expired and Mr Moffat highlighted that discussions between IT and QE Facilities had been ongoing to agree ownership. This has now been agreed to be IT responsibility and as such has been approved by the sub-committee. • Internal Audit Reports – as previously identified there had been a gap in respect of the visibility of outstanding and overdue actions within the SMT and Executive Team. This was reported to the Audit Committee as having been addressed and as such a rating of full assurance was awarded. • Digital System Infrastructure Strategy – assurance was received that the Channel 3 report for the review of the care flow contract will be ready for February 2022 and this will inform the strategy. • Full assurance was provided from the Committee sub groups.	

Agenda Item	Discussion and Action Points	Action By
	People and Organisational Development (POD) Committee Dr R Bonnington provided the assurance report for the Committee meeting held on 11th January 2022. There were two items for escalation: • Key issues were raised relating to registered nurse vacancies and the additional work which is ongoing relating to supply. The Committee noted that this is being overseen by the newly established Task and Finish Group and are focussing on 4 key strands of work, including international recruitment. Dr Bonnington also highlighted the significant risks relating to staff health and well-being as well as the overall delivery of services. • The Committee also discussed the position arising from the introduction of mandatory vaccines and the potential impact on staffing numbers and service delivery, along with the capacity risks which now arise for POD teams and some operational managers whilst this is implemented. Dr Bonnington also highlighted the following key points: • Guardian of Safe Working Report – full assurance was provided following a presentation from the new Guardian. • Freedom to Speak Up (FTSU) Guardian – partial assurance provided and further discussions will take place with the Committee Chair and Executive Lead to understand the implications of the increase in concerns being raised. Further work will also take place in the recruitment of FTSU Champions. **Audit Committee:** Mr A Moffat provided the assurance report for the Committee meeting held on 2nd December 2021. There were no items for escalation however the following key points were discussed: • Losses and Special Payments – this is a standard item for the Committee to receive evidence of costs of losses and claims and full assurance was provided. • Charitable Funds Accounts Audit – a final audit report is expected soon and will be shared with Members and Trustees. A partial assurance rating was awarded, reflecting that the audit was still in progress. • Internal Audit Reports – partial assurance. Three finalised audit reports were reviewed by the Committee. It was noted that the CQC interim audit was not rated as it will be revisited and finalised in Quarter 4. Assurance was provided to the Committee that the new team are now in place and focus is on addressing the matters identified to date. A risk was noted in relation to some outstanding actions however it was	

Agenda Item	Discussion and Action Points	Action By
	acknowledged that these were as a result of current operational pressures and restrictions on clinical areas. • Executive Risk Management Group Report – full assurance. The Committee noted that the new group is working well however further assurance on the impact assessment was requested in future reporting. • Audit Committee Terms of Reference – the revised terms of reference were approved and on the agenda today for Board ratification. Mrs Marshall thanked the Committee Chairs for their reports and felt that these highlight the important issues for the Board to consider for the rest of meeting. After consideration, it was: **RESOLVED:** to receive the reports for assurance	
22/10	**CHIEF EXECUTIVE'S UPDATE REPORT**: Mrs Y Ormston, Chief Executive, gave a verbal update to the Board on current issues: **Covid/OMICRON** Mrs Ormston reported that the current wave of Covid has tested systems across the region and December and January have been extremely challenging. The Trust currently has 100 patients with Covid which peaked at 107. In comparison, the peak in Wave 1 was 124. The Trust therefore made the difficult decision to restrict visiting and further measures have been undertaken to reduce further outbreaks. Mrs Ormston emphasised that this has been the most challenging winter ever seen and as such has had an impact on A&E waiting times and ambulance handovers. Teams continue to monitor the situation carefully. **Capacity and staffing issues** Mrs Ormston reported that staffing has been significantly impacted by OMICRON with 150 staff currently off. At the peak there were 344 reported staff absences on top of general sickness figures and vacancy levels. The Board acknowledged that staff will be tired and stressed but recognised they continue to work hard to ensure patient safety. Mrs Ormston reported that work continues around recruitment and services have been supported by volunteers including some of our Non-Executive Director colleagues. The management of Covid patients has impacted on bed capacity and admission avoidance and effective discharge is important with the	

Agenda Item	Discussion and Action Points	Action By
	support of community teams. Staffing pressures are being experienced by all organisations and has also impacted on the provision of care home and domiciliary care. This is also having an overall impact on the Trust's elective programme however cancer and complex cases are being given priority. **Mandated Vaccinations** Mrs Ormston reported that a significant amount of work is being undertaken to prepare for this. This work is also having a significant impact on capacity for staff managing the process and further implications will be outlined in a later agenda item. **Planning** Guidance for 2022/23 has now been received however timescales are challenging. **Provider Collaborative Development/ICS Framework** Mrs Ormston reported that the Provider Collaborative Managing Director is now in post and Samantha Allen has been appointed as ICS Chief Executive. Other statutory Director posts are now being advertised and Mrs Ormston and Mrs Marshall are involved in the interviewing process. Go live of the ICS has been delayed until July 2022 **Gateshead Citizens Advice** Mrs Ormston reminded the Board of the presentation at the last meeting and the direct access welfare support advice and information service for cancer patients has been well received. **Charitable Funds** The Trust has received a significant legacy and this will be managed via the Charitable Funds Committee. The Board acknowledged the current significant pressures and took the opportunity to thank all staff for their continued hard work during these difficult times. Cllr M Gannon, Non-Executive Director, highlighted that the number of Covid cases are still high within the community but is beginning to reduce. After further discussion, it was: **RESOLVED:** to receive the verbal update for assurance	
22/11	**GOVERNANCE REPORTS:** Miss J Boyle, Company Secretary, and Mrs G Findley, Chief Nurse, presented the following reports:	

Agenda Item	Discussion and Action Points	Action By
	Corporate Objective Delivery: Miss Boyle highlighted that the report provides assurance over the delivery of the 15 priority objectives and reported that 33% of Board priority objectives are considered to be fully delivered, with 60% on track, but with a risk to delivery. There are no objectives not yet started. She explained that assurance can be provided that there are no priority objectives identified as at significant risk of delivery, although it is acknowledged that current operational pressures and the impact of mandatory vaccinations present a clear risk in Quarter 4. **Board Assurance Framework (BAF) 2022/23** Miss Boyle highlighted that the BAF has been reviewed by the Board committees and updated at each meeting to assess levels of assurance and identify gaps. She reported that for each strategic aim the overall assurance rating has been maintained at partially assured. This aligns well to the corporate objective delivery ratings outlined in Agenda Item 11i, and demonstrates a consistent level of assurance and approach. Whilst overall ratings have not changed, there have been movements in individual assurance ratings and new assurance ratings assigned as the committees have considered new reports. Mrs Marshall highlighted that the BAF has been updated since the People & Organisational Development Committee but not the other Board Committees due the cycles of business. **Organisational Risk Register (ORR)** Mrs Findley drew attention to the identified organisational risks which covers the period 12 November 2021 to 17 January 2022 and have been presented to the Executive Risk Management Group for discussion. She reported that there are 5 new risks which demonstrate the current staffing and organisational pressures. Further discussion around staffing will take place within the staffing report (Agenda Item 16) and will review actions being taken. Risks have also been added in relation to the mandated vaccines and GP Practices which are also on today's agenda. Mrs Marshall confirmed that this reflects current discussions highlighted at the beginning of the meeting. After further discussion, it was: **RESOLVED:** to receive the reports for assurance.	

Agenda Item	Discussion and Action Points	Action By
22/12	**COVID UPDATE:** Mr A Beeby, Medical Director, provided a verbal update to the Board on the current Covid situation within the Trust. He reminded the Board of earlier discussions during the Chief Executive's Update (Agenda Item 10) and reported that staff continue to respond to the current pressures and challenges. Mrs Marshall thanked the staff for their continued hard work and also thanked the volunteers who have been supporting services. Mrs A Stabler, Non-Executive Director, queried whether junior doctor cover had been increased and Mr Beeby reported that the Trust's Workforce Cell have been co-ordinating medical staffing and continue to review and support capacity pressures. After discussion, it was: **RESOLVED:** to receive the update for assurance	
22/13	**MANDATORY VACCINATION UPDATE:** Mr A Beeby, Medical Director, presented the assurance report following the Government's announcement for all those staff who are deployed in the delivery of CQC regulated activity or work within areas where CQC regulated activity takes place, to have mandated vaccinations by 1st April 2022. This means that staff that are in-scope will need to have their first dose of the vaccine by 3rd February 2022 and their second dose by 31st March 2022. Mrs A Marshall emphasised that the Trust does not wish to terminate the employment of any staff however there is a legal requirement to undertake this work. Mr Beeby reported that as previously discussed, work has begun to establish the vaccinations status of those staff who are currently showing no evidence of having received any dose. He highlighted that there are a number of risks which have been identified within the report, with the most significant being the risk to clinical and other services where a number of staff remains unvaccinated and are potentially dismissed from employment. However work is currently underway to establish the risk at Business Unit/Team level. The Board also recognised the risk of diverting current resources to undertake this exercise and Mrs L Crichton-Jones, Executive Director for People & OD reported that additional admin support has been	

Agenda Item	Discussion and Action Points	Action By
	provided to assist with the work and the ICS Workforce Group are also looking at additional support. Mrs Y Ormston, Chief Executive, explained that office support is also being explored with the Clinical Commissioning Group (CCG), North of England Commissioning Support (NECS), NHS Business Services Authority (NHSBSA) and Local Authority (LA) however all organisations are current experiencing the same pressures. Cllr M Gannon, Non-Executive Director, queried how other trusts were managing the issue and whether intelligence was being shared. Mrs Crichton-Jones reported that daily national webinars are taking place and a North East and Cumbria Peer Support Group has been established to share issues and learning. Support is also being offered to affected staff and teams are working closely with the Joint Consultative Committee (JCC) and Local Negotiating Committee (LNC). Following further discussion, it was: **RESOLVED:** to receive the report for information, noting the risks and acknowledging the work undertaken to date.	
22/14	**FINANCE UPDATE:** Mrs J Bilcliff, Group Director of Finance, provided the Board with a summary of performance as at 31st December 2021 (Month 9) for the Group (inclusive of Trust and QE Facilities, excluding Charitable Funds). She reported that for the period April to December, the Trust has reported a revenue surplus of £4.485m. The Trust has spent £3.826m of its capital programme however Mrs Bilcliff highlighted potential slippage due to delays although plans are being reviewed to ensure this is used efficiently towards the year end. Following the release of the H2 planning guidance and negotiation of associated funding envelopes, the Trust has submitted a balanced plan for 2021/22. Mrs Bilcliff explained that the local financial envelope for 2022/23 has not yet been received however high level planning is taking place and a change in focus is expected due to initial indications of national and regional financial pressures. After consideration, it was: **RESOLVED:** to receive the report for assurance	
22/15	**INTEGRATED OVERSIGHT REPORT:**	

Agenda Item	Discussion and Action Points	Action By
	Mrs J Baxter, Chief Operating Officer, presented the Integrated Oversight Report (IOR) for November and December 2021, reporting performance where data is validated, signed off and submitted. The report summarises performance in relation to key NHS standards, requirements and Key Lines of Enquiry (KLOE) to outline the risks and recovery plans associated with COVID-19. The paper has been discussed and received in-depth scrutiny by the various Board Committees including Quality Governance and Finance & Performance. Mrs Baxter highlighted that pressures within the organisation have impacted on performance during January however the elective care programme has been maintained with cancer and urgent treatments remaining a priority. Increases in Covid admissions, general winter pressures and the inability to discharge patients in a timely manner continue to adversely impact on flow and operational pressures. She thanked staff for their continued efforts and explained that workforce pressures continue to affect delivery of services. Mrs G Findley, Chief Nurse, drew attention to the quality and safety indicators within the report which ensures full oversight and triangulation of any incidents within Trust performance. She highlighted that there had been five Serious Incidents (SIs) reported which have been notified through the appropriate channels and there were no maternity incidents reported. The Statistical Process Control (SPC) charts indicate potential under reporting of incidents and the new Head of Risk and Patient Safety will be undertaking some audit work to review this. The Hospital Standardised Mortality Ratio (HSMR) continues to show more deaths than expected and additional work is taking place around heart failure. Mrs Findley explained that feedback will be provided once the work has been completed. Maternity metrics are now included within the IOR and are being reviewed via the Quality Governance Committee and Maternity SafeCare meetings. Mrs Baxter concluded that the Trust remains in a relatively strong position against available benchmarking data and is one of the Top 3 performing trusts within the local Integrated Care Partnership (ICP) system. Mrs Marshall informed the Board that work is ongoing around Health Inequality data and will be included in reports in the future. Following a query from Mrs A Stabler, Non-Executive Director, on the number of 52 week waiters, Mrs Baxter provided assurance that plans are in place to reduce this in line with the trajectory. The Trust is currently reporting no 104 week waiters and will continue to support other organisations with the Integrated Care System (ICS).	

Agenda Item	Discussion and Action Points	Action By
	Mrs Stabler also raised a query in relation to the increase of gynaecology cancer waits due to support the Trust is providing to other ICS organisations and whether the impact of this has been acknowledged. Mrs Baxter reported that the Trust is working closely with Newcastle and South Tees to develop a lead provider model. The Board discussed the impact of delayed discharges and Mrs Baxter explained that a Multi-Disciplinary Team (MDT) meeting was being set up with Regional Chief Nurses, Local Authority and NECS to share good practice. Following further discussion and consideration, it was: **RESOLVED:** to receive the report for assurance and note the operational pressures directly impacting on the Trust's current performance	
22/16	**NURSE STAFFING EXCEPTION REPORT:** Mrs G Findley, Chief Nurse, presented the nurse staffing exception report for December 2021 which provides assurance to the Board that staffing establishments are being monitored on a shift-to-shift basis. It provides 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. Mrs Findley began by thanking staff for their continued hard work despite significant staffing challenges and pressures impacting services across the Trust on a daily basis. Assurance that the escalation process is operating as expected is provided via the number of Datix reports relating to staffing and this section will be expanded in future reports to include significant complaints and Freedom to Speak Up incidents. A Staffing Task and Finish Group has been set up to strengthen assurance going forward and will be looking at reporting, recording and escalation of staffing in more detail. Mrs Findley also reported that the International Nurse Recruitment team has now been appointed and additional funding is also available from NHS England around refugee opportunities to support inclusive working. Mrs A Stabler, Non-Executive Director, shared her experience of volunteering on Ward 4 and praised the work of the staff. Mrs L Crichton-Jones and Mrs Baxter also undertook an evening walkabout and credited staff on their loyalty and commitment to patient care despite current challenges and pressures.	

Agenda Item	Discussion and Action Points	Action By
	After further discussion, it was: **RESOLVED:** to receive the report for assurance and note the work being undertaken to address the shortfalls in staffing	
22/17	**ITEMS FOR INFORMATION:** The following items were removed from the main agenda in response to the "reducing the burden" letter and are available in the Reading Room and Supplementary Pack on the Trust's website: • Well-Led Review Action Plan Update • Improving People Practices Update After consideration, it was: **RESOLVED:** to receive the reports for assurance and information.	
22/18	**CYCLE OF BUSINESS:** Miss J Boyle, Company Secretary, presented the cycle of business which outlines forthcoming items for consideration by the Board. This will provide advanced notice and greater visibility in relation to forward planning. After consideration, it was: **RESOLVED:** to receive the cycle of business for information.	
22/19	**QUESTIONS FROM GOVERNORS IN ATTENDANCE:** Mr J Bedlington wished to thank Mr Neil Gammack on behalf of the patients and Governors for his excellent service to the Trust. He raised a query in relation to the Organisational Risk Register (ORR) in particular Risk 1636, which relates to the risk of potential exposure to cyber malware and felt that this was potentially a very serious risk, with a score of 25. He queried what assurances were in place and whether the Trust were aware of which servers did not have sufficient protection. Miss J Boyle, Company Secretary, explained that the Initial Risk Rating had been scored as 25 however due to controls and mitigations in place the Current Risk Rating is scored as 10. Mr A Moffat, Digital Committee Chair, highlighted that Key Performance Indicators (KPIs) have been developed which includes cyber security. Mr Bedlington also raised a query in relation to Mazars, the new	

Agenda Item	Discussion and Action Points	Action By
	External Auditors for the Trust and Mrs Bilcliff explained that work will begin shortly around the year-end audit following some positive initial meetings.	
22/20	**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 Wednesday 30th March 2022	
22/21	**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
21/159	28/09/2021	Draft Winter Plan – to provide position report for SDEC	26/01/2022	JMB	This was planned for the Jan 22 Board, but has been deferred in line with the NHS England and Improvement recommendations in their 'reducing the burden letter' which frees up time to respond to operational pressures. This will be presented as part of the Integrated Oversight Report in May 2022
21/171	28/09/2021	WRES & WDES – to look at roll out of reverse mentoring and set up training/scheme to share experiences and learning	31/12/2021	LCJ	OD team working on. Updates will come via the People and OD Committee – roll-out update is included within corporate objective reporting to the Board.
22/06	26/01/2022	Patient Story/Neurodiversity – to discuss potential improvements to processes/procedures	30/03/2022	LCJ / GF	A meeting has been scheduled. The Managing Director of QEF has also worked closely with Ms Newton on the planning for the forthcoming Neurodiversity Day on 30 March.
22/09	26/01/2022	F&P Assurance Report – delegated authority given to sign off draft 2022/23 financial plan prior to submission on 03.03.2022. Formal ratification to next Board or Strategy Session	30/03/2022	MR/JB	Included on March Board agenda – Part 2.

NHS
Gateshead Health
NHS Foundation Trust

Report Cover Sheet Agenda Item: 7

Report Title:	**Board Assurance Framework 2021/22 – Closing Position**			
Name of Meeting:	Board of Directors – Part 1			
Date of Meeting:	26 January 2022			
Author:	Jennifer Boyle, Company Secretary			
Executive Sponsor:	Gillian Findley, Chief Nurse			
Report presented by:	Jennifer Boyle, Company Secretary			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	To provide the Board with oversight of the full Board Assurance Framework (BAF) following review of its component parts at the Board committees.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☒ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	Board committees			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	• For each strategic aim the overall assurance rating has been maintained at **partially assured**. • This aligns well to the corporate objective delivery ratings outlined in Item 12i, demonstrating a consistent level of assurance and approach. • Whilst overall ratings have not changed, there have been movements in individual assurance ratings and new assurance ratings assigned as the committees have considered new reports. • This demonstrates that the BAF has been used as an active assurance tool at Board committee meetings throughout the year.			
Recommended actions for this meeting:	The Board is requested to: • Review the closing full position of the Board Assurance Framework for 2021/22			

<table>
<tr><td>Outline what the meeting is expected to do with this paper</td><td colspan="6">(acknowledging that the Finance and Performance Committee March ’22 update will be verbal given the timing of the meeting);
• Be assured that this has been subject to review and update as part of each Board committee meeting; and
• Be assured that whilst overall ratings remain at partial assurance, this report evidences that active updates have been made to the BAF throughout the year to reflect new and changed assurance levels.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
☒</td><td colspan="5">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☒</td><td colspan="5">We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3
☒</td><td colspan="5">We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4
☒</td><td colspan="5">We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5
☒</td><td colspan="5">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Trust corporate objectives that the report relates to:</td><td colspan="6">All priority objectives which support the strategic aims</td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
☒</td><td>Responsive
☒</td><td>Well-led
☒</td><td>Effective
☒</td><td colspan="2">Safe
☒</td></tr>
<tr><td colspan="7">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks and DATIX reference)</td><td colspan="6">Risks are documented on the BAF itself</td></tr>
<tr><td>Has a Quality and Equality Impact Assessment (QEIA) been completed?</td><td colspan="2">Yes
☐</td><td colspan="2">No
☐</td><td colspan="2">Not applicable
☒</td></tr>
</table>

Board Assurance Framework 2021/22 - Closing Position

1. Executive Summary

1.1. The Board Assurance Framework (BAF) has continued to be monitored by the Board committees with ratings, assurances, gaps and actions updated at each meeting.

1.2. Overall the BAF for each strategic aim has maintained a partial assurance (amber) rating at the year-end (note the March '22 rating from Finance and Performance Committee will be communicated verbally due to the timing of the meeting). Whilst overall ratings have not changed, there have been movements in individual assurance ratings and new assurance ratings assigned as the committees have considered new reports.

1.3. The partial assurance rating for each Strategic Aim from a risk management perspective is consistent with the ratings outlined in respect of priority objective achievement (as outlined in agenda Item 12i). This provides assurance over the joined-up approach to the achievement of corporate objectives and approach to seeking assurance over the management of strategic risks.

1.4. A summary position is outlined below:

Aim No.	April 21	May 21	June 21	July 21	Aug 21	Sept 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	March 22
1 Quality Governance Committee												
2 Human Resources Committee	N/A	N/A	N/A									
3 Finance and Performance Committee												TBC
4 Quality Governance Committee												
5 Finance and Performance Committee	N/A		N/A									TBC
Digital Committee												

2. Introduction

2.1. The Board Assurance Framework (BAF) is the means by which the Board and its committees seek assurance that potential risks to the delivery of strategic aims and corporate objectives are being managed effectively.

2.2. The BAF includes linkage to the Organisational Risk Register (ORR) as well as the cycles of business for the relevant Board committees, seeking to identify assurances, as well as control and assurance gaps from each agenda item. It enables the monitoring of identified actions to address gaps and awards an assurance rating for each key report.

2.3. The monitoring of the strategic aims and objectives for the Trust are delegated to Board committees, and as such each committee reviews an extract of the BAF which is aligned to its assigned strategic aim.

2.4. This report to the Board combines the BAF updates from each Board committee to provide an overall position.

2.5. The full Board Assurance Framework is appended to the report, but next section of this report highlights the pertinent points from the BAF for each strategic aim.

Level of Assurance		
Green	**Assured**	There are no gaps in assurance.
Amber	**Partially assured**	There are gaps in assurance but we are assured appropriate action plans are in place to address these.
Red	**Not assured**	There are significant gaps in assurance and we are not assured as to the adequacy of current action plans.

3. Key issues findings

Strategic Aim 1 - We will continuously improve the quality and safety of our services for our patients.

3.1. The BAF extract for this Strategic Aim is rated as **partial assurance** overall by the Quality Governance Committee as at February 2022.

3.2. The Committee has considered a number of reports since the last full BAF report to Board in January 2022. This included a number of reports, which were rated as **fully assured**, providing the Committee with a high level of assurance (Draft Quality Report Proposals 22/23, Quarterly Learning Report, Medicine Management Quarterly Report, Review of Sub-Groups).

3.3. A number of new reports have been considered and rated by the Committee, including:

- SafeCare Risk and Patient Safety Council Report – rated as **partially assured** – this reflects the positive progress made in establishing the Council in its new format. This has generated good attendance and engagement. The partial assurance rating reflects the continued evolution of the Council and its planned work on enhancing the identification and sharing of learning.

3.4. The Integrated Oversight Report continues to reflect **partial assurance**, which is indicative of the operational pressures and challenges facing the Trust. This does not detract from the continued positive development of the report itself, with maternity and community metrics

now included in the report. In addition, the Committee has used the report to good effect to request deep dives into particular areas.

Strategic Aim 2 – We will be a great organisation with a highly engaged workforce

3.5. The BAF extract for this Strategic Aim is rated as **partial assurance** overall by the People and Organisational Development Committee as at March '22, which is consistent with the rating reported to the Board in January '22.

3.6. Whilst most reports have maintained the rating of partial assurance, this does not mean that no further progress has been made in the closure of gaps in assurance and controls. As an example the People Metrics report has continued to evolve. Further examples relate to the reports on supply and vaccination as a condition of deployment (VCOD), which were rated as partial assurance. The rating for the supply presentation recognises the significant amount of work being undertaken, but also the scale of the task ahead. In relation to VCOD, the Committee was fully assured that the Trust is doing everything within its control in respect of continuing its planning for the outcome of the government review, with the overall partial assurance rating reflecting that the risk remains and is out-with the control of the Trust.

3.7. In March 2022 the Committee received the latest gender pay gap report and rated this as **fully assured**. Members felt that the report demonstrated continued progress and were assured by the actions being taken to strive for further improvements.

Strategic Aim 3 – We will enhance our productivity and efficiency to make the best use of our resources

3.8. The BAF extract for this Strategic Aim is rated as **partially assured** overall as at February '22 by the Finance and Performance Committee.

3.9. Most of the ratings have remained consistent since the previous Board update in January, although a number of identified actions to close gaps have been progressed. This includes the presentations of deep dive reports to the Committee in response to areas of concern from the Integrated Oversight Report, such as audiology for example.

3.10. The rating for the corporate objectives update report increased from **not assured** to **partially assured**, which reflected the new format of the report and the assurances this could then provide regarding progress in delivering the objectives.

3.11. Similar the rating for the financial revenue report increased from **partially assured** to **fully assured**, which reflected that the year-end financial target was forecast to be achieved.

3.12. Since the previous update the Committee has considered a number of new reports:

- Echocardiology spotlight report (January 2022) – **full assurance** – assurance received that activity is being recovered and the Trust is doing everything within its control to achieve the revised target in this area; and
- Annual planning update (February 2022) – **partial assurance** – the rating reflected that a significant amount of work is being undertaken in this area and work on the draft plan continues in advance of the submission deadline.

Strategic Aim 4 – We will be an effective partner and be ambitious in our commitment to improving health outcomes

3.13. This Strategic Aim is aligned to the Quality Governance Committee and received a rating of **partial assurance**. This is reflective of the assurance gained from the corporate objectives delivery report which is considered by this Committee in respect of Strategic Aim 4.

Strategic Aim 5 – We will develop and expand our services within and beyond Gateshead

3.14. This Strategic Aim is aligned to the Finance and Performance Committee. The BAF extract is rated as **partially assured** as at February '22, which is consistent with the previous update.

3.15. The rating for the corporate objectives update report increased from **not assured** to **partially assured**, which reflected the new format of the report and the assurances this could then provide regarding progress in delivering the objectives.

Digital Committee

3.16. The Digital Committee monitors a BAF extract which covers a number of objectives across Strategic Aims 1, 2 and 3 (the detail of which can be seen on the BAF itself). A rating of **partially assured** was maintained at the February '22 meeting.

3.17. The Committee improved the assurance rating for one report:

- Policy updates – increased from partial assurance to **full assurance**. This reflects that all digital policies are now up to date.

4. Solutions / recommendations and next steps

4.1. The Board is requested to:

- Review the closing full position of the Board Assurance Framework for 2021/22 (acknowledging that the Finance and Performance Committee March '22 update will be verbal given the timing of the meeting);
- Be assured that this has been subject to review and update as part of each Board committee meeting; and
- Be assured that whilst overall ratings remain at **partial assurance**, this report evidences that active updates have been made to the BAF throughout the year to reflect new and changed assurance levels.

4.2. At the Board strategy day on 23 February 2022 the Board reflected on current processes with a commitment to continuous improvement. This included agreed actions to:

- Review the format of the BAF for 2022/23 to develop a greater focus on controls; and
- A desire to ensure that there are fewer corporate objectives to enable greater clarity on priority areas.

4.3. These actions will be progressed by the Company Secretary with a proposal for the 2022/23 BAF shared with the Board as part of the April Board strategy day.

Strategic Aim 1 - We will continuously improve the quality and safety of our services for our patients. Enabling Strategy: Quality Strategy Monitoring Board Committee: **Quality Governance Committee** Lead Director: Medical Director and Chief Nurse						**Committee date**	**Apr 21**	**May 21**	**Jun 21**	**July 21**	**Aug 21**	**Sep 21**	**Oct 21**	**Nov 21**	**Dec 21**	**Jan 22**	**Feb 22**	**Mar 22**
						Assurance Level (document updated to)												
Key	**No assurances due**	*N/A*	**Gaps in assurance and no plans in place to address**	***Not assured***	**Gaps in assurance but clear plans in place to address**			***Partially assured***			**No gaps in assurance**				***Fully assured***			

BOLD TEXT in controls - Item on current agenda	(Date) prior to entry - When received/ identified	Red Text - New entry from preceding meeting	Green Text – Action from preceding meeting addressed

Priority Objective	**Risks which may prevent the achievement of the strategic aim and priority objective**	**Reports the Committee receives across the year providing assurance that strategic aims and objectives are being delivered and risks mitigated. (Controls)** *(I- internal/ E – External)*	**Identified gaps in controls – gaps within the reports that are therefore not a full control or report doesn't exist currently**	**Actions needed to address gaps in controls**	**Date action to be completed by; and who is responsible**	**Assurances gained during the committee's business – assurances received from the controls**	**Gaps in assurances it is felt that there are key items missing from the report (control) to provide assurance**	**Actions to address gaps in assurance**	**Date action to be completed by and who is responsible**	**Assurance rating received this period** *Not assured* *Partially assured* *Fully assured*
Priority Obj 1.1 Implementation of the recommendations of the Ockenden report on	2879 - There are risks relating to the trusts Maternity estate that have the potential to impact on the delivery of safe maternity services and the ability to satisfactorily address requirements (HSIB/ Ockenden/ Continuing Care/ Birthrate Plus). (Current score 8) Also impacted by Finance (2874/2873), Workforce (2764) and Future pandemic activity (2868)	Integrated Oversight Report (IOR Dashboard going forward) (monthly) (I)				(Feb 22) Partial assurance rating reflects the impact of operational pressures on patient flow and discharge, and the resulting impact on urgent and emergency care measures.	20/21 BAF CF – Complaint processes (Sept 21) Gaps identified in relation to DoC backlog and compliance levels. (Oct 21) Limited assurance in relation to Ambulance delays and Cancer 62day performance	20/21 BAF CF – report updating findings and actions from complaints process review (Sept 21) Formal update report to be received by the Committee in Jan 22 (Oct 21) report to include additional metrics from Safeguarding and SIs.	Sept 21 Chief Nurse Jan 22 Chief Nurse Jan 22 Chief Nurse	***Partially assured***
		Chief Nurse Update (monthly)				Feb 22 – assurance received that Covid numbers were starting to reduce. Assurance received that feedback from the Chief Nurse's visits was being captured and shared.	Feb 22 – no identified gaps but the significant operational pressures were acknowledged			**Partially assured**
Priority Objective 1.3 Understand the effects of Covid on mortality and look for learning Maternity Services **Priority Objective 1.10**	2868 - Risk of a further wave (s) of Covid -19 and increased demand. (current score 16) (also on Aim 3) 2779 - If we do not have a clear plan and capacity within	Medical Director Update (monthly)				Feb 22 – assurance that a workplan had been developed regarding fluid and electrolyte reviews and this would be subject to monthly monitoring at the Mortality and Morbidity Council.	Feb 22 – no identified gaps but the significant operational pressures were acknowledged			**Partially assured**
		Maternity assurance report (was monthly – now incorporated into IOR)				Nov 21 – noted that additional work was required in relation to training and recommendations received from the regional team visit.				**Partially assured**

Priority Objective	Risks which may prevent the achievement of the strategic aim and priority objective	Reports the Committee receives across the year providing assurance that strategic aims and objectives are being delivered and risks mitigated. (Controls) *(I- internal/ E – External)*	Identified gaps in controls – gaps within the reports that are therefore not a full control or report doesn't exist currently	Actions needed to address gaps in controls	Date action to be completed by; and who is responsible	Assurances gained during the committee's business – assurances received from the controls	Gaps in assurances it is felt that there are key items missing from the report (control) to provide assurance	Actions to address gaps in assurance	Date action to be completed by and who is responsible	Assurance rating received this period *Not assured Partially assured Fully assured*
Develop route map to CQC Outstanding **Other Objectives** 1.2 Develop clinically led Estates Strategy 1.7 Deliver National Patient Safety Strategy 1.8 Accreditation of Nursing & Midwifery Excellence Programme 1.9 Develop and delivery trusts quality strategy and quality accounts	the organisation to ensure compliance with CQC fundamental standards, we may be unable to achieve an outstanding rating (Current score 12) Also impacted by Finance (2874/2873), Workforce (2764) and Future pandemic activity (2868)					Monthly updates no longer required as metrics are now included in IOR				
		Birth Rate Plus				Sept 21 -Limited assurance received in relation to staffing gaps	Business case	Completed business case to go to SMT on 5 Oct 21	Oct 21	Partially assured
		Objectives delivery report (quarterly July, Oct, Jan)				Jan 22 – progress had been made with objective delivery since the last update, despite operational pressures.	Jan 22 – no specific gaps but partial assurance awarded reflecting that continued pressures present future delivery risks to outstanding objectives.			**Partially assured**
		Draft Quality Report proposals 22/23 (Jan & Mar 22) (I)				Jan 22 – assurance provided that a plan is in place to engage on the quality priorities and develop the quality report by June 22.				**Full assurance**
		Quality Objectives (March)								
		Quality priorities quarterly update (quarterly Jun, Sep, Dec, Mar) (I)				(Apr 21) FLO update – good assurance over the positive impact this service has for families. (G)	20/21 BAF CF -Staff attending human factors training low	20/21 BAF CF - Update on numbers trained in next report	Feb 22	**Partially Assured**
		Quality Strategy close out report 21/22 quality report (May 21) (I)								
		Final Quality Report 21/22 (June 21) (I)				(June 21) Assurance provided over the progress and work completed on Quality Priorities, with particular recognition of volunteers and patient experience. Clear quality priorities going forward. (Fully Assured)				**Fully Assured**
		FLO Annual Report (April 22) (REMOVED)								
		Annual review of the quality of training (TBD) (I)								

Priority Objective	Risks which may prevent the achievement of the strategic aim and priority objective	Reports the Committee receives across the year providing assurance that strategic aims and objectives are being delivered and risks mitigated. (Controls) *(I- internal/ E – External)*	Identified gaps in controls – gaps within the reports that are therefore not a full control or report doesn't exist currently	Actions needed to address gaps in controls	Date action to be completed by; and who is responsible	Assurances gained during the committee's business – assurances received from the controls	Gaps in assurances it is felt that there are key items missing from the report (control) to provide assurance	Actions to address gaps in assurance	Date action to be completed by and who is responsible	Assurance rating received this period *Not assured* *Partially assured* *Fully assured*
		Learning from deaths annual report (April 22) (I)								
		Learning from deaths outcome report (6-monthly April & Oct 21) (I)	(Oct 21) Report doesn't include a section on recurrent themes	(Oct 21) Recurrent themes to be included in next report to QGC	April 22 Medical Director	(Oct 21) The Committee received a presentation on learning from Covid deaths over the past year and agreed that a good level of assurance had been received.	Sept 21- LeDeR DNACPR Audit found that non-compliance in the completion of DNACRP forms Issues in relation to the completion of fluid balance charts (Oct 21) The Committee noted the importance of sharing learning and requested that a section on recurrent themes is noted in future reports	Sept 21- A task and finish group had already been convened to look at both issues with a formal paper coming back to the committee Jan 22 (Oct 21) plan in place to cascade the continuous learning for all patient deaths via the quarterly learning reports to QGC, monthly medical bulletins and information being shared at BU meetings	Jan 22 Medical Director April 22 Medical Director	Fully assured
		Medical Examiner Update (Jun 21)				(June 21) A presentation from the Lead Medical Examiner updating and providing assurance on the processes established.	(Jun 21) multiple policies for review and learning from deaths, investigation, SI, complaints and claims. (Jun 21) No formal feedback processes in place from families (at present) or established for consultants/ Junior doctors involved. (Jun 21) learning not fully captured and shared.	(Jun 21) Committee update on alignment of policies. (Jun 21) Update on formal feedback processes established, and feedback to date. (Jun 21) Update on the review into how learning shared	Mar 22 Medical Director/ Chief Nurse / Lead ME Dec 21 Lead ME Dec 21 Lead ME	**Partially Assured**
		R&D Annual Report/ Research Plan 21/22 (Nov 21(TBD)) (I)				Sept 21 - full assurance received for this report noting the level of engagement and activity carried out over the Covid Pandemic.				**Fully Assured**

Priority Objective	Risks which may prevent the achievement of the strategic aim and priority objective	Reports the Committee receives across the year providing assurance that strategic aims and objectives are being delivered and risks mitigated. (Controls) *(I- internal/ E – External)*	Identified gaps in controls – gaps within the reports that are therefore not a full control or report doesn't exist currently	Actions needed to address gaps in controls	Date action to be completed by; and who is responsible	Assurances gained during the committee's business – assurances received from the controls	Gaps in assurances it is felt that there are key items missing from the report (control) to provide assurance	Actions to address gaps in assurance	Date action to be completed by and who is responsible	Assurance rating received this period *Not assured* *Partially assured* *Fully assured*
		IPC Annual Report (Aug 21) (I)				Sept 21 - full assurance received for this report noting the level of engagement work carried out over the Covid Pandemic.				**Fully Assured**
		IPC BAF (NOTE – now reporting to IPC Committee)				Sept 21 – this will now report direct to the IPC Committee with any issues being escalated to QGC.				**Fully Assured**
		Quarterly Learning report (I)	Jan 22 – future learning reports will include triangulated data from inquests, audit, claims and research	Jan 22 - Plan already in place to include greater triangulation.	May 22 Chief Nurse	Jan 22 – report provided good assurance regarding identification of themes and learning.				**Fully Assured**
		Safeguarding annual report (Aug 21) (I)				Oct 21 – Good assurance received overall				**Fully Assured**
		Assurances from Strategic Safeguarding Group (quarterly A/J/O/J) (I) (note current meetings bi-monthly but proposal to change.				Jan 22 – the Committee received full assurance that the Group had continued to operate during times of operational pressure. Assurance was provided that new safeguarding training initiatives had been developed, although recognising that compliance rates remain challenging.				**Fully Assured**
		Older Persons Mental Health Integrated report (July 21)				Sept 21 - The Committee acknowledged the ongoing estates issues on the Cragside new build, however received good assurance robust plans have been put in place to mitigate against mixed sex accommodation				**Fully Assured**
		Patient Experience annual report (Jul 21) (I)				Oct 21 – Good assurance received overall noting the outstanding work carried out by the Volunteers during Covid				**Fully Assured**
		QIA CIP Report (6-monthly Sep 21 & Mar 22) (I)								

Priority Objective	Risks which may prevent the achievement of the strategic aim and priority objective	Reports the Committee receives across the year providing assurance that strategic aims and objectives are being delivered and risks mitigated. (Controls) *(I- internal/ E – External)*	Identified gaps in controls – gaps within the reports that are therefore not a full control or report doesn't exist currently	Actions needed to address gaps in controls	Date action to be completed by; and who is responsible	Assurances gained during the committee's business – assurances received from the controls	Gaps in assurances it is felt that there are key items missing from the report (control) to provide assurance	Actions to address gaps in assurance	Date action to be completed by and who is responsible	Assurance rating received this period *Not assured Partially assured Fully assured*
		Learning Disabilities Annual report (Nov 21) (I)				Nov 21 - update report received noting gaps in assurance, however acknowledged the work undertaken to improve the service by the newly appointed Learning Disability Nurse. Business Case for additional resource due to increased demand approved.	Nov 21 – the requirement to include autism in the learning disability portfolio raises a number of challenges but the additional resource will assist in addressing these challenges. No additional actions identified here.			**Partially Assured**
		Cancer services Annual report (June 21) (I)				(June 21) received for information				
		Route map to outstanding	(Initial review) Not yet developed	(Initial review) Route map in development	Sept 21 Chief Nurse	(Apr 21) CQC action plan reasonable assurance over must do actions (A)	(Initial review) Have not yet undertaken gap analysis against CQC fundamental standards 20/21 BAF CF – CQC inpatient survey 2019 – actions required and no action plan	(Initial review) Gap analysis and action plan to be developed 20/21 BAF CF – Action plan to be received	Sept 21 Chief Nurse Dec 21 COO	**Partially Assured**
		CQC Action plan update (bi-monthly, A, J, A, O, D, F) *NOTE – now reporting to SafeCare Council*				(June 21) Full CQC action plan presented proving assurance on progress but still some actions to complete. Report also received from QEF re Chlorclean and COSHH as requested to provide further clarity on this aspect. (Partially Assured)	(June 21) Full assurance over the completion of actions in relation to hazardous substances.	(June 21) Aim to complete and report back to committee.	Oct 21	**Partially Assured**
		CQC Insights report (quarterly) (E)								
		CQC MH Update report (6 monthly (sept/ march) (I)				Sept 21 - good assurance following a recent unannounced inspection of the Mental Health service noting the minor areas of improvement required.	Sept 21 - ongoing estates issues and the further revised competition date of the Cragside build to late Oct/ early Nov21			**Partially Assured**
		FTSU Guardian Update (I) *NOTE all future updates will be via People and OD Committee*				(June 21) F2SU Guardian updated the committee on activity and provided some assurance on the comparative position of the Trust, however a risk	20/21 BAF CF – No F2SU Guardian Strategy (June 21) Current governance reporting to	20/21 BAF CF – F2SU Guardian Strategy to be presented to Committee. (June 21) Agreed governance reporting	Oct 21	**Partially Assured**

Priority Objective	Risks which may prevent the achievement of the strategic aim and priority objective	Reports the Committee receives across the year providing assurance that strategic aims and objectives are being delivered and risks mitigated. (Controls) *(I- internal/ E – External)*	Identified gaps in controls – gaps within the reports that are therefore not a full control or report doesn't exist currently	Actions needed to address gaps in controls	Date action to be completed by; and who is responsible	Assurances gained during the committee's business – assurances received from the controls	Gaps in assurances it is felt that there are key items missing from the report (control) to provide assurance	Actions to address gaps in assurance	Date action to be completed by and who is responsible	Assurance rating received this period *Not assured* *Partially assured* *Fully assured*
						reflected from staff survey where the % on the question regarding staff feeling they can speak up had reduced (albeit still above average). Possible change in governance reporting as the recently complete well led review suggested reporting directly to Board. (Partially Assured)	be reviewed in line with well led feedback.	to be fed back to Committee.	Dec 21 F2SU Guardian	
		Nursing, Midwifery & AHP Strategy (Sept/Oct 21) (I) & Annual review of delivery								
		Inpatient Survey (Aug 21 – deferred to November)				(Nov 21) The Committee noted the following highlights: • 84% rated their overall experience as 7/10 or more • 98% felt they were treated with respect and dignity • 98% had confidence and trust in the Doctors				**Fully Assured**
		Maternity Inpatient Survey Results (Jan 21)								
		Annual report on Health & equalities outcomes								
		SI Report (quarterly M, A, N, F)				Sept 21- good assurance that that SI Panels had continued during the Covid Pandemic with the welcomed addition of the Medical Examiner and FLO attendance at the panels.	Sept 21 -60day reporting target being missed due to pressures resulting from the Covid Pandemic.	Sept 21 continuous monitoring of 60-day target		**Partially Assured**
		Serious Incident Update (monthly)	(Oct 21) Report is currently verbal	(Oct 21) Plan is currently in place to integrate SI	Nov 21 Chief Nurse	Feb 22 – assurance provided that learnings are being identified and triangulated with complaints. Good assurance provided over the				**Partially Assured**

Priority Objective	Risks which may prevent the achievement of the strategic aim and priority objective	Reports the Committee receives across the year providing assurance that strategic aims and objectives are being delivered and risks mitigated. (Controls) *(I- internal/ E – External)*	Identified gaps in controls – gaps within the reports that are therefore not a full control or report doesn't exist currently	Actions needed to address gaps in controls	Date action to be completed by; and who is responsible	Assurances gained during the committee's business – assurances received from the controls	Gaps in assurances it is felt that there are key items missing from the report (control) to provide assurance	Actions to address gaps in assurance	Date action to be completed by and who is responsible	Assurance rating received this period *Not assured* *Partially assured* *Fully assured*
				reporting into the IOR Feb 22 - request for a paper to support verbal update for future meetings	April 22 Chief Nurse	new process for SIs and the linkage to the Datix risk system.				
		Safer Staffing Report (bi-monthly – on months where there is no Trust Board)				(Feb 22) Staffing task and finish group initiated to review staffing establishment, manage sickness absence as well as reporting, recording and escalation of staffing challenges. Changes also made to the escalation process for dealing with staffing issues.	(Feb 22) No specific gaps that aren't already being addressed through process change, but acknowledgement that staffing challenges remain			**Partially Assured**
		Review of clinical audit programme (July and Nov 21) (I)				(July 2021) Good level of assurance received noting the high level of compliance against national audits undertaken Nov 21 - Good level of assurance received noting the high level of compliance against national audits undertaken and good mechanisms are in place to monitor audit compliance.				**Fully assured**
		Proposed Clinical Audit Plan 22/23 (Dec 22) (I)								
		NICE Guidance Annual Report (July)				The Committee noted a good level of assurance for this				**Fully assured**

Priority Objective	Risks which may prevent the achievement of the strategic aim and priority objective	Reports the Committee receives across the year providing assurance that strategic aims and objectives are being delivered and risks mitigated. (Controls) *(I- internal/ E – External)*	Identified gaps in controls – gaps within the reports that are therefore not a full control or report doesn't exist currently	Actions needed to address gaps in controls	Date action to be completed by; and who is responsible	Assurances gained during the committee's business – assurances received from the controls	Gaps in assurances it is felt that there are key items missing from the report (control) to provide assurance	Actions to address gaps in assurance	Date action to be completed by and who is responsible	Assurance rating received this period *Not assured* *Partially assured* *Fully assured*
						report and noted the high level of compliance.				
		Medicine Management Quarterly Report (S.D,M,J)				Feb 22 - The Committee received good assurance in relation to key medicines performance indicators within quarter 2 including the management of controlled drugs.				**Fully assured**
		H&S Annual Report (May 21) (I)								
		H&S Quarterly Report (Quarterly Aug, Nov, Feb) (I)				Jan 22 – comprehensive workplan received and assurance received that a new health and safety policy is in development.	Jan 22 – further detail required regarding COSHH risk assessment, compliance levels and RIDDORs	Jan 22 – agreed that further details would be provided in March 22, with a further update on the workplan in May 22	March 22 / May 22 Chief Nurse	**Partially Assured**
		Internal Audits/ External Reviews (where applicable) (E)	(Initial review) Ockenden Compliance Report –- Reporting not yet in place	(Initial review) Develop reporting mechanism.	July 21 Head of Midwifery	(May 21) Maternity review action plan update – robust assurance received. (A) re risks relating to estate.				**Partially Assured**
			Oct 21 - Final Internal Audit Report NICE Guidance 2021-22/16			(Oct 21) The Committee received good assurance and noted the four minor actions highlighted by AuditOne				**Fully assured**
			Nov 21 - Final Internal Audit Report Duty of Candour			Nov 21 - The Committee received good assurance and noted minor actions highlighted by AuditOne.				**Fully assured**
		IPC 6 Month Update Report (March)								
		Maternity 6 Month Update Report (March)								
		Mental Health 6 Month Update Report (March)								

Priority Objective	Risks which may prevent the achievement of the strategic aim and priority objective	Reports the Committee receives across the year providing assurance that strategic aims and objectives are being delivered and risks mitigated. (Controls) *(I- internal/ E – External)*	Identified gaps in controls – gaps within the reports that are therefore not a full control or report doesn't exist currently	Actions needed to address gaps in controls	Date action to be completed by; and who is responsible	Assurances gained during the committee's business – assurances received from the controls	Gaps in assurances it is felt that there are key items missing from the report (control) to provide assurance	Actions to address gaps in assurance	Date action to be completed by and who is responsible	Assurance rating received this period *Not assured* *Partially assured* *Fully assured*
		Mental Health Act Compliance Minutes (monthly)				Jan 22 – minutes received for assurance	Jan 22 – compliance figures for restrictive interventions were not available	Jan 22 – Chief Nurse to investigate why restrictive intervention compliance figures were not available and will report back to the Committee on this	Feb 22 Chief Nurse	**Partially Assured**
		SafeCare Risk and Patient Safety Council (J, S, D, M)				Jan 22 – good progress received regarding attendance and engagement at the meetings.	Jan 22 – partial assurance reflected the ongoing development of the report and continued work on enhancing learning. This is already underway so no additional actions required.			**Partial assurance**
		Review of sub-groups (Jan)				Jan 22 – good assurance received regarding the new proposed structure.				**Full assurance**
		Mandated vaccine update report (Jan 22)				Feb 22 – support put in place for colleagues affected by the mandated vaccine work prior to the national pause. Awaiting next steps nationally.				**Partial assurance**
		Mind the Gap Maternity Report (Jan 22)				Jan 22 – assurance provided that the Trust submitted a return template to NHS Resolutions confirming compliance. Further updates to come as part of the maternity report.				Item not rated as it was AOB item and future updates will be provided via the maternity report
		Reg 28 (if required)								

Strategic Aim 2 - We will be a great organisation with a highly engaged workforce Enabling Strategy: People and OD Monitoring Board Committee: **People and Organisational Development Committee** Lead Director: Director of People and OD					Committee date Bi Monthly meeting cycle	Apr 21	May 21	Jun 21	July 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22
					Assurance Level												
Key	**No assurances due**	*N/A*	**Gaps in assurance and no plans in place to address**	***Not assured***	**Gaps in assurance but clear plans in place to address**				***Partially assured***		**No gaps in assurance**				***Fully assured***		

BOLD TEXT in controls - Item on current agenda	(Date) prior to entry - When received/ identified	Red Text - New entry from preceding meeting	Green Text – Action from preceding meeting addressed

Priority Objective	Risks which may prevent the achievement of the strategic aim and priority objective	Reports the Committee receives across the year providing assurance that strategic aims and objectives are being delivered and risks mitigated. (Controls) *(I- internal/ E – External)*	Identified gaps in controls – gaps within the reports that are therefore not a full control or report doesn't exist currently	Actions needed to address gaps in controls	Date action to be completed by; and who is responsible	Assurances gained during the committees business – assurances received from the controls	Gaps in assurances it is felt that there are key items missing from the report (control) to provide assurance	Actions to address gaps in assurance	Date action to be completed by and who is responsible	Assurance rating received this period *Not assured* *Partially assured* *Fully assured*
Priority Objective 2.1 Establish a post Covid health and wellbeing programme to incorporate; The development of a HWB strategy, the roll out of HWB conversations, the continuing arrangement for a Trust Testing Track & Trace & vaccine service and a review of the trust occupational health service **Priority Objective 2.3** Develop a Trust wide approach to strategic workforce planning **Priority objective 2.4** Develop a leadership and OD Strategy with clear outcomes **Other Objectives** 2.2 Continue to learn and improve on the challenges in response to Covid	2759: Risk that we are not able to appropriately support the health and wellbeing needs of our workforce (12) 2764 - Risk of not having the right people in right place at the right time with the right skills (16) 2765: No Leadership and OD strategy in place across the trust resulting in failure to support our workforce (12)	**People and OD Strategy Items**								
		Update report from POD Portfolio Board (each meeting)				(March 22) Assurance was provided that workstreams and associate project meetings are being reinstated following VCOD and the latest wave of COVID.	(March 22) Rating of partial assurance reflects the stage of progress in relation to the workstreams restarting – no further actions identified.			**Partially assured**
		People Plan 20-21 Update and Guidance (Jul, Nov, Mar)				(Nov 21) Assurance provided over delivery of the outstanding actions, which have reduced since the last meeting. No actions rated red.	15 actions rated amber – not a gap but they will continue to be monitored by the Committee.	Continual monitoring of the action plan.	Jan 22 Lisa Crichton-Jones	**Partially assured**
		VCOD Update (March 2022)				(March 22) Assurance provided that despite national pause, weekly meetings are continuing to ensure that the Trust is as prepared as possible for any further government announcements. Fully assured that the Trust is doing everything it can within its control.	(March 22) Partial assurance rating reflects that the risks associated with VCOD remain, along with the uncertainty, but no additional actions identified for the Trust.			**Partially assured**
		Update on Supply (March 22)				(March 22) Assurance provided that a significant amount of work is being undertaken in this area.	(March 22) Partial assurance rating reflects the current stage of progress against plans – i.e. in progress but not yet fully delivered.			**Partially assured**
		Items for debate and discussion								

Priority Objective	Risks which may prevent the achievement of the strategic aim and priority objective	Reports the Committee receives across the year providing assurance that strategic aims and objectives are being delivered and risks mitigated. (Controls) *(I- internal/ E – External)*	Identified gaps in controls – gaps within the reports that are therefore not a full control or report doesn't exist currently	Actions needed to address gaps in controls	Date action to be completed by; and who is responsible	Assurances gained during the committees business – assurances received from the controls	Gaps in assurances it is felt that there are key items missing from the report (control) to provide assurance	Actions to address gaps in assurance	Date action to be completed by and who is responsible	Assurance rating received this period *Not assured* *Partially assured* *Fully assured*
2.5 Strengthen approaches to people related quality, performance and governance measures 2.6 Increase the number of non clinical staff who are working flexibly **Objectives enabled by Digital** 2.7 Develop digital skills programmes to enable staff to exploit the technology they have 2.8 Design user technology around them, reducing the number of devices they have 2.9 Improve service desk response		People and OD Metrics and IOR (each meeting)	(March 22) New report format welcomed but reflection that there may be too many metrics included. A need to use highlight reporting and drill down on business units where appropriate. In-month sickness figures to add to report to aid understanding of the latest position. (Sept 21) employee relations and recruitment metrics still has data accuracy issues which are being addressed through the service review actions. (Nov 21) update – this information remains outstanding but is expected by Jan 22.	(March 22) Review metrics to refine them; increase exception reporting at business unit level; and add in in-month sickness figures. (Jan 22) update new People metrics report presented to the Committee for the first time and will continue to evolve. Includes more recruitment metrics – further employee relations metrics will be added in due course.	Continued development through 2022/23 Lisa Crichton-Jones	(March 22) Comprehensive report presented including new metrics.	(March 22) Gaps in assurance link directly with the continued development of the report, recognising that good progress is being made in this respect, but will take time.	(March 22) As per gap in control – inclusion of the metrics will enable greater assurance to be sought.	Continued development through 2022/23 Lisa Crichton-Jones	**Partially assured**
		EDI Annual Update (WRES/WDES Annual reports 2022 and EDS2 update (TBD), Equality Report) (July)				(Sept 21) Confirmation received that timescales have been updated to reflect achievable delivery.				**Partially assured**
		Workforce Race Equality Standard (WRES) (Annual – Sep)				(Sept 21) Work ongoing and recognition was received in relation to ongoing work with the BAME Network.	(Sept 21) No specific gaps, as gaps covered within the action plan – rating reflects the scale of the task still ahead in	-	-	**Partially assured**

Priority Objective	Risks which may prevent the achievement of the strategic aim and priority objective	Reports the Committee receives across the year providing assurance that strategic aims and objectives are being delivered and risks mitigated. (Controls) *(I- internal/ E – External)*	Identified gaps in controls – gaps within the reports that are therefore not a full control or report doesn't exist currently	Actions needed to address gaps in controls	Date action to be completed by; and who is responsible	Assurances gained during the committees business – assurances received from the controls	Gaps in assurances it is felt that there are key items missing from the report (control) to provide assurance	Actions to address gaps in assurance	Date action to be completed by and who is responsible	Assurance rating received this period *Not assured* *Partially assured* *Fully assured*
						Whilst a lot of progress had been made, the Committee reflected that there was still a significant amount of work to complete, guided by the comprehensive action plan.	achieving compliance with the standard.			
		Workforce Disability Equality Standard (WDES) (Annual – Sep)				(Sept 21) Plan in place for work going forward and there are 10 standards. Whilst a lot of progress had been made, the Committee reflected that there was still a significant amount of work to complete, guided by the comprehensive action plan.	(Sept 21) No specific gaps, as gaps covered within the action plan – rating reflects the scale of the task still ahead in achieving compliance with the standard.	-	-	**Partially assured**
		Freedom to Speak Up Report (6 monthly – July, Jan)	None			(Jan 22) Report identified 29 concerns received up to Q3. Committee were partially assured with further work required to understand any potential themes and trends to be undertaken out with the Committee meeting.				**Partially assured**
		NHS Staff survey results (annual – May)				(Nov 21) The Survey response rate is currently 36% and final reminders are due to be circulated.	(Nov 21) No specific action – await outcome of the staff survey			**Partially assured**
		NHS staff survey & action plan (July)	None			(July 21) Overall steering group and individual BU and corporate directorates action plans presented, 7 areas had action plans, although 3 needed to clarify timescales 2 areas where no action plan currently in place.	(July 21) Actions plans needed for 2 areas.	(July 21) Action plans for 2 areas to be developed	Nov 21	**Partially assured**
		Quarterly Pulse Survey Results (Nov, March, July. Sept)				(Nov 21) This has received low levels of engagement and has been reported to SMT.	(Nov 21) Low completion rate for the Pulse Survey	(Nov 21) Continually monitor at the Committee – SMT tasked with increasing the completion rate	March 22 Lisa Crichton-Jones	**Partially assured**
		GMC Survey Results & Action Plan (Annual –				(Nov 21) The Trust had performed well in the Region	(Nov 21) Next step – identify actions for further focus	(Nov 21) Action plan to be monitored by the Medical	March 22 Lisa Crichton-Jones	**Partially assured**

Priority Objective	Risks which may prevent the achievement of the strategic aim and priority objective	Reports the Committee receives across the year providing assurance that strategic aims and objectives are being delivered and risks mitigated. (Controls) *(I- internal/ E – External)*	Identified gaps in controls – gaps within the reports that are therefore not a full control or report doesn't exist currently	Actions needed to address gaps in controls	Date action to be completed by; and who is responsible	Assurances gained during the committees business – assurances received from the controls	Gaps in assurances it is felt that there are key items missing from the report (control) to provide assurance	Actions to address gaps in assurance	Date action to be completed by and who is responsible	Assurance rating received this period *Not assured* *Partially assured* *Fully assured*
		deferred to Nov from Sept)				and were rated top in Clinical Supervision.		Workforce Group and assurance reported via the POD Portfolio Board updates.		
		ADQM Self-Assessment report (Annual - Jan)								
		Staff Side Insights (Deferred from Nov to Jan)								
		Terms of Reference Review (Annual review - Sep)				(Sept 21) Terms of Reference agreed by the Chair and Executive of the Committee.				**Fully assured**
		HRC Effectiveness Review (Annual review - Sep)				(Sept 21) item deferred to the year-end to ensure it is more meaningful given the Committee is undergoing a period of change				
		Assurance on delivery of strategic objectives								
		Summary strategic objective update report (March 22)				(March 22) Comprehensive summary report received demonstrating continued progress against the priority objectives. Committee felt assured by the report.	(March 22) Partial assurance rating reflects that objectives are still underway, rather than being indicative of a gap in assurance.			**Partially assured**
		Update on Delivery of Strategic Objective (2.1) Health and Wellbeing				(Jan 22) Significant amount of work undertaken with priority focus on mandatory vaccinations, redeployment, Covid risk assessments and health and wellbeing check-ins. Separate paper received to provide more granular information on vaccination.	(Jan 22) Recognition of the risks of mandatory vaccinations on staffing, service delivery and wellbeing; operational pressures impacting on wellbeing; and sustainability of health and wellbeing programme. Gap in assurance relating to quantifying the implications of mandatory vaccinations, but assured this is an area of priority.	(Jan 22) No specific actions over and above what is already being undertaken, but important to continue to keep Committee appraised on progress and risks.	March 22 Lisa Crichton-Jones	**Partially assured**
		Update on Delivery of Strategic Objectives (2.3)				(Jan 22) Area of significant focus. Assured that Staffing	(Jan 22) No additional actions identified other	(Jan 22) Regular progress reports to	March 22	**Partially assured**

Priority Objective	Risks which may prevent the achievement of the strategic aim and priority objective	Reports the Committee receives across the year providing assurance that strategic aims and objectives are being delivered and risks mitigated. (Controls) *(I- internal/ E – External)*	Identified gaps in controls – gaps within the reports that are therefore not a full control or report doesn't exist currently	Actions needed to address gaps in controls	Date action to be completed by; and who is responsible	Assurances gained during the committees business – assurances received from the controls	Gaps in assurances it is felt that there are key items missing from the report (control) to provide assurance	Actions to address gaps in assurance	Date action to be completed by and who is responsible	Assurance rating received this period *Not assured* *Partially assured* *Fully assured*
		– Strategic Workforce Planning (each meeting) NOTE – includes Supply presentation in Jan 22				Task and Finish Group established and meeting regularly. In early stages of implementing international recruitment. Assured this is an area of focus for the Trust.	than keeping the Committee appraised of progress given the importance of supply.	be provided at each meeting.	Lisa Crichton-Jones	
		Update on Delivery of Strategic Objective (2.4) – Develop a Leadership and OD Strategy (each meeting)				(Jan 22) Assurance that Leadership and OD Programme Board has been established. A number of tangible elements of progress identified including recent leadership masterclass.	(Jan 22) Not a gap but a recognition that the delivery of this objective has been paused to focus on mandatory vaccinations and staff volunteering. This drives the partial assurance rating.			**Partially assured**
		Update on Delivery of Strategic Objective (2.5) – People, Quality, Performance and Governance (each meeting)				(Jan 22) As outlined in the POD Portfolio Board item, the meeting was stood down in December. As per 2.1. the primary focus is on mandatory vaccinations and supporting operational services.	(Jan 22) As per 2.4 there is a recognition of the need to refocus and prioritise vaccination and staff volunteering in the short term. This drives the partial assurance rating.			**Partially assured**
		Continue to Lead and Improve on Challenges in Response to Covid (e-rostering) (2.2)								
		Supporting the Workforce with Tools/Skills knowledge (link to Digital) (2.6, 2.7, 2.8, 2.9)								
		Further assurance reports								
		POD Service Review Outcomes / Learning Lessons to Improve our People Practices (Jul, Sept, Nov, Mar)				(Jan 22) Committee were fully assured that actions were being progressed with no gaps noted.				**Fully assured**

Priority Objective	Risks which may prevent the achievement of the strategic aim and priority objective	Reports the Committee receives across the year providing assurance that strategic aims and objectives are being delivered and risks mitigated. (Controls) *(I- internal/ E – External)*	Identified gaps in controls – gaps within the reports that are therefore not a full control or report doesn't exist currently	Actions needed to address gaps in controls	Date action to be completed by; and who is responsible	Assurances gained during the committees business – assurances received from the controls	Gaps in assurances it is felt that there are key items missing from the report (control) to provide assurance	Actions to address gaps in assurance	Date action to be completed by and who is responsible	Assurance rating received this period *Not assured* *Partially assured* *Fully assured*
		Senior Management & Board Visibility (Annual – Nov)				(Nov 21) Walkabouts have now been reinstated, and a discussion was had on how in the future themes and information from these visits could be more formally collated.				**Partially assured**
		Audit reports and actions (as & when – list in rows below)								
		• Disciplinary Policy Audit report (July 21 with Nov update on audit actions)				(Nov 21) The Committee received full assurance that audit actions were progressing..				**Fully assured**
		• Covid 19 risk assessment audit report (July 21 with Nov update on audit actions)				(Nov 21) The Committee received full assurance that audit actions were progressing.				**Fully assured**
		TRAC implementation update (Nov)				(Nov 21) All vacancies are now on the TRAC system, with additional capacity sourced from an external partner.	(Nov 21) There are still some actions to complete and a new risk relating to increased recruitment workload.	(Nov 21) Continue to keep under review and report on progress to the Committee. Outputs to be seen in workforce metrics reporting.	Jan 22 Lisa Crichton-Jones	**Partially assured**
		Annual / quarterly reports								
		Guardian of Safe Working Report (July, Sep, Nov, Jan)				(Jan 22) There are no immediate safety concerns. The Committee were fully assured.				**Fully assured**
		Guardian of Safe Working Annual Report (Sept 21)				(Sept 21) Good overview received and exceptional work has taken place by the Junior Doctors through the Covid Pandemic.				**Fully assured**
		Equality Delivery System (EDS2)								

Priority Objective	Risks which may prevent the achievement of the strategic aim and priority objective	Reports the Committee receives across the year providing assurance that strategic aims and objectives are being delivered and risks mitigated. (Controls) *(I- internal/ E – External)*	Identified gaps in controls – gaps within the reports that are therefore not a full control or report doesn't exist currently	Actions needed to address gaps in controls	Date action to be completed by; and who is responsible	Assurances gained during the committees business – assurances received from the controls	Gaps in assurances it is felt that there are key items missing from the report (control) to provide assurance	Actions to address gaps in assurance	Date action to be completed by and who is responsible	Assurance rating received this period *Not assured* *Partially assured* *Fully assured*
		Library Quality Assurance Self-Assessment (Annual – Sept)				(Sept 21) Item deferred.				
		Revalidation Report (Annual – Sep)				(Sept 21) Good assurance over compliance provided- no specific gaps identified.	-	-	-	**Fully assured**
		Public Sector Apprenticeship Target (Annual- Sep)								
		ADQM Results and Outcome (Annual)				(Sept 21) Noted good assurance and for information. Learners are happy with the environment.				**Fully assured**
		Gender Pay Gap Reporting (usually March – c/f sept)	(March 22) identified the need to be clear on a target in future to track progress.	(March 22) Future report to include target following discussion at EDI programme board.	March 22 Lisa Crichton-Jones	(March 22) Fully assured over actions being taken to continue to improve in this area e.g. EDI programme board, analysing TRAC metrics and looking at ways to attract and retain staff.				**Fully assured**
		Items for Information								
		HR Policies - Schedule Update and Any for Approval (each meeting)				(Nov 21) Report presented covering policy position. Demonstrates progress is being made in respect of overdue policies. Plans in place to address these.	(Nov 21) – no addition actions required – work continues.			**Partially assured**

Strategic Aim 3 - We will enhance our productivity and efficiency to make the best use of our resources Enabling Strategy: Finance Framework/Digital Strategy & Clinical Monitoring Board Committee: **Finance and Performance** Lead Director: Group Director of Finance					**Committee date**	**Apr 21**	**May 21**	**Jun 21**	**July 21**	**Aug 21**	**Sep 21**	**Oct 21**	**Nov 21**	**Dec 21**	**Jan 22**	**Feb 22**	**Mar 22**
					Assurance Level												
Key	**No assurances due**	***N/A***	**Gaps in assurance and no plans in place to address**	***Not assured***	**Gaps in assurance but clear plans in place to address**			***Partially assured***		**No gaps in assurance**				***Fully assured***			

BOLD TEXT in controls - Item on current agenda	(Date) prior to entry - When received/ identified	Red Text - New entry from preceding meeting	Green Text – Action from preceding meeting addressed

Priority Objective	**Risks which may prevent the achievement of the strategic aim and priority objective**	**Reports the Committee receives across the year providing assurance that strategic aims and objectives are being delivered and risks mitigated. (Controls)** *(I- internal/ E – External)*	**Identified gaps in controls – gaps within the reports that are therefore not a full control or report doesn't exist currently**	**Actions needed to address gaps in controls**	**Date action to be completed by; and who is responsible**	**Assurances gained during the committees business – assurances received from the controls**	**Gaps in assurances it is felt that there are key items missing from the report (control) to provide assurance**	**Actions to address gaps in assurance**	**Date action to be completed by and who is responsible**	**Assurance rating received this period** *Not assured* *Partially assured* *Fully assured*
Priority Obj 3.4 Develop an approved capital and revenue plan. (and perform within) **Priority Obj. 3.8** Deliver the Operational transformation programme to improve productivity and efficiency of service delivery and recovery post Covid **Other Objectives** 3.5 accountability framework 3.6 delivery of transformation plan 3.7 costing strategy 3.9 SMART corporate reporting framework 3.10 capital funding to support estates strategy 3.11 Review and Establish Charity Strategy (sits under the remit of the Charitable Funds Committee)	2874 Risk that we are unable to formulate (and deliver) a coherent financial plan due to the uncertainty surrounding the financial framework (3) 2873 Risk that the Trust is unable to form a suitable capital plan and programme due to reduced levels of CDEL available (9) 2868 - Risk of a further wave (s) of Covid -19 and increase in demand (16) Also impacted by Workforce (2764)	Financial update report (Monthly) (I) (Obj 3.4, Risk 2874)	Report doesn't include transformation / efficiency	(Jul 21) Transformation Board reporting to the Committee to recommence when the Transformation Board is reinstated	December 21 DDoCS&T	(Feb 22) Full assurance received as the year-end financial target is forecast to be achieved. (Jan 22) Full assurance received over financial performance and assurance that planning and the relationship with the new auditors is progressing well.	(Oct-21) Gaps remain with divisional revenue run rates. (Dec 21) The Committee sought further assurance over progress made against the non-recurrent spend plan.	(Feb 22) Update - divisional finance reporting in shadow until the year end. Date amended to April 22. (Dec 21) Additional detail to be included in the regular report regarding non-recurrent spend and mitigating actions.	Revised date for divisional reporting – ~~December 21~~ April 22 DoF December 21 DoF	**Fully assured**
		H1 Plan update (April 21) (Obj 3.4, Risk 2874)				(Apr 21) Comprehensive update re H1 planning. (G)	none	none		**Fully Assured**
		H2 Plan 21/22 (July 2021) (I) (Obj 3.4, Risk 2874)				(Nov-21) Partial assurance was received and confirmed that the plan has been submitted.		(Nov-21) Action is the same as the Financial Revenue Report action (divisional budgets)	Revised date – December 21 DoF	**Partially assured**
		Submission of 22/23 Draft Plan / Annual Planning Update (Feb & March)				(Feb 22) Assurance provided that significant work is being undertaken on the draft plan, including the identification of risks as well as discussion with partners in the ICP.	(Feb 22) No specific gaps – partial assurance reflects that the work on the draft plan continues, with approval to be sought at the next F&P Committee meeting.			**Partially assured**
		Budget setting 22/23 Capital and Revenue (March 22)								
		Accountability Framework (July) (Obj 3.5)				(Oct-21) Partial assurance was received, and it was agreed that the framework would be reintroduced in shadow form.	(Oct 21) Reintroduced in shadow form until 1 April 2022.		March 22 DoF to provide update	**Partially Assured**

Priority Objective	Risks which may prevent the achievement of the strategic aim and priority objective	Reports the Committee receives across the year providing assurance that strategic aims and objectives are being delivered and risks mitigated. (Controls) *(I- internal/ E – External)*	Identified gaps in controls – gaps within the reports that are therefore not a full control or report doesn't exist currently	Actions needed to address gaps in controls	Date action to be completed by; and who is responsible	Assurances gained during the committees business – assurances received from the controls	Gaps in assurances it is felt that there are key items missing from the report (control) to provide assurance	Actions to address gaps in assurance	Date action to be completed by and who is responsible	Assurance rating received this period *Not assured* *Partially assured* *Fully assured*
						Good working relationships with the ICP.				
		Supply & Procurement Committee Update (Monthly) (I) (Obj 3.4, 3.8, Risk 2874)	(Dec 21) Identified that outcome column didn't include sufficient detail to provide the Committee with appropriate level of assurance	(Dec 21) Updated summary with greater detail on outcomes to be included in next report	Jan 22 DoF	(Dec 21) Partial assurance reflected the gaps in control identified in respect of requiring further information on outcomes.	(Feb 22) Item deferred and therefore previous gaps remain until next update in March 22. (Jan 22) Committee not assured by the level of detail provided in the paper.	(Jan 22) The Deputy Director of Finance to review the processes and information provision to the Committee	Deputy Director of Finance March 22	**Not assured**
		Budget Setting 22/23 (Feb 22) (Obj 3.4, Risk 2874)								
		Capital Plan Update (Bimonthly from Jun 2021) (I) (Obj 3.4, 3.10, risk 2873)				(Feb 22) Assurance received that slippage on a number of schemes enabled the purchase of another key capital item, which was approved by the Committee.	(Feb 22) No specific gaps – partial assurance reflects the significant risk of further slippage.			**Partially Assured**
		Internal Audit reports received (E)				(Feb 22) Good level of assurance was received on the accounts receivable audit. (July 21) Good level of assurance was received on the Risk Based Audit of Procurement Report.				**Fully assured**
		Policy Updates (monthly as required) (I)				(July 21) To be discussed at a forthcoming meeting.				
		Integrated Oversight Report (IOR) (Monthly) (I)	(April - CF) IOR still under development not yet reporting all key performance metrics	(April - CF) Continue to develop the IOR to incorporate all metrics – in the interim provide additional assurance reports where necessary	Ongoing development COO	(Feb 22) Positive assurances that despite pressures the Trust benchmarked well against peers in the region.	(Feb 22) No additional actions identified – partial assurance reflects the scale of the challenge and the impact on the delivery of services. (Nov-21) more detail was requested in respect of the audiology service	(Dec 21) IOR to continue to focus on areas of pressure through the deep-dive reporting. Expectation that the plan for the 127% elective activity target will be presented for consideration at a future Board. Audiology report still	Jan 22 COO	**Partially Assured**

Priority Objective	Risks which may prevent the achievement of the strategic aim and priority objective	Reports the Committee receives across the year providing assurance that strategic aims and objectives are being delivered and risks mitigated. (Controls) *(I- internal/ E – External)*	Identified gaps in controls – gaps within the reports that are therefore not a full control or report doesn't exist currently	Actions needed to address gaps in controls	Date action to be completed by; and who is responsible	Assurances gained during the committees business – assurances received from the controls	Gaps in assurances it is felt that there are key items missing from the report (control) to provide assurance	Actions to address gaps in assurance	Date action to be completed by and who is responsible	Assurance rating received this period *Not assured* *Partially assured* *Fully assured*
				(Nov 21) Report to include greater context for the community measures to aid understanding and interpretation	Jan 22 COO			required to come back to the Committee.		
		Audiology Recovery Report (March 22)								
		Waiting List Validation Report (Dec 21)				(Dec 21) External validation of RTT waiting list data didn't identify any immediate causes for concern and therefore full assurance awarded. Recommendation made regarding development of a centralized approach to provide staffing resilience and a business case would be developed in response.				**Fully assured**
		Cancer Service Action Plan (Dec 21)				(Dec 21) Report provided the Committee with assurance that action plans are in place and being progressed.	(Dec 21) Risks to current action plans relating to current operational pressures and staffing issues identified, which results in a partial assurance rating. No specific actions to be documented here – Committee satisfied that issues would be escalated through spotlight reports.			**Partial assurance**

Priority Objective	Risks which may prevent the achievement of the strategic aim and priority objective	Reports the Committee receives across the year providing assurance that strategic aims and objectives are being delivered and risks mitigated. (Controls) *(I- internal/ E – External)*	Identified gaps in controls – gaps within the reports that are therefore not a full control or report doesn't exist currently	Actions needed to address gaps in controls	Date action to be completed by; and who is responsible	Assurances gained during the committees business – assurances received from the controls	Gaps in assurances it is felt that there are key items missing from the report (control) to provide assurance	Actions to address gaps in assurance	Date action to be completed by and who is responsible	Assurance rating received this period *Not assured* *Partially assured* *Fully assured*
		Echo Performance Spotlight Report (Jan 22)				(Jan 22) Positive update received with progress being made in increasing activity in this area. Full assurance provided that the Trust is doing everything in its power to achieve the revised target.				**Full assurance**
		ECIST update (Jan 22)				(Jan 22) Full assurance received that an improvement plan is in place to incorporate the learnings from the ECIST report.				**Full assurance**
		Transformation Board update (March 22)								
		Objectives delivery report(quarterly)				(Jan 22) Partial assurance received which reflects the achievement of 6 objectives and 9 others being delivered (8 of which on track but with some risks to delivery)	(Jan 22) No specific gaps in assurance – reflects stage of delivery of objectives.			**Partial assurance**

Strategic Aim 4 - We will be an effective partner and be ambitious in our commitment to improving health outcomes Enabling Strategy: Partnership/Corporate Monitoring Board Committee: **Quality Governance Committee** Lead Director: Chief Executive/ Medical Director					**Committee date**	**Apr 21**	**May 21**	**Jun 21**	**July 21**	**Aug 21**	**Sep 21**	**Oct 21**	**Nov 21**	**Dec 21**	**Jan 22**	**Feb 22**	**Mar 22**
					Assurance Level (document updated to)												
Key	**No assurances due**	*N/A*	**Gaps in assurance and no plans in place to address**	***Not assured***	**Gaps in assurance but clear plans in place to address**			***Partially assured***			**No gaps in assurance**				***Fully assured***		

BOLD TEXT in controls - Item on current agenda	(Date) prior to entry - When received/ identified	Red Text - New entry from preceding meeting	Green Text – Action from preceding meeting addressed

Priority Objective	**Risks which may prevent the achievement of the strategic aim and priority objective**	**Reports the Committee receives across the year providing assurance that strategic aims and objectives are being delivered and risks mitigated. (Controls)** *(I- internal/ E – External)*	**Identified gaps in controls – gaps within the reports that are therefore not a full control or report doesn't exist currently**	**Actions needed to address gaps in controls**	**Date action to be completed by; and who is responsibl e**	**Assurances gained during the committee's business – assurances received from the controls**	**Gaps in assurances it is felt that there are key items missing from the report (control) to provide assurance**	**Actions to address gaps in assurance**	**Date action to be completed by and who is responsibl e**	**Assurance rating received this period** *Not assured* *Partially assured* *Fully assured*
Priority Objective 4.3 / 4.4 Strong partner working at Place, ICP, ICS levels and beyond to manage population health and tackle health inequalities. **Priority Objective 4.1** Establish an Acute Tobacco Dependency Service (based on the CURE model - full implementation) **Other objectives** **4.2 –** Target the public health inequalities with partners across Gateshead at Place **4.5 -** Assess value (deteriorated, maintained, improved) through application of costing strategy	2880 - Risk that Place/ICS/ICP strategy and plans do not fully align with our objectives and aspirations to tackle health inequalities. (current score 9) Also impacted by Finance (2874/2873), Workforce (2764) and Future pandemic activity (2868)	Objectives delivery report (quarterly ~~A,~~ S, O, D,)				Jan 22 – progress had been made with objective delivery since the last update, despite operational pressures.	Jan 22 – no specific gaps but partial assurance awarded reflecting that continued pressures present future delivery risks to outstanding objectives.			**Partially assured**

Strategic Aim 5 - We will develop and expand our services within and beyond Gateshead Enabling Strategy: Clinical and Estates Monitoring Board Committee: **Finance and Performance** Lead Director: Chief Operating Officer/ Managing Director QEF					**Committee date**	**Apr 21**	**May 21**	**Jun 21**	**July 21**	**Aug 21**	**Sep 21**	**Oct 21**	**Nov 21**	**Dec 21**	**Jan 22**	**Feb 22**	**Mar 22**
					Assurance Level												
Key	**No assurances due**	***N/A***	**Gaps in assurance and no plans in place to address**	***Not assured***	**Gaps in assurance but clear plans in place to address**			***Partially assured***			**No gaps in assurance**				***Fully assured***		

BOLD TEXT in controls - Item on current agenda	(Date) prior to entry - When received/ identified	Red Text - New entry from preceding meeting	Green Text – Action from preceding meeting addressed

Board Priority Objective Other Committee Objectives	**Risks which may prevent the achievement of the strategic aim and priority objective**	**Reports the Committee receives across the year providing assurance that strategic aims and objectives are being delivered and risks mitigated. (Controls)**	**Identified gaps in controls – gaps within the reports that are therefore not a full control or report doesn't exist currently**	**Actions needed to address gaps in controls**	**Date action to be completed by; and who is responsible**	**Assurances gained during the committees business – assurances received from the controls**	**Gaps in assurances it is felt that there are key items missing from the report (control) to provide assurance**	**Actions to address gaps in assurance**	**Date action to be completed by and who is responsible**	**Assurance rating received this period** *Not assured* *Partially assured* *Fully assured*
Priority Obj. 5.3 Prepare a bid for Community Diagnostic Hub for North ICP **Priority Obj. 5.5** Continue to further develop our pathology offer using innovation and technology **Priority Obj. 5.6 & 5.7** Optimise Commercial Opportunities. **Other Objectives** 5.1 Specialist breast service 5.2 tertiary gynae oncology service 5.4 Surgery Centre for Excellence 5.8 Expand wholesale pharmacy drugs Expand NE transport hub	2882 - Risk of commercial market climate changes, due to political, environmental or other factors, affecting the ability to maximise opportunities. ***Risk now closed*** Also impacted by Finance (2874/2873), and Workforce (2764)	Objectives delivery report(quarterly)				(Jan 22) Partial assurance received which reflects the achievement of 6 objectives and 9 others being delivered (8 of which on track but with some risks to delivery)	(Jan 22) No specific gaps in assurance – reflects stage of delivery of objectives.			**Partial assurance**
		QE Facilities update (6 monthly May/ Nov)	None	None		(Nov 21) Positive assurance and a comprehensive update received in relation to the financial control and efficiency of QEF.	(Nov 21) Delays in relation to mask production, although not sufficient to award partial assurance.	(Nov 21) Continue with the projects revised timeframe and updated aims, finalise UKCA, decide on Patent application, be selling certified masks in the new calendar year	Jan 2022 Anthony Robson/Ben Walker	**Fully Assured**

Digital objectives – Aim 1, Aim 3 and enabling for Aim 2. Enabling Strategy: Digital Strategy Monitoring Board Committee: **Digital Committee** Lead Director: Medical Director and Chief Information Officer					**Committee date** **Bi Monthly meeting cycle**	**Apr 21**	**May 21**	**Jun 21**	**July 21**	**Aug 21**	**Sep 21**	**Oct 21**	**Nov 21**	**Dec 21**	**Jan 22**	**Feb 22**	**Mar 22**
					Assurance Level												
Key	**No assurances due**	***N/A***	**Gaps in assurance and no plans in place to address**	***Not assured***	**Gaps in assurance but clear plans in place to address**			***Partially assured***			**No gaps in assurance**			***Fully assured***			

BOLD TEXT in controls - Item on current agenda	(Date) prior to entry - When received/ identified	Red Text - New entry from preceding meeting	Green Text – Action from preceding meeting addressed

Priority Objective	**Risks which may prevent the achievement of the strategic aim and priority objective**	**Reports the Committee receives across the year providing assurance that strategic aims and objectives are being delivered and risks mitigated. (Controls)** *(I- internal/ E – External)*	**Identified gaps in controls – gaps within the reports that are therefore not a full control or report doesn't exist currently**	**Actions needed to address gaps in controls**	**Date action to be completed by; and who is responsible**	**Assurances gained during the committees business – assurances received from the controls**	**Gaps in assurances it is felt that there are key items missing from the report (control) to provide assurance**	**Actions to address gaps in assurance**	**Date action to be completed by and who is responsible**	**Assurance rating received this period** *Not assured* *Partially assured* *Fully assured*
Priority Obj 1.6 Maximise the use of Carestream to digitise all imaging **Other Digital Objectives** **Aim 1** 1.4 - Maximise the use of Nervecentre to improve patient care 1.5 Maximise the use of DocStore to digitise legacy paper used by clinicians **Aim 2** 2.6 Increase the number of non-clinical staff who are working flexibly 2.7 Develop digital skills programmes to enable staff to exploit the technology they have 2.8 Design user technology around them, reducing the number of devices they have 2.9 Improve service desk response **Aim 3**	The risks to delivery of the objectives are included on Datix – Risks 2929 There is a risk of disrupted or delayed implementation of the Trusts digital strategic objectives - due to lack of digital resource, clinical resource, reprioritisation of workload (e.g. pandemic), supplier failure, financial constraints - resulting in failure to achieve the desired outcomes.	Strategic Aims & Objectives – allocated to Digital Committee Strategy and transformation roadmap (each mtg)				(Dec 21) Windip position has improved and therefore action relating to this can be closed. (Feb 22) Paper presented flagging progress, with some delays relating to resourcing issues, from within digital and across the Trust. Review of Digital workload underway, to be reported through DTG in March. Recognition that priority is BAU to safely maintain current services and systems	(Dec 21) Report provided high level of assurance but Committee requested review of 'greens' as percentage completion rate and RAG-ratings appeared to be misaligned in some cases. (Feb 22) Percentages updated but slippage clear	(Dec 21) Undertake a further review of progress with a view to determining whether current status appropriately considers potential risks and slippage (Feb 22) Prioritisation of workload underway to be reported to DTG in March and then April Digital Committee.	Andrea Adams Feb 22	***Partially assured***
		Global Digital Exemplar milestones (each mtg)				(Dec 21) Good assurance that milestones achievable by target dates. (Feb 22) Excellent progress continues with 1 KPI on track for closure in Feb.				***Fully assured***
		Service key performance indicators (each mtg)				(Dec 21) Continues to evolve and generating some positive discussions. (Feb 22) Paper presented with limited updates due to staffing capacity to complete KPI report. Noted that this is not the tool management use to review progress, so as part of the realignment of the Committee reporting the KPIs will be reviewed and	(Dec 21) Partial assurance reflects the continued evolution of this report.	(Feb 22) Develop updated assurance reports to reflect the new reporting timetable.		**Partially Assured**

Priority Objective	Risks which may prevent the achievement of the strategic aim and priority objective	Reports the Committee receives across the year providing assurance that strategic aims and objectives are being delivered and risks mitigated. (Controls) *(I- internal/ E – External)*	Identified gaps in controls – gaps within the reports that are therefore not a full control or report doesn't exist currently	Actions needed to address gaps in controls	Date action to be completed by; and who is responsible	Assurances gained during the committees business – assurances received from the controls	Gaps in assurances it is felt that there are key items missing from the report (control) to provide assurance	Actions to address gaps in assurance	Date action to be completed by and who is responsible	Assurance rating received this period *Not assured* *Partially assured* *Fully assured*
3.1 Replace the ward dashboards to support more efficient patient flow 3.2 Implement 3 robotic process automations to remove repetitive tasks 3.3 Utilise non-face-to-face outpatient consultation as the first choice						assigned to individual managers.				
		Data Security Protection toolkit (Apr, Aug)				(Aug 21) Report covering DSPT Audits received and noted. 96% achieved for the toolkit. No update due (Feb 22) Verbal update that the Trust has recently undergone an NHS Digital cyber review by Dionach. The review report is awaited but as part of the audit, it was clear that there is little expectation that organisations with the complexity of a hospital would ever be able to achieve cyber essentials plus	(Aug 21) Cyber essentials accreditation not yet due	(Aug 21) Submit cyber essentials in December and report back to Committee (Feb 22) Share the Dionach report when published.	Andrea Adams Feb 22	**Partially Assured**
		SIRO Annual report (Apr)				(Apr 21) Report submitted based on national template. Top 3 risks identified to be monitored through DSP Toolkit. No update due				**Fully Assured**
		Clinical Safety Assurance (Jun, Dec)				(Jun 21) Fully trained clinical safety officers in place, need executive lead. Not fully complaint with requirements, although action plan in place. No update due (Feb 22) Paper presented on external clinical safety resource in place to support this area, with a longer term plan being developed.				**Partially Assured**
		Policy Updates – (annual plan Apr, Oct)	(Oct 21) QEF Telecomms policy has expired.	(Oct 21) IT to continue to support QEF		(Oct 21) All policies up to date with the exception of the Telecommunications one	(Dec 21) Continued work on the telecoms policy – Committee agreed partial assurance rating to			**Fully Assured**

Priority Objective	Risks which may prevent the achievement of the strategic aim and priority objective	Reports the Committee receives across the year providing assurance that strategic aims and objectives are being delivered and risks mitigated. (Controls) *(I- internal/ E – External)*	Identified gaps in controls – gaps within the reports that are therefore not a full control or report doesn't exist currently	Actions needed to address gaps in controls	Date action to be completed by; and who is responsible	Assurances gained during the committees business – assurances received from the controls	Gaps in assurances it is felt that there are key items missing from the report (control) to provide assurance	Actions to address gaps in assurance	Date action to be completed by and who is responsible	Assurance rating received this period *Not assured* *Partially assured* *Fully assured*
				with the review.		which IT are supporting QEF with. (Feb 22) Assurance provided through DAG report, which approved a refreshed Telecommunications policy. All other digital policies up to date.	reflect this. Committee will be kept updated on this. (Feb 22) IG05 short term extension to March 22 DAG noted.			
		Audit One Reports (Apr, Aug, Dec) *Need to add audit reports – e.g. clinical systems management*				(Dec 21) Previously identified gap in respect of the visibility of outstanding and overdue actions has been addressed with reporting to the Committee. (Feb 22) Report presented, current 3 outstanding Digital actions provided by AuditOne. Excellent Outpatient Digital Audit.				**Fully Assured**
		Digital strategy (Jun, Oct) Including Clinical Systems strategy				(Oct 21) Clinical Systems Options Appraisal review commissioned – to clarify the organisations clinical digital requirements for the coming 5-10 years – draft report due December (Dec 21) Channel 3 report coming back in February 22. Assured work is sufficiently timely to be able to inform the strategy (Feb 22) Report presented, excellent engagement across the organisation with some key recommendations that will be tracked through DTG. Next steps are to develop the OBC to inform the decision going forward.				**Fully Assured**

Priority Objective	Risks which may prevent the achievement of the strategic aim and priority objective	Reports the Committee receives across the year providing assurance that strategic aims and objectives are being delivered and risks mitigated. (Controls) *(I- internal/ E – External)*	Identified gaps in controls – gaps within the reports that are therefore not a full control or report doesn't exist currently	Actions needed to address gaps in controls	Date action to be completed by; and who is responsible	Assurances gained during the committees business – assurances received from the controls	Gaps in assurances it is felt that there are key items missing from the report (control) to provide assurance	Actions to address gaps in assurance	Date action to be completed by and who is responsible	Assurance rating received this period *Not assured* *Partially assured* *Fully assured*
		Productivity and efficiency (Dec, Feb)				No update due (Feb 22) Verbal update – a final update on this will be included in the GDE Programme Closure report				**Not due**
		Workforce digital adoption plan (Aug, Feb)				(Aug 21) Verbal update, limited progress due to service pressures. Agreed to incorporate this update in the corporate objectives update in future and as such this is not separately rated No update required				**N/a**
		Sub-committee updates Digital Transformation Group (each mtg)				(Dec 21) Assurance report received and no issues identified by the Committee. (Feb 22) Assurance report received and no issues identified by the Committee.				**Fully Assured**
		Sub-committee updates Digital Assurance Group (each mtg)				(Dec 21) Assurance report received and no issues identified by the Committee. (Feb 22) Assurance report received and no issues identified by the Committee.				**Fully Assured**

Gateshead Health
NHS Foundation Trust

Report Cover Sheet Agenda Item: 8

Report Title:	**Board Committee Terms of Reference**			
Name of Meeting:	Board of Directors – Part 1			
Date of Meeting:	30 March 2022			
Author:	Jennifer Boyle, Company Secretary			
Executive Sponsor:	Gillian Findley, Chief Nurse Non-Executive Director Committee Chair – Anna Stabler			
Report presented by:	Jennifer Boyle, Company Secretary			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☒	**Discussion:** ☐	**Assurance:** ☐	**Information:** ☐
	The terms of reference are presented for ratification following a number of amendments.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☒
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	Quality Governance Committee			

Key issues:
Briefly outline what the top 3-5 key points are from the paper in bullet point format
 	
Consider key implications e.g.
• *Finance*
• *Patient outcomes / experience*
• *Quality and safety*
• *People and organisational development*
• *Governance and legal*
• *Equality, diversity and inclusion*
	• Amendments have been made to reflect:
	  • Changes to the regular attendees in order to include two new senior managers from the Quality team;
	  • Reference to the role of 2 nominated Governors in observing the Committee;
	  • A change to the frequency of the Committee from monthly to bi-monthly, as approved by the Committee in February 2022;
	  • The new sub-group structure supporting the work of the Committee; and
	  • Clarification on how assurance is gained on performance and governance of the Trust's maternity services.			

Recommended actions for this meeting: *Outline what the meeting is expected to do*	The Board is requested to ratify the revised terms of reference of the Quality Governance Committee.			

with this paper					
Trust Strategic Aims that the report relates to:	**Aim 1** ☒	We will continuously improve the quality and safety of our services for our patients			
	Aim 2 ☒	We will be a great organisation with a highly engaged workforce			
	Aim 3 ☒	We will enhance our productivity and efficiency to make the best use of resources			
	Aim 4 ☒	We will be an effective partner and be ambitious in our commitment to improving health outcomes			
	Aim 5 ☒	We will develop and expand our services within and beyond Gateshead			
Trust corporate objectives that the report relates to:	These Board committees have responsibility for seeking assurance over a significant number of the corporate objectives that support each of the 5 aims.				
Links to CQC KLOE	Caring ☒	Responsive ☒	Well-led ☒	Effective ☒	Safe ☒
Risks / implications from this report (positive or negative):					
Links to risks (identify significant risks and DATIX reference)	No risks directly linked to this paper, although effective committees with robust terms of reference should support the timely identification and management of risks.				
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒		

Committee

Terms of Reference

Gateshead Health NHS Foundation Trust

Quality Governance Committee

Constitution and Purpose – The Quality Governance Committee is a formal committee of the Board with delegated responsibility to monitor, review and make recommendations to the Trust Board with regard to all aspects of quality of clinical care; quality and clinical governance systems; clinical risk issues, research & development; and regulatory standards of quality and safety.

The Committee is authorised by the Trust Board of Directors to investigate any activity within its Terms of Reference. Any decisions of the Committee shall be taken on a majority basis. All members of the Committee have an equal vote. In the event of a tied vote, the Chair of the meeting will hold the casting vote.

Date Adopted / Reviewed	**Revised February 2022** – approved by the Quality Governance Committee March 2022 – ratified by the Board of Directors
Review Frequency	Annually
Review and approval	Quality Governance Committee
Adoption and ratification	Trust Board

Membership	The Committee shall be appointed by the Trust Board and shall consist of: • 2 Non-Executive Directors – one with clinical / medical expertise and knowledge to act as Committee Chair • Medical Director • Chief Nurse • Chief Operating Officer • Director of People and Organisational Development A Non-Executive Director shall be nominated as Deputy Chair for the Committee.
Attendance	The following will be expected to attend the Committee on a routine basis: • Deputy Director of Nursing, Quality and Safety • Deputy Medical Director • Deputy Director of Corporate Services and Transformation • Head of Quality and Patient Experience • Head of Risk and Patient Safety Executive Directors and senior managers should ensure that a deputy attends in their absence.

	Other Executive Directors and Senior Managers may be invited to attend meetings depending upon the issues under discussion. Two nominated Governors will be in attendance at the Committee as observers.
Meeting frequency and quorum	Meetings shall be held **bi-monthly.** Additional extraordinary meetings of the Committee can be called by the Chair in accordance with business need. To be quorate there should be at **least 1 Non-Executive Director** and 2 **Executive Directors** present. Members and regular attendees are expected to achieve **75% attendance** annually.
Meeting organisation	The Committee shall be supported administratively by the Corporate Management Team secretarial body. In accordance with the Trust's Standing Orders, **papers will be circulated to members and attendees six days before the meeting** wherever possible, and no later than three clear days before the meeting, save in emergency. Minutes of the Committee's meetings are held by the Corporate Management Team secretarial body and are circulated (alongside the agenda for the following meeting), to members and attendees.

Committee duties and responsibilities	
Strategy, planning and risk	To **seek assurance over the delivery of the corporate objectives** mapped to the Committee for monitoring at the commencement of the financial year. To seek assurance over the **delivery of national and local-level strategies** relating to the remit of the Committee, including the Quality Strategy and Quality Improvement Strategy. To **review the sections of the Board Assurance Framework (BAF)** mapped to the Committee for oversight and assurance, triangulating the control and assurance assertions on the BAF with the assurances and risks identified during each meeting. To **review the quality / medical–related risks on the Organisational Risk Register**, seeking assurance over the effective management of these risks towards the achievement of their target scores. The Committee will triangulate the risk registers against the assurances and risks emerging from the meeting for completeness.

Safety	The **Integrated Oversight Report** will be used to provide an overview of aspects of safety performance (in accordance with the metrics defined in NHS England and Improvement's Single Oversight Report) and enable spotlight reporting on areas of greatest risk. This report includes maternity and neonatal quality and safety indicators and is also reviewed by the Board (resulting in monthly review of maternity metrics). Seek assurance that the Trust has **effective systems for safety**, with particular focus on quality, patient safety, staff safety and wider health & safety requirements. This should also include routine assurance regarding compliance with **safe staffing levels**. Seek assurance over the **robustness of procedures to ensure that adverse incidents and events are detected, openly investigated, with lessons learned being promptly applied** and appropriately disseminated in the best interests of patients, of staff and of the Trust. To seek assurance that the Trust embeds **learning from deaths** and had a robust process in place which complies with mandatory requirements. To seek assurance that the Trust appropriately **responds to requests and requirements from coroners and other regulatory bodies** in respect of patient safety. To gain assurance that the Trust has in place such systems of work and controls that **ensure medicines are effectively managed** and complaint with legislative requirements. To gain assurance that the Trust has in place such systems of work and controls that **ensure medical devices are effectively managed** and complaint with legislative requirements. To gain assurance that the Trust has in place systems of work and controls that ensure **infection prevention and control** is effectively managed and compliant with legislative requirements. To gain assurance that **safeguarding** is compliant with national and local requirements such that patients are safe in the Trust's care. On behalf of the Board the Committee will seek assurance on **maternity services** at least quarterly. This report will include: • Serious Incident key themes • Maternity staffing for all relevant professional groups • Clinical outcomes and compliance • Essential training compliance
Patient experience	The **Integrated Oversight Report** will be used to provide an overview of aspects of patient experience metrics (in accordance with the metrics defined in NHS England and Improvement's Single Oversight Report) and enable spotlight reporting on areas of greatest risk. Seek assurance that the Trust has **effective systems for delivering a high quality experience** for all its patients and users, with particular focus on **involvement and engagement** for the purposes of learning and making

	improvement. To provide assurance to Trust Board that there are robust systems for **learning lessons from complaints**, and action is being taken to minimise the risk of occurrence of adverse events. This should include the **sharing of aspects of good practice identified through compliments** and patient feedback. To seek assurance that the Trust is **delivering high quality care for patients with learning disabilities** in accordance with nationally and locally prescribed standards.
Clinical effectiveness, leadership and training	The **Integrated Oversight Report** will be used to provide an overview of aspects of clinical effectiveness and outcomes (in accordance with the metrics defined in NHS England and Improvement's Single Oversight Report) and enable spotlight reporting on areas of greatest risk. Seek assurance that the Trust has **effective systems for monitoring clinical outcomes and clinical effectiveness,** with particular focus on ensuring patients receive the best possible outcomes of care across the full range of Trust activities. To seek assurance over the **effective engagement of clinical leads** in the development and delivery of quality improvement initiatives. To review the **clinical audit plan and progress reports** to support the assurance process regarding effective clinical practice. Through close working with the HR Committee, seek assurance that **statutory and mandatory training requirements** relating to quality of care and clinical practice are being fulfilled.
Regulatory and governance	To monitor, scrutinise and provide assurance to the Trust Board on the Trust's **compliance with core regulatory standards**, including the Care Quality Commission's Fundamental Standards, quality-related elements of NHS England and Improvement metrics and NICE guidance. On behalf of the Board, take a lead role in **seeking assurance that the Trust's annual Quality Report is compliant with regulatory requirements**, reflective of the main achievements and challenges during the year and has been appropriately consulted upon. To triangulate through assurance the **robustness of quality-assurance processes relating to all research undertaken** in the name of the Trust and / or by its staff, in terms of compliance with standards and ethics, and clinical and patient safety improvement processes. To receive an annual assurance report on the compliance with the NHS England and Improvement '**Developing Workforce Safeguards'** requirements. To receive for information and assurance **Internal Audit reports** pertaining

	to the remit of the Committee. To receive for information and assurance any **reports from external reviews** pertaining to the remit of the Committee. To review **feedback from NHSI** relating to quality and safety. To review any material **emerging regulatory guidance / requirements** in relation to quality and clinical matters on behalf of the Board.

Reporting and monitoring	
Sub-groups	The following sub-groups report into the Committee: • Mental Health Act Compliance Group • Nursing, Midwifery and AHP Professional Forum • Group Health and Safety Committee • Infection, Prevention and Control Committee • Safeguarding Committee • Mortality and Morbidity Steering Group • Safecare, Risk and Patient Safety Council The minutes and summary of assurances and escalations documents are received by the Committee as part of the flow of assurance through the Trust's governance structure. The Committee will receive detailed assurance reports from the Mental Health Act Legislation Committee.
Board reporting	An assurance report from the Committee will be presented by the Chair to the next meeting of the Board of Directors.
Monitoring	Compliance with the terms of reference will be reviewed via an annual self-assessment. This will inform any proposed revisions to the terms of reference and the cycle of business. The outcome of the effectiveness and terms of reference review is presented to the Board of Directors following consideration by the Committee.

Gateshead Health
NHS Foundation Trust

Report Cover Sheet Agenda Item: 9

Report Title:	Green Plan 2022-25			
Name of Meeting:	Board of Directors – Part 1			
Date of Meeting:	Wednesday 30 March 2022			
Author:	Sarah Medhurst, Sustainability and Waste Manager QE Facilities			
Executive Sponsor:	Anthony Robson, Managing Director QE Facilities			
Report presented by:	Anthony Robson, Managing Director QE Facilities			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☒	**Discussion:** ☐	**Assurance:** ☐	**Information:** ☐
	The report sets out the significant progress in reducing our emissions from our own activities in recent years. The Green Plan sets out the short term pathways to meet the longer term targets of 'net zero' by 2040 and 2045 and incorporate the priority areas and actions. Board approval of the Plan is sought.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☒
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	-			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	• The contents of the Green Plan are broad-ranging, covering models of care, estates and facilities, travel and transport through to medicines, supply chain, food and nutrition. • Once approved by the Board the Trust's Green Plan will be shared with the North East and North Cumbria Integrated Care System. • The Green Plan covers a 3 year period and annual updates will be provided to the Trust Board to provide assurance over progress towards achieving the objectives and measurable targets outlined within the Plan.			

Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The Board of Directors is requested to review and approve the Trust's Green Plan 2022-2025 prior to its submission to the Integrated Care System.				
Trust Strategic Aims that the report relates to:	**Aim 1** ☒	We will continuously improve the quality and safety of our services for our patients			
	Aim 2 ☐	We will be a great organisation with a highly engaged workforce			
	Aim 3 ☐	We will enhance our productivity and efficiency to make the best use of resources			
	Aim 4 ☒	We will be an effective partner and be ambitious in our commitment to improving health outcomes			
	Aim 5 ☒	We will develop and expand our services within and beyond Gateshead			
Trust corporate objectives that the report relates to:	5.7 – improving efficiency through use of the Washington warehouse 5.9 – provision of safe and efficient transport through the transport hub				
Links to CQC KLOE	Caring ☐	Responsive ☒	Well-led ☒	Effective ☒	Safe ☒
Risks / implications from this report (positive or negative):					
Links to risks (identify significant risks and DATIX reference)	None identified on organisational risk register.				
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒		

NHS
Gateshead Health
NHS Foundation Trust

Green Plan 2022 - 2025

Gateshead Health NHS Foundation Trust

Contents

Foreword

Gateshead Health NHS Foundation Trust has made significant progress in reducing our emissions from our own activities in recent years. Investment in technologies such as bio diesel CHP's (combined heat and power) providing heat and electricity at zero carbon reducing emissions by around 800 tonnes whilst also generating an income from Renewable Obligation Certificates (ROC) sales.

The Trust recognises the enormity of climate change and the issues it presents to the health of everyone including our local community, the wider North East region and beyond; in particular the key issue of air quality which is linked to respiratory diseases, heart disease and cancer.

As one of the largest employers in the area, we create a significant carbon footprint and contribution to air pollution, with the NHS as a whole responsible for around 5% of England's carbon footprint and 6.7bn road miles from patients and visitors. We must take conscious action on how we impact air quality, from staff, patients and suppliers and our impact on climate change.

This Green Plan will set out the short term pathways to meet the longer term targets of 'net zero' by 2040 and 2045 and incorporate the priority areas and actions from the Delivering 'Net Zero' NHS report and the regional ICS Green Plan as it is vital that we work collectively as a region to deliver change.

Whilst we've had some achievements there is still so much more needed to be undertaken together and as individuals, as it is everyone's responsibility to take action and reduce the negative impact upon the planet and the subsequent health impacts. It may seem a daunting task but for every small change made, a difference can be achieved and will benefit the lives of many.

1.0 Introduction

Gateshead Health NHS Foundation Trust provides a range of hospital and community services across the Gateshead region, from our leading facilities, including our primary site the Queen Elizabeth Hospital (QEH), and other sites Blaydon Urgent Care Centre and Bensham Hospital. The primary focus is providing a full range of excellent general hospital services for in patients, outpatients and day cases to our local community with key specialist areas from maternity, gynaecology and palliative care. Alongside these hospital services the Trust provides South of Tyne pathology and breast screening services and we are the North Eastern hub for the National Bowel Cancer and AAA Screening Programmes, covering around a population of seven million people.

The Trust and QE Facilities Ltd; who provide the Trust estates and facilities services employ as a group around 4,500 staff and deliver services to over 450,000 people annually. These services delivered each year have a significant environmental impact and carbon footprint; from the buildings, equipment, pharmaceuticals, waste and travel as just a few examples.

1.1 Sustainability at Gateshead

The Trust and QE Facilities (Group) have made great progression in reducing their carbon emissions over the years and been recognised as a result, recently winning an International Green Apple Award for Environmental Best Practice. This follows on from other local and national recognition including the Lord Carter Innovation Award – Highly Commended in 2019 for delivering carbon reductions.

This Green Plan will establish our high level vision and objectives moving forward and the necessary actions to achieve these, developing and building upon the previous Sustainable Development Management Plan (SDMP) and incorporating new guidance and national targets.

However to be able to set out this vision the Group must first understand and review the local issues climate change currently poses to our community and Group operations. As an area Gateshead's key distinguishing feature is its topography, the land rises 230 feet from Gateshead Quays to the town centre and continues rising to a height of 525 feet at the Queen Elizabeth Hospital. This is in contrast to the flat and low lying Team Valley location on the western edges of town, with the risk of flooding in areas from the River Tyne, River Derwent and River Team. There is even a risk from surface water flooding affecting hilly areas of the region as well. This geographical location and topography poses several risks from the impacts of climate change, which may affect ability to run services and treat patients effectively.

Along with incidents of flooding already impacting the region as a result of climate change, the other issue having an effect is poor air quality. Both these issues are exacerbated by the level of deprivation in the region with around 16% of residents living within the most deprived 10% of Lower Layer Super Output Areas (LSOA's) in England.

The North East may have strong acute health services and increases in life expectancy over recent years, partly as a result of a significant reduction in smoking greater than elsewhere in the UK. However the poor health outcomes and health inequalities in the region are still much greater, with the regions spend on health and care is mainly spent on tackling the consequences of ill health through hospital and specialised care with very little spent on prevention.

As a health care provider facing increasing pressure and demand each year, we must play a vital role in how we can prevent ill health in the local community and our employees. Through reducing carbon emissions by reviewing how we provide healthcare and models of care communities will be supported to have healthier and more active lifestyles, access to nature, cleaner air and access to new job opportunities, which in turn should help reduce the local health inequalities we currently experience whilst improving health and well being.

1.2 Sustainability at a National Level

The UK is committed to becoming carbon neutral by 2050 as part of the Climate Change Act 2008; however climate scientists agree that we have less than a decade to change our trajectory in order to stay within the safe limit of 1.5C defined in the United Nations Paris Agreement. Therefore it is key the UK and the NHS which contributes 4% of the nation's emissions and a workforce of over 1.3 million steps up and takes significant action sooner rather than later.

The Sustainable Development Unit was originally set up to aid the NHS to take action in reducing its carbon emissions, then in January of 2020 Sir Simon Stevens CEO of NHS England announced the "For the Greener NHS" Campaign. This campaign led to the publication of 'Delivering a Net Zero National Health Service' report in October 2020 and subsequent set up of the Greener NHS Team. The report expands on previous targets set under the Climate Change Act 2008 to cover the full scope of emissions and utilises the Greenhouse Gas Protocol (GHGP) scopes to cover a wider set of emissions with the addition of patient and visitor travel and medicines used within the home.

These scopes and emissions can be visualised in the NHS Carbon Footprint and Carbon Footprint Plus in Figure 1 and a percentage breakdown in terms of emissions in Figure 2:

Figure 1: GHGP scopes in the context of the NHS

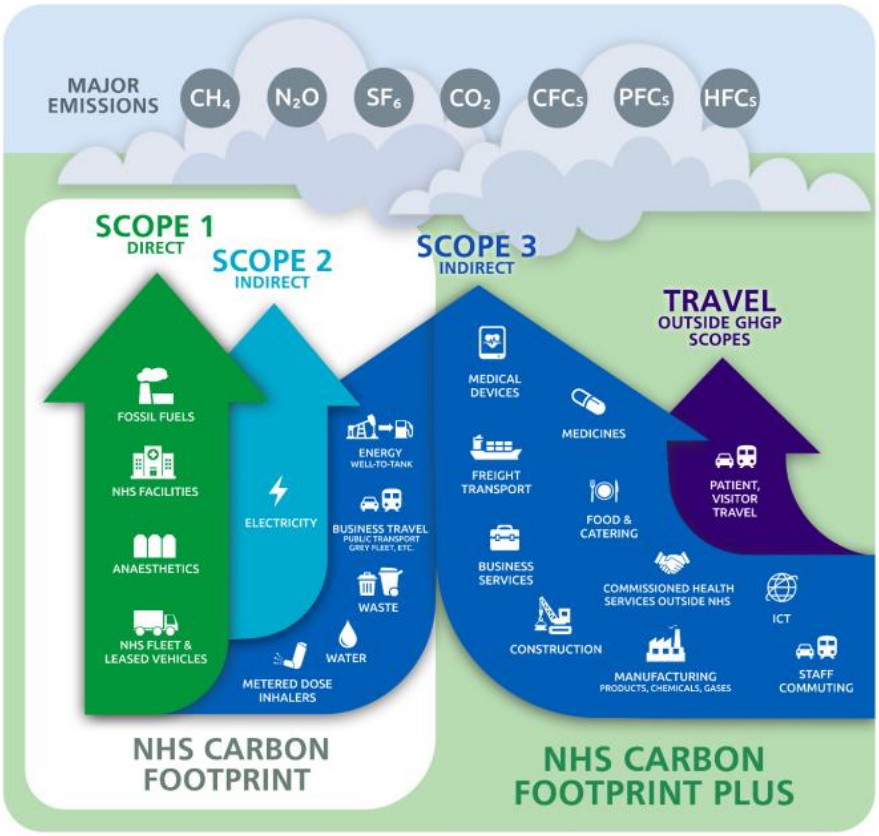
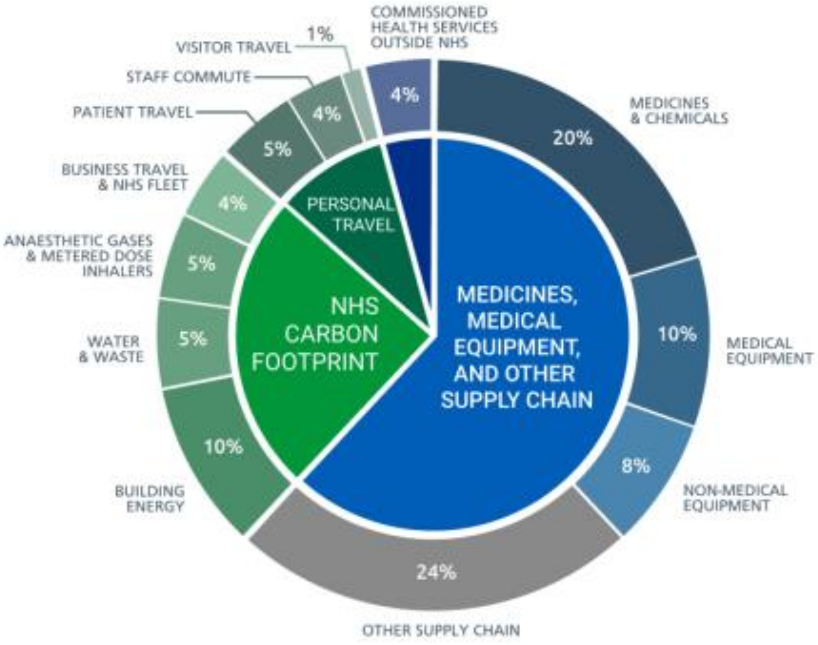


Figure 2: Sources of carbon emissions by proportion of NHS Carbon Footprint Plus



The two separations seen above in the NHS Carbon Footprint and Carbon Footprint Plus form the basis of the two net zero targets that the NHS has set out to achieve:

- **Net zero by 2040 for the NHS Carbon Footprint, with an ambition for an 80% reduction (compared with a 1990 baseline) by 2028 to 2032.**
- **Net zero by 2045 for the NHS Carbon Footprint Plus, with an ambition for an 80% reduction (compared with a 1990 baseline) by 2036 to 2039**.

These are the targets as a Group (Trust & QE Facilities) we vision to achieve through developing our Green Plan, however it is appreciated that accelerated intervention is required and where possible we will try and beat these targets to help ensure that global carbon budgets aren't breached and help be part be a part of England's Greenest Region in our Integrated Care System (ICS).

Considerable progress has already been made in reducing the NHS Carbon Footprint as a whole and can be seen in table 1 below:

Table 1: NHS emissions from 1990 to 2020

Carbon footprint scope	1990	2010	2015	2019	2020 (est)
Climate Change Act – carbon budget target		25%	31%		37%
NHS Carbon Footprint ($MtCO_2e$)	16.2	8.7	7.4	6.1	6.1
NHS Carbon Footprint as a % reduction on 1990		46%	54%	62%	62%
NHS Carbon Footprint Plus ($MtCO_2e$)	33.8	28.1	27.3	25.0	24.9
NHS Carbon Footprint Plus as a % reduction on 1990		17%	19%	26%	26%

2.0 Organisational Vision

The Trust recognises that carbon reduction and sustainable development is a key critical factor in how our organisation operates going forward to ensure we provide a healthcare system that delivers first class care both now and in the future and preventing the potential health impacts of climate change through ensuring we adapt and resilient going forward.

The Groups vision and objectives are underpinned by the four sustainable healthcare principles as set out by the Centre for Sustainable Healthcare:

- Prevention: Improving public health by tackling the underlying causes of disease;
- Patient empowerment and self-care: educating the public and patients and giving patients a greater role in their own health;
- Lean Systems: being more efficient in healthcare delivery;
- Low carbon alternatives: e.g. low carbon medicines.

These visions are in effect incorporated within the Trusts ICORE values as seen below:

Our vision is to be leader in sustainable healthcare within the NHS, to the benefit of our local community.

2.1 Objectives

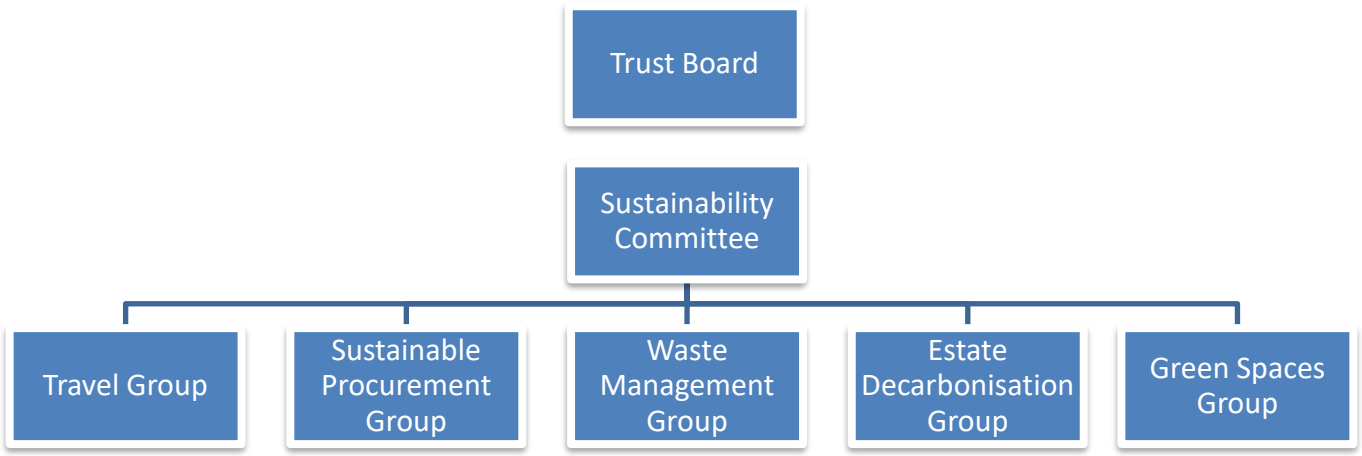
Our objectives support this vision and will require the support of everyone within the Trust and QE Facilities Ltd along with patients, visitors and suppliers with change occurring at pace to ensure the net zero targets are met.

1. An educated and engaged workforce who embed sustainability in their everyday actions.
2. Improve local air quality through reducing and eliminating (where possible) emissions from vehicles.
3. Achieve net zero of our NHS Carbon Footprint by 2040 and NHS Carbon Footprint Plus by 2045.
4. Ensure that our activities and care benefit the wider local community.

It is felt that these key priorities in particular the second point will help improve the local air quality and the subsequent health implications that affect the local community. Meanwhile the education, social prescribing and circular economy would further benefit the organisation and have potential financial benefits too, as well as aiding and benefiting the local community and economy.

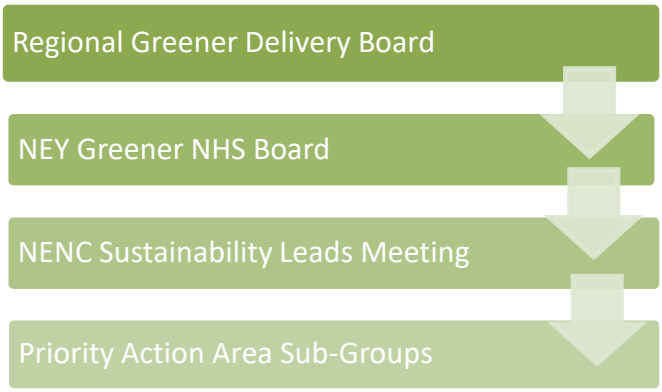
2.2 Governance Structure

The working arrangement and governance structure has been reviewed to ensure that progress against the Green Plan is progressed, monitored and reported on. The structure detailed below has been adopted to make progress against the objectives and areas of focus, although this structure is open to change and adaption as work progresses and the plan develops in the future.



As well as the above internal structure the Trust will also play a key role in the ICS reporting structure with representation at the North East North Cumbria (NENC) Sustainability Leads meeting and at least two of the priority action area groups, as it is vital to work collectively with other Trusts as we're all on a journey to achieve a net zero sustainable healthcare system.

NENC Sustainability Governance Structure



The Trust also reports data directly in at a national level through the Greener NHS, who monitors the entire NHS progress towards net zero.

3.0 Gateshead's Journey so Far

2001
- Launched first Green Travel Plan

2013
- First Sustainability Strategy
- First Green Champions

2014
- Bio Diesel CHP installed as part of Pathology Centre generating zero carbon heat and power

2015
- Second bio diesel CHP installed as part of Emergency Care Centre
- Additional cycle lockers and shower facilities installed

2016
- Achieved a 10% reduction in single occupancy staff driving to work

2017
- Introduced emissions levy on staff car parking permits
- Introduced car sharing scheme

2017
- First Hopsital to be awarded Go Smarter Platinum Award for travel after previosuly achieving bronze, silver & gold awards.

2018
- Recognised by the SDU, HFMA & NHSI for excellence in Sustainability Reporting for second time

2019
- Signed NHS Plastic Pledge
- Lord Carter Innovation Award – Highly Commended for delivering carbon reductions

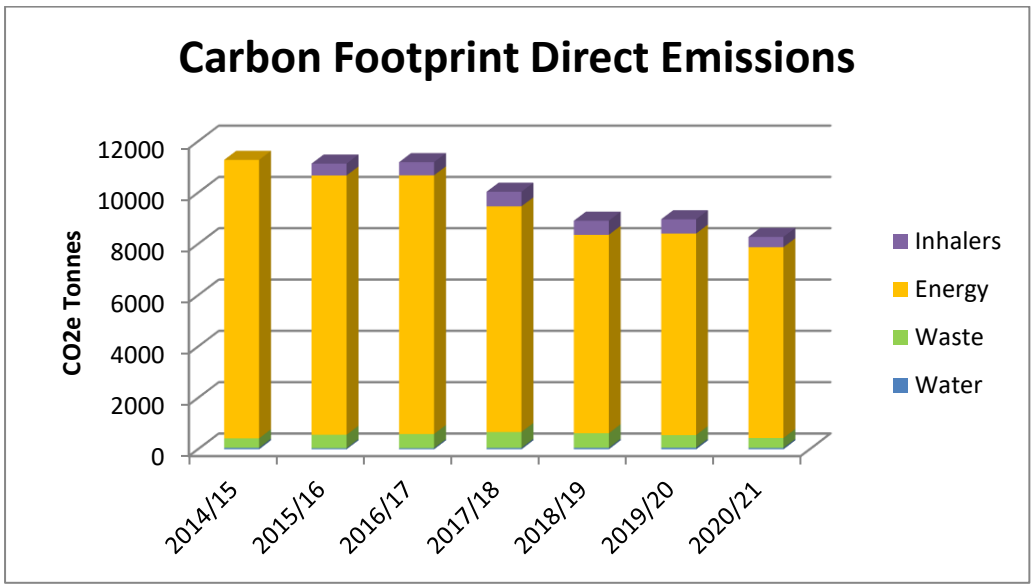
2020
- Won International Green Apple Environment Award
- Zero waste to landfill & increased recycling more widely

2021
- Introduced zero emission e-bike courier service as part of Pathology Transport Service
- REGO certified Green Electricity

2021
- New Governance Structure for sustainability in the Group
- Reusable sharps boxes introduced

3.1 Current Data

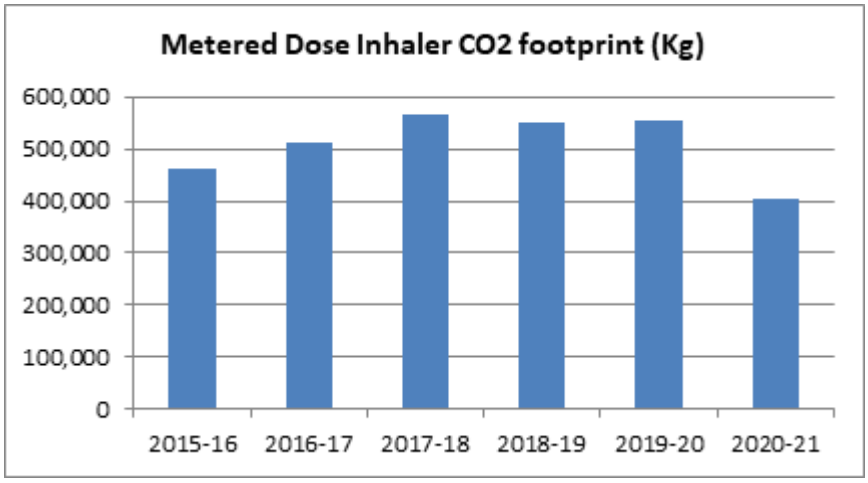
This is our current data for some of the emissions we directly control energy, waste, water and inhalers from 2014/15 to 2020/21, the aim is to expand this data in future to cover fleet vehicles, business travel and anaesthetic gases.



*All calculations have used either the current government conversion factors or those detailed in ERIC (i.e. waste) and note that there is no data for inhalers in 2014/15.

- 30% reduction in overall carbon emissions from 2014/15 to 2020/21 including a 31% reduction in energy emissions.
- It should be noted that this data is very limited to four areas (17.5% of the NHS Carbon Footprint Plus or 72.5% of NHS Carbon Footprint). The overall carbon footprint of the Group is likely to be significantly higher and reductions in these areas may be offset by other areas not included i.e. the significant increase in QEF fleet operations through its transport department. This will be included in future plans to review.
- The other scope of emissions which the Group does not directly control listed under the NHS Carbon Footprint Plus are much harder to calculate due to the complexity in tracking through the supply chain and is an area of focus going forward in future reports.

The graph below highlights the amazing work undertaken within pharmacy to reduce the carbon impact of inhalers with 150.5 tonne CO2e reduction (150,000kg CO2e) in one year from 2019/20 to 2020/21 through the increased prescription of dry powder inhalers.



3.2 Highlights to Date

- **800 tonnes of CO2e** saved per annum through the use of Bio Diesel CHP's.
- Awarded **£1.6m** from the Public Sector Decarbonisation Fund.
- **1.5 tonnes** of single use metal instruments were recycled instead of incinerated in 2021 saving **335kg in C02e**.
- Introduction of reusable sharps bins in 2021 will help save a projected **16 tonnes** of single use plastics being produced and incinerated over 12 months saving an estimated **93.12 tonnes of CO2e**.
- In the last 3 years the organisation has recycled over **330 tonnes** of waste saving **108 tonnes of CO2e.**
- In 2020 the organisation **won an International Green Apple Award** for Environmental Best Practice.
- **30% reduction** in direct carbon emissions from energy, waste and water.
- **24% staff using active and sustainable** modes of transport as their main mode of transport to work whilst another 10% car share.
- **18% of patients and visitors uses active and sustainable** modes of transport to access the Queen Elizabeth Hospital.
- QE Facilities have set up a **local mask manufacturing** site to make FFP3 masks bringing more jobs to the local area and providing a resilient more sustainable supply chain.
- **27% reduction** in carbon emissions from **metered dose inhalers** from 2019/20 to 2020/21.

4.0 Areas of Focus

This plan will focus around the areas which address the Trusts vision and local issues the Group and community are facing alongside specific NHS targets. The 10 key areas of focus are:

1. Workforce System & Leadership
2. Sustainable Models of Care
3. Digital Transformation
4. Travel & Transport
5. Estates & Facilities
6. Medicines
7. Supply Chain & Procurement
8. Food & Nutrition
9. Adaptation

Each area will set out specific objectives for that particular area alongside measurable targets that will be monitored on a six monthly basis to track progress against the Trust vision and targets to report back to the board via the governance structure. Each area will also take into account the UN Sustainable Development Goals.

4.1 Workforce System & Leadership

A strong leadership and engaged workforce are key to achieving progress on climate change and reducing emissions within the Trust as it becomes a key responsibility of all staff at all level within the organisation to act upon. Professional bodies and staff are advocating for a stronger health response to climate change, however we must provide the tools and education to be able to achieve this and realise there may be a financial cost to the Group to achieve the vision and targets.

Objectives:

- An educated and informed workforce on sustainability and carbon reduction.
- Empowered network of Green Champions.
- Upskilled and empowered board members, who understand their role in sustainability and carbon reduction, who lead by example and engage with staff on the issue.
- Engagement and partnership working with the ICS, Local Authorities and other organisations to help in achieving our vision.

Targets:

1. By March 2023 70% of staff will have completed the ESR course 'Building a Net Zero NHS' and it will be included as mandatory induction for all new starters.
2. By March 2023 100% of board members will be trained on sustainability and how it needs to be considered at all levels within their divisions.
3. By 2024 every department or ward will have at least one green ambassador.
4. By 2025 there will be a budget for sustainable initiatives in the organisation in which departments can apply for individual schemes that are deemed to aid the objectives and vision.
5. By 2024 sustainability and the Green Plan's visions and objectives will be included and considered in all business plans.

Current Position:

- Nominated sustainability board lead
- ICS representation at Management Board and Sustainability Group
- Governance Structure in place to monitor and track progress against the Green Plan.

Actions:

1. 'Building a Net Zero NHS' to become mandatory to enable and encourage staff to complete it.
2. Promote, engage and educate Green Ambassadors.
3. Ensure all board members attend an appropriate sustainability training course.
4. Embed the Green Plan into the Trust, making it accessible to all and provide regular updates to staff on progress with specific branding.
5. Include sustainability and carbon reduction into job descriptions and staff appraisals.
6. Improve all carbon data availability, analysis and reporting across all scopes.
7. Regular board updates on progress against the targets set out in the Green Plan's Areas of Focus.

4.2 Sustainable Care Models

At the heart of the Trusts ICORE vision and values is 'caring for you' ensuring excellent, clean, safe, personal and patient focused care. It is vital going forward that the care undertaken is sustainable in both provision of treatment and prevention, ensuring that every contact counts.

Objectives:

- Develop sustainable patient care pathways that also embed prevention to help address the wider detriments of health.
- Utilise position within the community to aid education on the impacts of climate change on health and how to get involved.
- Utilise technology and community sites to deliver care closer to home.

Targets:

1. By 2025 link sustainability in the review and development of patient pathways and begin to quantify benefits.
2. By 2025 all clinicians will receive carbon literacy training.
3. By 2023 a Sustainable Care Sub Group to be set up as part of the governance structure.
4. Undertake 25% of outpatient activity remotely.

Current Position:

- Outpatient appointments have been undertaken remotely during the COVID-19 pandemic.
- Pathways reviewed to improve patient flow across the site i.e. ECC development and use of technologies such as Nervecentre.

Actions:

By 2024 the Trust will:

1. Increase use of remote outpatient activity reducing the need for patients to travel.
2. Educate clinical staff on carbon literacy.
3. Begin to utilise 'Make Every Contact Counts' to highlight the impact climate change may be having upon health.
4. Begin review of pathways takes into account sustainability and potentially quantify the wider benefits i.e. financial and social or calculate the carbon impact of specific models of care.
5. Invite clinicians, pharmacists, IT to a Sustainable Care Group to focus on sustainable care pathways and this will include medicines, anaesthetic gases, inhalers, and use of digital technology.

4.3 Digital Transformation

The use of digital in healthcare is continually growing and enhancing the range and ability of treatment and organisational operations. It often is more sustainable, however it should be noted that even digital options have a carbon footprint that is continually growing and needs to be accounted for.

Objectives:

- Digitally enabled care models and channels, with care closer to home.
- Utilise technology systems to eliminate use of paper and printing, and where possible postage as well.
- Improve patient pathways through the use of technology.
- Optimise space utilisation and reduce energy demand through technology.

Targets:

1. Reduce paper consumption by 5% each year.
2. Increase the use of digital out-patients appointments each year.

Current Position

- Utilising Microsoft teams to host meetings.
- Utilising technology for digital appointments
- Medicines optimization system reduced rate of drugs prescribed and subsequent wastage.
- Digital remote monitoring to communicate with patients reducing paper and missed appointments.
- GDE projects to digitise patient records linking to nerve centre and care flow assessments.
- Patient portals in areas such as maternity to eliminating paper for a digital file.
- Great North Care Record – regional tool eliminating use of taxis to move records between Trusts.
- Telemetry system and devices to monitor patients across the hospital, reaching all areas across ECC, Medicine and Surgery.
- Nervecentre Systems – mobile system used to capture e-observations, escalate deteriorating patients and has the ability to capture assessments and documentation at the patient's bedside. It includes tools including sepsis screening improving patient outcomes and may lead to a reduced stay.

- Testing cutting-edge Artificial Intelligence (AI) technology – which could potentially transform breast cancer detection, improve patient experience and free up valuable time for staff.

Actions:

1. Encourage and promote the continued use of Teams meeting, allowing staff to work flexibly and encourage no cameras for internal meetings to reduce the emissions generated from video (estimated to range between 150 to 1000g of CO2 for every 60 minutes).
2. Upgrade the Building Management System to help improve control and enhance the ability to monitor energy demand and improve efficiency.
3. Utilise systems to monitor occupation of spaces to improve space utilisation and energy efficiency maximising the use of the estate to its full potential.
4. Use digital options to deliver outpatients appointments.
5. Support staff in the option to work from home where possible and provide the necessary technology, whether this is full time or flexibly as it allows reduction in travel and occupancy on site.
6. Great North Care Record – expand and implement patient app which will include digital letters.
7. Roll out mobile devices to clinicians to see records at hand.
8. Continue to digitise patient records in areas such as out patients and A&E.

4.4 Travel & Transport

At the heart of improving air quality lies travel and transportation, it accounts for 9.5 billion miles and 3.5% of all road travel in England or 14% of the systems total emissions. The NHS Long Term Plan states the NHS must cut business mileage and fleet air pollution by 20% by 2023/24, despite having a successful green travel plan for a number of years the Trust must take further action to significantly reduce air pollution as it is a key issue in the local area.

Objectives:

- Reduce the emissions we directly control through business travel and fleet vehicles.
- Provide access to and promote means of active travel to staff, patients and visitors.
- Regularly monitor how staff, patients and visitors travel to the site.
- Educate on the impacts of air quality upon health.

Targets:

1. By 2025 90% of fleet vehicles will be ultra-low or zero emission vehicles.
2. By 2025 10% of parking spaces will have access to charging infrastructure
3. By 2025 55% of staff surveyed will travel to work by car.
4. By 2025 all staff who drive as part of their job will receive fuel efficient driver training to reduce their emissions.
5. By 2025 all clinical staff will be aware and have access to information about the impact of air quality on health and where necessary provide advice to vulnerable groups who are particularly affected.

Current Position:

- Green Travel Plan since 2001, last updated in 2021.
- Two cycle to work schemes of which one has a much higher cap to allow the purchase of electric bikes and over 50 cycle spaces available for staff and visitors alongside numerous staff shower facilities.
- Discounted public transport passes available for staff and car sharing incentives.
- Information available to staff and visitors about alternatives means of travel.
- Electric car charging points available for staff use.
- Extensive use of digital technology to reduce the need for travel for meetings (staff) or appointments (patients).

Actions:

1. Implement a business travel policy that strongly encourages sustainable travel options with the use of flights banned unless approved by a director.
2. Review car parking permits to ensure only those required park on site and encourage staff to use sustainable alternative means.
3. Increase and improve cycle facilities for staff and visitors at all sites.
4. Move all fleet vehicles to electric and where this is not possible utilise Ultra Low Emission Vehicles (ULEV's) and provide training to drivers on fuel efficient driving.
5. Review deliveries to try and consolidate where possible and encourage suppliers to deliver by electric vehicles.
6. Undertake annual travel surveys to monitor the change in staff and patient/visitor travel.
7. Work with the ICS, Local Authorities and local businesses to reduce local air pollution and the provision of better access to low carbon or active travel.

4.5 Estates & Facilities

The estate and its facilities are at the heart of every NHS Trust and contribute to a large sector of the NHS Carbon Footprint, whether it be energy, waste or water all of which have a target to be Net Zero by 2040, although by 2030 the Trust is to achieve net zero carbon status for energy emissions. The area and scope may be large within this area, but there is plenty of reason to be hopeful with all the achievements made so far and the planned work over the next few years.

Objectives:

- Reduce energy and water consumption.
- Improve and optimise space utilisation.
- Build sustainable capital projects applying whole life costing in design and construction.
- Optimise the use of green spaces on site and improve biodiversity within them.
- Work with contractors and suppliers to reduce their emissions in line with our targets.
- Replace fossil fuels with low and zero carbon energy sources.

Targets:

1. Reduce waste tonnage by at least 5% every year and increase recycling by 5% every year till 2025.
2. Improve the biodiversity and green spaces on all sites measured through ecologist surveys.
3. Improve the energy efficiency of existing buildings measured through reduction in energy consumption.
4. All capital projects to be built in line with Net Zero Hospital Standard and/or BREEAM standards or Passivhaus Standard.

Current Position:

- 100% REGO certified electricity contract.
- 2 Bio-diesel CHP's generating zero carbon heat and power.
- LED lighting installed across the Trust.
- Zero waste to landfill and reduced consumption in single use plastics.
- Awarded £1.6m as part of the public sector decarbonisation fund.

Actions:

1. Install air source heat pumps, solar panels and BMS upgrades as part of public sector decarbonisation fund and track and report upon progress.
2. Remove food waste from domestic waste stream and process for recycling either on or off site.
3. Improve the current reuse scheme, record and monitor savings to report back.
4. Undertake bio diversity surveys of all green spaces on Trust sites to understand current position and produce a biodiversity action plan.
5. Undertake site wide survey of building infrastructure to understand our current position and develop an action plan going forward to improve energy efficiency and reduce energy demand.
6. Educate staff on waste segregation and energy efficiency within their role.
7. Develop a standard for all capital and build projects that is in line with the Net Zero Hospital Standard and/or BREEAM or Passivhaus standards; ensuring the inclusion of sustainability aims and outcomes throughout the process from design brief, tender, build, furnishing and final use.
8. Review the space across the estate and plan how it can be optimised to improve efficiency and reduce energy demand.

4.6 Medicines

Medicines play a key role in treating patients and can help prevent further aid when used correctly, however they also account for 25% of NHS emissions. Anaesthetic gases account for 2% and inhalers account for 3% of these emissions, therefore it is vital the Trust looks at these areas

Objectives:

- Eliminate the use of desflurane within the Trust.
- Reduce nitrous oxide waste and prevent atmospheric release.
- Explore the utilisation of social prescribing to reduce the use of medication.
- Review the process of prescribing and point of use to reduce wastage where possible.
- Increase the number of dry powder inhalers (DPI's) that are prescribed.

Targets:

1. By 2023 eliminate the use of desflurane completely within the Trust.
2. By 2025 reduce the carbon impact of inhalers by 45% based on 2019/20 baseline.
3. Implement inhaler recycling scheme.
4. Implement means of capturing nitrous oxide waste.

Current Position:

- Very low user of desflurane less than the 10% overall volume target set in the Memorandum of Understanding regional targets.
- Best profile in the region with 78% pressurised inhalers vs 22% dry powder inhalers for 2020-21
- The Medicines Optimization System includes an electronic prescribing and medicines administration system (EPMA) and automated drugs cabinets (Omnicell) have both steadily reduced the rate of omitted doses of critical medicines.

Actions:

1. Install a device such as a Mobile Destruction Unit in areas like Maternity for Entonox capture and breakdown of residual gas.
2. Educate staff on the options for inhaler prescription and the benefits of DPI's to increase usage.
3. Work with primary care to look at recycling schemes for inhalers.
4. Educate and explore the use of social prescribing as an alternative means to medicine, utilising the learnings from trials.

4.7 Supply Chain & Procurement

Supply chain and procurement accounts for approximately 62% of total carbon emissions in the NHS, therefore it is vital that the buying power we have as an organisation and as a collective NHS must be used to its full potential to make change.

All clinicians and departments must begin rationalising their decisions of safe clinical use against the sustainability impact and look to reduce single use and wastage in their purchasing decisions and/or influence. Estates & Facilities also need to review their purchasing in line with environmental impacts choosing to reduce waste or reuse and optimise usage overall whether this be catering or a new build project. Reductions in use will also be paired with improvements to the disposal and recycling of plastic material that remains in operation.

Objectives:

- Reduce single use plastics purchased.
- Prioritise reuse of equipment and stock across the organisation.
- Work with and challenge suppliers to reduce their emissions.
- Ensure sustainability and net zero is included in all tenders.

Targets:

1. Adopt PPN 06/01 so that all contracts above £5m will require suppliers to publish a carbon reduction plan for their direct emissions by April 2023.
2. Ensure that by April 2024 all Group suppliers report their emissions and publish a carbon reduction plan aligned to the NHS net zero target for their direct emissions irrespective of contract value.
3. Reduce procurement of single use plastics and eliminate single use items when there is a viable reusable alternative.
4. Utilise Sustainability Impact Assessments in all business cases.

Current Position:

- Sustainable Procurement group set up to review data and impact of purchases and work on procuring suitable alternatives.
- NHS Supply Chain working in the towers to reduce emissions of products available on catalogue in line with NHS targets.
- Basic reuse system in place to be improved to increase utilisation and record and monitor savings.
- Walking aid refurbishment scheme in place.
- Recycled paper used across the organisation.

- Signed NHS Plastics pledge and lowest spend on single use plastics in catering across the region in 2020/21.
- Switched from single use plastic sharps bins to reusable saving 16 tonnes of single use plastic per annum.

Actions:

1. Implement a Sustainable procurement policy and procedures that includes the reduction of purchasing through utilising a reuse and or refurbishment system of equipment and stock to eliminate potential waste (this maybe via a regional hub) and the use of whole life cycle costing.
2. Measure our scope 3 emissions to begin tracking annual progress.
3. Train and educate procurement team in carbon literacy within their role.
4. Implement sustainability impact assessments into all business cases.
5. Educate staff on the impact of their purchases on emissions and environmental impact and improve sharing of items across the organisation.
6. Work with clinicians and infection control to look for suitable alternative products when found to have a large impact on emissions or products that could be used more effectively to reduce wastage.

4.8 Food & Nutrition

Food and nutrition is key to the development and health of everyone and is an integral part of our lives, in particular a patient's care plan. Eating well reduces the risk of developing cancer, heart diseases, diabetes and stroke, whatever your weight and eating well when you're in hospital is especially important to effectively support your care. However a nutritious meal is no benefit if it goes in the bin, with the annual reported cost of food waste for the NHS being £230 million, 39% of the total food budget; and with food and catering services producing 6% of total emissions or 1543kt CO2e each year it is vital action is taken to reduce the environmental impact and cost.

Objectives:

- To reduce food waste throughout the production and service of both patient and staff meals
- Utilise local, seasonal and sustainably grown food in catering.
- Educate staff and patients on the benefits of a low carbon diet.

Targets:

1. Reduce food waste by 20% by 2025.
2. Increase the use of locally grown food within catering.
3. Improve access to free drinking water for everyone.
4. Achieve accreditation such as the Soil Association 'Food for Life served here' award.

Current Position:

- Increased access to vegan food options.
- Sustainability representation on the Nutritional Steering Group.
- Improving out of hour's access to staff for healthy food.
- Improving education on nutrition with staff and access to digital weight management system for staff and residents within Gateshead.
- Well-fed project underway to audit areas and use data to help shorten length of stay for patients moving forward through improved nutrition.

Actions:

1. Increase locally sourced food through regular seasonal menus.
2. Install refill hydration stations across the Trust in high traffic areas.
3. Investigate the potential to donate to foodbanks or shelters at end of service/near expiry or best before across all catering and service outlets.
4. Work with suppliers to ensure they have sustainable production and transportation practices in line with NHS Targets.
5. Implement means of collecting food waste from all catering outlets and services in the Group and look at either specific collections or on site processing.
6. Improve education to staff, patient and visitors on the health and environmental benefits of a health low carbon diet.
7. Increase organic and fair trade food options available.
8. Identify means of reducing plate wastage for patients.

4.9 Adaptation

The green plan sets out and details our objectives and targets to reach net zero and reduce our emissions and environmental impact, we still need to be prepared and plan for and to mitigate the risks and effects of climate change and severe weather that may impact upon our business and functions.

Objectives:

- Incorporate climate change into the Group's business continuity, emergency planning and risk assessment procedures.
- Ensure the Group has the necessary business continuity plans in place that account for the impacts of climate change and severe weather.
- Design and adapt the operation of the estate to cater for the potential effects of climate change.

Targets:

1. Undertake a climate change risk assessment of all group sites to be included on risk register.
2. Develop an adaptation plan.
3. Every estates project is to include impacts of climate change into the design or planning process.

Current Position

- Adverse weather plan in place and has been utilised several times during heat waves for example.
- Winter Team in operation to ensure the sites are safe and accessible to staff and patients during cold months.
- Transport Department has been utilised to help people access site in bad weather.
- Reduced reliance on national grid with use of 2 bio diesel CHP's and upcoming installation of air source heat pumps and solar panels.
- QE Facilities own and operate a warehouse that can store supplies close to Trust sites.
- QE Facilities operate a FFP3 mask manufacturing production site, ensuring resilience in supply chain.

Actions:

1. Undertake a climate change risk assessment for each site and add the risks to the Group Risk Register to ensure it is highlighted and reviewed annually.
2. Write and develop an adaptation plan and present to the board for approval.
3. Assess what measures are needed to be included into the design of estates projects for impacts such as heatwaves and cold weather and incorporate into Estate Strategy and procedures.
4. Develop and update protocols aligned to national heat wave plans, cold weather plans and flood plans and specific climate change risk assessment.
5. Assess the financial implications of climate change to the organisation and the cost of doing nothing to help prevent it and communicate to the board, as being sustainable will cost money and this needs to be recognised.

Finance and Performance Committee

Gateshead Health NHS Foundation Trust

Assurance Report

Agenda Item: 10i

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
Committee Reporting Assurance:	Finance and Performance Committee – 25.1.22			
Name of Meeting:	Trust Board			
Date of Meeting:	30.3.22			
Author:	Mrs K Mackenzie and Mrs D Renwick			
Executive Lead:	Mrs K Mackenzie and Mrs J Baxter			
Report presented by:	Mr M Robson, Chair of Committee			
Matters to be escalated to the Board:	None identified			
Executive Summary: ***(outline assurances and gaps including mitigating actions)***	<u>Supply Procurement Committee Summary Table</u> The Committee is not assured on this item as the report does not provide enough detail. It was agreed that the Standing Orders would be reviewed as these may be out of date. <u>Integrated Oversight Report</u> The Committee received partial assurance and noted that everything is being done in order to hit targets and mitigate risks. An update on vaccinations will be provided at the Trust Board meeting as this will be a huge undertaking and a risk to the Trust. The elective care programme was maintained in December with indicative levels at 101% despite winter and Covid pressures. <u>Echo Performance Spotlight Report</u> The Committee received a positive update on the above and agreed a level of assurance, and noted that everything that can be done is being done. The revised target looks achievable. <u>Financial Revenue Report – Month 9</u> The Committee received the report and agreed a level of full assurance. Members noted that a draft summary timetable is required to be submitted by 12 noon on 3 March 2022 and that the Trust Board would be asked to delegate authority to the Finance and Performance Committee to sign off the 2022/23 plan prior to			

	submission. This will then be ratified by the Trust Board at the March meeting. Mr M Robson agreed to raise this at the Trust Board meeting. Mrs A Marshall advised that if there were any problems then this could also be raised at the Board Strategy Session scheduled for 23 February 2022. <u>ECIST Update</u> The Committee were assured and noted that a detailed assessment has been completed following the ECIST visit to the Trust on 16 November 2021, and that the report will be received in due course. The Committee agreed that transformation plans/progress reports would be brought to the Committee bi-monthly. <u>Capital Update</u> The Committee received a verbal update and were partially assured. <u>Review of Objectives</u> The Committee received the report and received assurance that the objectives are performing well with 6 objectives having now been completed. <u>Board Assurance Framework (BAF)</u> The Board Assurance Framework was updated accordingly.				
Recommended actions for Board					
Trust Strategic Aims that the report relates to: **(Including reference to any specific risk)**	**Aim 1** ☐	We will continuously improve the quality and safety of our services for our patients			
	Aim 2 ☐	We will be a great organisation with a highly engaged workforce			
	Aim 3 ☒	We will enhance our productivity and efficiency to make the best use of resources			
	Aim 4 ☐	We will be an effective partner and be ambitious in our commitment to improving health outcomes			
	Aim 5 ☒	We will develop and expand our services within and beyond Gateshead			
Financial Implications:	Included in narrative				
Links to Risks (identify significant risks and DATIX reference)	Risks identified on the Organisational Risk Register include: • FIN 2873 - Risk that the Trust is unable to form a suitable capital plan and programme due to reduced levels of CDEL available. (9) • FIN 2874 - Risk that we are unable to formulate a coherent financial plan due to uncertainty surrounding the financial framework. (3)				
People and OD Implications:	-				
Links to CQC KLOE	Caring	Responsive	Well-led	Effective	Safe

	☒	☒	☒	☒	☒
Trust Diversity & Inclusion Objective that the report relates to: (including reference to any specific implications and actions)	**Obj.1** ☐	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			
	Obj. 2 ☐	All patients receive high quality care through streamlined accessible services with a focus on improving knowledge and capacity to support communication barriers			
	Obj. 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			

Finance and Performance Committee

Gateshead Health NHS Foundation Trust

Assurance Report

Agenda Item: 10i

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
Committee Reporting Assurance:	Finance and Performance Committee – 22.2.22			
Name of Meeting:	Trust Board			
Date of Meeting:	30.3.22			
Author:	Miss J Boyle			
Executive Lead:	Mrs J Bilcliff and Mrs J Baxter			
Report presented by:	Mr M Robson, Chair of Committee			
Matters to be escalated to the Board:	No items identified for escalation			
Executive Summary: ***(outline assurances and gaps including mitigating actions)***	<u>Submission of the 2022/23 Draft Plan</u> The Committee received partial assurance, reflecting that work remains ongoing to develop the draft plan in advance of the final deadline in April. The Committee discussed the priorities for the plan and the work being undertaken to develop detailed estimates of income and expenditure. The performance and finance risks were discussed, along with the collaborative work with partners in the Integrated Care Partnership to formulate the plans. It was agreed that the final plans will be shared with the Committee in March for approval. <u>Supply Procurement Committee Summary Table</u> This item was deferred to the next meeting. <u>Integrated Oversight Report</u> The Committee received partial assurance which reflected the operational challenges faced during the reporting period. The Committee received assurance that the Trust continued to benchmark well against its peers in respect of overall performance within the region. <u>Financial Revenue Report – Month 10</u> The Committee received the report and agreed a level of full assurance, given that the year-end financial target is forecast to be achieved. Assurance was provided that divisional financial reporting is being monitored in shadow format until the year-end.			

	<u>Capital Update</u> The Committee received partial assurance on the capital update presentation. This reflected a risk of further slippage at year-end and the potential impact of this on the 2022/23 capital expenditure limit. Assurance was received that the Trust had utilised slippage in the plan to fund an additional scheme which would benefit patient care, and the Committee approved the revised capital plan. <u>Internal Audit Report</u> The Committee received the accounts receivable audit report for information and were fully assured on this item.					
Recommended actions for Board	The Board is requested to note the assurances and risks identified by the Committee and be mindful of this when reviewing and discussing related agenda items.					
Trust Strategic Aims that the report relates to: **(Including reference to any specific risk)**	**Aim 1** ☐	We will continuously improve the quality and safety of our services for our patients				
	Aim 2 ☐	We will be a great organisation with a highly engaged workforce				
	Aim 3 ☒	We will enhance our productivity and efficiency to make the best use of resources				
	Aim 4 ☐	We will be an effective partner and be ambitious in our commitment to improving health outcomes				
	Aim 5 ☒	We will develop and expand our services within and beyond Gateshead				
Financial Implications:	As outlined in the Finance Report paper on the agenda.					
Links to Risks (identify significant risks and DATIX reference)	Risks identified on the Organisational Risk Register include: • FIN 2873 - Risk that the Trust is unable to form a suitable capital plan and programme due to reduced levels of CDEL available. (9) • FIN 2874 - Risk that we are unable to formulate a coherent financial plan due to uncertainty surrounding the financial framework. (3)					
People and OD Implications:	Workforce planning assumptions will form part of the annual plan submission.					
Links to CQC KLOE	Caring ☒	Responsive ☒	Well-led ☒	Effective ☒	Safe ☒	
Trust Diversity & Inclusion Objective that the report relates to: (including reference to any specific implications and actions)	**Obj.1** ☐	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				

	Obj. 2 ☒	All patients receive high quality care through streamlined accessible services with a focus on improving knowledge and capacity to support communication barriers
	Obj. 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

Gateshead Health
NHS Foundation Trust

Assurance Report

Agenda Item: 10.2

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☒
Committee Reporting Assurance:	Quality Governance Committee from 19 January 2022			
Name of Meeting:	Trust Board			
Date of Meeting:	30 March 2022			
Author:	Mrs A Stabler, Non-Executive Director			
Executive Lead:	Mrs G Findley, Chief Nurse			
Report presented by:	Mrs A Stabler, Non-Executive Director			
Matters to be escalated to the Board:	**Mandated Vaccine Update Report** The Committee acknowledged the huge scope of this work and the clear risks associated with legislation and agreed that oversight of this work would be reported to the Quality Governance Committee as well as the People and OD Committee. Further work required to identify which clinical services are likely to be affected as well as what mitigation will be put in place to ensure continuity of patient care. The Committee agreed a level of partial assurance due to the ongoing work required.			
Executive Summary:	**Items received for assurance:** **Maternity - Mind the Gap (Baby Lifeline Nov 2021)** The Committee noted that the Trust have submitted a return template to NHS Resolutions confirming compliance against year three training. This work will be updated via the maternity report and Maternity Champion meetings. **Update on Fluid Chart Audits** The Committee noted that a dedicated task and finish group has been convened to engage with clinicians and develop training and education to be delivered in ways to ensure the key messages are shared. This work will be monitored via the Mortality and Morbidity Council.			

	Integrated Oversight Report The Committee acknowledged the number of patients under the right to reside and received assurance that significant work was taking place between the Trust and Local Authority to manage this safely. The Committee agreed full assurance had been provided, noting the correct information is now being included within the report. **Quality Report Proposal 2022/23 Update** The Committee noted that a virtual stakeholder engagement event would take place in February to set the 2023 quality priorities. A further event would then be arranged for June to close off the 2022 priorities. The Committee agreed to extend the Nursing Strategy to the end of 2022 to allow this to be aligned to the overall Trust Strategy. The Committee agreed full assurance had been provide from this update. **Objective Delivery Report:** The Committee acknowledged that despite the operational pressures faced work has continued resulting in 4 objectives being completed with 8 remaining amber. The Committee agreed a partial level of assurance was received as continued pressures present future risk to delivery of the outstanding objectives. **Assurance Report from Strategic Safeguarding Group:** The Committee noted that in response to face-to-face training being stepped down due to Covid several new safeguarding training initiatives have been put in place resulting in improvements in overall training compliance rates. The Committee acknowledged that all statutory posts were filled and welcomed the appointment of the designated safeguarding doctor for children Dr Neelmanee Ramphul. The Committee agreed a full level of assurance had been received from this update. **Assurance Report from SafeCare, Risk & Pt Safety Council:** The Committee noted that the December 2021 meeting was stood down due to operational pressures, however noted that these meetings are well attended with good engagement from the Business Units.

	The Committee agreed a level of partial assurance had been received from this update acknowledging that work is still required around learning. **Quarterly Learning Report** The Committee noted the common themes identified which have been triangulated through patient safety investigations, mortality reviews, formal complaints and PALS processes, which highlight areas of learning and good practice as well as actions taken. The Committee acknowledged that future quarterly learning reports would link in the quality and overall Trust strategy. The Committee agreed full assurance had been provided. **Health and Safety Quarterly Report:** The Committee received this report for assurance as well as copy of the workplan which highlights the gaps in assurance which have been escalated to the Health and Safety Committee. It was agreed that an update would be brought back to the March 2022 Committee on RIDDOR reportable incidents and COSH compliance. The Committee agreed a partial assurance level had been received from this report.	
Recommended actions for Board	Board are asked to note the work of the committee and the assurances received and note the areas of risk identified but note the actions in place to resolve.	
Trust Strategic Aims that the report relates to: **(Including reference to any specific risk)**	**Aim 1** ☒	We will continuously improve the quality and safety of our services for our patients
	Aim 2 ☐	We will be a great organisation with a highly engaged workforce
	Aim 3 ☐	We will enhance our productivity and efficiency to make the best use of resources
	Aim 4 ☐	We will be an effective partner and be ambitious in our commitment to improving health outcomes
	Aim 5 ☒	We will develop and expand our services within and beyond Gateshead
Financial Implications:	None to Note	
Links to Risks (identify significant risks and DATIX reference)	ORR Risks, 2879 – Maternity, 2779 CQC Compliance/ Improvement, 2868 – Further wave of Covid, 2880	
People and OD Implications:	Gaps in workforce in nursing, midwifery and mental health.	

Links to CQC KLOE	Caring ☒	Responsive ☒	Well-led ☒	Effective ☒	Safe ☒
Trust Diversity & Inclusion Objective that the report relates to	**Obj.1** ☐	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			
	Obj. 2 ☒	All patients receive high quality care through streamlined accessible services with a focus on improving knowledge and capacity to support communication barriers			
	Obj. 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			

NHS
Gateshead Health
NHS Foundation Trust

Assurance Report

Agenda Item: 10ii

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☒
Committee Reporting Assurance:	Quality Governance Committee from 16 February 2022 meeting			
Name of Meeting:	Trust Board			
Date of Meeting:	30 March 2022			
Author:	Mrs A Stabler, Non-Executive Director			
Executive Lead:	Mrs G Findley, Chief Nurse			
Report presented by:	Mrs A Stabler, Non-Executive Director			
Matters to be escalated to the Board:	**Maternity Update:** **Okenden Update – One year on letter** **Staffing:** • 9.6 wte midwifery posts vacant (inclusive of 5.3 wte supported by ockenden) Trust have recruited 2 wte students from the January 2022 cohort and are in process recruiting students due to qualify in September 2022 Rolling recruitment advert out Supporting international recruitment 0 wte Maternity support worker posts vacant 1 wte HCA posts vacant • Pressures Dec – Jan on Midwifery Continuity of Care (MCOC) teams to support the Acute unit due to vacancies and Covid sickness. Hence to ensure the safe running of the unit a decision to delay roll out of third MCOC until June 2022 team has been taken. • Specialist roles appointed to - Diabetic lead midwife and Recruitment and Retention midwife • Workforce strategy in development • Medical staff across all specialties also struggling with covid absences. Cover for Obstetrics/Neonates is prioritised but this impacts on other clinical duties. • Pressures to release staff for skills drills training – Planned PROMPT week March 2022 to focus on increasing face to face attendance. **Incidents:** • SI reports, last one October 2021- Final draft report expected this month			

	• All incidents which meet HSIB criteria are reported regionally as an SI • Draft HSIB report from incident in September 2021 received this month. Two safety actions identified. • Actions for the maternity team following the Trust power outage, including review of BCP and escalation triggers, as well as looking as resilience options for Badger. **Ockenden:** Letter to the system sent by Ruth Mary on 25th January asking that Trusts discuss progress against the Ockenden recommendations at our public Board before the end of March 2022. Reported to QGC Feb 2022. Trust board to be aware of: • Progress with implementation of the 7 Immediate Essential Actions (IEA) outlined in the Ockenden report and the plan to ensure full compliance, • Maternity services workforce plans • Progress must be reported to regional maternity team by 15 April 2022. **Ockenden current Gap analysis and assessment of compliance** - **IEA 1** compliant - **IEA 2** – National work ongoing regarding the development and role descriptor for the Trust Senior Advocate role – guidance not yet confirmed - **IEA 3** Staff training – Letter from DOF confirming that rebate from Year 3 MIS £254k to be ring fenced to ensure Maternity service safety and quality improvements received - Face to Face training is being resumed and a full week of skills drills planned May 2022 - **IEA 4 -** Compliant - **IEA 5 - Further** audits around risk assessment to be performed. Guidance to be developed around mothers choice of birth, including choice out with recommendations - **IEA6** – Addition to recommendations 2022. A second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support – compliant. - **IEA 7-** Need to focus on improvement of Trust website and available information for our mothers and families. Working with Comms to develop this. Video of unit completed and working with MVP to develop

	information leaflets and develop the personalised care plans on the patient portal. **Staff Essential Training Compliance:** - Core skills mandatory training: - Community Midwives – 72.27% - MCOC teams – 67.5% - Antenatal/Postnatal 72.69% - Del suite 62.52% - SCBU 67.61 - Specialist midwifes 72.65% - WHC – 79.2% - We are working towards improved data capture with Business Information team **Additional Information** • 2 staff received star of the month awards for recognition of deteriorating baby on the postnatal ward • Neonatal Badger Business case supported and work to begin with the project to create a fully integrated maternity and neonatal digital record has begun Feb 22 • Estates work underway and good progress • The Health and Social Care Committee Report on The Safety of Maternity Services in England (July 2021) recommended an immediate end to the use of total Caesarean Section percentages as a metric for maternity services, and that this is replaced by using the Robson criteria to measure Caesarean Section rates more intelligently.
	Items received for assurance: **CQC Maternity Survey Results 2021** The Committee noted the excellent survey results received showing the Trust as one of the top hospitals for our Maternity Services. **Integrated Oversight Report** The Committee acknowledged that the operational pressures have impacted on the ability to maintain patient flow and the discharge process whilst leading to a further deterioration in urgent and emergency care measures. A total of 3 serious incidents were reported between December and January 2022, none of which related to Maternity Services. The Committee agreed partial assurance had been provided from this report.

	Safer Nurse Staffing Update The Committee acknowledged that January 2022 continued with significant staffing challenges following on from December 2021 as the Trust managed the impact of Covid on staffing resource and the clinical operating model. The Committee noted that assurance will be strengthened going forward as the safe staffing task and finish group has been initiated to review staffing establishments, managing sickness absence, as well as reporting, recording and escalation of staffing challenges. The Committee agreed that this report provided partial assurance. **Mandated Vaccine Update Report:** The Committee acknowledged that this work had been suspended as per the new national guidance. **Medicine Quarterly Update Report:** The Committee received good assurance in relation to key medicines performance indicators within quarter 2 including the management of controlled drugs. The Committee noted that a Trustwide audit of controlled drugs was due to go-live and confirmed that the results of this would be shared with the Trust Board in March 2022. **IPC Terms of Reference:** These were ratified by the Committee. **Future Committee Cycle of Business Proposal:** The Committee agreed that going forward the meeting would be held on a bi-monthly basis and would be increased to two and a half hours in line with other Board accountable Committees.	
Recommended actions for Board	Board are asked to note the work of the committee and the assurances received and note the areas of risk identified but note the actions in place to resolve.	
Trust Strategic Aims that the report relates to: **(Including reference to any specific risk)**	**Aim 1** ☒	We will continuously improve the quality and safety of our services for our patients
	Aim 2 ☐	We will be a great organisation with a highly engaged workforce
	Aim 3 ☐	We will enhance our productivity and efficiency to make the best use of resources
	Aim 4 ☐	We will be an effective partner and be ambitious in our commitment to improving health outcomes
	Aim 5 ☒	We will develop and expand our services within and beyond Gateshead

Financial Implications:	None to Note				
Links to Risks (identify significant risks and DATIX reference)	ORR Risks, 2879 – Maternity, 2779 CQC Compliance/ Improvement, 2868 – Further wave of Covid, 2880				
People and OD Implications:	Gaps in workforce in nursing, midwifery and mental health.				
Links to CQC KLOE	Caring ☒	Responsive ☒	Well-led ☒	Effective ☒	Safe ☒
Trust Diversity & Inclusion Objective that the report relates to	**Obj.1** ☐	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			
	Obj. 2 ☒	All patients receive high quality care through streamlined accessible services with a focus on improving knowledge and capacity to support communication barriers			
	Obj. 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			

Gateshead Health
NHS Foundation Trust

Assurance Report

Agenda Item: 10iii

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
Committee Reporting Assurance:	Digital Committee Assurance Report from Meeting held on 14 February 2022			
Name of Meeting:	Board of Directors			
Date of Meeting:	30 March 2022			
Author:	Mr A Moffat, Chair of the Digital Committee			
Executive Lead:	Mrs J Bilcliff, Group Director of Finance and Digital			
Report presented by:	Mr A Moffat, Chair of the Digital Committee			
Matters to be escalated to the Board of Directors:	No specific matters to escalate to the Board for further action.			
Executive Summary: ***(outline assurances and gaps including mitigating actions)***	**Strategic Aims and Objectives / Strategy and Transformation Roadmap** The report provided a good level of assurance with the percentage progress updated, however slippage related to capacity/resourcing issues was noted. The Committee requested a review of workload priorities to ensure the limited resource capacity is focussed on the correct deliverables, but ensuring the main focus is on maintaining current services and systems. A rating of partial assurance was awarded. **Global Digital Exemplar Milestones** Good assurance was received that milestones are achievable by the target dates. Formal approval due (and issued) by NHS England on 1 March 2022. A rating of full assurance was awarded. **Service Key Performance Indicators** This continues to evolve and will be updated in April to reflect the new Committee Terms of reference. A rating of partial assurance reflects the continued evolution of this report. **Cyber Update** External Cyber review undertaken, awaiting report which will be shared at the April meeting. A rating of partial assurance reflects the status of waiting for the report.			

	Policy Updates Telecoms policy rewritten by the Digital team and approved at Digital Assurance Group – all other Digital policies up to date. A rating of full assurance was awarded. **Internal Audit Reports** Currently 3 Outstanding audit actions, none of which are overdue as such a rating of full assurance has been awarded. **Digital Strategy** Channel 3 report presented, demonstrating excellent engagement across the organisation; proceeding to Outline Business Case stage – due in draft March 2022. A rating of full assurance was awarded. **Sub-Group Reporting** Assurance reports were received from the Digital Transformation Group and the Digital Assurance Group. As no gaps in assurance were identified, full assurance was awarded.					
Recommended actions for the Board of Directors	The Board is requested to take assurance from the work of the Committee and note the assurances, actions and decisions of the Committee in framing related items on the Board agenda.					
Trust Strategic Aims that the report relates to: **(Including reference to any specific risk)**	**Aim 1** ☒	We will continuously improve the quality and safety of our services for our patients				
	Aim 2 ☐	We will be a great organisation with a highly engaged workforce				
	Aim 3 ☒	We will enhance our productivity and efficiency to make the best use of resources				
	Aim 4 ☐	We will be an effective partner and be ambitious in our commitment to improving health outcomes				
	Aim 5 ☐	We will develop and expand our services within and beyond Gateshead				
Financial Implications:	None to note					
Links to Risks (identify significant risks and DATIX reference)	There are no significant risks on Datix relating to the business conducted at this meeting.					
People and OD Implications:	None to note.					
Links to CQC KLOE	Caring ☐	Responsive ☐	Well-led ☒	Effective ☐	Safe ☒	
Trust Diversity & Inclusion Objective that the report relates to: (including reference to any specific implications and actions)	**Obj.1** ☐	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				

	Obj. 2 ☐	All patients receive high quality care through streamlined accessible services with a focus on improving knowledge and capacity to support communication barriers
	Obj. 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

Gateshead Health
NHS Foundation Trust

Assurance Report

Agenda Item: 10iv

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
Committee Reporting Assurance:	People and OD Committee – 8 March 2022			
Name of Meeting:	Trust Board			
Date of Meeting:	30 March 2022			
Author:	Jennifer Boyle, Company Secretary			
Executive Lead:	Lisa Crichton-Jones, Director of People & OD			
Report presented by:	Ruth Bonnington, Non-Executive Director			
Matters to be escalated to the Board:	No items identified for escalation			
Executive Summary: ***(outline assurances and gaps including mitigating actions)***	The key agenda items discussed were as follows: <u>Update on Supply</u> A comprehensive presentation was delivered, providing updates on the workstreams relating to supply, noting that supply and recruitment is a key priority for the Trust. The Committee was fully assured that a significant amount of work is being progressed and that it is receiving due consideration and focus. The Committee was partially assured on the item overall, reflecting that workstreams remain ongoing and the risks associated with potential lack of supply are significant. <u>Vaccination as a Condition of Deployment (VCOD)</u> The Committee was assured that despite the national pause, the Trust continued to hold weekly meetings to progress with the planning for potential future iterations of VCOD. As such the Committee was fully assured that the Trust was doing everything in its control to reduce future risk, but the national uncertainty resulted in a partially assured rating. <u>Update Report from POD Portfolio Board</u> The Committee was partially assured on this item, given that workstreams were in the early stages of restarting following the reprioritisation for VCOD and the Omicron response. Assurance was provided that workstreams and meetings are recommencing.			

	People & OD Metrics The new format report continues to develop and was welcomed by the Committee and people-related performance challenges remain consistent with previous months given the pressures which impacted upon quarter 4. A need to clearly highlight exceptions at business unit level was identified, as well as the need to include in-month sickness absence figures to more clearly identify emerging trends. A partial assurance rating was awarded to reflect the continued development of the format. Gender Pay Gap The Committee received the report and noted that there were some improvements across the middle and upper quartiles and a reduction in the mean pay gap. An increase in the mean bonus pay gap was highlighted, noting that this solely relates to Clinical Excellence Awards which are nationally driven – as the Trust has a higher proportion of male consultants, this will therefore result in the gap and there is little local action that can be taken to influence this. The Committee were assured around the actions being taken to continually improve, including the establishment of the Equality, Diversity and Inclusion (EDI) programme board, analysis of TRAC recruitment metrics / trends and initiatives to attract and retain staff. It was recognised that it would be beneficial to set a target improvement threshold for future gender pay gap reports, but this did not detract from the full assurance which the Committee awarded this report. Strategic Objective Achievement The Committee received a summary report which provided a progress update against the strategic objectives mapped to the Committee for monitoring. Improvements in RAG-ratings were noted in some areas including in relation to the objective linked to staff health and wellbeing and the objective relating to the development of leadership and organisational development strategies. The Committee awarded this area partial assurance, recognising the continued progress being made.	
Recommended actions for Board	Note main assurances against the strategic People and OD themes detailed and key associated risks.	
Trust Strategic Aims that the report relates to: **(Including reference to any specific risk)**	**Aim 1** ☐	We will continuously improve the quality and safety of our services for our patients
	Aim 2 ☒	We will be a great organisation with a highly engaged workforce
	Aim 3 ☐	We will enhance our productivity and efficiency to make the best use of resources

	Aim 4 ☐	We will be an effective partner and be ambitious in our commitment to improving health outcomes
	Aim 5 ☐	We will develop and expand our services within and beyond Gateshead
Financial Implications:	No significant new financial implications to highlight to the Board.	
Links to Risks (identify significant risks and DATIX reference)	Three risks from the organisational risk register were reviewed: 2764 – Right People, Right place, Right skills – 16 2765 – Leadership and OD – 12 2759 – Health & Wellbeing – 12	
People and OD Implications:	As set out	

Links to CQC KLOE	Caring ☒	Responsive ☒	Well-led ☒	Effective ☒	Safe ☒

Trust Diversity & Inclusion Objective that the report relates to: (including reference to any specific implications and actions)	**Obj.1** ☒	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
	Obj. 2 ☐	All patients receive high quality care through streamlined accessible services with a focus on improving knowledge and capacity to support communication barriers
	Obj. 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

Gateshead Health
NHS Foundation Trust

Assurance Report

Agenda Item: 10ii

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
Committee Reporting Assurance:	Audit Committee Assurance Report from Meeting held on 3 March 2022			
Name of Meeting:	Board of Directors – Part 1			
Date of Meeting:	30 March 2022			
Author:	Miss J Boyle, Company Secretary			
Executive Lead:	Mrs J Bilcliff, Group Director of Finance and Digital			
Report presented by:	Mr A Moffat, Chair of the Audit Committee			
Matters to be escalated to the Board of Directors:	Progress in relation to the Internal Audit plan to inform the Head of Internal Audit Opinion.			
Executive Summary: ***(outline assurances and gaps including mitigating actions)***	**<u>Executive Risk Management Group – Update</u>** The Committee received assurance over the impact of the Executive Risk Management Group, as evidenced by movement of risks and risk scores. It was noted that there is an intention to develop the utilisation of risk appetite and maturity in informing the approach to risk management. A rating of full assurance was assigned reflecting the view of Members that the report provided assurance that risks are being managed appropriately in the Trust. **<u>Board Assurance Framework (BAF) – Process Assurance</u>** The report provided the Committee with an overview of the controls and processes in place for monitoring and updating the BAF throughout the year. The report referred to recent Board discussions and reflections on the BAF, noting the future intention to strengthen the focus on controls. A rating of partial assurance was awarded, recognising the progress made but also the commitment to continuous improvement of the BAF. **<u>Counter Fraud – Progress Report</u>** An overview of Counter Fraud activity was provided, including continued fraud awareness work, updates to the counter-fraud policy and the outcome of a proactive review into time and e-rostering. The review identified some recommendations but also areas where implemented changes had improved the robustness of controls.			

	The Committee noted that 9 recommendations had not been implemented by the due date and it was agreed that this needed to be an area of improvement for the Trust, with realistic dates agreed and set in the first instance. A rating of partial assurance was awarded to reflect the slippage in dates for implementation of recommendations. **Internal Audit – Progress Report** The Committee particularly focussed on the Control of Substances Hazardous to Health (COSHH) audit findings, noting the high priority recommendations. It was agreed that this would be an area which would be monitored closely by the Quality Governance Committee. The Committee approved the recommendations to defer audits in relation to HealthRoster, the Data Security & Protection Toolkit and medical gases (QE Facilities). This provides increased capacity to focus on the audits which inform the Head of Internal Audit Opinion. It was noted that progress against some audit action recommendations had slipped. It was agreed that criteria would be developed for requesting the attendance at Audit Committee of the escalation officer for each delayed audit action (should the criteria be triggered). With regards to progress against the audit plan it was noted that a risk had been identified to the quality of the Head of Internal Audit Opinion given the level of work still to complete. A lengthy discussion took place, with further follow-up outside of the meeting between AuditOne and the Trust in respect of resource allocation. A rating of partial assurance was awarded, which reflected the timescales for audit actions and completion of the audit plan. **External Audit – QE Facilities 2021/22** It was noted that additional sampling and external audit capacity issues had caused a delay in sign-off. A three month extension had been granted from Companies House. The accounts were filed before the expiry of the extension. A rating of full assurance was awarded, recognising that the accounts had been filed and the handover process to the new auditors, Mazars, was progressing well. **External Audit Plan 2022/23**

	Assurance was provided that the new auditors were progressing well with the planning of the audit and a positive relationship was being developed with the Trust. **<u>Constitution and Standing Orders</u>** A progress update was provided on the review of these core governance documents. A number of areas were highlighted for consideration in relation to modernising the documents, reducing repetition and reflecting the system boundaries of the Integrated Care System. The work would be further progressed and shared at the next Audit Committee. A rating of partial assurance was awarded, reflecting the ongoing nature of this work. **<u>Losses and Special Payments</u>** The Committee approved the losses and special payments register for Quarter 3. A rating of full assurance was awarded.					
Recommended actions for the Board of Directors	The Board is requested to take assurance from the work of the Committee and note the assurances, actions and decisions of the Committee in framing related items on the Board agenda.					
Trust Strategic Aims that the report relates to: **(Including reference to any specific risk)**	**Aim 1** ☒	We will continuously improve the quality and safety of our services for our patients				
	Aim 2 ☐	We will be a great organisation with a highly engaged workforce				
	Aim 3 ☒	We will enhance our productivity and efficiency to make the best use of resources				
	Aim 4 ☐	We will be an effective partner and be ambitious in our commitment to improving health outcomes				
	Aim 5 ☐	We will develop and expand our services within and beyond Gateshead				
Financial Implications:	None to note					
Links to Risks (identify significant risks and DATIX reference)	There are no significant risks on Datix relating to the business conducted at this meeting.					
People and OD Implications:	None to note.					
Links to CQC KLOE	Caring ☐	Responsive ☐	Well-led ☒	Effective ☐	Safe ☒	
Trust Diversity & Inclusion Objective that the report relates to: (including reference to any specific implications and actions)	**Obj.1** ☐	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				
	Obj. 2 ☐	All patients receive high quality care through streamlined accessible services with a focus on				

		improving knowledge and capacity to support communication barriers
	Obj. 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

Gateshead Health
NHS Foundation Trust

Gateshead Health NHS Foundation Trust

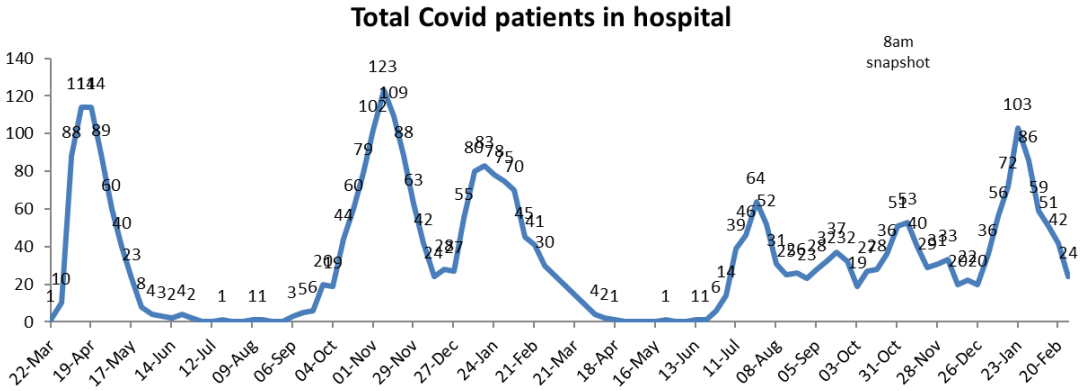
Chief Executive Update

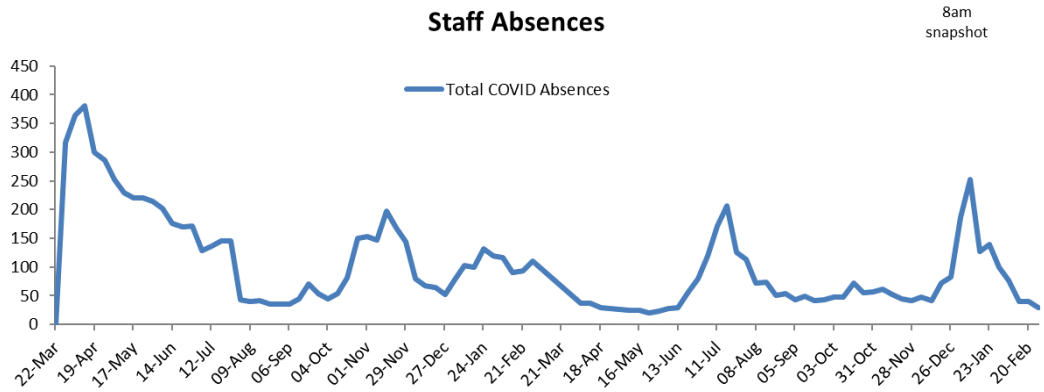
Yvonne Ormston
March 2022

Operational performance

Gateshead Health NHS Foundation Trust

- COVID
  - Numbers reduced in February 2022
  - Increased again in March peaking so far at 48 Covid patients on 23 March and 128 staff absences on the same day.
  - Covid patients not typically in ITU – no Covid patients in ITU since 10 March

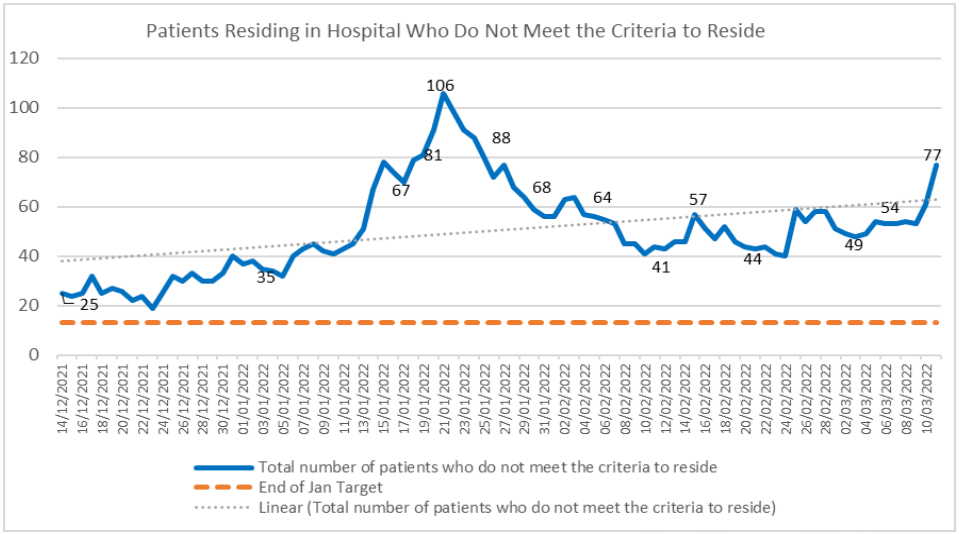




Operational performance

Gateshead Health NHS Foundation Trust

- Medically optimised patients
  - the total number of patients who current do not meet the criteria to reside rose towards the end of February and continues to do so into March.
  - As of 11th March there were 78 patients who do not meet the criteria to reside
  - Has a significant impact on patient flow and front door capacity, including A&E performance and elective recovery
  - A number of actions being taken internally and with partners to support discharge of patients who do not meet the criteria to reside – e.g. securing care packages, bed capacity in care centres and our own home monitoring capacity.



Recruitment

Gateshead Health
NHS Foundation Trust

- Significant focus on recruitment – top priority.
- RPIW taking place w/c 28th March 2022
- Staffing Task and Finish Group meeting fortnightly.
- International recruitment team in place and first cohort of international staff expected to join the Trust in the summer.
- Recruitment and retention initiatives being progressed – including launch of Managing Well pilot and rotational programmes for staff.

NHS
Gateshead Health
NHS Foundation Trust

Provider Collaborative

A development Day facilitated by Sir Mike Farrar was held on 8 March 2022.

The session included:

- The current context including national developments and expectations
- ICS progress and relationships and opportunities for Provider Collaborative
- Developing the Collaborative impact ie what is the overarching strategy, assessing the approach to elective recovery and urgent care reform, unresolved issues
- Discussion about the resources needed to undertake the work of the collaborative and where clinical networks would feed in

At the business meeting on the 22 March 2022, the agenda includes updates on:

- Mental health collaboratives
- ICPs
- Elective recovery work including the TIF bids
- Urgent and emergency care
- Capital and Estates planning
- The 22/23 Planning round
- Governance arrangements including the Memorandum of Understanding.

Integrated Care System/Integrated Care Board (ICS/ICB)

Progress has been made in appointing to the Board of the ICB as follows

- Executive Medical Director, Dr Neil O'Brien
- Executive Chief Digital and Information Officer, Professor Graham Evans
- Executive Director of People, Annie Laverty
- Executive Director of Corporate Governance, Communication and Involvement, Claire Riley
- Executive Director of Innovation, Aejaz Zahid
- Executive Director of Finance, Jon Connolly
- Executive Director of Place Based Partnerships (Central and Tess Valley), Dave Gallagher
- Executive Director of Place Based Partnerships (North and North Cumbria) Mark Adams

Given the appointment of Neil O'Brien to the Medical Director role the decision was taken to reduce the number of Place Based Directors from three to two.

The Director of Strategy and Director of Nursing posts are still to be appointed to.

Independent Non-Executive Member appointments also being made.

Engagement work has commenced on what the operating model will look like and what place based arrangements will look like. This work is important as it will shape how the system as a whole works, where decisions are made and by whom, ways of working and structures.

General Update

- Visits:
  - Pharmacy
  - IVF, Paediatrics & Gynae Oncology
  - Critical Care & Rehabilitation
  - Theatres & T&O
  - OPMH
  - Memory Hub
  - Woodside
  - Rapid Response Team, Bensham
  - Maternity
  - Women's Health
  - Surgery Centre
  - Wd 27, 21, Surgery Nurse Specialists and Chemo Day Unit
- Meetings
  - Consultants
  - Interview panel for NENC ICB Chief People Officer
  - Community Services Team Meeting
  - National Elective Recovery Webinar
  - International Women's Day Podcast
  - Private Dinner with RCS England
  - Gateshead Collaboration meeting with Baltic/Gateshead College and Gateshead LA
  - Chair Pathology Network Board Meeting
  - CBC
- Planning and Development
  - Annual Plan
  - Exec Team Away Day
  - SMT and EMT Development
  - Strategy Development

NHS
Gateshead Health
NHS Foundation Trust

Report Cover Sheet Agenda Item: 12i

Report Title:	**Corporate Objectives Update**			
Name of Meeting:	Board of Directors – Part 1			
Date of Meeting:	30 March 2022			
Author:	Jennifer Boyle, Company Secretary			
Executive Sponsor:	Yvonne Ormston, Chief Executive			
Report presented by:	Jennifer Boyle, Company Secretary			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	This paper seeks to provide assurance over the delivery of the Trust's corporate objectives, with a particular focus on the 15 priority objectives, noting that Board committees have received more detailed assurance reports which include other corporate objectives.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☒
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	Board committees – January to March 2022			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	• 40% of Board priority objectives are considered to be fully delivered, with 47% on track, but with a risk to delivery. This is an improved position and demonstrates continued progress. • Objectives not completed at year-end will continue to be progressed into 2022/23, with a number of workstreams being longer-term pieces of work / projects. • A process is commencing to develop the new objectives for 2022/23.			
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The Board is requested to review the report and be assured that whilst there have been operational challenges impacting upon the delivery of the Board			

	priorities, progress has been made against each of the 15 objectives.				
Trust Strategic Aims that the report relates to:	**Aim 1** ☒	We will continuously improve the quality and safety of our services for our patients			
	Aim 2 ☒	We will be a great organisation with a highly engaged workforce			
	Aim 3 ☒	We will enhance our productivity and efficiency to make the best use of resources			
	Aim 4 ☒	We will be an effective partner and be ambitious in our commitment to improving health outcomes			
	Aim 5 ☒	We will develop and expand our services within and beyond Gateshead			
Trust corporate objectives that the report relates to:	This links to all corporate objectives by its nature				
Links to CQC KLOE	Caring ☒	Responsive ☒	Well-led ☒	Effective ☒	Safe ☒
Risks / implications from this report (positive or negative):					
Links to risks (identify significant risks and DATIX reference)	2868 – risk of a further wave of COVID-19 impacting upon the capacity to deliver on corporate objectives and priorities. POD 263: Risk that following the Covid vaccine being mandated for NHS staff - staff may leave roles/ employment impacting on service delivery and further staff pressures/wellbeing.				
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒		

Corporate Objective Delivery

1. Executive Summary

1.1. Assurance can be provided that Board committees have monitored the delivery of strategic aims and associated objectives on behalf of the Board. Board Members will have received high level assurance on this via the assurance reports to Board from committee chairs.

1.2. This paper seeks to provide a summary position against each strategic aim focussing on the 15 Board priority objectives, given that more detailed reports on all objectives are received by the Board committees throughout the year.

1.3. The summary position on the year-end status of Board priority objectives is as follows (note that no objectives were either identified as not yet started or at significant risk of delivery, so these categories are not shown in the table below) with the comparative position from January 2022 shown in brackets:

Strategic aim	No. of Board priority objectives	Complete	Partial assurance – on track but risks to delivery	On track with no identified risks
We will continuously improve the quality and safety of our services for our patients.	**4**	**1** (1)	**3** (2)	**0** (1)
We will be a great organisation with a highly engaged workforce	**3**	-	**1** (3)	**2** (0)
We will enhance our productivity and efficiency to make the best use of our resources	**2**	**2** (1)	**0** (1)	-
We will be an effective partner and be ambitious in our commitment to improving health outcomes	**2**	**1** (1)	**1** (1)	-
We will develop and expand our services within and beyond Gateshead	**4**	**2** (2)	**2** (2)	-
TOTAL	**15**	**6 (5)**	**7 (9)**	**2 (1)**
%		**40% (33%)**	**47% (60%)**	**13% (7%)**

1.4. This summary demonstrates that 40% of Board priority objectives are considered to be fully delivered, an increase from 33% in January 2022. 13% are on track to deliver with no identified risks, an increase from 7%. As a consequence the proportion of priority objectives on track but with risks to delivery reduced from 60% to 47%.

1.5. This demonstrates continued progress over Quarter 4 particularly given the impact of Omicron on the Trust and its partners, as well as the need to reprioritise resource on responding to issues such as the now-paused mandatory vaccinations for staff. Those

objectives which have not been completed by year-end remain ongoing and continue to make progress, as demonstrated by this paper and the more detailed reports to Board committees.

2. Introduction

2.1. In March 2021 the Board of Directors agreed 5 strategic aims for 2021/22. Each strategic aim is supported by a number of enabling objectives, with the Board identifying 15 priority objectives.

2.2. The delivery of the strategic aims is monitored by the Board committees, as shown in the below chart. The Board committees also monitor extracts of the Board Assurance Framework (BAF) which support the effective management of risks which may prevent the achievement of the 15 priority objectives.

	Strategic Aim	Number of Board priority objectives	Executive Director Leads	Board Committee
1	We will continuously improve the quality and safety of our services for our patients.	4	Chief Nurse & Medical Director	Quality Governance Committee & Digital Committee
2	We will be a great organisation with a highly engaged workforce	3	Director of People and Organisational Development	People and Organisational Development Committee & Digital Committee
3	We will enhance our productivity and efficiency to make the best use of our resources	2	Director of Finance and Digital & Chief Operating Officer	Finance and Performance Committee
4	We will be an effective partner and be ambitious in our commitment to improving health outcomes	2	Chief Executive Officer Trust Chairman	Quality Governance Committee & Digital Committee
5	We will develop and expand our services within and beyond Gateshead	4	Chief Operating Officer Managing Director, QEF	Finance and Performance Committee

2.3. This report provides a summary year-end position of progress against each of the strategic aims, with a primary focus on the delivery of the Board priorities.

3. Summary of progress

Strategic Aim 1 - We will continuously improve the quality and safety of our services for our patients

3.1. Progress against this aim and associated objectives was reviewed at the Quality Governance Committee in January '22 and the Digital Committee in February '22. There are four Board priority objectives under this strategic aim.

3.2. In relation to objective 1.1. *Implementation of the Ockenden Report Recommendations* this continues to be an area of priority focus. The Board received an update on Ockenden One Year On as part of the public Board meeting in March 22. This demonstrates the positive progress made, whilst also identifying those workstreams which continue to be progressed. This objective was rated as partially assured (plans are in place with some risks to delivery).

3.3. In relation to objective 1.3. *Understanding the Effects of Covid on Mortality* this objective was marked as complete in October '21, as outlined in the previous Board report on corporate objective delivery in January '22.

3.4. In relation to objective 1.6 *Maximising the use of Carestream to Digitise Imagery*, the Digital Committee received assurance that all cardiology images captured digitally are now available on Carestream. Work on clinical photography solutions continues and the related business case has been approved, although the go-live date for this will be in the new financial year. As such this objective was rated as partially assured (plans are in place with some risks to delivery).

3.5. The final objective is 1.10 *Develop Route Map to CQC Outstanding*. This work is being led by the recently appointed Head of Quality and Patient Experience. This includes a gap analysis and outline of next steps. The gap analysis has commenced, with initial internal assessments being due by the end of March 2022. The rating of partially assured (plans are in place with some risks to delivery) reflects that this work remains ongoing with further scoping and refinement once the initial assessments are completed.

Strategic Aim 2 – We will be a great organisation with a highly engaged workforce

3.6. The most recent update on the delivery of the corporate objectives was presented to the People and Organisational Development (POD) Committee in March 2022. There are 3 priority objectives which are subject to monitoring at this Committee.

3.7. With regards to objective 2.1. *Promotion of Health and Wellbeing* positive progress has been made in a number of areas, including the development of a draft strategy, launch of health and wellbeing conversations, a focus on vaccinations (and particularly planning for mandatory vaccinations before the national pause) and the external review of occupational health. Work continues to finalise the strategy, improve health and wellbeing conversation compliance and recruit to posts within occupational health. As such this objective was rated as on track with no identified risks to delivery.

3.8. With regards to objective 2.3 *Develop a Trust-wide approach to strategic workforce planning* an external firm has been appointed to support with this. The Trust's international recruitment team are fully established and the plan with timescales will be agreed following the set-up meeting with the external partner. The POD team are fully engaged in the current annual planning round. As such this objective was rated as partially assured (plans are in place with some risks to delivery). This reflects the continued progress made in respect of this objective, as well as the risks to delivery caused by a combination of internal and external pressures and risks.

3.9. With regards to objective 2.4 *Development of a Leadership and OD Strategy* key appointments have been made to the team and plans are in place to launch the newly developed initiatives, including Leading Well and Managing Well. Executive and Senior Management Team development has also commenced, with plans in place in relation to communicating and engaging on the latest staff survey results. As such this objective was rated as on track with no identified risks to delivery, which reflects the positive progress made.

Strategic Aim 3 - We will enhance our productivity and efficiency to make the best use of our resources

3.10. The Finance and Performance Committee seeks assurance over the delivery of 2 Board priorities in relation to Strategic Aim 3, with the latest update being in March '22.

3.11. In relation to priority 3.4 *Develop an Approved Capital and Revenue Plan* this objective is considered to be completed, as outlined in the previous report to Board in January '22.

3.12. In relation to priority 3.8. – *Deliver the Operational Transformation Plan* this objective is considered to be complete, with the operational transformation plan launched and underway. A programme board meets fortnightly to oversee delivery and the Transformation Board has been re-established with monthly meetings reporting into the Finance and Performance Committee. The transformation plans are sizeable with delivery anticipated to take 18 to 24 months. As the operational transformation programme has been established with delivery underway the objective itself is complete, with this moving into business as usual.

Strategic Aim 4 - We will be an effective partner and be ambitious in our commitment to improving health outcomes

3.13. The Quality Governance Committee seeks assurance over the delivery of 2 Board priorities in relation to Strategic Aim 4.

3.14. In relation to priority 4.1 *Establish an Acute Tobacco Dependency Service* this objective is considered to be complete, as reported in the January update. The service is now live and is being actively promoted.

3.15. In relation to priority 4.4 *Work Collaboratively as Part of Gateshead Place* this objective remains ongoing. Work has continued to progress as much as possible, given Trust and system operational pressures. This includes collaboration with the Gateshead Citizens Advice Bureau as well as the establishment of a Health Inequalities Board, which includes the Director of Public Health for Gateshead as a member. A joint session is planned with the Gateshead system to review priorities and set objectives for 2022/23. This objective was rated as partially assured (plans are in place with some risks to delivery).

Strategic Aim 5 - We will develop and expand our services within and beyond Gateshead

3.16. The Finance and Performance Committee seeks assurance over the delivery of 4 Board priorities in relation to Strategic Aim 5.

3.17. In relation to priority objective 5.3. *Community Diagnostic Hub Bid* this bid was prepared and delivered in summer 2021 and therefore is considered complete.

3.18. In relation to priority objective 5.5. *Develop our Pathology Offer* a business case relating to this has been approved at Board and this work continues. This objective was rated as partially assured (plans are in place with some risks to delivery).

3.19. In relation to priority objective 5.6 *Manufacture FFP3 Masks* work is being progressed by QE Facilities with international partners. Certification is anticipated by the end of March 2022, with the mask now including unique features, such as being able to be used during certain diagnostic procedures. Timescales have been elongated to ensure that opportunities in relation to this opportunity are maximised. This objective was rated as partially assured (plans are in place with some risks to delivery).

3.20. In relation to priority objective 5.7. *Make Effective Commercial Use of the QE Facilities' Washington Warehouse* this objective is considered to be achieved, as reported in the January 2022 update.

4. Solutions / recommendations and next steps

4.1. A process is commencing to review the year-end status of all objectives and link this to the development of the new corporate objectives for 2022/23 and beyond. This will involve determining priority areas and determining how to ensure that momentum is maintained on those areas which are not fully delivered at year-end (recognising that they may not be corporate objectives for 22/23 but this does not mean that progress will be halted).

4.2. The Board is requested to review the report and be assured that whilst there have been operational challenges impacting upon the delivery of the Board priorities, progress has been made against each of the 15 objectives. Where objectives are rated as amber, good progress has been made since the last Committee objective update, so whilst internal and external risks and pressures do represent a potential risk to future delivery, this has been managed to-date.

Board of Directors

Gateshead Health NHS Foundation Trust

Report Cover Sheet

Agenda Item: 12ii

Report Title:	Organisational Risk Register			
Name of Meeting:	Board of Directors			
Date of Meeting:	30 March 2022			
Author:	Kendra Marley, Corporate Risk Manager			
Executive Sponsor:	**Gill Findley, Chief Nurse**			
Report presented by:	**Gill Findley, Chief Nurse**			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☒	**Assurance:** ☒	**Information:** ☐
	To ensure the Board and Committees are clearly sighted on those risks that have an organisational -wide impact, the organisational risk register is compiled by the Executive Risk Management Group of those risks that impact on the delivery of strategic aims and objectives. This includes risks included within the Board Assurance Framework (BAF) as well as risks identified by the Group for inclusion as having an organisational impact and impact on delivery of strategic aims and objectives. The supporting report shows the risk profile of the ORR, includes a full register, and provides details of review compliance, and risk movements.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☒ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	The attached report is now received in the Executive Team Meeting each week, and monthly at the Executive Risk Management Group.			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety*	The register shows 1 closure, reducing the number of risks to 16. 1 risk has also been reduced. Risk 2961 – relating to recruitment delays due to systems and processes has been closed.			

<table>
<tr><td>

- *People and organisational development*
- *Governance and legal*
- *Equality, diversity and inclusion*

</td><td colspan="5">Risk 2963, relating to mandatory vaccination, has also been revised and reduced from 16 to 9.

Risk and action review compliance has dipped and will continue to be followed up.</td></tr>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="5">The Board are asked to:
• Review the risks and actions, discuss and seek further information relating to new/ reduced risks as appropriate and take assurance over the ongoing management of organisational risk.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
☒</td><td colspan="4">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☒</td><td colspan="4">We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3
☒</td><td colspan="4">We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4
☒</td><td colspan="4">We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5
☒</td><td colspan="4">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Trust corporate objectives that the report relates to:</td><td colspan="5">Each risk is linked to a corporate objective, see report.</td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
☐</td><td>Responsive
☐</td><td>Well-led
☒</td><td>Effective
☐</td><td>Safe
☐</td></tr>
<tr><td colspan="6">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks and DATIX reference)</td><td colspan="5">Included in report</td></tr>
<tr><td>Has a Quality and Equality Impact Assessment (QEIA) been completed?</td><td colspan="2">Yes
☐</td><td colspan="2">No
☐</td><td>Not applicable
☒</td></tr>
</table>

Organisational Risk Register

Executive Summary

To ensure the Board and Committees are clearly sighted on those risks that have an organisational -wide impact, the organisational risk register is compiled by the Executive Risk Management Group of those risks that impact on the delivery of strategic aims and objectives.

This includes risks included within the Board Assurance Framework (BAF) as well as risks identified by the Group for inclusion as having an organisational impact and impact on delivery of strategic aims and objectives.

The supporting report shows the risk profile of the ORR, includes a full register, and provides details of review compliance, and risk movements.

This report covers the period 7th February to 11th March (extraction date for this report).

Organisational Risk Register - Movements

Following last month's meeting there have been no additions or removals from the ORR, although 1 risk has been closed, and 1 reduced.

Risk 2961, relating to the risks of delays in recruitment as a result of the systems and processes in place, has been closed following the successful implementation and fully established TRAC system now in place.

Risk 2963, relating to mandatory vaccination, has been revised and reduced from 16 to 9. The risk has been reworded to reflect the current uncertainty regarding next steps in this evolving situation. The initial risk rating was reduced to reflect the changes, and as no steps are in place to address this risk due to the uncertainty while awaiting external decisions and actions, the current risk remains at a 9.

Risk and action review compliance has dipped and will continue to be monitored and followed up.

Recommendations

The Board are asked to:

- Review the risks and actions, discuss and seek further information relating to new/ reduced risks as appropriate and take assurance over the ongoing management of organisational risk.

Organisational Risk Register Report

07-Feb-2022 to 11-Mar-2022

Gateshead Health NHS Foundation Trust

Risk Profile (Current/Managed)

Competency - 1

POD 2765 - No Leadership and OD strategy in place across the trust resulting in failure to support our workforce (12)

Resources - 2

COO 2744 - Risk of low or inadequate staffing to operate effective and efficient service provision as a result of covid surge and response. (16)

POD 2764 - Workforce - Risk of not having the right people in right place at the right time with the right skills. (16)

Wellbeing - 1

POD 2759 - We are not able to appropriately support the health and wellbeing needs of our workforce (12)

Business Continuity - 1

IMT 1636 - UCRF R01/R03/R20/R23 - Malware such as Ransomware Compromising Unpatched Endpoints, Servers and Equipment (10)

Digital - 1

COO 2945 - Availability of Business Intelligence (12)

Finance - 2

FIN 2873 - Risk that the Trust is unable to form a suitable capital plan and programme due to reduced levels of CDEL available. (9)

FIN 2874 - Risk that we are unable to formulate a coherent financial plan due to undertainty surrounding the financial framework. (3)

Effectiveness - 2

COO 2869 - Unintended harm to patients, due to the impact of reduced services, delayed treatment and pathway starts (16)

MEDIC 2982 - Risk of delayed transfers of care and increased hospital lengths of stay (16)

Safety - 1

COO 2879 - Risks relating to the trusts Maternity estate that have the potential to impact on the delivery of safe maternity services (8)

Compliance - 3

NMQ 2779 - The Trust fails to meet the CQC Fundamental Standards. (12)

POD 2963 - Risk that uncertainty relating to next steps for covid vaccine for NHS staff - staff may leave roles/ employment (9)

CEOL2 2964 - There is a risk that there is insufficient and formal oversight on the 4 GP practices currently hosted by the trust (16)

Delivery of Objectives - 2

COO 2868 - Further waves of Covid may impact on the ability to deliver key performance targets and recovery plans (16)

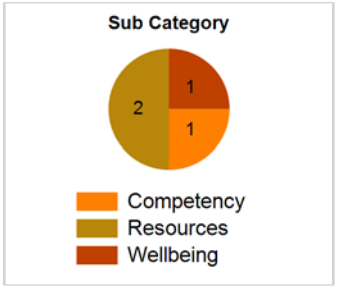
CEOL2 2880 - Risk that Place/ICS/ICP strategy and plans do not fully align with our objectives and aspirations to tackle health inequalities. (9)

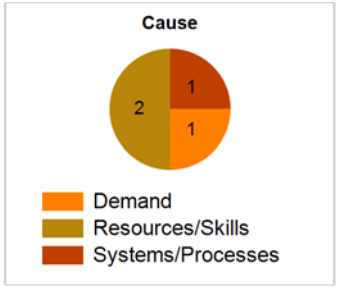
Organisational Risk Register Report

07-Feb-2022 to 11-Mar-2022

Gateshead Health NHS Foundation Trust

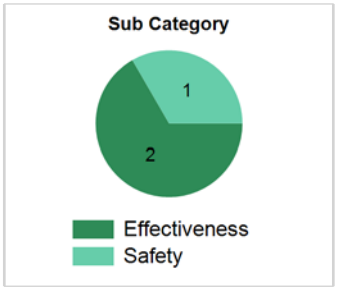
People & Resources

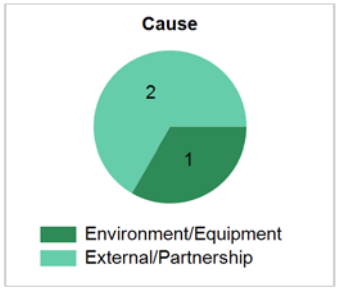




Risk Sub Cat	Risk Cause	No. Risks
Competency	Systems/Processes	1
Resources	Resources/Skills	2
Wellbeing	Demand	1

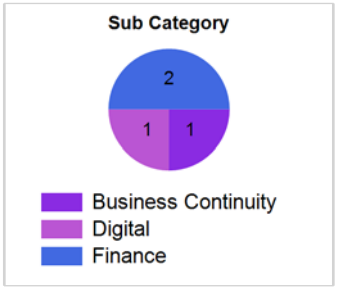
Quality Outcomes

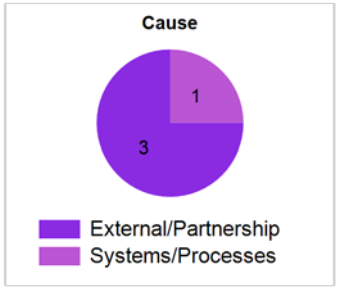




Risk Sub Cat	Risk Cause	No. Risks
Effectiveness	External/Partnership	2
Safety	Environment/Equipment	1

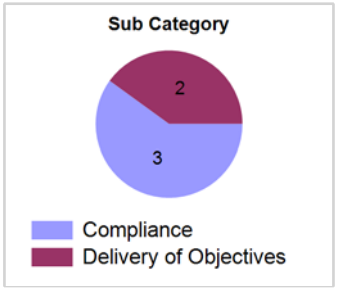
Finance & Efficiency

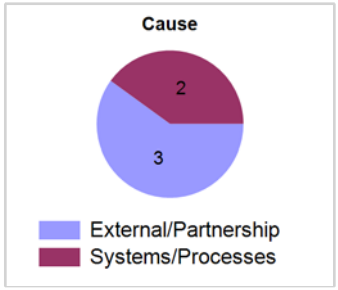




Risk Sub Cat	Risk Cause	No. Risks
Business Continuity	External/Partnership	1
Digital	Systems/Processes	1
Finance	External/Partnership	2

Regulation & Compliance, Reputation





Risk Sub Cat	Risk Cause	No. Risks
Compliance	External/Partnership	1
	Systems/Processes	2
Delivery of Objectives	External/Partnership	2

Organisational Risk Register Report

07-Feb-2022 to 11-Mar-2022

Gateshead Health NHS Foundation Trust

Organisational Risk Register (sorted by highest CRR and risk ID) - Current/Managed Risks

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR
2744 01/07/2020 Joanne Baxter Chief Operating Officer EPRR & Site Resilience 10/02/2022 BU_DIR ORG 3.8P Deliver the Operational transformation programme to improve productivity and efficiency of service delivery and recovery post covid	Risk of low or inadequate staffing to operate effective and efficient service provision, due to significant gaps in nursing, AHP's, Medics, and other staff groups, as a result of covid surge and response, resulting in service interruption, pathway delays, potential impact on patient safety, effectiveness and experience and staff safety and wellbeing.	20	1.Annual review and establishment of safe nursing staffing levels. 2.Safe staffing report (nursing)produced and forecasting robust. 3.Workforce bank in place (see linked risk) 4.Expanded Agency usage (process for approval) 5.Critical staff payment offer approved and in place. 6.Workforce absence etc captured via ESR/ healthroster 7.New operating model aligns staffing requirements to activity and service plans. 8. Volunteers - recruitment and use 9.Deployment Hub to improve use of available resources	16	active recruitment to vacancies	Lisa Crichton-Jones 31/03/2022	6
					Additional volunteers recruited and expanded use of roles.	Jane Conroy (Completed 13/12/2021)	
					Establish critical staff payment agreement - Exec approval	Amanda Venner (Completed 22/12/2021)	
					establish deployment hub	Amanda Venner (Completed 31/12/2021)	
					Support from CCG and LA to support surge response	Gillian Findley (Completed 31/12/2021)	
2764 17/11/2020 Natasha Botto People and OD Workforce Development 04/04/2022 BAF HRC ORG 2.3P Develop a trust wide approach to strategic workforce planning	Risk of not having the right people in right place at the right time with the right skills due to lack of workforce capacity, resources and expertise across the organisation to support workforce planning resulting in failure to deliver current and future services that are fit for purpose.	20	Task and finish group established to coordinate all strands of work relating to staffing International recruitment is progressing and is on track Domestic recruitment is being actively pursued and monitored Over recruiting to HCSW positions to fill some of the Registered Nurse vacancies RPIW scheduled March to look at the efficiency of the recruitment process. Refreshed dataset provided to The Whole System Partnership on 01 March 2022. (to enable workforce planning)	16	Workforce planning to be scoped and future resource identified.	Natasha Botto 22/04/2022	8

Organisational Risk Register Report

07-Feb-2022 to 11-Mar-2022

Business Intelligence

Gateshead Health NHS Foundation Trust

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR
2868 27/04/2021 Joanne Baxter Chief Operating Officer EPRR & Site Resilience 10/02/2022 BAF EPRR FPC ORG QGC 3.8P Deliver the Operational transformation programme to improve productivity and efficiency of service delivery and recovery post covid	Further waves of covid impact on the delivery of the new operating model and associated transformation plans therefore impacting on key performance and recovery plans	20	EPRR incident response and surge plans in place Reconfiguration from previous waves and learning applied. Workforce management plans in place and monitoring of staff absences available	16	De-escalation	Nicola Bruce 28/02/2022	6
					re-start of elective programme	Helen Routh 28/02/2022	
2869 27/04/2021 Helen Routh Chief Operating Officer EPRR & Site Resilience 10/02/2022 ORG 3.8P Deliver the Operational transformation programme to improve productivity and efficiency of service delivery and recovery post covid	There is a risk of unintended harm to patients, due to the impact of reduced service provision, delayed treatment and pathway starts as a result of Covid 19. This may Result in patients accessing treatment who are more unwell than otherwise would have been, longer stays in hospital and longer recovery periods	20	Detailed elective recovery plans have been developed Additional capacity is being facilitated to reduce waiting times Clear trajectory to reduce long waiters clinical review of those long waiters	16	delivery trajectory to address all 52 week waiters	Helen Routh 31/03/2022	8
					work with newly appointed public health consultant and gateshead system to determine health inequalities	Andrew Beeby 31/03/2022	
					deliver the planned and elective recovery transformation plan	Helen Routh 26/09/2022	
2964 28/10/2021 Jacqueline Bilcliff Chief Executive Office Chief Executive Office 17/02/2022 BU_DIR ORG 2.5 Strengthen approaches to people related quality, performance and governance measures	There is a risk that there is insufficient and formal oversight on the 4 GP practices currently hosted by the trust resulting in clinical, quality, financial and people risks not being sufficiently understood or mitigated against	16	Some informal oversight by Medical Director / Chief Nurse and COO.	16	Longer term strategy for primary care / GP practices under consideration.	Jacqueline Bilcliff 31/03/2022	6

Organisational Risk Register Report

07-Feb-2022 to 11-Mar-2022

Gateshead Health NHS Foundation Trust

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR
2982 06/12/2021 Amy Nesbit Medical Services Medical Services - Divisional Management 09/04/2022 BU_DIR ORG 3.8P Deliver the Operational transformation programme to improve productivity and efficiency of service delivery and recovery post covid	description: Increased risk of delay in transfer to community due to lack of social care provision and intermediate care beds. Risk of: patients remaining in hospital when medically optimised creating risk to these patients as well as other patients as bed capacity not able to meet demand. Due to: there is currently increased numbers of patients awaiting POC up to 30 patients in medical wards. This delay adds significant pressures to acute bed availability, escalation beds being required and significant risk of problems with flow through hospital impacting A&E breach standards and risk of patients being delayed within ambulances. Resulting in: patient harm or death, patients deconditioning and increased risk of failed discharge secondary to this. Staff health and wellbeing, job dissatisfaction and poor performance due to pressures.	20	Monitoring of Delayed transfers of care twice weekly meeting Escalation of delays of care to the community BU and social services at twice weekly meetings. Monitoring of any levels of harm - Datix incidents. Monitoring of Breach levels and times. Monitoring of Ambulance delays. Monitoring increased LOS of medically optimised patients. Escalation of patients requiring social services support raised weekly at Discharge Systems group which includes Social services management and CCG representative. Medically Optimised meeting 2x week, passed to IPC/CCG ECIST work Pilot on 2 wards re improving discharges.	16			9

Organisational Risk Register Report

07-Feb-2022 to 11-Mar-2022

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR
2759 16/11/2020 Amanda Venner People and OD Human Resources 04/04/2022 BAF HRC ORG 2.1P Establish a post covid health and well being programme to incorporate; The development of a hwb strategy, roll out of HWB conversations, the continuing arrangement for a Trust Testing Track & Trace & vaccine service and a review of the OH service	Risk that we are not able to appropriately support the health and wellbeing needs of our workforce due to insufficient capacity to support these needs resulting in backlog of Occupational Health work and slow turn around times for management referrals, counselling and proactive management of staff HWB. Resulting in reduced resilience levels low, with mental and physical health needs emerging, potentially resulting in higher levels of absence and turnover and safety incidents as well as an inability to deliver of the relevant HWB aspects of the NHS people plan.	16	HWB Programme team recruited and fully in place from June 2021 Occupational Health Service Manager appointed. Board HWB Guardian identified. Regional HWB established which GHNT is part of. Partnered with Talk Works to provide talking therapies and counselling services to reduce waiting times for counselling and psychological support services. Access to local and national resources. Occupational health referral systems(self referral and management referral)and process in place. HWB stalls set up to seek the views on HWB gaps/needs/wants/views of staff. Rebranding of HWB programme underway. Occupation Health external review completed, with improvement plan now being implemented. HWB "check ins" rolled out across the Trust. Ts and Vs Business case to extend Covid testing and tracing service to end March 2022 agreed. HWB initiatives received confirmation of ICS funding for Emotional Health and Wellbeing support for staff. Health and Wellbeing dashboard of early warning metrics established and discussed at the programme board, ops meetings and HRC health needs assessment in place.	12	Improved alignment with ICS HWB strategy to be developed	Lisa Crichton-Jones 31/03/2022 Amanda Venner 30/04/2022	8

Organisational Risk Register Report

07-Feb-2022 to 11-Mar-2022

Business Intelligence

NHS Gateshead Health NHS Foundation Trust

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR
2765 17/11/2020 Laura Farrington People and OD Workforce Development 04/04/2022 BAF HRC ORG 2.4P Develop a leadership and OD Strategy with clear outcomes	Risk that we have leaders in the organisation that do not demonstrate the Trust values and lead with an expected level of competence and that we do not invest in, develop and nurture leaders of the future due to no leadership and OD strategy being in place across the Trust resulting in a failure to support our workforce in the way we would strive to.	20	Interim Head of Workforce now appointed. OD practitioner support engaged via a contractor at present. OD practitioner post being recruited to on an fixed term basis. New Deputy Director of People and OD appointed with Leadership and OD experience. Leading Well at Gateshead' paper has been drafted and presented to SMT outlining the first stage to a stages approach to leadership development. Vision work currently underway. Focus group arranged with those who attended the joint Just Culture training within NEAS in 2019. Programme Board in place, met for 1st time 12/10/21. Appointed a substantive Head of Leadership, OD and staff engagement.	12	Pilot of the leading well programme	Laura Farrington 08/04/2022	8
					Initial roll out and review of the leading well programme	Laura Farrington 30/07/2022	
2779 01/07/2020 Jane Conroy Nursing, Midwifery & Quality Quality Governance 04/04/2022 BAF ORG QGC 1.10P Develop Route Map to CQC Outstanding	The Trust fails to meet the CQC Fundamental Standards resulting in potential regulatory action, harm to patients, decline in ratings, and resulting reputational damage.	16	CQC readiness action plan Inspection action plans Nursing Strategy and Safe Staffing planning & delivery Governance Framework Risk Management systems and processes Health & Safety Governance and processes NICE guidance governance processes Learning Disability Support processes Cancer Services delivery plans Scheduled audits of operational safety elements.	12	Ensure any areas of improvement from last inspection are in place	Jane Conroy 04/04/2022	6
					Develop a route map to Outstanding	Jane Conroy 04/04/2022	

Organisational Risk Register Report

07-Feb-2022 to 11-Mar-2022

Business Intelligence

NHS Gateshead Health NHS Foundation Trust

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR
2945 14/09/2021 Joanne Baxter Chief Operating Officer EPRR & Site Resilience 10/02/2022 BU_DIR ORG 3.8P Deliver the Operational transformation programme to improve productivity and efficiency of service delivery and recovery post covid	Risk of ineffective and inefficient management of services due to availability and access to appropriate and timely business intelligence to deliver and improve services	15	Programme of work established to work on improving access to BI and improve board reporting along with service line access to quality performance and workforce data Project Manager appointed to lead on this work with support from NECS. Programme involves 3 projects Static reporting – Look back - this is what we achieved Live reporting – this is how we are doing now and where we need to intervene to prevent poor performance Forecasting – these are the trends to be able to plan services much more effectively to meet demand the later two points need further development Some BI available in sitreps and excel format	12	• Work with the BU managers looking at what is available and start to build what is needed and get rid of what is not used/helpful	Debbie Renwick 31/01/2022	4
					• Improve data quality by working with teams and provide resilience to teams doing the RTT etc	Debbie Renwick 31/01/2022	
					• Assess what is currently available and set up in yellow fin under relevant business units	Michael Smith 31/03/2022	
					project groups established and PID developed and plans developed for delivery	David Thompson 04/04/2022	

Organisational Risk Register Report

07-Feb-2022 to 11-Mar-2022

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR
1636 10/11/2014 David Thompson Digital IT 07/06/2022 DIGC MDMG ORG	UCRF R01/R03/R20/R23 Malware such as Ransomware Compromising Unpatched Endpoints, Servers, Equipment or due to Lack of Hardened Build Standards. There is a risk of potential exposure to published critical cyber vulnerabilities. Laptops, workstations and medical devices compromised by ransomware or botnets, due to endpoints being susceptible to compromise through the use of obsolete, old, or unpatched operating systems and third party software, including Java. Endpoints often not monitored for patch status. Endpoints compromised more easily through dangerous browser plugins (such as Java, Flash), or unsupported browsers. Servers compromised by ransomware, due to servers susceptible to compromise through the use of obsolete, old, or unpatched operating systems and software. Servers often not monitored for patch status. Due to failure to maintain all Digital assets, including installing Operating system patches, AV patches or other software and hardware updates across the IT estate, including network equipment and medical devices. Resulting in potential harm to patients, data leaks, impacts on service delivery.	25	AV on all end points AV up to date ATP in place site wide NHSD & Microsoft group policy templates Ongoing updates routinely planned as they are released Patching regime	10	Manage replacement of End of life Network Hardware Complete Cyber Essential Plus Accreditation Develop comprehensive Cyber KPIs & IT Security Assurance Report	Jon Potts 31/03/2022 Jon Potts 31/05/2022 Dianne Ridsdale (Completed 18/01/2022)	5
2873 30/04/2021 Kris MacKenzie Finance Finance 31/03/2022 BAF FPC ORG 3.4P Develop an approved capital and revenue plan	Risk that the Trust is unable to form a suitable capital plan and programme Due to reduced levels of CDEL available and the management of capital within the ICS Resulting in the inability to fund capital requirements to meet the development needs of the Trust.	20	Approved Capital and Revenue Plan 2021/22 Additional funding is being made available centrally, which may impact on size of CDEL available	9			8

Organisational Risk Register Report

07-Feb-2022 to 11-Mar-2022

Gateshead Health NHS Foundation Trust

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR
2880 30/04/2021 Mr Andrew Beeby Chief Executive Office Medical Directorate 11/04/2022 BAF ORG QGC 4.3P Strong partner working at place, ICP, ICS levels and beyond to manage population health and tackle health inequalities - Appoint a consultant in Public Health jointly with LA & CCG	Risk that Place/ICS/ICP strategy and plans do not fully align with our objectives and aspirations to tackle health inequalities. Due to slightly different aims and objectives, or ways of doing things. Slow or no progress against health inequalities.	12	Being involved with ICS / ICP / Place in the development of work (co-production)	9			6
2963 28/10/2021 Amanda Venner People and OD Human Resources 30/06/2022 BU_DIR ORG 2.3P Develop a trust wide approach to strategic workforce planning	Risk that uncertainty relating to next steps for covid vaccine for NHS staff - staff may leave roles/ employment impacting on service delivery and further staff pressures/ wellbeing, impact on recruitment.	9	Current vaccination program and known % of staff vaccinated New recruits asked for vaccination status Current progress and project plan known Agreed process for discussing vaccination status, redeployment/ other options	9	Task and finish group to complete actions below	Laura Farrington 30/04/2022	4
2879 29/04/2021 Joanne Baxter Chief Operating Officer EPRR & Site Resilience 14/03/2022 BAF ORG QGC 1.1P Implementation of the recommendations of the Ockenden report on Maternity Services	There are risks relating to the trusts Maternity estate that have the potential to impact on the delivery of safe maternity services and the ability to satisfactorily address actions from local and national requirements (HSIB/ Ockenden/ Continuing Care/ Birthrate Plus.	12	Ockenden Compliance Report – Assurance Assessment tool see separate risks. Quality and safety of services monitored	8	Agree a plan to mitigate current risk	Kate Hewitson 29/04/2022	10
					Deliver the full project plan for a new maternity build in collabaration with QEF	Joanne Baxter 20/10/2022	

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR
2874 30/04/2021 Kris MacKenzie Finance Finance 31/03/2022 BAF FPC ORG 3.4P Develop an approved capital and revenue plan	Risk that we are unable to formulate a coherent financial plan, Due to there being a lack of guidance and great deal of uncertainty surrounding the financial framework for the second half of the financial year, Resulting in unclear financial position and plan in year, impacting financial decisions, and unknown financial trajectory for full year.	20	Financial report regularly to F&P and Board.	3			8
							16

Changes in CRR - Current/Managed Risks

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR	Latest Progress Note	PRR
2963 28/10/2021 Amanda Venner People and OD Human Resources 30/06/2022 BU_DIR ORG 2.3P Develop a trust wide approach to strategic workforce planning	Risk that uncertainty relating to next steps for covid vaccine for NHS staff - staff may leave roles/ employment	9	Current vaccination program and known % of staff vaccinated New recruits asked for vaccination status Current progress and project plan known Agreed process for discussing vaccination status, redeployment/ other options	9	Task and finish group to complete actions below	Laura Farrington 30/04/2022	4	Risk updated to reflect the current uncertain position around vaccination as a condition of employment/ link to professional registration.	16
									1

Risks Moved to Managed in Period

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR
							0

Risks Closed in Period

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due / (Open Actions)	TRR	Closure Details	PRR
2961 25/10/2021 Rebekah Coombes People and OD Human Resources 07/02/2022 BU_DIR ORG 2.5 Strengthen approaches to people related quality, performance and governance measures	Risk to delays in recruitment due to increased activity and implementation of a new system	16	Team in place. Additional capacity from Workforce 1 and Audit 1 to assist Additional scrutiny by head of People Services TRAC system fully implemented	6			6	systems fully in place. Any delays due to volume of activity.	12
									1

Risks Added in Period

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR	Latest Progress Note / Date Added to ORR

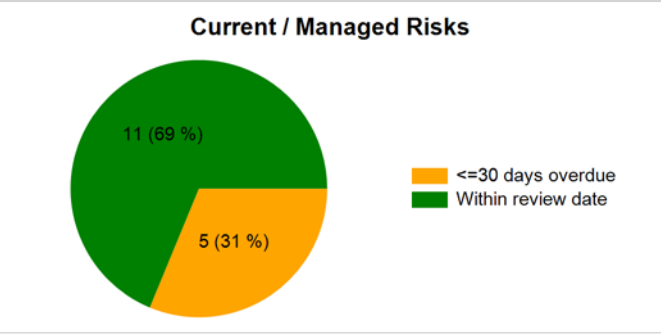
0

Risks Removed in Period

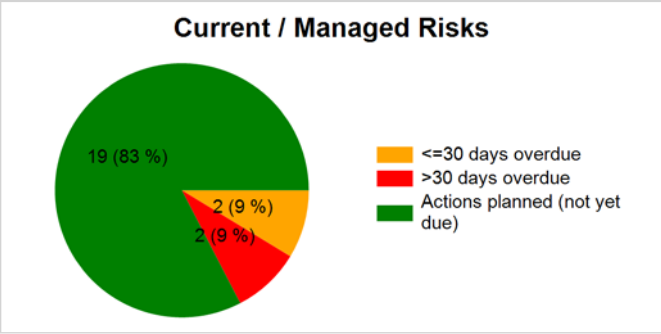
Risk ID / Date Identified	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR	Latest Progress Note / Date Removed from ORR
Handler BU Service Line Next Review Date BAF / Risk Register Objectives								

0

Risk Review Compliance



Risk Action Compliance



Movements in CRR

				CRR											
BU	Service Line	ID	Risk Description	Apr-2021	May-2021	Jun-2021	Jul-2021	Aug-2021	Sep-2021	Oct-2021	Nov-2021	Dec-2021	Jan-2022	Feb-2022	Today
Chief Executive Office	Chief Executive Office	2964	There is a risk that there is insufficient and formal oversight on the 4 GP practices currently hosted by the trust							16	16	16	16	16	16
	Medical Directorate	2880	Risk that Place/ICS/ICP strategy and plans do not fully align with our objectives and aspirations to tackle health inequalities.		9	9	9	9	9	9	9	9	9	9	9

Organisational Risk Register Report

07-Feb-2022 to 11-Mar-2022

Business Intelligence

NHS Gateshead Health NHS Foundation Trust

				CRR											
BU	Service Line	ID	Risk Description	Apr-2021	May-2021	Jun-2021	Jul-2021	Aug-2021	Sep-2021	Oct-2021	Nov-2021	Dec-2021	Jan-2022	Feb-2022	Today
Chief Operating Officer	EPRR & Site Resilience	2744	Risk of low or inadequate staffing to operate effective and efficient service provision as a result of covid surge and response.	12	12	12	12	12	12	12	12	12	16	16	16
		2868	Further waves of Covid may impact on the ability to deliver key performance targets and recovery plans	12	12	12	12	12	12	12	9	9	16	16	16
		2869	Unintended harm to patients, due to the impact of reduced services, delayed treatment and pathway starts	16	16	16	16	16	16	16	16	16	16	16	16
		2879	Risks relating to the trusts Maternity estate that have the potential to impact on the delivery of safe maternity services		15	15	15	15	15	15	15	15	15	8	8
		2945	Availability of Business Intelligence						16	16	16	16	16	12	12
Digital	IT	1636	UCRF R01/R03/R20/R23 - Malware such as Ransomware Compromising Unpatched Endpoints, Servers and Equipment	10	10	10	10	10	10	10	10	10	10	10	10
Finance	Finance	2873	Risk that the Trust is unable to form a suitable capital plan and programme due to reduced levels of CDEL available.		16	16	16	16	16	9	9	9	9	9	9
		2874	Risk that we are unable to formulate a coherent financial plan due to undertainty surrounding the financial framework.		16	16	16	16	16	16	16	16	3	3	3
Medical Services	Medical Services - Divisional Management	2982	Risk of delayed transfers of care and increased hospital lengths of stay									16	16	16	16
Nursing, Midwifery & Quality	Quality Governance	2779	The Trust fails to meet the CQC Fundamental Standards.	12	12	12	12	12	12	12	12	12	12	12	12
People and OD	Human Resources	2759	We are not able to appropriately support the health and wellbeing needs of our workforce	16	12	12	12	12	12	12	12	12	12	12	12
		2963	Risk that uncertainty relating to next steps for covid vaccine for NHS staff - staff may leave roles/ employment							12	12	12	16	16	9
	Workforce Development	2764	Workforce - Risk of not having the right people in right place at the right time with the right skills.	25	16	16	16	16	16	16	16	16	16	16	16

Organisational Risk Register Report

07-Feb-2022 to 11-Mar-2022

Gateshead Health NHS Foundation Trust

				CRR											
BU	Service Line	ID	Risk Description	Apr-2021	May-2021	Jun-2021	Jul-2021	Aug-2021	Sep-2021	Oct-2021	Nov-2021	Dec-2021	Jan-2022	Feb-2022	Today
People and OD	Workforce Development	2765	No Leadership and OD strategy in place across the trust resulting in failure to support our workforce	20	16	16	16	16	16	12	12	12	12	12	12

NHS
Gateshead Health
NHS Foundation Trust

Report Cover Sheet Agenda Item: 13

Report Title:	**NHS Staff Survey 2021: Trust Board Update**			
Name of Meeting:	Trust Board			
Date of Meeting:	30 March 2022			
Author:	Laura Farrington (Head of Leadership, OD & Staff Experience)			
Executive Sponsor:	Lisa Crichton-Jones (Executive Director of People & OD)			
Report presented by:	Lisa Crichton-Jones (Executive Director of People & OD)			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☒
	Share the 2021 Staff Survey results with the Board for information and assurance of next steps.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	N/A			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	1. As a Trust we are either in line with or have exceeded the average scores of our benchmarking group in all but one of the People Promise & Theme results. Some positive areas include: • We saw an increase of 7.5% in completion, with 46.5% colleagues completing the 2021 survey. • 80% colleagues agreed that the care of patients and services users is the organisations top priority. • 65% colleagues would recommend our organisation as a place to work. • We are Compassionate & Inclusive, scored significantly higher than the sector average at 7.37 2. We Are Always Learning, people promise theme, showed a below average score of 5.1 out of 10.			

	3. We have seen a drop in both our Staff Engagement and Morale scores this year with Advocacy and Work Pressure respectively showing the most significant drop. 4. We have scored significantly better than 2020 in 2 questions and significantly worse in 20 questions. 5. Those questions that showed the largest negative variance from 2020 suggest high levels of presentism, concerns with supply, negative impacts on morale and limited opportunities for flexible working. 6. Those questions that relate directly to our WRES and WDES, which have shown the most significant change, surround incidences and reporting of harassment and bullying. Next steps include communicating results with key stakeholder groups, engaging with colleagues across the organisation to understand the story behind the data and working with teams and departments to develop plans for the taking the results forward and ensuring they make a difference to the working lives for colleagues at Gateshead.				
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	Receive the report for information and assurance of action.				
Trust Strategic Aims that the report relates to:	**Aim 1** ☒	We will continuously improve the quality and safety of our services for our patients			
	Aim 2 ☒	We will be a great organisation with a highly engaged workforce			
	Aim 3 ☐	We will enhance our productivity and efficiency to make the best use of resources			
	Aim 4 ☐	We will be an effective partner and be ambitious in our commitment to improving health outcomes			
	Aim 5 ☐	We will develop and expand our services within and beyond Gateshead			
Trust corporate objectives that the report relates to:					
Links to CQC KLOE	Caring ☒	Responsive ☒	Well-led ☒	Effective ☒	Safe ☒
Risks / implications from this report (positive or negative):					
Links to risks (identify significant risks and DATIX reference)					
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒		

NHS Staff Survey 2021: Trust Board Update

1. A Look Back

Following the publication of the 2020 Annual Staff Survey results a number of key Trust priorities were identified and were overseen by the Staff Survey Steering Group. The group was formed in direct response to the ask from colleagues to be more closely involved in the survey process and, having now been in operation for 12 months, has recently undergone an internal review to ensure it remains effective, representative and of value. The priorities for 2021 were to:

- Increase engagement and completion of the Annual Staff Survey
- Create a culture where staff feel safe to raise concerns and speak up.
- Increase support for line managers to ensure they have the knowledge and skills needed to effectively lead their team.
- Support a compassionate and inclusive culture that promotes equality, diversity and inclusion.

Increase engagement and completion of the Annual Staff Survey
Our approach to engaging colleagues with the 2021 survey aligned with the 7 themes of the People Promise and included a programme of communication and engagement activities developed in partnership with our operational colleagues, staff side partners, Staff Networks, Health & Wellbeing team, and Communication leads. This programme aimed to raise awareness and increase completion and included:

- Increased use of paper surveys to increase accessibility for patient facing colleagues.
- Weekly articles shared with colleagues that focused on promoting the 7 aspects of the People Promise.
- On-site Staff Survey Hubs where colleagues could either post their paper survey or complete their electronic survey.
- Incentives to take part including café vouchers, branded cupcakes, entry into individual and team prize draws.
- The Staff Survey Steering Group continued to meet throughout and review progress and consider additional ways of engaging hard-to-reach groups.
- A significant amount of social media activity took place, with high levels of engagement.

The impact of this was a completion rate of 47%, compared with 39% in 2020. 47% also exceeded the median response rate for our benchmarking group, Acute & Acute Community Trusts, which was 46% across 126 organisations.

Create a culture where staff feel safe to raise concerns and speak up.
Following the publication of the 2020 staff survey results we ran a series of workshops with colleagues where we invited them to come along and share their thoughts, insights and ideas with us in more detail. These workshops focused on areas such as communication, line manager support, inclusivity and health and wellbeing and the outcomes helped to shape our approach.

An increased focused on creating a psychologically safe workplace with the creation of Freedom to Speak Up Champions (FTSU), Cultural Ambassadors, Health & Wellbeing leads, a review of the FTSU service, a renewed focus on Human Factors and closer partnerships between People & OD and our Staff Networks have all contributed to an increase in the number of colleagues who report that they would feel safe to raise concerns.

Increase support for line managers to ensure they have the knowledge and skills needed to effectively lead their team.
The need to increase line manager support was clear from the 2020 survey results and in response we have a new Managing Well programme being piloted, aimed at supporting line managers with their day-to-day responsibilities. Leading Well is also underway, with a range of initiatives aimed at developing our leaders and providing a safe space to discuss key issues and our coaching and mentoring offer is currently being relaunched.

Support a compassionate and inclusive culture that promotes equality, diversity and inclusion.
In November 2021, we had the pleasure of virtually welcoming Professor Michael West CBE to Gateshead and listening to him share his thoughts and insights on the importance of leading with compassion, as well as the part that self-compassion plays in our ability to do this. This has been followed by a development programme delivered in partnership with Levati Learning for both our Executive and senior management teams whilst we finalise the content of our 3 day, Leading Well course which will be delivered to leaders across the Trust in 2022. We have also launched a new monthly newsletter, 'Main Stage', for people managers across Gateshead and the POD senior management team continue to work closely with our EDI Lead and Network Chairs to support the ongoing inclusivity agenda.

2. The Results

The 2021 NHS Staff Survey has had a complete redesign. with a number of key changes. From 2021 onwards the questions within the NHS Staff Survey will be aligned to the People Promise, with the aim of focusing on those things that NHS colleagues have confirmed would most improve their working experience. There has also been the addition of 32 new questions and, as an organisation; we also added a number of bespoke Health & Wellbeing questions this year.

The results of the NHS Staff Survey are now measured against the seven People Promise elements, as well as two of the themes reported in previous years, namely Staff Engagement and Morale. The reporting also includes new sub-scores, which feed into the People Promise elements and themes.

We received our full organisational benchmarking report in February 2022, with the results embargoed until 30 March 2022 when they will be published nationally. We have begun sharing these with key internal stakeholder groups and this paper, along with the full

benchmark report and accompanying slides highlights key findings from this year's data and proposed next steps.

2.1 People Promise & Theme Level

As a Trust we are either in line with or have exceeded the average scores of our benchmarking group in all but one of the People Promise & Theme results. *We Are Always Learning* showed a below average score of 5.1 out of 10 and correlates with a number of responses relating to opportunities for career progression and development. Whilst it is likely this has been impacted by the availability of opportunities as a result of the pandemic, it is a key area of focus for us this year, with a number of pivotal development programmes in early pilot stages.

We have seen a drop in both our Staff Engagement and Morale scores this year with Advocacy and Work Pressure respectively showing the most significant reduction. Whilst an impact on feelings of work pressure could be expected given the working environment that colleagues have experienced over the last 12 months, a drop in Advocacy is an area of interest and relates closely to how engaged colleagues are with the organisation and their reflections on both the staff and patient experience. We will be focusing closely on this metric, particularly at a team level, to understand thoughts and concerns in more detail and determine those things that will make the most difference to the colleague's experiences and perceptions of the organisation.

2.2 Question Level

When considering our results at a question level we can see that we have scored significantly better than 2020 in 2 questions, specifically in the area of feeling confident and safe to raise concerns. This is encouraging and suggests the increased focus on creating a physiologically safe culture is being felt by colleagues. This is only the start of this work, which will progress to include the introduction of a Just & Restorative Culture within the organisation over the coming 12 months, which it is hoped with strengthen this further.

We can also see that we scored significantly worse than 2020 in 20 questions and when we look at those 5 of the 20 that showed the largest variance the themes suggest high levels of presentism, concerns with supply, negative impacts on morale and limited opportunities for flexible working. Whilst the data shows that there is a similar picture across the sector there are things that we can do at an organisational level to address these. Supply, flexible working opportunities and the effective management of absence are all current priorities for the organisation and work is underway in all areas. When we also consider those areas that indicate a drop in engagement and morale, it is hoped that work focused on these contributing factors will have a positive impact.

2.3 Workforce Equality Standards

Those questions that relate directly to our WRES and WDES, which have shown the most significant change, surround incidences of harassment and bullying. The data suggests that an increased number of colleagues with a long term condition or illness have experienced harassment and bullying from patients or service users, which is of concern. However, the number of colleagues feeling confident to report these instances has increased, which is encouraging and aligns with other data trends we have seen throughout the report.

This worrying trend is mirrored with an increased number of BME colleagues also experiencing harassment and bullying from patients or service users and will be explored further in the work we do surrounding the creation of a psychologically safe place to work.

3. Next Steps

Our ability to benchmark more widely, across our comparator group, will be possible once the results are published on 30 March however, based on the indicative comparison provided by Quality Health our data is largely in line with our benchmarking group. The drop in some key metrics however, including engagement and morale require further attention, as does the increase in bullying, harassment and abuse experienced by colleagues at work, will be explored at both an organisational and business unit level.

Key areas of focus identified by Quality Health also include a focus on appraisal, particularly amongst more hard to reach groups and increased transparency around development and career progression pathways. This feeds into our commitment regarding the *We are always Learning* People Promise, where we scored the lowest, and the work underway to develop our colleagues through targeted development opportunities based on their current role and aspirations. This will be supported by the appraisal review currently underway, which will include an informal talent management check-in, aligned with the national direction and focusing on individuals next steps.

Over the coming weeks we will continue to communicate the results both across the Trust and to key stakeholder groups specifically. This will be in addition to bespoke, partnership working between our People and OD teams and Business Units to understand those factors, at a local level, that have informed this data and support teams to develop their newly designed People Action Plan. The People Action Plan will be designed around the 7 People Promises and will be informed by a range of information including the staff survey, pulses survey, people metrics and local anecdotal information.

We will also develop, for the first time, a Psychological Safety Dashboard to bring together the data from those questions that directly impact on how psychologically safe colleagues feel. Psychological safety can be described as “a shared belief held by members of a team that the team is safe for interpersonal risk taking” and will include questions such as ‘My immediate manager is interested in listening to me when I describe challenges I face’, ‘I think that my organisation respects individual differences (e.g. cultures, working styles, backgrounds, ideas, etc)’ and ‘The people I work with are polite and treat each other with respect.’ It is hoped that this targeted analysis will help to highlight those specific areas where targeted support and intervention will be key.

Gateshead Health
NHS Foundation Trust

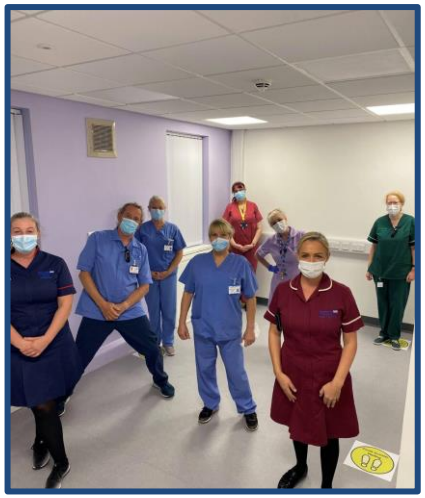
NHS Staff Survey 2021 Results

Board Overview

Quality and excellence in health

Gateshead Family 2021

NHS
Gateshead Health
NHS Foundation Trust



Quality and excellence in health

Looking Back - 2021

NHS
Gateshead Health
NHS Foundation Trust

NHS STAFF SURVEY 2021 - 5PM DEADLINE:

Over the past couple of months you've told us in your own words how we live the NHS People Promise here at Gateshead. Below you'll see examples in each of the seven promises, along with the words that featured most when we asked you: 'What does it mean to be part of the Gateshead Family?'

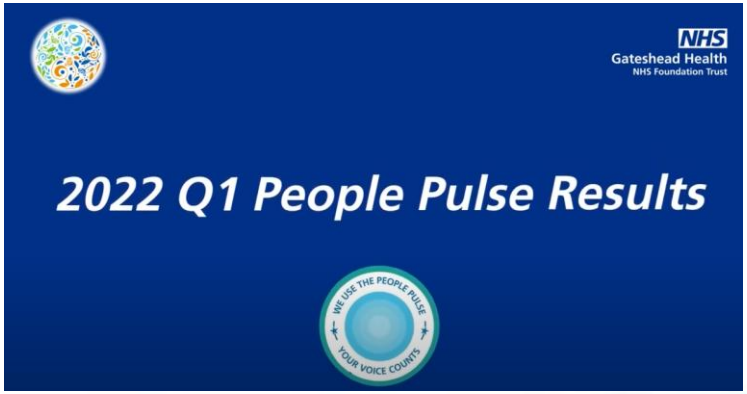
We'd like to thank everyone who has taken part in the Staff Survey this year, whether by participating or going above and beyond to help us promote it by getting involved our campaigns and/or sharing your thoughts with the rest of the **#GatesheadFamily**.

Our HR and OD team have been busy out hand-delivering the 2021 NHS Staff Survey to all of the teams that opted for paper surveys this year 📪

Deliveries are now complete, so please check in with your manager if you haven't already got your survey, or check your inbox for a digital copy.

Please take 10 minutes to complete your survey and help us drive change. We will listen, we will hear and we will act. This is our promise to you 💙

If you've not received your online or paper survey by this Friday, please get in touch immediately via email on ghnt.staffsurvey-gateshead@nhs.net or by calling Quality Health on freephone 0800 783 1775.



People Pulse Results Video

Quality and excellence in health

LEADING Well

NHS
Gateshead Health
NHS Foundation Trust

Compassionate and Inclusive Leadership

Hello everyone,

Firstly, thank you to all of you who were able to join our Compassionate & Inclusive Leadership Masterclass with Prof Michael West a few weeks ago. I don't know about you but I have found myself quoting, reflecting and considering so many of the insights he shared and am sure I will continue to do so for quite some time to come.

The Main Stage

Must-See Development News for our People Managers

Hi People Managers,

Welcome to The Main Stage, our new monthly newsletter for people managers across Gateshead Health. Within The Main Stage you'll find all the 'must-see' development news and opportunities including important updates, useful resources, events and new ways for you to connect with both your internal and external manager networks.

In this months newsletter, you'll find:

- **Coaching** at Gateshead Update
- **Rest and Restore** Spaces for Senior Leaders
- Join us in **Conversation Corner**
- Compassionate and Inclusive Leadership **Events Calendar**
- **Leadership Opportunities**
- **People Pulse** Results
- Main Stage **Giveaway**

Managing Well

Quality and excellence in health

2021 Trust Survey Response

Gateshead Health
NHS Foundation Trust

Organisation details

Completed questionnaires	1,873
2021 response rate	47%

See response rate trend for the last 5 years

Survey details

Survey mode	Mixed
Sample type	Census

This organisation is benchmarked against:

Acute and Acute & Community Trusts

2021 benchmarking group details

Organisations in group: **126**

Median response rate: **46%**

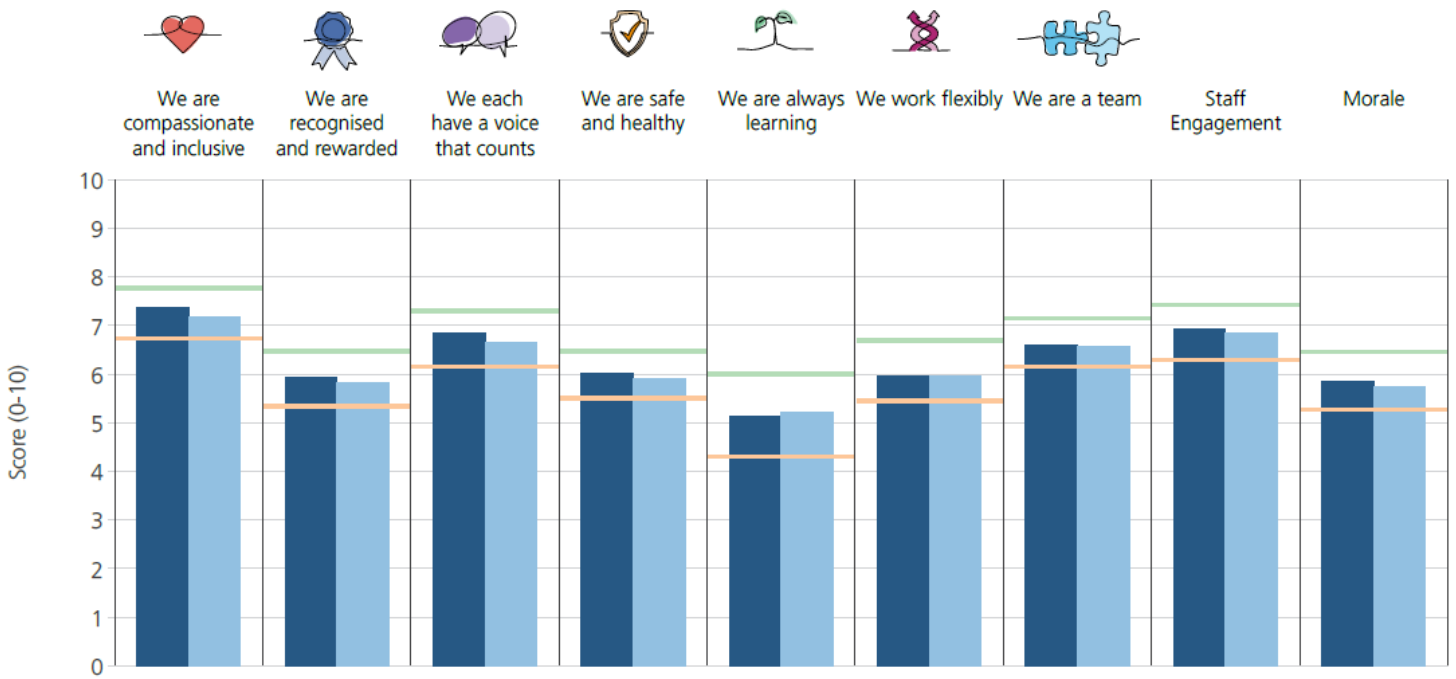
No. of completed questionnaires: **444,326**

***2020 Response Rate was 39%**

Quality and excellence in health

Overview
People Promise & Theme Results

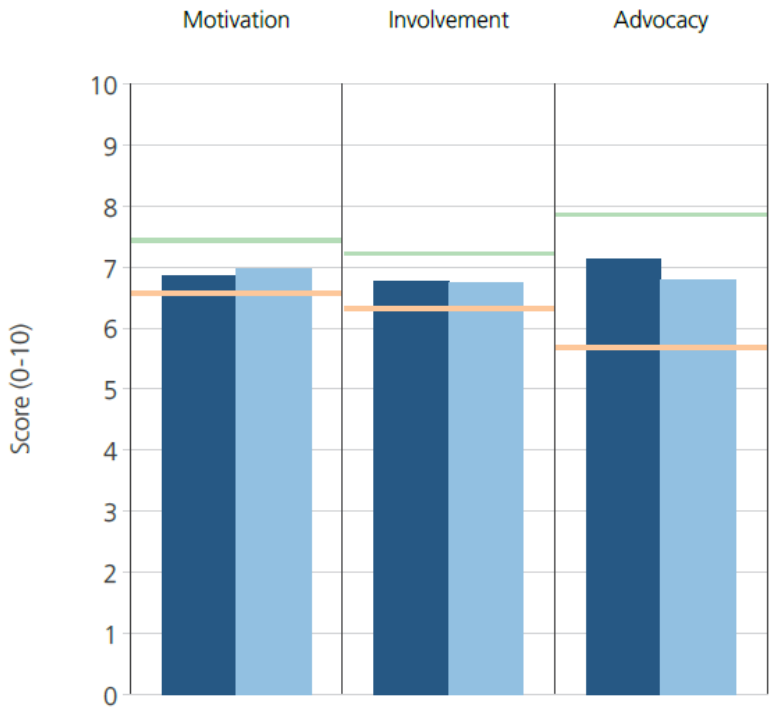
Gateshead Health
NHS Foundation Trust



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Best	7.8	6.5	7.3	6.5	6.0	6.7	7.1	7.4	6.5
Your org	7.4	5.9	6.9	6.0	5.1	6.0	6.6	6.9	5.9
Average	7.2	5.8	6.7	5.9	5.2	5.9	6.6	6.8	5.7
Worst	6.7	5.3	6.1	5.5	4.3	5.4	6.2	6.3	5.3
Responses	1,872	1,862	1,843	1,850	1,766	1,855	1,867	1,869	1,870

Staff Engagement

NHS
Gateshead Health
NHS Foundation Trust



	Motivation	Involvement	Advocacy
Best	7.4	7.2	7.9
Your org	6.9	6.8	7.1
Average	7.0	6.7	6.8
Worst	6.6	6.3	5.7
Responses	1,852	1,869	1,866

Advocacy
Scored Significantly Worse than 2020

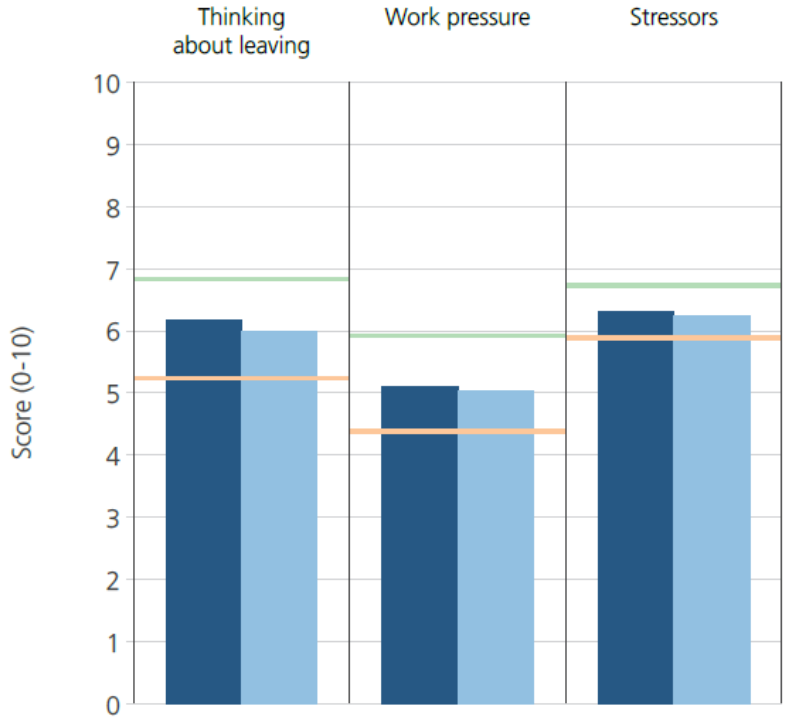
Gateshead Health
NHS Foundation Trust

	2021 Score	2020 Score	Diff
Motivation	6.86	7.14	-0.28 (Not sig.)
Involvement	6.75	6.83	-0.08 (Not sig.)
Advocacy	7.13	7.46	-0.33 (Sig.)
Overall Staff Engagement	6.91	7.14	-0.23 (Not sig.)

		2021		2020
Subscore 3 - Advocacy		7.46	Significantly Declined	7.13
21a.	Care of patients / service users is my organisation's top priority.	84%	Significantly Declined	80%
21c.	I would recommend my organisation as a place to work.	71%	Significantly Declined	65%
21d.	If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.	80%	Significantly Declined	75%

Morale

Gateshead Health
NHS Foundation Trust



	Thinking about leaving	Work pressure	Stressors
Best	6.8	5.9	6.7
Your org	6.2	5.1	6.3
Average	6.0	5.0	6.2
Worst	5.2	4.4	5.9
Responses	1,862	1,866	1,865

Work Pressures
Scored Significantly Worse than 2020

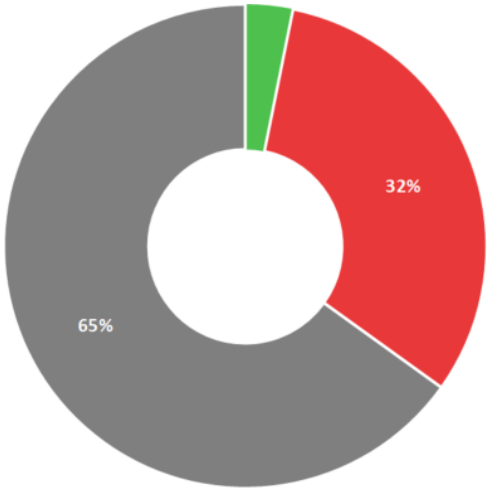
Gateshead Health
NHS Foundation Trust

	2021 Score	2020 Score	Diff
Thinking about leaving	6.16	6.44	-0.27 (Not sig.)
Work pressure	5.09	5.56	-0.47 (Sig.)
Stressors (HSE index)	6.30	6.44	-0.15 (Not sig.)
Morale	5.85	6.14	-0.29 (Not sig.)

	2021		2020
Subscore 2 - Work pressure	5.56	**Significantly Declined**	5.09
3g. I am able to meet all the conflicting demands on my time at work.	48%	**Significantly Declined**	42%
3h. I have adequate materials, supplies and equipment to do my work.	63%	Not Significant	61%
3i. There are enough staff at this organisation for me to do my job properly.	37%	**Significantly Declined**	26%

Question Level Overview

Gateshead Health
NHS Foundation Trust

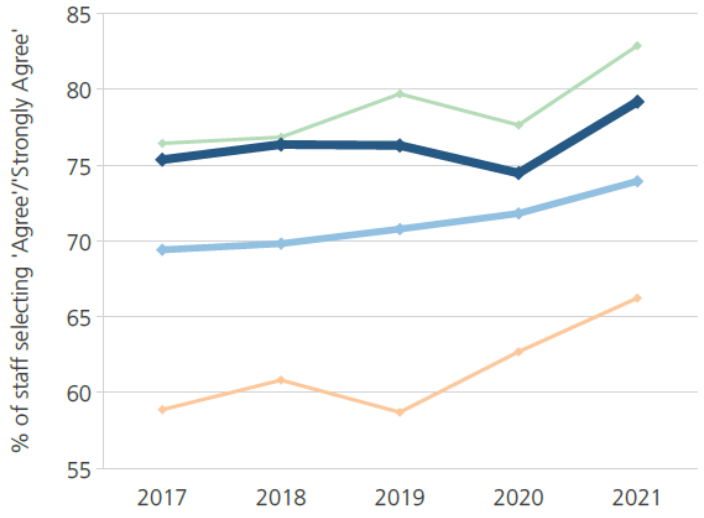


- 2 (3%) question(s) scored significantly better than in 2020
- 20 (32%) question(s) scored significantly worse than in 2020
- 41 (65%) question(s) showed no significance in relation to the 2020 score or score is suppressed

Scored Significantly Better than 2020 (17a & 17b)

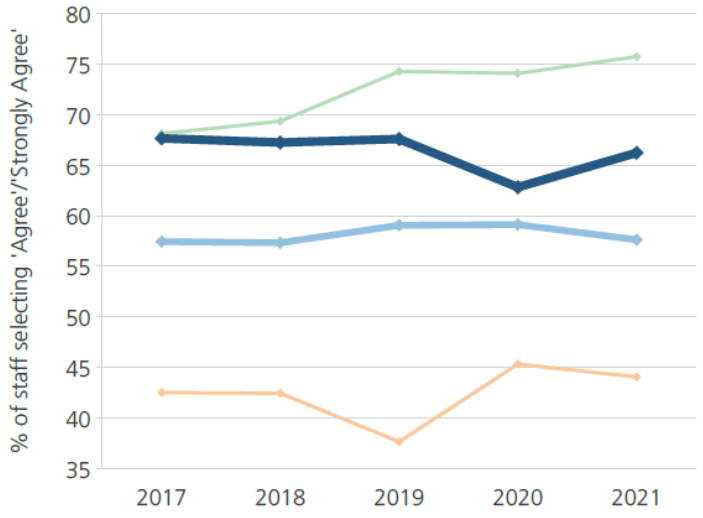
Gateshead Health
NHS Foundation Trust

Q17a
I would feel secure raising concerns about unsafe clinical practice



	2017	2018	2019	2020	2021
Best	76.4%	76.9%	79.7%	77.7%	82.9%
Your org	75.4%	76.4%	76.3%	74.5%	79.2%
Average	69.4%	69.8%	70.8%	71.8%	73.9%
Worst	58.9%	60.8%	58.7%	62.7%	66.2%
Responses	1,555	1,398	1,536	1,499	1,855

Q17b
I am confident that my organisation would address my concern



	2017	2018	2019	2020	2021
Best	68.1%	69.4%	74.3%	74.1%	75.7%
Your org	67.7%	67.3%	67.6%	62.8%	66.2%
Average	57.4%	57.3%	59.1%	59.1%	57.6%
Worst	42.5%	42.4%	37.6%	45.3%	44.1%
Responses	1,554	1,393	1,537	1,499	1,850

Significantly worse scores from 2020 have been recorded in 20 areas in total

Gateshead Health NHS Foundation Trust

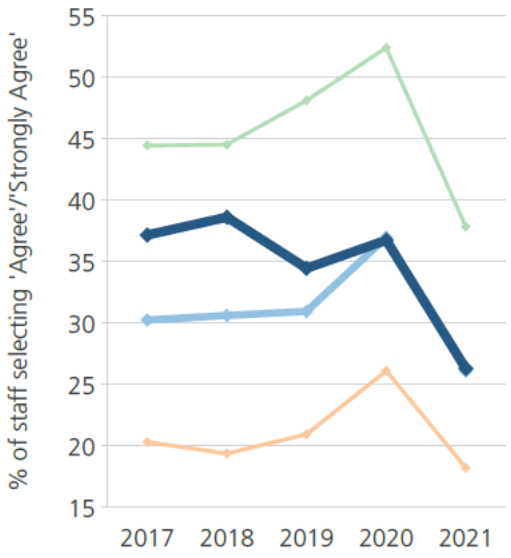
Significant Questions (bottom 5)	2021	2020
In the last three months I have come to work despite not feeling well enough to perform my duties.	56%	↑ +12.1%
There are enough staff at this organisation for me to do my job properly.	26%	↓ -10.5%
I look forward to going to work.	50%	↓ -7.5%
I would recommend my organisation as a place to work.	65%	↓ -6.1%
I am satisfied with the opportunities for flexible working patterns.	52%	↓ -5.8%

Scored Significantly Worse than 2020

Significant Questions (bottom 5)

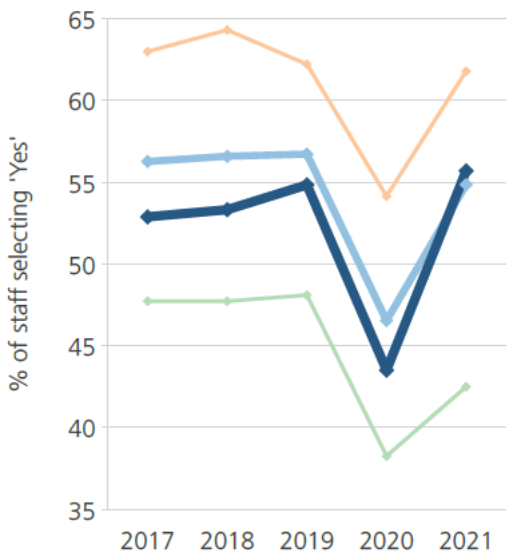
Gateshead Health
NHS Foundation Trust

Q3i
There are enough staff at this organisation for me to do my job properly



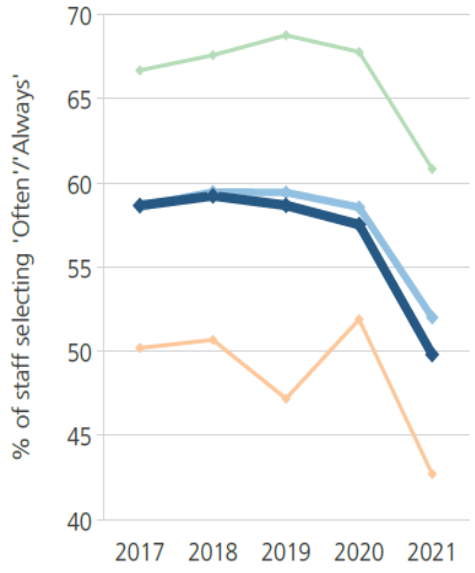
	2017	2018	2019	2020	2021
Best	44.4%	44.5%	48.1%	52.4%	37.8%
Your org	37.1%	38.6%	34.4%	36.7%	26.2%
Average	30.2%	30.6%	30.9%	36.9%	26.0%
Worst	20.3%	19.3%	20.9%	26.1%	18.2%
Responses	1,565	1,403	1,555	1,495	1,862

Q11d
In the last three months have you ever come to work despite not feeling well enough to perform your duties?



	2017	2018	2019	2020	2021
Worst	63.0%	64.3%	62.2%	54.2%	61.8%
Your org	52.9%	53.3%	54.8%	43.5%	55.7%
Average	56.3%	56.6%	56.7%	46.5%	54.9%
Best	47.7%	47.7%	48.1%	38.3%	42.5%
Responses	1,556	1,399	1,539	1,498	1,854

Q2a
I look forward to going to work



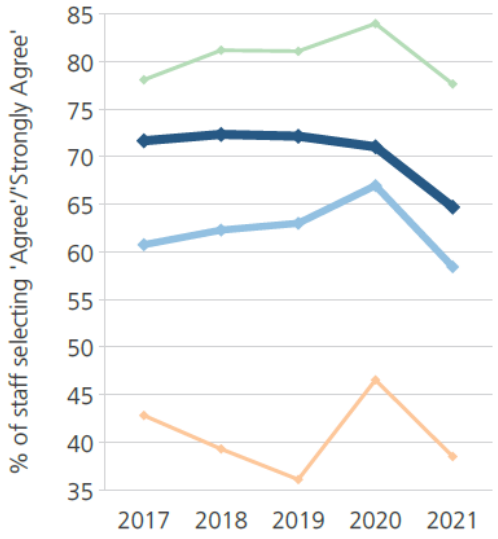
	2017	2018	2019	2020	2021
Best	66.7%	67.6%	68.8%	67.8%	60.8%
Your org	58.7%	59.2%	58.7%	57.5%	49.8%
Average	58.6%	59.5%	59.4%	58.6%	52.0%
Worst	50.2%	50.7%	47.2%	51.9%	42.7%
Responses	1,568	1,407	1,558	1,496	1,861

Scored Significantly Worse than 2020

Significant Questions (bottom 5)

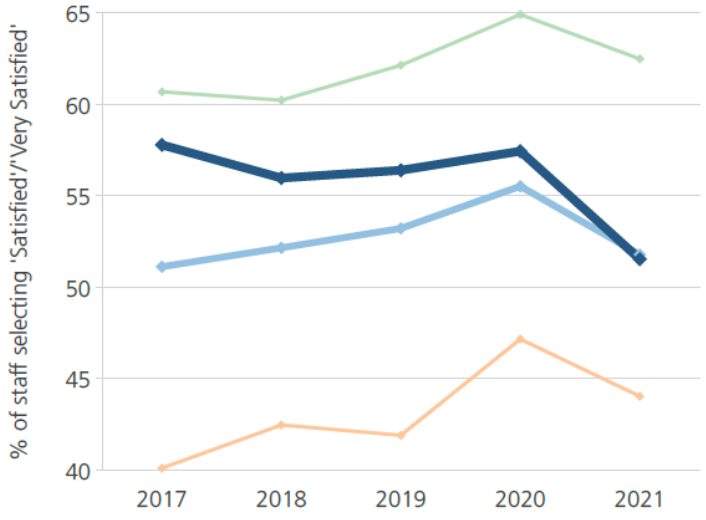
Gateshead Health NHS Foundation Trust

Q21c
I would recommend my organisation as a place to work



	2017	2018	2019	2020	2021
Best	78.1%	81.2%	81.1%	84.0%	77.6%
Your org	71.7%	72.4%	72.2%	71.0%	64.7%
Average	60.8%	62.3%	63.0%	67.0%	58.4%
Worst	42.8%	39.3%	36.1%	46.5%	38.5%
Responses	1,535	1,389	1,528	1,497	1,860

Q4d
The opportunities for flexible working patterns



	2017	2018	2019	2020	2021
Best	60.7%	60.2%	62.1%	64.9%	62.5%
Your org	57.8%	56.0%	56.4%	57.4%	51.5%
Average	51.1%	52.1%	53.2%	55.5%	51.8%
Worst	40.1%	42.5%	41.9%	47.2%	44.0%
Responses	1,560	1,399	1,555	1,498	1,857

Workforce Equality Standards
Scored Significantly Better than 2020

Gateshead Health
NHS Foundation Trust

Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it

	2018	2019	2020	2021
Staff with a LTC or illness: Your org	36.6%	42.9%	40.5%	44.6%
Staff without a LTC or illness: Your org	30.1%	39.3%	42.3%	44.1%
Staff with a LTC or illness: Average	45.4%	46.9%	47.0%	47.0%
Staff without a LTC or illness: Average	45.0%	46.1%	45.8%	46.2%
Staff with a LTC or illness: Responses	101	126	148	195
Staff without a LTC or illness: Responses	299	341	310	367

Workforce Equality Standards Scored Significantly Worse than 2020

Gateshead Health NHS Foundation Trust

Percentage of staff experiencing harassment, bullying or abuse from patients / service users, relatives or the public in last 12 months

	2017	2018	2019	2020	2021
White: Your org	21.0%	22.5%	21.2%	22.1%	23.7%
BME: Your org	20.3%	23.8%	29.5%	16.5%	21.0%
White: Average	27.1%	27.1%	27.7%	25.4%	26.5%
BME: Average	27.5%	28.8%	29.5%	28.0%	28.8%
White: Responses	1,445	1,288	1,429	1,394	1,742
BME: Responses	79	84	78	85	105

	2018	2019	2020	2021
Staff with a LTC or illness: Your org	25.0%	22.8%	26.0%	30.8%
Staff without a LTC or illness: Your org	22.2%	21.2%	20.5%	20.8%
Staff with a LTC or illness: Average	33.6%	33.2%	30.9%	32.4%
Staff without a LTC or illness: Average	26.6%	26.5%	24.5%	25.2%
Staff with a LTC or illness: Responses	280	320	365	504
Staff without a LTC or illness: Responses	1,096	1,195	1,123	1,339

Next Steps

Gateshead Health
NHS Foundation Trust

- Communicate results to key stakeholder groups.
- Analyse Trust level data and develop organisation level People Action Plan.
- People & OD teams support Business Unit and department level discussions and development of localised People Action Plans.
- Develop a Psychological Safety Dashboard to highlight key areas of focus and concern regarding the colleague experience.

Gateshead Health
NHS Foundation Trust

Report Cover Sheet Agenda Item: 14

Report Title:	**Consolidated Finance Report – Part One**			
Name of Meeting:	Trust Board			
Date of Meeting:	30th March 2022			
Author:	Mrs Jane Fay, Assistant Director of Finance – Strategic Finance			
Executive Sponsor:	Mrs Jacqueline Bilcliff, Group Director of Finance			
Report presented by:	Mrs Jacqueline Bilcliff, Group Director of Finance			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☒	**Assurance:** ☒	**Information:** ☐
	The purpose of this paper is to provide assurance against priority objective 3.4 (develop an approved capital and revenue plan) and address risk 2874.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☒ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*				
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	For the period April to February the Trust has reported a revenue surplus of £10.311m after adjustments for donated assets and gain/losses of asset disposal. This is an increase of £2.579m from the reported January surplus. For the same time period the Trust has spent £7.238m of its capital programme an increase of £2.303m from that reported in January. Following the release of the H2 planning guidance and negotiation of associated funding envelopes, the Trust has submitted a balanced plan for 2021/22 and is currently forecasting a surplus of £13m.			
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	This report seeks to provide assurance in respect of the priority objective 3.4 – develop an approved capital and revenue plan; addressing risk 2874 – risk that the Trust is unable to formulate a coherent financial plan due to the uncertainty surrounding the financial framework.			

	To note the summary of performance as at 28th February 2022 (Month 11) for the Group (inclusive of Trust and QE Facilities, excluding Charitable Funds).				
Trust Strategic Aims that the report relates to:	**Aim 1** ☒	We will continuously improve the quality and safety of our services for our patients			
	Aim 2 ☐	We will be a great organisation with a highly engaged workforce			
	Aim 3 ☒	We will enhance our productivity and efficiency to make the best use of resources			
	Aim 4 ☐	We will be an effective partner and be ambitious in our commitment to improving health outcomes			
	Aim 5 ☐	We will develop and expand our services within and beyond Gateshead			
Trust corporate objectives that the report relates to:	Priority objective 3.4 – develop an approved capital and revenue plan. Risk 2874 – risk that the Trust is unable to formulate a coherent financial plan due to the uncertainty surrounding the financial framework.				
Links to CQC KLOE	Caring ☐	Responsive ☐	Well-led ☒	Effective ☐	Safe ☐
Risks / implications from this report (positive or negative):					
Links to risks (identify significant risks and DATIX reference)					
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒		

1. Introduction

1.1 The purpose of this report is to provide a summary of financial performance as at 28th February 2022 (month 11) for the Group (inclusive of the Trust and QE Facilities, excluding Charitable Funds).

2 2021-22 Financial Framework

2.1 Following on the from the financial framework implemented for the period 1st October 2020 to 31st March 2021 planning guidance issued in March 2021 confirmed a similar framework for the period April 2021 to September 2021 referenced in the guidance as 2021-22 H1.

2.2 The financial planning guidance for the period October 2021 to March 2022 referenced as 2021-22 H2 is underpinned by broadly the same principles as those in 2021-22 H1 as detailed below:

- A continuation of the block contract values agreed in 2021-22 H1 with an inflation uplift of 1.75% for pay award arrears for the period April 2021 to September 2021 and 1.16% inflation uplift inclusive of a 0.82% efficiency target
- Additional funding to support urgent care pathways
- Funding envelopes to be issued to Integrated Care System (ICS) with a requirement for each ICS to achieve a breakeven position
- Funding envelopes to be delegated to each Integrated Care Partnership (ICP) with a requirement for each ICP to achieve a breakeven position
- Additional funding streams defined as funding outside of the system envelope to continue including specific schemes for the Trust relating to COVID pathology testing and vaccination programmes
- The continuation of the elective recovery fund to support activity recovery in addition to system financial envelopes.

2.3 The Trust's H2 financial plan reports a deficit totalling £2.588m for the period October to March 2022 to achieve an overall breakeven position for the 2021-22 financial year.

2.4 Reporting for February is against the Trusts H2 financial plan.

3 Income and Expenditure

3.1 The Trust has reported a surplus of £2.578m for the month of February 2022 and a year to date surplus of £9.162m prior to and £10.311m after an adjustment for donated assets, profit / losses on disposal of assets and the net impact of donated PPE from DHSC.

3.2 This is a positive variance of £12.179m against the year to date plan as detailed on the Trust Statement of Comprehensive Income (SOCI) presented in Table 1.

3.3 For the month of February 2022 the Trust has reported actual income of £30.455m and £331.468m for the period to date resulting in an in month positive variance of £0.835m from the NHSEI plan and a year to date favourable variance of £13.133m. Included in the income position is Elective Recovery Fund (ERF) income totalling £2.594m.

3.4 For the month of February 2022 the Trust has reported actual operating expenditure of £26.923m resulting in an in month positive variance of £2.742m with a year to date adverse variance of £1.527m. These figures include £8.621m of spend directly attributable to the Trust's response to the COVID-19 pandemic.

STATEMENT OF COMPREHENSIVE INCOME

February 2021-22 Red >100k over Amber <> (£50k) - £99.99k Green <(£50.1k)	GROUP POSITION NHSI/E APRIL - MARCH 22 H1 + H2 REVISED PLAN			VARIANCE	
	Revised 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	(321,438.8)	(294,217.8)	(303,050.9)	(8,833.1)	(8,418.2)
Income From Local Authority Care Contracts	(90.0)	(83.0)	(85.3)	(2.3)	1.0
Private Patient Revenue	(1,043.5)	(969.5)	(724.3)	245.2	248.9
Injury Cost Recovery	(300.0)	(278.0)	(297.7)	(19.7)	(11.7)
Other non-NHS clinical revenue	(414.0)	(345.0)	(692.6)	(347.6)	(368.1)
Total Operating Income From Patient Care activities	**(323,286.4)**	**(295,893.4)**	**(304,850.9)**	**(8,957.5)**	**(8,548.1)**
Other Operating Income					
Education and Training Income	(9,138.8)	(8,462.8)	(9,012.0)	(549.2)	(351.2)
R&D Income	(671.0)	(618.0)	(616.7)	1.3	(12.4)
Funding ouside of System Envelope	-	-	(3,172.5)	(3,172.5)	(3,124.4)
Other Income	(13,238.5)	(12,006.5)	(13,462.0)	(1,455.5)	(1,220.3)
Donations & Grants Received	-	-	(229.2)	(229.2)	-
Total Other Operating Income	**(24,673.3)**	**(22,442.3)**	**(26,617.4)**	**(4,175.1)**	**(3,749.3)**
Total Operating Income	**(347,959.6)**	**(318,335.6)**	**(331,468.2)**	**(13,132.6)**	**(12,297.5)**
Operating Expenses					
Employee Expenses - Substantive	210,655.4	193,374.4	187,552.6	(5,821.7)	(6,087.0)
Employee Expenses - Bank	8,276.3	7,356.3	10,268.8	2,912.4	2,436.5
Employee Expenses - Agency	4,259.7	3,948.6	4,941.1	992.4	704.3
Employee Expenses - Other	1,094.7	971.3	1,295.3	324.0	(30.1)
Total Employee Expenses	**224,286.2**	**205,650.6**	**204,057.8**	**(1,592.8)**	**(2,976.2)**
Purchase of Healthcare - NHS bodeis	5,736.7	5,270.2	5,728.8	458.6	444.0
Purchase of Healthcare - Non NHS bodies	2,630.6	2,327.0	2,503.8	176.7	230.0
Purchase of Social Care	-	-	-	-	-
NED's	185.2	170.6	166.1	(4.5)	(9.8)
Supplies & Services - Clinical	32,415.7	29,983.3	33,977.7	3,994.5	4,580.9
Supplies & Services - General	7,959.4	6,881.2	4,389.5	(2,491.7)	(1,260.0)
Drugs	17,804.4	16,252.2	17,273.4	1,021.2	1,097.5
Research & Development expenses	31.7	26.7	29.3	2.6	7.5
Education & Training expenses	2,170.9	2,092.1	1,003.2	(1,088.9)	(1,134.1)
Consultancy costs	340.1	293.8	340.8	47.0	58.1
Establishment expenses	6,217.2	5,520.8	5,198.8	(322.0)	1,130.6
Premises	18,525.6	16,764.6	18,062.0	1,297.4	1,941.0
Transport	1,207.4	1,102.8	1,162.7	60.0	117.6
Clinical Negligence	8,201.7	7,520.3	7,262.2	(258.1)	(236.9)
Operating Leases	1,020.0	850.0	1,686.6	836.6	791.8
Other Operating expenses	10,675.2	9,594.0	8,626.7	(967.3)	(1,356.5)
Operating Expenses included in EBITDA	**339,407.9**	**310,300.1**	**311,469.3**	**1,169.2**	**3,425.4**
Depreciation & Amortisation - Purchased / Constructed	6,962.0	6,363.0	6,717.8	354.8	377.8
Depreciation & Amortisation - Donated / Granted	429.0	389.5	333.1	(56.4)	(46.5)
Depreciation & Amortisation - Finance Leases	-	-	-	-	-
Impairment & Revaluation	(277.2)	(261.6)	(202.6)	59.0	512.2
Restructuring Costs	-	-	-	-	-
Operating Expenses excluded from EBITDA	**7,113.8**	**6,490.9**	**6,848.3**	**357.5**	**843.5**
Total Operating Expenses	**346,521.7**	**316,791.0**	**318,317.6**	**1,526.7**	**4,268.9**
(Profit)/Loss from Operations	**(1,438.0)**	**(1,544.7)**	**(13,150.6)**	**(11,605.9)**	**(8,028.5)**
Non Operating					
Non-Operating Income					
Finance Income	(56.0)	(51.6)	(65.5)	(13.9)	(3.8)
Total Non-Operating Income	**(56.0)**	**(51.6)**	**(65.5)**	**(13.9)**	**(3.8)**
Non-Operating Expenses					
Finance Costs	610.1	553.1	998.5	445.4	(59.6)
Gains / (Losses) on Disposal of Assests	(46.0)	(46.0)	131.5	177.5	177.5
PDC dividend expense	2,984.5	2,717.3	2,148.7	(568.6)	(496.8)
Total Finance Costs (for non-financial activities)	**3,548.6**	**3,224.4**	**3,278.8**	**54.3**	**(378.9)**
Other Non-Operating Expenses					
Misc. Other Non-Operating expenses	-	-	-	-	-
Total Non-Operating Expenses	**3,548.6**	**3,224.4**	**3,278.8**	**54.3**	**(378.9)**
(Surplus) / Deficit Before Tax	**2,054.6**	**1,628.1**	**(9,937.4)**	**(11,565.5)**	**(8,411.2)**
Corporation Tax	715.4	630.0	775.5	145.5	231.0
(Surplus) / Deficit After Tax	**2,770.1**	**2,258.1**	**(9,161.9)**	**(11,420.0)**	**(8,180.1)**
(Surplus) / Deficit After Tax from Continuing Operations	**2,770.1**	**2,258.1**	**(9,161.9)**	**(11,420.0)**	**(8,180.1)**
Remove capital donations / grants I&E impact	(429.0)	(389.5)	(103.9)	285.6	46.5
Gain on disposal of assets	-	-	46.3	46.3	46.3
Loss on disposal of DHSC assets	-	-	(177.8)	(177.8)	(177.8)
Remove net impact of consumables donated from other DHSC bodies	-	-	(913.4)	(913.4)	(913.4)
Adjusted Financial Performance (Surplus) / Deficit	**2,341.1**	**1,868.6**	**(10,310.7)**	**(12,179.2)**	**(9,178.5)**
Adjusted Financial Performance (Surplus) / Deficit	**2,341.1**	**1,868.6**	**(10,310.7)**	**(12,179.2)**	**(9,178.5)**

Table 1: Trust Statement of Comprehensive Income

4 Cost Reduction Programme (CRP)

4.1 Included in the Trusts 2021-22 H1 financial plans is an efficiency requirement of £2.225m and £2.100m for H2 totalling a required annual efficiency of £4.325m to achieve breakeven. Non-recurring schemes totalling £3.975m have been identified and whilst this mitigates the financial risk for April to February it is imperative the Trust continues to identify recurring schemes via its transformation programme with work currently underway to refine and scope the supporting schemes.

5 Cash and Working Balances

5.1 The Trust opened the financial year with £43.862m of cash. The cash position of £57.568m as at 28th February is equivalent to an estimated 44.95 days operating costs and represents a £0.754m decrease from January 2022.

5.2 The liquidity metric has improved by 2.02 days against January to +6.45 days driven by a £1.885m increase in the working capital balance.

5.3 The balance sheet is presented in Table 2.

Statement of Position - February 2022

	2021/2022 January 2022 Group	2021/2022 February 2022 Group	Movement from Prior Month	2021/2022 February 2022 QEF	2021/2022 February 2022 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	116,698	118,409	1,710	1,233	117,176
Trade and Other Receivables, Net	1,988	1,937	(51)	729	1,207
Finance Lease - Intragroup				42,743	0
Trade and Other Receivables - Intragroup Loan	0	0	0		15,789
Total Non Current Assets	118,766	120,425	1,659	44,785	150,997
Current Assets					
Inventories	4,495	4,329	(166)	2,451	1,879
Trade and Other Receivables - NHS	14,032	11,197	(2,835)	757	10,440
Trade and Other Receivables - Non NHS	4,003	5,108	1,105	751	4,357
Trade and Other Receivables - Other	0	0	0		0
Prepayments	4,293	3,991	(302)	812	3,179
Cash and Cash Equivalents	58,332	57,568	(763)	6,899	50,669
Other Financial Assets - PDC Dividend	0	0	0		0
Accrued Income	1,721	1,780	59	1,236	544
Finance Lease - Intragroup				57	0
Trade and Other Receivables - Intragroup Loan					337
Total Current Assets	95,839	83,973	(2,902)	12,963	71,404
Liabilities					
Current Liabilites					
Deferred Income	7,289	9,083	1,794	148	8,935
Provisions	5,368	5,554	187	320	5,235
Current Tax Payables	4,335	5,257	922	390	4,867
Trade and Other Payables - NHS	1,873	1,622	(252)	719	902
Trade and Other Payables - Other	8,638	9,314	675	3,463	5,850
Trade and Other Payables - Capital	767	135	(631)	0	135
Other Financial Liabilities - Accruals	48,912	41,399	(7,513)	7,605	33,795
Other Financial Liabilities - Borrowings FTFF	499	499	0	0	499
Other Financial Liabilities - PDC Dividend	571	767	195	0	767
Other Financial Liabilities - Intragroup Borrowings	0	0		337	0
Finance Lease - Intragroup	0	0		0	57
Total Current Liabilities	87,216	73,631	(4,622)	12,982	61,043
NET CURRENT ASSETS (LIABILITIES)	8,622	10,342	1,720	(20)	10,362
Non-Current Liabilities					
Deferred Income	2,124	2,124	0	1,794	330
Provisions	2,584	3,184	600	0	3,184
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	15,789	0
Other Financial Liabilities - Borrowings FTFF	14,010	14,010	0	0	14,010
Finance Lease - Intragroup				0	42,743
Total Non-Current Liabilities	18,718	19,318	600	17,583	60,267
TOTAL ASSETS EMPLOYED	**108,671**	**111,450**	**2,779**	**27,183**	**101,092**
Tax Payers' and Others' Equity					
PDC	139,314	139,314	0	0	139,314
Taxpayers Equity	0	0	0	0	0
Share Capital	0	0	0	16,824	0
Retained Earnings (Accumulated Losses)	(37,353)	(34,574)	2,779	19,411	(53,985)
Other Reserves	0	0	0	0	0
Revaluation Reserve	6,611	6,611	0	0	6,611
Misc Reserve	99	99	0	0	99
TOTAL TAXPAYERS EQUITY	108,671	111,450	2,779	36,236	92,038
TOTAL ASSETS EMPLOYED	**108,671**	**111,450**	**2,779**	**36,236**	**92,038**

Table 2 – Statement of Position

6 Capital

6.1 The Trusts 2021/2022 CDEL limit had been set at £6.825m, with additional capital funding of £11.390m approved in the year to increase the Trust's CDEL to £18.215m as summarised in the below:-

CDEL	£000's
Net Depreciation*	6,213
Internal Cash	612
Accelerator Scheme PDC	1,050
Donation - Decarbonisation grant	1,528
Community Diagnostic Hub	5,329
TIF PDC	2,775
Cyber Security PDC	250
Digital Workstations PDC	198
Charitable Funds Donations	230
Maternity PDC	30
Total	18,215

* After Principal Loan Repayments of £1.178m

6.2 All new PDC awards are supported with additional external cash, with the Trust recently awarded PDC of £1.050m for the Accelerator Scheme which was previously to be funded via internal cash. An unconfirmed PDC award of £90k for oxygen infrastructure had been included in the annual CDEL, however as confirmation of the PDC has not been received these works will now be funded internally.

6.3 The Trust was issued Public Dividend Capital (PDC) in 2021/2022 to the value of £5.329m to commission and deliver a Community Diagnostic Hub. Third party delays in the fabrication and delivery of the respective modules, together with groundworks and power supply issues have resulted in only £1.916m being deliverable within 2021/2022 with £3.413m having to be deferred into the 2022/2023 financial year. There is current uncertainty as to whether the Trust will secure PDC to this value in 2022/2023 with the remaining £3.413m of expenditure being committed and therefore a financial pressure on capital resources until funding is confirmed.

6.4 Programme delays in the delivery of the grant funded decarbonisation schemes (£0.129m) and donations from charitable funds (£0.100m) have further reduced the available CDEL to £14.573m.

6.5 As at the end of February the Trust had a capital forecast outturn totalling £14.593m, £0.050m above the Trust's revised CDEL, with expenditure to be controlled and monitored to ensure CDEL is not exceeded, with any outstanding commitments carried forward into the 2022/2023 financial year.

6.6 Actual expenditure up to 28th February totals £7.238m mainly in respect of 2020-2021 carried forward schemes, information technology infrastructure, building maintenance, equipment replacement, infrastructure works, the Accelerator Scheme, the Community Diagnostic Hub and the maternity scheme.

7 Risk

7.1 Given that the Trust is forecasting a surplus for the year end position, at Month 11, the risk of not meeting the revenue financial plan requirements has now been mitigated. However, risks remaining for 2021/22 which have not been resolved/mitigated are

- the risk that increased slippage on the capital programme will result in the Trust missing its CDEL target and being 'penalised' in following years due to ongoing commitments and the ICS framework for setting CDEL
- the Trust will be reporting a surplus for 2021/22. There is the potential here for reputational damage and also a need to 'manage' the difficult message of reporting a surplus whilst going into a period of forecast deficit and CRP for the Trust
- the Trust 2021-22 H2 financial plan forecasts a deficit of £2.588m to achieve a breakeven position for the 2021-2022 financial year. However, the current forecast position is a material movement from this to a £13m surplus. Within that forecast there are a number of risks
    - Sale of Dunston Hill
    - Capital impairment
    - Review of existing and new provisions
    - Audit.

Jacqueline Bilcliff, Group Director of Finance
18th March 2022

Gateshead Health
NHS Foundation Trust

Report Cover Sheet Agenda Item: 15

Report Title:	**Integrated Oversight Report**			
Name of Meeting:	Board of Directors – Part 1			
Date of Meeting:	30 March 2022			
Author:	Deborah Renwick and IOR Reporting Leads			
Executive Sponsor:	Joanne Baxter			
Report presented by:	Joanne Baxter, Gill Findley, Andy Beeby and Lisa Crichton-Jones			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☒	**Assurance:** ☒	**Information:** ☐
	To summarise performance in relation to key NHS standards, requirements and KLOE's to outline the risks and recovery plans associated with COVID -19. This report covers the reporting period of February and January.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☒ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	Chief Operating Officer's Senior Management Team Trust Senior Management Team Finance and Performance Committee			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	The number of covid positive patients in hospital reduced in February, however delayed discharges and continuing winter pressures continue to place the Trust under significant pressure. Improvements in UEC measures this month, with significant reductions in ambulance delays, slightly better A&E performance against the 4hr standard with no patients waiting longer than 12hrs to be admitted. Benchmarking data (January) places the Trust 33rd/139 Providers. In February the Trust re-started of the full elective programme, with activity levels demonstrating marked improvements across all points of care delivery from last month. The Trust also achieved in month expectations for digital/remote outpatient appointments and Patient Initiated Follow-up appointments and continues to			

<table>
<tr><td></td><td colspan="6">proactively manage long waiters in RTT and cancer pathways despite the trend in higher referrals.

Workforce capacity to deliver the elective programme has been impacted by staff absence and testing positive in key areas.

Quality & Safety: 7 Serious Incidents were STEIS reportable in February and are currently under review.</td></tr>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="6">This report seeks to provide assurance in respect of the priority objectives to 3.8 deliver operational transformation to improve productivity and efficiency.

The recommendations to the Board are to receive this report, discuss the potential implications and record as partial assurance as a direct consequence of the impact on activity recovery, long waiting times and performance.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
☒</td><td colspan="5">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☒</td><td colspan="5">We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3
☒</td><td colspan="5">We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4
☒</td><td colspan="5">We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5
☐</td><td colspan="5">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Trust corporate objectives that the report relates to:</td><td colspan="6">3.8 (F&P) Deliver operational transformation to improve productivity & efficiency

3.9 (F&P) Develop smart integrated reporting framework</td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
☒</td><td>Responsive
☒</td><td>Well-led
☒</td><td>Effective
☒</td><td colspan="2">Safe
☒</td></tr>
<tr><td colspan="7">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks and DATIX reference)</td><td colspan="6">• Activity & Elective Recovery (2560, 2884,2869)
• Emerging increase in referrals rates – Breast, T&O and urology)
• UEC performance and flow
• Cancer rising referral rates (breast) Gynae transfers
• Workforce fatigue and health and well being
• Staffing and workforce gaps in key areas (2956, 2942, 2514, 2946, 2938, 2953, 1675)
• Backlog reduction:
Cancer – Urology, Gynaecology (2514), LGI Echocardiology (2730)
• Outpatient capacity to see patients face to face
• Maternity pressures (1675)</td></tr>
</table>

Has a Quality and Equality Impact Assessment (QEIA) been completed?	Yes	No	Not applicable
	☐	☐	☒

INTEGRATED OVERSIGHT REPORT – MARCH COMMITTEES

1. Introduction

1.1 This report summarises performance across key NHS standards, requirements and KLOE's outlining the risks and ongoing recovery plans associated with COVID -19. This report covers the reporting period of January and February, reporting performance where data is validated, signed off and submitted, as highlighted below.

Area	Data Item	Reporting Period	Data Quality Sign Off
Recovery	Activity	Internal February reporting	**
Responsive	A&E	Submitted February	***
	2 week waits		**
	RTT	Provisional January	**
	Cancer		**
	Diagnostics		**
Safety	SI's	Reported February	***
	Open Safety alerts	February	***
	Reporting Safety incidents	February	***
Effective	HMSR	Jan 20 to December 21	***
	Long Lengths of Stay	February CDS	***
	Criteria to reside	Daily Sit-Rep snap-shot	*
Well Led	People & Workforce	January	***
Maternity	All sub-set standards	February	***
*** Signed off Unlikely to change, ** Subject to validation * snapshot position			

1.2 Trust Corporate Objectives relating to this report and overseen by the following Committees are:

Quality Governance Committee:

- 1.2 Implementation of Board level reporting: Okenden and maternity services
- 1.8 Achieve accreditation of Nursing and Midwifery excellence programme
- 1.10 Supporting the route map to CQC Outstanding

People & OD:

- 2.5 Strengthen approaches to people related quality, performance & governance measures

Finance & Performance Committee:

- 3.8 Deliver operational transformation to improve productivity & efficiency
- 3.9 Develop smart integrated reporting frameworks

2. Key issues & findings

2.1 Covid Summary: During February the number of covid positive patients in hospital has reduced. At the beginning of the month the Trust reported 78 covid patients in hospital falling to 24 patients by the of the month. Covid occupied bed-days fell from 20% to 5% resulting in the decompression of the covid bed footprint into one ward by the end of the month. These changes have positively impacted on the re-start of the elective care programme during February; although cleaning regimes, flow issues and staff testing positive with covid have impacted on the planned delivery of elective care in month. Infection Prevention and Control measures are under review to ensure they remain fit for purpose.

2.2 Flow and Discharge: The hospital and NENC remains under significant pressure with ED, Urgent and Emergency Care and Community continuing to care for patients with increased acuity. Delayed discharges constrained by (i) limited care packages in the community and (ii) reduced capacity in nursing homes, and (iii) limited access to residential homes has continued during February and resulted in a significant volume (3-4 wards, circa 16% of G&A beds) of patients residing in hospital who are medically optimised and are fit to go home. Consequently, the number of patients in hospital with longer lengths of stay is again high and continues to display special cause variation. Difficulties experienced in maintaining patient flow manifest in 'blockages' in the front of house and delays allocating specialty beds.

2.3 Workforce: Sickness absence levels (in January) continue to rise with levels at 7.9%. QEH contributes to the increase in sickness absence whilst QEF maintain a 3-month downward trend, moving towards expected levels. Trust level appraisal compliance is at 61.7% and continues below the 85% target. Core training data also continues to display special cause variation and is outside of expected levels at 70.3% overall.
Our workforce has yet again rallied to the challenge of responding to covid by providing flexible staffing solutions in challenging times. We have asked staff to care for patients within different clinical operating models whilst flexing staffing teams to respond to fluctuations in the volume of covid patients in the hospital whilst coping with covid outbreaks across the Trust. The impact of Covid on staffing and supporting personal resilience remain a key priority within the Trust and our People Plan.

2.4 Activity

2.4.1 February's combined **elective activity** is at 99% of 2019/20 baseline activity, representing an increase on last month's aggregated activity levels. Overnight elective activity is at 68%, representing a 9% improvement upon January's position. Daycases improved to 91% (from 78%) and Outpatient attendances improved to 99%. Patient Initiated Follow-up (PIFU) attendances are at 1.5% against a requirement of 1.5% of total outpatient appointments and the Trust reported 25.4% remote outpatient appointments against a transformational requirement of 25%.

Diagnostic activity levels continue to exceed 2019/20 levels with activity at 104%. Echocardiology activity improved to 121%, with pressures in month in endoscopy with levels at 88% of pre-covid levels.

2.4.2 Non-elective activity is 107% higher than pre-covid levels. Patient activity for those we turn around in a day is at 228% of pre-pandemic levels - SDEC activity is captured within this activity as

'day beds'. Over-night admissions, or for patients who go on to require a base ward bed activity is at 79% of pre-covid levels in February.

2.4.3 Attendances through ED is at 78% of pre-pandemic levels, although average daily attendances are 82 per day higher than February last year. SDEC have reviewed 744 patients of which 80.38% were discharged on the same day – this activity will also be included within Trust volumes of Non-elective admissions.

2.4.4 Community Care continue to support secondary care services by keeping patients in their own home. District Nursing teams across Gateshead saw 26,814 patients in February (averaging 957 per day). In total the rapid response team reviewed and or treated 4,044 patients. Rapid Response achieved a compliance rate of 52% for patients referred within 2 hours, 84.8% for patients referred within 4 hours, and 100% for those over the 4 hour referral criteria.

Winter bed escalation plans were instigated early this year and the Trust continues to operate with maximum winter escalation beds open at times alongside full capacity protocols.

2.5 Performance - Access and Recovery of Back-log Waiters

2.5.1 Urgent and Emergency Care: Remains under significant pressures. General winter pressures and barriers to discharging patients home has put significant pressure on Trust services and continues to cause pressure across the wider local health system. Trust performance against the 4hr standard is at 77%, with bed pressures continuing to be main reason for delays in A&E. Ambulance delays at the front door are also triggering concern. However, the number of ambulance delays reported decreased from 75 patients in January to 47 patients in February taking between 30-60 mins to transfer into the hospital. Delays greater than 60 minutes also decreased from 60 patients in January to 11 patients in February. New (shadow monitoring) UEC measures demonstrate that patients are generally waiting longer in ED; however in February we saw a reduction in the number of patients waiting longer than 12 hours before discharge with a 42% or 135 patient reduction. There were no patients waiting longer than 12 hours before admission in February.

Staffing levels in ED (and across the site) remain challenging with most departments carrying vacancies with additional pressures from absences due to covid, isolation guidance and annual leave.
The Trust has also seen general increases in attendances with daily attendances averaging 82 more patients than February last year coupled with a general increase in elderly patients with higher acuity levels presenting at the front door.

Transformation work is on-going to prevent admission and improve discharge, ECIST are now providing focused support to the Trust.

The Trust's benchmarked position relates to January (not the current reporting month) and is placed 33rd out of 139 providers**.** ECIST remains the Trust critical friend until the end of March in support of:

- Site management, reviewing systems and processes & practical support around use of BI data and operational intelligence to support flow
- Support in developing the Front Door assessment model – SDEC & frailty
- Frailty model and management exploring possible community options for care
- Discharge and expediting patients who no longer meet the right to reside

2.5.2 RTT: NHSE/I continue to focus on reducing patient backlog.
Reduced activity over the summer and increased referrals for surgical specialties coupled with reduced bed capacity has increased the number of patients awaiting treatment from 9,025 in July to 10,507 waiting at the end of January. The waiting list is now triggering special cause variation. Clinical prioritisation continues with a particular focus on patients with long waits or who continue to choose to wait longer for care, where offers for care and treatment have repeatedly been declined. The Trust is now following guidance which involves individualised patient level risk management involving joint reviews with GP's for on-going patient management and care. Weekly patient level reviews continue with a focus on long waiters and proactive care management. The Trust is also a pilot site for 'My Planned Care' to allow patients to access waiting time information and clinical guidance.

The backlog of patients waiting longer than 52 weeks is at 51 at the end of January and there are no patients waiting over 104 weeks. The Trust is unlikely to achieve the planned reductions due to standing down elective work to accommodate covid patients.

2.5.3 Cancer: NHSE/I recognises the pressure in achieving this target across the NHS and H2 Planning guidance focuses on backlog reduction and increasing capacity to treat patients. At the end of February there were 15 patients waiting longer than 104 days. 55 patients were waiting longer than 62 days, this represents an in month decrease of 14 patients. H2 planning expectation is for the Trust to have no more than 55 by the end of the year. The Trust continues to support the ICS wide provision of cancer services and difficulties in gaining access to treatments across shared pathways.

Performance against the 2week standard improved to 88.1% in February albeit below the 93% target, but an improvement upon the January position. Increases in breast referrals continue to cause pressure in this high volume tumour group.

The Trust did not achieve the **Faster diagnostic standard** in January with performance at 73.45% against the 75% target. Gynaecology, Upper GI, Lower GI and urological tumour sites are challenged.

Performance against **62 day cancer treatment** target is at 54.9% in January, service pressures continue to treat patients within 62 days across all tumour groups.

2.5.4 Diagnostics Activity levels are at 104% across all H2 planning modalities. Echocardiology activity levels of activity are at 121% (an increase from 91% in January) of baseline year activity, and the performance position has improved to 27% patients waiting within 6 weeks. Recovery of backlog waiters is now forecast in August 2022.

Audiology pressures remain as part of DM01 monitoring with 61% of patients waiting less than 6 weeks, a full recovery report is scheduled for February F&P Committee 2022.

2.6 Quality and Safety Effectiveness

2.6.1 Trust level SI's: 7 incidents were reported in February, which is just over the average for the last 18 months. Three of the SI's related to incidents which occurred in February; the remaining four have been reported in month following the review process. Two of the seven SI's were deemed

as causing catastrophic harm or resulted in death : the first incident was related to test results and reporting, and the second related to delay in recognising complications of treatment. The remaining 5 incidents were all classified as severe or resulting in major harm and themes include 2 relating to test results, 2 relating to falls and 1 relating to child protection.
There were no maternity SI's were reported in February.

2.6.2 Patient Safety Alerts: There are 2 open patient safety alerts.

2.6.3 Under Reporting of Patient Safety Incidents – Continues to trend on the low side with special cause variation.

2.6.4 HMSR Continues to show more deaths than expected with an HSMR of 14.3 for the rolling period of Jan 21- Dec 21.

2.6.5 Maternity Okenden Progress present ongoing actions towards compliance across all the required areas. In summary the action plan details that the Unit are fully complaint against 5/7 Immediate and Essential Actions and present partial compliance against 2/7 IEAs. Actions include further audits focusing on risk assessments throughout pregnancy and improving communications on personalised care across a range of communication mediums.

Total number of births were within expected range. C.sections were at 22.8% - just below the *30% threshold*. *Please note there will be a change to this indicator in-line with Okenden recommendations, and this indicator will be replaced by the Robson criterion to enable smarter reporting. Smoking at time of delivery remains high at 14.5% against the 5% target and breast feeding at discharge remains a concern, although the trajectory is demonstrating early signs of improvement. Babies admitted directly to SCBU > 37 week gestation is at 4.3% and within normal range, whilst the pre-term birth rate at 4.4 % is within expected levels.

2.6.5 Right to Reside – The daily sit-rep reports a snapshot in time, as of 10/3/22 there were 77 patients in hospital beds who no longer meet the criteria to reside. The main reasons for delays remain the same as last month: access to care homes and access to packages of care in support of improved domiciliary care. Combined delays account for lengths of stay of 2,531 days of which 1,026 are excess bed days since medical optimisation.

2.7 Benchmarking
The Trust remains in a relatively strong position against available benchmarking data:

Indicator	*QEH Performance*	*View*	*Position*
A&E 4 hour waiting time	76.1%	January	33rd / 139 NHS Providers
Latest weekly PTL: patients waiting > 104 weeks	0	w/e 27/02/22	Joint 1st /8 Providers in ICS
Latest weekly PTL: patients waiting > 52 weeks	51	w/e 27/02/22	2nd / 8 Providers in ICS
Latest weekly PTL: patients waiting > 62 days for cancer treatment	78	w/e 27/01/22	1st / 8 Providers in ICS
62 day backlog as % of waiting on the list	10.5%	w/e 13/02/22	58 (top 20 under NHSE/I scrutiny

3. Recommendations

The Committees are recommended to note the content of this report, in summary:

3.1. Operational pressures in discharging patients safely have particularly impacted on our ability to maintain patient flow, however despite a high volume of patients remaining in hospital who are medically fit for discharge there has been improvement across all UEC measures.

3.2. Workforce pressures and decisions taken to balance covid and winter pressures have directly impacted on the delivery of the elective programme, resulting in longer than planned waiting times affecting both RTT and cancer pathways. Activity increases in February will improve waiting times; early indications via the weekly waiting lists now demonstrate slight improvements and the Trust remains a top performer in the ICS for reducing our backlog of longer waits.

3.3. Support the ongoing health and well-being actions in support of frontline employees and acknowledge the increase in staff absences (January data).

3.4. There were 7 SI's reported to STEIS in February. Two of the SI's resulted in death/ catastrophic harm and 5 were classed as causing severe or major harm. All SI's are under review.

3.5. Okenden update demonstrates the Trust is fully complaint against 5 out of the 7 Immediate and Essential Actions (IEA's) and partially compliant against 2 actions.

Integrated Oversight Report: March 2022

Gateshead Health NHS Foundation Trust

Contents:

KLOE Summary: Indicators triggering concern or displaying Special Cause Variation

Indicators triggering variation or failing targets are summarised below – with spotlights referenced within the report. All indicators are now detailed in the appendices of this report.

Responsive 22 of 30 applicable indicators triggering SPC/underachieving against targets

Effective 2 of 5 applicable indicators triggering SPC/underachieving against targets

Caring 0 of 1 applicable indicators triggering SPC/underachieving against targets

Safety 3 of 8 applicable indicators triggering SPC/underachieving against targets

Well Led 9 of 13 applicable indicators triggering SPC/underachieving against targets

Maternity 5 of 6 applicable indicators triggering SPC/underachieving against targets

KLOE Summary

Responsive

UEC: February 22 Performance against the 4 hour standard 77.15%. Footfall through UEC reduced in February, however is on average 82 attendances per day more than last year (44.1% increase), although activity remains below pre-covid levels. The latest national benchmarking data (January) places the Trust at 33rd of 139 Type 1 providers. The Trust reported 47 30-60 minute and 11 over 60 minute ambulance delays in February.

RTT: January 22 Performance against the 18 week standard is at 77.32% with an increase of patients on the RTT waiting list from 10,319 to 10,507, with an increase to 51 patients waiting over 52 weeks.

Cancer: 2ww The Trust position against the 2 week wait target in February was 88.1%, below the 93% standard, the high volumes of Breast referrals in previous weeks continues to contribute to the delay in 2 week wait attendances. In February 1061 Two week wait referrals were received which shows an increase of 4% in comparison to the same period last year and up by 15.7% on the same period in 2019. The Breast service received 625 referrals in February, an increase of 89 over the same period in 19/20.

Cancer: 62 day treatments The Trusts position against the 62 day standard showed a decrease in performance for January reporting performance at 54.9% with no tumour site reaching the performance standard of 85%.

Diagnostics: The Trust failed the diagnostic standard in January reporting a slight improvement to 72.41% of patients seen with 6 weeks of referral. Echocardiography continues to be the main challenge at 22.88% however Audiology is also reported below target at 49.49% and highlighted as an area of concern.

Duty of candour: Verbal compliance with Duty of candour was 100% in February. Data collection and classification processes are ongoing to ensure compliance with reporting criterion.

KLOE Summary

Safe

Total number of **Trust reportable SI's:** 7 STEIS reported in month, open and under investigation
Potential of under recording of safety incidents is triggering concern
No maternity **Serious Incidents** reported in February
There are currently two **open patient safety alerts** not completed by deadline
The latest **Never Event** was observed in October 2020

Effective

The Trust **Hospital Standardised Mortality Ratio** (HSMR) continues to shows more deaths than expected for this indicator. Outlying diagnosis groups are Pneumonia and Congestive Heart Failure. One additional Mortality Council meetings to review a selection of Heart failure cases has been undertaken. This metric continues to be reviewed and discussed at the Mortality and Morbidity steering group.
The **stranded patient** indicator, or patients with a **Length of stay greater than 21 days** continues to trigger special cause variation.

Well Led

Core training performance remained broadly the same at 70.3%
Appraisals decreased to 61.7% in January
Sickness Absence rates increased noticeably to 7.9% in January

Caring

There are **no caring indicators triggering concern**. Electronic patient feedback mechanisms are being rolled out across the Trust.

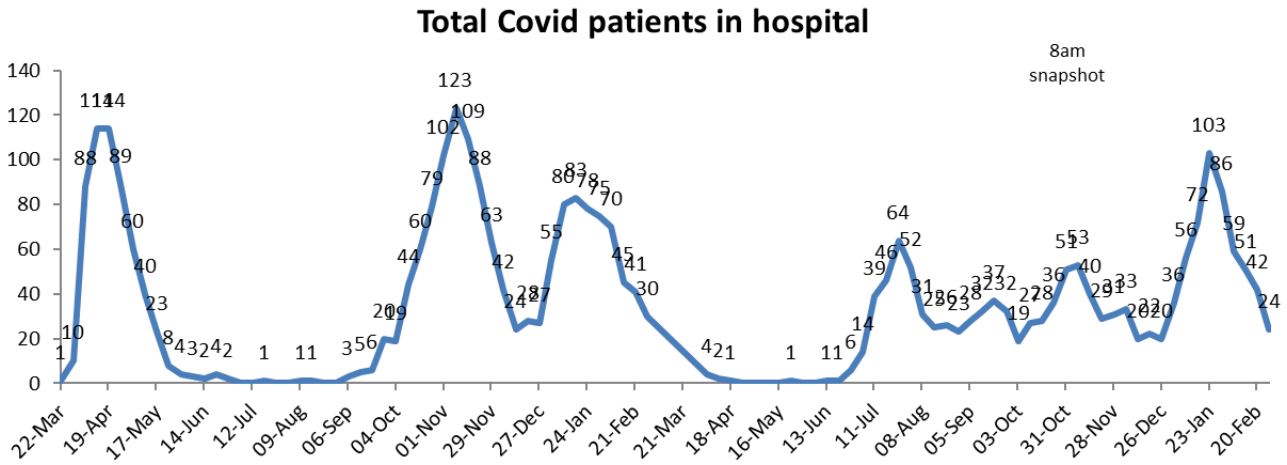
Maternity

Includes a sub-set of indicators taken from the maternity dashboard.
Breast feeding at time of discharge currently triggering concern as target consistently not achieved.
Progress with **Ockenden recommendations** included.

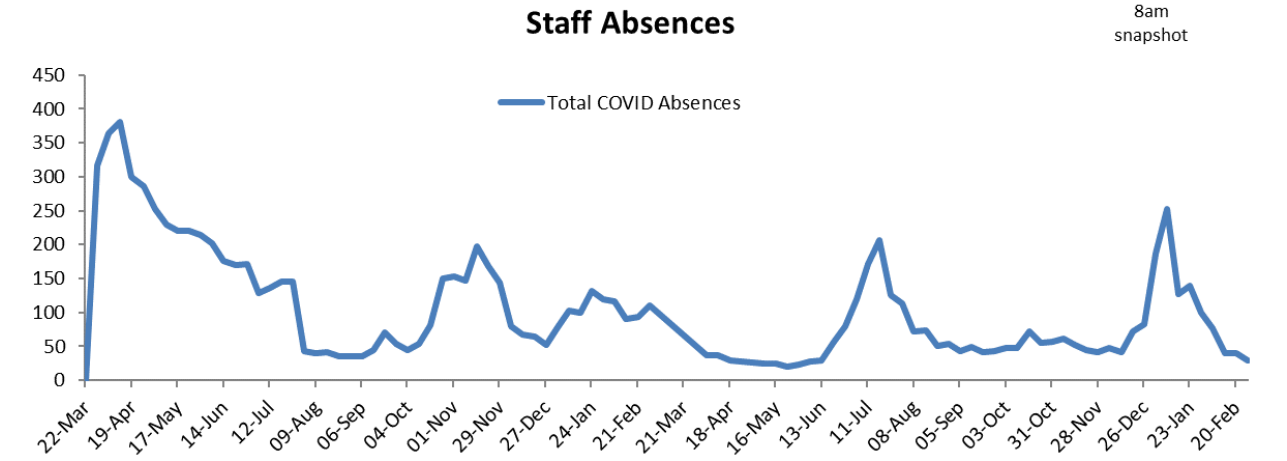
Covid-19: Statistical Update

The level of Covid-19 patients in the hospital is shown in chart (1). The Trust has treated more than 2,500 patients.
This pattern is indicative across the NENC ICS patch. COVID positive patients are currently being treated according to NHSI/E, PHE guidelines. The Trust has mobilised a clinical model to accommodate COVID patient care safely.
The staff absences on chart (2) demonstrate the impact of track and trace and increase in COVID cases on staff absence. (Admin, clerical and nursing only).

1



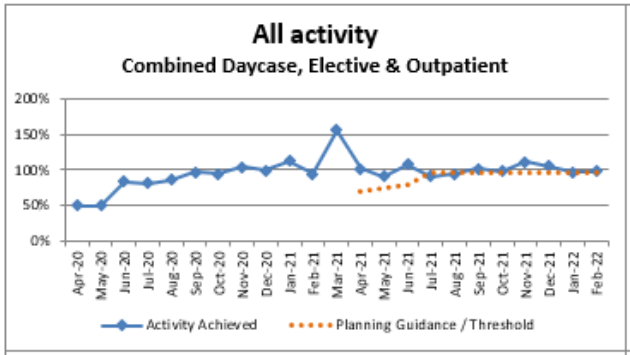
2

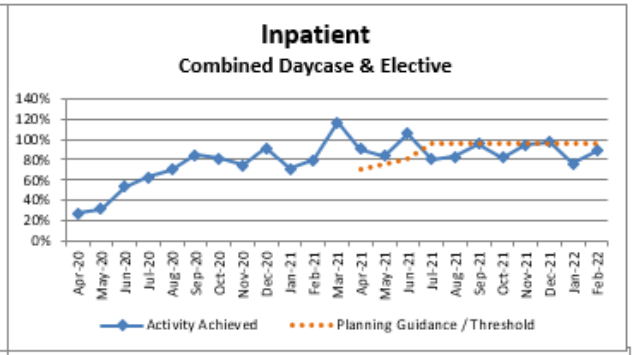


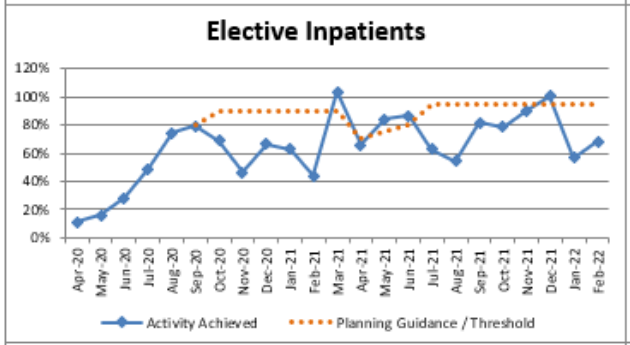
H2 Activity & Recovery

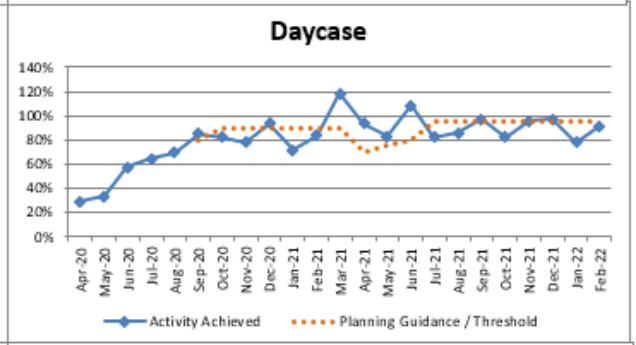
Gateshead Health NHS Foundation Trust

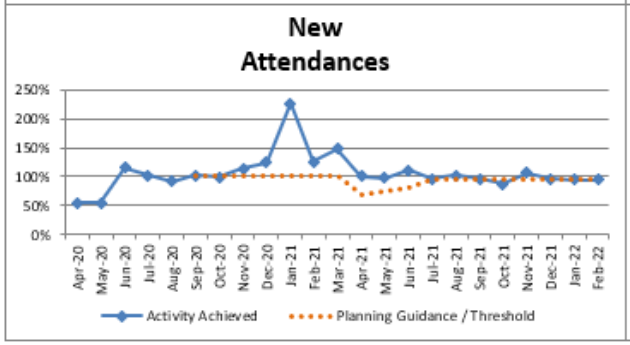
H1 Planning guidance had stated Trusts should meet the following activity (value) thresholds as a minimum:
70% April, 75% May, 80% June, 95% from July onwards.
H2 expectation is to maximise elective activity and eliminate waits of over 104 weeks, taking full advantage of opportunities to transform the delivery of services.

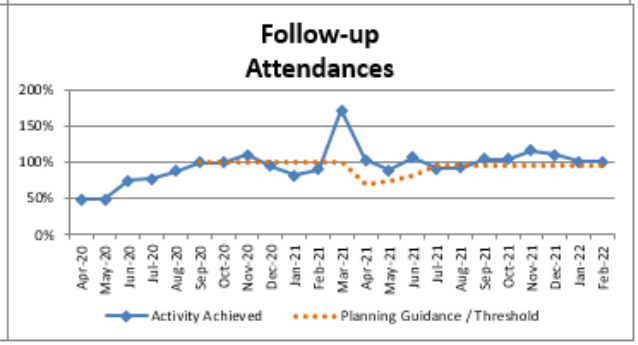












February (Indicative) Activity:

- **Combined elective activity 99%**
- **Day cases 91%**
- **Elective inpatients 68%**
- **Outpatients 100%**

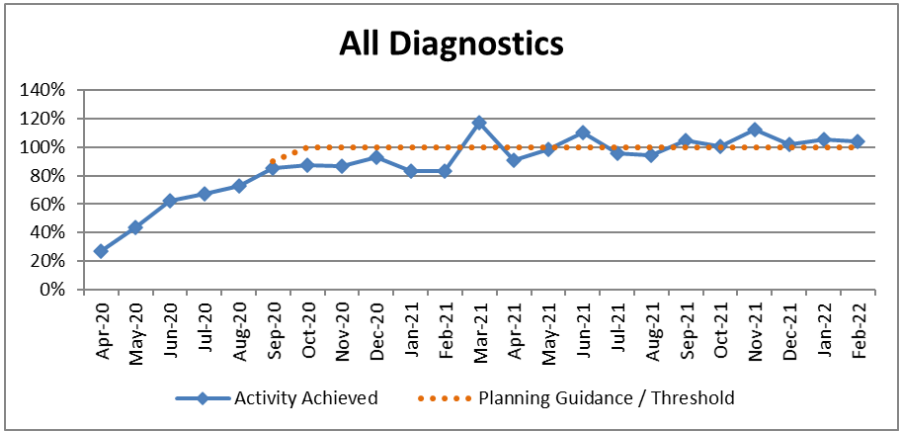
Other key requirements:
25% of Outpatient appointments to be virtual and PIFU activity to achieve 1.5% of all outpatients by December 21 and 2% by March 2022.

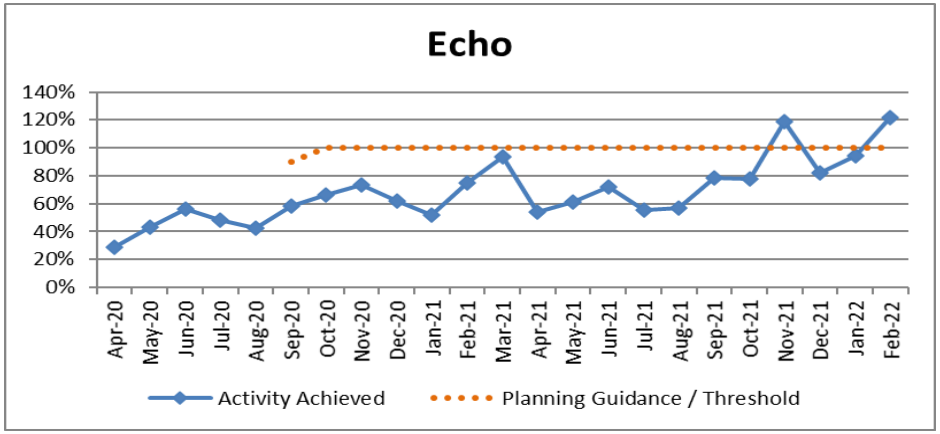
The Trust is reporting 25.4% of all outpatient attendances conducted remotely and 1.5% of all OP recorded as Patient Initiated Follow-Up activities recorded in the 5 specialties Respiratory medicine, Rheumatology, cardiology, Gastroenterology and Trauma & Orthopaedics

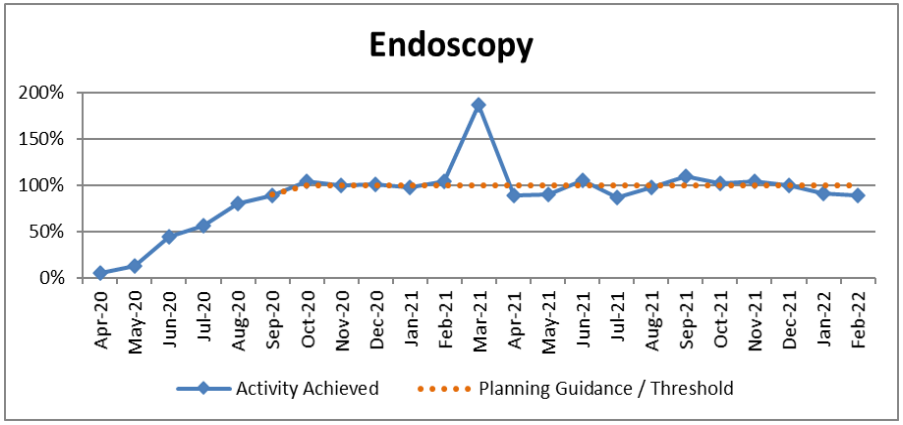
H2 Activity & Recovery

Gateshead Health NHS Foundation Trust

Whilst there are no specific planning thresholds for diagnostic delivery, Trusts are expected to deliver as much as they can to support elective recovery. **All Diagnostics**: 104% of activity in same period 19/20**, Endoscopy: 88**% of activity in same period 19/20**, Echocardiography: 121**% of activity in same period 19/20







As part of a national initiative to manage diagnostic risk, the Trust is required to review and clinically prioritise (as with inpatient waiters) all waiters over 6 weeks.

The diagnostic modalities most at risk are detailed below with % of the total wait over 6 weeks.

- Echocardiography accounts for 77.8% of the diagnostic waiters > 6 weeks with 77.1% of the echocardiography tests waiting longer than 6 weeks.
- Audiology accounts for 19.4% of the diagnostic waiters over 6 weeks with 50.5% of the audiology patients waiting longer than 6 weeks.

SPOTLIGHT REPORTING

Gateshead Health NHS Foundation Trust

This section covers detailed reports for:

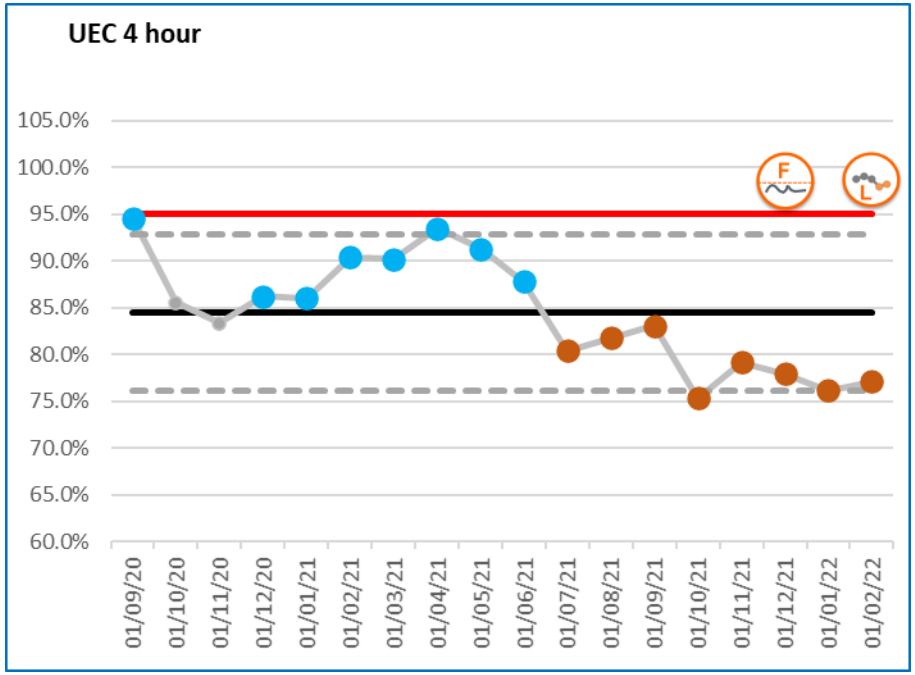
- **Indicators triggering concern or displaying Special Cause Variation**
- **Spotlights requested specifically by Committee or Board**

Report by exception: Spotlight Responsive – UEC maximum waiting time of four hours

Gateshead Health NHS Foundation Trust

Detail on this measure is included as the standard has not been met since July 2020 and will achieve or fail the target subject to random variation

Responsive



Situation – 4 hour performance 77.15%
Overall activity is 78.27% of pre-covid levels**.** Footfall and patient numbers decreased in February, however daily attendances averaged 82 more than the same period in 2021 (44.1%).

Assessment
Whilst the Trust does have more beds in the new operating model, the rise in covid cases creates greater inefficiencies:

- Loss of beds due to outbreaks
- Deep cleaning regimes
- Staff absences
- 'surge' arrival of patients have presented challenges and affect flow throughout the Trust and extended ED duration times
- Discharges occurring later in the day
- All Trusts are reporting extreme pressure and region wide difficulties in flow

Actions

- Continued focus on hospital flow & embedding the New Operating Model
- Talk before you Walk & Telephone triage for Urgent Treatment Centre continue
- Initial testing of ED streaming underway
- Access to POC testing to allow streaming of patients direct to surgical wards
- Review data capture and ECDS Submission to be compliant with H2 requirements
- Review of speciality pathways & streaming patients front house
- External Flow Coaching programmes: SDEC & EAU
- Review ward ways of working and BI to support flow
- Discharge workshop to review ward & Board rounds earlier in the day
- External ECIST support commenced in November
- A regional review of UEC is underway, as ED presentations across the region are increasing and pressure across primary care is evident.
- Additional 2 Consultants appointed, starting in August 2022
- New SOP implemented for emergency huddle to allow patients to be managed within 12 hours of arrival in ED

Recommendation
Finance & Performance Committee to receive updates from service.

UEC measures

NHS Gateshead Health NHS Foundation Trust

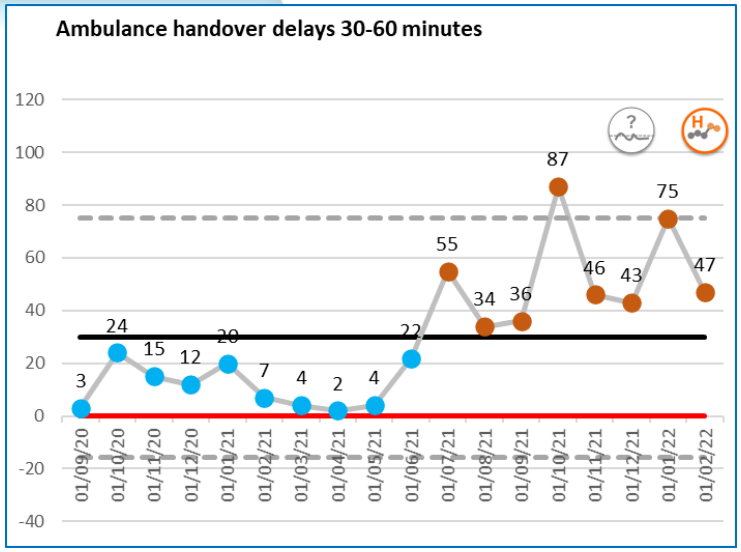
Waiting Times			Quality Access & Outcomes											
Quality Access & Outcomes	Requirement	Target	April	May	June	July	August	September	October	November	December	January	February	March
UEC Shadow Performance Measures	95 % Target	95%	93.45%	91.30%	87.78%	80.69%	81.78%	83.08%	75.32%	79.14%	77.96%	76.15%	77.15%	
	QEH ED Total Attendances		7390	7790	8394	8115	7998	8355	8699	8199	8099	7944	7527	
	(Activity levels 2019/20)		10268	10636	10350	10987	10740	10621	10731	10878	11107	10624	9628	
	Activity as proportion of base year		72%	73%	81%	74%	74%	79%	81%	75%	73%	75%	78%	
	Type 1 Attendances		4951	5205	5556	5555	5404	5614	6132	5593	5598	5214	4870	
	Type 3 Attendances		2439	2585	2838	2560	2594	2741	2567	2606	2501	2730	2657	
	No Attendances Assessed within 15 mins		2352	2310	2895	2883	2593	3241	3642	3249	2882	2977	2853	
	Attendances Assessed within 15 minutes		5038	5480	5499	5232	5405	5114	5057	4950	5217	4967	4674	
	Percentage Assessed within 15 minutes		68.17%	70.35%	65.51%	64.47%	67.58%	61.21%	58.13%	60.37%	64.42%	62.53%	62.10%	
	30 minute Ambulance Breaches		2	4	22	55	34	36	87	46	43	75	47	
	Total patients spending > 12hrs in Dept.		4	6	5	52	81	32	211	112	180	317	182	
	No of patients with TCI > 12 hours		0	0	0	0	5	0	0	0	0	12	0	
	Average Time in Dept - Non-Admitted		132	130	135	147	145	142	160	150	149	152	148	
	Average Time in Dept - Admitted		243	264	293	363	354	339	417	384	410	465	429	
SDEC	% of 0 LOS Admission as proportion of total NEL Activity		21.44%	22.36%	20.80%	19.97%	19.13%	34.45%	36.98%	35.63%	37.15%	40.57%	40.73%	
Supplimentary Information	Ave Time in Dept in Hours - Non-Admitted		2.20	2.17	2.25	2.45	2.42	2.37	2.67	2.50	2.48	2.53	2.47	
	Ave Time in Dept in Hours - Admitted		4.05	4.40	4.88	6.05	5.90	5.65	6.95	6.40	6.83	7.75	7.15	

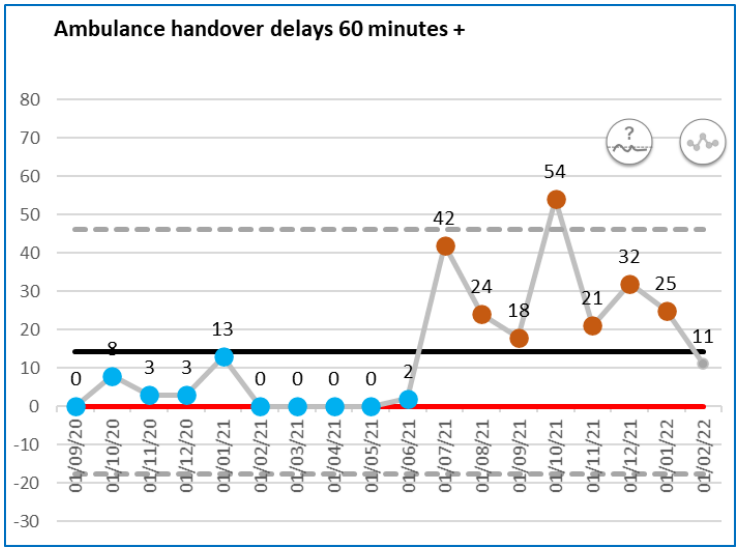
Report by exception: Spotlight Responsive - UEC Ambulance Handover Delays

Gateshead Health NHS Foundation Trust

Detail on this measure is included as delays have increased and special cause variation (concern) triggered in recent months and the national focus on zero tolerance to ambulance delays.

Responsive





Background

The NHS Long Term Plan set out a vision to reduce Ambulance delays. Ambulance delays are risky as they delay assessment and treatment for those waiting in an ambulance queue. Delays can compromise safety in the community by reducing the number of ambulances available to respond to emergencies.

There is now greater focus on reducing ambulance delays following AACE publication of clinical review (15/11) which states that the review should take 15 mins with no patients waiting more than 30 minutes.

Situation

A noticeable increase in handover delays can be observed from July 2021 Special cause variation is observed for both 30-60 minute and over 60 minute delays with the number of delays above the 18 month mean for seven a eight consecutive months respectively. The upper process s limit was breached for 30-60 minute delays in Oct-21 and Jan-22, and for over 60 minute delays in Oct-21

Actions taken to Mitigate Risk & Accept ambulance transfers rapidly

- Implementation of 10 point UEC action plan ongoing via Urgent Care Board
- Direct referrals to SDEC for GP/111/999
- SDEC provision in place for 7/7 – 12 hours per day
- Flexible FOH surge capacity: Enhanced discharge lounge – space to accommodate 4 front of house arrivals
- Access to Clinical Decision makers: Front of House frailty provision 70 hrs+ (work with geriatric team underway)
- CRtP recorded to support onward timely care
- Fit to Sit implemented
- Community Discharge capacity to support flow and prevent admission via rapid response team – rapid response team reviewing access to P3 & P4 activity with NEAS.
- Community are reviewing gap analysis re: community support and pathway operating model
- Utilising HALO support in handover of care

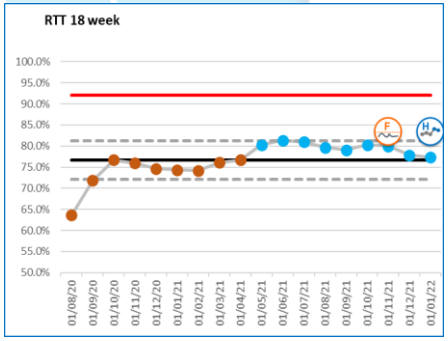
Recommendation

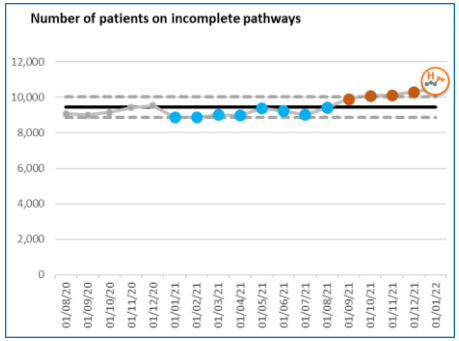
Finance & Performance Committee to receive updates from service and feedback from ECIST findings.

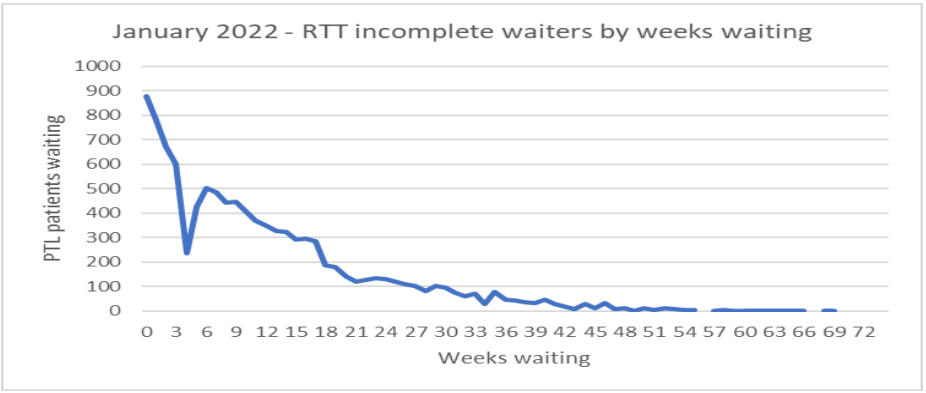
Report by exception: Responsive – Spotlight Maximum time of 18 weeks from point of referral to treatment (RTT) 92%

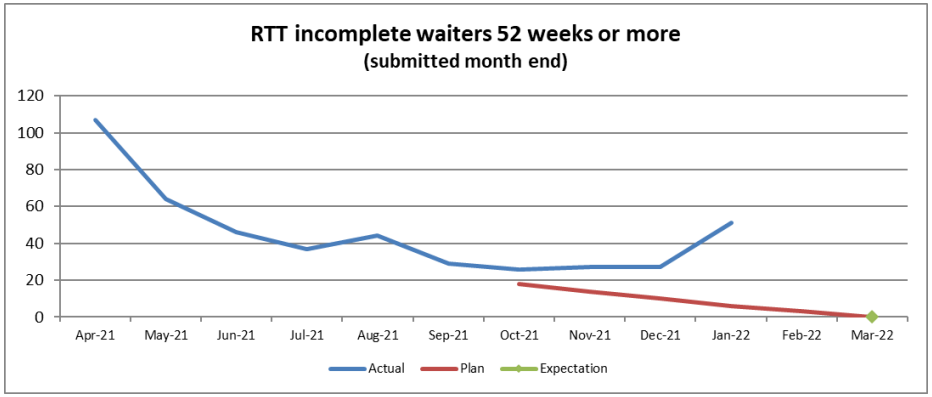
NHS Gateshead Health NHS Foundation Trust

Responsive









Situation

The planning guidance recognises the challenges faced by the NHS in achieving this target and had introduced the expectation to remove all 104 week waiters and manage the backlog of over 52 week waiter to zero by March 2022.

The Trust is still within the trajectory to report no over 104 week waiters, however the number of over 52 week waiters has increased to 51 over 52 week waiters in January (above H2 planned trajectory).
The Elective Programme Board continues to provide leadership and oversight on all stages of treatment in RTT: Outpatients, diagnostics and inpatients.
The priority for the Trust is to make sure all patients have TCI dates and to limit cancellations where possible, whilst prioritising out P2's and cancer patients. Clinical prioritisation is ongoing and centralised scheduling supports reducing long waiters and booking patients in clinical priority then longest waits.

The main areas of risk now are recovering from the impact of the current covid wave and reinstating the elective programme to catch up on lost elective capacity to reduce the waiters. Areas of risk continue to include workforce staffing in theatres and reduced staffing across a number of surgical specialties. Agency staffing and WLI continue to support areas of workforce pressures.

The total numbers of patients reported on the PTL has increased in month – major increased in referrals have been seen in Breast, T&O General Surgery and Urology.

Actions

- Business Units are managing the risk to long waiters by continuing to clinically prioritise with weekly prioritisation of available capacity.
- Principles of Maximising Day case potential & working through additional capacity plans to deliver the gateway criteria at ICP/ICS levels.
- Plans to deliver zero >52 week waiters are now at risk, compounded by constraints in outpatient capacity.
- Technical validation of the waiting list to be repeated to understand patients' treatment options and refresh those choosing to delay treatment but remain on the waiting list, supporting the removal of P5's classifications on the waiting list.

Recommendation

Finance & Performance Committee are to note that the orthopaedic programme commenced w/c 14th February. Although operational delivery has been impacted by staff testing positive.

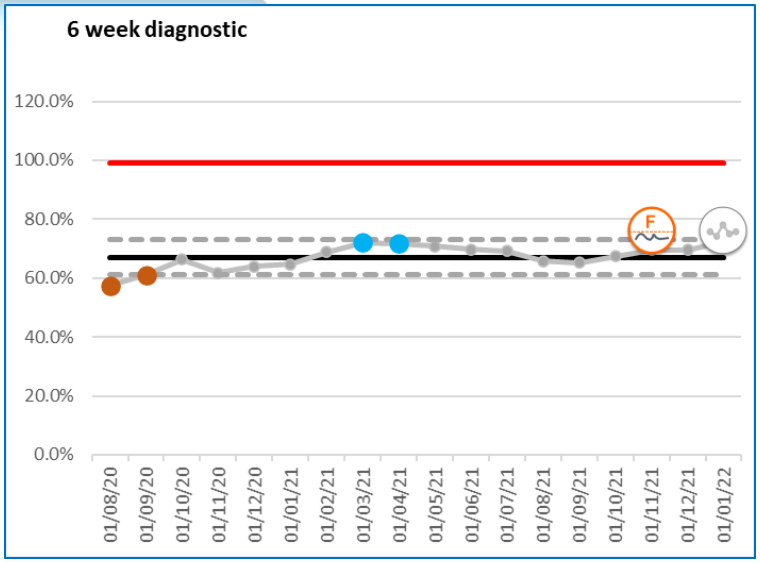
Report by exception: Responsive – Maximum 6-week wait for diagnostic procedures

Detail on this measure is included as the standard has not been met and special cause variation triggered.

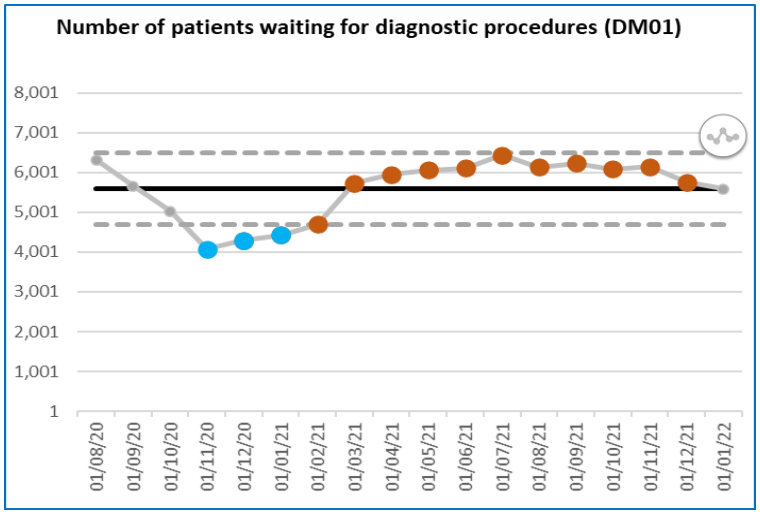
NHS Gateshead Health NHS Foundation Trust

Responsive

1



2



Background

1. This indicator measures, at the end of each month, the percentage of patients waiting less than 6 weeks for specified diagnostic tests and the number of patients waiting for those specified diagnostic tests.
2. The volume of patients waiting for a diagnostic procedure

Assessment

Recovery plans are in place to re-instate additional capacity, Echocardiography still remains a particular area of concern accounting for 77.8% of the patients waiting over 6 weeks. Activity levels for echocardiography increased in February to 121% from 94% in December.

Increasing referrals in Audiology are also impacting on waiting times with more than 49.49% waiting more than 6 weeks. Capacity is now being reviewed on a weekly basis, along with service reprovision.

Actions

- Echocardiography action plan includes estates work for additional room and also using external resource to meet the capacity gap - Backlog recovery of all long waits revised to August 22.
- Weekly management of audiology referrals is in place – recovery report presented to F&P Committee in March 2023.
- Emerging risks with Service Line Management pressures in Clinical Support & Screening

Recommendation

Detailed discussion and scrutiny of audiology recovery at Finance & Performance Committee.

Report by exception: Responsive – Maximum 6-week wait for diagnostic procedures (supplementary monitoring)

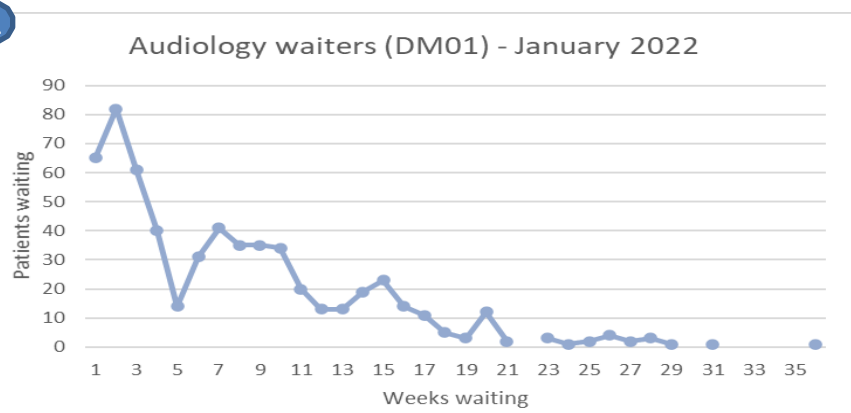
Gateshead Health NHS Foundation Trust

Responsive

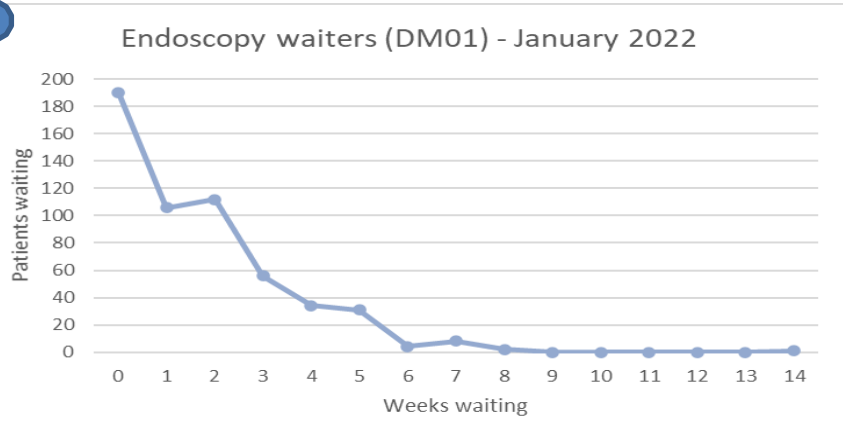
Audiology patients waiting and also those waiting more than 6 weeks has been steadily increasing this financial year, Chart 1 shows the number of patients waiting by week band with the longest wait at 37 weeks.
Endoscopy waiters have increased in January to 544 from 532 in December and are currently showing a longest wait of 14 weeks Chart 2

Compliance with the 6 week target for Echocardiography has increased slightly from 20.59% to 22.88%. Charts 3 and 4 demonstrate the total waiters with the recovery trajectory and delivered activity levels.

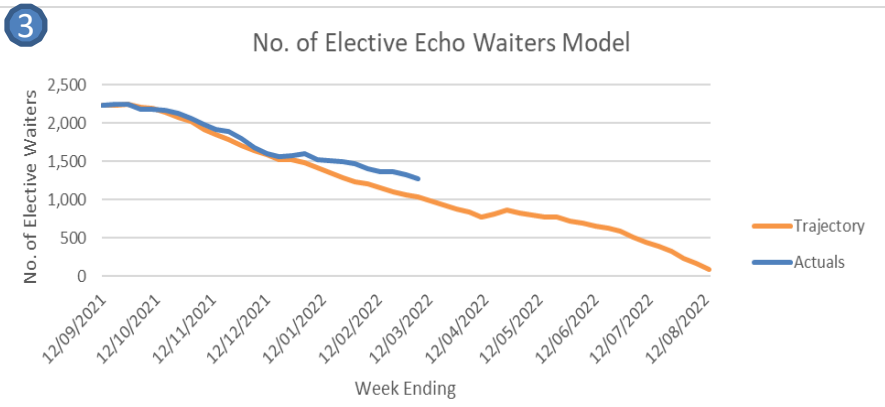
1



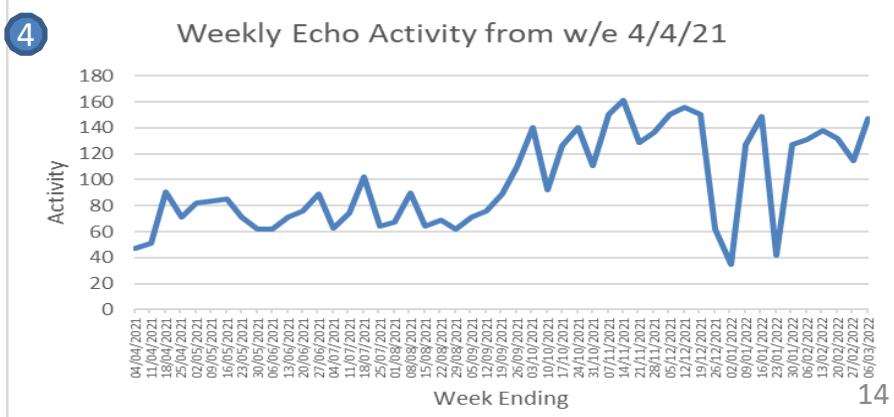
2



3



4

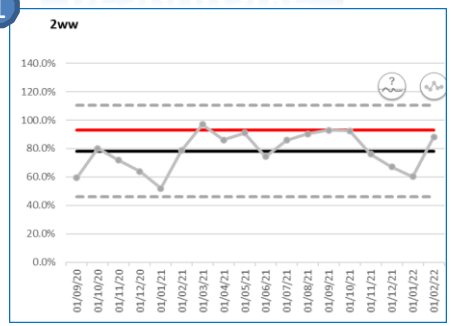


Report by exception: Responsive – Cancer Standards Summary

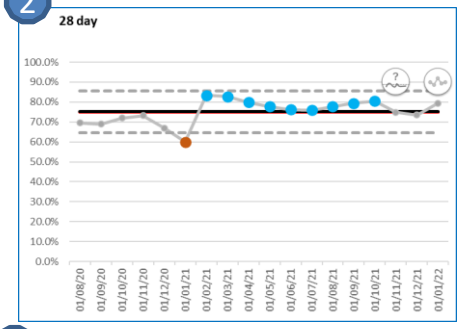
NHS Gateshead Health NHS Foundation Trust

Responsive

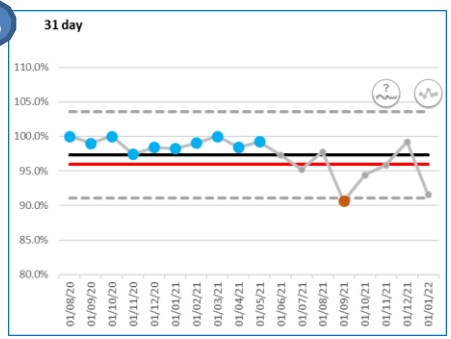
1



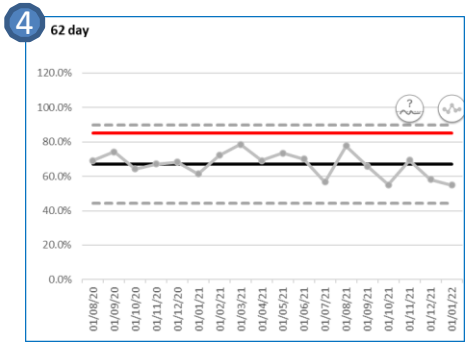
2



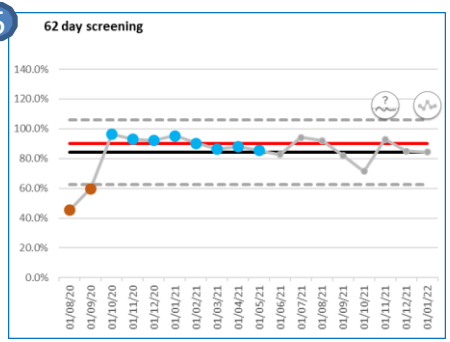
3



4



5



1. **2 Week Waits – 88.1%** February's performance is below to the 93% threshold but has increased from previous months..

There were pressures in February in all tumour sites with only Gynaecology and Haematology exceeding the 93% target.
Clinic attendances in February were at higher levels than pre- covid , however capacity issues still prevail with rising demand and workforce pressures across the services.

2. 28 Day Faster Diagnostics January: 73.45% The target has not been achieved in the last three consecutive months . This measure will replace the 2 Week wait in the new system oversight framework.

3. 31 Day Diagnostic Standard – performance 91.5%, Breast was below standard. January treatments increased to 142.

4. 62 Day Treatment January: 54.9% All Tumour groups were below standard.
Gynaecology performance also affected by our support to S.Tees with 2ww patients breaching the 62 day target.
Whilst the national target is set at 85%, the planning guidance recognises the challenges faced by the NHS and has set a recovery trajectory based on the volume of patients waiting over 62 days.
At the end of February reported 55 patients waiting over 62 days on a 2ww classic pathway (172 on all pathways).
The ask within the operational guidance was that 'Systems are being asked to plan to restore >62-day backlogs to the relative backlog using urgent suspected cancer referral volumes seen in Q3 2019/20 compared to the overall national backlog for the w/e 16th February' by March 2022 for Gateshead this was a position of 55 however due to the pressures supporting the ICS the Trust submitted a plan of 75 at March 2022, 72 for the month of February 2022 which was not met.
The number of long waits (> 104 days) on a 62 day (2ww) pathway at the end of January was 10 patients (37 on all pathways).

5. 62 Day Screening January: 84.4% Performance is below the 90% standard.

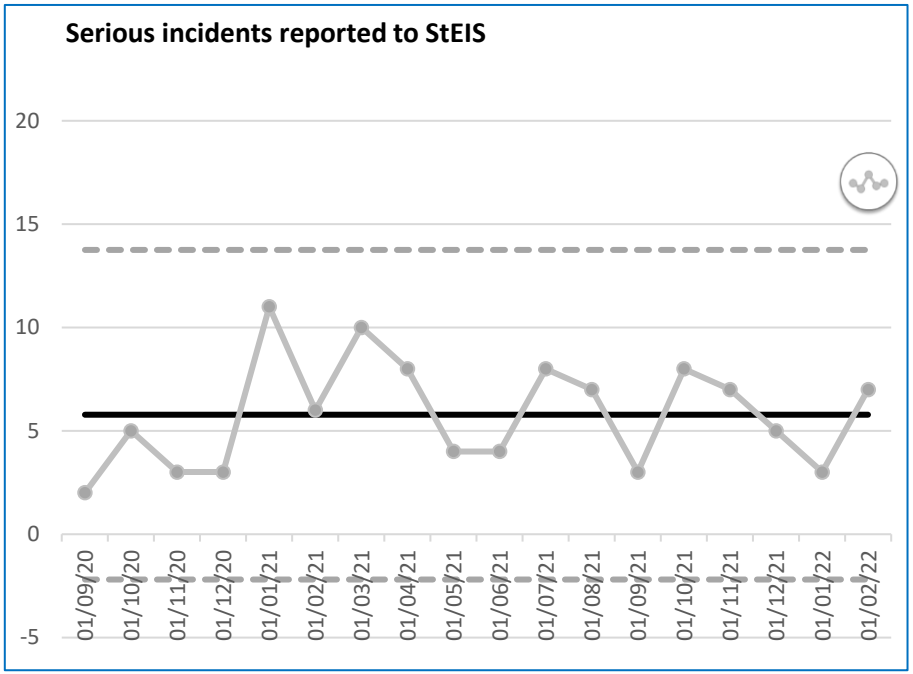
Actions
Ongoing liaison with specialist commissioning to develop a funding model to support our development as lead provider for gynae-oncology surgery.
Ongoing weekly liaison and collaboration within ICP at Cancer hub
Liaison with NUTH to agree attendance at their weekly urology PTL which will improve collaboration between teams. .
Ongoing development of cancer performance dashboard to aid business unit monitoring of performance and waiting times.
Ongoing engagement with weekly tumour specific cancer tracking meetings which supports improvements within pathways and individual patient journeys.

Report by Exception Integrated Oversight Report

Gateshead Health NHS Foundation Trust

Safe

Serious Incidents reported to StEIS



Serious Incidents in health care are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified.
Serious Incidents include acts or omissions in care that result in; unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm - including those where the injury required treatment to prevent death or serious harm, abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services.

This indicator is included routinely as a monthly Board Update; this indicator is not triggering a cause for concern. 3 of the 7 incidents below are related to incidents occurring in February, 4 remaining incidents are historic and have been identified following the review process. A summary of the themes are detailed below:

Death / Catastrophic Harm
1 x Test results / reports - incorrect
1 x Monitoring - delay in recognising complication of treatment

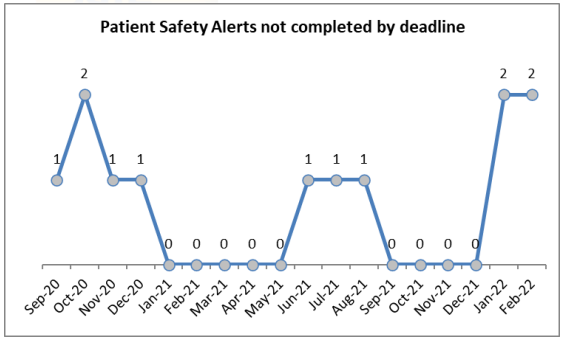
Severe / Major Harm
1 x Test results / reports - failure / delay to interpret or act on
1 x Test results - failure / delay in acting upon
1 x Fall on same level - cause unknown
1 x Fall from height - chair
1 x Protection of children issue

Report by exception: Safe – Patient Safety Alerts not completed by deadline

Detail on this measure is included as there are patient safety alerts currently open which were not completed by the deadline in the last 18 months

Gateshead Health NHS Foundation Trust

Safe



Combined impact analysis

Financial impact

Quality impact

Workforce impact

Operational performance impact

Situation

There are two patient safety alerts currently open for the Trust that were due for completion in November 2021.

NatPSA/2021/003/NHSPS - Eliminating the risk of inadvertent connection to medical air via a flowmeter
Issue date: 16/06/2021
Completion Deadline date: 16/11/2021
Status on 1st February 2022: Assessing relevance (this has been corrected to action required – ongoing 11.03.2022)

NatPSA/2021/009/NHSPS- Infection risk when using FFP3 respirators with valves or Powered Air Purifying Respirators (PAPRs) during surgical and invasive procedures
Issue date: 25/08/2021
Completion Deadline date: 25/11/2021
Status on 1st February 2022:Acknowledged (this has been corrected to action required – ongoing 11.03.2022)

Background

National patient safety alerts are overseen by the Medical Director with appropriate senior leads being allocated to progress the actions required. They are also added to the Risk Register to facilitate the monitoring of actions through the agreed governance groups.

Assessment

There is one outstanding action for NatPSA/2021/003 which involves ensuring that Trust policies are compliant with the new guidance and with British Thoracic Society guidance.
There are four actions for NatPSA/2021/009 which are being led by QEF and require that the trust makes available type II FRSMs and non-valved PARPs when undertaking surgical or invasive procedures; removal of valved FFP3/PARPs from areas that do not use them; informing staff whose only protection is valved FFP3 or PARP not to use them for undertaking sterile or surgical procedures and where valved and non-valved FFP3/PARPs need to be stocked, clear points of warning are displayed that they are not to be used when undertaking sterile/surgical procedures.

Actions

Confirmation received 11.03.2022 that Trust policies are compliant with BTS and therefore this shared with Medical Director to agree compliance on CAS system – it is anticipated this will be closed by the end of the financial year. Leads of actions for NatPSA/2021/009 contacted to provide update.

Recommendation

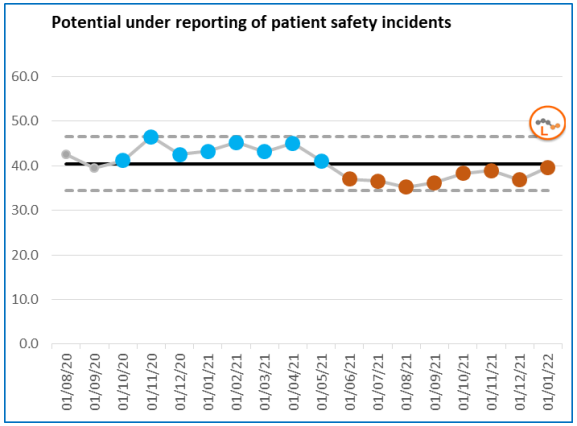
To evaluate the effectiveness of the current process which will be demonstrated by timely compliance and closure of national patient safety alerts.

Report by Exception Integrated Oversight Report

Gateshead Health NHS Foundation Trust

Safe

Potential under reporting of patient safety incidents



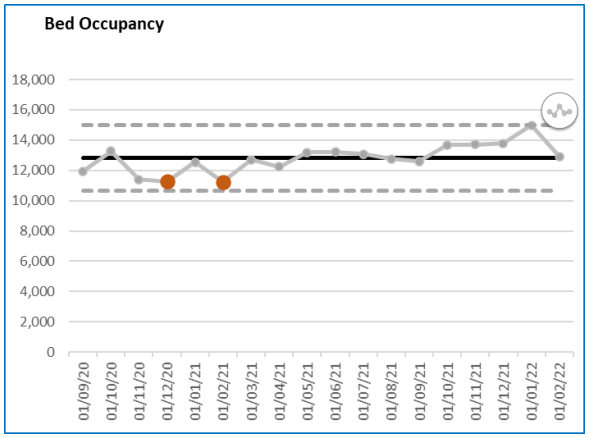
This indicator is included as the rate of patient safety incidents per 1000 bed days is triggering for special cause variation (low) following a shift in the reporting rate from June 2021.

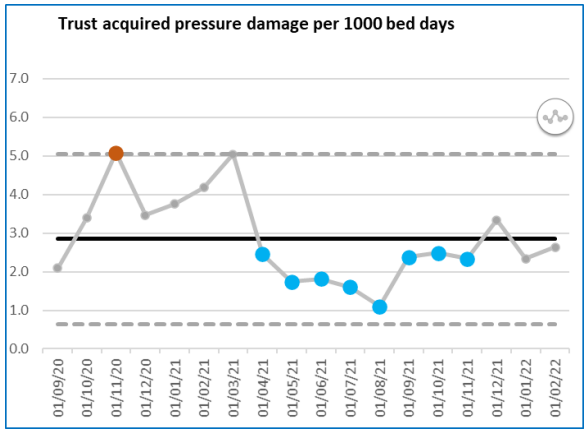
Considering the numerator and denominators involved. The number of patient safety incidents (numerator) is displaying common cause variation for the 18 month period, however the highest volume of incidents was observed in January 2022 and the lowest volume in February 2022. The bed occupancy (denominator) is close to displaying special cause variation with recent figures above the 18 month average.

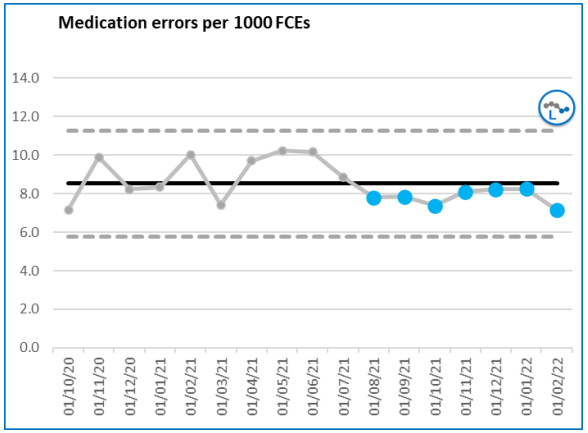
The combination of high bed occupancy alongside more subtle increases in incidents has resulted in a fall in the patient safety incident rate when measured in this manner.

Other contributing factors include
Pressure damage incidents remain relatively low following a period of special cause variation
Medication error rate is triggering low.

Recommencement of widespread datix training alongside improved access for booth acute and community staff is anticipated to improve this position.





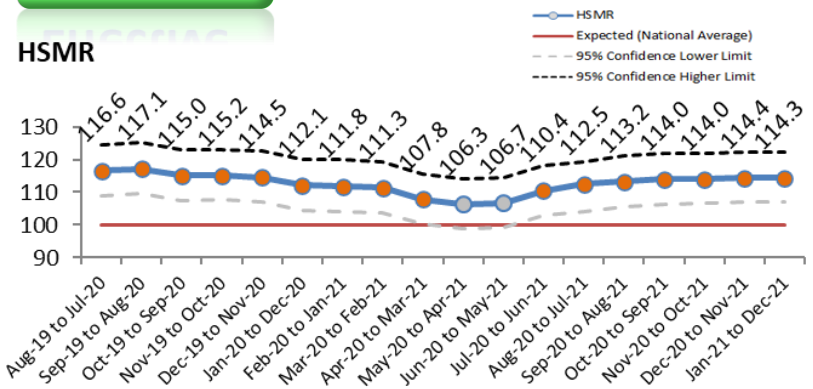


Report by exception: Effective – Hospital Standardised Mortality Ratio

NHS Gateshead Health NHS Foundation Trust

Effective

HSMR



Mortality Review

Period: February-2021– January 2022

	Deaths in period	Deaths reviewed	%	Hogan 1	Hogan 2	Hogan 3	Hogan 4	Hogan 5	Hogan 6	Potentially Avoidable Deaths
All Deaths	1210	611	55.5%	95.7%	3.9%	0.3%	0.0%	0.0%	0.0%	0.0% (0)
Learning Disability Deaths	19	9	47.4	77.8%	22.2%	0.0%	0.0%	0.0%	0.0%	0.0% (0)

Alert	CCS Diagnostic Group	Period	Expected Deaths	Observed Deaths	Obs -Exp	HSMR / CUSUM Score	% Reviewed (where death within Trust)	% Definitely not preventable	% NCEPOD Good Practice
HSMR	Cancer of the Oesophagus	Dec-20 to Nov-21	5	11	6	244	54.5%	100%	83.3%
HSMR	Congestive heart failure; non hypertensive	Dec-20 to Nov-21	44	76	32	172	36.8%	96.4%	74.1%
HSMR	Pneumonia	Dec-20 to Nov-21	123	156	33	127	48.7%	97.4%	81.6%
SHMI	Congestive heart failure: non hypertensive	Oct-20 to Sep-21	47	73 (61 in Hospital)	26	158	42.6%	96.0%	79.2%
SHMI	Septicaemia	Nov-20 to Oct-21	57	80 (64 in Hospital)	23	139	62.5%	90.0%	85.0%
SHMI	Pneumonia	Nov-20 to Oct-21	133	168 (141 in Hospital)	35	126	50.0%	98.6%	87.1%
HSMR CUSUM*	Congestive hear failure; non hypertensive	Nov-21	9	18	9	7.41	16.7%	100%	100%
HSMR CUSUM*	Septicaemia	Sep-21	16	19	3	3.00	31.6%	100%	100%
HSMR CUSUM*	Cancer of bronchus; lung	Nov-21	13	22	9	4.83	45.5%	100%	80.0%
HSMR CUSUM*	Respiratory failure; insufficiency; arrest	Nov-21	3	6	3	3.35	33.3%	50.0%	50.0%
HSMR CUSUM*	Liver disease: alcohol related	Oct-21	6	11	5	3.57	72.7%	100%	100%

Situation – The Trust HSMR remains at 114 for the fourth consecutive month with a banding of 'More Deaths than Expected' for the most recent available period.

The HSMR has remained stable over recent months. Following recent discussions with NEQOS, the Board were reassured that looking at other measures (ME work, Mortality reviews, SI's) was a better way to understand mortality and look for learning / identify problems

Background - The HSMR is a measurement tool that considers observed hospital deaths with the an expected number of deaths based on certain risk factors identified in the patient group.

Assessment - Mortality indicators show the Trust deaths relative to the expected deaths per the statistical models for HSMR and SHMI. The HSMR is showing 'More Deaths than Expected whereas the SHMI is showing deaths are within the expected range. The Trust continues to trigger for Pneumonia and Congestive Heart failure diagnosis groups.

Mortality review data for the last 12 months demonstrates that 95.7% of deaths reviewed were definitely not preventable. Cases scoring more than Hogan 1 are subject to a review at Mortality Council, the majority of these cases are also patient safety incidents and would go through the Trusts Serious Incident Panel. Since the inception of the Medical Examiner Service in September 2020, they review all deaths and escalate cases for additional investigations i.e. Mortality Council, patient safety investigation

The mortality models are influenced by a trust's coding, in particular the Primary diagnosis, also the Secondary and Palliative Care coding (for the HSMR). The models have different exclusion criteria for COVID-19 diagnosed patients. Due to the impact of Covid-19 and the fundamental weaknesses of the HSMR and SHMI indicators, the Trust should be more reliant on other methods and sources of intelligence to monitor mortality. For instance, outcomes from Mortality Reviews, Medical Examiner reviews and Serious Incident Patient Safety Investigations. This indicator may continue to flag for sometime.

Actions

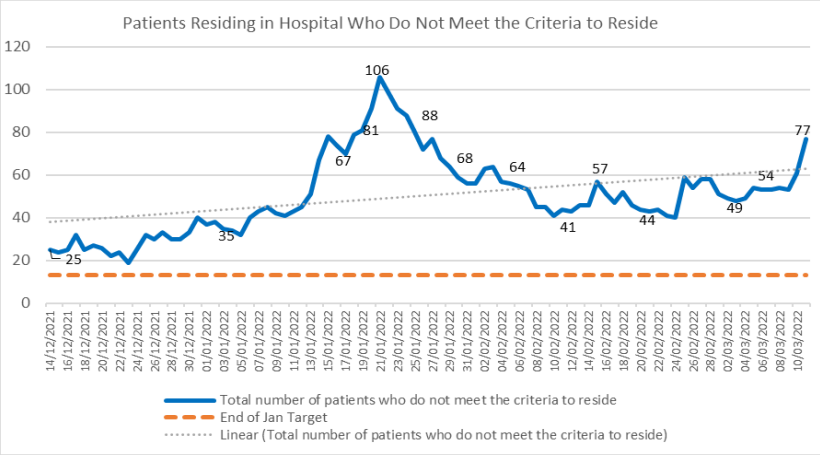
- Two additional Mortality Council meetings have been scheduled to review heart failure deaths. One of these meetings has taken place – nine cases were reviewed. 7 x Hogan 1, 2 x Hogan 2. 6 x NCEPOD 1, 1 x NCEPOD 3, 2 x NCEPOD 4. The second meeting is scheduled for April 2022. Learning identified in terms of NCEPOD 3 and 4's was 1) delays in discharges as a result of delays in obtaining social care packages, 2) recognition of patient dying, 3) reduced access to obtaining ECHOs and telemetry and appropriateness of placing patients in wards were there is limited access to monitoring 4) ECGs not documented within patient notes.
- Task & Finish Group set up to incorporate the Medical Examiner Review into the level 1 process. A large proportion of deaths are expected and well managed, particularly in the Medical Business Unit. Changing the process will release capacity and allow the ward teams to concentrate their efforts on reviewing the deaths where is the most learning and areas for improvement. First meeting took place on 16th February, very well attended, agreement to change process and action plan development to achieve this.
- Explore the use of HIE to ensure all comorbidities are captured more efficiently in the initial clerking document in order to be coded appropriately, lead for Great North Care Record, he is going to take it back to the HIE – completed full access to HIE is available
- Review the admission document to ensure all differential diagnoses can be added and coded appropriately has this been done – this is to be discussed at the Mortality & Morbidity Steering Group in July 2021 – this meeting was stood down therefore item has been rolled over to September 2021 – completed.

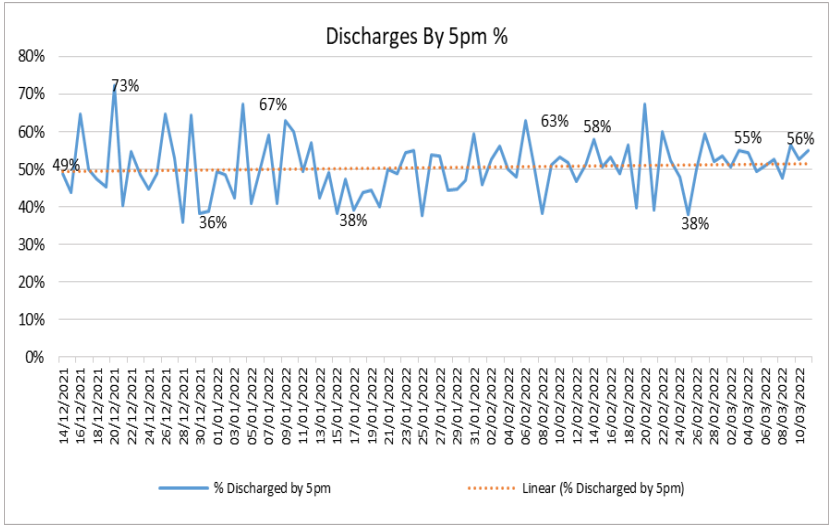
Recommendation - Continue to inform & note actions undertaken at Mortality and Morbidity steering group and Quality Governance Committee via the Integrated Oversight Report and Mortality Paper.

Report by exception: Patients who no longer meet the Right to Reside

Gateshead Health NHS Foundation Trust

Effective





Situation

The hospital and NENC remains under significant pressure with ED, Urgent and Emergency Care and Community continuing to care for patients with increased acuity. The continued management of covid-19 and elective recovery, constrained by capacity for care packages has resulted in increased bed occupancy and a consequential impact on pathways affecting discharge.

Background

To prepare for Omicron the NHS and DHSC were tasked to create collective capacity to support peaks of activity.

Personal health budgets, live in carers, use of IS therapy staff to be utilised whilst the systems:

1. Improve domiciliary care (pathway 1)
2. Maximise remote monitoring – as an alternative to admission
3. Increase bed capacity in care centres
4. Discharge more people per day who no longer meet the reasons to reside, and delays associated with internal hospital factors
5. Establish Covid Virtual wards
6. Introduce hospital at home

Assessment

The SHAPSHOT daily sitrep identifies the total number of patients who current do not meet the criteria to reside rose towards the end of February and continues to do so into March. As of 11th March there are 78 patients who do not meet the criteria to reside

Actions

- Oversight and review at urgent & Emergency Care Board
- Development of ward based 'heart beat/discharge targets in progress
- Improvement work to focus on 33% discharges by noon and 70% by 5pm
- Review with ECIST support
- Expedite focus on discharge
- Additional capacity (16 beds) secured in care homes
- Hospice at home repurposed to accommodate 8 hours per day
- Rapid Response team are able to monitor 8 patients at home
- Prime Team (LA discharge team) appointed 9 additional staff
- Operational reporting –linked to oversight monitoring

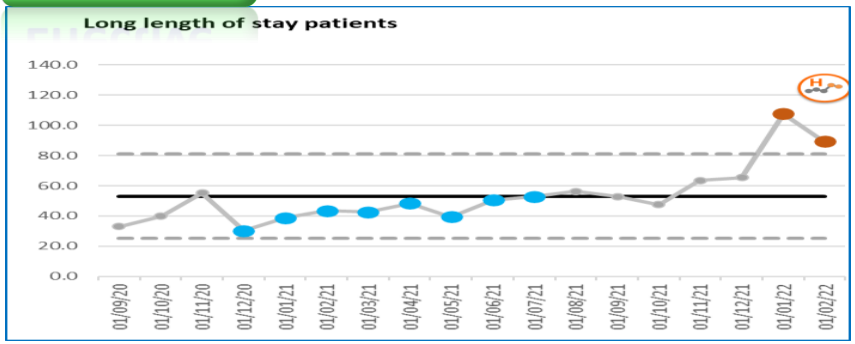
Recommendation

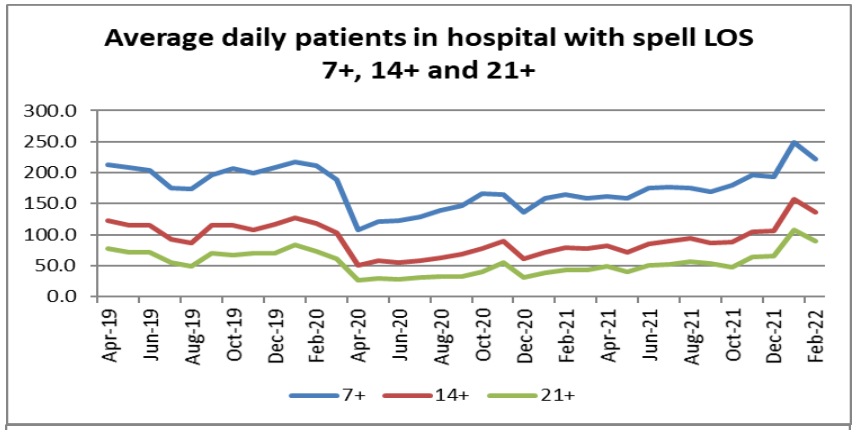
Review plans actions and expedite discharge as part of Daily operational oversight at Emergency Care Board & COO Meetings.

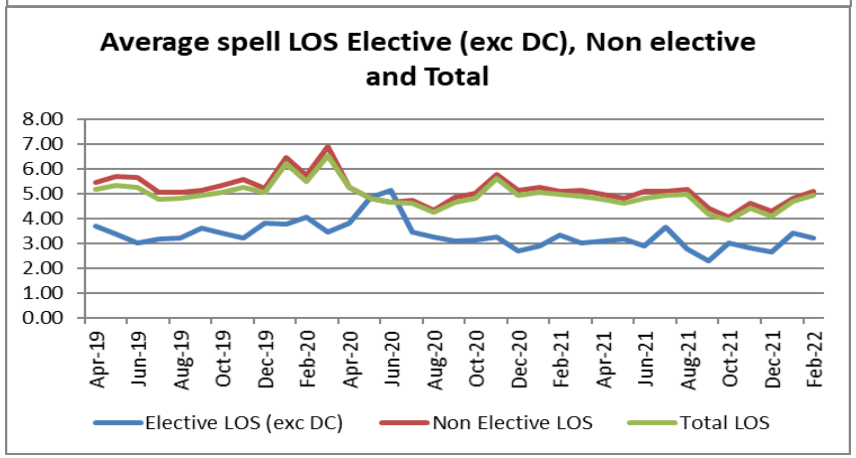
Report by exception: Effective – Long Length of Stay Patients

NHS Gateshead Health NHS Foundation Trust

Effective







Situation The average number of patients in hospital with 21+ days LOS is triggering special cause variation (concern). A general upward trend is observed and the January and February figures are above the upper process limit with the average at 107.6 and 89.2 respectively.

The ECIST existing target of 59 is subject to either pass or fail based on common cause variation.

Background
An expectation that the daily average number of patients staying 21+ days would not exceed 59.

Assessment
Complex high acuity patients requiring multi faceted treatment plans genuinely do require longer lengths of stay in hospital – these patients are deemed as meeting the right to reside in hospital criteria. However, patients who no longer meet the criteria to reside (and are medically optimised) are usually more complex discharges where external delay factors such as limitations on packages of care and the ability to place patients into a care homes are the usual reasons behind the delays.

Snapshot update: As of 11/03/22 there are currently 78 patients who are medically optimised who do not meet the criteria to reside. The greatest volumes of Patients on Pathways 1, 2, & 3

- Pathway 1 – Care Home service 42(54%)
- Pathway 2 – Awaiting rehabilitation bed availability 18 (23%)
- Pathway 3 – Awaiting residential / nursing bed 5 (6%)

Actions

- Daily focus on medically optimised patients
- Long stay patient reviews
- Additional capacity (16 beds) secured in care homes
- Hospice at home repurposed to accommodate 8 hours per day
- Rapid Response team are able to monitor 8 patients at home
- Operational reporting –linked to oversight monitoring

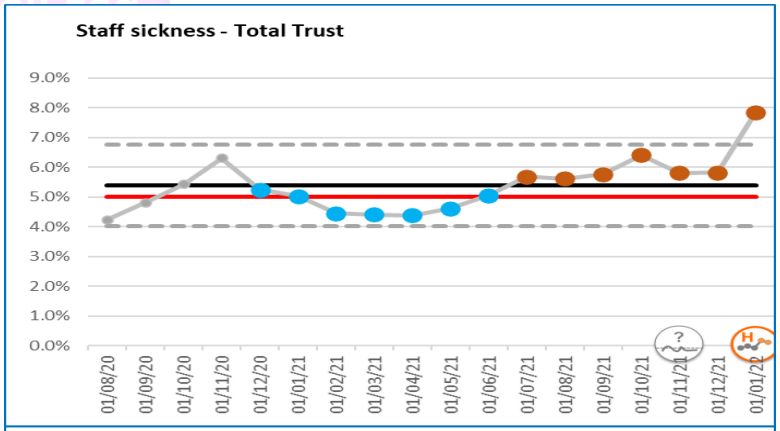
Recommendation
Review as part of Discharge workstream under the Urgent and Emergency Care Board

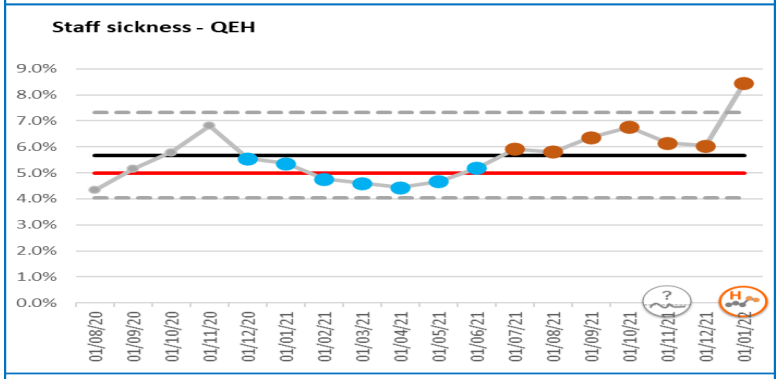
Report by exception: Well led – Sickness Absence

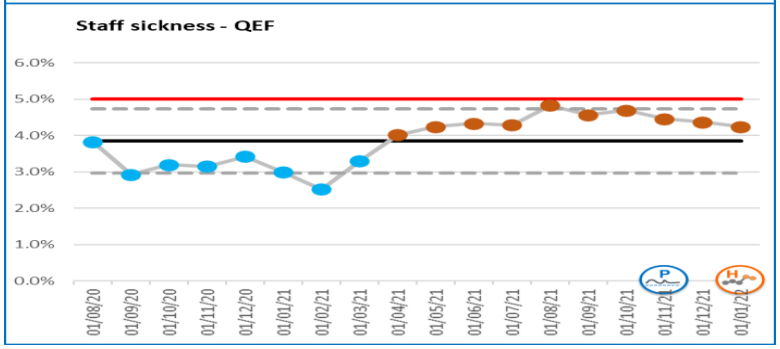
Detail on this measure is included because the target will either be achieved or failed based on variation within the performance and special cause variation identified.

NHS Gateshead Health NHS Foundation Trust

Well Led







Situation Special cause variation displayed for the Trust overall and both QEH and QEF.

Current performance of 7.85 % represents a fail of the Trust target.

Background

Sickness levels understandably peak during waves of the Covid-19 pandemic. Whilst there are a range of absence rates across services, the four operational business units have a much higher rate of sickness absence than corporate services.

Assessment

Whilst we have seen a small decrease in sickness absence levels we continue to see a fail against the Trust target.

Actions

The impact of absence is a key part of the 'supply' pressure across the Trust. The supply focus group has identified a number of actions to improve the position including additional support for managers with short term absence management and a focus of the POD Team on managing long term absence. Recruitment continues for HCA's, Registered Nurses, the Bank and the new operating model. The progress of recruitment is monitored on a weekly basis. These actions should enable more timely and appropriate interventions to enable staff to return to work sooner, and ultimately reduce sickness absence. Metrics are produced for the People and OD Committee to track the absence position and POD Leads are holding sessions within business units to highlight the cost of absence among other issues.

Recommendation

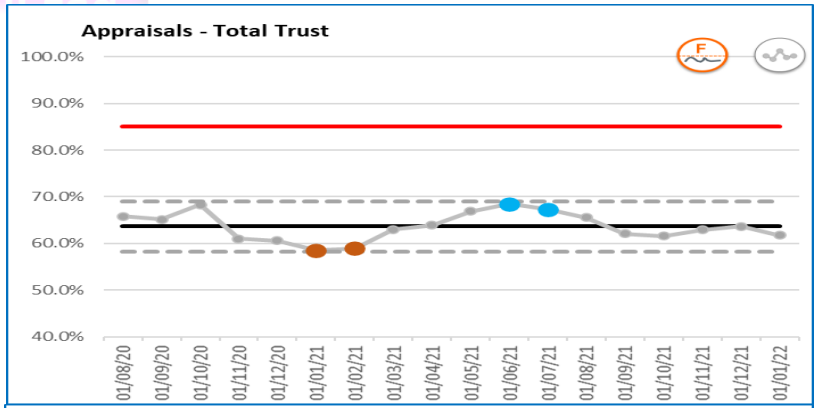
Review, management and oversight by Senior Team and continued management by operational teams with support from the People Services Team.

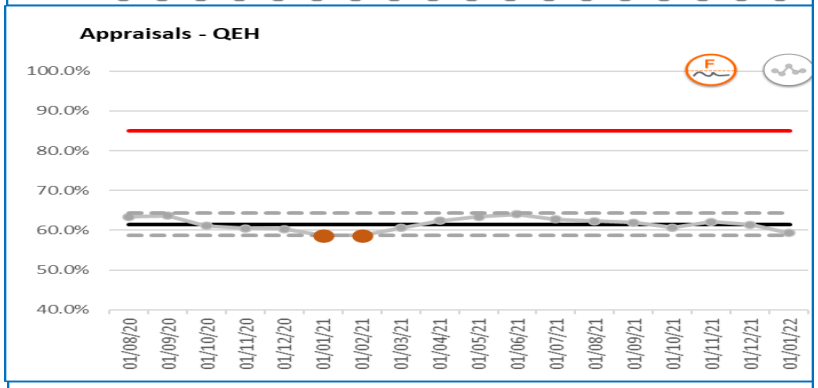
Report by exception: Well led – Appraisals

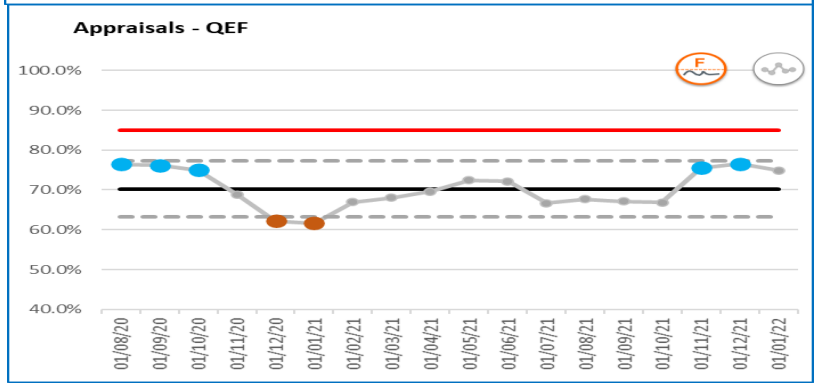
Detail on this measure is included because the target is consistently not met

NHS Gateshead Health NHS Foundation Trust

Well Led







Situation

Appraisal compliance consistently fails the 85% target, with this target not being achieved during the past 18 months.

Background

The Trust expects all staff, as valued members of the organisation, to have an annual conversation about their objectives, performance and development as a minimum. However it is recognised that in times of extreme pressure the focus has been on supporting staff to achieve the operational demands of the service as safely and effectively as practicable. Rates of Appraisal in operational business units have therefore been lower during the pandemic than corporate services, with Ward based services such as Medicine and Surgery having the lowest rates of appraisal compliance.

Assessment

Compliance rates are monitored via ESR and reported to business units as part of the suite of workforce metrics that are produced. Current compliance is 62.48% against an 85% target. Services remain under significant pressures from Covid-19 and work to improve compliance will continue.

Actions

POD continue reporting monthly to line managers, with the aim of reducing the volume of information, and include additional data about appraisals due in the next 90 days. The aim is to encourage managers to make realistic plans for the coming months. Work continues to provide support by updating ESR on behalf of managers and the new Education, Learning & Development Group, which has now been established, will oversee a wider review of the process.

Recommendation

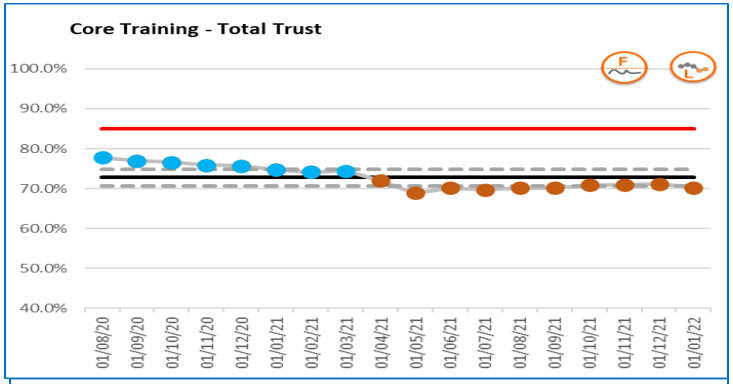
Review, management and oversight at Senior Leadership Team and continued management by operational teams.

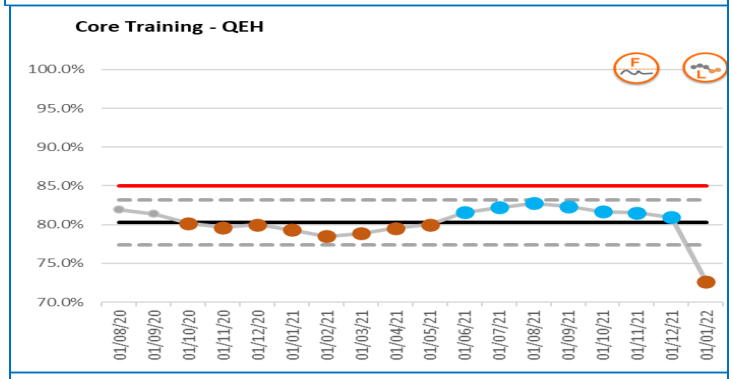
Report by exception: Well led – Core training

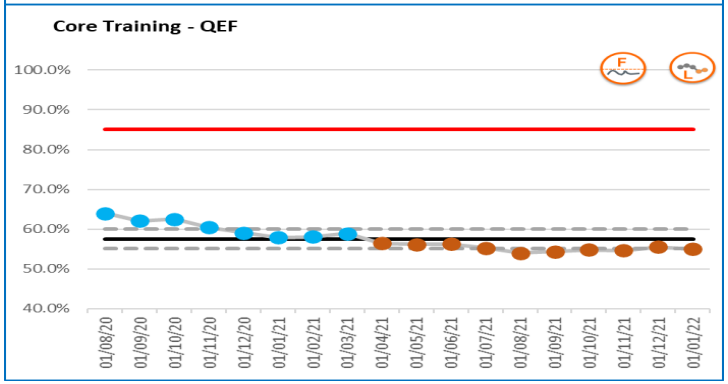
Detail on this measure is included because the target is no longer being met and special cause variation indicates a shift in performance.

Gateshead Health NHS Foundation Trust

Well Led







Situation

A shift in core skills compliance is observed from April 2021 with special cause variation (deterioration) triggering with the latest ten months below the 18 month mean.

QEH and QEF figures are both currently triggering special cause deterioration.

The indicator is flagging to consistently fail the target based on current performance and monthly variation.

Background

Core training covers those programmes which are recognised as core or essential training for all employees. However the need to respond to the significant demands on staff and services as a result of the pandemic and recovery, has meant this was not as high a priority in some services. In addition it was necessary to cancel attendance at a number of taught core skills courses; capacity on taught courses is still reduced as a result of social distancing measures; and difficulties to source other suitable accommodation. This inevitably affects capacity to improve certain core skills performance.

Assessment

Current compliance is at 70.3% against an 85% target

Actions

A core skills review has made recommendations which will result in greater clarity re: requirements, increased focus on national packages, agreed processes for statutory training requests, improved ESR functionality and improved access via the ESR App.

Recovery plans have been requested for business units to ensure there is plan to improve compliance. This project will be overseen by the newly formed Education, Learning & Development Group and will include BU recovery planning in partnership with POD Leads.

Recommendation

Review, management and oversight at Senior Leadership Team and continued management by operational teams.

Report by exception: Maternity – Progress with Ockenden recommendations

Maternity

NHS Gateshead Health NHS Foundation Trust

Situation
National requirement that Ockenden Action Plan signed off by your Trust Board by end March 2022.
The Health and Social Care Committee Report on The Safety of Maternity Services in England (July 2021) recommended an immediate end to the use of total Caesarean Section percentages as a metric for maternity services, and that this is replaced by using the Robson criteria to measure Caesarean Section rates more intelligently.
The second part of the Ockenden report was expected on 22 March 2022 (delayed due to parliamentary hold-ups, date for release tbc)

Background
This is the Trust self-declared position on the 7 IEs (including the 12 clinical priorities) from the Ockenden report published December 2020. The Regional Maternity team have been informed that there will be an urgent deep dive in to maternity and neonatal services for regional teams over the next few months. CMO visit planned to Maternity services in May 2022.
NHS England and Improvement notification to all maternity units to ensure that they are aware of this changes around LSCS performance targets. (Feb 2022). Maternity service dashboard to be changed to reflect the Robson criteria as reported to the MDS and National Maternity Dashboard.

Assessment
IEA 1 Enhanced safety - compliant
IEA 2 Listening to women & families – National work ongoing regarding the development and role descriptor for the Trust Senior Advocate role – guidance not yet confirmed
IEA 3 Staff training – Letter from DoF confirming that rebate from Year 3 MIS £254k to be ring fenced to ensure Maternity service safety and quality improvements received Face to Face training is being resumed and a full week of skills drills planned March 2022, remains on risk register
IEA 4 Managing complex pregnancy - compliant
IEA 5 Risk assessment - Further audits around risk assessment to be performed. Guidance to be developed around mothers choice of birth, including choice out with recommendations
IEA6 Monitoring fetal wellbeing – Addition to recommendations 2022; a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support - compliant
IEA 7 Informed consent - Need to focus on improvement of Trust website and available information for our mothers and families. Working with Comms to develop this. Video of unit completed and working with MVP to develop information leaflets and develop the personalised care plans on the patient portal.

Actions
See next slide which was submitted to the Regional team with the assurance and assurance template completed. Quarterly compliance reports sent to the NENC in relation to MIS and Ockenden compliance . Safety Champion walkabouts planned for 2022. Compliance reported internally within maternity governance structures and via Risk and Safety Committee and Quality Governance Committee.

Recommendation
The Trust board is asked to receive this exception report as assurance that there is a live action plan to achieve current and ongoing compliance with the Ockenden report 7 IEA's and underlying actions.

Maternity

NHS

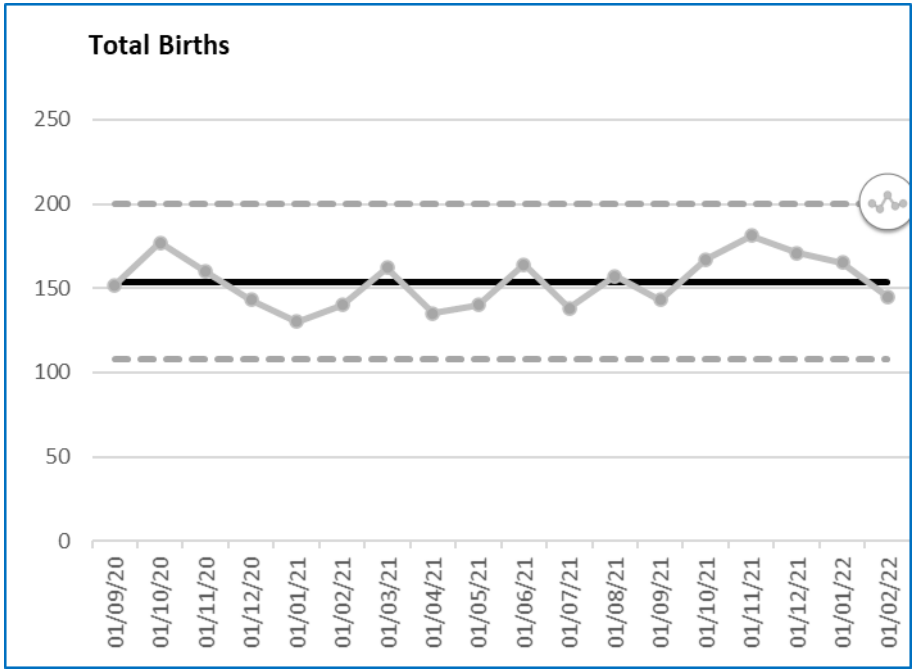
7 Ockenden IEAs (including 12 Clinical Priorities): Trust _Gateshead Health Foundation Trust Exec Sign off _____	Compliant	Partially Compliant	Non-Compliant
1) Enhanced Safety			
A plan to implement the Perinatal Clinical Quality Surveillance Model	**yes**		
All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB	**yes**		
2) Listening to Women and their Families			
Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services	**yes**		
Identification of an Executive Director with specific responsibility for maternity services and confirmation of a named non-executive director who will support the Board maternity safety champion	**yes**		
3) Staff Training and working together			
Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week	**yes**		
The report is clear that joint multi-disciplinary training is vital. We are seeking assurance that a MDT training schedule is in place.	**yes within Covid restrictions**		
Confirmation that funding allocated for maternity staff training is ringfenced	**yes**		
4) Managing complex pregnancy			
All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place	**yes**		
Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres	**yes**		
5) Risk Assessment throughout pregnancy			
A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance		**yes**	
6) Monitoring Fetal Wellbeing			
Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.	**Lead Midwife and Consultant for SBL in post Yes**		
7) Informed Consent			
Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.		**yes**	

Report by exception: Maternity – Total births

Detail on this measure is included because the target will either be achieved or failed based on variation within the performance.

Gateshead Health NHS Foundation Trust

Maternity



Combined impact analysis

Financial impact

Quality impact

Workforce impact

Operational performance impact

Situation Common cause variation displayed
145 births in February represents birth rates within expected range.

Background
The birth thresholds are used to monitor staffing ratios on the delivery suite and the capacity of the unit. Birth rates consistently above 170 would flag a significant increase and a review of staffing levels would be required.

Assessment
The variation in total number of births shows common cause variation and does not indicate a sustained increase in births. The increase in acuity is also having a significant impact on the input required from the Obstetric and Anaesthetic teams, due to increased levels of intervention. The Special Care Baby Unit continues to experience significant increases in cot occupancy/length of stay due to the increased acuity.

Actions
A full review of Midwifery staffing has been performed and the recruitment process is underway to aim for Birth rate compliance. The acuity of mothers is recorded on a four hourly basis on the delivery suite and postnatal ward. This is reviewed daily and weekly and informs the HOM staffing review and report to the Chief Nurse.

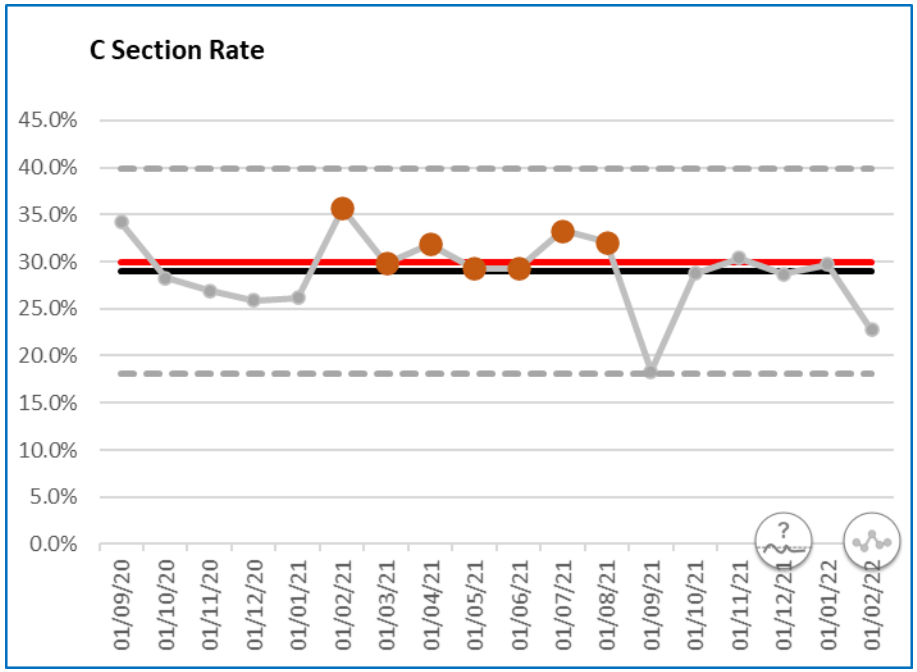
Recommendation
The service was unable to recruit to all vacancies on the last round of recruitment; further successful recruitment has taken place but still well below full staffing. Additional non-clinical & HCA support, & specialist midwifery roles have attracted staff into the Trust. Continue to monitor intervention rates and discuss whether additional medical/theatre staffing is required. There are added pressures due to covid sickness absence as with all staffing.

Report by exception: Maternity – C section rate

Detail on this measure is included because the target will either be achieved or failed based on variation within the performance.

NHS Gateshead Health NHS Foundation Trust

Maternity



Combined impact analysis

Financial impact

Quality impact

Workforce impact

Operational performance impact

Situation Common cause variation is displayed.
Current performance of 22.8% is below the set standard of 30%

Background
The target for combined emergency and elective LSCS levels has been agreed by the NE &Y Regional Perinatal Quality Oversight Group as 13% for Elective LSCS and 17% for Emergency LSCS, combined limit at 30%.
The Health and Social Care Committee Report on The Safety of Maternity Services in England (July 2021) recommended an immediate end to the use of total Caesarean Section percentages as a metric for maternity services, and that this is replaced by using the Robson criteria to measure Caesarean Section rates more intelligently.
NHS England and Improvement notification to all maternity units to ensure that they are aware of this changes around LSCS performance targets. (Feb 2022).

Assessment
The elective LSCS rate in January was 16.4% which is a increase to above the target rate of <13%, but combined with a lower emergency LSCS rate in December at 13.3%% keeps the overall rate within the upper control limit of 30%. This was the third consecutive month of a significantly higher number of births compared to the last financial year.

Actions
LSCS and Emergency LSCS rates are monitored monthly and triangulated with other indicators such as term admissions and post-partum haemorrhage to identify any quality or performance issues.
Maternity service dashboard to be changed to reflect the Robson criteria as reported to the MDS and National Maternity Dashboard.

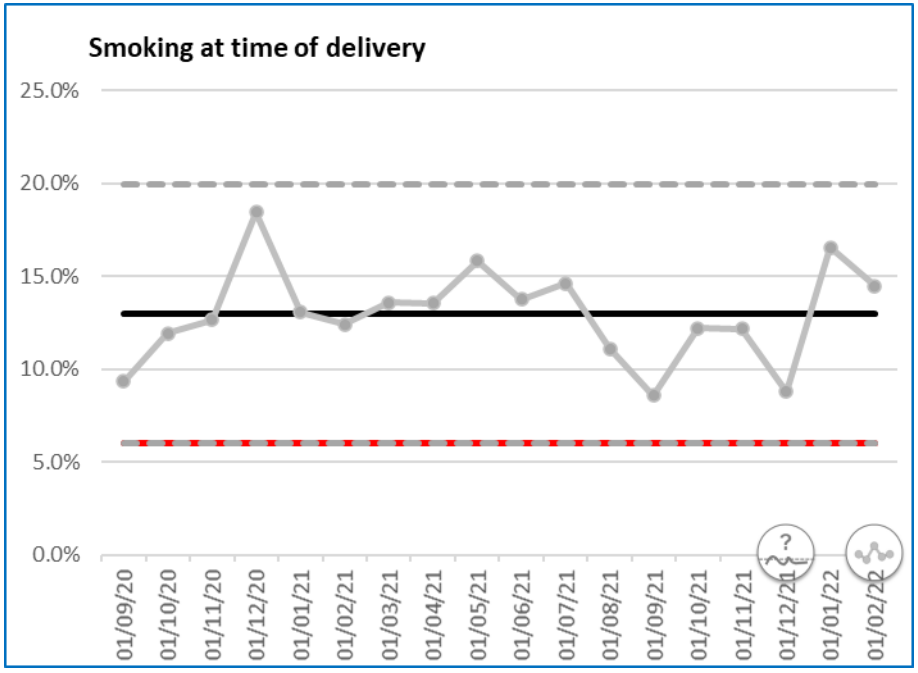
Recommendation
Assessed as common cause variation.

Report by exception: Maternity – Smoking at time of delivery

Detail on this measure is included because the target will either be achieved or failed based on variation within the performance.

Gateshead Health NHS Foundation Trust

Maternity



Combined impact analysis

Financial impact

Quality impact

Workforce impact

Operational performance impact

Situation Common cause variation is displayed
The target has not been achieved in the last 18 months

Current performance of 14.5% is above the Trust target.

Background
Strategic/LTP aim to achieve 5% or less women tobacco dependant at time of birth by 2025.
Embed enhanced stop smoking support and NRT as per ambitions of the NHS LTP through maternity provision. Support and enhance the ICS Tobacco Dependency in Pregnancy pathway to maximise support to those with highest health inequalities.

Lead Midwife appointed with MSW funding to support. Smoke Free leads appointed and plans in place to target mothers who smoke and their partners in high risk clinics in WHC..

Assessment
Working towards compliance with Saving Babies Lives Care bundle and compliance with MIS year 4 which includes access to smoking referral pathways and improved training and dedicated smoking cessation leads.

Monthly reporting of CO monitoring. Appointment of PH leads and smoking cessation Band 3 in process.

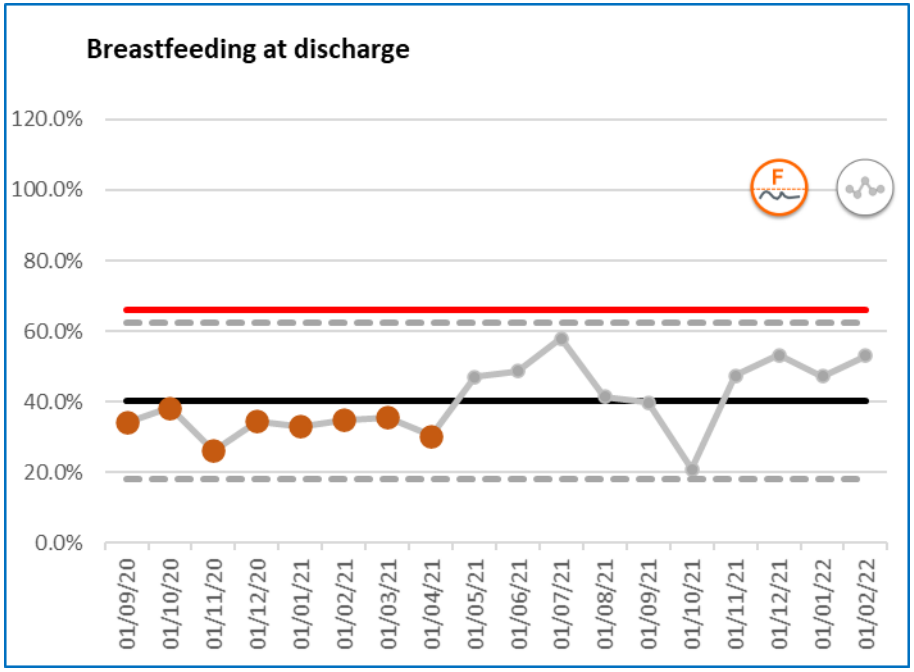
Recommendation
PH plans in place to address KPI's

Report by exception: Maternity – Breastfeeding at discharge

Detail on this measure is included because the target will either be achieved or failed based on variation within the performance.

NHS Gateshead Health NHS Foundation Trust

Maternity



Combined impact analysis

Financial impact

Quality impact

Workforce impact

Operational performance impact

Situation

Better Births (2016), the Maternity Transformation Programme and the NHS Long Term Plan (2019) highlight the importance and benefits of breastfeeding. There is a regional breastfeeding target to achieve of 72% by 2025, currently the department initiation rate 66.2% in January 2022.

Background

As part of the NHS's ongoing vision to improve postnatal care, the Long Term Plan includes a commitment to support maternity services to deliver an accredited, evidence-based infant feeding programme (such as the UNICEF UK Baby Friendly Initiative.)

The targets are set as:

100% of units at UNICEF level 2 by 2020

100% of units at UNICEF level 3 by 2025

Assessment

Gateshead Health NHS Foundation Trust is accredited at Level 1 and is eligible for Level 2 support: accreditation assessment costs and additional support. UNICEF Breastfeeding & Relationship Building Course facilitated - March, and we are planning to meet up to discuss commencing the relevant UNICEF audits.

The maternity infant feeding guidelines were assessed as part UNICEF stage 1 accreditation in September 2019 and will be due to be reviewed again in the summer. SCBU planning for level 1 accreditation will start with review of infant feeding guidelines to review.

Actions

Monthly face to face UNICEF staff training and Practical Skills Review's re-commenced from October 2021.

Working towards stage 2 accreditation July 22.

Recommendation

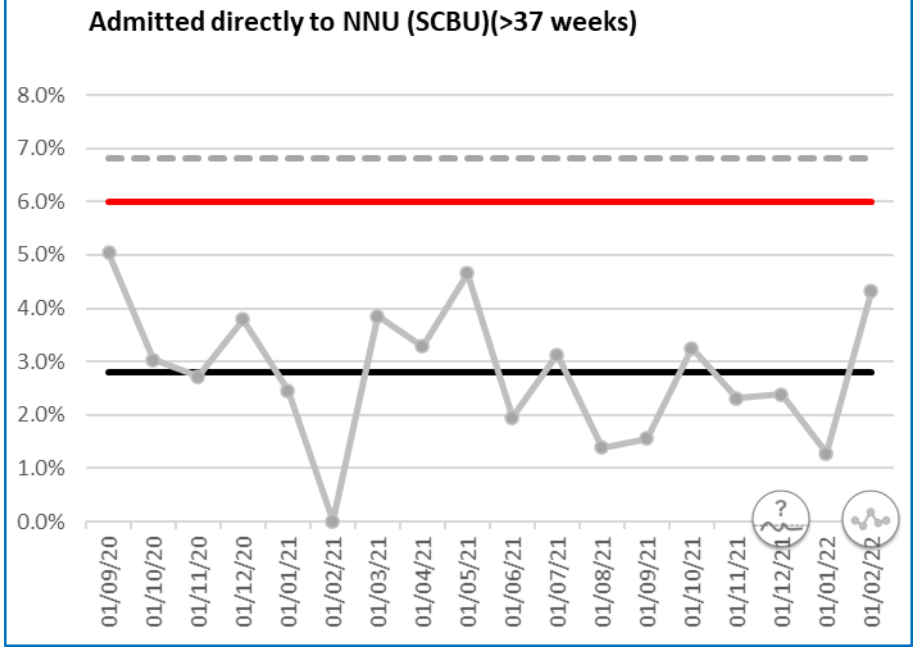
There will always be some mothers who do not continue to fully breast feed for various reasons. A full review of target indicators will be part of Maternity Sub group reporting and benchmarked regionally with the NENC Infant feeding leads.

Report by exception: Maternity – Admitted directly to NNU >37 weeks

Detail on this measure is included because the target will either be achieved or failed based on variation within the performance.

NHS Gateshead Health NHS Foundation Trust

Maternity



Combined impact analysis

Financial impact

Quality impact

Workforce impact

Operational performance impact

Situation Common cause variation displayed
The target has been achieved for every month in the last 18 months .
Current performance of 4.3% represents an achievement of the Trust target.
On target to achieve Year 4 MIS safety action.

Background
Our transitional care model enables babies who would have once been admitted to SCBU to remain with their mothers and be supported on the postnatal ward with input from the Neonatal nurse practitioners and maternity support workers. This reduces SCBU admissions and enables mother and baby bonding.

Assessment
KPI set at 6% for direct term admissions to SCBU by NE&Y Regional Perinatal Quality Oversight Group. Local dashboard amended to reflect this and targets met.

Actions
Quarterly audit of all term admissions ongoing and themes and trends reviewed at Perinatal Mortality meeting.
This KPI is also reported as compliance with Safety Action 3 of MIS year 4 and the Maternity service declared compliance with Year 3 in July 2021.
Working towards Year 4 and on target for compliance.

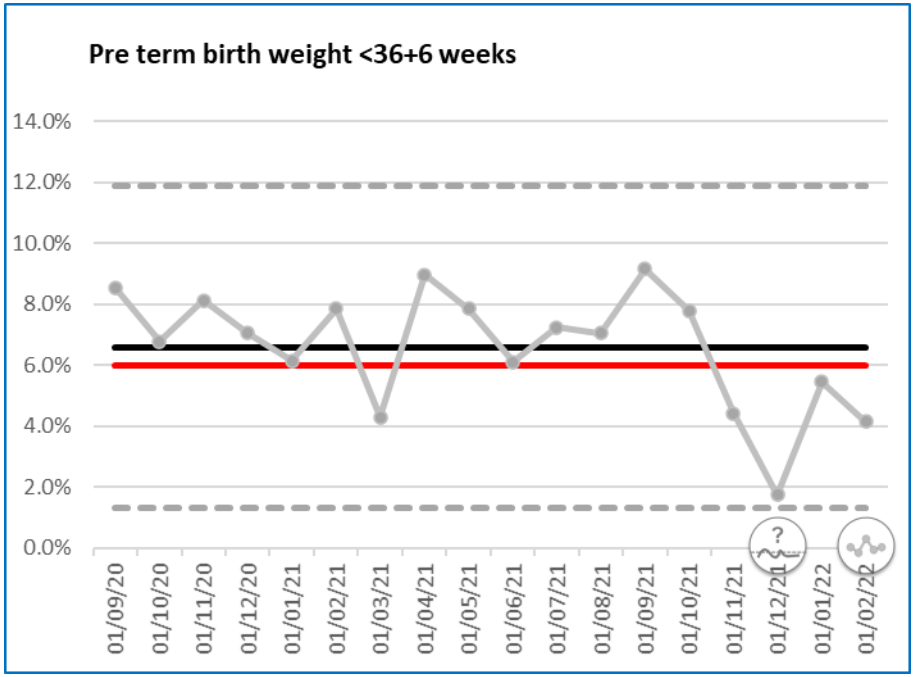
Recommendation
Review of transitional care staffing and succession planning for development of the ANNP role as without this the model will not function.

Report by exception: Maternity – Pre term birth rate <36+6 weeks

Detail on this measure is included because the target will either be achieved or failed based on variation within the performance.

NHS Gateshead Health NHS Foundation Trust

Maternity



Combined impact analysis

Financial impact

Quality impact

Workforce impact

Operational performance impact

Situation Common cause variation displayed
The target has been achieved in four of the last eighteen months.

Current performance of 4.4% represents a pass of the Trust target.

Background
The DoH report "Safer Maternity Care" (2017) set a target to reduce the national rate of pre-term birth from 8% to 6%

Assessment
Data capture of any pre-term births (definition; delivery prior to 37 weeks gestation**) is monitored and reported.**

Actions
Engagement with regional preterm birth network including allocated funding to provide specialist pre-term birth clinic – metrics to be reported to NENC LMNS
Engagement with MatNeoSIP national pre-term birth optimisation pathway
Implementation of Saving Babies Lives v2 care bundle (element 5 relates to preterm birth)
Trust preterm birth quarterly meetings commenced, lead midwife & HCA in post & additional fetal fibronectin machine to be purchased utilising LMNS funding, sonographer hours to be submitted to Trac

Recommendation
Continue to engage & monitor outcomes following full implementation of these work streams. Reported to the Neonatal Network.

Gateshead Health
NHS Foundation Trust

Report Cover Sheet Agenda Item: 16

Report Title:	**Nursing Staffing Exception Report**			
Name of Meeting:	Board of Directors – Part 1			
Date of Meeting:	30 March 2022			
Author:	Karen Roberts, Deputy Director of Nursing Laura Edgar, People Data and Information Lead			
Executive Sponsor:	Gillian Findley, Chief Nurse and Professional Lead for Midwifery and AHPs			
Report presented by:	Gillian Findley, Chief Nurse and Professional Lead for Midwifery and AHPs			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☒
	This report is to provide assurance to the Board that staffing establishments are being monitored on a shift-to-shift basis.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	Quality Governance Committee			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	This report provides information relating to ward staffing levels (funded against actual) and details of the actions taken to address any shortfalls. February continued with significant staffing challenges as we move into recovery of elective programmes. The organisation continued to manage the COVID-19 activity that impacted on staffing resource and the clinical operating model. Significant staffing challenges remain due to vacancies and we continue focused work around the recruitment and retention of staff. Wards where staffing fell below 75% of the funded establishment are shown within the paper. Detailed context and actions taken to mitigate risk are documented. A staffing escalation protocol is now in operation across all areas within the organisation and assurance of this operating as expected is provided by the			

<table>
<tr><td></td><td colspan="5">number of staffing incident reports raised within the Datix system.

Ongoing concentrated work continues within the safe staffing Task and Finish Group to review staffing establishments, managing sickness absence, recording and escalation of staffing challenges. Regular updates are shared with the executive team as the group progresses.</td></tr>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="5">The Board are asked to:
receive the report for assurance
note the work being undertaken to address the shortfalls in staffing</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
☒</td><td colspan="4">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☒</td><td colspan="4">We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3
☒</td><td colspan="4">We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4
☐</td><td colspan="4">We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5
☐</td><td colspan="4">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Trust corporate objectives that the report relates to:</td><td colspan="5"></td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
☒</td><td>Responsive
☒</td><td>Well-led
☐</td><td>Effective
☒</td><td>Safe
☒</td></tr>
<tr><td colspan="6">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks and DATIX reference)</td><td colspan="5">There were 6 safe staffing incidences raised via datix throughout the month of February. From these 6 incidences there was no patient harm identified.</td></tr>
<tr><td>Has a Quality and Equality Impact Assessment (QEIA) been completed?</td><td colspan="2">Yes
☐</td><td colspan="2">No
☐</td><td>Not applicable
☒</td></tr>
</table>

Gateshead Health NHS Foundation trust
Nursing and Midwifery Staffing Exception Report
February 2022

1. Introduction

2. Staffing

The actual ward staffing against the budgeted establishments for February are presented in Table 1. Whole Trust wards staffing are presented within this report in appendix 1, broken down into each ward areas staffing. In addition, the Trust submit monthly care hours per patient day (CHPPD) as a national requirement to NHS Digital.

Table 1: Whole Trust wards staffing February 2022

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 (%)
83.9%	109.0%	93.0%	115.4%

The Trust is required to present information on funded establishments (planned) against actual nurses on duty. The above figures are average fill rates and thus do not reflect the daily challenges experienced during COVID pandemic and operational pressures to maintain adequate staffing levels.

Exceptions:
The guidance on safe staffing requires that 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, Gateshead Health NHS Foundation Trust reports to the Board if the planned staffing in any area drops below 75%.

A Safer Nursing Care Tool (SNCT) data collection was undertaken throughout the month of January and will be triangulated with key performance indicators and professional judgement templates in line with the National Staffing review from the National Quality Board. The outcome and recommendations from this review will be presented at Trust Board in April.

Contextual information and actions taken

Critical care department have shown low fill rates due to lower bed occupancy rates accompanied by higher sickness absence rate, at 17.5%. There are currently 3.7 registered WTE vacancies within the department and continuous active recruitment into the department remains.

JASRU continue to have significant vacancy rates, equating to 3.92 WTE registered staff. JASRU continue to support ward 12 medicine with two registered staff.

Ward 8 demonstrates ongoing reduced registered fill rates as they continue to support areas across the trust with 2.85 WTE registered staff. The ward also supports acute outpatient services which are currently under review.

Ward 9 is currently running at reduced bed capacity due to maintaining 2m distance between bed space in bays following covid outbreak in January. They also currently have 5.66 WTE registered nurse vacancies.

Ward 11 are also operating at a reduced bed capacity following an outbreak at the beginning of February. They had a period of closure where staff were redeployed to support other clinical areas within the Trust.

Ward 22 have experienced higher sickness absence rates in February, accumulating to 9.9% within the area. They also demonstrate significant registered nurse vacancies, requiring 6.5 WTE to meet the establishment model.

Cragside have experienced an above target registered nurse sickness absence at 13.69% for February. They have also had a significant reduction in bed occupancy.

The exceptions to report for February are as below:

February 2022	
Qualified Nurse Days	**%**
Cragside Court	66.3%
Critical Care Dept	73.3%
JASRU	69.0%
Ward 08	70.2%
Ward 09	61.6%
Ward 11	73.6%
Ward 22	65.0%
Qualified Nurse Nights	**%**
N/a	
Healthcare Assistant Days	**%**
N/a	
Healthcare Assistant Nights	**%**
N/a	

In February the Trust worked to the agreed clinical operational model which meant at times some wards listed above had lower patient occupancy and staff were redeployed appropriately to areas with the greatest clinical need. Throughout February, areas of deficit were escalated as per staffing policy and mitigations were put in place by the Matron teams using professional judgement as to the acuity and demand in each area which included:

- Redeployments of Registered Nurses and HealthCare assistants on a daily and at times hourly basis between wards according to patient acuity and demand.
- Concentrated support from the Matrons and the People and Organisational Development team to address the sickness absence levels within the divisions and to recruit to vacant posts.

3. Care Hours Per Patient Day (CHPPD)

Following the Lord Carter Cole report, it was recommended that all trusts start to report on 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)

Ward level CHPPD is outlined in Appendix 1. For the month of February, the Trust total CHPPD was 8.3. This compares favourably when benchmarked with other peer reviewed hospitals.

4. 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 discussed at the Nursing and Midwifery Professional Forum. This report helps identify areas where nurse staffing may have fallen below planned levels and what actions were taken to manage the situation.

There were 6 staffing incidents in February. Of the identified staffing incidents within February, there were no patient harms relating to reduced staffing numbers.

The numbers of staffing incidents are an effect of the Global COVID19 pandemic and subsequent government guidelines around self-isolation when staff have tested positive or had significant contact throughout the 4th wave of COVID 19.

5. Governance

Actual staff on duty on a shift to shift basis compared to planned staffing is displayed on the ward boards alongside key quality and outcome metrics i.e. safety thermometer; infection measures.

6. Conclusion

This paper provides an exception report for nursing and midwifery staffing in February 2022.

7. Recommendations

The Board is asked to receive this report for assurance.

Gill Findley

Appendix 1- Table 3: Ward by Ward staffing February 2022.

	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
Wards 1 & 2	86.5%	115.8%	75.4%	110.4%	1238	5.8	4.0	9.9
Ward 4	99.1%	77.7%	96.7%	146.8%	750	2.8	3.1	5.9
Ward 8	70.2%	99.4%	101.6%	103.0%	573	3.3	3.1	6.4
Ward 9	61.6%	93.4%	86.9%	123.9%	590	3.5	3.3	6.8
Ward 10	77.8%	133.7%	80.7%	120.8%	460	3.4	4.6	8.0
Ward 11	73.6%	98.8%	98.4%	109.0%	477	3.3	4.0	7.4
Ward 12	89.7%	215.4%	105.6%	143.1%	671	2.4	3.7	6.1
Ward 14 Medicine	76.4%	115.4%	102.2%	132.3%	562	2.9	3.8	6.7
Ward 14A	80.4%	119.8%	94.8%	95.0%	508	3.4	4.6	8.0
Ward 21	77.5%	93.9%	93.1%	107.4%	236	5.9	6.1	12.0
Ward 22	65.0%	101.4%	102.1%	93.9%	681	2.4	3.6	6.0
Ward 23	92.3%	124.9%	105.5%	113.6%	607	2.8	4.2	7.1
Ward 24	79.7%	111.1%	114.7%	116.0%	800	2.4	3.6	5.9

	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 25	86.1%	96.2%	116.2%	113.1%	834	2.4	3.0	5.5
Ward 26	84.5%	153.8%	126.1%	130.9%	743	2.8	4.2	7.1
Ward 27	76.9%	106.2%	111.2%	114.8%	784	2.4	3.0	5.4
Cragside Court	66.3%	107.3%	90.6%	168.6%	275	5.0	8.2	13.2
Critical Care	73.3%	91.9%	83.2%	89.4%	232	25.8	4.6	30.4
JASRU	69.0%	75.5%	102.1%	103.9%	521	3.0	3.8	6.8
Maternity	115.1%	127.7%	89.8%	98.1%	547	11.5	4.5	16.0
Paediatrics	117.5%	91.5%	105.2%		39	54.2	12.0	66.2
SCBU	89.5%	122.3%	94.7%	92.9%	160	9.4	3.7	13.1
St Bedes	104.0%	104.2%	98.9%	147.8%	235	6.2	5.3	11.5
Sunniside	114.9%	87.8%	115.1%	102.0%	252	7.3	3.7	11.0
QUEEN ELIZABETH HOSPITAL - RR7EN	**83.9%**	**109.0%**	**93.0%**	**115.4%**	**12775**	**4.4**	**3.9**	**8.3**

Meeting:	Trust Board
Chair:	Alison Marshall
Financial year:	2021/22 and 2022/23

	Lead	Type of item	Public/Private	Mar-22	April 22 (ext)	May-22	June 22 (ext - TBC)	Jul-22	Sep-22	Nov-22	Jan-23	Mar-23
Standing Items			Part 1 & Part 2									
Apologies	Chair	Standing Item	Part 1 & Part 2	√		√	√	√	√	√	√	√
Declaration of interests	Chair	Standing Item	Part 1 & Part 2	√		√	√	√	√	√	√	√
Minutes	Chair	Standing Item	Part 1 & Part 2	√		√		√	√	√	√	√
Action log	Chair	Standing Item	Part 1 & Part 2	√		√		√	√	√	√	√
Matters arising	Chair	Standing Item	Part 1 & Part 2	√		√		√	√	√	√	√
Chief Executive's Update Report	Chief Executive	Standing Item	Part 1 & Part 2	√		√		√	√	√	√	√
Cycle of Business	Company Secretary	Standing Item	Part 1 & Part 2	√		√	√	√	√	√	√	√
Patient & Staff Story	Company Secretary	Standing Item	Part 1	√		√		√	√	√	√	√
Questions from Governors	Chair	Standing Item	Part 1	√		√		√	√	√	√	√
Items for Decision			Part 1 & Part 2									
Annual Declarations of Interest	Company Secretary	Item for Decision	Part 1	√								√
Trust Strategic Aims & Objectives	Chief Executive	Item for Decision	Part 1	√		√						√
Board Assurance Framework - approval of closing and opening position	Company Secretary	Item for Decision	Part 1	√		√						√
Standing Financial Instructions & Delegation of Powers	Company Secretary / Group Director of Finance	Item for Decision	Part 1			√						
Calendar of Board Meetings	Company Secretary	Item for Decision	Part 1									
Winter Plan	Chief Operating Officer	Item for Decision	Part 1						√			
Constitution and Standing Orders - annual review	Company Secretary	Item for Decision	Part 1			√						
Board Committee Terms of Reference - Ratification	Company Secretary	Item for Decision	Part 1									
Board Committee Annual Reviews of Effectiveness and Terms of Reference Update	Company Secretary	Item for Decision	Part 1			√						
Items for Assurance			Part 1 & Part 2									
Board Committee Assurance Reports	Committee Chairs	Item for Assurance	Part 1	√		√		√	√	√	√	√
Corporate Objective Delivery	Company Secretary	Item for Assurance	Part 1	√		√			√		√	
Board Assurance Framework	Company Secretary	Item for Assurance	Part 1			√			√		√	
Organisational Risk Register	Chief Nurse	Item for Assurance	Part 1	√		√		√	√	√	√	√
Annual Staff Survey Results	Exec Director of People & OD	Item for Assurance	Part 1	√								√
Finance Report	Group Director of Finance	Item for Assurance	Part 1 & Part 2	√		√		√	√	√	√	√
Integrated Oversight Report	Chief Operating Officer	Item for Assurance	Part 1	√		√		√	√	√	√	√
Nurse Staffing Exception Report	Chief Nurse	Item for Assurance	Part 1	√		√		√	√	√	√	√
Nurse Staffing Annual Capacity & Capability Report	Chief Nurse	Item for Assurance	Part 1			√					√	
Learning from Deaths (6 monthly report)	Medical Director	Item for Assurance	Part 1			√				√		
SIRO Report & Digital Update	Group Director of Finance	Item for Assurance	Part 1			√			√			√
EPRR Core Standards Self-Assessment Report	Chief Operating Officer	Item for Assurance	Part 1						√			
CNST Maternity Compliance Report	Medical Director	Item for Assurance	Part 1			√						
Sustainable Development Management Plan	QEF Managing Director	Item for Assurance	Part 1			√						
QEF 6 monthly update report	QEF Managing Director	Item for Assurance	Part 1			√				√		
Freedom to Speak Up Guardian Report	Exec Director of People & OD	Item for Assurance	Part 1					√			√	
Improving People Practices Update	Exec Director of People & OD	Item for Assurance	Part 1					√			√	
WRES and WDES Report (6 monthly report)	Exec Director of People & OD	Item for Assurance	Part 1	√		√			√			√
Quality Accounts Priorities 6 monthly update	Chief Nurse	Item for Assurance	Part 1							√		
People's Plan Briefing (dependent upon national publication)	Exec Director of People & OD	Item for Assurance	Part 1									
Items for Information			Part 1 & Part 2									
Ad Hoc Items (i.e. items emerging during the year)			Part 1 & Part 2									
Trust Green Plan 2022-2025 annual updates	QEF Managing Director	Item for Assurance	Part 1	√								√
Charitable Fund Board												
Charitable Funds Audited Financial Performance	Group Director of Finance	Item for Board of Trustees									√	
Charitable Funds Annual Objectives (TBC)	Group Director of Finance	Item for Board of Trustees										